

Think Piece

In Place of Fear:
Narrowing health inequalities

Professor Danny Dorling

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In this paper Danny is writing in a personal capacity, building on the work in his latest book *Unequal Health: The Scandal of Our Times*.

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Executive summary

In place of fear, the title of Aneurin Bevan's book published on the 10th anniversary of the Beveridge Report, is synonymous with all that the welfare state stood for and what it sought to achieve. By 1952, a consensus had formed in Britain that it was possible to create a society where all could live without fear of going hungry, being poorly housed, or of living with (or dying in) great pain. Although there was still much to argue about, by a generation after the stock market crash of 1929, that consensus was one which regarded the possibilities of the future with optimism.

In 2013, as the principles of Bevan and Beveridge are being killed off, the belief that inequalities should narrow is also under attack. The 1930s were the last time the population of Britain was as polarised in terms of their health as we are today. It was not simply the introduction of the NHS in 1948 that halved inequalities in health in Britain between the 1930s and early 1950s. The overall improvement in living standards brought about by the introduction of the welfare state had a significant impact. It is now well known that the strongest correlate to poor health is poverty, and the longer people live in poverty the shorter lives they can expect to live. Geographical inequalities in health tend to fall when social inequalities in income and wealth fall. What we can now be sure of is that as income and wealth inequalities rise, so too do health inequalities. By May 2010, it had become apparent that men and women had a combined average life expectancy of 74.3 years in Glasgow, as compared to 88.7 in the Royal Borough of Kensington and Chelsea.

The last time actual rises in mortality were reported was during the depression of the 1930s. Falling life expectancy is being recorded again today, first it was in Glasgow (Norman et al. 2011, McCartney et al. 2012), but soon it could be more widespread as mortality counts during 2012 and 2013 have been rising. Fear is common and rising again. As fear rises the number of people who report that their health is good or very good falls. Anxiety can make us sick. At the extreme it may even hasten mortality. No-one in Britain yet knows how the recent increase in mortality among the elderly is related to anxiety and the cuts, or if it will result in falling life expectancies being reported, but we do know that the recent rise in deaths bucks a long term trend of falling mortality rates among the elderly (ONS 2013, Hennell 2013).

When it comes to providing a health service, it is harder to provide a good health service in a more economically unequal country, especially one in which inequalities are growing. The rich in a very unequal country are more likely to opt out of national health services, and have less interest in the quality of that service. Health inequalities are worse in affluent countries where the richest 1 per cent have become the most acquisitive and their greed is least well controlled by the 99 per cent. When the poorest lose the most, it is within the rest of the population that income inequalities grow to be much higher than are found in more equal affluent nations, and everyone's health and happiness suffer as a result.

Policies in place of fear need not be costly policies but they need to be a genuine commitment. One reason why Britain now has such higher health inequalities compared to other affluent nations is that in the past it did not, collectively, choose to reduce strife. Most other affluent nations did and their top 1 per cent now accrue much less, with most people in those more equal societies living longer, with less anxiety, and less fear.

Introduction

The phrase “in place of fear” is synonymous with all that the welfare state stood for and what the Beveridge report of 1942, the Education Act of 1944 and the NHS Act of 1946 sought to achieve. It was also the title of Aneurin Bevan’s famous book, published in 1952, on the tenth anniversary of the Beveridge report.

Fear brings out the worse in people. Racism and fascism are far more easily provoked when people are living in fear. That was all clear by 1952, after so much of what had occurred within Nazi Germany was revealed. It was growing inequality and poverty which preceded the Nazi’s rise to power. People can be taught to fear and hate immigrants, the poor, the disabled, and any other group which is weak.

By 1952, a consensus had formed in Britain that it was possible to create a society where all could live without fear of going hungry, of being without adequate shelter, without fear of their children not being schooled, or of themselves living with (or dying in) great pain. There was still much to argue about and Bevan, more than many others, did argue, but a generation after the stock market crash of 1929, a consensus had been reached.

Aneurin Bevan first became Member of Parliament for Ebbw Vale in the year of the 1929 crash. He was optimistic when many others then were not. He was even optimistic in the face of the coming war because he thought it would usher in social change, greatly accelerating a change which was already occurring. He was right, and he is best remembered as the father of the NHS.

Our times are very different but it is again possible to be optimistic five years after another economic crash, this time the 2008 crash. If optimism was possible even in the 1930s, then, with what we know today, we should argue against fear and once again believe a better future is possible, even in the worst of economic times.

