

## **CHAPTER 4: Geographical inequalities in health over the last century**

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### **Introduction**

A century ago, infant mortality rates in parts of Britain were as high as in the poorest of countries today. Life expectancy similarly and largely as a result was low, but there were still wide variations between different parts of cities, as had been the case throughout the Victorian period. However, it was not until 1921 that statistics were published for areas similar enough to those used today to allow comparisons to be made directly between the present and the past for the whole of Britain.

In this chapter, we review evidence on geographical inequalities in health in Britain from 1921 up to the latest data available: 2006 in England and Wales, and the end of 2007 in Scotland. To bring our analysis up to the present, we replicate previous studies with more recent data. To extend it back to 1921, we have expanded past time series back to that year. As part of our analyses, we have calculated for the first time comparable statistics on inequalities in mortality from 1921 up to 2006 across Britain by geographical area.

The central message of our chapter is summarised in Table 4.3. Geographical inequalities in mortality ratios under age 65 fell in Britain from 1921 until around 1936. They then rose to their highest levels recorded over the whole period. In the late 1930s, people living in the worst-off areas were 2.25 times more likely to die than those in the best-off. After the war, the first published statistics were for the 1950-53 period. These showed that inequality had fallen to its lowest recorded rate for the entire 1921-2006 period: a ratio of 1.60. That fall coincided with the 1945-

1950 Labour government's period of office. The ratio then rose to 1.76 by the end of 1963, before falling again to 1.58 coincident with another Labour government period of tenure (1964-1970). No statistics were available for the period 1973 to 1980 due to cost cutting in the government statistical service by the incoming 1979 government. By the early 1980s, the ratio had risen to 1.70; by the late 1980s to 1.78; by the early 1990s to 1.93 and by the late 1990s to 2.17. Again under another Labour government, the extreme ratio measured for deaths under age 65 fell in the early 2000s, albeit only slightly, to 2.14. However, as the chapter makes clear using other data, when the most recent changes are measured in other ways they cannot even be described as a slight narrowing of geographical inequalities. What successes there have been in reducing geographical inequalities have been in reducing deaths slightly faster at very young ages in some of the poorest areas, as compared to the reductions of death rates for similarly aged people in the most affluent areas.

It was against the backdrop of widening geographical inequalities in health that New Labour came to office in 1997. Of all the inequalities they had to tackle, they knew what mattered most. The new health secretary, Frank Dobson, spelt it out to the House of Commons. He said 'There are huge inequalities in our society. Poor people are ill more often and die sooner. And that's the greatest inequality of them all – the inequality between the living and the dead' (cited in Warden 1998:493). In the late 1990s, the government identified two targets through which to measure the success of their policies in reducing health inequalities. The first focuses on infants for whom information on father's occupation is recorded on the birth certificate and seeks to reduce the gap in death rates in the first year of life between infants born to fathers in working class occupations ('routine and manual' socio-economic group) and the national average. The second is concerned with the differences in life expectancy found between different areas across the country. Further information on the two targets, and on the socio-economic classification used for the infant mortality target, is provided in Chapter 1.

The definitions of both targets were altered over time. But almost however the targets are measured, in general their progress has been in one direction only: toward greater inequality. Health inequalities have increased year-on-year under New Labour. The only exception to this has been a decline in infant mortality inequalities over the

2004-06 period. Health inequalities reflect inequalities in society in general but are the most obvious and important outcome of the government's failure to tackle inequality locally<sup>1</sup>.

We undertake our review of geographical inequalities in health by beginning with the recent past before looking back at trends over the last century. The section below assesses the evidence on health inequalities from 1996 to 2006 in the two outcomes which form the basis of England's health inequalities targets: infant mortality and life expectancy. Next, we examine trends in area inequalities from 1990 to 2007 and from 1921 to 2006 as measured by mortality before discussing the role that housing policy could play in tempering area inequalities.

### **Inequalities in infant mortality and life expectancy from 1996**

Figure 4.1 focuses on babies whose fathers are in routine and manual occupations, the target group for England's health inequalities target. It shows the percentage by which infant mortality rates among this group of infants have been above average levels in England and Wales for each year between 1996 and 2006 inclusive (the data were taken from DH 2005, DH 2006 and DH 2008<sup>2</sup>). If there were no differences between the chances of these babies dying during the first year of life (most in their first few weeks), the bars would have zero height. Note that the scale on the graph starts at the '10' percentage point. That point has not been attained in any of the years between 1996 and 2006. For every 10 babies that die in Britain, 11 die to poorer parents. At times during these years, the inequality has risen to almost 12 babies born to poor parents dying for every ten that die on average. The statistics were moving towards equality from 1996 to 1998. However, from 1998 to 2004, apart from a 'blip' in 2002, the gap grew relentlessly. It has fallen since 2004 but is still much higher than when the Labour government came to power in 1997.

