
Inequalities in mortality rates under New Labour

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NOTE – THIS IS THE DRAFT OF THE CHAPTER AS SUBMITTED FOR PUBLICATION. THE FINAL PUBLISHED CHAPTER WILL VARY FROM THIS VERSION THROUGH COPY-EDITING AND PROOF-READING.
New Labour came to power in 1997 to the theme of D'Ream's “Things can only get better”. As the lyrics to their campaign tune said, they thought they’d found the cause of all that was wrong in Britain and they were the people who would be the cure to the disease of prejudice and greed. They were going to be angels – and things could only get better.

Prior to 1997, throughout the long 18 years of Conservative government, Labour had referred to the issue of increasing social inequalities in health as an area of particular concern. Thus it was surely a good sign that before the May 1997 election they had announced that they would launch an independent inquiry into inequalities in health? The Inquiry was launched in July 1997, with Tessa Jowell, the new Minister for Public Health, criticising the health strategy of the previous administration for “its excessive emphasis on lifestyle issues” which “cast the responsibility back on to the individual” (DH, 1997). She gave a commitment regarding the Independent Inquiry’s findings that these “conclusions, based on evidence, will contribute to the development of a new strategy for health” (DH, 1997).
The Independent Inquiry report duly appeared (Independent Inquiry into Inequalities in Health, 1998). It presented a wealth of evidence on the extent and trends of inequalities in health. This, together with a large body of other evidence drawn together in the Report, demonstrated clearly that the previous two decades had seen large and growing inequalities in income in Britain, and that these had been accompanied by equally stark increasing inequalities in health and in life chances more generally defined. The main task of the Independent Inquiry had been to produce recommendations for policies that could alleviate inequalities in health. Some 39 recommendations, many with sets of sub-recommendations, were given. While they contain some focused policies, the overall force of the recommendations was considerably weakened by a lack of prioritisation; by being inadequately concrete; and by being uncosted (Davey Smith et al, 1998).

Because the recommendations were not presented in any hierarchy the essential fact that inequalities in health followed closely on inequalities in wealth was under-emphasised. In fact, inequalities in wealth continued to rise under New Labour well into their third term and will almost certainly continue to increase beyond that (Dorling et al, 2005). The recommendations on the necessity to ‘reduce poverty and income inequalities’ thus appeared at the time to have similar status to those regarding reducing traffic speed, or offering concessionary fares to pensioners. The fundamental role of inequalities in material circumstances in producing the inequalities in other exposures and outcomes was therefore missed, and it became a possibility that many of the Report’s recommendations could be adopted – at least nominally – without addressing the underlying determinants of health inequalities.

Many of the sets of recommendations were also too vague to be useful. Recommending “measures to prevent suicide among young people, especially among young men and seriously mentally ill people”, or “the development of policies to reduce the fear of crime and violence, and to create a safe environment for people to live in”, received universal support, but they were of little use in practice since it was not specified how these
things were to be brought about. Rates of violence in Britain subsequently rose under New Labour, although suicide rates did not (Hillyard et al., 2005).

As an example of how the recommendations were inadequately concrete, the Report advocates the development of a high quality public transport system which is affordable to the user and specifically refers to the large relative increases in rail fares compared to motoring costs, but it failed to make the obvious link with the privatisation of the railways. Rail prices have subsequently risen as the railways were not re-nationalised (Dorling, D. 2005, page xv)

Lastly, as the recommendations were not costed, it was impossible to evaluate the relative costs of their implementation, the predicted social benefits which would follow and the opportunity costs of not investing in other areas. This lack of costing allowed the key recommendations to be side-stepped by implying that they were unrealistic and could not be implemented in the current economic climate. (Davey Smith et al. 1998)

The previous major report on inequalities in health had been that of the committee chaired by Sir Douglas Black (which produced the so called Black Report (DHSS, 1980)), commissioned by the previous Labour government in 1977 and reporting to the then new Conservative administration in 1980. The Black Report discussed the inequalities in health and in income that existed at the time and made a series of policy recommendations. These were rejected by Patrick Jenkin, then Secretary of State for Social Services, as being unrealistic; the Report was deliberately released before a national holiday, with no press release or press conference, and with only 260 copies produced. (It was subsequently published as a paperback -Townsend et al, 1982 - and widely read.)

