

Factual – Measured - Critical

FOCUS: Dismantling Universalism: inequality and public health
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In London, in November 2012, Alex King, aged seven weeks and five days, died unnecessarily, "...when a routine cold that had developed into pneumonia went untreated despite repeated calls and visits over the course of five days to the out-of-hours doctors' service run by private contractor Harmoni."¹ Cases of political policies causing harm are rarely as easy to illustrate as this. But when a baby dies from a preventable illness and the private company charged with providing the care is seeking to maximise its profits, then, many will see such deaths not only as individual tragedies, but as potentially the direct result of policy.

This issue is especially significant given the evidence that shows that a nationalised health care system saves lives when compared to a privatized system. When the *Health and Social Care Act* became law on 27 March 2012 it removed from national government the responsibility to ensure provision of a universal standard of health care to all regardless of income, age or postcode. The Act also removed the responsibility from government to ensure that care was only being provided when it was needed and not when it wasn't.

The new system of Clinical Commissioning Groups

The origins of the 2012 Act derive from three factors. First, the continuation of privatizing 'reforms' already begun under the previous Labour administration; secondly, the desire of the incoming coalition to reduce the role of the state in our lives, even where the state was most efficient; and thirdly, the influence of ideas from the US, one of the few affluent countries where health inequalities are greater than in the UK.

At first things will appear to be very similar to the old NHS. Patients will not immediately be charged for access to NHS services, but the option to charge is now in place. Under the system of Clinical Commissioning Groups (CCG), private providers in the health care market can choose the services they wish to provide. Patients and the 'operational leadership teams' can decide whether patients will be charged for those services: As Price and Pollock put it, "the principle is not, as the coalition repeatedly claimed, increased patient choice but increase choice of patient."²

Under the 2012 Act, the CCG business, which replaces the NHS service, is not required to provide a comprehensive range of health services for all people living in a geographical area, as the NHS used to, but only "...such services or facilities as it considers appropriate."³ In fact, although it can retain the NHS "brand", should a CCG wish to behave like the old NHS, it is actively prohibited from doing so. The monitoring

Factual – Measured - Critical

body established by the Act would consider “...whether a licensee has engaged in anti-competitive behaviour which is against the interests of health care users. ...This includes allocating patients in particular geographical areas.”⁴ The CCG monitoring body is charged with ensuring that this does *not* occur because such a universal local service is seen as ‘anti-competitive’.

Being competitive is now seen as better, as a higher aim, than being good for people’s health. Such ideas have previously been give their clearest expression in the United States. In 2009 in the US the top five private health insurance companies saw a “staggering” 56% increase in their profits, which rose to \$12.2 billion because they purged people who might make claims from their lists by rapidly increasing premiums. By doing this they both raised more monies, from those who chose to stay insured, and reduced their costs by not having to treat those who were most likely to need the insurance but least likely to be able to pay the increased premiums. As Stuckler and Basu comment in their recent book, *The Body Politic*, “So, the rich got richer, and the sick got sicker.”⁵

They conclude that, “...the OECD had previously labelled the NHS the most efficient, effective, and responsive system in the world; the Tory government is now turning it into an unresponsive market-based health care system like that in the USA.”⁶

Why emulating very unequal countries is bad health policy

The USA has the lowest life expectancy, the worst record of infant mortality and the highest rates of poor mental health recorded for any rich nation on earth. Becoming more like the USA in terms of how health care is delivered is not going to improve our health or our well-being, but more importantly, nor is emulating it in terms of increasing economic inequality

The character of health care *systems* is important for overall public health. A privatized system is always more expensive. This is because health care is not a ‘product’ that ‘consumers’ wish to repeat purchase and, therefore, patients do not become expert in finding a bargain. However, it is also possible to have better overall population health without also having the most efficient nationalized health care system. Health care is not the primary determinant of overall public health. Once people have attained a certain minimum standard of living, variation in health outcomes depend primarily on variations in income and wealth within a given nation state.

There are many reasons as to why inequalities in health and wealth are so important in influencing population level health outcomes in affluent countries. For example, more people tend to be obese in more economically unequal countries. This may be because

Factual – Measured - Critical

they comfort-eat more often due to increased anxiety, or because food corporations are less well controlled over what they can advertise to eat. The important outcome is that regardless of the precise details of the direct mechanisms at play, as Wilkinson and Pickett show, overall health suffers when obesity rises.⁷ A more efficient nationalized health system can deal better with the consequences of rising obesity, but it is better not to have the problem in the first place.

