6

Health

'Eliminating health inequities is important as a matter of social justice because health is an asset and a resource critical to human development' and because of 'scientific evidence that health inequalities are the outcome of causal chains which run back into and from the basic structures of society'.[1] Of course, public policy cannot determine how healthy or long-lived any given individual will be. But public policy does not determine individual educational attainments or earnings, either, and this does not stop its making all the difference to the justice or injustice of their distribution. The distribution of ill-health and long life in the population depends on relative incomes, on racial and ethnic stigmatization, on autonomy or powerlessness in the workplace and on a multiplicity of other aspects of the basic structure of the society. Virtually every significant feature of a society has differential effects on health, according to its impacts on people in different locations within the social structure. By the same token then, there will be very few areas of public policy that do not have implications for the justice of the distribution of health. 'Because health inequalities are multi-determined, policies need to exert leverage at multiple points.'[2]

All the quotations in this chapter so far have been from a collection of articles entitled *Health and Social Justice* that was published in 2003. Apart from its existence, what is interesting about this book is that its contributors are drawn from the fields of public health (a majority), social epidemiology, sociology and (in one case) political science; but there is not a single contribution by a political philosopher. This may seem curious in a book about social justice, and the absence of such a contribution reveals itself in the lack of any systematic discussion of the concept of social justice and its relevance to health. There is, however, a good explanation: as far as I am aware, no such discussion exists. To the extent that political philosophers write about social justice and health, they confine themselves to the distribution of health *care*. The underlying assumption appears to be that everything to do with social justice and health has been included when health care has been discussed, whereas the truth is that this is only a small part of the picture.

We can see this equation of health with health care at work in an article by Ronald Dworkin, which sets up as a premise for an argument (whose content is irrelevant here) 'that health care is, as René Descartes puts it, chief among all goods: that the most important thing is life and health and everything else is of minor importance'.[3] No citation is offered, but if Descartes really said that health care (as against health) was the chief good, then he must have had extraordinarily poor judgement. It is certain that until some time late in the nineteenth century, when bleeding and prescribing (literally) poisons had gone out of fashion and antiseptic surgery was creeping in, medical care was more likely to kill than cure. Descartes's contemporary, Thomas Hobbes, exhibited sterling good sense in saying he would sooner trust his health to the care of a wise old woman than to a qualified doctor.[4] Few people, it has been asserted, would wish to insist 'that medicine's effectiveness went back much before the advent of antibiotics in 1940 or sulphonamides in the 1930s'.[5]

Go round any English churchyard and you will see pathetic tombstones from the mid-nineteenth century recording the death of perhaps a dozen children in infancy. By the end of the century, they have disappeared. This cannot have been due to any significant improvements in the quality of health care: the technology did not change a lot and access to it was just as hit and miss:

> There is evidence that modern preventive and therapeutic medical care can account for only a minor fraction of the dramatic improvements in individual and population health over the past 250 years. . . . Even analysts admiring the impact of medical science on health, for example, estimate that only about five years of the 30-year increase in life expectancy in the United States in the twentieth century has been due to preventive or therapeutic medical care. . . . The remainder is attributable primarily to increasing socioeconomic development and associated gains in nutrition, public health and sanitation, and living conditions.[6]

Scourges such as typhoid fever and cholera were wiped out in Britain in the nineteenth century by the provision of pure drinking water and

the safe disposal of human wastes. Another public health measure – the use of quarantining – virtually eliminated scarlet fever and diphtheria long before there were any effective drugs. An important contribution to 'living conditions' was the improvement in housing, thanks to city codes (as in New York) mandating ventilation standards and the reduction in overcrowding. This did much to reduce the spreading of pulmonary tuberculosis among families.

A vivid illustration of the role played by housing is that tuberculosis has reappeared in New York City in recent years. It is associated with 'an upsurge of family homelessness' because, when people lose their homes, the only alternative to the street or a temporary shelter is 'doubling up with other families'.[7] This deterioration is the direct effect of public policies aimed against the poor, especially those suffering from the concentrated disadvantages found in the ghetto, such as a real reduction in the value of welfare benefits (especially in relation to housing costs) and the inadequate supply of subsidized public housing. (I shall return to the issue of responsibility for homelessness in chapter 12.)

The relative insignificance of health care can be established by plotting the proportion of the GDP spent on health care against expectation of life for OECD countries: we find a distribution of points that looks more like currants in a Christmas pudding than the kind of linear relationship that might be naively expected. Japan, with the greatest longevity, is a below-average spender, whereas the USA, which spends by far the most, has a rather mediocre average expectation of life.[8] On the most generous estimate, 'the benefits provided by each of the main areas of medical services, including screening, immunisation and the main areas of treatment . . . added at the most five years to the life expectancy of Americans'.[9]

To put this in perspective, it will be useful to contemplate figures such as the following: 'Americans in the top 5 per cent of the income distribution can expect to live about nine years longer than those in the bottom 10 per cent.'[10] This gap is not atypical. 'These health inequalities usually account for differences of five to ten years in life expectancy between rich and poor within countries – and occasionally for as much as a fifteen-year difference.'[11] In Britain, 'professional men now live nine-and-a-half years longer than unskilled manual workers, the widest gap on record. The death rates for under-65s in our poorest urban areas are two-and-a-half times higher than in our richest areas.'[12]

What matters most, apart from being alive at all (and arguably matters more than that) is being in good health, in as far as this is the necessary condition for achieving many of one's goals. It makes a difference to job opportunities, to abilities to have and raise children, and generally to the chance of enjoying life – at least given a minimally decent physical and social environment. But those who live less long are also dogged by ill-health from an earlier age. This may, indeed, be an even more pronounced inequality:

> In East Surrey, Kingston and Richmond, wealthy suburbs of London, the average expectation of life is 79. The expectation of a healthy life unaffected by disability or poor health is 67 years. In Barnsley [a relatively poor town about twenty miles north-east of Manchester] the expectation of life is 76, with only 52 years of healthy life.[13]

Moreover, while few people can be aware of the way in which psychosocial processes lead to early ill-health and death, they do affect 'the real subjective quality of life among modern populations'.[14] As Richard Wilkinson puts it:

> If the whole thing were a matter of eating too many chips or of not taking enough exercise, then that would not in itself mean that the quality of life which people experienced was much less good. You can be happy eating chips. But sources of social stress, poor social networks, low self-esteem, high rates of depression, anxiety, insecurity, the loss of a sense of control, all have such a fundamental impact on our experience of life that it is reasonable to wonder whether the effects on the quality of life are not more important than the effects on the length of life.[15]

I shall explain the way in which stress has deleterious physiological effects later. Before that, it is high time for me to deal systematically with the fundamental question: what constitutes social justice in health?

I suggest that, if 'health inequalities are the outcomes of causal chains which run back into and from the basic structure of society', then wherever we find groups defined by class (however measured), ethnicity, race or any other structural characteristic that experience differences in the quality of their health, the society has a prima facie unjust distribution of health. How can the prima facie injustice be shown not to be a real injustice? The only way consistent with the principles of justice laid out in this book is to trace the whole of the inequality between the average health of two groups to systematically different choices made by members of these groups under circumstances that generated personal responsibility. I shall take up the question of personal responsibility at the end of this chapter. But I can anticipate the result of that enquiry now by saying that 'lifestyle' is very largely a red herring in the context of health and social justice.

The reason for this is, to put it intuitively, as follows: if two groups systematically behave differently in ways that affect their health, it is overwhelmingly likely that these differences will in turn have their basis in the social locations of the two groups. If this is so, we are still looking at the effects on health of the basic structure of society, but this time mediated by structurally induced differences in behaviour.

Since, as I showed in chapter 3, there exists a global basic structure, what I have said here for justice within countries extends naturally to justice in the world as a whole. To the extent, for example, that people (especially infants and young children) are dying of lack of nutrition and simple cost-effective public health measures, they are to a large degree being killed by the policies of the IMF, the World Bank and the WTO, exacerbated by the dismal record of rich countries in supplying economic aid. Of course, if a large part of a poor country's income (however derived) is syphoned off by its rulers or spent on instruments of domestic repression and external aggression, these rulers bear a heavy responsibility too. But we must recognize that these regimes themselves are an element in the overall system of international politics, and are very often sustained (sometimes actually brought into being) because they serve the interests of governments and firms in rich countries. What is at first sight a paradox – that the countries in sub-Saharan Africa with the most natural resources have had the worst economic records since independence – dissolves once we see how the possession of natural resources invites political manipulation.[16] The insurgents in Sierra Leone, for example, maintained themselves with money from diamond companies. And the chaos in the Congo suits international firms just fine, since there is nobody capable of taxing or controlling them.

