ONE

Introduction

> Inequality in health is the worst inequality of all. There is no more serious inequality than knowing that you'll die sooner because you're badly off. (Frank Dobson/DoH, 1997a)

This book examines and explains a simple fact: that at the end of the 20th century inequalities in health are extremely wide and are still widening in Britain. These inequalities are shown most clearly through the premature deaths of hundreds of thousands of people living in this country over the last two decades. We argue that such inequalities are patently unfair and that inequalities in health are the direct consequence of inequalities in wealth and the growth of poverty in Britain. We also propose that policies to reduce poverty would reduce inequalities in health and that without such fundamental policies we can only expect inequalities in health to continue to widen. However, before we present the evidence of the health gap in Britain, how it has been widening, and, most importantly, what we think should be done about it, it is appropriate to first consider the context of health inequalities and policy in Britain over the past two decades.

From the Black Report to the Independent Inquiry into Inequalities in Health

At the end of the 1970s the previous Labour government appointed Sir Douglas Black to chair a working group to review the evidence on inequalities in health and to suggest policy recommendations that should follow. The report was published (DHSS, 1980) – although with no press release and only 260 copies initially printed. Under the incoming Conservative government in 1980 the Report received a cold reception. A subsequent edition published by Penguin, however, made the findings widely available, and it was later published in conjunction with a later report *The health divide*, which updated the findings (Townsend and Davidson, 1988). The major finding of the Black Report was that there

were large differentials in mortality and morbidity that favoured the higher social classes, and that these were not being adequately addressed by health or social services. The Report presented a number of costed policy suggestions, and concluded:

> Above all, we consider that the abolition of child poverty should be adopted as a national goal for the 1980s. (Townsend and Davidson, 1988, p 206)

However, the political will to implement the necessarily redistributive policies that would achieve this goal did not exist at the time. For 17 years in opposition the Labour government made political capital out of the non-implementation of the suggestions of the Black Committee. Before they were elected in May 1997, it was announced that, if elected, Labour would commission an Independent Inquiry into Inequalities in Health, which it duly did in July of 1997, under the chairmanship of Sir Donald Acheson (a former chief medical officer). Tessa Jowell, the Minister for Public Health, criticised the previous administration for "its excessive emphasis on lifestyle issues" which "cast the responsibility back onto the individual" (Jowell/DoH, 1997a). However, despite a commitment that the report of the Inquiry Committee "based on evidence, will contribute to the development of a new strategy for health" (*Independent Inquiry into Inequalities in Health*, 1998) there was also the stipulation that its recommendations should fall within the broad framework of the government's overall financial strategy (see Box 5.1 in Chapter 5). This strategy included maintaining the overall fiscal plans of the previous Conservative administration, at least for the first two years of office.

The report of the Independent Inquiry into Inequalities in Health was published, after some delay, at the end of November 1998. The report contained a comprehensive review of current knowledge on the extent and trends in health inequalities and contained a raft of policy recommendations, many not dissimilar to those in the Black Report. Despite this, however, three key criticisms were levied at the report (Davey Smith et al, 1998a). The first was that there was not adequate prioritisation among the 39 sets of recommendations. Thus the fundamental role of poverty and income differentials was lost in a sea of (albeit worthy) recommendations ranging from traffic curbing to the fluoridation of the water supply.

The second, and related, criticism of the Inquiry's report was that many of the recommendations were simply too vague and de-

contextualised from the contemporary policy and political agendas to be useful. For example, greater use of and access to public transport was advocated without reference to the price-increasing effects of recent privatisation policies.

The third set of criticisms of the report related more directly to the implementation of the recommendations: the costing of the suggested policies. As the recommendations of the Acheson Report (unlike the Black Report) were not costed, it is impossible to weigh up the costs, benefits and opportunity costs of implementation or inaction. It is thus also impossible to judge the extent to which these suggestions are 'cost-effective' (whatever this was intended to mean), as the remit for the Inquiry requested. (Costings of the recommendations of the Black Report, by the original authors of that report, for both 1982 and 1996 prices, are presented in the Foreword to this book.)