There are many other ways in which high and rising economic inequalities can both harm health and health care systems. For example medical doctors tend to be in, or close to, the top 1% of earners across the world. Often medical doctors come from families within or near to that top echelon. In more economically unequal countries, such as the UK, even with an NHS allocating them to jobs, many doctors try to live in much more affluent parts of the country and consequently at some distance from most of their patients. This strengthens the *inverse care law* in countries like the UK. It is harder to deliver good healthcare locally in a more economically unequal country.

One effect of rising economic inequality is the increasing proportion of incomes in more economically unequal countries taken by the salaries of the best-off tenth of the population and especially of the best-off 1%. In the UK the proportion of all pay awarded to the best off 10% has risen from 20% in the 1970s, to almost 40% in 2013. That reduces the amount of money available for the rest of the workforce and also reduces the number of people who can be employed because there is less money available in almost every firm's pay-roll to employ more people. This problem is mainly, but not solely, located in the private sector. Universities and hospitals employ fewer staff, with the same resources, in those countries where a few consultants and hospital managers at the top are paid very high salaries.

As I have shown elsewhere,⁸ unemployment is widely known to double a person's chances of premature mortality occurring at any point while they are unemployed, even after all other measurable factors have been accounted for. Low paid work is also detrimental to health. It was only when the UK had a far more even pay structure, when the best-off tenth were paid *only* twice as much as the average worker that full-employment was affordable. Living costs of the best-off tenth were also lower then. Less excess pay meant that housing prices were far lower too and so people found it easier to get by.

Under the last Labour government health spending rose greatly but economic inequalities hardly fell at all. Indeed in some years there was an increase in health inequalities. This has been measured for Coronary Heart disease where overall rates of the disease fell, but "...a social gradient in the pace of fall was apparent, being steepest in the least deprived quintile. Thus, while absolute inequalities narrowed over the

Factual – Measured - Critical

period, relative inequalities increased. From 2000, the decline in the mortality rate slowed or leveled off in the youngest groups, notably in women aged 45–54 in the least deprived groups. In contrast, from age 55 years and older, rates of fall in CHD mortality accelerated in the 2000s, likewise falling fastest in the least deprived quintile.”⁹ In other words, for women mortality from the most common cause fell fastest in the New Labour years among those living in the best-off fifth of areas, among women who already enjoyed the longest life expectancy.

When economic inequalities in the United States reached previously unprecedented post-war highs during 2008, “life expectancy of Americans fell for the first time in 15 years, as the nation’s oldest adults died from heart disease, cancer and respiratory ailments”, according to a report by the National Center for Health Statistics.¹⁰ In 2008 life expectancy in the U.S. fell by 36.5 days compared with 2007 to 77.8 years. It goes on: “... Children born in 2008 lost a little over a month of expected life. The drop in expectancy was largely the effect of increased mortality among the oldest adults - those at least 85.”

During the last two years in the UK (2012 and 2013) there has been a rapid increase in the mortality counts of people aged over 85. Rates of mortality increase rather than actual numbers have yet to be calculated, but it appears to be the first time for a 15 year period that mortality rates have risen, and not due to especially cold winters, or if that is the superficial cause, it is the increased inability to heat homes rather than the cold outside them that is the underlying reason for this recent increase in mortality in the UK. Simply blaming the cold and ‘disease’ is not good enough.

How a wide range of Government Policies can impact on health

Government policy, which has allowed fuel poverty to rise abruptly, may have resulted in more deaths in Britain in 2012 compared to 2011 and this increase in deaths is continuing. In April of 2013 it was reported that in the first three weeks of March 4,206 more deaths were recorded than the average for the past five years. Experts say the death rate is linked to the cold weather and that at least 1,000 extra deaths were expected to be recorded for the last week of March. Pensioners accounted for the majority of those affected. Shadow health minister Andrew Gwynne said: “When winter weather bites we’ve all got a responsibility to look in on older neighbours and relatives.”¹¹

Despite improvements, by 2013 the proportion of households unable to afford to heat their home had risen above its 1983 level, and both in relative and absolute terms more people were suffering from the cold and getting ill in the UK.¹² Furthermore, more people are having to resort to soup kitchens in order to eat. Today they are called ‘food

Factual – Measured - Critical

banks'. Add that shame to more quietly getting colder and it should be no surprise that health is being impacted, especially for the very elderly.