Let me now return to systematic health inequalities within wealthy countries. How can the big gaps that I have cited be accounted for? Notwithstanding what I have said about the relatively small impact of medical care, it is still worth observing that those in the more advantaged social positions tend to get more expensive care. This is notoriously true in the United States, though the overtreatment of the well-insured in that country may undo a lot of the good done by health-improving treatments. (I shall return to this.) In Britain, within the National Health Service, resources are quite closely matched to *demands*, but 'minority ethnic groups and very low income groups [make] *less* use of health services for a given level of morbidity (illness)'.[17] A British study published in November 2003 found that 'affluent achievers from the middle class were 40% more likely to get a heart by-pass than the "have-nots" from lower socioeconomic

groups, despite the much higher mortality from heart disease in the deprived group. Poorer people were 20% less likely to get a hip replacement, although they were 30% more likely to need one.'[18] Similarly, a report published 'by Cancer Research UK revealed [in March 2004] that it is the affluent who are profiting the most from faster diagnosis and better treatment, while the prospects for the poor lag years behind'.[19]

The explanation hypothesized by the research team was that 'rich people are quicker to go to the doctor when they suspect something is wrong and know how to demand attention'.[20] This is the sense of entitlement, articulacy and self-confidence in pushing doctors that middle-class parents pass on to their children, as we saw in the previous chapter. Needless to say, New Labour's vaunted extension of 'patient choice' within the National Health Service will inevitably widen the class gap by increasing the advantages of pushiness and know-how. A further point (analogous with the school case) is that the choice of a distant hospital is much more feasible for those whose family have flexible hours and the ability to afford the means of travel to inaccessible places. This explains differential take-up of formally equal options by saying that they are not really equal, because many of these options are infeasible to those outside the middle class or feasible only at greater cost in time and effort. But the larger number of visits to a doctor by middle-class people for any given degree of illness has also been attributed, at least partially, to cost: they usually have enough flexibility in their work schedules to visit a doctor without facing loss of pay. Again, it has been found that doctors are very poor at conveying what they intend to say to any patients except middle-class ones, with the results that others often fail to follow the regime prescribed for them.[21]

It is important to recognize, however, that lack of knowledge, articulacy and pushiness also have origins in the class structure. There is no reason for thinking that the poor value health less than the rich. If a large proportion of the poor were Christian Scientists and only a few of the rich, it would be a different matter. Medical care should not be imposed on adults against their will, so that those who spurn it as a result of religion or cultural beliefs are responsible for any adverse consequences for their health.[22] This sort of difference is totally implausible as an explanation of the actual phenomenon. The technology for overcoming the transmission of disadvantage in getting the most out of institutions (including the health care system) is known, as we saw in the previous chapter. All that is needed (all!) is the political will to commit the necessary resources. Injustice in the distribution of health care has tangible consequences: lives blighted

or truncated by preventable or curable disease because treatment goes to the pushy rather than the needy.

Having said all that, it still has to be added that differential quality of medical care cannot possibly explain more than a fraction of the class gap in health. One way of seeing this is to imagine that the richest 5 per cent of Americans got no health care whatever, while the poorest 10 per cent benefited from every possible form of intervention: the richest would still live on average about four years longer than the poorest. The key to a long and healthy life is not getting sick in the first place. But what are the determinants of staying well? Confronted with the finding that 'health inequalities are wider where income differentials are larger', our first thought is likely to be that this is because a more unequal society will tend to have more poor people in it, and poverty is bad for health.[23] This is undoubtedly true, but primarily for societies that have a low average income: life expectancy and gross domestic product are significantly related, but the best-fitting curve relating them shows expectation of life increasing sharply with average income up to about $5,000 per head, then flattening out up to about $10,000 per head, after which it almost levels off.[24] This curve gives us an increase of only four years (from 74 to 78) as we go from $10,000 a head to $25,000, which is pretty small beer when we compare it with the gain in expectation of life from a little over 50 to a little over 65 between $1,000 a year and $5,000.

At low average incomes, it must be added, the best-fitting curve does not fit very well.[25] Around $2,000 per annum, average longevity ranges from a little over 45 to a little under 75 – close to the average expectation of life in the United States. This is consistent with the idea that in a poor country an unequal distribution of income will leave a large proportion of the population in destitution, with a devastating effect on average mortality rates. In rich countries, however, the class gradient of longevity must be explained mainly in some other way. For if it were mediated through absolute deprivation, we would expect the effects of inequality on expectation of life to become smaller and smaller as we moved up from $10,000 to $25,000, whereas differences of ten years or more from top to bottom persist even in very wealthy countries. Furthermore, 'the usual pattern is a continuous gradient across the whole society, with death rates declining and standards of health improving step by step, all the way up the social hierarchy. In this way, even people who are comfortably off tend to be less healthy than the very well off.'[26]

Anyone who lives in Manhattan and looks at a map of zip codes (post codes) will instantly recognize that they are drawn up to make

life easy for marketers by demarcating each zip code area so that it is as economically and ethnically/racially homogeneous as possible. Why should the age-adjusted mortality of men who lived in an area with an average income (in 1980 dollars) of $33,000 or more have been higher than that of men with an income of between $30,000 and $32,999?[27] Surely, there could be no form of nutrition, housing, access to a gym or any other directly health-improving product that was within reach of the first group but not the second. Again, a division of men in England and Wales between the ages of 20 and 64 into four social classes showed a sharp increase in standardized mortality rates from the lowest class to the highest in 1989. A similar division of Swedish men showed a fairly large decrease between the top class and the next down (though less than in Britain), but only relatively small differences among the other three.[28] This is, if we place our bets on direct material effects, profoundly counterintuitive.

The answer is that anxiety and stress tend to increase as we move down the social scale. I shall give a number of reasons for this in a moment, but let me first explain how chronic stress leads to ill-health and premature mortality. Stress in short bursts contributes to survival in emergencies, which is why human beings (in common with other primates) are equipped with the ability to produce

> glutcocorticoids [which] are steroid hormones released during stress as part of the 'fight or flight' mechanism. As such, they are a major component of the system by which the body's resources are diverted from non-urgent tasks, such as growth, tissue repair and the immune system, to preparing the body for immediate action and mobilising the necessary energy resources for muscles.[29]

The effect of stress on the immune system is illustrated by 'a study which examined throat swabs from medical students during exams'. It found that 'exam stress weakened their immunity'.[30] An experiment comparing the rate at which high-stress and low-stress people developed colds when dosed with nasal drops containing the cold virus found that the former had a 75 per cent higher chance of contracting a cold than the latter.[31]

Cortisol, though beneficial in short bursts as a response to stress, is very bad for you if you live in an environment that generates chronic stress, because the feedback mechanism that controls its production is destroyed.[32] Constantly elevated levels of cortisol result in underweight babies and stunted growth, as well as a depleted immunity system and a high concentration of lipoproteins of the kind that give rise to cholesterol deposits.[33] Fibrinogen, another stress product,

makes the blood clot more readily – an obvious gain in coping with a glancing blow from a sabre-toothed tiger, but a recipe for coronary heart disease and other ills when it becomes too much of a good thing.[34] Finally, chronic stress creates high blood pressure.[35] This was something I discovered for myself when I spent four years near the University of Chicago in a constant (and justifiable) state of apprehension about the risk of violence from people who, if they did not accost you in the street, were quite capable of smashing your door down and helping themselves after immobilizing you.

The more materialistic a society – the more that it is generally believed that money is the only significant goal in life – the more that people with a lot of money will feel like winners and those with a little will feel like losers. This feeling will intensify if those who are better off than others believe that they are more virtuous and those who are worse off share this belief. As we shall see in chapter 10, the idea that countries such as Britain and the United States are 'meritocracies' has been propagated with great effectiveness even though it is wildly contrary to the facts. There is no reason why this association of money with superiority and inferiority should not ascend all the way up the scale: a cottage, Marx said, shrinks to a hovel if somebody builds a castle next to it; but the castle shrinks to a cottage if someone builds an enormously larger castle next to it. (I shall take up the wasteful and mutually destructive nature of the competition unleashed by invidious comparison in chapter 13.) We are not talking about a subjective sense of success or failure alone. Almost all everyday interactions are mediated by the parties' estimates of their relative social standing. Even those who do not acknowledge their class position are affected by it:

> [A]mong groups of teenagers from high school, all of whom are doing equally well academically, working-class kids showed prolonged rises in cortisol under any kind of stress while upper-class kids showed a quick spike and then a decline. The physiology of working-class youngsters was altered by their social location, whether or not they acknowledged their working [class] status.[36]

In Britain, inequalities of income are interwoven with the subtleties of social status. The *locus classicus* for the anatomy of snobbery among the toffs is Proust's *A la recherche du temps perdu*, but the true poets of the phenomenon among the middle of the middle class (where what Freud called the 'narcissism of minor differences' reaches its apogee) are playwrights such as Alan Ayckbourn and numerous writers of British sitcoms in which such amusement as

there is derives heavily from their exploitation of the minutiae of class differentiation. In the United States, outside some long-established cities such as Boston and Philadelphia, money and status are tightly connected, with one huge exception: race. The black–white gap in average life expectancy holds up even when we compare blacks and whites in the same range of incomes. Using figures for 1979–89, it was found that the gap at the age of 45 was more than three years for women and two for men in the lowest two of the four income groups into which the population was divided. In the upper two, the gap was almost two years for women and more than one for men.[37] (To put a gap of this size into perspective, bear in mind that eleven of the thirty-three countries with incomes over $10,000 a year fall within the two-year interval of 74–76 and another eleven within that of 76–78.)[38]

Two explanations can be offered for black–white differences in longevity among people in the same income group. One is that a key component of American racism is the belief that blacks are 'naturally' inferior – a belief not-so-subtly reinforced by the kind of 'scientific' racism that I shall dissect in chapter 9. 'A few studies have operationalized the extent to which African Americans internalize or endorse' these stereotypes, and 'found that internalized racism is positively associated to psychological distress, depressive symptoms, substance use, and chronic physical health problems'.[39] The other cause of stress is the everyday experience of racism: snubs, slights, social exclusion, and the like. This can explain why there is a black–white gap at the top end of the income scale as well as the bottom. Black professionals may be well treated at work and by their neighbours in their professional-dominated neighbourhoods. But in the impersonal transactions that are such a large part of everyday experience, they are much more likely to be exposed to the common fate. A distinguished (and no doubt well-paid) professor at Harvard complained in a television documentary aired in spring 2004 of his frustration in often seeing cabs sail past him and pick up a white passenger a few yards further along the road.

