Health crisis is a class question UK studies confirm

Richard Tyler, Thomas Scripps
5 August 2021

Last month, the Office for National Statistics (ONS) published an analysis of ethnic differences in life expectancy between 2011 and 2014. It found that “males and females in the White and Mixed ethnic groups had lower life expectancy than all other ethnic groups, while the Black African group had a statistically higher life expectancy than most groups.”

Mixed ethnicity men had a life expectancy of 79.3, White of 79.7, Black Caribbean of 80.7, Bangladeshi of 81.8 Indian of 82.3, Black Africans of 83.8 and Asian Other of 84.5. The figures for women were Mixed (83.1), White (83.1), Black Caribbean (84.6), Indian (85.4), Asian Other (86.9), Bangladeshi (87.3) and Black African (88.9).

The ONS study was the first to link extensive census data (over 50 million records) with death registrations and GP patient records covering England and Wales. Its authors note that their overall life expectancy estimates are likely “slightly overestimated” and that “the exact results should therefore be treated with caution”, but states, “the overall patterns are consistent with the findings of other published studies”.

These statistics demonstrate the bankruptcy of an approach to society which substitutes racial categories for class analysis. If racial inequality, with Whites at the top, is the dominant social problem, then what is one to make of the higher life expectancies of Blacks and Asians?

On a racial analysis, the problem of the population’s health is entirely confused and distorted. According to a recent summary by the Kings Fund healthcare thinktank, the Chinese and Black African groups have lower rates of disability than the White group, but Black Caribbean, Indian, Bangladeshi and Pakistani have higher. Health related quality of life scores at older ages are lower among most ethnic minority groups compared to Whites, but not Black Caribbean, Black African and Mixed. The poorest overall health is reported by the White Gypsy and Irish Traveller group.

Many different social and cultural factors contribute to these differences. The ONS authors of the life expectancy study write that it is “likely that Asian and Black ethnic groups engage less in harmful health-related behaviours, such as being less likely than the White ethnic group to smoke or drink alcohol.” They also note, “Potential reasons for the higher life expectancy found in the Black African and Asian Other ethnic groups include that they contain a higher proportion of more recent migrants than other ethnic groups. Previous research shows that people who migrate tend to be healthier than others.”

These are important factors. But they are of an entirely secondary order of magnitude. The health crisis they set out to address is overwhelmingly a class question. Social class is the overwhelmingly dominant influence, across all ethnicities, of social class and inequality, but this is entirely obscured in a discussion on health based on racial categories.

Smoking is not a risk factor universally common to “white people”, but hits the poorest sections of the working class hardest. While only 7.6 percent of the population in the wealthiest communities smoke, the rate is three times as high in the poorest communities, at 22 percent. Around 11,000 smoking-related cancers are diagnosed in the poorest 20 percent of the population each year, compared to around 6,000 in the richest 20 percent.

The racialisation of social statistics is so far advanced that it is largely impossible to make similar points for ethnic minority groups. The last prominent piece of research on intra-ethnic inequality was produced by the Joseph Rowntree Foundation in 2011, which revealed higher household income inequality rates for Chinese, Indian, African, Pakistani and Caribbean households than White British.

The centrality of class was confirmed with brutal clarity by another health report published last month, in

The Lancet medical journal, on the impact of cuts to local government funding on life expectancy in England. The report explains, “Funding reductions were greater in more deprived areas and these areas had the worst changes in life expectancy.”

Each £100 reduction in per capita funding between 2013 and 2017 was associated with an average decrease in life expectancy at birth of 1.3 months. The cuts were associated with almost 10,000 additional deaths in those aged below 75 in England. Adverse trends in life expectancy had “disproportionately affected the most deprived areas, reversing improvements” over the decade prior to 2011.

These findings echo those of the Institute of Health Equity in its February 2020 report, “Health Equity in England: The Marmot Review 10 Years On”. It found that, since 2011, life expectancy in England has stalled for the first time at least since the turn of the last century, an outcome produced by the fall or stagnation of life expectancy in the working class under the blows of austerity.

The report explains, “between the least and most deprived deciles was 9.5 years for males and 7.7 years for females... In 2010-12, the corresponding differences were smaller—9.1 and 6.8 years, respectively.”

For years of good health, the class divide is far worse. The Kings Fund wrote this April, “The rich–poor gap in healthy life expectancy is even greater—almost two decades—than the gap in life expectancy. Those living in the most deprived areas spend nearly a third of their lives in poor health, compared with only about a sixth for those in the least deprived areas.”

COVID-19 has vastly intensified these inequalities. The Kings Fund writes, “There have been two turning points in trends in life expectancy in England in the past decade. From 2011 increases in life expectancy slowed after decades of steady improvement, prompting much debate about the causes. Then in 2020, the Covid-19 pandemic was a more significant turning point, causing a sharp fall in life expectancy the magnitude of which has not been seen since World War II.”

Life expectancy for males fell to 78.7 years and for women to 82.7 years, the level of a decade ago. Those who died from Covid each lost about a decade of life on average.

Multiple studies have proved the close link between deprivation and COVID-19 mortality rates, which largely underlies the disproportionate impact on generally poorer ethnic minorities. A July report by the Health Foundation shows that the connection between social class and the chance of death from COVID-19 is even stronger among the working-age population, under 65 years old.

Among this group, COVID-19 mortality rates were found to be nearly four times higher in the most deprived areas in England when compared to the least deprived areas. Those in the fifth most deprived decile were still more than twice as likely to die than those in the first, the wealthiest.

Mortality rates in this demographic were higher in the second wave of the virus than in the first and were higher in urban areas, as the “back to work” policy of the Johnson government, backed by the Labour Party and the trade unions, forcing millions of people back onto public transport and into unsafe workplaces, took its effect.

The effects of the pandemic in compounding the health crisis confronting the working class will be long-lasting.

COVID-19 has not even begun to be brought under control on a global scale. Long-term health consequences of COVID infections already affect millions in the UK. National Health Service waiting lists are at record levels. Local councils, whose budget cuts the *Lancet* study identified as a driver of stalling life expectancy, have been left more financially vulnerable by the pandemic. A vicious social counter-revolution is being prepared to recoup the costs of multi-billion corporate handouts.

Confronting these dangers means understanding their origins in class society and the war being waged against the whole working class by the super-rich. A counter-offensive must be organised to seize the obscene fortunes of the oligarchy and make resources available for the fulfillment of pressing social needs. The fight for this programme requires a rejection of racialist politics which divides workers against one another and offers no progressive solution to the social crisis confronting millions.