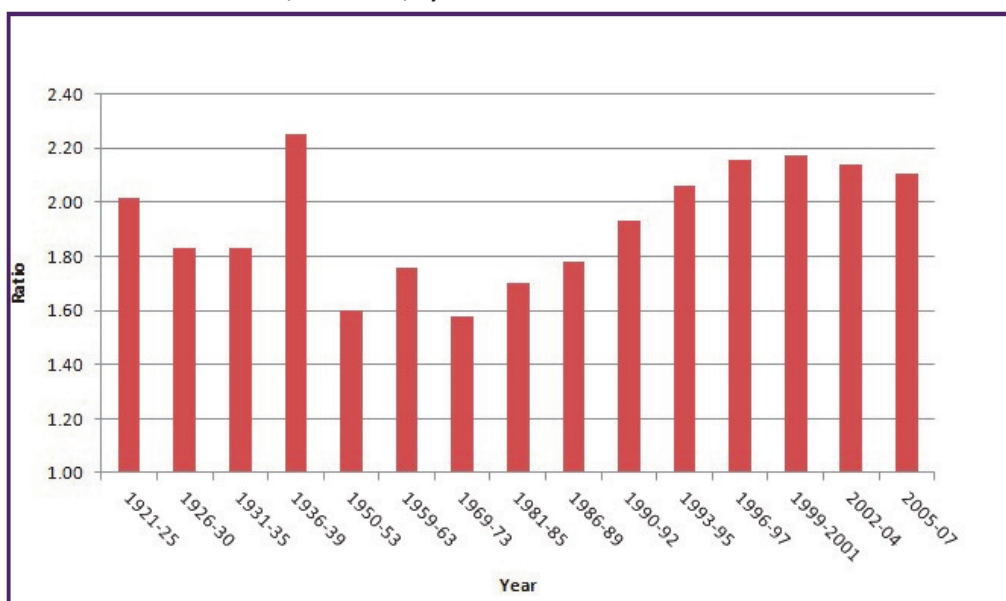
As the principles of Bevan’s NHS are being killed off, the belief that inequalities should narrow is under attack. The principal that those in greater need should receive most care is being discredited. Instead those with more money are considered to matter most. Yet even today we can and should be optimistic. We have faced worse times, even more challenging opinions, and a greater prevalence of ignorance than we are currently facing today.

Health inequalities: A history

During the 1920s health inequalities in Britain fell. At the start of the decade people aged under 65 in the worst-off geographical areas of the country were twice as likely to die as compared to people in the best-off areas. This even occurred when mortality rates were much higher than today and life expectancies much shorter, when many of the affluent could themselves expect to die before 65.

Inequality fell to the worst-off being 80 per cent more likely to die young by 1929 compared to the chances of the best-off. A large part of the improvement came from improved infant health, partly due to government intervention in the poorer areas of the UK. However, as Chart 1 shows, all of those gains were reversed by the end of the 1930s.

Chart 1: How many times more likely the worse-off tenth are likely to die under the age of 65 than the best-off tenth in Britain, 1921-2007, by area.



Source: Dorling, 2013, Table 38.1

The late 1930s were so bad that actual rises in mortality were recorded at that time (Davey Smith, G. and Marmot, M., 1991) and by 1936-39 the worst-off tenth of people in British society, by geographical area, were 120 per cent more likely to die young as compared to the best-off tenth. Many of these people lived in the areas designated as in need of immediate extra assistance in the Special Areas Act of 1934.

That was the then government's inadequate response to the crisis that was brought about by the economic crash of 1929. Special Areas are being created again today, now called Assisted Areas. Much appears to be being repeated.

The 1930s were the last time the population of Britain was as polarized in terms of their health as much as we are today. With mass unemployment common in much of the North, in Wales, Scotland and Northern Ireland, geographical inequalities became greater during that four year period (1936-39) than those recorded at any other time since 1921. Chart 1 shows those terrible times, but it also shows how quickly health inequalities can be reduced and overall health improved, even in a period of greater austerity and when the country was virtually bankrupt.

Between 1939 and 1950 inequalities in health fell by the greatest amount ever recorded: they halved in size. Health gains were experienced by every group, but the greatest gains were for those who were at most risk of illness and premature mortality. The last time Britain was in as dire financial straits as it is today was also the time of the greatest improvement in overall health and the fastest reductions in inequalities.

It was not simply the introduction of the National Health Service in 1948 that halved inequalities in health in Britain between the 1930s and early 1950s. The overall improvement in living standards brought about by the introduction of the welfare state meant that people needed doctors less, but could use them more if they did need to.

More people survived to be able to retire. The introduction of proper pensions meant that retirement was much more attractive. Even the suicide rate for the elderly plummeted in the years up to 1948, before the NHS opened its doors, but then the population enjoyed knowledge of, and optimism for, what was just about to come.

Chart 1 provides one of the clearest summaries of twentieth century trends in life chances because it is about the most important life chance of all, your chance not to die young. Thirteen years of Conservative rule, from 1951 to 1963 were accompanied by a modest rise in inequalities, although overall mortality rates and illness rates did fall.

Then, in just six years, the 1964/66 Labour governments presided over another fall, to result in geographical health inequalities being brought down to their lowest ever recorded level by 1969-73. The Wilson government did not just keep Britain out of the Vietnam War, saving many lives; it saved even more lives at home too by reducing health inequalities and improving overall health so quickly (Mitchell et al., 2000).

While not as successful as the 1945 Labour government, Wilson's administration did much better than its 1997-2010 successors in terms of its record on reducing health inequalities and improving overall health.

