Health Inequalities in England and Wales

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I missed my favorite U.S. holiday when I traveled to London last Thanksgiving, but got a further glimpse at the politics of health in the United Kingdom. A new focus on social and physical environments and their impact on health may make it easier for the new Labour government to fix the National Health Service without simply throwing money at it. I began my visit by talking with bureaucrats like myself.

Government offices are not very different around the world these days. Office landscaping, computers, and informally dressed bureaucrats of many sizes, colors, and shapes no longer give you a hint as to what the office does. Moreover, office parties aren't very different as one travels around the world. The one I happened on while visiting the Office for National Statistics in London had wine (red and white), beer, salsa and tortilla chips, plus the obligatory cake. But the occasion was truly special—celebrating the release of a decennial supplement, *Health Inequaties,*[1] on which the office had labored for over a year. Karen Dunnell, whom I was visiting, heads the health unit at ONS and hosted the informal event. The two principal authors of the supplement had returned from new assignments: Margaret Whitehead, who is now working with the King's Fund, and Frances Drever, on loan to staff an inquiry created by the new Labour government, chaired by Donald Acheson, to study the very same question, health inequalities. I also met the analysts, computer folk, number crunchers, and members of the one group singled out for special recognition, the proofreaders.

When the new Labour government first announced its inquiry into health inequalities, the ONS report was completely written but almost five months from scheduled publication. ONS decided that Acheson's commission must not start its inquiry without the new report in hand. This constituted the closest thing they could imagine to a statistical emergency. The usual, slightly desultory schedule was intolerable. So with volunteers from the ranks, the 250-page report was proofread in two days, instead of two weeks. Then the printers were cajoled, and the report appeared for the start of the Acheson inquiry.

From a U.S. point of view, the report itself deserves attention. Intended for a broad readership, it is crisp, readable, and informative. *Health Inequalities* comes at a time of great upheaval in the National Health Service (NHS), not dissimilar to changes occurring in this country. The report reminds us that the managers, policy makers, and legislators who tinker with health care and public health programs would do well to pay attention to the health of the whole population and all its various parts. Health is by no means homogenized across the populace.

Differences in health services cannot explain many differences in death and disease rates. Because the NHS serves everyone in England and Wales, the case for social and physical environments causing differences in people's health is not complicated by great differences in medical care. As the report points out, along with improvements in life expectancy and a steep decline in infant mortality in this century, "different sectors of society have benefited to different extents. Differentials in health can be observed across the social groups within the population, with a gap of five years in life expectancy between men in Social Classes I/II and IV/V."[1]

The very mention of social class may seem strange to American readers. In the United States, it is almost as if our ideological commitment to being a classless society has prevented us from employing that useful tool for understanding the causes of wellness and of poor health.[2] In England and Wales, the Registrar General introduced the system of occupationally determined social class in 1911. By 1921, the forerunner of today's five-class system was first used to analyze infant and adult male mortality. When women were added in 1931, unmarried women were

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grouped by their parents' or own social class and married women by their husband's social class. Despite vast improvements in health services, many of the Social Class differences seen early this century persist.

Health Inequalities, in both its subject matter and conclusions, is strangely at odds with the politics of health in Britain today. Labour was elected, at least in part, because of its promise to preserve and strengthen the NHS. Low spending—health captures only 7% of the GDP in Britain—and a new wave of consumerism seem to have made the long waiting times and examples of poor service far more politically problematic than in the past. It is a matter of opinion whether the "market reforms" introduced in the NHS by the Conservatives over the last 18 years made things worse or prevented the situation at the NHS from being far worse today. Most public concerns about health center on the NHS, while *Health Inequalities* suggests that other factors are more important in terms of morbidity and mortality.

This is not a new bind for governments. Marc Lalonde, Minister of National Health and Welfare in Canada in 1974, generated *A New Perspective on the Health of Canadians*[3] in response to a similar dilemma—how could the Federal government improve health while contributing less to provincial medical insurance programs? Because of Lalonde's efforts, today almost every industrial democracy has its own version of the Lalonde report. Our latest is *Healthy People 2000*, and *Healthy People 2010* is in the works.[4]

I am learning that an editor is richly rewarded by his continuing interactions with the journal's contributors. In my case, Allyson Pollock, who a year ago, along with Dorothy Rice, authored an article for *PHR* on health data in the United States,[5] made my brief stay in London particularly rewarding by directing me to friends and colleagues, including Karen Dunnell. I wanted to see how the *Health Inequalities* report might influence policy and programs, so Allyson sent me across London to learn about one new Labour initiative, Health Action Zones, that does seem to track with the findings of *Health Inequalities*.

Dr. Maggie Barker, the Director of Public Health for the Camden-Islington District Health Authority, explained to me that the new government would probably try to fix most of the problems in the NHS without spending much more money. They would direct as much new spending as possible toward the districts with populations having the worst health—often the inner-city areas like hers that had voted heavily for Labour. Her district is one of a handful asked by the Department of Health to submit proposals for Health Action Zone funds. The government would like Health Action Zones to stimulate collaboration between the NHS at the district level and the local authorities who run housing, social services, public transport, and the schools to get at the root causes of ill health.

Dr. Barker has begun to map out plans for the collaboration. For someone trained in public health, nothing is quite as exciting as being asked to design an attack on the causes of poor health. She seemed, as most of us would, almost intoxicated with the challenge.

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References

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Health Inequalities, Decennial Supplement No. 15, is available for £35. The *Health Inequalities Data Diskette* containing the data from the report is available for £25. The price and handling charges may be paid by Visa or AMEX. Write to the Sales Office, Office for National Statistics, 1 Drummond Gate, London SWIV 2QQ; tel. 44 171 533 5678; fax 44 171 533 5689.