Reducing inequalities in health

Despite its shortcomings, the presence of the Independent Inquiry emphasised the centrality of the issue of health inequalities. The reduction of inequalities in health, and reducing inequalities in general, are core concerns of the Labour government. The government pledged to eliminate childhood poverty by 2019. The Green Paper, *Our healthier nation* (DoH, 1998a) – published before the Inquiry's report – had as one of its aims:

> ... improving the health of the worst off in society and narrowing the health gap.

And the Prime Minister himself pledged:

> I believe in greater equality. If the next Labour Government has not raised the living standards of the poorest by the end of its time in office it will have failed. (Tony Blair, 1996, quoted in Howarth et al, 1998, p 9)

However, the strategy that the Labour government has adopted in order to pursue this goal was somewhat different to that which we might have expected before the 1997 General Election. In *Scotland: The real divide* (1983), on the issue of inequality, Gordon Brown and Robin Cook wrote the following:

> This [attaining greater equality] would mean restoring to the centre of the tax system two basic principals: the first, that those who cannot afford to pay tax should not have to pay it; and the second, that taxation should rise progressively with income. Programmes that merely redistribute poverty from families to single persons, from the old to the young, from the sick to the healthy, are not a solution. What is needed, is a programme of reform that ends the current situation where the top 10% own 80% of our wealth and 30% of income, even after tax. As Tawney remarked, 'What some people call the problem of poverty, others call the problem of riches'. (Brown and Cook, 1983, p 22)

A statement by government Minister Stephen Byers showed how the Labour Party has moved away from this notion of redistribution through direct taxation over the last 16 years:

> The reality is that wealth creation is now more important than wealth redistribution. (Stephen Byers, Minister for Trade and Industry, quoted in Jones, 1999)

New Labour believed that the income raised from economic growth could be used to eradicate poverty, and that redistribution as we have known it in the past – through increasing the tax burden of the better-off and raising benefits and incomes in real terms for the poorer – should no longer be seen as the key policy option.

Instead, policies focused on getting people into work or increasing the incomes of those already in work (eg Welfare to Work, the Minimum Wage, Working Families Tax Credit) were welcomed. However, as we show in this book, the majority of those living on very low incomes are not in work and could not take work even if more work were available (because they are caring for children and other dependants or are over retirement age). Policies which target only a small proportion of the population (eg Health Action Zones, Employment Action Zones, Sure Start) will only reach a small proportion of those in need. In addition, bringing pensions and benefit changes in line with changes in average earnings does not reduce inequalities, it simply maintains them. It is therefore our concern that the Labour government elected in 1997, while laudable in its aims, will not have a substantial effect on inequalities in Britain.

The widening gap

This book is driven by our concern about the increasing inequality of health outcomes. In the following four chapters we present our own review of the current extent of health inequalities in Britain and what should be done about them.

Chapter 2 presents new evidence of the extent of the health gap. The Black Report and its successor contained a vast array of evidence, but we update this further. For example, whereas the report of the Independent Inquiry referred to mortality by social class for the years 1991-93, we include data referring to the period 1992-96. These data show that the social class mortality gap is even wider than previously thought. For instance, the life expectancy gap between men in social class I (professional occupations) and social class V (unskilled manual occupations) is now a staggering 9.5 years; for women it is 6.4 years (Hattersley, 1999). The health gap between different communities also widened as the Acheson Committee was sitting (the Inquiry did not address geographical inequalities).

We also have a broader scope, in that we include a geographical dimension in our analysis. We present the first geographical data on mortality at the constituency level for the whole of Britain. We compare the fortunes of people living in the constituencies containing the one million people with the highest mortality rates, with the fortunes of the one million people in constituencies with the lowest mortality rates. The difference is such that death rates for the 'worst health' million are 2.6 times those for the 'best health' million. Had the mortality ratios of the 'worst health' million been the same as the 'best health' million then 62% of the deaths under 65 would not have occurred in the period 1991-95. We compare these 'best health' and 'worst health' constituencies as we consider the health gap and the socio-economic gap which underlies it through different stages of the life-course. We show how in contemporary Britain unequal chances of death are interwoven, in social and spatial terms, with unequal chances in life, in terms of education, employment, income and wealth.

