Was Mackenbach right? Towards a practical political science of redistribution and health inequalities

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A B S T R A C T

In 2010, Mackenbach reflected on England’s lack of success in reducing health inequalities between 1997 and 2010, asserting that “it is difficult to imagine a longer window of opportunity for tackling health inequalities”; asking “if this did not work, what will?”, and concluding that reducing health inequalities was not politically feasible at least in that jurisdiction. Exploring the empirics of that observation offers a window into the politics of reducing health inequalities. For purposes of future comparative research, I outline three (not mutually exclusive) perspectives on political feasibility, identify their implications for a political science of health inequalities, and explore what they mean for advocacy in support of reducing those inequalities.

1 Introduction

For the “New Labour” government of the United Kingdom (UK), elected in 1997, reducing inequalities in health that were related to socioeconomic position was a stated policy priority. Whatever the seriousness of that commitment, it was at best imperfectly achieved. By 2007, before the financial crisis and subsequent recession, economically patterned health inequalities at least in England were, on some measures, larger than at any point since before the Great Depression of the 1930s (Thomas et al., 2010). Other research finds that the socioeconomic gradient in life expectancy as plotted against economic deprivation at the small area level became less steep between 1999–2003 and 2006–10, while overall life expectancy increased (Buck and Maguire, 2015, p. 34). However, this outcome cannot reflect the consequences of post-2010 austerity policies, including those described later in this article. Further, such trends as a concentration of unhealthy behaviours at the low end of the socioeconomic spectrum may be “storing up inequalities in life expectancy in the future” (Buck and Maguire, 2015, p. 34), yet will not be reflected in relatively short-term trends in health outcomes.

Johan Mackenbach (2010, p. 1249) reflected on this lack of success in reducing health inequalities between 1997 and 2010 by asserting that “it is difficult to imagine a longer window of opportunity for tackling health inequalities” and asked: “If this did not work, what will?”. Seeming to undermine this rhetorical query, he conceded that “health inequalities are the result of the cumulative impact of decades of exposure to health risks, some of them intergenerational, of those who live in socioeconomically less advantaged circumstances.” This important observation means not only that reducing health inequalities “requires a massive re-allocation of societal resources” (p. 1252) but also that, even given a serious political commitment, 13 years might not be long enough – a point borne out by the importance of lagged effects and insights from life course epidemiology (Bartley, 2011; Blane et al., 2013; Offiﬁani et al., 2013; Gustafsson et al., 2014; Halfon et al., 2014). Other recent analyses of health inequalities have emphasized the complexity and multiplicity of the relevant causal pathways (Kelly and Doohan, 2012; Whitehead et al., 2016). However, the point of this article is not to offer a detailed assessment of New Labour’s policies, but to address the political core of Mackenbach’s argument: his assertion that “it is unlikely that a majority of the English electorate would have supported the substantial redistribution of income and wealth that would have been necessary” (p. 1252) to reduce health inequalities. Assessing this claim offers a window into broader questions of the politics of reducing health inequalities by narrowing inequalities in people’s life chances and living standards. Mackenbach concludedFlatly that “reducing health inequalities is currently beyond our means,” even though pursuit of the objective should continue as a moral imperative (p. 1252). The strength

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and quality of the evidence for redistributive policies as a necessary, although perhaps not sufficient, condition for reducing health inequalities is debated (cf. Schrecker, 2013; Kaufman and Harper, 2013; Preda and Voigt, 2015), but that debate is not explored here. The reference to the UK’s House of Commons and the ‘devolved’ context of current UK health policy; the strategy to which Mackenbach refers was an English initiative.

Although the UK is admittedly an extreme case in terms of the pursuit of neoliberal policies (Schrecker and Bambra, 2015), such questions are of far more parochial interest. Indeed, they are fundamental to developing a political science of health inequalities - a project the importance of which has been identified by several authors (Bambra, Fox, and Scott-Samuel, 2005; Bernier and Clavier, 2011; de Leeuw et al., 2014; Participants, 2015; Lynch, 2017). Response to this challenge on the part of researchers has been limited. Relevant work has tended to emphasize the content of official policy documents (e.g. Graham, 2009); the organizational structure of government and the views of participants in the policy process (e.g. Smith, 2013a, 2013b; Carey and Crommond, 2015; Lynch, 2017); or correlations among left-right partisan orientation, welfare state structure and health outcomes (Espelt et al., 2008; Muntaner et al., 2011). Much of this body of work arguably confuses explanans and explanandum, leaving unresolved the key questions of why particular official actors or electorates have the policy preferences that they do, and of how institutional frameworks influence the pathway from those preferences to the control of government. Kaveri Qureshi’s (2013) important ethnography of the English health policy process likewise found “that evidence was used by civil servants in accordance with their perceptions of what politicians conceive to be electorally palatable” (p. 10), thus directing our attention to the influences on conceptions of palatability.

