

Article

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Observations

Body Politic

Mind the gap

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Britain is a profoundly unequal country, and there's not much that health care can do about that

One of the first acts of the incoming Labour government in 1997 was to ask Donald Acheson, then chief medical officer, to carry out a review of health inequalities. A decade after his recommendations the Department of Health published, in May, a review of what has happened since (www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098936). It is a first class report—but what piffling progress it records. Health inequalities are as wide as ever, wider in some cases. Successes, where they exist, are measured in fractions of a percentage, at the margin of statistical significance.

You would have been hard pressed to discern this from the speech made by Alan Johnson, secretary of state for health at the time of publication. He rightly celebrated improvements in life expectancy and infant mortality but did not acknowledge the unwelcome figures that his own report spelt out. The gap between disadvantaged groups and the rest of the population in these two measures has not changed, it says: "The current data (for 2005-07) shows that the gap is no narrower than when the targets were first set."

Speaking to the Fabian Society, Mr Johnson thought he could win an easy point by saying that under the Conservatives the difference in the mortality rate in men between the lowest and highest socioeconomic groups had widened, so that by the early 1990s it was "three times higher." That is true. But more to the point is that it has not changed since. As for infant mortality, the gap between the lowest groups and the rest was 13% in 1997-9 and 17% in 2004-6.

Disregarding the politics, these are extremely disappointing figures when set alongside Labour's sincere efforts to reduce health inequalities. It was certainly hard to share Mr Johnson's optimism when he said, "The fact that the gap is wider does not mean that our approach is wrong—indeed it has been acknowledged that the evidence based

approach we have taken is leading the way internationally. We now have a strong foundation on which to make further and faster progress."

The truth is that health inequalities have relatively little to do with health care and lots to do with inequality generally. Of course, it helps to ensure that everybody has access to a GP and that health care of a consistent standard is universally available, but if that were all that is needed the NHS would have eliminated inequalities years ago, as its founders doubtless expected.

Much more important are gaps in wealth between rich and poor, and here Labour's record is doubly disappointing for anyone raised in the belief that the people's party stands for equality. Peter Mandelson's comment that New Labour was "intensely relaxed about people getting filthy rich" is notorious, but the rider was (I assume) that the very rich help everybody else to advance by providing investment and jobs.

The evidence is that under Labour income inequality has in fact widened, though not as rapidly as it did in the Thatcher years. The best measure is the so called Gini coefficient, which condenses income inequality into a single number between 0 (complete equality of incomes) and 1 (where a single individual has all the money and nobody else has anything at all). In the 1980s the UK's Gini coefficient rose from 0.25 to reach 0.34 by the early 1990s. It dipped under the Major government and rose again under Blair. At 0.35 it is higher now than it ever was under Mrs Thatcher, in spite of tax credits, child poverty programmes, and the like.

The main reason for this is what has happened at the extremes. The top 10% of earners have seen their incomes grow far faster than the average, while those of the bottom 15% have grown far more slowly than average. So Labour's attempts to equalise incomes have failed to penetrate as far as the filthy rich or the underclass.

Even more striking are the figures for regional disparities in wealth, which have widened to an extraordinary degree since 1997. Britain has the widest range of gross domestic product (GDP) per person of any country in the Organisation for Economic Co-operation and Development, from 54% of the national average in the most disadvantaged regions to 444% of the average in the most prosperous. For comparison, the range is 71% to 154% in Denmark and 73% to 125% in the Netherlands.

The United Kingdom really is two countries, with a huge and growing gap between them. GDP per person in west London is four times the national average, while at the other extreme in Anglesey it is half. These regional disparities, already high in 1995, grew rapidly in the next 10 years, with the financial sector of the economy, based principally in London, as the main driver.

From this perspective Labour's failure to reduce health inequalities is understandable: indeed, you might even claim that it has done well to stand still while wealth disparities

exploded. But that's small consolation, as Labour was in charge of the economy, too, while that widening gap in wealth developed. It encouraged it through economic policies that made financial services the motor and allowed the banks free rein.

So, does the recession offer a glimmer of light? Unfortunately not. The evidence is that with the exception of a few bankers who lost their jobs, the pain of unemployment is mainly being felt in northern regions. And when the reckoning comes and public spending is forced to fall to rebalance the books, it will be these less prosperous regions that suffer most, for it is there that most spending is concentrated. In Scotland, Wales, Northern Ireland, and the north east of England the state accounts for more than two thirds of the economy.

Michael Marmot, professor of epidemiology and public health at University College London, has been asked to chair a panel to decide what next to do to reduce health inequalities. I wish him well, but the prognosis is not good. Britain is a profoundly unequal country: health inequalities are merely one small manifestation of that.

Letter

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Letters

Mind the gap

Reducing the gap

Hawkes emphasises the widening in health inequalities with the increasing inequality in absolute income.¹ People in the most deprived areas live in the poorest quality housing with poor insulation. Thus heating the house, even inadequately, takes a disproportionate percentage of an already low income. Poor insulation also leads to the development of mould, which affects health and family economics.

In Easthall, a part of Easterhouse, a very deprived area of Glasgow, two blocks of flats (36 flats) were refurbished to a high standard, thanks to the determined efforts of residents.² Blood pressure fell from a mean of 142/85 mm Hg to 122/73 mm Hg.² This fall is greater than that seen in studies showing the beneficial effects of lowering blood pressure.^{3 4 5} In one resident the incidence and severity of cardiac incidents fell dramatically. The incidence of respiratory disease also fell, three people with severe asthma being able to stop all drug treatment. Patients with arthritis could reduce their treatment.

Reducing the temperature differential between the rooms rather than the absolute temperatures was important in improving health. Before the refurbishment, many families could afford to heat only one room: in winter they would have had to spend

£60/week to achieve the recommended healthy temperatures throughout and to avoid the risk of condensation dampness. However, the refurbished flats could be kept comfortably warm throughout for about £7/week, including plenty of hot water. The absence of damp and mould also meant not having to replace furnishings damaged by mould.

Thermal refurbishment of poor quality housing is an opportunity to decrease financial disparities and health inequalities.

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