#### Figure 4.1

The widening gap in infant mortality reflects well the growth of the gap between the material living standards of their parents and the average for the population. It is important to note that the government's decision to differentiate non-working

individuals without children from those with children in the welfare and benefit system has led to many infants being born to new parents who lack the financial support they need during pregnancy. Tax credits, like child benefit and other benefits paid to families with children, can be delivered too slowly to improve the living standards of families for most of these additional children who die so soon after birth. For example, child benefit can only be claimed once the baby is born and registered, and HMRC 'aim to ... pay you within seven to eight weeks of getting your claim form' (HM Revenue & Customs 2008). It is interesting to note that the narrowing of the gap in infant mortality since 2004 coincides with the slight fall in material inequalities as measured through income inequalities that occurred about a year prior to then, but which ended in 2005/6 (Institute for Fiscal Studies 2008).

Figure 4.2 shows the difference in life expectancy between the best and worst-off districts in the UK in years between 1999 and 2006. The government uses complex measures to calculate inequalities in life expectancy by area, and their preferred measures have changed over time. But the government's figures highlight the same trends of rising inequalities as are seen in infant mortality rates, except with no recent improvement. Figure 4.2 illustrates the trend by comparing life expectancies of the populations of the most extreme districts year-on-year. With the largest increases occurring in the most recent years, the Figure is hardly good evidence that the continuing widening of the gap is a legacy<sup>3</sup> of a past era of Conservative policies<sup>3</sup>.

#### Figure 4.2

The overall life expectancy of a population is a health indicator that responds more slowly to policy interventions than does infant mortality. Part of this widening gap will include the legacy of the different rates at which smoking, for instance, declined by social class in the past. However, the exacerbated sorting of people by social class and ability to pay for housing between areas under New Labour has greatly magnified any such legacy effects (Thomas and Dorling 2007). Figure 4.3 shows the current map of health inequalities.

#### Figure 4.3

Just as the increasing inequalities in infant mortality reflect the increasing material inequalities between poor parents (and most importantly prospective parents) and the rest, so rising inequalities in life expectancy between areas are a mirror of the rising economic inequalities that have emerged so much more clearly than before between different parts of Britain under New Labour. Regional geographical inequalities have risen faster under New Labour than they did under Margaret Thatcher (Dorling et al 2008). This may not have been the intention, but the effect in terms of relative health inequalities has been devastating.

### **Trends by Standardised Mortality Ratios 1990-2007**

For this chapter, we have revised and extended previous work on trends in Standardised Mortality Ratios (SMRs) among the population under the age of 75 (Davey Smith et al 2002). Revisions were necessary for the 1990s as there were significant revisions to population estimates for the 1990s following the 2001 Census. Because of those revisions to past population at risk estimates, the figures for the early and mid 1990s that we report here are slightly different to those reported earlier. However, the trends are identical.

Standardised Mortality Ratios (indirect) are the ratio of the observed number of deaths in an area divided by the expected number predicted to occur over a particular time period. The ratios are usually multiplied by one hundred. The expected number is calculated as the number of deaths that would have been expected to have occurred had the mortality rates by people in the area by age and sex been identical to national average rates. The national average rates we use are those for England and Wales at each time period considered. We recalculated the 1990s SMRs using revised 'Estimating with Confidence' population figures (Norman et al 2008) for the 1991 Census, aggregated from 1991 census wards to 2001 parliamentary constituencies and interpolating between 1991 and 2001. We calculated SMRs for the parliamentary constituencies of Britain grouped into ten equal (population) sized 'decile' groups when all constituencies were ranked by their experience of poverty as measured around the year 2000. This ranking of poverty is more up-to-date than we used in our previous work. This again influences the results slightly, but the effect of all these changes was, in policy and trend terms, negligible as we illustrate next.

There was in fact minimal change from the previously published results, with the largest change in SMR (due to denominator revision) being 4 percentage points (falling from 109 to 105 for decile 4 in 1990-1991). For post-millennium years, we used the mid-year population estimates released by the Office for National Statistics for Census Area Statistics wards for England and Wales and by the Registrar General for Scotland for Datazones; the small area geographical data were aggregated to 2001 parliamentary constituencies. As the 2001 Census and subsequent mid-year population estimates locate students studying away from home at their term-time addresses, we needed to apply a correction factor to relocate students studying away from home to their home constituencies (details can be found in the technical appendix to Shaw et al 2008).

Mortality data were supplied by the Office for National Statistics (England and Wales) and the General Register Office for Scotland. The data were supplied with the residential postcodes of the deceased which were assigned to the relevant parliamentary constituency. There were a small number of records with no postcodes, and these were not included in the calculations. Such records are generally of visitors to Britain who are not normally resident<sup>4</sup>. Single year data were combined into two year groupings. We used the Breadline Britain Index 2000 (Dorling et al 2007) for ranking parliamentary constituencies into equal sized population deciles, with the same ranking deciles used for each of the time periods. We used parliamentary constituencies as our basic unit as they are of similar population at risk sizes.