After 1973, the trend in health inequalities moved from being one of progress marred by the occasional disaster, to disaster becoming the norm. Almost every year from 1981 through to 1997 saw health inequalities in Britain rise, and rise sharply. By the time Margaret Thatcher was forced out of office, inequalities were higher than at any point since 1945. They have risen further and remained very high ever since.

In 1990, as John Major took over, the inequalities between areas rose to exceed even the excesses of the early 1920s. The rise in health inequalities measured in this way only stalled once New Labour abandoned Conservative spending plans in 1999. For a few years Labour worked, both as a party and a government, a little harder to reduce poverty, improve housing, to better fund the health service and to do all those actions that have to be done if our quality of life is both to continue to improve, and the gap between life chances is not to continuously widen between rich and poor.

New Labour did not do enough to help the very worst-off areas and, at the extremes, the gaps still grew wider when they were in power (Thomas et al., 2010). There were some successes during Tony Blair's time in office, although more impressive in terms of reducing education inequalities than in improving health (Dorling, 2010).

People in London did better, as migrants tend to be healthier and London attracted so many new arrivals (Tunstall et al., 2011). Labour did succeed in preventing the late 1930s peak of inequality being surpassed. Increased NHS spending almost certainly helped here, but a sticking plaster is less effective than preventing disease and illness in the first place.

It is now well known that the strongest correlate to poor health is poverty and the longer people live in poverty the shorter lives they can expect to live. New Labour identified some of the worst areas in which to intervene. However, despite some successes, overall the people in its 'Spearhead' areas did not experience the improvement in health that was promised (Barr et al, 2012). Health improvements under New Labour were often greatest for those who already had the best chances to begin with (Bajekal et al, 2013).

Geographical inequalities in health tend to fall when social inequalities in income and wealth fall. Apart from the rapid rise in mortality in poorer areas during the mass unemployment in the late 1930s this relationship has held very well over time. It is found both in Britain and in many other countries (Wilkinson and Pickett 2010).

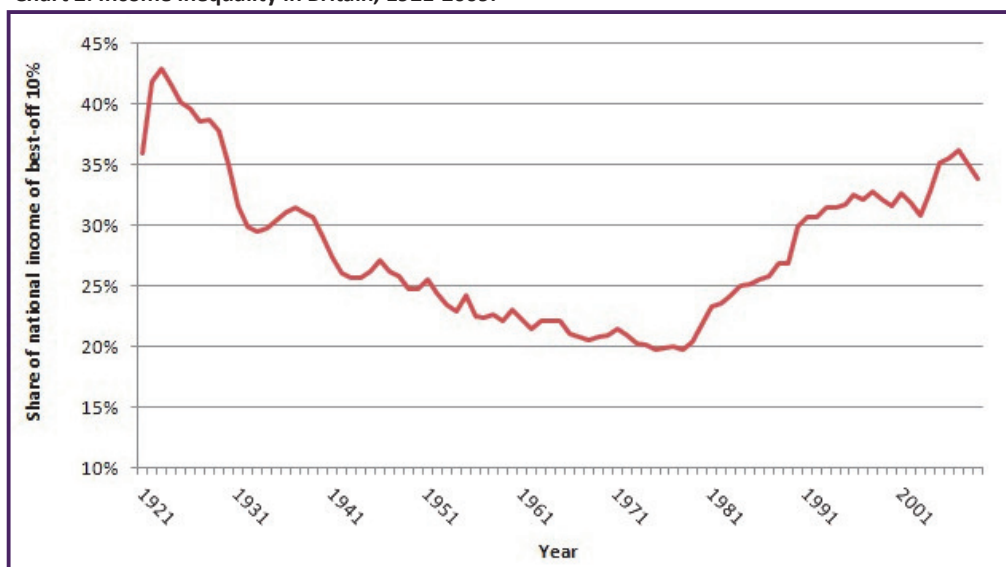
Chart 2 shows that in the early 1920s the best-off tenth of people in British society used to get more than 40 per cent of the total national personal income, more than four times the average, leaving everyone else on an average of less than two thirds of the overall average income. In the time series shown in Chart 2, 1923 was a peak year of UK inequality, but it was also a time when greater inequalities were being suffered across the rich world.

1923 is the year after Scott Fitzgerald's *Great Gatsby* novel depicted gross inequalities reaching their limit in US society. In the USA, income inequalities remained high until the 1940s. In contrast, in the UK, they fell from around 1924, when the very first Labour government came to power with Liberal support. That government, and its December 1929 Labour successor, may have been remembered mostly as a disappointment, but both represented turning points, as we can see in hindsight from Chart 2.

The acts of successive governments, combined with a growing sense of what was just, ensured that income inequality continued to fall and the financial share of the best-off tenth hit a new minimum of three times the national arithmetic mean average income in 1932, 2.5 times in 1949, and just 2 times by 1973. It was when the best-off were just twice as well off as the national average that health inequalities in Britain reached their *minima*. Then, from 2 times in 1979, Thatcherism resulted in the income share of the top tenth climbing to 2.5 times by 1984, 3 times by 1990, 3.3 times by 2001 and 3.6 times by 2007, before the recent post economic crisis correction. All these figures are taken from Chart 2.