For 17 of the 18 years of Conservative government the Labour Party had made political capital out of the non-implementation of the recommendations of the Black Report. The report’s enthusiasm for addressing inequalities in health appeared to be one element which survived the transformation from old to new Labour. A few weeks before the May 1997 Labour election victory
Baroness Jay had stated that the Black Report “provided the essential base and policy guide to any responsible government wanting to take action” on inequalities in health (Lords Hansard, 1997). She then committed the incoming Labour government to a health strategy in which the distribution of economic resources would be a key element (DHSS, 1980). In the same debate another Labour peer had stated that the “failure since 1980 to implement any of the Black Report recommendations has caused disappointment to many and must have caused a great deal of needless suffering on the part of many of the poorest families” (Lords Hansard, 1997).

Thus following the election landslide of 1997 and in the light of Labour’s long-term declared policy on inequalities in health it was very disappointing that a major limitation on the Independent Inquiry was its brief from the government which stated that it had to be carried out “within the broad framework of the Government’s overall financial strategy” (see preamble to: Independent Inquiry into Inequalities in Health, 1998). This set the stage for what happened next and constrained the Inquiry from proposing markedly redistributive fiscal policies, given the commitments on taxation made by Labour prior to the 1997 election.

In understanding the position New Labour inherited it is worth remembering that the Black report was commissioned in 1977, when inequalities in income were in fact at an historic low point. In 1977 only 7% of the population were on incomes below half of the average after housing costs; by 1995/6 this had more than trebled to 24% (DSS, 1998) (where it remains, give or take a percentage point, today). The increasing inequalities in income – which led the U.K. to lead the developed world in income inequality and child poverty (Lynch and Kaplan, 1997) – started under the last Labour government, in 1977. Twenty years later Tony Blair declared that “I believe in greater equality. If the Labour government has not raised the living standards of the poorest by the end of its time in office it will have failed” (Howarth et al, 1998). However, the New Labour strategy of saying one thing and doing another was already clear. When the report of the Independent Inquiry was commissioned it was done with the constraint that its recommendations needed to fall within
the broad framework of the Government’s overall financial strategy (Davey Smith et al, 1999; Black et al, 1999). Since this strategy included maintaining the overall fiscal plans of the previous Conservative administration this meant no increase in taxation and therefore excluded the major strategy to reduce inequalities in income. After nearly two decades of the Labour party out of office promoting the implementation of the recommendations of the Black report, the commissioning of a new report with such constraints applied in advance was in fact a step backwards, although with characteristic New Labours spin the commissioning was presented as demonstrating commitment to the cause of reducing inequalities, rather than as the first of a number of side-steps of the central issue of inequality in income and wealth.

2. Midterm – We’ll get up and start again

Lifted up today, lifted all the way, yeah we could be lifted
We could be lifted from the shadows, we could be lifted
Lifted up to new horizons
When it all gets dark again, it doesn’t really matter ‘bout the rain
When it all gets dark again, it doesn’t really matter ‘bout the rain

http://www.lyricsdepot.com/lighthouse-family/lifted.html

New Labour went on to win the 2001 general election. Although its policies related to social inequality had been criticised, too little time had passed since 1997, it was argued, for their actual effect to be monitored (Dorling 2006). There was also no serious political alternative to Labour, and their reputation and record did not yet appear tarnished (even if they had chosen a campaign song with the chorus “we could be lifted” and ending “.when it all gets dark again, it doesn’t really matter ‘bout the rain”) The widening gap between rich and poor? continued to grow.