Table 4.1 shows the age and sex standardised mortality ratios for death before age 75, the ratio of worst-off to best-off decile, and the relative index of inequality for mortality (RII), for the period 1990-2005. The RII is the relative rate of mortality for the hypothetical poorest compared with the richest in the population. It is calculated here by putting a regression line through a graph of all parliamentary constituencies where they are placed according to their poverty rank on the X axis and their SMR on the Y axis. The RII is the hypothetical worst-off rate divided by the hypothetical best-off and is influenced by all the data points rather than just the extremes. Where the constituency inequality distribution is quite linear, the RII is the same as the decile range. Thus in the 1990-91 period, the RII of 1.61 is identical to the ratio of the worse

to best off decile. By 2004-05, the RII was nearly ten percentage points higher (at 1.91) than the simple ratio (which is 1.8158), indicating that by 2005, considering all constituencies, the gap was wider than if just the extreme deciles were compared.

The RII has risen steadily over the period, but fastest between 1995 and 1997, and slowest between 1999 and 2001. The gap between the SMRs of the most and least deprived deciles widened up to the late 1990s and has remained unchanged since. Put simply, the rot may have almost stopped but there has been no improvement as yet.

#### Table 4.1

Table 4.1 shows that, up until the end of 2005, inequalities in mortality by area across Britain were continuing to rise as measured by the relative index of inequality applied to standardised mortality rates (of those dying under age 75). Thus the more complex analysis supports the impression that the simple comparison of life expectancy ranges gives as shown in Figure 4.2. We have found through experimentation that inequality change estimates by this method are really only stable when applied to people dying under age 75 if 24 months of data are combined. Thus the columns in Table 4.1 all compare pairs of years. This has the added advantage of including two winters so that one 'bad' one does not have too much influence. Similarly, tainted heroin, a scare over immunisation for influenza, suicides falling or rising in response to particular events, has less of an impact over a two-year time period.

We do not yet have access to mortality data for 2007 for England and Wales and so, in the interim, we have calculated a final column for the years 2005-6. This produces the intriguing possibility that there has been a reduction in the relative index of inequality. Note that the overall range between deciles remains at 1.82 since 2001 with no change evident in the most recent time-period (2005-06). This equates to 82% more people in the worse-off decile dying each year under age 75 than in the best-off having allowed for age and sex differences. It is possible that our population denominators are becoming biased with distance from the 2001 Census so we are cautious about placing too much weight on this result. However, if it was confirmed when data for 2007 become available, then it may become possible to claim, finally, that the gap between the health of areas in Britain had stopped widening by 2007.

We do currently have access to mortality data for Scotland for the year 2007. As standardised mortality rates in Scottish constituencies are the highest in Britain, it is worth looking at trends there to try to gain an impression of whether the gap might be beginning to close. Table 4.2 shows the absolute numbers of people who died, each year 2004 to 2007, in each of the ten Scottish constituencies with the highest mortality ratios in recent years. These are the 2007 Scottish parliamentary constituencies, that is those used to elect Members of the Scottish Parliament (the same as 2001 Westminster parliamentary constituencies; new Scottish constituencies for the Westminster parliament were created for 2005 but we do not use those here).

Between 2006 and 2007, in only four of the ten Scottish parliamentary constituencies do the number of these deaths fall. The total number of deaths remains lower in 2007 than it was in 2004, but there is still no clear sign here of improvements in areas with the worst health profile. These are actual counts of people who have died, not age sex adjusted figures, as population estimates by age and sex for 2007 are not yet available.

#### Table 4.2

### **Trends by Standardised Mortality Ratio 1921 -2006**

In previous work, we described standardised mortality ratios for the period 1950 to 1992 by decile areas of Britain for deaths under age 65 (Shaw, Dorling and Brimblecombe 1998). Due to limitations of the data for the 1950s to 1970s, these statistics used only five age bands (age 0, 1-4, 5-14, 15-44 and 45-64) for men and women, and were of areas amalgamated from the 1974 local authorities and sorted at each time period by SMR before being grouped by each population decile.

#### Table 4.3

Table 4.3 shows these statistics, with those for the 1990-92 period replaced by revised data, and the 1993-2006 and 1921-1939 data added. The penultimate row of the table is the ratio of worst-off to best-off decile.

In the period 1921 to 1925, the worst-off tenth of the population by area had an age-sex standardised mortality rate below age 65 that was 41% higher than the national average of the time. The best-off tenth had a rate which was 70% of the national average. The ratio of worst to best off tenth was  $141/70 = 2.02$ . Thus, in any given year a person aged under 65 was twice as likely to die if they lived in the worst-off areas rather than in the best-off.

The ratio of 2.02 in the 1920s had risen by the end of the 1930s to 2.89. It then fell sharply to 1953, then rose in the 1950s to 1963 (under a Conservative government), before falling from 1964 through to 1973. At some point in the late 1970s, the tide turned and the gap steadily widened. The last row of the table shows the RII from 1921 to 2006. The story told using the relative index of inequality is identical in terms of the timings of the improvements of these trends being coincident with post-war Labour governments and dramatic increases in mortality inequalities under the 1979-1996 Conservative government carrying on into the first two years of the New Labour government.