When you look at the trends in income inequality shown in Chart 2 and compare them to the trends in health inequality shown in Chart 1, you realise that we are again as unequal as we last were in 1930. It is perhaps then far less surprising to know that that was also the last time life expectancies varied between towns and cities so much and the last time that an actual reduction in life expectancy for certain groups was being recorded (Davey Smith and Marmot 1991).

Chart 2: Income inequality in Britain, 1921-2009.



Source: Dorling, D. (2013) Fairness and the changing fortunes of people in Britain, *Journal of the Royal Statistical Society A*, 176, 1, 97-128 http://www.dannydorling.org/?page_id=3597

Falling life expectancy is being recorded again today. First highlighted in Glasgow (Norman et al. 2011, McCartney et al. 2012), it could soon be more widespread as mortality counts during 2012 and 2013 have been rising (ONS 2013). The only other rich country to have recorded falls not in a time of natural disaster is the USA in 2008 (Steenhuysen, 2010) when overall life expectancy fell from 77.9 years to 77.8 (Lowe, 2010).

The current rise in mortality in the UK is concentrated in elderly women dying over the age of 85, but dying a little younger than might be expected given their backgrounds. Women are more likely to be without a partner in old age than are men because men usually die earlier. Many of these women may well have been affected in direct and indirect ways by falling living standards. Mortality appears to be rising faster than would be expected for the elderly in areas with more nursing and care homes.

Health inequality now

In 2013, it is almost impossible to believe that large numbers of people could live with hope in place of fear, especially into old age. Full employment went first, and then jobs for life, then welfare you could survive on. Surveys are being released showing that the numbers going hungry are rising again (Gordon et al. 2013). This trend has not been observed since 1934, the last time we were as unequal as we are now, during a time when many despaired so much for the future.

Fear is widespread and rising again. As fear rises the number of people who report that their health is good or very good falls. Anxiety can make us sick. At the extreme it may even hasten mortality. No-one in Britain yet knows how the recent increase in mortality among the elderly which has been recorded throughout 2012 and into the start of 2013 is related to anxiety and the cuts, or if it will result in falling life expectancies being reported. But we do know that the recent rise in deaths in England and Wales, and the increase reported in those two countries during 2012, bucks a long term trend of falling mortality rates among the elderly.

During the first eight weeks of 2013 the Office for National Statistics (ONS, 2013) reported that 90,736 people had died in England and Wales, some 1,531 more deaths than the average number for the corresponding eight weeks for the previous five years – an absolute rise of 1.7 per cent. This was not due to rapid population aging or an influx of elderly immigrants. However, as the increase in deaths was largely concentrated among the elderly, and mostly among women, it was probably worse among older people without partners.

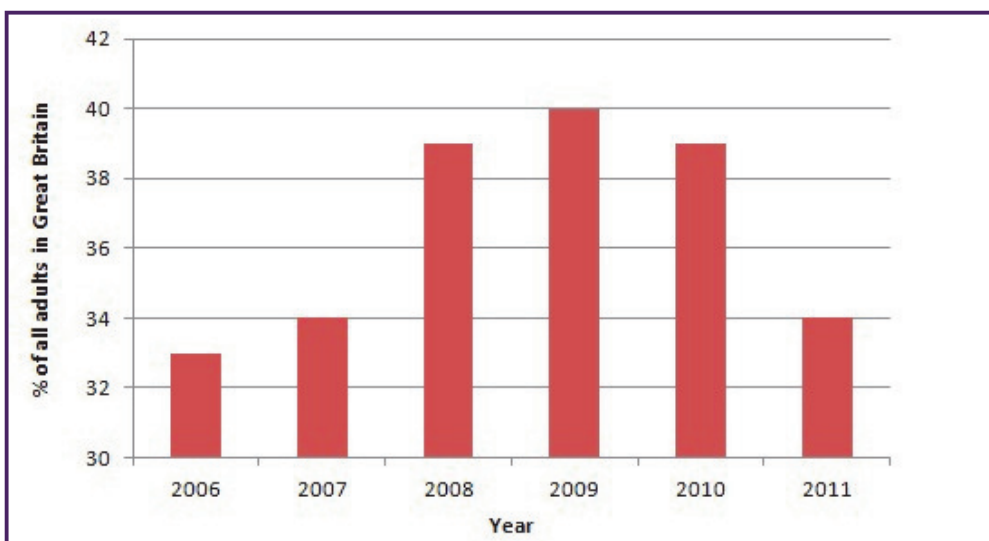
One pension provider has already noted the increase in mortality, which reduces its potential liabilities, but puts it down to the cold weather even though winters before had been colder (Tower Watson, 2013). After this news was reported, and even when the weather became warmer, more than 12,000 deaths in England and Wales were reported in a single week later on in April. This was the highest number registered in a week outside of winter for many years. Of course, if fewer elderly people can afford to heat their homes then a mild winter becomes a cold winter.

For years ONS has been reporting falls in mortality every year. The recent rise has occurred despite a rapid fall in deaths from respiratory diseases over the first eight

weeks of 2013 and no unusually cold weather. It is a rise that comes on top of increases in additional deaths, more than would be expected, reported during 2012, again especially among the elderly (Hennell 2012). Unusually high death rates in residential homes for the elderly would be expected to show up demographically as an increased death rate in women over 85 years old.