The widening gap in health by social class could be seen not only in the mortality rates of adults, but also in infants. In fact, it was the infant mortality rate that Labour expected to improve most quickly as that was not in any straightforward way affected by, for instance, the lagged impact of smoking
rates twenty years earlier. In his last report as Chief Medical Officer on the State of the Public Health, 1997) Sir Kenneth Calman in 1997 highlighted in his introduction a number of overall improvements in health, including the fact that infant mortality had reached its lowest recorded rate of 5.9 deaths per 1000 live births. However, a closer inspection of these rates revealed that, while overall infant mortality rates had levelled off in the 4 years prior to 1997, when these rates were considered by social class (of father), a different picture emerged. As figure 1a shows, there were growing differences between the death rates of babies with social class I fathers (professional occupations) and babies with social class V fathers (unskilled manual workers) - babies of unskilled manual workers were 2.2 times more likely to die than babies with fathers in professional occupations. For every 1000 babies born whose father was social class V, eight babies died within their first year.

These trends were based on only a few years of data when we first reported them (Davey Smith et al, 1999) - because of changes in how data are reported - and a relatively small number (statistically speaking) of deaths. Therefore, it was important to monitor the infant mortality rate by social class over the coming years to see if this trend continued. In fact, this infant mortality indicator was used as a government target, and as figure 1b shows, the excess mortality rate of the more widely defined infants in the “routine and manual” class actually fell when compared to “all” between 1996 and 1997 and 1997 and 1998. Unfortunately, after that it rose fairly relentlessly.
Figure 1. Infant mortality by social class, 1993-1996 and 1996-2003

![Infant mortality by social class, 1993-1996](chart1.png)

Figure 1a 1993-1996 death rate

![Excess over average "routine and manual" infant mortality (%)](chart2.png)

Figure 1b 1996-1997 excess mortality
Although the new infant mortality figures were not released in full until 2005, in New Labour’s third term, it had become obvious during the second term that mortality inequalities were not declining between areas. In fact, as table 1 shows, they had reached an all time high by the first two years of the New Labour government, but the lag-time in releasing and analysing data meant that that this was not known until their second term (Davey Smith et al, 2002).

Table 1: Geographical inequality in mortality in Britain 1990-1999

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Thus inequalities in health were rising both between social class for infants and between areas for premature mortality during both the first and second terms of the government, despite their pledge to reduce those inequalities as a priority.
Although a great deal could be written about what Labour did do in its first and second terms, that would detract from what actually happened on the ground. The Labour government has also written reams and reams of reports and papers itself on what it has done. We could also speculate about what might have happened had Labour not won power in 1997 and again in 2001, but it did win power. By this time Labour had become obsessed with its image and was releasing statistics showing that everything it measured was getting better everywhere (we do not exaggerate: see Dorling et al, 2002)). It was perhaps no coincidence that their third campaign theme song included the line “I know I'm not a hopeless case”. They had begun to believe their own spin.

The second term was also when the Labour government went to war, hand in hand with George Bush’s USA government, in Afghanistan and Iraq, further increasing inequalities in health worldwide. It was also in this term that Tony Blair increased his own pay by 41% in one year(Grice, 2001). Inequalities in wealth continued to rise (Wintour, 2004).

3. Third Term: I know I'm not a hopeless case

It was a beautiful day  
Don't let it get away  
Beautiful day  
Touch me  
Take me to that other place  
Reach me  
I know I'm not a hopeless case

What you don't have you don't need it now  
What you don't know you can feel it somehow  
What you don't have you don't need it now  
Don't need it now  
Was a beautiful day

Labour chose a song from U2 as their third campaign theme to help them secure the general election of 2005. Shortly after they won that election on a depleted majority they secured their own “Black report” moment. This came with the release of the government’s then long promised report on health
inequalities: ‘Health Inequalities – Status Report on the Programme for Action’, released on 14th August 2005. In July 2003, the government had stated that there would be an annual report from the Department of Health’s Health Inequality Unit on health inequality indicators in relation to the health inequality targets. Nothing appeared for more than two years, then, conveniently soon after the 2005 election and two years after the promise of an annual report, the Status Report finally appeared. The eventual release was also a curious affair (DH, 2005). It was reminiscent of the deliberately covert release of the Black Report on an August Bank Holiday Monday in 1980 discussed above. The Report also appeared at a time when the responsible Minister – Caroline Flint, Minister for Public Health, - was on holiday, and her deputy was unavailable. Even stranger, the press release referring to the Report (DH, 2005) deflected attention from the key finding of widening inequalities in life expectancy and infant mortality by headlining that twelve “early adopter sites” were to be the first areas to have “health trainers”.

