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Social inequalities in health

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Although *The Health of the Nation* never considers making social inequalities in health a key area, it acknowledges the effects of "social circumstances" and the "physical and social environment" on health and accepts that health varies "significantly" according to social and occupational group.¹ It even provides two examples. Given the usual official reticence on the topic this represents progress.

In his foreword Mr Waldegrave goes a step further: he accepts that remedial measures work. Providing financial support for certain groups and putting a decent home within the reach of every family is partly justified by "their relation to health." But the document backs down from the obvious next step: tackling social inequalities in health head on. Instead it counsels "tempering idealism with pragmatism" when confronting the challenge of the variations. "The Government does not believe there is any panacea—here or elsewhere in the world—either in terms of a full explanation or a single action which will eradicate the problem." Progress may be possible on three fronts:

- Through the continued general pursuit of greater economic prosperity and social well being
- Through trying to increase understanding of the variations and the action which might effectively address them
- Through specific initiatives to address the health needs of particular groups.

In his valedictory report on the state of the public health the last chief medical officer wrote that low income, unhealthy behaviour, and poor housing and environmental amenities had the clearest links with the

excess burden of ill health.² At the press conference launching his report Sir Donald was more forthright, saying that health inequalities will be eradicated only by government measures to tackle poverty and improve the conditions in which people live. "While to specialists in public health the most attractive points of initial attack are health promotion initiatives to reduce risk factors such as smoking, poor diet, and physical activity, there is a limit to the extent to which such improvements are likely to occur in the absence of a wider strategy to change the circumstances in which these risks arise by reducing deprivation and improving physical environment."

Social inequalities in health must therefore warrant further scrutiny as a possible key area.

Major cause of ill health

The Health of the Nation recommends judging candidates for key area status against three criteria. How do social inequalities in health measure up? The first criterion is that the area should be a major cause of premature death or avoidable ill health in the population as a whole or among specific groups. Examining "burdens of disease"—mortality, morbidity, and cost—is one way suggested for identifying the most serious problems.

MORTALITY

A gap exists between the death rates of non-manual and manual workers for most causes of death in almost every age group, and the gap is widening (figs 1 and 2³). In 1981, 62 of the 66 "major list" causes of death in

men were more common in social classes IV and V (combined) than in other classes. Of the 70 major causes of death in women, 64 were more common in women married to men in social classes IV and V.⁵

Stillbirths, deaths within the first year of life, and deaths in children are all more common in the lower socioeconomic groups (fig 1). If the whole population had experienced the same death rates as the non-manual classes there would have been 700 fewer stillbirths and 1500 fewer deaths in the first year of life in England and Wales in 1988,⁶ 750 fewer deaths in children in England and Wales in 1981,⁷ and 17 000 fewer deaths in men aged 20-64 in Great Britain in 1981.⁸

The Health of the Nation also suggests using less "crude" measures of mortality, such as "years of life lost." When this is done the familiar socioeconomic gradient reappears, although it is steeper than for the

FIG 1

TABLE 1—Comparison of social class differences in years of potential life lost (per 1000 population) and standardised mortality ratio; 1981 data for Great Britain*

Social class:	Men aged 20-64		Women aged 20-59	
	Years of potential life lost	Standardised mortality ratio	Years of potential life lost	Standardised mortality ratio
I	39	66	16	69
II	45	76	18	78
III Non-manual	57	94	22	87
III Manual	63	106	23	100
IV	72	116	27	110
V	114	165	34	134
Ratio of classes V:I	2.9	2.5	2.1	1.9

FIG 2

standardised mortality ratio (table I). It has also increased between 1971 and 1981.⁹

MORBIDITY

Data from the general household surveys show a difference in the prevalence of longstanding illness between manual and non-manual groups, which has increased between 1980 and 1988.¹⁰ Clear socioeconomic gradients exist for the commonest reported causes of longstanding illness: musculoskeletal, circulatory, and respiratory conditions.² Davey Smith and colleagues cite numerous studies that have been published since the Black report that show social class differentials in morbidity.¹¹ Less privileged groups therefore not only have a shorter life span but also spend more of their lives in poor health.

Effective interventions

The second criterion is that effective interventions to improve health should be possible. The gap between the pay of the highest and lowest paid is now greater than at any time since official records began in 1886 (fig 3).^{12,13} The widening gap continues a trend that began during the 1979-81 recession after several decades of stable pay differentials.