He might be better off if they *always* did, because random occurrences create uncertainty and hence stress. This is a point with general application. The direct health effects of being born, living and dying on the street in Mumbai are doubtless bad compared to those of living in a house in a rich country. But if you spend all the time worrying about losing the house because interest rates or rents go up or because you become unemployed, you are probably worse off from the psychosocial angle. It is now well established that 'a large part of the link between health and unemployment is related to job

insecurity and the anticipation of unemployment'.[40] Hence, your health starts to deteriorate when redundancies are announced, regardless of whether it turns out that you are going to lose your job or not.[41] Job insecurity is most extreme among those with ill-paid, marginal jobs, but it extends all the way up the scale, helping to explain the continuous health gradient. A further point is that wealth is highly correlated with income (though far more unequally distributed), so a bigger income is likely to go with a bigger cushion against economic adversity, thus making the prospect of a sudden loss of income less threatening.

Finally, control over working conditions makes for better health and longer life. When we bear in mind how much time people spend at work and how significant for their sense of self-worth their job is for many people, this is scarcely surprising. Earnings are a pretty good proxy for power (or lack of it) at work. Thus again, we have a case in which the continuous gradient of health and longevity is not actually caused by income but by a source of stress strongly associated with it. The most conclusive evidence comes from a study carried out on '17,000 civil servants working in government offices in London [which] found that death rates were three times as high among the most junior office staff as they were among the most senior administrators'.[42] None of those studied was a manual worker, so this large health difference was contained in the upper part of the income hierarchy in Britain.[43]

A further refinement, which points to stress resulting from lack of autonomy is that 'although . . . seniority . . . is closely related to the amount of control people have over their work, control over work was significantly related to health, even after controlling for employment grade and a number of other risk factors'.[44] Similarly striking results have been obtained in the United States. For example, 'women who reported having a heavy workload and limited job control were at three times greater risk for coronary heart disease than women who had heavy workloads combined with control over their work.'[45] The link between stress and coronary heart disease is also illustrated by the study of British civil servants. It may be recalled that 'bad' lipoproteins and fibrinogen are concomitants of stress that contribute to coronary heart disease. Significantly, elevated levels of these 'accounted for about one-third of the increased heart disease among low-ranking civil servants.'[46] The rest remained unexplained, but it is hard to see how anything except stress could be the cause. We can only conclude that stress kills in more ways than have yet been nailed down.

To sum up so far: extreme poverty kills directly through malnutrition, poor housing, and so on, but it also kills, especially in rich countries, because the extremely poor constitute a stigmatized minority. The power of stigmatization as an independent factor in ill-health is demonstrated by the lower expectation of life among American blacks at all income levels. *Relative* poverty, however, has psychosocial effects that help to account for the continuous gradient of longevity from the bottom to the top because of the relation between income and status in materialist societies. Differences of income also serve as markers for other factors implicated in early death. In this context, I looked at anxiety about becoming unemployed and control or lack of it over working conditions. But there are other forces at work that relate relative poverty, as conventionally measured, to shorter life.

A very important link is political. Those who have more disposable resources are able to manipulate public policy in their favour at the expense of those with fewer: 'inequality kills because it affects public policy, altering the distribution of education, health care, environmental protection, and other material resources.'[47] This is true in rich countries and poor ones, and regardless of the existence of elections and political parties. Cuba produces better outcomes in education and health than the United States on a fraction of the income. By way of contrast, in India 'about four-fifths of healthcare spending . . . is effectively private medicine. Spending on universities rather than schools sees the country produce 2 million graduates a year and leaves more than half the country's women illiterate.'[48] This arises because 'India's development is one born of policies that have been skewed in favour of the rich and the aspirational since independence'.[49] With very little change, all this could equally be said of the USA.

The irrelevance of absolute income is illustrated by a case I discussed earlier: the larger the income gradient, the more likely the society is to be one in which those who are relatively poor will be incapable of resisting the siting of toxic waste dumps where they live. The point is that this is entirely a matter of *relative* income. In New York the concentration of toxic wastes in poor areas has gone hand in hand with increased inequality. It makes no odds that at the same time the United States has become far wealthier. If anything, this makes things worse, because, in the absence of government regulation, a wealthy society will produce more rather than less toxic waste from chemical plants and hospitals as well as more domestic rubbish. The absence of government regulation to cut down on the production of toxic wastes as a by-product is itself much more likely if the wealthy and powerful can avoid coming into contact with them.

If everybody were liable to exposure to toxic wastes, 'not in my back yard' would soon be transformed into 'not in anybody's back

yard'. 'Much of noxious industry need not exist at all. . . . Many adverse impacts could be ameliorated or eliminated altogether by the use of industrial best-management practices, application of waste reduction measures at the source', and so on.[50] The German system in which the cost of disposal is built into the price of a car could be extended to all products with great advantage. Gratuitous rubbish could be stopped by taxing everything down to toothbrushes on the cost of disposal – including environmental costs in the calculation. Faced with a tax on the unnecessary cardboard and plastic in which they are encased (which is a bother, anyway), manufacturers of toothbrushes would doubtless rediscover the virtues of simplicity, while, at the other end of the scale, creating toxic wastes would be very expensive and nuclear power an economic impossibility.

If high inequality is associated with 'systematic underinvestment across a wide range of human, physical, health and social infrastructure', it will also tend to kill through psychosocial effects.[51] Participation in common institutions makes for increased social solidarity, which has been shown to be good for everybody's health.[52] But the absence of universal high-quality public services has especially malign effects on those who are at the bottom end of the social scale. For they are as a result liable to find themselves excluded from many mainstream activities in their society and forced into the use of stigmatizing services that are shunned by those who can afford better. However, social exclusion can also be experienced by a majority, when members of a rich minority are able to pull out of common institutions and resort to private education and health care, ultimately isolating themselves completely from the common fate by shutting themselves up in gated communities and providing all their own services.[53]

This has a bearing on health care. Although, as we have seen, its quality does not make a great difference to health, the form that it takes may still do so through its psychosocial effects. It has been suggested that 'the common lament that 15 per cent of Americans [currently more] are "uncovered" by health insurance' may be misplaced. 'The uninsured are treated in public clinics and in emergency rooms, which (although they lack the conveniences of insured care and may have long queues) provide competent services both standard and high-tech.'[54] Also, by being treated only when they actually become ill, the non-insured have the advantages of avoiding unnecessary treatment that may be debilitating or even lethal. Nevertheless, this antiseptic description of the public facilities fails to bring home their demoralizing and stigmatizing quality within a system where medical care covered by insurance is the norm:

> It is an ordinary enough afternoon at Highlands public hospital in Alameda County, California [i.e. no multiple crashes or shoot-outs] . . . and yet . . . in the shabby concrete building on the outskirts of Oakland . . . patients are told to expect a four hour delay [in the acute care clinic]. In the emergency room . . . any rush of critical cases can mean the rest must wait into the night. . . . 'Emergency tests take too long, x-rays take even longer,' said a senior administrator.[55]

A British reader may be forgiven for thinking that this just sounds like the NHS but a bit worse. Remember, however, that these patients have no equivalent of a GP (primary care physician in America) and – this is the crucial point – only a small minority of the British population can afford to opt out of the public service. As a result, the political pressure for improvement in health care is extremely strong. In contrast, this kind of inferior treatment affects only a minority of Americans, so 'there have been few political points to score by imposing any change'.[56] That was written in 1990, but the main thing that has happened since is that the number of people not covered by insurance has increased, while political points have been scored for immiserating the poor further, not for improving their lot. My hypothesis is that, even if the care received by the 'medically indigent' is technically competent (eventually), it still raises mortality rates because of the adverse effect on health of being excluded from the society's common institutions in such an unignorable way. In other words, being forced to use a public hospital may make little difference to your chance of being cured once you are ill, but it may make you much more likely to become ill.

This raises the question of the compatibility of private health care with social justice. Of course, even if private health care were prohibited within a country, there would be nothing to stop those with enough money from travelling to another that had high-quality private health care. The same might be said, quite accurately, about schools; but sending one's children abroad to school is a far bigger step than travelling abroad for a major operation. Leaving that on one side, it does not seem to me that private health care is a straightforward breach of equal opportunity in the way that private education is, in virtue of its buying an unfair advantage for a child in the competition for places in elite universities and for desirable occupations. Health care is not inherently zero sum in the same way. In a market society, a higher income gives its recipients the opportunity to consume more of everything whose sale is not prohibited (and maybe some of that). But in a society in which the extent of inequality was consistent with social justice, there would on the face of it be

no more objection to those who were better off spending it on medical care than to their spending it on, say, expensive holidays. If, however, private care lures away qualified doctors and nurses from the public system, it does constitute an abuse of wealth: the rich are now making the poor worse off.