The data for the most recent period enables us to measure changes in the RII since 2001. Comparing 2002-4 with 2004-6, health inequalities between areas for deaths under age 65 have increased again, albeit by a single percentage point from 2.83 to 2.84, with the latter figure being just five points below the 1936-1939 maxima of 2.89. By 2006, the picture on relative inequalities in mortality is remarkably similar to that of 1936; the absolute death rates are, however, completely different.

## **Discussion**

Clearly, by 2007, relative health inequalities in Britain had reached levels not seen since before the Second World War (the period 1936-39). They may be about to fall, although if they do fall it would need to be in poor parts of England that the falls begin. We would expect London to lead the way as the poorest London boroughs have benefited from high rates of immigration (and almost all immigrants tend to be healthier than those they join). The monitoring of these trends is important, but what matters most is reducing the inequalities. To reduce health inequalities between areas

requires reducing general inequalities between areas so that people do not try disproportionately to leave places such as the ten listed in Table 4.2 above, when they are able. It also requires policies that allow people who might have poorer health and lower financial resources to live in more affluent areas. A 'right to sell' your house to the council and become a tenant would be one mechanism.

If we were to suggest one policy that would help achieve this, it would be to extend the scheme allowing and assisting social landlords to purchase homes at auction and those being offered for private sale on the market for which, in late 2007 and throughout 2008 at least, there were no buyers. It would need central funding given that one of the banks that went 'bust', Bradford and Bingley, was one of the largest funder of Housing Associations. It would result in the achievement of numerous government goals on social mixing, reducing local inequalities, stabilising the housing market and so on. In few other circumstances would it be popular amongst home owners than during the recession that began in late summer 2007. And it could help reduce the massive disappointment of the 60,000 people now registered, say, on Sheffield's waiting list, or the estimated 4 million people registered nationally for a council or housing association home (Local Government Association 2008). Health inequalities in places like Sheffield are stark because housing inequalities are so stark. If there were much more social housing in those parts of cities, like Sheffield, that had the least to begin with, it is hard to see how health inequalities within Sheffield would not fall.

Social inequalities in Britain as a whole have been rising in recent decades (Dorling et al 2008) and this has led to a spatial polarisation of the population by poverty and wealth and consequently health. If social inequalities continue to rise, housing is likely to be distributed more and more inequitably. It is much more how we distribute wealth and opportunity within the country that determines how well people are housed than how many people chose to live in each place, not to leave, are not so desperate to move in, and so on and on (Dorling forthcoming [will finalise details at proof stage]).

If we wish to see health inequalities fall between areas, we need to match type of housing supply to need. In some areas, high proportions of one/two bed flats have

been built but people want houses with gardens. In many affluent parts of London, there are homes which are empty for much of the week because the occupants live elsewhere. Many homes in and around London and in other particular cities are not occupied at weekends. There has been an explosion in the ownership of second homes and this exacerbates area inequalities (National Housing and Planning Advice Unit 2008). This under-use of housing is also often in close proximity to areas where children are often living below the bedroom standard.

The social divisions between people have changed more obviously in recent years when people are sorted by address rather than occupation; this suggests slow and steady increases in social immobility over time (Dorling et al 2007). The address you are born in matters more now than it did in the 1940s, 1950s, 1960s and 1970s for your chances of dying young, being poor or wealthy and so on. Wealth inequalities also matter more than income inequalities now as compared to the recent past (Dorling 2008). Inequalities in wealth, and particularly in housing wealth, have, like health inequalities, risen over time. We have noted elsewhere that in Britain:

In the best off tenth of areas the housing wealth per child has increased by 20 times more than that of the lowest decile since 1993. The children of Great Britain are clearly becoming quickly more differentiated through the relative wealth of their families. Much is written about rising student debt and similar problems. Very little is said about the increase, in just ten years, of £61,842 per child in the housing wealth of families with children living where prices have risen the most in ten years. At current prices, if the housing wealth of the best tenth of families by area is shared out amongst their children that housing wealth was £82,490 per child by the end of 2003. As house prices rise over the medium and long term (if not the short term) the real wealth gap will be much greater in future. (Thomas and Dorling 2004: 5).

The rapid onset of national and global recession in 2008 has dented political and public faith in markets: the assumption that the choices of those with most money are the 'best choices' has taken a hit. In key issues such as housing, education and health, governments will need to do more with less in the future. This will require an increase

in efficiency, and it is going to be very hard for those brought up under orthodox economic thinking to cope with this change. However, such a change in thinking at the centre offers the chance to enable any halt in the decade-on-decade widening of area health inequalities to be translated into a sustained narrowing in health inequalities. In the 1950s and 1960s, there were no areas of Britain where people were a quarter more likely than average to die young simply due to where they lived.

## **Conclusion**

In this chapter, our major focus has been on changes over time in relative health inequalities between areas in Britain from 1921 to 2006. We began by discussing England's two targets for health inequalities: the area-based life expectancy target and the infant mortality target designed to level-up life chances for infants in poorer families. We have discussed how there has been a slowdown in the rise in inequalities in health, but no actual fall, as yet, in those inequalities. Inequalities in mortality rates between areas of Britain were, by the end of 2006, at their highest since the gap was measured for 1936-39.

