Health inequalities and New Labour: how the promises compare with real progress

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Inequalities in health between rich and poor areas of Britain widened in the 1980s and 1990s, and the current government has repeatedly expressed its intention to reduce these inequalities. In this article, however, the authors report that inequalities in life expectancy have continued to widen, alongside widening inequalities in income and wealth, and argue that more potent and redistributive policies are needed.

This year marks the 20th anniversary of the World Health Organization’s Global Strategy for Health for All by the Year 2000, which proposed 38 targets to reduce inequalities in health.1 These targets were taken up by the governments of many countries, including Margaret Thatcher’s Conservative government in the United Kingdom, which, just like Tony Blair’s current administration, wished that inequalities in health would fall (see box).

In Britain the observation of and preoccupation with health inequalities has a much longer history than the last two administrations,1 and many recent studies have documented a social and spatial polarisation of life chances continuing into the 1980s and late 1990s from a possible lull in the 1970s.4–7 Clearly then, the Health for All aim of reducing inequalities between groups of the population had not been reached by the end of the 1990s—in fact, the opposite had occurred even though the fourth goal of increasing life expectancy has been attained.

Increasing health inequalities have been shown to reflect trends in income inequality, which also increased substantially over the last decades of the 20th century.8,9 While in opposition, the Labour party had made political capital out of the non-implementation of the recommendations of Black report.4,9,10 The New Labour government that came to power in 1997 did not initially shy away from acknowledging the wider (social and even structural) determinants of health (although the recent public health white paper “Choosing Health” very much places the responsibility for health with the individual11). In 1997 Tessa Jowell, then minister for public health, criticised the previous administration for its “excessive emphasis on lifestyle issues” that “cast the responsibility back onto the individual.”4

Labour has repeatedly expressed rhetoric directed at tackling health inequalities: “Tackling health inequalities is a top priority for this government” (Hazel Blears, parliamentary under secretary of state for public health12). Indeed, the government has launched repeated and unprecedented initiatives signalling its intent to tackle health inequalities through an independent inquiry,2 a “cross-cutting review,”12 and a “programme for action.”13 In February 2001 it announced two headline national targets for 2010—to reduce the gap in infant mortality across social groups and to raise life expectancy in the most disadvantaged areas faster than elsewhere.14

The four cornerstones of the Health for All policy2

- Ensuring equity in health by reducing gaps in health status between countries and between population groups within countries
- Adding life to years by helping people achieve, and use, their full physical, mental, and social potential
- Adding health to life by reducing disease and disability
- Adding years to life by increasing life expectancy

Despite government rhetoric to the contrary, inequalities in health and wealth have continued to increase in Britain.
The original wording of the latter target, as announced by the secretary of state in February 2001, was: “Starting with health authorities, by 2010 to reduce by at least 10 per cent the gap between the quintile of areas with the lowest life expectancy at birth and the population as a whole.” This is not simply a health target but, arguably (given that Frank Dobson, then secretary for health, stated in 1997: “Inequality in health is the worst inequality of all. There is no more serious inequality than knowing that you’ll die sooner because you’re badly off”), is the most basic of all government targets for “bringing Britain together.”

Technically, however, this is only a partial target for health inequalities because it concerns people with the worst life expectancy in comparison with the average rather than the worst compared with the best. Although comparing worst and best can be used to good effect to convey the extent of inequalities (fig 1), better still is the slope index of inequality, which takes into account the position of all groups across the gradient simultaneously (see below).

The progress towards the life expectancy target can be monitored by means of the statistics that the government now makes available (www.statistics.gov.uk), but it should be noted that the target now states: “Starting with local authorities, by 2010 to reduce by at least 10 per cent the gap between the fifth of areas with the lowest life expectancy at birth and the population as a whole” (because health authorities as defined at the time of the original target no longer exist). The baseline for the target has been set at 2001, and the most recent life expectancy data available are for 2001-3, so we cannot yet, even eight years after the election of New Labour, assess progress completely—but we can look at the trend up to the end of 2003.

Tracking progress towards (sensible) targets

In this article we check progress by using a modified version of the government’s target that can be calculated for different times and which is less sensitive.
Taking poverty into account

Having obtained life expectancy and population data by area over time, we then need to order areas in some way. The official method is to rank areas, at each time point, by life expectancy. An alternative, and arguably better practice,\(^2\) is to rank the areas by a measure that reflects the residents’ socioeconomic circumstances at the start of the period studied; we use a measure of poverty.

