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Commentary

Explaining health inequality: Evidence from the UK

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With its uniquely long historical series of officially collected data on occupational mortality, researchers in the UK have been well placed to investigate the causes of health inequality. Since 1921, the decennial Census of England and Wales has contained an "Occupational Mortality Supplement" that tabulates mortality according to groups of occupations, which came to be known as "social classes". After 1931 the class groups were sufficiently comparable to allow trends to be discerned. The Black Report of 1980 (DHSS, 1980; Townsend, Davidson, & Whitehead, 1988), which put health inequality onto the agenda of research and policy for the next 30 years, was based on these official statistics. The official measure of social class used in the Report was not ideal as a measure of social inequality, as it was never clear exactly what it operationalized. In some census volumes it was described as a measure of 'occupational skill' and in others as 'general standing in the community'. No attempts were ever made to validate either of these definitions. This may be one of the reasons why the official statistics, so influential in their description of health inequality, were less helpful when it came to understanding why it occurs.

The Decennial Supplements on Occupational Mortality show the relentless increase of inequality in mortality, which if anything accelerated after the introduction of the UK's National Health Service in 1946 and the implementation of the raft of policies known as the "Welfare State". During this period, 'full employment' was an objective of government policy (for men only), as were the abolition of the other Five Great Evils of Squalor, Disease, Ignorance and Want. In pursuit of these aims, post war governments of both political colours built new housing and improved schooling as well as maintaining free health care and benefits for the unemployed.

The increase in inequality depicted in Fig. 1 took place against a background of steady falls in mortality at the population level (shown in Fig. 2). If the mortality rate for men and women in 1950 is thought of as 100, then the death rate fell between 1936 and 1995 from 40% above the 1950 level to 30% below. This "standardised mortality ratio" in Fig. 2 takes account of the fact that during this period, the overall population grew considerably older.

It is interesting to place these trends against the economic background of the period. GDP and average earnings were rising, as shown in Fig. 3

Income inequality fell somewhat in the post-2nd World War period before increasing sharply from the 1970s (Lindert, 1998). Average wealth indicators do not, however, show how relatively lower wages cluster with occupational hazards, job insecurity and unemployment across the life course. Those who are most likely to need to save for periods without employment are the least likely to have sufficient income to allow them to do so. The same may be said for the risk of needing to leave work at an early age due to industrial accidents or disease; those who do so are the least likely to have benefited from generous occupational pension provision whilst in work.

The social policy authority Richard Titmuss coined the terms "occupational welfare" and "fiscal welfare" in the 1950s to refer to arrangements such as expenses allowances and tax rebates on pensions and mortgages which only benefited the middle classes. On top of these benefits, it was already evident to Titmuss in the early days of the Welfare State that equal access to services does not guarantee equal treatment, so that universal services such as health care and education also in effect yielded greater benefits to middle class patients and parents.

Even if the data on earnings in Fig. 3 could be taken at face value, a healthy life does not just depend on income. It depends on income in relation to needs. In 1997 Morris calculated the cost of a healthy

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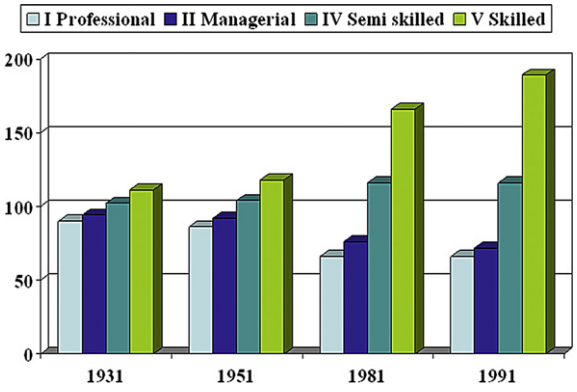

Fig. 1. increase in the mortality gap between social classes in England and Wales from 1931 to 1991: Standardised. (Sources: Based on Wilkinson, 1986 table 1.1; Drever, Bunting, & Harding, 1997 table 8.2).

life for a young man, based on the full range of available evidence (Morris, Donkin, Wonderling, Wilkinson, & Dowler, 2000 – see below).

The total was about the same as the UK Minimum Wage but far more than benefit level at the time of the research. What is notable is that 'biological necessities' (food, heat) make up only the minority of the costs. There is a high cost associated with social participation. This included things like having new clothes rather than second hand, soap, toothpaste and shampoo, a daily newspaper and money for one outing to the cinema or public house per week with friends. All these were judged necessary for the individual to maintain membership of a social group. Lack of such social support is known to be as hazardous to health as many forms of risky behaviour (Berkman & Syme, 1979; Holt-Lunstad, Smith, & Layton Bradley, 2010). The highest cost, however, was to pay for somewhere to live. Whereas the cost of social participation depends on the norms and values in a society (e.g. a certain level of cleanliness and awareness of what is going on in the world, and the ability to reciprocate the generosity of others), the cost of lodging depends on wider political and economic forces.