Life expectancy in the wealthy parts of London, in Kensington and Chelsea, have in recent years been recorded as rising by slightly more than a year each year. In the poorest districts rates have been hardly rising at all. Current rates of growth in area health inequalities are unsustainable. Rises of a year every year in life expectancy, if sustained, result in immortality. That alone tells us that we have been living through very strange times. Of course, such rises are unsustainable because immortality is not possible: life expectancy in areas where it was already high cannot carry on rising as quickly. Similarly, there are levels below which infant mortality cannot fall (probably of around 1 infant dying per 1000 born). Partly because of this, we should expect inequalities in infant health to improve in the future. The fact that we are not immortal should not be a comfort to those in the New Labour government who hope to welcome the turning of the trend in these graphs as proof that their policies have finally worked. When compared to the stated aims of New Labour when it came to power in 1997, what has been allowed to occur over the last ten years has been an abject failure. 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 in both the immediate and longer term. There is no efficient alternative to increasing economic equality if the government's aim is a motivated, well-educated and healthy population.

Governments have a traditional trick of suggesting that, at any moment now things are going to get better, the data are just a little bit old, signs of a turn around are in the air, we are spending so much, so committed, and so on. Improving disadvantaged areas has been a government priority for improving health; clearly they have not been enough of a priority. A government that proposes to narrow the inequalities gap by helping people to make 'healthier choices' in their daily lives is likely to be one which is out of touch with the realities of life for the most disadvantaged. Health inequalities in Britain did not occur, increase and persist because people 'chose' not to be healthy and because people 'chose' poverty.

At some point soon, calculations will be made of the number of babies that would have lived to see their first birthday, the number of women who would not have seen their children die before them and the number of men who would have made it to 65 years had New Labour achieved its ambitions to reduce inequalities in health in the period May 1997 to May 2007. All these infants and children and adults have now died. By far the greatest proportion will be those that voted Labour in 1997, or whose parents and grandparents had voted Labour in both that year and were the basis of that party's success in the past. Perhaps every Labour MP and Minister needs this list (Dorling 1998)<sup>5</sup> to help them understand who amongst those they represented from 1997 are no longer here as a result of this policy failure. If we do not learn that what has been achieved since 1997 is not enough - for so many people - then there is little point in counting the dead.

In 1936, Britain was in the depths of economic recession. Very few people would have imagined that within 14 years mortality rates between areas would be at their most equal. In 2006, Britain was approaching the end of the longest-ever economic boom in its recorded history. But it was living with levels of geographical inequalities in health that were almost at those 1936 levels - and which were still rising slightly

when counted in some ways. Anyone expressing the hope that, within 14 years - by 2020 - mortality rate ratios between areas could be reduced to levels last seen in the 1950s would sound as utopian as their equivalents in 1936. Except, of course, in 1936 nobody knew of any of these trends.