In Chapter 3 we move beyond description of the health gap and review explanations for the health gap and the evidence for these. We show how recent research has demonstrated that social circumstances across the entire life-course – from birth through to late adulthood – influence people's health and well-being. In addition, the characteristics of the areas in which people live, as well as their individual characteristics, are shown to be important in influencing their health. While factors

such as education and behaviours such as smoking are important factors in producing health inequalities, we show that health differentials are primarily related to the long-term material well-being of social groups, not to the psychosocial effects of position in hierarchies. Reduction of inequalities in health cannot be brought about by people feeling better about their (unfair) lot in the world – only the redistribution of material resources will produce such a reduction.

In Chapter 4, we present evidence of the extent to which the social and spatial health gap in Britain has widened over the past two decades, and that this polarisation has mirrored socio-economic widening, primarily in the form of increased income inequality and increased poverty. Britain has experienced some of the fastest growth in income inequality in the developed world and by the late 1990s had some of the highest levels of poverty seen within Europe. We also demonstrate that widening inequality is not inevitable and that these differentials narrowed in the 1960s and 1970s. Just as the gap can widen, so it can narrow. This chapter illustrates the possible consequences of inadequate policies. The trends of growing inequality show no signs of abating and the consequences of such a widening gap are dire.

In the final chapter we present the policy options that we consider to be essential if inequalities in health are to be tackled. We also address the convoluted policy debate on inequalities in health. Here we have a simple message: the key policy that will reduce inequalities in health is the alleviation of poverty through the reduction in income and wealth inequality. We show how there is widespread public support for poverty reduction in Britain. We argue that poverty can be reduced by raising the standards of living of poor people through increasing their incomes ‘in cash’ or ‘in kind’. The costs would be borne by the rich and would reduce inequalities overall – simultaneously reducing inequalities in health. It is our firm belief that if the health inequalities which are described and explained in this book are to be reduced, as is the stated aim of the government, then policies which actively and actually address the reduction of poverty and the reduction of inequality through redistribution must be pursued.

In short the structure of this book has been made as simple as possible. We produce evidence that the extent of the health gap is wider than official reports suggest (Chapter 2). We present the most up-to-date evidence of the causes of those inequalities in health (Chapter 3). We provide clear statistical evidence as to how the health gap is continuing to widen, but how it has not always done so (Chapter 4). And we have prepared and argued for an alternative policy agenda (Chapter 5), which,

if you accept the overall picture presented in earlier chapters, would narrow the health gap.

TWO

The health gap

Summary

This chapter provides evidence of the geographical and social inequalities in health in contemporary Britain. We compare the extreme areas of Britain – using parliamentary constituencies as the geographical unit – with the lowest and highest premature mortality. We compare life chances in these areas through stages of the life-course:

- Infant mortality is 2.0 times more likely in the 'worst health' compared to the 'best health' constituencies.
- In the 'worst health' constituencies 4.2 times as many households with children live in poverty compared to the 'best health' constituencies.
- In the 'worst health' constituencies GCSE failure rates are 1.5 times higher and post-school qualifications are half the rate of those in the 'best health' constituencies.
- There are more people in social classes IV and V and less in social classes I and II in the 'worst health' constituencies than the 'best health' constituencies but this only partially accounts for the health differences between those areas.
- The 'worst health' constituencies have 3.6 times as many people not working and 2.8 times as many people with a limiting long-term illness as compared to the 'best health' constituencies.
- Average household incomes in the 'worst health' constituencies are 70% of those in the 'best health' constituencies.
- The 'best health' constituencies have 9.1 times more households with 3 or more cars and 6.5 times more households with 7 or more rooms than the 'worst health' constituencies.
- In the 'worst health' constituencies women aged 75-84 are 60% less likely to be married than those in the 'best health' constituencies because men there are more likely to die relatively early in life.