The rise in deaths also follows sharp falls in reported wellbeing during 2010 and 2011, as shown in Chart 3.

Chart 3: Proportion of People in Great Britain who say their health is very good (2006-2011).



Source: General Lifestyle Survey, Office for National Statistics (2013)

There are many reasons why people are becoming more fearful and why reports of wellbeing are falling, including alarmist reporting by some of the media. Over a year ago, on 13 February 2012, The Mail on Sunday ran the following headline on (the then Secretary of State) Andrew Lansley's attempts to privatise the NHS:

"The firm that hijacked the NHS: MoS [Mail on Sunday] investigation reveals extraordinary extent of international management consultant's role in Lansley's health reforms."

Recently, journalists having been trying to work out why mortality rates among the elderly are rising. They initially suggested it was the cold, but recent winters have not been that cold and we had no flu epidemic (Metro, 2013). The rise also began

during much warmer weather. Over a thousand extra deaths a week are being reported. This recent increase in deaths coincides with the current trends both to privatise healthcare and to allow both inequality and absolute poverty to rise. That this might occur was suggested before the latest ONS figures were released (Dorling, 2013, page 8).

Because the current mortality rises appear to be greatest among the elderly, who are the group with the most to fear in the short term when health and other services such as meals on wheels and care homes are cut, the cuts and abandonment of some health targets should be viewed as a possible cause. The elderly were the group who benefited most immediately from the introduction of the NHS in 1948. Living with hope in place of fear was part of the story of the success of the 1945 government.

It is worth repeating that the last time actual rises in mortality in England and Wales were reported was during the depression experienced between the two world wars, at a time when unemployment rates were historically high, and rising, and in the aftermath of a global financial crash. It was only with the introduction of the National Health Service that living standards rose for all, in all areas, across all the countries of the UK. In recent decades living standards rose fastest for the richest and only marginally for the poorest. Almost no group experienced rising mortality rates until it was reported that men in parts of Glasgow were dying younger, in research published in 2011 (Norman et al. 2011, McCartney et al. 2012).

The NHS reduces fear and gives confidence, as much as it directly improves health. Just knowing it is there and is available makes us feel safer, and calmer, because we are safer. The same is true for the welfare state as a whole, and of the effects of maintaining near full employment in the 1950s and 1960s. Having a National Health Service alone does not guarantee good health for people. It is necessary but not sufficient.

In those parts of Scotland where the recent falls in life expectancy for men occurred, they did so even before New Labour lost power in May 2010 (Norman et al. 2011), and before the onset of increasing privatisation of the NHS. Those falls can be seen as part of the overall poor performance of the UK when it comes to health

outcomes. Health outcomes tend to be worse in unequal countries where the rich take most, regardless of whether there is a NHS.

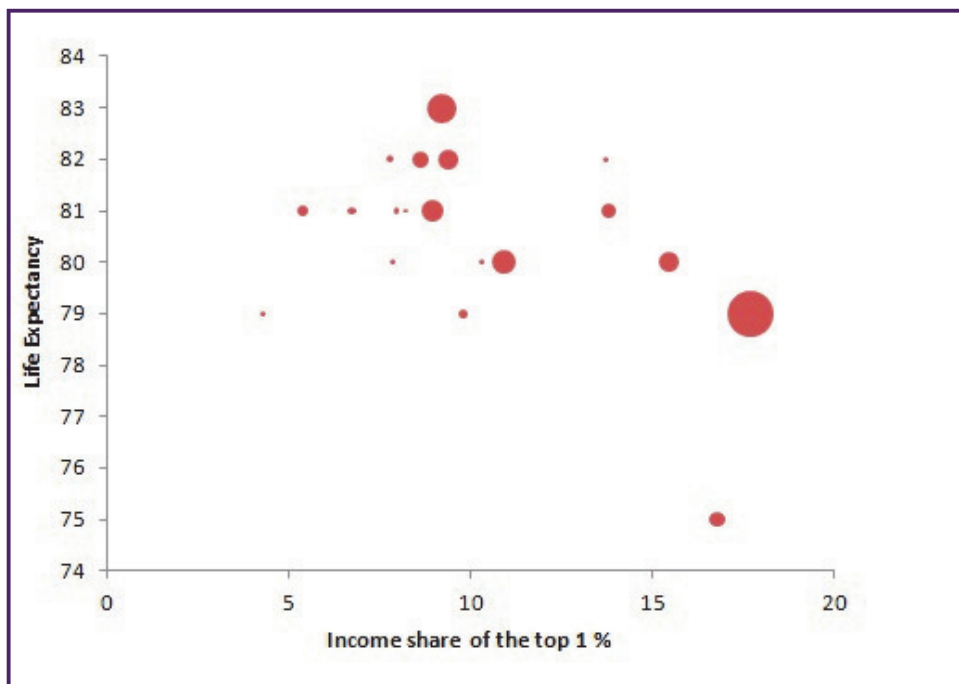
The position of the UK in comparison to other similar states is shown in Table 1. The table is sorted by life expectancy and includes every country for which comparable income inequality data on the top 1 per cent are available. Chart 4 is based on the data in Table 1 and highlights the relationship between how much the best-off take in income, and overall life expectancy.