Even if a system of private health care is considered to be compatible with social justice, it is still important that the standard of publicly provided health care must be found adequate by a large majority of the population. Only in this way can the stigmatization of those who use the basic service be avoided. This is partly a question of funding the service adequately but it is equally a matter of convincing people that the funding is going on the right things. Mammograms, for example, are still being pushed hard by the medical industry in the USA and women are having them at ever higher rates, despite screening programmes of this kind having been shown (to the satisfaction of just about everybody without a vested interest) to be on balance harmful, because aggressive treatment of tiny clusters of cancerous cells kills as many women as it saves, while subjecting a much larger number of others to distressing, disabling surgery, chemotherapy and radiotherapy.[57] The size of the vested interest in the USA must not be underestimated: 'almost three-quarters of all women are screened, at a cost of $3 billion a year' – enough to transform public health in the whole of sub-Saharan Africa.[58] Only the naive will be surprised to learn that 'the National Committee for Quality Assurance, an independent agency that sets standards for the health care industry, wants to increase [the proportion of women screened] to 81 per cent'.[59] Britain's National Health Service does not have anything approaching the perverse financial incentives for overtreatment inherent in the American system.[60] But it still persists with expensive procedures such as mammograms that do more harm than good.

To keep people satisfied, emphasis would need to be put on 'running repairs' to knees, hips, varicose veins, and so on. At the same time, people might become less willing to entrust themselves to hospitals if they were made aware that in the United States as many as 100,000 patients a year may be being killed because the wrong person is operated on or medicated.[61] There must be very many non-fatal cases of mistaken identity for every fatal one: amputating the wrong leg, so that the victim becomes a double amputee for example, or – a case known to me – operating on the wrong eye so that the victim becomes blind. So perhaps a million Americans are being injured or killed every year by American hospitals just through this one sort of error. Since there are many other sources of error, one might conclude that, unless the hospitals are doing a remarkable amount of good to the other patients whom they manage not to harm, closing them down might improve America's health. This thought is reinforced by profit-driven overtreatment and response to profit-driven advertising: 'We [in the USA] kill nearly two hundred thousand a year through improper medical interventions. Many more die due to misuse of heavily advertised prescription medicines, over-the-counter remedies, and other preparations.'[62]

One day after the report on errors in the *New York Times*, the *Guardian* carried a report saying that a million patients per year – a tenth of the total admitted – 'will suffer some accidental harm, from a minor fall to serious injury or death' in NHS hospitals.[63] Since hospitals absorb the lion's share of the health care budget, a more realistic estimate of potential benefits and costs would help to save money. A bigger contribution would be to make it compulsory for doctors to act on 'living wills' specifying treatments people did not want in the event that they were incapable of deciding for themselves and also, of course, if doctors were required to respect patients' wishes about the withholding of treatment if they could indicate them. Whether in advance or at the time, patients should be able in addition to specify euthanasia so as to avoid the pointless suffering and degradation of terminal illness. Since about half the hospital budget goes on people in their last six months of life, this measure in conjunction with the others would probably make it possible to afford a health service that avoided arbitrary limits on treatment and was perceived by the great majority as acceptable.

Finally, let me return to the question of personal responsibility for health. It is highly convenient for defenders of social and economic inequality to suggest that class and race differences arise from good and bad lifestyle choices:

> If social and economic inequalities are as powerful in determining health expectancies as current research indicates they are, then [governments that accept a responsibility for health] would seem obligated to narrow these inequalities, or to find ways to reduce their effect on health and longevity. But if we assign responsibility for the excess mortality and morbidity associated with economic inequality to individuals (on the premise that these misfortunes stem from differences in lifestyles that reflect different personal priorities, tastes and character traits), then we cannot demand remedial action by [such] states.[64]

Since 'none of the principal studies of health inequalities linked to socioeconomic status points to differing lifestyles as the key expla-

nation', the potential role of individual responsibility is limited.[65] But the residual link between different choices and different outcomes could be made a question of personal responsibility only if a lot of other things could be established. To begin with a very simple point: do social class differences in behaviour have the same impact on health? They do not. There is a class gradient with regard to smoking: its incidence increases as we go down the social scale. But smoking (say) a pack of cigarettes a day will on the average impair your health more the lower your socioeconomic status. 'American smokers of high social status are less likely to contract cancer and are more likely to live longer when they do contract it than Americans near to the bottom of the pecking order.'[66] If this is so, the stress that (as we shall see) causes the class gradient in smoking also exacerbates the ill-effects of smoking.

A poor physical environment can make the effects of contracting a disease much worse than they would be in an environment that was more conducive to good health in the first place. For example, the HIV virus impairs the immune system, so those whose environment contains more sources of infection are more liable to become sick and die than are others with a safer environment. Such sources (arising from, among other things, lack of pure water and sanitation) are much more common in Africa than in wealthy countries, so the effects of becoming HIV positive will be worse there even if medical care were equally good. Again, nutritional deprivation in childhood directly produces poor health in later life. But it also makes controlling weight difficult by impairing metabolism in a way that results in storing fat rather than burning it up. Of two adults with different backgrounds who eat the same diet, take the same exercise, and so on, one is liable to gain weight while the other does not.[67]

To generalize: wherever adverse conditions exacerbate the bad effects of 'unhealthy' choices, a class gradient in such behaviour will turn into a bigger class gradient in health outcomes. Even if we hold people fully responsible for their choices, therefore, we still have to say that members of different classes are only partly responsible for differential outcomes. But is it reasonable to hold that 'unhealthy' choices have 'all the attributes – informed, voluntary, uncoerced, spontaneous, deliberated, and so on – that, in the ideal case, are conditions for full personal responsibility'?[68] Even the British and American governments have recognized that meeting these conditions is the last thing that tobacco companies want. On the contrary, when tobacco companies started worrying about people giving up smoking, they responded by spiking cigarettes secretly with extra

nicotine on the strength of scientific advice that this would make them more addictive. Governments have therefore insisted on their supplying health warnings and information about tar content and have exerted control over advertising and sponsorship. Yet in both Britain and America, as we shall see, they remain passive in the face of the enormous increase in the incidence of obesity.

One obvious way of 'blaming the victim' is to hold poor people responsible for choices that arise directly from the relatively limited set of options that poverty (by definition) gives rise to in the market. Faced with the same limited set of alternatives – between eating, keeping warm and avoiding having the water cut off, for example – people who are currently wealthy might very well make exactly the same decisions as do those who actually face this range of options. You may be perfectly well aware that a healthy diet requires plenty of fresh fruit and vegetables. But if you live on one of the big post-war housing estates built outside big cities, you simply will not be able to find them without travelling (by non-existent public transport) to the city centre. And in any case, if you have a hungry family to feed and are living on state benefits or a job at the minimum wage, you will have to fill their bellies with the cheapest food you can buy, which means carbohydrates. It would not be a bad place to start to take it as axiomatic that nobody actually desires chronic ill-health and early death. There must, if that is so, be some reason for people making choices that have a tendency to lead to this result. Among the candidates are two already given: lack of resources and lack of information (or false information) – much of which is deliberately disseminated by companies to sell their products. The differences in health and life expectancy that are left over after allowing for the effects of choices cannot all be accounted for – recall the large unexplained variation in death from coronary heart disease among British civil servants – but they must arise from some way or other in which the better off enjoy a more favourable environment than the less well off.[69]

I want to concentrate here on one way in which an environmentally induced killer – stress – gives rise to 'unhealthy' behaviour as a way of coping with it. The evidence suggests that 'smoking, heavy alcohol consumption and eating for comfort may . . . be responses to anxiety'.[70] Barbara Ehrenreich reports that her fellow workers in high-stress/low-pay jobs found her ability to get through a shift without smoking incomprehensible.[71] If she had been serving a life sentence rather than taking a quick dip into the underside of work to gather copy, there is no reason for thinking she would not have behaved in the same way:

> Smoking increases inversely with the degree of freedom one has at work. . . . The unhealthy choices people make are not irrational choices. We have to see them as constrained rationality, making the best of a bad situation . . . so it is unlikely that their behavior will change by lecturing to them. You have to change the context within which the choice is made.[72]

Smoking has a very steep class gradient, alcohol and illegal drugs somewhat less and the immense number of psychiatric drugs obtained on prescription even less so. Overall, it appears that anxiety and stress are dispersed throughout society (even if not evenly), again illustrating that the primary causes of bad health in rich countries have to be looked for outside material deprivation. Eating 'comforting foods', which 'usually have high sugar and fat content', is 'one of the many ways people respond to stress, unhappiness and unmet emotional needs'.[73] Epidemiological studies have shown that this works. 'There are now a number of studies showing an association between low plasma cholesterol and higher risks of suicide, violence and accidents.'[74] Richard Wilkinson had the evidence for the association but could only speculate on the explanation. However, in 2003 a study reported the identification of a 'biological mechanism' forming the basis for 'comfort foods actually help[ing to] block the effects of high levels of stress'.[75] The author of the report suggested that 'in the short term, if you're chronically stressed', it might be worth fighting the ill-effects in this way, 'perhaps at the expense of a few pounds'.[76] For those who suffer from chronic stress, this solution is obviously a recipe for unlimited weight gain, and 'fixing the source of the stress' is easier said than done.[77] As we know, it would require profound social changes to reduce insecurity and to promote social solidarity in place of stigmatization and competitiveness – in a word, to create a society of equals.