Poverty in 1991 can be best indexed by a modified version of the 1991 Breadline Britain index, based on lack of basic amenities and access to a car, unskilled and semiskilled manual occupations, unemployment, households that are not owner-occupiers, and lone parent households. This index has the advantage of being based on what a sample of the population consider to be the conditions and extent of poverty and is a validated indicator of poverty.\(^21\)

We therefore ranked local authority districts according to this poverty measure and grouped them into 10ths of equal population size on the basis of this ranking. We used the same 10ths, based on the 1991 census data, for each of the time periods so that, all else being equal, inequalities should attenuate over time as the poverty rate is for areas ranked at the start of the study period. In practice the choice of census date is immaterial as the geography of poverty has changed little since 1991 (the correlation coefficient of the 1991 Breadline Britain index and a preliminary version of the 2001 index for local authorities in Britain being \(r = 0.97\)\(^2\)); indeed there is some evidence that the broad geography of poverty in Britain has changed little over the past century.\(^23\)

Note that a poverty ranking of areas tends to be robust—in contrast with the official measure of health inequalities, which sorts areas into 10ths on the basis of the contemporary life expectancies. The official measure is highly volatile because individual authorities can enter or leave the worst off fifth of areas as the result of a tiny number of events.\(^25\)

The most inclusive measure of inequality in life expectancy is the slope index of inequality, which we calculated for each three year period from the slope of the regression line from the hypothetically poorest individual to the hypothetically richest individual derived from the relative poverty ranks of life expectancy for each local authority district, weighted for population size.\(^26\) The slope index of inequality takes into account all measures for all areas and not, say, simply the worst-off and best-off 10th or fifth of areas. The index is most effective as a summary measure when the two measures are linearly related, as is the case with the data we Analysed. The index has a further advantage that it is, by definition, unaffected by general increases or decreases in life expectancy over time (in this case the constant changes but not the slope).

The table shows the life expectancy for males, females, and both sexes combined by poverty. Over the 10 years studied life expectancy has risen for all poverty groups. However, the slope index of inequality for both sexes has also edged upwards, from 3.71 in 1992-4 to 3.87 in 2001-3. The absolute difference in life expectancy between the top and bottom poverty groups has increased to more than four years. Similarly the difference between the individual local authority

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announcements were implemented in April 2002. The income distribution, since the 2001 budget side increases in benefits for those at the lower end of may have become slightly more redistributive, along-
factors contributing to this suggests that direct taxation
most recent period for which data are available income
inequality (by poverty by area) and income inequality
the first years of the 21st century, both mortality and
New Labour government thus inherited a slightly
Conservative government was in power. The current
slightly in the early 1990s —when John Major’s

†Individual local authority areas with the highest and lowest life expectancies.
*Groups formed by ranking local authority districts according to poverty and grouping them into 10ths of equal population size on the basis of this ranking.

Figure 2 shows the trend in slope index of inequality in life expectancy alongside trend data for income inequalities from the early 1980s to the early 2000s. W e
Trends in both series of data fell
Both sexes combined
Males
Females
Poverty group*:
Both sexes combined
Males
Females
1 74.4 74.8 75.5 76.2 71.2 71.7 72.5 73.3 77.4 77.8 78.3 79.0
2 75.4 75.9 76.4 77.1 72.3 73.0 73.6 74.5 78.2 78.6 79.0 79.5
3 75.7 76.1 76.7 77.4 72.8 73.4 74.0 74.8 78.4 78.7 79.3 79.8
4 75.7 76.1 76.8 77.3 73.0 73.3 74.0 74.9 78.4 78.7 79.2 79.7
5 76.2 76.6 77.2 77.7 73.4 73.9 74.5 75.3 78.9 79.2 79.6 80.0
6 76.9 77.3 77.8 78.4 74.1 74.6 75.4 76.1 79.5 79.8 80.2 80.6
7 77.2 77.6 78.3 79.0 74.6 75.2 75.9 76.8 79.7 79.9 80.6 81.1
8 77.5 78.0 78.6 79.3 74.9 75.6 76.3 77.1 80.0 80.4 80.8 81.4
9 78.0 78.4 79.0 79.7 75.4 76.0 76.8 77.7 80.3 80.6 81.1 81.7
10 76.3 78.4 79.5 80.3 75.9 76.5 77.3 78.3 80.6 81.0 81.5 82.2
Slope index of inequality
3.71 3.69 3.80 3.87 4.47 4.50 4.57 4.64 3.00 2.94 3.08 3.12

What does all this show?
The new data and the use of conventional measures such as slope index of inequality show increases in health inequalities in the early years of the 21st century in the UK; life expectancy continues to rise in the most advanced areas of the country at a greater pace than in the poorest areas. This is despite much government rhetoric during the two terms of its administration proclaiming its intention to tackle health inequalities.

Moreover, for almost 20 years now, income inequality has remained at a historically high level. Income inequalities rose markedly in the 1980s and have been sustained throughout the 1990s and into the 2000s. These inequalities are such that the poorest 10% in society now receive 3% of the nation’s total income, whereas the richest 10% receive more than a quarter. Income inequality is only part of the picture, however.

