This is the authors version of an article published as:
Dorling, D. (2009) Healthy, wealthy but not wise. *National Health Executive*, May/June, pp.18-19.

Healthy, wealthy but not wise

The latest House of Commons Health Committee report on health inequalities was published in March. **Professor Danny Dorling** wonders why it ignores what is the fundamental determinant of inequalities in health – inequalities in income and wealth.

The House of Commons Health Committee published its third report of session 2008-09 on health inequalities on 15 March. The report has been produced because the government is set to fail to achieve its target on health inequalities set in 2003. The target was to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth by 2010. The report describes this as perhaps one of the 'toughest' health targets in the world. However, other affluent countries don't need such tough targets because, apart from the United States, they tend not to have health inequalities that have such an impact on the overall the health of their citizens.

There is a precedent for all this 'tough' talk. In 1985 Margaret Thatcher had agreed to a tougher target of a 25% reduction in health inequalities by the year 2000 when she then signed up to the World Health Organisation inequality targets. Britain spectacularly failed then, with health inequalities increasing dramatically instead. They continued to increase under New Labour and even the most recent statistics show little sign of the widening gap abating. No wonder the committee thought it should conduct an inquiry.

The committee report is flawed. It admits as much itself on page 11 where it says it has ignored what many people have said are the main determinants of health inequalities.

The main determinants of health inequalities are inequalities in income and wealth. They say they ignore these because they do not have the expertise to comment on changes in the tax and benefits systems that would be needed to reduce these inequalities in income and wealth. It is odd to read that a House of Commons committee, which is simply a group of MPs, feel that it is qualified enough to consider health inequalities but cannot cope with issues of how people are taxed and what social security benefits they receive!

The report also says the second reason why the MPs could not address what they themselves understand to be the fundamental determinants of health inequalities, is that they "received no compelling evidence to suggest that anybody knows at present what changes would be most effective at lowering health inequalities".

The evidence is that all affluent societies which have low income inequalities have better overall health. There are many ways in which it is possible to have lower income inequalities than the United Kingdom. Almost every affluent country in the Northern Hemisphere other than the United States has managed to achieve better overall health by achieving lower income inequalities.

This is the authors version of an article published as:
Dorling, D. (2009) Healthy, wealthy but not wise. *National Health Executive*, May/June, pp.18-19.

Countries which achieve lower income inequalities do so in a variety of ways. These range from redistribution via the tax system in Scandinavia to simply having a more equal distribution of pay in the first place, as is the case in Japan.

Kate Pickett and Richard Wilkinson's new book *The Spirit Level* provides the most up to date and convincing collection of evidence. But the basic evidence has been around for decades. It is impossible to imagine that none of this was passed under the noses of the committee given who they say they talked to and who advised them. So a key question is why then did the committee choose to ignore what they themselves recognise as the fundamental determinants of inequalities in health?

Instead of concentrating on the fundamentals they suggest that what is most urgent is that the UK "signs up to the agreements to control supply with the tobacco companies Philip Morris International and Japan Tobacco International as a matter of urgency" to try to curtail slightly the smuggling of tobacco into the country (page 8 and end of executive summary). Curtailing smuggled tobacco would lead to either less smoking by the poor (who mostly roll it), the poor spending more on legal tobacco, or other drugs in its place, or a mix of these things.

Helping people to stop smoking is great, but the committee themselves report that Richard Wilkinson, one of the authors of *The Spirit Level*, gave evidence on this point, arguing that 'health-related behaviour is all about resolutions to give up the things you do not want to give up and to do the things you do not want to do. You cannot do that, you cannot make the resolutions and stick to them, unless you are feeling on top of life." Given his thesis, he will have gone on to explain the evidence of how it is much harder to feel on top of life when you are poor in a rich but very unequal society.

The committee itself goes on to explain in its report, with graphs, how "high socio-economic classes who smoke live longer than those from lower socio-economic classes who do not smoke:" Given that they know this, given that they are helping to explain it to us even, why did they not come out up front and say that the greatest problems are economic inequalities between socio-economic classes, the curtailment of which should be the greatest priority? Reduce social inequalities and you reduce the need people have to do things like smoke, including smoking illegally smuggled tobacco and many much more health damaging activities, just to get through the day.

Wide gaps between the living standards of rich and poor result in wide gaps between their life expectancies. There are many ways in which this will occur and those ways vary over time.

A century ago the rich smoked more than the poor, but still lived longer because they did not suffer from other diseases as much. The particular causes, tuberculosis, tobacco, road traffic accidents, change in how important they are in creating the gap. What remains is that the wider the economic gap between rich and poor the wider the health gap. So why ignore that?

This is the authors version of an article published as:
Dorling, D. (2009) Healthy, wealthy but not wise. *National Health Executive*, May/June, pp.18-19.

There is one clue as to why the committee chose to ignore what is patently obvious to most people and most researchers. They cite a single article in a Health Economics journal (reference 33) which suggests that how people describe their health is not so closely related to inequalities. This may be the case. The man coughing up in the pub may say he's 'fine', but the government targets are not about how people describe their health status.

Later in the report, another economist is reported to have told the committee that there is a trade off between reducing health inequalities and improving overall health in a population. This is what people in the United States of America came to believe which is why that country has one of the lowest life expectancies amongst affluent OECD nations, why the health of the average American is so poor, why so many have no healthcare, and why in that country private-medicine milks the rich for as much of their money as it can get, undertaking expensive procedures to maximise profit.

The United States spends more per head on health than any other affluent OECD country, the least on reducing health inequalities, and has the worse health. It is free-market economists that provide the rationale for why health care is organised as it is in the United States.

Clearly, when you read into the footnotes of the committee report that same thinking free-market thinking remains very powerful in influencing policy in Britain. Powerful enough for a committee to release a report that it says, in the introduction, it knows itself is inadequate.