I would argue that what we are seeing, both in the time trends presented here and in differences in health inequality between nations, is the result of cultural and political forces as much as changes in income and wealth *per se*. In some communities and nations more than others, social support and acceptance depend more on factors that require money purchases (i.e. which are commodified). Similarly, in some political and economic settings,

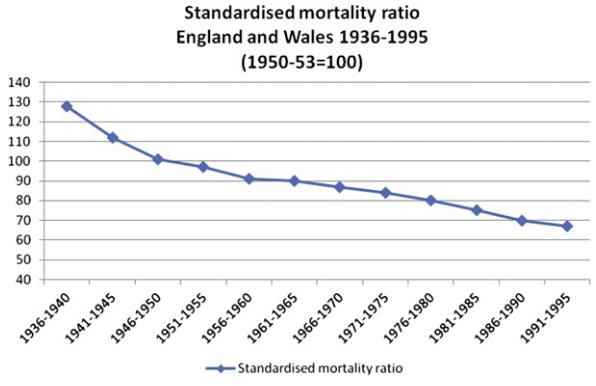

Fig. 2. Mortality 1950–1995 men and women. Standardised to take account of population ageing. Source: Based on data from: Office for national statistics: Mortality statistics general. Series DH1 no. 33 (London: ONS, 2002) Accessed at: http://www.statistics.gov.uk/downloads/theme_health/DH1_33_revised_14Nov03/DH1_33_revised_14Nov03.pdf, 18 may 2011.

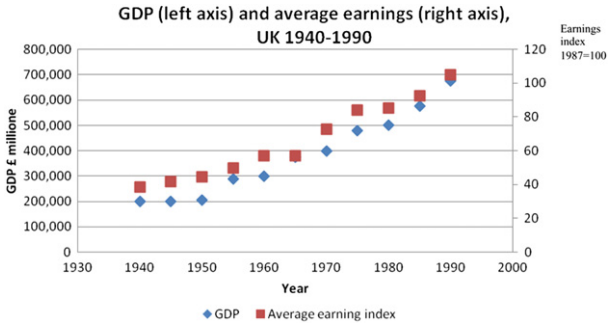

Fig. 3. Trends in Gross domestic Product and average earnings, UK, 1940–1990. Source: Based on : L Craig. A century of labour market change: 1900 to 2000. *Labour market trends* March 2003: 133–144.

the cost of lodging is subsidised and therefore requires a far lower proportion of the income of those on a relatively low wage, than in others. Amartya Sen's concept of "capability" offers insight into ways of explaining differences in health inequality. The concept of capability leads us to understand that the affordability of biological necessities depends on the costs of social participation. As Sen (1992:115) puts it:

> "Relative deprivation in the space of incomes can yield absolute deprivation in the space of capabilities. In a country that is generally rich, more income may be needed to buy enough commodities to achieve the same social functioning, such as 'appearing in public without shame'. The same applies to the capability of 'taking part in the life of the community'".

People do not pay for biological needs first at the expense of social participation, so the costs of social participation effect how much money is left for 'basic needs'. If income is rising, but at the same time social participation and acceptance are increasingly dependent on spending money, the overall result will be that there is less money to support the costs of a healthy life. Income will not buy the same amount of good health in all societies.

The health disadvantage of a relatively low income can, therefore, be understood in terms of how much is left to be spent on the material components of a healthy life once the costs of social integration are covered. If this is the case, we would expect to see less health inequality at times and places where social participation and housing are less of a financial burden on the individual. This may come about because of differences in cultural norms regarding "fraternity" and social solidarity, perhaps combined with policy provision for housing lower income citizens. Policies give signals as to the relative importance of social solidarity versus wealth and status. A high level of taxation, for example, would signal the lower importance of wealth in itself, and could of course also result in resources being shifted from individual luxury consumption towards the provision of low cost, high standard housing. Such a policy could incidentally also lower the cost of at least one of the 'biological' necessities, namely domestic heating costs.

Conclusion

The evidence on trends in health inequality in the UK and its constituent countries, set against that on income trends shows the importance of psychosocial and cultural factors. Considerable increases in overall national prosperity and individual earnings were accompanied by large increases in social class mortality differentials. The search for understanding of health inequality needs to pay far more attention to wider social factors such as the tax and welfare systems, the values that are embedded in economic and political institutions.

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