With the widening gap in pay came a massive increase in the number of relatively poor people. The number of people living on less than half the average income—the European Community's definition of poverty¹⁴—more than doubled between 1979 and 1988, regardless of whether disposable income was assessed before or after the deduction of housing costs (table II).¹⁵ Depending on the definition used either one in four or one in five children was living below the poverty line in 1988.

Although real income grew by about one third for the whole population between 1979 and 1988, the median income (after deduction of housing costs) of people in the lowest two deciles of the income distribution increased by only 2% and 5%—hardly the "trickledown" that was predicted. In the United States, whose economic policies Britain's most resembled in the 1980s, the same thing happened: "the rich got richer and the poor got poorer," the numbers in poverty increased, and trickledown similarly failed to materialise.¹⁶ This must cast some doubt on the assertion that "the continued general pursuit of greater economic prosperity and social well being" necessarily leaves everyone better off.

One of the government's responses to social inequalities has been to target financial help to those in greatest need, and the benefit system was revised in

1988 to facilitate this. Whether the change is achieved this goal will have to await analysis of the next *Households Below Average Income*, which is unlikely to be published before next year. Early figures suggest that uptake of the new benefits has been no better than for those they replaced. Even for families receiving their full entitlement the adequacy of the new benefits has been repeatedly questioned. Agencies such as Barnado's, Child Poverty Action Group, National Associations of Citizen's Advice Bureaux, and National Children's Home doubt that the 1988 changes did anything to improve the conditions of those most in need.

Clearly the current arrangements are failing children, who can hardly be blamed for the circumstances in which they find themselves. Common decency justifies attempts to improve their welfare now. But evidence has also been accumulating that socioeconomic circumstances in childhood may affect the development of diseases in later life,¹⁸ doubly justifying efforts to improve children's lot.

With substantially more benefits unlikely to be available for the needy, what interventions offering "significant scope for improvement in health" are possible? Quick and Wilkinson suggest a way forward.^{19 20} On the basis of recent research they argue that overall health standards in developed countries are more dependent on the distribution of income within a population than with its average level. The most effective way of improving health is therefore to make incomes more equal. In the nine developed countries for which data are comparable life expectancy is closely correlated with the distribution of income (defined as the proportion of total income after tax and benefit income received by the least well off 70%). Their findings suggest that two thirds of the variation in life expectancy between these countries is related to differences in income distribution.

Redistributing income to offset the health disadvantage experienced by the poor would therefore be the best way of improving the average standard of health. Because in developed countries increases in income produce sharply diminishing health returns redistributing income from the relatively rich to the relatively poor might have little negative effect on the health of the better off.

Supporting evidence comes from a comparison between Britain and Japan. At the beginning of the 1970s income distribution and life expectancy were quite similar. Japan now has the most equally distributed income in the world—and the longest life expectancy.²¹ Further evidence comes from Britain during both world wars. Paradoxically, civilian life

TABLE II—Number (percentage of people living on less than half average income (Great Britain))¹⁵

	All	Children
	<i>Before deduction of housing costs</i>	
1979	3 750 000 (7.1)	1 310 000 (9.8)
1988	9 130 000 (16.8)	2 530 000 (21.1)
	<i>After deduction of housing costs</i>	
1979	4 930 000 (9.4)	1 620 000 (12.2)
1988	11 750 000 (21.6)	3 010 000 (25.1)

expectancy increased two to three times faster in wartime than during the rest of the century. Both wars were periods of rapid income redistribution. More recently—as Britain has become a much less equal society—mortality in men aged 15-44 has begun increasing (even after excluding deaths from AIDS).²

Setting targets and monitoring progress

The third government criterion is that it should be possible to set objectives and to monitor progress towards their achievement. If the objective is to reduce social inequalities in health, what should the targets be? One could be to reduce the social class gradients in mortality and morbidity (measured as the ratio of morbidity or mortality experienced by different classes—either V:I or manual:non-manual).

Analyses of deaths by occupational group are available only every 10 years—too long to wait to check progress. Socioeconomic data on stillbirths and deaths in infants under 1 year are available annually (although with a two and a half year delay) and could be used. Among the various measures available postneonatal mortality (deaths between 28 days and one year) is regarded as the most sensitive to socioeconomic factors. What may muddy the waters is the NHS Management Executive's decision to make variations in infant mortality one of its two main targets this year. Infant mortality would become less useful as a proxy for the health of the whole population if extra resources were being devoted to it.