Wilkinson remarked that 'it is interesting to note that there were dramatic increases [in Britain] in the numbers of obese men and women of working age during the later 1980s while income differences were widening so rapidly.'[78] Since then, inequalities of income – and even more, of wealth – have increased further to an enormous degree in both Britain and the United States and have been accompanied by what has been described as literally an obesity epidemic. With the exception of some South Sea islanders, Americans are the fattest people on earth. In the last twenty years, the proportion of overweight Americans – 'overweight enough to begin experiencing health problems as a direct result of that weight' – has risen from 25 per cent to 61 per cent, while the rate of (life-threatening) obesity is

now 20 per cent.[79] In Britain, the adult obesity rate has tripled in the last twenty years, so that it now challenges the American figure.[80] Child obesity is particularly worrying, both because it sets the stage for a lifetime of ill health and because it has grave immediate risks: in both countries, doctors are seeing rapidly increasing numbers of children with Type 2 diabetes – normally a disease of adults – in grossly overweight children. 'Obesity in British children has doubled in two decades.' 'Among six year olds it . . . increased [between 2001 and 2003] from 8.5% to 10% and among 18 year olds from 15% to 18%.'[81]

It will hardly come as a surprise that obesity is not evenly distributed across the population:

> Poverty. Class. Income. Over and over these emerged as the key determinants of obesity and weight-related disease. True, there was a new trend that saw significant numbers of the middle and upper class also experiencing huge weight gains. But the basic numbers were – and are – clear and consistent: the largest concentration of the obese, regardless of race, ethnicity, and gender, reside in the poorest sections of the [American] nation.[82]

Among the explanations is one that I have already mentioned as undermining responsibility: asymmetry of information. A study of twelve thousand obese adults discovered that fewer than half were advised by their doctors to lose weight, but that there was a class bias: 'Patients with incomes above $50,000 were more likely to receive such advice than were those with incomes below.'[83] Indeed, the whole notion of having 'a doctor' does not apply to those who are not covered by medical insurance. Indigent blacks, another study found, have 'a remarkable lack of perception about obesity'.[84] Why do not schools address the information gap? The answer to this question illustrates the way in which the public agenda in the United States is driven by middle-class concerns, as a result of their control over public policy.

'Most anorexics come from the middle class', and their numbers are far smaller than their lobbying group maintains.[85] Moreover, anorexia as a disease of middle-class girls preceded current preoccupations with thinness.[86] (A number of female saints were clearly sufferers but found a creative way of using it.) Finally, 'the data – and the experience of physicians, health workers and others in the field – consistently indicate' the falsity of the common assumption 'that too much fat awareness somehow causes eating disorders'.[87] In spite of all this, and the immensely greater significance of obesity, measuring

body fat and counselling in schools are stymied by the anorexia scare. As a professor of nutrition says about this, 'the number of kids with eating disorders is positively dwarfed by the numbers with obesity. It side-steps the whole class issue.'[88]

It is instructive to contrast this situation with that of France, where for a century (since the Public Health Act of 1904), the state has been actively involved in the nutrition of children through clinics and schools. The attitude was that 'raising a child could be a rational act, but only if the parents were given the encouragement, facts and tools to do so'.[89] In recent years, the incidence of child obesity in France has doubled and the level of overall obesity has risen to 10 per cent – half that of Britain and the United States. This has been enough for 'the French health authorities [to] have launched a vigorous effort to reinforce the old attitudes [that parents must control their children's diets] while addressing the needs of new immigrant groups'.[90] Needless to say, 'You will not find Coca-Cola in a French middle school', as you may in Britain and America.[91] 'There is already a comprehensive set of public health goals, including the training of all school nurses in screening for obesity and its prevention, special care for obese children and rigorous control of advertisement messages about food products aimed at children.'[92]

The United States lies at the other extreme, with Britain, as usual, somewhere in between: benighted by the standards of the rest of Western Europe but more enlightened than America though moving towards it. Both in Britain and the United States, fast-food chains and soft-drink manufacturers have got themselves inside the schools, but companies have succeeded in exploiting the financial plight of many schools in America to gain an extraordinary degree of leverage, so that the schools themselves become co-opted as pushers. For example, back in 1996 Colorado Springs School District 11 negotiated a deal with Coca-Cola that required it to shift seventy thousand cases of the product within the first three years for the contract to be lucrative. By the beginning of the 1998 school year, sales were lagging behind schedule, so a school district administrator sent a memo to all school principals suggesting that they should allow students to bring Coke into the classrooms and should reposition the machines to increase sales: 'Research shows that vendor purchases are linked to availability. . . . Location, location, location is the key.'[93]

That was only a harbinger of the corporate takeover of American schools. The man who negotiated the Colorado Springs deal moved on to a school district in Texas to solicit advertisements 'not only for [its] hallways, stadiums, and buses, but also for its rooftops – so that passengers flying into Dallas-Fort Worth airport could see them – and for its voice-mail systems. "You've reached the Grapevine-Coleyville school district, proud partner of Dr. Pepper" was the message [he] proposed.'[94] The deputy superintendent told the *Houston Chronicle* that the school district would not have lent itself to this 'if it weren't for the acute need for funds'.[95]

The same desperation has driven 'thousands of school districts to us[ing] corporate-sponsored teaching material'.[96] The largest group producing this stuff boasts that its publications get to more than sixty million schoolchildren. It is remarkably frank in explaining the value of its wares. 'Now you can enter the classroom through custom-made learning materials created with your specific marketing objectives in mind', ran one of its pitches.

> 'Through these materials, your product or point of view becomes the focus of discussion in the classroom,' it said in another, '. . . the centerpiece in a dynamic process that generates long-term awareness and attitudinal change.' The tax cuts that are hampering American schools have proved to be a marketing bonanza. . . . The money that these corporations spend on their 'educational' materials is fully tax-deductible.[97]

The same tax dollars could have been used instead to buy real textbooks, instead of this kind of thing:

> Procter and Gamble's *Decision Earth* program taught that clear-cut logging was actually good for the environment; teaching aids distributed by Exxon Educational Foundation said that fossil fuels created few environmental problems and that alternative sources of energy were too expensive; a study guide sponsored by the American Coal Foundation dismissed fears of a greenhouse effect, claiming that 'the earth could be benefited rather than harmed from increased carbon dioxide.'[98]

As if this were not enough, there is a 'commercial television network whose programs are now shown in classrooms, almost every school day, to eight million of the nation's middle, junior and high school students – a teen audience fifty times larger than MTV'.[99] Needless to say, the fast-food chains are well represented among the advertisers. More all-pervasive is advertising on children's television programmes. In notable contrast to the attitude of the French government, the Federal Communications Commission has exerted no control over advertising on American television, with the result that by the late 1980s, 'there was so much money for youth advertising that entire new ad agencies were formed simply to handle the "Saturday A.M. buy" ', and a study in 1993 found that '41 per cent of

all Saturday morning kids show ads were for high-fat foods', with firms such as McDonald's and Pizza Hut driving their advertising agencies to ever greater efforts.[100] In Britain, too, no regulatory body has intervened to prohibit the same kind of targeting: 'Nearly 40 per cent of commercials shown during children's programmes are for food products, most of them high in fat and sugar.'[101] The first five places are taken by three chocolate bars, McDonald's and Kentucky Fried Chicken. Even the healthier-sounding cornflakes that follow them are in fact laden with sugar: the top one is 49 per cent sugar and the next two 40 per cent.[102] In response to the proposal that such advertising should be banned, Tessa Jowell, the UK Minister of Culture, ruled it out on the ground that it would cause the commercial television companies to lose too much advertising revenue.

If the core of social democracy is encapsulated in the slogan 'people before profits', it would be hard to find a clearer indication of the way in which New Labour represents the antithesis of social democracy. The contributions of the junk-food manufacturers to television stations are not, after all, a form of charity. They spend the amount they do because market research has told them that this level of advertising expenditure increases sales so much that their increased profits more than cover the costs. The people running advertising agencies exult in the ease with which children can be manipulated. The president of one agency said: 'Advertising at its best is making people feel that without their product, you're a loser. Kids are very sensitive to that. . . . You open up emotional vulnerabilities, and it's very easy to do with kids because they're the most emotionally vulnerable.'[103]

Children are not the only victims of a major source of obesity, which is the enormous increase in the number of calories in 'supersized' fast foods and soft drinks. It is instructive that the McDonald's French operation has actually advised the public not to eat its product more than once a week – presumably to pre-empt tough government measures – while the American corporation's objective is to have as many families as possible eating three meals a week.[104] Someone who had been eating the 'same' meal at McDonald's for many years would have been consuming more and more calories – with no warnings, of course. A serving of french fries constituted 200 calories in 1960 and has grown steadily to 610, while a 'meal' has grown from 590 to 1,550 calories.[105] Helping to explain the rapid rise of obesity in Britain is the increasing penetration of American ice-cream parlours, and the staggering number of calories and grams of fat in their typical offerings. Whereas a standard British-style ice cream has 65 calories and 2 grams of saturated fat, a cone of Haagen-Dazs or Ben and Jerry's with toppings can contain 1,000 calories and 30 grams of fat – as against a recommended total daily intake of 20 grams.[106] One of the nutritionists who undertook the research into these new products pointed out that a seemingly innocuous frozen yoghurt had been dosed up to have 'the calories and saturated fat of two pork chops, a caesar salad and a buttered baked potato'.[107] It is hard to see how any responsible government could resist calls for tobacco-style labelling of junk foods, 'warning about high-fat diets causing obesity and increasing the risk of cancer, heart disease and diabetes'.[108]

So far from acting to stem the obesity epidemic, the British government is instead enthusiastically cheering on efforts to increase the incidence of child obesity even further. In 2003, a scheme under which 'children as young as seven [were] to be targeted in a multimillion pound campaign by Cadbury to encourage them to buy chocolate bars in exchange for new school sports equipment' received 'the backing of the government' and the strong endorsement of the Sports Minister.[109] Schools that sign up will thus actually do Cadbury's work for it, encouraging children to acquire tokens by eating exactly the kind of sugary, fatty snack food that is already contributing to the epidemic. A spokesman for the Prime Minister declined to comment, except to say: 'This is an independent campaign by a private-sector organisation.'[110] This extraordinary statement is not an aberration: it is simply an application of the dogma that government concern for what goes on in the private sector is to be shunned as 'Old Labour' thinking. Addressing the national conference of the CBI (the employers' organization) in November 2003, in a speech to which the delegates 'responded warmly', Tony Blair said: 'We have to free Europe away [sic] from the idea that the modern social agenda is about regulation. . . . The issue today is not to get rid of the social agenda but redefine it so that it becomes about jobs and skills.'[111] Obviously, there is no room here for the idea that jobs should not exist unless they can survive regulation to protect workers, the environment or (as in the case at hand) public health.

