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Inequality Downturn

Danny Dorling

"Health inequality getting worse, Alan Johnson admits" ran the headline in the Guardian Newspaper on 9 June this year. Alan Johnston is an able government minister. He knows when not to keep digging. He knows to admit when things are not going well.

Three years ago, a previous government minister, one whose remit included public health, had claimed something very different. Writing to the British Medical Journal on 9 September 2005, Caroline Flint declared: "We are determined to reduce health inequalities. The [inequalities] report showed that we are moving in the right direction and highlighted the further work that needs to be done."

Clearly, in hindsight, government was not moving in the right direction back then, nor had it been for many years. Government does, however, have a traditional trick of suggesting that, at any moment now things are going to get better, the data is just a little bit old, signs of a turn around are in the air, we are spending so much, caring so much, so committed, and so on.

Ms Flint's letter, published online by the British Medical Journal in 2005, continued: "However, the report's data dated back to 2003. Last November, we published the Choosing Health White Paper aimed at improving health and tackling health inequalities. Health trainers are one of many initiatives in Choosing Health which will help narrow the inequalities gap by helping people to make healthier choices in their daily lives. Infant mortality rates, a key indicator of health inequalities, have fallen in the "routine and manual" group as well as the total population. Government action including Sure Start, better neonatal services, stop smoking services, breastfeeding campaigns are all having an impact. Progress is slower in more disadvantaged areas which is why spearhead primary care trusts are piloting many of the key Choosing Health recommendations, including health trainers, in those areas. Health inequalities are and will continue to be a government priority."

They may have been a priority, but clearly they were not enough of a priority. As far as I can tell with the historic data on geographical inequalities in health, all previous Labour (and before them twentieth century Liberal) governments have presided over periods of falling health inequalities between areas and falling social divisions in infant mortality rates. It is very hard to believe that this occurred simply by chance. I suspect it happened because

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previous governments that called themselves progressive valued people more and markets less.

Where are the people who deliberately did not "choose health", to use Caroline's branding? They were disproportionately born, grew up and lived in the parliamentary constituencies of Labour MPs. The highest proportions failed to "choose health" in the constituencies of government ministers, because government ministers tend to be ambitious MPs who are good at securing themselves nominations for safe parliamentary seats.

One of the highest number of people who did not "choose health" are the 1,000 people who are no longer able to vote in the constituency of Hazel Blears who would not have died before age 65 since 1997 had Labour achieved their initial targets to reduce health inequalities. It is possible to count up the numbers of voters who died early, due to government failing to meet its inequality narrowing ambitions, in all members of parliament's seats (*).

Health inequalities in Britain did not rise because people chose not to be healthy or because people chose poverty but because others chose greed, or allowed greed to flourish, were seriously relaxed about greed or thought somehow the encouragement of greed was good. The greatest improvements in health as measured through falls in mortality since 1997 occurred in those areas where people disproportionately voted Conservative back in that year.

Labour health ministers have repeatedly talked the talk. "There can be no more chilling form of inequality than someone's social status at birth determining the timing of their death," said the health secretary Alan Johnson in a speech on 12 September 2007. He added that "a man living in Manchester is likely to die almost nine years before a man living in the Royal Borough of Kensington & Chelsea".

If anything, Johnson's figures understated the extent of health inequalities as understood then. In November 2006, the Office for National Statistics reported that the life expectancy gap between these two extreme districts of England had grown to 9.7 years. The widest gap for men was between Glasgow and Kensington & Chelsea—a record high of 12.3 years. The problem is not just the size of health gap but the rapid rate at which it was and still appears to be growing. And those rising inequalities in health reflect our growing inequalities in wealth. Or at least did until the economic events of the summer of 2007 and subsequent probable falls in wealth inequalities.

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It is often claimed by those in power with responsibilities to reduce inequalities in health that there are huge time lags involved between social interventions and health outcomes. These are, however, rarely quantified. Clearly, programmes which are successful in reducing smoking rates amongst the poorest will see most of the benefit in terms of reduced mortality in years far into the future.

But they can also have an almost immediate effect at the margins (on the trends) because at a population level stopping smoking improves health marginally within days. Prescribing statins where there is most need will similarly have an almost immediate as well as long term effects on population statistics. Ensuring economic circumstances that make the lives of the rich and poor less different - essentially ensuring that there are fewer who are disproportionately rich and fewer who are disproportionately poor - will have similar effects both immediately and long term. There is no efficient alternative to increasing economic equality if your aims are a motivated, well educated and healthy population.

This is what past progressive governments in Britain achieved. Health targets such as those concerned with infant mortality clearly do not lag so long. Studying their movements over the course of the last one hundred years and comparing infant mortality rate changes to political policies and economic trends has convinced me that the key to the most rapid falls in infant mortality, and simultaneously the gaps between the infant mortality rates of rich and poor narrowing, is to have progressive politicians in power (**). Having seen the rapid growth in health inequalities between poor and average infants since Labour came to power in 1997, it is hard not to suspect that the reduction of the material living standards of lone mothers reliant on benefits in 1998 and 1999 did not have a toll in terms of slightly more deaths amongst poorer infant than would otherwise have occurred. The incoming Labour government of 1997 pledged to carry out the planned Conservative spending cuts that would harm the living standards of many of Britain's poorest mothers and infants earlier on in their rule. They carried out that pledge. The implementation of those Conservative spending cuts may well have been part of the reason why, on mortality measures, the current Labour government looked more like a Conservative administration in terms of outcome and achievement on narrowing health inequalities.

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(*) Details of those who did not choose are given in ：Dorling, D. (2007) Health, in Compass (Eds) Closer to equality? Assessing New Labour's record on equality after 10 years in government, London: Compass.

(**)Dorling, D. (2006) Infant mortality and social progress in Britain, 1905-2005, Chapter 11 of E. Garrett, C. Galley, N. Shelton, and R. Woods, (Eds.) Infant Mortality, Aldershot: Ashgate.