Table 1: Income inequality and life expectancy, all countries with data, 2009.

Country	Year of latest available income inequality data	Top 1% richest people's share of all income (%)	Life expectancy in years 2009	Population estimate 2010 (millions)
Japan	2005	9.20	83	126.6
Switzerland	1995	7.76	82	7.6
Australia	2008	8.59	82	22.3
Spain	2008	8.61	82	46.1
Italy	2009	9.38	82	60.6
Singapore	2009	13.7	82	5.1
Netherlands	1999	5.38	81	16.6
Sweden	2009	6.72	81	9.4
Norway	2008	7.94	81	4.9
New Zealand	2009	8.22	81	4.4
France	2006	8.94	81	34.0
Canada	2007	13.78	81	5.4
Finland	2002	7.86	80	5.4
Ireland	2000	10.30	80	4.5
Germany	1998	10.88	80	82.3
United Kingdom	2007	15.45	80	62.0
Denmark	2005	4.29	79	5.6
Portugal	2005	9.77	79	10.7
United States	2008	17.67	79	310.4
Argentina	2004	16.75	75	40.4
China	2003	5.87	74	1348.9
Mauritius	2008	7.20	73	1.3
Indonesia	2004	8.46	68	239.9
India	1999	8.95	65	1224.6
South Africa	2007	16.25	54	50.1

Source: Life expectancy and population figures from WHO data: <http://apps.who.int/ghodata?vid=710#income> (note Australian Statisticians dispute WHO figure for life expectancy shown here). Accessed 20 April 2012. Table is sorted by life expectancy. The inequality data used is from the Paris School's World Top Income database: <http://g-mond.parisschoolofeconomics.eu/topincomes/> (excluding Tanzania where only data to 1970 was included).

Chart 4: Life Expectancy (2009) versus income share of the best-off 1% (latest year).



Source: Dorling 2013, Figure 1.1, each circle is a rich country, area in proportion to population. The largest circle is the USA and the second largest is Japan.

There have now been several reasons suggested to explain why the relationship between inequality and early mortality, while convincing, is not neater than that shown in Table 1 and Chart 4. For example it is known that in Denmark people live shorter lives because smoking rates in the 1980s were higher than in the UK.

Recent research has revealed that in Denmark, wealth (rather than income) inequalities are wider than in the UK (Nowatzki, 2012). This has only just been reported but highlights that it is necessary to reduce inequalities in wealth as well as in income, if Britain wants to reduce high inequalities in health and relatively poor overall health.

Just as we don't know the precise reason why mortality rates have risen in the UK we don't know whether wealth inequalities in Denmark influence behaviour such as smoking. Although we do know that high wealth inequalities are harmful, it is important to understand how much is not known. Similarly, despite being a very economically unequal country, Singapore is highly placed when affluent countries are ranked by life expectancy, but in Singapore there are strong incentives for the

poorest in that society, “guest workers”, to leave upon becoming ill or if they are pregnant. This particularly affects the reported very low rate of infant mortality in that nation-state (Dorling, 2013, p. 325). If Britain introduced a guest worker scheme as draconian as that in Singapore, with deportation of the poor when they become sick, similar ‘good’ results might be expected.

What we can now be sure of is that as income and wealth inequalities rise, so too do health inequalities. By May 2010 it had become apparent that men and women had a combined average life expectancy of 74.3 years in Glasgow, as compared to 88.7 in the Royal Borough of Kensington and Chelsea (Dorling, 2013, Figure 41.3). By the end of New Labour’s 13 years of power, the gap between one London borough and all of Glasgow exceeded 14 years, the gap had been 9 years at the start. This was a 19 per cent difference in life expectancy by 2010. That extremely high inequality may now be rising to become even greater again.

It is necessary to go back to the recession of the 1880s to find a greater gap between areas. At that time, life expectancy was 46 years in Bristol compared to 36 years in Liverpool, a 10-year absolute, and 28 per cent relative difference between the two ports (Szreter and Mooney, 1998, table 1). Inequalities in health had to rise all through the 1980s, 1990s and in some ways through the noughties to end with life expectancy gaps between whole cities again being of Dickensian extreme.

We should not fool ourselves into thinking that the situation by May 2010 was good. It was not. It is just that it is now getting worse. New Labour allowed economic inequalities to grow. The National Health Service, with the extra resources it was given between 1997 and 2010, managed to prevent that growing economic inequality resulting in rising mortality amongst the worse-off. That time has now ended.

Why economic inequality and health are related

There are many ways in which economic inequalities damage health. For instance, in more unequal affluent countries people tend to become obese more easily than in more equal affluent countries (Pickett, K. and Wilkinson, R., 2012). They become obese for many reasons. Anxiety and stress are higher. The normal curbs on advertisers trying to sell food that is bad for children and adults tend to be weaker. More people are too poor to be able to eat healthy and stay thin. There is less trust, more fear, more comfort eating. Academics argue about what factors connected with economic inequality matter most, but almost all agree that high and rising inequality is detrimental to good public health.