I began this chapter by referring to the book *Health and Social Justice*. Let me end by drawing attention to the title of one of the articles in it: 'Is Capitalism a Disease?'[112] It seems hard to deny by now that its author was right in concluding that it is. It should be added that it is a disease whose severity can be reduced by government intervention to equalize the distribution of wealth and income, insulate all public services (including health and education) from the market, control firms to make the workplace and the environment safer, prohibit the sale of dangerous products while monitoring the labelling and advertising of others, and making use of all the other

methods that successful social democracies have employed to tame the beast.

Unfortunately, however, it is in just the countries that are most in need of strong government action that rich individuals and corporations, directly or through foundations that they finance, have gained the most pervasive grip over the commonly shared ideology and the public agenda. The lying propaganda disguised as information disseminated through textbooks and televisions in American schools may perhaps be the most repulsive manifestation of this, but it is only the tip of the iceberg. I shall explore the phenomenon more fully towards the end of the book in chapter 17 and then in the remaining chapters ask what forces may nevertheless bring about change.

7

The Making of the Black Gulag

In this chapter, I shall describe a particularly striking case of cumulative disadvantage, which can be illustrated best by following the typical career of a black male raised in an American inner-city ghetto. I shall move quickly through the early stages, simply pointing out the way in which the poverty and poor education of the parent(s), plus the multiple social pathologies of the ghetto, combine with wretched schools to produce terrible educational outcomes. In Chicago, for example, 'half of the city's high schools place in the bottom one per cent on the American College Test, two thirds of the city's ghetto students fail to graduate, and those that do graduate read, on average, at an eighth grade level' (out of twelve grades).[1] This, together with the disappearance of blue-collar jobs in the ghetto, sets the stage for large-scale unemployment or at best casual or insecure jobs carrying no benefits (such as health care insurance, sick leave or paid holidays) and paid so poorly that it is impossible to afford minimally decent housing, adequate nutrition and other necessities with a full-time job at the legal minimum wage, while a lot of casual employment pays even less.

Many of those in these marginal positions get involved in behaviour classified (reasonably or not) as crime. But cumulative disadvantage continues here. The high level of police surveillance (backed up by a network of informers) in the ghetto, combined with a discriminatory use of police discretion, results in a very high rate of arrests among African Americans in large cities: with 15 per cent of the population, they accounted in 1994 for 43.4 per cent of arrests for vagrancy, 34.2 per cent for disorderly conduct, 39 per cent for prostitution and slightly over 40 per cent on drug abuse charges.[2] The very

definition of 'disorderly conduct' is discretionary: whether 'hanging out on the front steps of a building or loitering with neighbours' counts as criminal behaviour or not depends on who does it where.[3] Soliciting and street drug-dealing is more likely to be detected in areas of high intensity policing, and in any case prostitution in the suburbs tends to be more discreet while drug distribution is carried on by word-of-mouth contact through bars, athletic leagues and so on.[4] A suburb with its own jurisdiction can make it clear to the police that their future depends on turning a blind eye to legal offences that arouse no complaint from the neighbours.

In the whole country, 75 per cent of drug users are estimated to be white and around 15 per cent black, yet blacks account for '35 per cent of all drug arrests, 55 per cent of all drug convictions, and 74 per cent of all the sentences for drug arrests'.[5] Prosecutors make discriminatory use of their discretion in deciding what offence to charge the defendant with. Especially in relation to drugs, they can also decide whether to put the case before a federal or a state court, and this makes a big difference. Federal mandatory sentences for drug offences are much more severe than typical sentences in state courts for the same verdict: in California, for example, sentences were frequently eight years less than those for the same offence in a federal court in 1988–99, during which period no whites were convicted in federal courts, whereas hundreds were in state courts.[6]

The discrepancy between outcomes for blacks and whites can be further explained by the way in which 'jury commissioners and lawyers have long engaged in discriminatory practices that result in disproportionately white juries.'[7] If all else fails, the venue can be changed, as in the example of a particularly brutal assault on a black prisoner by white policemen: on the ground that everybody in New York City would be 'biased', the case was moved to upstate New York. The point is that, even if white jurors are not guilty of crude racial prejudice, their experience of the police is likely to have been far more benign than that of blacks, so they are strongly inclined to believe them. Where the defendant is black, the views of a black juror are a good deal more relevant than those of a white one. These different perceptions of the police no doubt underlay the belief of a big majority of whites that O. J. Simpson should have been convicted, while a big majority of blacks supported his acquittal.[8]

What made Simpson's case distinctive was that he was one of the relatively few blacks in the country who could afford expensive representation. 'The way in which a wealthy defendant's resources could purchase DNA testimony, pursue investigative leads regarding police misconduct, and assemble an all-star defence team' illustrates the

comparative burdens borne by any 'indigent defendant, or even defender of limited means'.[9] Almost any other black man accused of killing a white woman and a white man would have to rely on a defence provided by the state or federal government. The priority this expenditure receives is indicated by its running on 2 per cent of total state and federal justice expenditures. In fact, the national average per capita spending on indigent defence (at state and federal levels) in 1990, the latest year for which figures are available, was $5.37; Arkansas spent eighty-eight cents and Louisiana an even more derisory eleven cents.[10]

Public defenders, salaried employees of the state, are normally so overburdened that they can offer only a perfunctory service, often meeting the accused for the first time in the courtroom, having glanced at the papers on the way to it.[11] But most of the accused are represented by court-appointed counsel, and cannot be expected to get much for the amounts offered. For example, Mississippi sets an arbitrary limit of $1,000 per case, including capital ones. Two experienced attorneys who did a thorough job (though falling far short, no doubt, of an all-out Simpson-style defence) calculated that they had been working for two dollars an hour.[12] An especially significant point, which adds further to the defendant's disadvantage, is that the court has complete discretion in choosing who to appoint, with no obligation to favour counsel who sometimes get their clients acquitted or those with any knowledge or experience of trying such cases, as long as they have a bar qualification.

In fact, diligence and competence are viewed as positive drawbacks: courts prefer to appoint counsel who can be counted on not to waste their time by mounting a serious defence. A study in 1986 'concluded that assigned counsel "were court functionaries . . . who comply with its goals by providing cost-efficient, expeditious dispositions, and [that the system] alienates those who view the defence function in adversarial terms" '.[13] Courts have held the constitutional right to 'effective assistance' as satisfied when counsel slept through part of the trial, was drunk throughout the proceedings, admitted in evidence to not being prepared on either the law or the facts or, in a capital case, could not name a single Supreme Court decision on the death penalty.[14]

The net result of the discrepancies between the treatment of black and white adults is that blacks are three times more likely than whites to be imprisoned if arrested and get on the average a six-month longer sentence for the same offence.[15] As far as juveniles are concerned, their treatment does not lend itself to such simple summarization because more discretion exists with regard to them; but this

57 See Field and Sanchez, *Equal Treatment*, *passim*.
58 'All the parents we observed wanted their children to be successful students and productive citizens': Hart and Risley, *Meaningful Differences*, p. 210.
59 Ibid., p. 213.
60 Polly Toynbee, 'Going Nowhere', *Guardian*, 2 April 2004, p. 15.
61 Ibid.
62 Jo Blunden, 'Mobility has Fallen', *Centre Piece* (Centre for Economic Performance, London School of Economics, vol. 7, no. 2, Summer 2002), pp. 8–13: p. 13.
63 David Walker, 'New Breed of Middle Classes Closes Ranks', *Guardian*, 18 May 2002, p. 9.
64 'Oh Lords, Oh Derry', extract from Robin Cook's diaries, *Sunday Times*, 12 October 2003, pp. 1 and 2 of 'News Review': p. 2.
65 Nicholas Barr and Iain Crawford, 'Myth or Magic', *Guardian Higher*, 2 December 2003, p. 20.
66 Carole Leathwood, 'A Critique of Institutional Inequalities in Higher Education (or an Alternative to Hypocrisy for Higher Educational Policy)', *Theory and Research in Education* 2 (2004), pp. 31–48: table 1, p. 35. The actual figures are: Oxford 12.2, Cambridge 11.9, Imperial 8.1, North London 22.8, Guildhall 20.5 and Thames Valley an extraordinary 35.
67 Walker, 'New Breed of Middle Classes Closes Ranks'.
68 Leathwood, 'A Critique of Institutional Inequalities', table 2, p. 37. (The classes are IIIM, IV and V.)
69 Ibid., p. 41.
70 Will Woodward, 'UK Spending on Education Lags behind Rivals', *Guardian*, 14 June 2002, p. 8.
71 Phil Revell, 'Poor Little Rich Schools', *Guardian* (Education), 23 April 2002, p. 2.
72 Ibid.
73 Howard Glennerster and William Low, 'Education and the Welfare State: Does it Add Up?', pp. 28–87 in John Hills, ed., *The State of Welfare: The Welfare State in Britain since 1974* (Oxford: Clarendon Press 1990), p. 52.
74 Ibid., p. 53. Even more outrageously, private schools have been given generous sums of money from the national lottery: two grants of £500,000 for a sports hall and a tennis centre, the latter to a school miles away from the nearest town and whose 'prospectus makes no mention of community use of its facilities'. Eton College – the richest of the public schools – got £3.8 million for a rowing lake and sports centre open to the public but on its own grounds and with free access to its pupils. Revell, 'Poor Little Rich Schools'.
75 Woodward, 'UK Spending'.
76 Jenni Russell, 'Pay as You Learn', *Guardian*, 8 April 2002 (G2), pp. 2–3: p. 2.
77 Ibid.