Wealth (which can be financial, such as savings, or in terms of other assets, such as house ownership) is more unequally distributed than is income. From a life course perspective wealth—which reflects lifelong circumstances—is a more salient measure than income. The distribution of wealth became more equal through much of the 20th century, but since the 1970s wealth inequality has increased, particularly so since 1995-6. Between 1990 and 2000 the percentage of wealth held by the wealthiest 10% of the population increased from 47% to 54%, and the share of the top 1% rose from 18% in 1990 to 23% in 2000. In Britain by area between 1993 and 2003, the housing wealth of the best off 10th of children increased by 20 times more than that of the worst off 10th of children.

Clearly for some health outcomes there will be a delay in terms of the effect of material circumstances; the full impact of present income inequalities on population health may not be immediately apparent. Wealth inequalities, on the other hand, better reflect the accumulation of lifetime (dis)advantage, and the growing inequalities in wealth seen in recent years do not bode well for future trends in health inequalities.
Education and debate

Summary points

Inequalities in health widened in the 1980s and 1990s, and the current government has repeatedly expressed its intention to reduce these inequalities.

The health inequalities targets that have been set are symbolically important, but may be little more than that.

New analysis shows that inequalities in life expectancy between rich and poor areas of the UK continued to widen in the first years of the 21st century, alongside widening inequalities in wealth, suggesting that more potent and redistributive policies are needed.

It is not adequate simply to compare the worst off with the average, nor to pull some of the worst off out of poverty and assume inequalities in health will reduce.

Raising the living standards of some of the poorest people in Britain has not reduced overall inequalities in health, while inequalities in wealth have continued to grow and are likely to be transmitted to the next generation.

Are these inequalities inevitable?

Inequalities vary between countries, and some have reduced their internal inequalities in recent years.3 Inequalities in income and wealth are determined by policies on tax and benefits. Our levels of social security benefit for those out of work are relatively low compared with EU poverty standards40 and too low to sustain good health.41 42

Are these inequalities acceptable?

The British Social Attitudes Survey series has tracked the population’s opinion on the key issue that underlies health inequality since 1983,43 asking: “Thinking of income levels generally in Britain today, would you say that the gap between those with high incomes and those with low incomes is too large, about right or too small?”

In 1983, 72% of the population said that this gap was too large, and since 1989 this has been the view of 80% or more; in 2002, 82% of people thought this gap too large. Moreover, most people in each socio-economic group, income group, and self rated hardship group thought that the gap between people on high and low salaries was too large (77% of those “living comfortably,” 84% of those “coping,” and 90% of those “having difficulty”). There is also consensus with this view across the broad political spectrum, by party identification (71% of Conservative voters, 88% of Labour voters, 84% of Liberal Democrats voters, and 81% of those with no affiliation).44

Yet “redistribution” is a dirty word in British politics, and we are a far cry from Denis Healey’s threat to “tax the rich until the pips squeak.” In the run up to the general election Labour and the Conservatives will not even hint at any tax rises; only the Liberal Democrats have a manifesto policy to increase the minimum wage, new deal, and tax credits, more substantial redistributive policies are needed that address both poverty and income inequality.

What do recent changes suggest for inequalities in the future?

The current trend of growing inequalities in wealth suggests that we are likely to see growing inequalities, transmitted to and magnified among future generations. However, if there were the political will, the reduction in income inequalities seen for 2002-3 could signal a turning point in this vitally important trend.

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Readers guide to critical appraisal of cohort studies: 3. Analytical strategies to reduce confounding

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Analytical strategies can help deal with potential confounding but readers need to know which strategy is appropriate.

The previous articles in this series1 2 argued that cohort studies are exposed to selection bias and confounding, and that critical appraisal requires a careful assessment of the study design and the identification of potential confounders. This article describes two analytical strategies—regression and stratification—that can be used to assess and reduce confounding. Some cohort studies match individual participants in the intervention and comparison groups on the basis of confounders, but because matching may be viewed as a special case of stratification we have not discussed it specifically and details are available elsewhere.3 4 Neither of these techniques can eliminate bias related to unmeasured or unknown confounders. Furthermore, both have their own assumptions, advantages, and limitations.

Regression

Regression uses the data to estimate how confounders are related to the outcome and produces an adjusted estimate of the intervention effect. It is the most commonly used method for reducing confounding in cohort studies. The outcome of interest is the dependent variable, and the measures of baseline characteristics (such as age and sex) and the intervention are independent variables. The choice of method of regression analysis (linear, logistic, proportional hazards, etc) is dictated by the type of dependent variable. For example, if the outcome is binary (such as occurrence of hip fracture), a logistic regression model would be appropriate; in contrast, if the outcome is time to an event (such as time to hip fracture) a proportional hazards model is appropriate.

Regression analyses estimate the association of each independent variable with the dependent variable after adjusting for the effects of all the other variables. Because the estimated association between the intervention and outcome variables adjusts for the effects of all the measured baseline characteristics, the resulting estimate is called the adjusted effect. For example, regression could be used to control for differences in age and sex between two groups and to estimate the intervention effect adjusted for age and sex differences.