Public Health Minister Caroline Flint said in the press release that: “Many people have difficulty in changing to a healthier way of life […] Health trainers are one of the many initiatives in the white paper which will help narrow this gap by supporting people to make healthier choices in their daily lives.” [DH 2005a] To Labour Party traditionalists, opposed to victim-blaming approaches to health promotion, this must have triggered memories of Conservative Minister Edwina Currie admonishing the poor to buy cheap but healthy food (Shaw et al. 2005a). To New Labour-by the end of the second term any admonition of greed having disappeared, relaxed about the rich getting richer (Blair 2001) and comfortable with the wholesale adoption of Conservative ideology - however, it was perhaps grist to the mill.
The scientific endorsement of the Report was also at odds with its key findings. After years of making seminal contributions to the study of the 'social gradient' in mortality, the chair of the Scientific Reference Group on Health Inequalities, the eminent epidemiologist, Sir Michael Marmot, implied that current inequalities within England were insignificant in comparison to marked historical improvements and international comparisons:
Now we’re talking about an average of 5 per 1000 live births for the
country and in the worst off areas it’s 6. It sounds like a scandal; why
hasn’t it got better? But in fact we’re looking at the most dramatic
improvement…..The worst off group is 6 per 1000 live births. The best
in the world is Iceland at 3 per 1000 live births, the worst in the world is
Sierra Leone with 196, so on a scale from Iceland to Sierra Leone the
worst off in Britain is 6. They’re very close to the Iceland
figures”.(Marmot, 2005)

Of course, such comparisons do add sobering perspective to the extent of
inequalities within England, but it was strange to hear the Chair of the
Scientific Reference Group on Health Inequalities dismiss inequalities within
his own society so easily. Even the most conservative measures of
inequalities in health between large areas in England show that all infants in
poorer areas are at least twice as likely to die in their first year of life than
those in more affluent areas (ONS, 2005). If the comparisons are made
between smaller areas and between the chances of babies born to affluent
couples versus those whose birth is registered to a poorer single parent or to
parents in lower social classes, the inequalities are considerably more stark
than the headline figure. Similarly the growing life expectancy difference
between areas (Shaw et al, 2005) equates to millions of years of life ended
prematurely every year in the United Kingdom. To imply that the suffering
caused as inequalities worsen is ‘minimal’ is surely misleading, and contrasts
Sir Michael Marmot’s comments a year earlier:

In 2004 it is not acceptable – at least to me – that life expectancy
should decline by a year for each of the next six stops you travel
eastwards along the London Underground District Line from Tower Hill
in the East End. Talking about individual choice in health makes good
political rhetoric. But the scientific reality is that peoples’ choices are
determined by their social arrangements and life circumstances.
(Marmot, 2004 page 11)
In fact, the circumstances of the Report’s release fortunately did not in the end
detract from its main message – that health inequalities, as measured by both
spatial differences in life expectancy and socio-economic differences in infant
available then showed that the gap between England as a whole and the fifth
of local authorities with the lowest life expectancy had increased, by 2% for
males and by 5% for females (DH 2005). Inequalities continued to rise
throughout 2004 as Figure 2 summarises (original to this chapter). Likewise,
around 1995, babies of working class parents had been 15% more likely to
die in their first year of life compared to all infants; that rate of inequality fell to
a low of 12% by 1997 but rose again to its maxima of 19% by 2003, which
was the latest year of data available for the Report.