78 Ibid.
79 Ibid.
80 Patrick Wintour, 'Bold No. 10 Idea for Tax and Schools', *Guardian*, 27 April 2001, p. 1.
81 Lucy Ward, 'Parents Will Bribe or Blag Children's Way to Best Schools', *Guardian*, 19 April 2004, p. 3.
82 Ibid.
83 Orfield, 'Policy and Equity', p. 418.
84 Will Woodward, 'London Schools Supremo to Woo Rich Parents', *Guardian*, 2 July 2002, p. 9, quoting Stephen Twigg, then junior education minister with special responsibility for London.
85 Fiona Millar, 'Admissions Impossible', *Guardian* (Education), 11 November 2003, p. 2.
86 Ibid.
87 Russell, 'Pay as You Learn', p. 3.
88 Lucy Ward, 'Help for Popular Schools Risks "Spiral of Decline"', *Guardian*, 14 October 2003.
89 Ibid.
90 Ibid.
91 Ibid.
92 Orfield, 'Policy and Equity', p. 412.
93 Ibid.
94 For an analysis of what is taught in these schools, see chapter 6 of my *Culture and Equality* (Cambridge: Polity Press, 2001; Cambridge, Mass.: Harvard University Press, 2001).
95 US Department of Education statistics, which may be found at <www.policyalmanac.org/education/archive/privateschools.pdf>.
96 Nancy Folbre, 'Leave No Child Behind?' pp. 68–77 in Kuttner, ed., *Making Work Pay*, p. 71.
97 Lisa W. Foderaro, 'Using Love, and Chess Lessons, to Defy Theories on Race and Test Scores', *New York Times*, 7 April 2002, p. 33.
98 Summary of Douglas S. Massey, 'The Age of Extremes: Concentrated Affluence and Poverty in the Twenty-First Century', pp. 155–88 in Ackerman et al., eds., *The Political Economy of Inequality*, p. 157.
99 Ibid., p. 156.

Chapter 6 Health

1 First quotation from Richard Hofrichter, 'Preface', pp. xvii–xxi in Hofrichter, ed., *Health and Social Justice: Politics, Ideology and Inequity in the Distribution of Disease* (San Francisco: Jossey-Bass, a Wiley Imprint, 2003), p. xviii; second quotation from the Acheson Report: D. Acheson, *Independent Inquiry into Inequalities in Health* (London: Stationery Office, 1998), p. 7, quoted in Hilary Graham, 'From Science to Policy: Options for Reducing Health Inequalities', pp. 522–41 in Hofrichter, ed., *Health and Social Justice*, p. 538.
2 Graham, 'From Science to Policy', p. 538.

3 Ronald Dworkin, 'Justice in the Distribution of Health Care', pp. 203–22 in Matthew Clayton and Andrew Williams, eds., *The Ideal of Equality* (London: Macmillan, 2000), p. 205.
4 John Aubrey, *Brief Lives*, ed. Oliver Lawson Dick (London: Penguin Books, 1987), p. 234.
5 William Muraskin, 'Nutrition and Mortality Decline: Another View', in *The Cambridge World History of Food* (Cambridge: Cambridge University Press, 2000), vol. 2, pp. 1389–97: p. 1390.
6 James S. House and David R. Williams, 'Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health', pp. 89–131 in Hofrichter, ed., *Health and Social Justice*, p. 97, citations suppressed.
7 Arline T. Geronimus, 'Addressing Structural Influences on the Health of Urban Populations', pp. 542–56 in Hofrichter, ed., *Health and Social Justice*, p. 544.
8 House and Williams, 'Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health', figure 3.8, p. 112. The numbers are for 1990, but the same general picture continues to be accurate.
9 Richard Wilkinson, *Unhealthy Societies: The Afflictions of Inequality* (London: Routledge, 1996), p. 67.
10 Christopher Jencks, 'Does Inequality Matter?' pp. 49–65 in *Daedalus*, Winter 2002, p. 61.
11 Richard G. Wilkinson, *Mind the Gap: Hierarchies, Health and Human Evolution* (London: Weidenfeld and Nicolson, 2000 and New Haven, Conn.: Yale University Press, 2001), p. 5.
12 Will Hutton, 'The Truth about Ageing', *Observer*, 6 October 2003, p. 24.
13 Howard Glennerster, *Understanding the Finance of Welfare: What Welfare Costs and How to Pay for it* (Bristol: The Policy Press, 2003), p. 67.
14 Wilkinson, *Unhealthy Societies*, p. 5.
15 Ibid.
16 For discussion of this issue and possible changes in international law to cope with it, see Thomas Pogge, *World Poverty and Human Rights* (Cambridge: Polity, 2002), ch. 6.
17 Glennerster, *Understanding the Finance of Welfare*, p. 65; emphasis in original.
18 John Carvel, 'Rich Patients get Better NHS Care', *Guardian*, 7 November 2003, p. 10.
19 Sarah Boseley, 'Rich Benefit Most from Improved Treatment of Cancer, say Scientists', *Guardian*, 10 March 2004, p. 5.
20 Ibid. Blacks in the United States are disadvantaged in remarkably similar ways. 'A 2002 Institute of Medicine report points out that blacks are less likely to receive appropriate cardiac medications or be referred for coronary artery bypass surgery. If they have kidney problems, they're less likely to receive dialysis or a transplant. Studies have shown that doctors dispense lower dosages of pain medicine to African-Americans. According to the Institute's report, blacks receive lesser medical care regardless of their income and whether they have health insurance.' *Newsday*, 9 March 2004, p. B47.

21 This problem could be fixed by making the ability to communicate a prerequisite for gaining a medical qualification and by setting up an inspectorate to observe interactions between doctors and patients so as to tell them how to do better. The trouble is, of course, that patients' advocacy groups represent the articulate middle class, leaving the victims of class-related inequalities in health care without a voice. This is a pattern we have already seen and will see more of as this book progresses.
22 For a discussion of this point, see pp. 37–8 of my *Culture and Equality* (Cambridge: Polity, 2001; Cambridge, Mass.: Harvard University Press, 2000).
23 Quotation from Wilkinson, *Unhealthy Societies*, p. 92.
24 John W. Lynch et al., 'Income Inequality and Mortality: Importance to Health of Individual Income, Psychosocial Environment, or Material Conditions', pp. 217–27 in Hofrichter, ed., *Health and Social Justice*, figure 7.1, p. 220.
25 Ibid., figure 7.2, p. 221.
26 Wilkinson, *Mind the Gap*, p. 5.
27 Wilkinson, *Unhealthy Societies*, figure 5.1, p. 73. The gradient was continuous over all the twelve groups into which the population was divided, with one exception. If we thought that material deprivation was the driving force behind the relation, we would expect any inconsistency to come somewhere in the top half of the income distribution, whereas the only group that was out of line was the group one from the bottom.
28 Ibid., figure 5.8, p. 88.
29 Ibid., p. 193.
30 Ibid., p. 179.
31 Ibid. This will come as no surprise to those who recall Adelaide's lament in *Guys and Dolls* (first produced in 1950), in which she summarized a physiology textbook by saying that under conditions of chronic insecurity 'a person could develop a cold'.
32 Ibid., p. 194.
33 Ibid., p. 195.
34 Ibid., p. 196.
35 Ibid., p. 195.
36 Richard Levins, 'Is Capitalism a Disease? The Crisis in Public Health', pp. 365–84 in Hofrichter, ed., *Health and Social Justice*, p. 373.
37 House and Williams, 'Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health', table 3.1, p. 90.
38 Lynch et al., 'Income Inequality and Mortality', figure 7.2, p. 221.
39 House and Williams, 'Understanding and Reducing Socioeconomic and Racial/Ethnic Disparities in Health', p. 107. Internalized racism is also, of course, bad for health through its contribution to poverty: if

you are told you are rubbish so often that you believe it, you are hardly going to achieve anything. (See ibid. for this point.)