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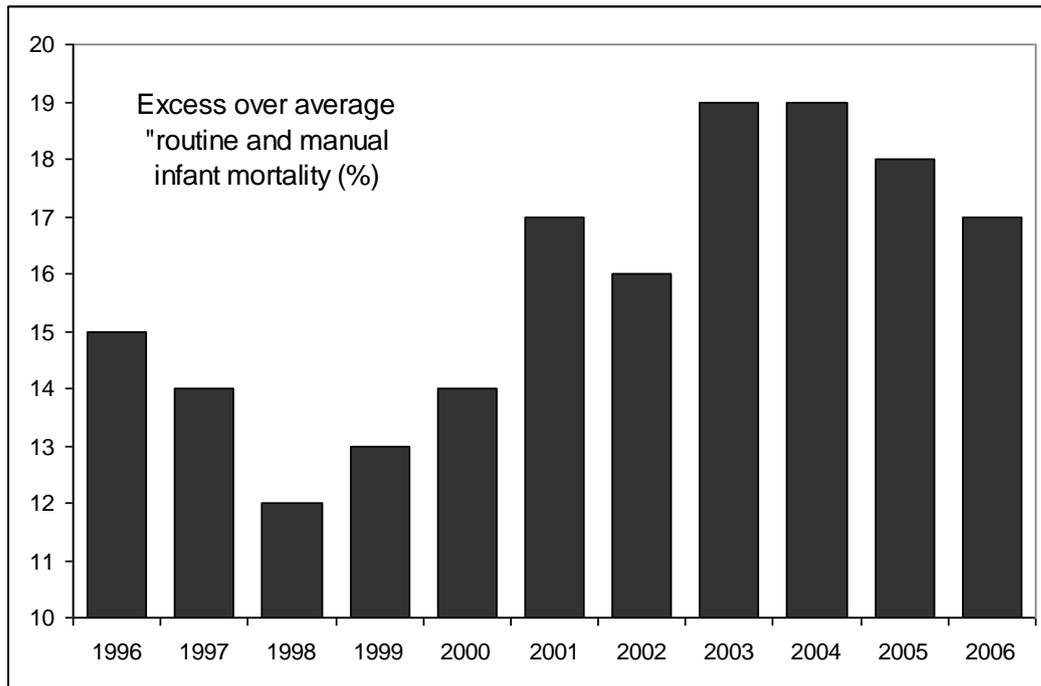
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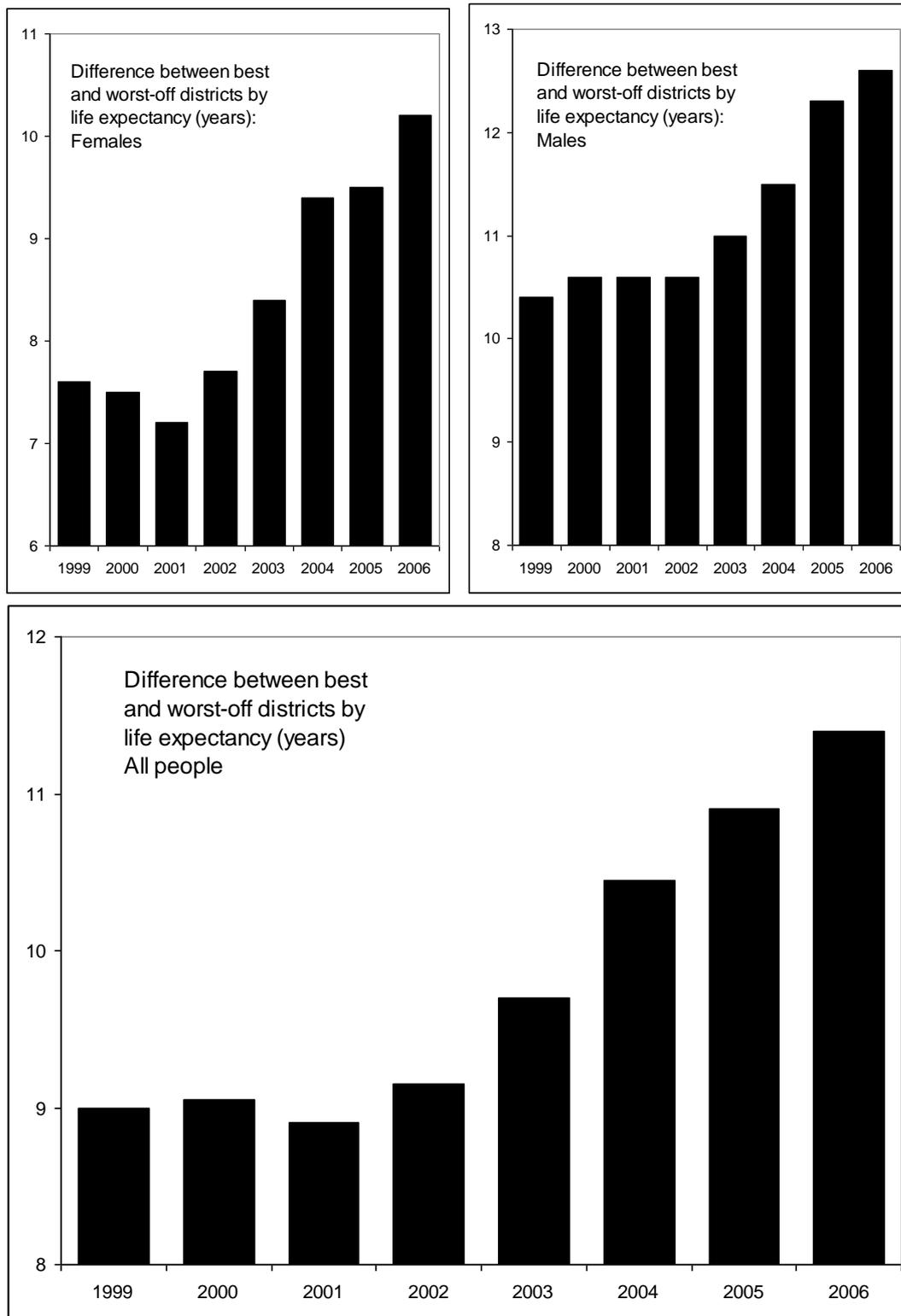
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**Figure 4.1: Infant mortality rates in England and Wales 1996-2006**