Another proxy measure—perhaps the least amenable to "interference"—might be mortality in men aged 15-44, particularly since it has been increasing recently. Figures for mortality by age and sex are available with the least delay of all the potentially useful demographic variables.

Morbidity may respond more rapidly than mortality to interventions, although morbidity lacks the unambiguity of death. For example, differences in "illness behaviour" among socioeconomic groups might invalidate the use of responses to the general household survey, visits to doctors, or absenteeism from work as reliable indicators of morbidity. More detailed studies that have attempted to validate subjective measures with objective indicators of morbidity have been done, although regular studies of sufficient size would be extremely expensive. Perhaps the government's programme of national health surveys will provide more details on how morbidity varies by socioeconomic group, although resources are apparently posing problems.

The case against

Why not make social inequalities a key area, Mr Waldegrave was asked at the press conference marking the publication of *The Health of the Nation*. Wasn't reducing inequalities in health between and within countries the first and possibly most important target of the World Health Organisation's European strategy for Health for All by the Year 2000? (Britain signed up with the strategy in 1985: *The Health of the Nation* may be seen as the government's belated response to national target setting.)

FIG 3

Source: IFS Fiscal Studies

Mr Waldegrave replied that although reducing inequalities in health was "a perfectly legitimate target," the divisions were so fundamental, complicated, long lasting, and recalcitrant that they were not a suitable government target. Targets needed to be specific, measurable, and most of all achievable—"otherwise the whole thing comes into disrepute."

None of these reasons for rejection stands up to scrutiny. Reducing inequalities may be difficult but not impossible. Britain has already managed it during two world wars; Japan managed it over the past 20 years. Sweden's social class differentials in health may persist after 50 years of effort to reduce them, but they are less than Britain's.²²

The exact mechanisms linking social inequality and poor health may remain poorly understood, but action doesn't need to await fuller understanding. The accurate identification of the organism responsible for cholera epidemics was not necessary for effective preventive action. Identifying the carcinogens in tobacco smoke wasn't a prerequisite for reducing cigarette smoking.

What should the strategy be?

We need government policies on benefits and taxation that would result in more equally distributed incomes. If this sounds like some Scandinavian (or worse, Stalinist) social engineering it's as well to recall that the sudden widening in the distribution of income (fig 3) and the sudden increase in relative poverty since 1979 (table II) flowed directly from government policies and was not a "natural" phenomenon.

The government's policies on taxation have meant that all income groups pay less direct tax now than they would have done in 1979, although the highest tax payers have benefited disproportionately. Of the £28.7bn tax cuts made between 1978-9 and 1991-2, £480m (1.7%) has gone to the 3.7 million taxpayers earning less than £5000 a year whereas £9500m (33%) has gone to the 400 000 people earning over £50 000 a year.²³

The main factor in the increased numbers of people living in relative poverty was the government's decision in 1980 to index social security benefits to prices rather than to earnings. Since 1979 the relative value of retirement pensions, unemployment benefit, and invalidity benefit has fallen by one fifth compared with average earnings.²⁴

John Hills has calculated that since 1979 the changes in direct taxation and benefits have been achieved at virtually zero net cost. "The cuts in direct taxes have been entirely paid for by the cuts in the generosity of benefits... the overwhelming majority of the bottom

half... have lost; the overwhelming majority of the top 30% have gained."²⁵

What of poor housing's "clear link" with the excess burden of ill health?²⁶ The government has discouraged building of new council houses (new starts are down by three quarters since 1979) and encouraged the sale of existing council houses. High interest rates, recession, and unemployment have taken their toll: mortgage repossessions and households accepted as homeless are both at record highs. Government policies have been responsible for this: government policies could just as easily reverse these trends. The government provides some £7bn in mortgage relief, which goes to the relatively better off. (In 1988-9 the estimated cost of the relief was equivalent to nearly three quarters of the total public expenditure on housing, including housing benefit.²⁷) Expenditure on mortgage relief could easily be diverted to better housing for the poor.