When it comes to providing a health service it is harder to provide a good health service in a more economically unequal country, especially one in which inequalities are growing. The rich in a very unequal country are more likely to opt out of national health services, and have less interest in the quality of that service. It can become harder to encourage well paid doctors and surgeons to live and work in poorer areas and regions in a more unequal country (Shaw and Dorling, 2004). A National Health Service is not enough, but losing the collective ethos of a National Health Service, while becoming more and more unequal, is not at all conducive to improving health.

When Britain was more economically equal, when the richest 1 per cent 'just' received six times average earnings ('just' four times after tax), the NHS was a 24/7 healthcare system. All was not perfect, but people, including people at the top, behaved differently. General Practitioners would visit you in your bed if you were ill, any day or night of the week. In contrast, by May 2012, on one night, two thirds of the county of Cornwall was covered by only a single GP "in a car west of Bodmin" working for a private profit-making company undertaking work now contracted out of the NHS (Lawrence, 2012).

When considering inequalities in health it is all too easy to come to a depressing but incorrect conclusion. This tends to be worded slightly differently depending on the political biases of the proponent, but it mostly comes down to this: a belief that misery will always be with us, a great many will always be poor, only a few can be rich, and most will die, on average, much earlier than the best-off. This is not

because we cannot control our numbers, invent cures or prevent pain, but because human beings are inherently predisposed to be selfish and, in being selfish, to harm others.

A virtue of selfishness is built up on the political right. It is seen as the driving force for the machinery of commerce. The suggestion is that there is no alternative to current levels of selfish behaviour except poverty for all. On the political left, capitalism is often not seen as curable, but merely containable. A more optimistic stance is possible, but living in times and places of great inequality can restrict the imagination.

What could be done?

New Labour's ambition was limited. The ethos was that the very worst effects of unbridled selfish behaviour could be slightly mitigated, so in some rich countries inequalities are lower than in others, but that all rich countries must sustain their affluence at the expense of many others – if not the poor within their own borders, then the poor abroad. The code for this in political speeches is “winning the global race”.

Selfish intentions can be hidden in what may initially appear as idealistic calls for everyone to take responsibility. A claim was once made, and vehemently denied, that Tony Blair said ‘I can't slim for you’, while discussing health as Prime Minister as he shared a public stage in Nottingham with the Chief Executive of Boots and the Managing Director of Slimming World (Donnelly, 2006). Boots is now owned by a hedge fund and companies like Slimming World profit more in unequal affluent countries where more people become obese.

There is growing evidence that a small proportion of the population is much more likely to engage in unethical behaviour than others and that, as affluent societies are currently constituted, members of this small minority often end up with far more resources and hence more power. The collective ability to control this selfish few has become weakened in recent decades, but there is also growing evidence that this is becoming more widely understood, further exposed, and that the malaise is now being acted on more than before.

We are becoming better at recognising that some people at the top are not nice people. We are also beginning to better recognise group behaviour, where members of an elite and isolated group develop amoral and antisocial behaviour in relation to those outside their group. Many of those who join the elite are unable to empathise with people outside their own small group. We are learning that we need to control the elite.

Learning about selfishness

During 2012, a study was published in the Proceedings of the National Academy of Science (PNAS). The study reported the results of a series of experiments on upper-class individuals which found, among other things, that they:

“... were more likely to break the law while driving, relative to lower-class individuals. In follow-up laboratory studies, upper-class individuals were more likely to exhibit unethical decision-making tendencies (study 3), take valued goods from others (study 4), lie in a negotiation (study 5), cheat to increase their chances of winning a prize (study 6), and endorse unethical behavior at work (study 7) than were lower-class individuals” (Piff et al, 2012, p 4086).

If we are trying to understand what is happening to the NHS a study such as this can be useful. The results of the PNAS study were disseminated worldwide. The National Science Foundation in the US issued a press release (NSF, 2012) and quoted the lead author of the study as explaining:

“The relative privilege and security enjoyed by upper-class individuals give rise to independence from others and a prioritization of the self and one’s own welfare over the welfare of others – what we call greed.... This is likely to cause someone to be more inclined to break the rules in his or her favor, or to perceive themselves as, in a sense, being ‘above the law’, ... and therefore become more prone to committing unethical behavior.”

The most interesting experiment in the study was designed to see whether people would become more likely to behave unethically if they were made to feel superior to others. This was done to check the extent to which it might be possible to alter selfish behaviour. If people could easily be made more selfish, then perhaps it would not be naive to believe that a large group could be helped to be far less selfish if they had their eyes and minds opened up to the collective effects of the selfishness of their actions. There is now some evidence that minds are opening as the set of quotations in Box 1 imply.