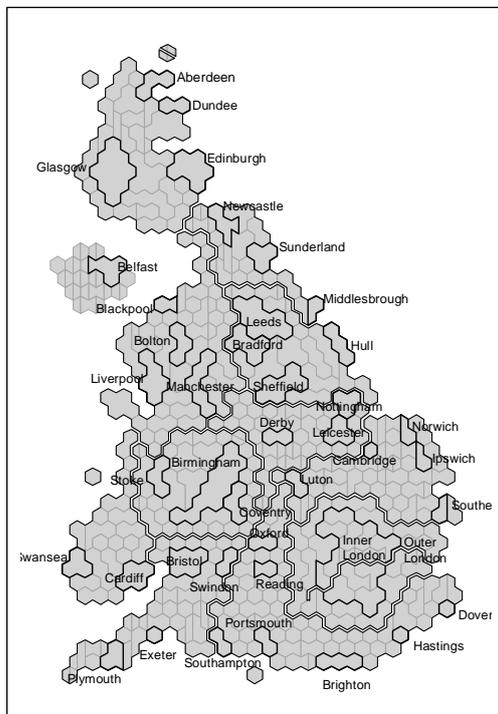
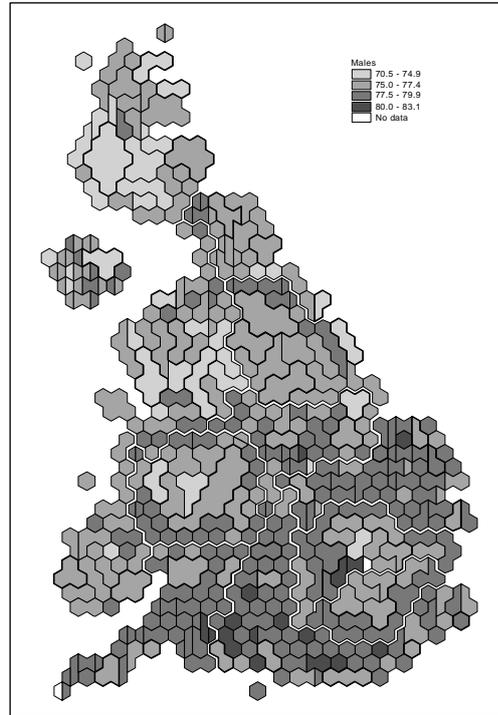
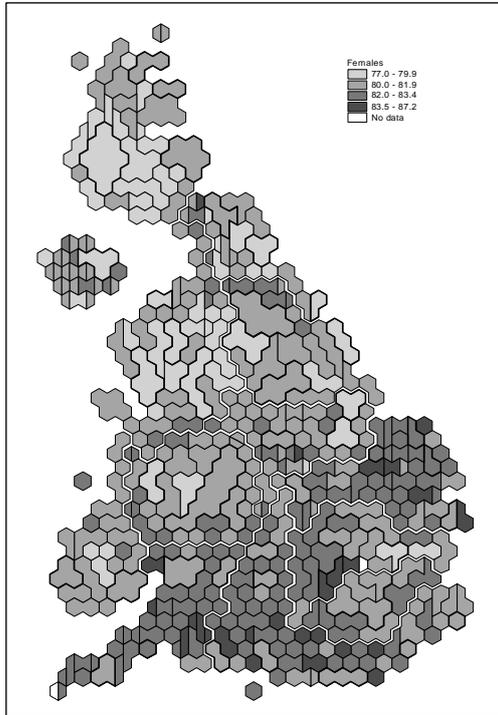


**Figure 4.2: A measure of social integration between geographical areas:  
Life expectancy estimates diverging in the United Kingdom 1999-2006**



Note: the top two graphs show the trends of men and women separately. The bottom graph combines those trends. All show a similar picture, although the gap for men is greatest. The gap shown is the greatest range in officially reported life expectancies between Local Authorities across the whole of the United Kingdom.

**Figure 4.3: Life expectancy at birth 2004-2006, females on the left and males on the right. Due to their small populations, data are not supplied for the City of London and the Isles of Scilly. A key map showing some towns and cities is also shown**



**[Note to editor – if there are going to be colour plates these maps could be redone in colour]**

**Table 4.1: Age and sex standardised SMRs (0-74) according to decile of poverty, and the relative index of inequality (note that the final column is not a direct continuation of the series but the latest available two years' data): Britain**

<b>SMR 0-74</b>	<b>1990-91</b>	<b>1992-93</b>	<b>1994-95</b>	<b>1996-97</b>	<b>1998-99</b>	<b>2000-01</b>	<b>2002-03</b>	<b>2004-05</b>	<b>2005-06</b>
Decile 1	129	132	135	137	138	139	138	138	138
Decile 2	116	118	118	120	121	119	121	121	121
Decile 3	113	115	114	115	115	116	117	117	116
Decile 4	105	107	106	108	109	109	107	108	108
Decile 5	103	102	102	101	103	103	103	103	104
Decile 6	96	94	95	94	95	95	96	95	96
Decile 7	91	90	90	90	89	90	90	90	90
Decile 8	86	86	85	85	84	84	85	86	85
Decile 9	85	83	83	82	81	81	81	81	80
Decile 10	80	79	79	78	77	76	76	76	76
<b>Ratio</b>	1.61	1.67	1.71	1.76	1.79	1.83	1.82	1.82	1.82
<b>RII</b>	1.61	1.67	1.71	1.81	1.86	1.86	1.90	1.91	1.89

**Table 4.2: the numbers of deaths in the ten Scottish constituencies with the worst SMRs in Scotland in 2006**

<b>Constituency</b>	<b>Number of deaths</b>			
	<b>2004</b>	<b>2005</b>	<b>2006</b>	<b>2007</b>
Airdrie and Shotts	406	392	433	448
Glasgow Anniesland	317	340	322	324
Glasgow Baillieston	378	327	328	346
Glasgow Cathcart	267	194	232	283
Glasgow Govan	316	364	370	330
Glasgow Maryhill	417	328	321	368
Glasgow Pollok	443	387	383	397
Glasgow Shettleston	461	364	402	393
Glasgow Springburn	528	509	500	472
Paisley North	350	403	411	348
<b>Total</b>	<b>5,887</b>	<b>5,613</b>	<b>5,708</b>	<b>5,716</b>