Government appears to be oblivious or uninterested in rising fuel poverty and growing evidence of hunger in Britain, which is hardly surprising given their overall programme of cuts. If they cared more they would cut less where the impact is greatest. They would cut less for the poorest and most vulnerable. However, a further £19bn a year which will soon be taken away from society, mainly from poorer families and especially those in which people are already ill or disabled. The biggest financial losses arise from reforms to incapacity benefits (£4.3bn a year), changes to Tax Credits (£3.6bn a year) and the 1 per cent up-rating of most working-age benefits (£3.4bn a year). According to a report by Beatty and Fothergill, the Housing Benefit reforms result in more modest losses – an estimated £490m a year arising from the 'bedroom tax' for example – but for the households affected the sums are nevertheless still large."¹³

People living in Blackpool will be most affected by the cuts, each adult losing on average £910 a year. The cuts will have the least effect in the City of London (£180 a year), then in Hart (in Hampshire), Cambridge, Wokingham, Rutland and South Oxfordshire. Cutting £19bn from the excess wealth of a few billionaires and the land holdings of many multimillionaires is not considered a viable option, nor is cutting spending on nuclear weapons or the funding of overseas wars. Health could be improved worldwide by government's spending less on supporting war. It is not just government economic policy that harms health, but it is defence policy as well. This works in a number of ways, indeed, a large proportion of homeless men, of men in prison in Britain, and of men with mental health problems are ex armed service personnel.¹⁴

Conclusions

In 2012 a study by Piff and his colleagues, reported the results of a series of experiments (conducted by psychologists at the University of California, Berkeley, and the University of Toronto, Canada) on upper-class individuals and found, among other things, that they were more likely to break the law while driving than lower-class individuals.¹⁵ In follow-up laboratory studies, upper-class individuals were found to be more likely to exhibit unethical decision-making tendencies, take valued goods from others, lie in a negotiation, cheat to increase their chances of winning a prize and endorse unethical behavior at work than were lower-class individuals. The researchers even found that people could be conditioned to begin to behave like this by being encouraged to feel superior. However, if people can be so easily encouraged to be more selfish then perhaps it isn't naive to hope that they could be encouraged to be far less selfish if they had their eyes and minds opened up to the collective selfishness of their actions.

Factual – Measured - Critical

Often at the end of a piece of writing like this a list of policy options is given. But often policy options can appear as placebo treatments when what really needs to be tackled are the underlying causes. I return to Axel King, the baby who died last year under the supposed care of private provider Harmoni. Dr David Lee, its medical director, said: "We would like to express our deepest and heartfelt sympathy to the Peanberg King family. We believe we have the right underlying systems, policies and procedures to ensure a safe and robust-out-of hours service. We will now be taking full regard of the coroner's findings. We know that the review of very difficult incidents such as this always identifies learning points. Our overriding priority is to ensure that this learning is acted on."¹⁶

Acting on what he thinks he has learnt might be Dr Lee's overriding priority, or at least one of the priorities he is willing to admit to, but his other priorities will include his continued commitment to the owners of Harmoni. It is this which is emblematic of government policy. Maybe his response can be a "learning point" for us all? It is worth comparing what he said in early 2013, with what his predecessor said, just two years earlier. When Dr Fred Kavalier, the former clinical lead at Harmoni, resigned in January 2011, he forwarded to the senior management concerns raised by a Harmoni GP who warned that cuts in the service had led to "dangerous" pressure on appointments. The GP feared this "could lead to mistakes being made ... the current system is putting patients' health at severe risk."¹⁷

In the short term, the implications of many of the coalition government's policies for public health would appear to be very worrying. Previous Secretaries of State for Health have included Aneurin Bevan and Barbara Castle. In contrast, Andrew Lansley and Jeremy Hunt are unlikely to be remembered fondly, if at all. However, their policies and the of their wider Liberal and Tory parties they sit in are now so extreme, and the harm being suffered by such a large section of the population of Britain is so great, that, just like their Liberal and Conservative Secretary of State predecessors whose names are long forgotten, they too could usher in damaging change through their neglect of society.

Previous Liberal and Conservative parties and Secretaries of State for Health allowed public health to become side-lined both before and after the establishment of the NHS in 1948. They did this through both action and inaction. Coalition policy, dividing communities from each other, and individuals from their communities, even increasing inequalities within families living in different parts of the same country, might be what it takes to inspire future generations once again to put care in 'place of fear' again, as the architect of the NHS, Nye Bevan advocated when setting it up.

Factual – Measured - Critical

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