Box 1: A rainbow coalition in the making

In March 2012 the Deputy Prime Minister, Nick Clegg, called for the introduction of a tycoon tax targeting millionaires who employ “*an army of lawyers and accountants*” to reduce their tax bills (Channel 4 News, 2012). By March 2013 his party, and Labour, were arguing about what kind of tycoon tax might be best (BBC, 2013). This could be viewed with despair, or as evidence that there is a wider understanding evolving.

A year ago again, in March 2012, the leader of the Scottish Nationalist Party (SNP), Alex Salmond, committed his Party to paying a living wage, saying: “*We have taken the first steps already, with every employee of the Scottish Government, the NHS and our agencies, guaranteed from this year at least the living wage of £7.20 an hour. Two thirds of the thousands who have benefited have been women.... I can announce today that every SNP-led council elected in May will also introduce the living wage*” (STV, 2012).

In April 2012, in the US, President Obama continued to support taxation policies that would reduce income inequality. He stated in his speech on the Republican Budget: “*The income of the top 1 percent has grown by more than 275 percent over the last few decades, to an average of \$1.3 million a year. But prosperity sure didn’t trickle down. Instead, during the last decade, we had the slowest job growth in half a century. And the typical American family actually saw their incomes fall by about 6 percent, even as the economy was growing*” (Los Angeles Times, 2012).

During the same spring Christine Lagarde, the International Monetary Fund’s then Managing Director, called on China to reduce inequality, saying “*... more equal societies are able to achieve greater economic stability and lasting growth*”. She will have also known that quintile income inequalities in China and the US are almost identical (IMF, 2012). A year later the New Chinese premier, Li Keqiang “*...vowed to curb public discontent by tackling inequality*” (Branigan, 2013).

Stepping back a year ago, Angel Gurría, the OECD’s (Organisation for Economic Co-operation and Development) Secretary-General, continued the theme, suggesting: “*Inequality should be at the centre of our attention for economic, social and political reasons. Above all, inequality threatens social mobility ... countries with high inequality essentially reinforce the vicious cycle of poverty*” (OECD, 2012). And the rhetoric across Europe, if not in South East England, a year later changed again in response.

It can be hard to see the changes day by day. Year by year it is clearer to see, especially if you are not based in London and if you look out from England. If you just look to Westminster you are likely to react with despair. In April 2013 even the notorious Barclays banker Rich Ricci became “*a casualty of a management shake-up*” (Moore, 2013). Good news can be found in many places.

Conclusion

Health inequalities are worse in affluent countries where the richest 1 per cent have become the most acquisitive and their greed is least well controlled by the 99 per cent. As the implications of Table 1, discussed earlier in this paper suggested, it is in those more unequal affluent countries where overall health is poorer. This is hardly surprising. People become ill when the best-off 1 per cent of the population take up to a fifth of all income, leaving 99 per cent of the population with just four fifths of the national income to live on.

There is still much debate taking place as to the nature of the mechanisms that lead to more unequal affluent countries having worse health. Some who address this debate suggest that the worst is yet to come as “...income inequality may ... exert its strongest effects on health up to 15 years later” (Subramanian and Kawachi, 2004:86).

In studies involving over 60 million subjects in 28 separate trials it was found that since the 1990s, the strongest associations between income inequality and ill health existed in the most unequal of countries, and were strongest when the health effects could be measured some time after the rise in inequality (Kondo et al., 2009).

A tiny reduction in the income of the very richest 1 per cent, taking their share of national income down by just a percentage point through taxation, would raise much more than adding a penny on income tax for all other earners. Taxation on wealth, including on land values, would gain even more if (and when) more was needed. And curtailing the riches of the rich could even make most of them more sociable.

In contrast, a policy to make the poor poorer encourages the majority to become more selfish. As poverty rises everyone becomes more frightened and increasingly violent in attitude and sometimes action. When the poorest lose the most, it is within the rest of the population that income inequalities grow to be much higher than are found in more equal affluent nations, and everyone's health and happiness suffers as a result.

Policies in place of fear need not be costly policies but they need to be a genuine commitment. One weak point for Conservatives is that they require fear for their

popularity to spread. Their policies are based on the belief that it is only out of fear that most people can be made to work, behave, and even go to school. Tories think that it is only out of fear of economic catastrophe that the majority can be cajoled not to complain when they lose access to a health service that was once both free at the point of delivery and which once did not serve to help a few make great profits.

There is wide support from some Liberals, many Nationalists in Scotland and Wales, from Greens, and in the Labour party, for policies in place of fear. These groups are opposed by those who would use fear of the poor, fear of immigrants, fear of relying on benefits and fear of poverty itself, to try to split up opposition to the privatisation of everything that can be privatised, from the water you drink, to the universities you may study at, to the health service you will, one day, rely on.

This paper began by talking about *In Place of Fear*, Bevan's 1952 book. Seventeen years after it was published another giant of the Labour party (Barbara Castle) put forward the White Paper, "In Place of Strife", in January 1969. Its recommendations were never implemented. One reason why Britain now has such higher health inequalities as compared to other affluent nations is that during the 1970s it did not, collectively, choose to reduce strife. Most other affluent nations did and their top 1 per cent now take much less and most people in those normal, more equal societies live for longer, with less anxiety, and less fear.

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