In this article, I explicate three perspectives on Mackenbach’s claim, which imply varying degrees of pessimism about prospects for reducing health inequalities in high-income jurisdictions with relatively functional democratic institutions. Although explicated primarily with reference to the United States and UK, the perspectives have broader applicability in comparative research; the extent of their generalizability across multiple jurisdictions and institutional contexts remains to be explored. My analysis offers few answers, but rather an improved and more sophisticated way of considering questions of political feasibility that are critical to all of us committed to reducing health inequalities.

2. Background: The post-2010 social and macroeconomic policy landscape

In the UK context, Mackenbach’s skepticism about electoral support for redistributive policies that would address the underlying drivers of health inequalities appears to have been vindicated by the election results of 2010 and (in particular) 2015, when the Conservative party won an unexpected Parliamentary majority and with it the ability to pursue more effectively than under the post-2010 coalition with the Liberal Democrats a “root and branch restructuring” of the UK’s economy and society, of which “[t]he longer-term goal is to shrink the state, free the market and set British political economy on a new course” (Taylor-Gooby, 2012, p. 61). A decisive plurality of the electorate apparently has had little trouble with a set of economic and social policies that have systemically redistributed income and wealth upward, with the most serious impacts concentrated among those people and places near the bottom of the economic distribution.

On what might be called the vertical dimension, De Agostini et al. (2015) found that the combined impact of tax and benefit changes under the Conservative-led coalition government had been regressive across the income distribution as a whole; “under most sets of assumptions the main gains were in the upper middle of the income distribution and the main losers were at the bottom and those close to, but not at, the very top” (p. 5). A later projection incorporating the effects of post-2015 changes concluded: “By early 2021, [benefit] claimants are ... expected to have lost a cumulative total of more than £27bn a year as a result of the welfare reforms implemented since 2010. This is rather more than one pound in every four previously paid to working-age benefit claimants” (Beatty and Fothergill, 2016, p. 12).

The effects are not confined to benefit recipients, although they bear some of the harshest impacts: analysis by the Institute for Fiscal Studies finds that the combined impact of tax and benefit changes between May 2015 and April 2020 would cost households with children and no one in work an average of approximately £4000 per year in 2020 (Waters, 2017).

On the horizontal or place-related dimension, policy changes have hit not only the poorest people but also the poorest and least healthy places hardest. Local authorities (the smallest units of elected government) vary widely in the prevalence of deprivation as measured by a composite Index of Multiple Deprivation; within the boundaries of a number of local authorities, no small areas’ rank in the UK’s most deprived fifth, while in others, notably cities hard hit by deindustrialization, more than half of small areas fall into this category. By 2020-21, the cumulative impact of all post-2010 benefit reforms is estimated to cost the local economies of some of the poorest areas close to or more than £1000 per working age adult per year (Fig. 1), and “[t]here is a clear and unambiguous relationship: as a general rule, the more deprived the local authority, the greater the financial hit” (Beatty and Fothergill, 2016, p. 24).

Above and beyond the effects of benefit cuts are reductions in the central government grant that is a major element of local authority budgets (Subramanian, 2016). These have had the biggest impact on authorities where premature mortality (at or before age 75) is highest (Taylor-Robinson et al., 2013) - important not least because local authorities rather than the National Health Service (NHS) now have statutory responsibility for public health programs. Many of the poorest areas are also the sickest, and some of the regions where these cumulative impacts will fall most heavily are already poorer than any regions in France, Germany, Belgium, the Netherlands, Luxembourg, Austria, Ireland, Denmark, Finland and Sweden (Eurostat, 2014). Thus, at least in the UK regressive redistribution has a strong place-related element, conventionally (if rather simplistically) described in terms of a North-South divide (The great divide, 2012).

These developments are occurring in parallel with a continuing crisis in the NHS and in public-sector social care, which is provided by local authorities (Humphries et al., 2016; Maynard, 2017). Elaborating on this would require a separate article; suffice it to say that financial

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3 Although not (yet) as extreme as the United States, for example with regard to the savagery of the latter’s health care financing arrangements, its use of punitive debt collection mechanisms (The new debtors’ prisons, 2013; Kristof, 2016), or “hyperincarceration” (Wacquant, 2014) as a strategy for disciplining and managing the marginalized (former) working class.

4 This terminology is used at several points in the text, reflecting the fact that under most electoral regimes, the proportion of eligible voters who actually decide electoral outcomes can represent a small proportion of the total electorate, especially in a first-past-the-post system like that of the UK – meaning, as an aside, that reference to “a majority of the English electorate” is in some respects misleading. Low electoral turnouts and the unequal representation entrenched by the structure of institutions like the US Electoral College (which was the basis of Donald Trump’s presidential victory, after drawing almost three million fewer votes nationwide than his Democratic opponent) can further affect the composition of the decisive plurality. Thus, the distinctive characteristics of national political institutions add another, unavoidable layer of complexity to the political science of health inequalities.

5 Lower Layer Super Output Areas (LSOAs): administratively defined spatial units with 1000 – 3000 residents; there are more than 41,000 such areas in the UK.
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