Problems of implementation

The problem of making social inequalities of health a key area is that the solutions lie beyond the Department of Health, and the omens for interdepartmental cooperation are not good. Mr Waldegrave may be reluctant to tackle social inequalities in health; some of his colleagues seem unaware of any connection between socioeconomic circumstances and health (fig 4). As Wilkinson says, "the Chancellor has a much greater impact on health than the Secretary of State for Health, a thought that may well not cross the minds of either."¹⁹

The sad fact is that the first aim of political parties is to get elected (or re-elected) to government. Reversing the tax cuts of high earners and abolishing mortgage relief could be political suicide for whichever party proposed it.

Convincing enough people of the benefits of income redistribution will be difficult if not impossible. (Haven't the poor always been with us?) The first step must be to emphasise that there is nothing "natural" about the current state of affairs: it results from political choices. Choices could be different, and changing government policy need not necessarily spell industrial ruin. In fact, it could mean the opposite: look at egalitarian, long living Japan or the work of Alesina and Rodrik, who found that among democracies more equal income distribution was associated with higher growth rates.²⁸

If the health of the nation—the whole nation—is to improve then the distribution of the disposable income of its population needs to be made more equal.

FIG 4—Come on down: the price is right

Establishing a classless society would not necessarily produce this outcome, although it would vastly increase the likelihood of doing so.

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Junior Doctors. The New Deal

The negotiating perspective

Stephen Vallely

For many years the problem of the excessive number of hours worked by doctors in training simmered quietly below the surface of hospital life. Now, however, their plight is more recognised and public opinion is firmly behind them in their attempt to provide a safe service for patients by securing a reduction in the hours which they are expected to work. Junior doctors are no longer willing to sit back and suffer in silence. A survey conducted last year by the Hospital Junior Staff Committee (now the Junior Doctors Committee) emphasised the intensity of feeling: 98% of doctors in the training grades were prepared to take some form of action to limit their hours, with 53% willing to provide an emergency only service.¹

The government has also been aware of the problem for a long time and in 1990 the Minister for Health set up a working party. In December 1990 heads of agreement was published, committing all the signatories "to reduce average contracted hours to 72 per week, particularly for those in hard pressed posts. . . . In the short term . . . no junior in a hard pressed post should be required to be on duty for more than an average 83 hours a week."² The Junior Doctors Committee was asked to "open negotiations immediately in the appropriate negotiating forum to secure the necessary changes in the contracts and conditions of service of junior hospital doctors—and rates of remuneration—to reflect and encourage flexible working patterns."² In conjunction with the Department of Health the committee's negotiating subcommittee decided to divide the task into two phases. The outcome of the first phase was the new deal launched in June.³ The second phase—to agree rates of remuneration for the new working patterns which had been established—is now under way.

In the past the JDC's negotiations on hours of work have had two objectives: to introduce legislation to limit hours or to persuade the Doctors' and Dentists' Review Body (DDRB) to recommend penal rates of pay for out of hours work. Neither objective has been achieved. The Department of Health and the DDRB

are reluctant to agree piecemeal changes to the out of hours pay rates, arguing that this would be expensive and inefficient—those who would gain most were not necessarily the most hard pressed—and might encourage juniors to contract for excessive hours for personal financial gain. Furthermore, the prospect of legislation to limit hours is remote—at least in the short term. The government has consistently dismissed legislation as a crude weapon.

The DDRB's 1990 report suggested that the most satisfactory solution to the problem would be to negotiate a new contract for junior doctors.⁴ The present contract is incapable of recognising variations in workload with no incentive to health authorities to decrease hours. And the remuneration for out of hours work is totally inadequate.

Basic principles

Three basic principles should be borne in mind in any attempt to renegotiate the contract. Firstly, there is a more pressing need to reduce hours for pre-registration house officers and senior house officers. The Dowie report showed that the percentage of average duty hours actually worked varied in a predictable fashion between 56% for senior registrars and 71% for house officers.⁵ On average senior house officers worked for 66% of their duty hours and registrars for 59%. Secondly, advances in medical practice have taken place since the contract was last negotiated. The same type of contract is, in most instances, no longer appropriate either for doctors in general professional training or for doctors in higher specialist training. Finally, in renegotiating the contract it is essential that the majority of doctors in training do not suffer financially from any new arrangements. With these principles in mind we embarked on negotiations with the Department of Health to secure alternatives to the present system.

Out of hours cover is normally provided by doctors working a rota system with its inherent disadvantages

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