40 Wilkinson, *Unhealthy Societies*, p. 178.
41 Ibid.
42 Ibid., p. 53.
43 Ibid.
44 Ibid., p. 107.
45 Sarah Kuhn and John Wooding, 'The Changing Structure of Work in the United States: Implications for Health and Welfare', pp. 251–65 in Hofrichter, ed., *Health and Social Justice*, p. 254.
46 Wilkinson, *Unhealthy Societies*, p. 196.
47 Jencks, 'Does Inequality Matter?' p. 60.
48 Randeep Ranesh, 'The Last Thing on their Minds', *Guardian*, 13 May 2004, p. 15.
49 Ibid.
50 Juliana A. Maantay, 'Zoning, Equity and Public Health', pp. 228–50 in Hofrichter, ed., *Health and Social Justice*, p. 243.
51 Lynch et al., 'Income Inequality and Mortality', p. 222.
52 See Wilkinson, *Unhealthy Societies*, Part III.
53 See my 'Social Exclusion, Social Isolation and the Distribution of Income,' pp. 13–29 in John Hills, Julian Le Grand and David Piachaud, eds., *Understanding Social Exclusion* (Oxford: Oxford University Press, 2002).
54 Robert W. Fogel and Chulhee Lee, 'Who Gets Health Care?', *Daedalus*, Winter 2002, pp. 107–18: p. 115.
55 Brian Deer, 'American Health Care goes on the Critical List', *Sunday Times*, 2 September 1990, p. 11.
56 Ibid.
57 Marcia Sherman, 'Doubts on Mammograms do not Affect their Use', *New York Times*, 23 June 2002, section 15, p. 2.
58 Ibid.
59 Ibid.
60 'Medical decisions are not always made for medical reasons. . . . We [in the USA] do a lot more implanting of pacemakers than Europe and perform more caesarian sections and hysterectomies.' Hospitals buy expensive equipment to compete with other hospitals (which thus generates excess capacity) and then have to pay for it by charging insurance companies for unnecessary use. Further, 'to keep the "batting average" high, [a] surgeon has to perform [several hundred] operations [a year of a particular kind] . . . so there's an incentive to keep both surgeons and machines working.' Levins, 'Is Capitalism a Disease?' pp. 371, 372.
61 Denise Grady, 'Oops Wrong Patient: Journal takes on Medical Mistakes', *New York Times*, 18 June 2002, section 4, pp. 1 and 6.
62 Levins, 'Is Capitalism a Disease?' p. 372.
63 Sarah Boseley, '1 m Patients "Suffer Harm in Hospitals"', *Guardian*, 19 June 2002, p. 4.

64 Daniel Wikler, 'Personal Social Responsibility for Health', *Ethics and International Affairs*, 16 (2002), pp. 47–55: p. 49.
65 Ibid., p. 53.
66 Ibid., p. 52.
67 Greg Critser, *Fat Land: How Americans Became the Fattest People in the World* (Boston: Houghton Mifflin, 2003), pp. 129–30.
68 Wikler, 'Personal Social Responsibility for Health', p. 50.
69 This is not to deny, of course, that the total effects on health of environmental factors for any particular person depend on the interaction between it and that person's genome. (See chapter 9.) But the entire analysis here is carried out at the level of groups. Conceivably, there is a group-wide genetic basis for the weight (see text below) of the inhabitants of certain islands in the South Seas, but this kind of explanation would be a desperate resort as an explanation of group differences in health within countries such as Britain and America. Positive evidence for the failure of this hypothesis is that people who lose well-paid employment and start living in poverty and insecurity start to exhibit just the same traits as those who were poor all along.
70 Wilkinson, *Mind the Gap*, p. 65.
71 Describing life working in a chronically understaffed cheap restaurant, Barbara Ehrenreich says of a table adjacent to the toilets that its function is 'to house the ashtrays in which servers and dishwashers leave their cigarettes burning at all times, like votive candles, so that they don't have to waste time lighting up when they dash back here for a puff'. When she complains that the lack of any breaks in an eight-hour shift leaves no time for eating, one of her fellow server replies, 'Well, I don't understand how *you* can go so long without a cigarette.' Barbara Ehrenreich, *Nickel and Dimed: On (Not) Getting on in America* (New York: Henry Holt and Co., 2001), pp. 30, 32.
72 Levins, 'Is Capitalism a Disease?' p. 380.
73 Wilkinson, *Unhealthy Societies*, pp. 185–6.
74 Ibid., p. 188.
75 Severin Carrell, 'Comfort Eating Releases Chemicals that Fight Stress', *Independent on Sunday*, 14 September 2003, p. 5.
76 Norman Peccarano, quoted in ibid.
77 Ibid.
78 Wilkinson, *Unhealthy Societies*, p. 186.
79 Critser, *Fat Land*, p. 116.
80 Beezy Marsh, 'Obesity: New Child Alert', *Daily Mail*, 8 October 2003, pp. 1 and 6: p. 6.
81 Ibid.
82 Critser, *Fat Land*, p. 116.
83 Ibid., p. 5.
84 Ibid., p. 120.
85 Ibid., p. 123.
86 Ibid.
87 Ibid.

88 Ibid., p. 121.
89 Greg Critser, 'New Front in Battle of the Bulge', *New York Times*, 18 May 2003, WK, p. 7.
90 Ibid.
91 Ibid.
92 Ibid.
93 Eric Schlosser, *Fast Food Nation: The Dark Side of the All-American Meal* (New York: HarperCollins, 2002 [2001]), p. 57.
94 Ibid., p. 52.
95 Ibid.
96 Ibid., p. 55.
97 Ibid., p. 56.
98 Ibid., p. 55.
99 Ibid., p. 56.
100 Critser, *Fat Land*, p. 114.
101 Sean Poulter, 'Junk the Food Ads: Children "at Risk" from Hard Sell', *Daily Mail*, 21 July 2003, p. 13.
102 Ibid.
103 Quoted in Tim Kasser, *The High Price of Materialism* (Cambridge, Mass: The MIT Press, 2002), p. 91.
104 The connection between fast food and calorie intake is amazingly close: a study of 50,000 American adolescents found that those who ate three or more fast-food meals a week (a fifth of the total) averaged a daily intake of 2,752 calories, while those who ate one or two averaged 2,192 and those who ate none averaged 1,952 (Critser, *Fat Land*, p. 115).
105 Ibid., p. 28.
106 Sean Poulter, 'The Ice Creams that Pack a Cool 1000 Calories', *Daily Mail*, 26 July 2003, p. 35.
107 David Adam, 'Super Calorific Ice Cream Can Contain Staggering Amounts of Fat', *Guardian*, 25 July 2003, p. 2.
108 Ibid.
109 Jo Revill, 'Cadbury's Condemned Over School Sports Sweetener', *Observer*, 30 March 2003, p. 25.
110 Ibid.
111 David Gow and Larry Elliot, 'PM Seeks Industry Support for Reforms', *Guardian*, 18 November 2003, p. 19.
112 Levins, 'Is Capitalism a Disease?'

Chapter 7 The Making of the Black Gulag

1 Loïc Wacquant, 'Deadly Symbiosis: Rethinking Race and Imprisonment in Twenty-First Century America', *Boston Review*, 27(2), April/May 2002, pp. 23–31: p. 27.
2 Bernard E. Harcourt, 'Policing Disorder', *Boston Review*, 27(2), April/May 2002, pp. 16–22: p. 20.
3 Ibid., p. 21.

4 David Cole, *No Equal Justice: Race and Class in the American Criminal Justice System* (New York: The New Press, 1999), p. 50.
5 Ibid., p. 144.
6 Ibid., p. 156.
7 Ibid., p. 8.
8 This does not mean (as some commentators ignorantly suggested) that those in favour of acquittal thought it less likely that Simpson was guilty than that he was innocent. All they (we) had to hold was that, whether through incompetence or fraud, the police had rendered the material evidence unreliable – and, in the absence of an eye-witness, that was all the prosecution had.
9 Marc Mauer, *Race to Incarcerate* (New York: The New Press, 2001 [1999]), p. 162.
10 Ibid., pp. 84–5.
11 Ibid., pp. 81–3.
12 Ibid., p. 85. The lawyers did finally win expenses and overheads in addition to the fee, but only a highly dedicated lawyer would fight a capital case all out for that.
13 Ibid., p. 86; internal quotation from study cited.
14 Ibid., pp. 78–9.
15 Erin Texeira, 'Study on Blacks: Gains but still Shortages', *Newsday*, 25 March 2004, p. A5.
16 Ibid., p. 145.
17 Ibid.
18 Jerome J. Miller, 'Tracking Racial Bias' (summary of his *Search and Destroy: African-American Males in the Criminal Justice System* (Cambridge: Cambridge University Press, 1996), ch. 2), pp. 259–62 in Frank Ackerman et al., *The Political Economy of Inequality* (Washington DC: Island Press, 2000), p. 261.
19 Cole, *No Equal Justice*, p. 145; see this page also for more detail.
20 Miller, 'Tracking Racial Bias', p. 261.
21 Ibid., p. 262.
22 Wacquant, 'Deadly Symbiosis', p. 28; emphasis in original.
23 David Sheff, 'The Good Jailer', *New York Times Magazine*, 14 March 2004, pp. 44–7: p. 46.
24 Cole, *No Equal Justice*, p. 146.
25 Ibid., p. 147.
26 Ibid.
27 Ibid., p. xi.
28 Ibid., p. 148.
29 Ibid.
30 Al Baker, 'Fees, as Surely as Taxes, will Rob the State of Jobs, Critics of Pataki Budget Say', *New York Times*, 16 February 2003, p. 38.
31 Cole, *No Equal Justice*, p. 144. As Jeremy Bentham first pointed out, penalties should be graduated so that someone who commits one crime is not given an incentive to commit a greater one. Here, it is worth killing any number of police officers to avoid arrest for a drug offence.