For the first time we also learnt from the Report that, apparently, these poor
results were to be expected: “There is, as expected over this short timescale,
no narrowing of health inequalities against the PSA target. There is a
continued widening of these inequalities as measured by infant mortality and
life expectancy, reflecting the long-term trend.” (Caroline Flint, DH 2005, p.1)
Thus, despite the publication of the Acheson report in 1998 (Independent
Inquiry into Inequalities in Health, 1998), a raft of policy documents since and
an historic third term for Labour, it is still apparently too early to expect
change as “many interventions will only be coming on stream after 2003” (DH
2005, p.6). Expectations thus seem to have dwindled since the heady days of
“things can only get better”, “I believe in greater equality” (said Tony Blair in
1996) (Shaw et al, 1999) and “the whole Government, led from the top by the
Prime Minister, is committed to the greatest ever reduction in health
inequalities” (Frank Dobson, then Health Secretary in 1998) (quoted in Shaw
et al. 1999)

The assessment of trends in health inequalities was not helped by the shifting
sands of the targets themselves, which had their spatial and social units
altered, their start dates changed and measures adjusted repeatedly. The life
expectancy target first mentioned health authorities, which were soon
abolished; then, the fifth of local authorities with the lowest life expectancy,
and now refers to a “spearhead” group. Curiously, the 12 “early adopter sites” which are to get “health trainers” overlap with (but are not exclusively drawn from) the “spearhead” group. Thus the spearhead group will (for) now be used to measure progress towards the life expectancy target. The infant mortality target has likewise been reformulated, as the official measure of social class has changed. Moreover, neither of the targets are true health inequalities targets as they compare the worst off groups with the average for the population as a whole, rather than considering the entire distribution. Indeed, the rapid ‘moving of the goalposts’ seems to have confused the drafters of the Status Report, with 2001, 2002 and 2003 being given at various points as when the targets were set (DH 2005). In fact, the first New Labour health inequality target was given in February 2001 and was quite complexly worded even then(DH, 2001).

As we outlined at the beginning of the chapter, in opposition Labour consistently promised to implement the recommendations of the Black Report and were incensed at the shoddy attempt made to cover it up, as they were by the similar attempt to suppress the impact of the follow-up Health Divide in 1987 (Berridge, 2002). The fear raised by the hushed up release of this 2005 Status Report was that the bold statements and unprecedented promises of New Labour’s first years in power (for example, the pledge to eradicate child poverty within a generation Waugh, 1999) have been wholly overtaken by the individualistic rhetoric of behavioural prevention and “choosing health”, with its three principles of “informed choice, personalisation, and working together” (DH, 2004). The linking of the adverse trends in health inequalities with the introduction of health trainers is a prime example of why this anxiety has grown (coupled with comments of the Prime Minster such as those quoted below). While the proportion of children living in low-income households is a national indicator (Dorling 2006), nowhere in the Status Report is there any mention of measuring, let alone directly tackling, the static or widening inequalities in income and wealth over which New Labour have presided – with widening housing wealth inequalities as a prime example (Shelter, 2005). At the time of the Status Report’s release, the authors argued that, rather than focusing on changing the ‘health choices’ of millions of individuals, the
government should perhaps think more about a healthier way to govern –
making the long overdue, but still salient, choices at its disposal to use the tax
and benefit systems to kerb growing social inequalities and redistribute
income and – most importantly – wealth (Shaw et al, 2005a authors’ italics).
By 2005, of 26 countries in Europe only four had a higher rate of child poverty
than the United Kingdom and only one recorded a higher rate before state
transfers of benefits: the Slovak Republic (Hirsch, 2006). Under the first ten
years of the New Labour government, inequalities in mortality rates rose
relentlessly. They did not do so under previous Old Labour administrations
(Shaw et al, 1999).

Conclusion

During his ‘new thinking’ lecture tour of 2006 the Prime Minister announced
that public health problems were no longer public health problems. Attempting
to achieve for social medicine what Margret Thatcher so famously tried for
sociology when she said that there was no such thing as society. Tony Blair’s
exact words were:

“Our public health problems are not, strictly speaking, public health
questions at all. They are questions of individual lifestyle - obesity,
smoking, alcohol abuse, diabetes, sexually transmitted disease.”

(Blair, 2006).

Within six weeks of making that claim the Prime Minister was forced to
announce that he would resign within the year. Although his pillorying of
public health may not have been at the forefront any list of reasons suggested
by those who forced his hand; he, and by implication much New Labour
thinking, had clearly become part of the problem rather than part of the
solution to reducing inequalities in health in Britain.
References