**Table 4.3: Standardised Mortality Ratio 0-64 (1921 -2006)**

Decile	1921- 25	1926- 30	1931- 35	1936- 39	1950- 53	1959- 63	1969- 73	1981- 85	1986- 89	1990- 92	1993- 95	1996- 97	1999- 2001	2002- 04	2004- 06
1	141.1	136.7	135.5	154.8	131.0	135.5	131.2	135.0	139.2	144.3	148.9	152.6	151.3	150.4	149.1
2	123.9	121.7	120.0	121.8	118.1	123.0	115.6	118.6	120.9	122.1	121.7	123.0	123.9	124.1	123.4
3	114.0	111.8	112.0	110.7	112.1	116.5	112.0	114.2	113.9	112.8	113.5	114.9	115.6	115.2	116.3
4	107.8	107.3	105.7	105.1	107.0	110.7	108.1	109.8	106.9	106.8	106.8	109.0	108.0	108.0	108.7
5	102.5	102.8	102.1	100.5	102.5	104.5	103.0	102.1	102.2	99.6	98.4	98.3	99.7	100.2	100.8
6	95.6	97.0	97.2	94.4	98.6	97.4	96.9	95.7	95.6	93.7	93.7	94.2	94.7	94.7	95.5
7	89.7	89.9	90.2	87.8	93.1	90.9	91.8	91.6	91.9	90.7	90.6	90.7	90.1	90.7	89.7
8	83.9	82.9	83.7	82.1	88.7	87.6	88.9	89.3	89.1	86.0	85.4	85.1	83.0	82.3	82.8
9	77.3	79.0	80.5	77.9	85.7	83.1	87.0	84.3	83.0	79.6	78.7	76.8	77.2	76.7	76.0
10	70.0	74.7	73.9	68.7	81.8	77.1	83.0	79.2	78.1	74.6	72.3	70.7	69.7	70.2	69.7
Ratio	2.02	1.83	1.83	2.25	1.60	1.76	1.58	1.70	1.78	1.93	2.06	2.16	2.17	2.14	2.14
RII	2.64	2.41	2.35	2.89	1.96	2.25	1.92	2.12	2.22	2.49	2.64	2.80	2.85	2.83	2.84

Note to Table 4.3: Note that the time periods vary due to data limitations; in particular, there is a large gap between 1939 and 1950. For 1990 (included in 1990-92), 1991 population figures were used. For 2006 (included in 2004-06), 2005 mid-year estimates (the latest available at small area geography) were used. Note that the final column does not follow on but overlaps; it is the latest 3 years for which mortality data were available for all of Britain.

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<sup>1</sup> There is, of course, a far greater body count that will dominate the history of New Labour: see Kim McPherson, 2005. As McPherson notes, 'counting the dead is intrinsic to civilised society. Understanding the causes of death is a core public health responsibility' (2005:550).

<sup>2</sup> Note that infant mortality figures are for England and Wales only; figures are for the three year period ending December of the date shown.

<sup>3</sup> It was of course the Conservative governments of 1979-1997 that saw and helped the gap widen from historically low levels of inequality experienced in the 1950s, 1960 and early 1970s.

<sup>4</sup> Similarly, there were a small number of records with no cause of death given. As the ages of the deceased in these records ranged from the full age range in some years' data, to all the ages being zero in other years, these records too were discarded from the analysis.

<sup>5</sup> The list of potential victims of policy failure was drawn up shortly after the 1997 election victory. Table 5 in Dorling 1998 listed the number of voters who would continue to die young 1997 onwards, by their MPs, in the worse-off areas, were inequalities to remain so high. Many of those Labour MPs whose constituents have suffered most due to the failure to narrow inequalities have had the power to change policy. Past and current Ministers include Hazel Blears who loses over 100 potential voters a year due to the continuation of such inequalities: one thousand excess young deaths in her constituency since she first contended her Salford seat. There are 750 fewer folk to vote for John Reid now where he has been MP since 1997; 640 fewer for Jack Straw; 590 less for Harriet Harman; and 360 less in the Dunfermline East constituency of Gordon Brown. These deaths are all due to the continued extent of inequalities in life chances in the United Kingdom. These figures all represent people who have died before they reached age 65 because rates in their area remain so much in excess of the national average. When these figures were first calculated, they were the hypothetical deaths that would result from policy failure. Now they are gravestones in cemeteries and plaques in crematoria: memorials to lives that need not have ended so soon. For a few MPs, enough of their constituents have died both prematurely and unnecessarily since 1997 to have been able to fill the House of Commons from their constituency's toll alone. It may well have been worse had another party won power in 1997, but for so many it could have been so much better.