The art of medicine

Lower taxes or greater health equity

"We have to lower taxes." A former UK Government minister and prominent member of the Conservative Party recently said this nine times in 3 minutes. He said it with passion, as if it were a fresh diagnosis of the problem. It was probably his solution to any problem, but this time we were on a radio news programme to discuss inflation and the cost-of-living crisis. It is not a uniquely British obsession. The sour joke in the USA is that Republicans were put on earth to lower taxes. Perhaps equally predictably, my concern was not a priori with the level of taxation, but with what action was necessary to prevent a severe impact on health equity from the cost-of-living crisis. Such action was necessary to build back fairer—the title we, at the UCL Institute of Health Equity, gave to four reports we published in 2020 and 2021. Simply, the politician and I have different aims: he wants to lower taxes; I want to help create a society with greater equity of health and wellbeing.

Such debate resonates in the current political situation in many countries. The UK is going through political drama after a disgraced Prime Minister was forced to resign. In the USA, the polarised debate between left and right is becoming more extreme—in his boasts about cutting taxes, the former US President Donald Trump neglected to highlight that these cuts favoured the rich. The re-elected French President faces off against extremes of right and left. A full democracy is present in only 21 of 167 countries rated by the Economist Intelligence Unit in 2022. In these contexts, it is worth asking what kind of society we want. In the UK, as politicians vie with each other to become leader of the Conservative Party, and hence Prime Minister, much of what passes for debate revolves around who can cut taxes further and faster. There is no mention of the impact of government on the health and wellbeing of the population, let alone of the likely effects of cutting taxes on health inequities.

The impact of inflation and the cost-of-living crisis, affecting countries across the world, is but the third recent major crisis to have a negative impact on health equity—the other two were the global financial crisis of 2007–09 and the continuing COVID-19 pandemic. We should bring into the public square a debate about equity of health and wellbeing, and the degree to which people can lead lives of dignity. Low taxes or high taxes should be seen not as intrinsically good or bad, but in light of their impact on equity of health and wellbeing of the population. As successive reports I have written with colleagues have laid out, government expenditure can have beneficial effects on the social determinants of health. If cutting taxes means cutting programmes that benefit health equity, particularly the health of the most deprived populations, surely we should want politicians, the journalists who report on them, and the general public to have equity of health and wellbeing as a central concern.

The UK provides an unfortunate case study. The government elected in 2010, in the wake of the global financial crisis, presented austerity and control of the public finances as the number one priority. Somewhat sotto voce they admitted that although the short-term goal was reducing debt and cutting public expenditure, the longer-term aim was reducing the size of the state. Government ministers alternated between declaring that in reducing public expenditure they were cutting out waste, a noble endeavour; and, almost its direct opposite, that they were taking the difficult choices, and regretted the real pain they caused. There was a steady drum beat of blaming the most disadvantaged people in society for their poverty—an apparent justification for a series of cuts to welfare programmes.

UK public expenditure went from 42% of gross domestic product (GDP) in 2010 to 36% of GDP by the end of the decade. Accompanying austerity and regressive cuts to social expenditure was a worsening health picture. The rate of rise of life expectancy slowed dramatically—the slowdown in the UK was more marked than in any other high-income country, apart from Iceland and the USA; health inequalities increased, and life expectancy for the poorest people in the UK declined. Correlation is not causation, but a causal link between austerity and the grim health picture in the UK is likely. In the 2020 report *Health Equity in England: the Marmot Review 10 Years On*, we documented adverse changes to all six of the key recommendations we made in 2010. All six of these social determinants of health would be affected adversely by cutting taxes further.

Drawing on the findings of this 2020 report, I want to ask would-be prime ministers what they hope to "achieve" by cutting taxes. In the decade after 2010, child poverty in England rose from 27% to 30% (poverty defined as <60% median income). This increase was a direct result of changes to tax and benefits. Cutting taxes is likely to lead to a further rise in child poverty. Other countries do things differently. UNICEF's Report Card 16 highlighted what factors shape child wellbeing; in 41 mostly high-income countries reported on, average child poverty in 2018 was 20%. Ranked 1–4, the countries with the lowest poverty at 10–11% were Iceland, Czechia, Denmark, and Finland. Ranked 40 and 41, with child poverty at 32–33%, were Romania and Türkiye. The UK ranked 31 out of 41, with child poverty at 24% (a different mode of calculation to the 30% I mention above); the USA, with 30% of children in poverty, ranked 38 out of 41. Before redistribution through tax and benefits, child poverty in Finland was higher than in the USA. It is government policy in Finland to use fiscal and social policy—tax dollars—to reduce child poverty.

It can also be government policy to increase expenditure on good child development. The average spend on children aged 0–5 years in countries in the Organisation for Economic Co-operation and Development is about US$6000 per child. In Norway, it is a little over $12 000. In the UK, it is around $4000, but not as low as in the USA at closer to $3000. Perhaps tax-cutters in the UK and USA want their countries to be even further below the average?

Per pupil spend on education in England went down by 8% in the decade after 2010. Cut it further? There were regressive cuts to local government spending: 16% reduction in the least deprived quintile of local authorities, a shocking 32% in the most deprived quintile. Cut local services even more? Public sector pay did not keep up with inflation. Make public sector workers even poorer? If someone becomes unemployed in Denmark they receive 90% of their previous salary, in the Netherlands 75%, and in Germany 60%. In the UK, Universal Credit is 14% of median pay. Immiserate the unemployed even further?

Funding of the UK National Health Service, with an annual increase of about 1% a year since 2010, fell below the historical trend since 1997 of about 3·8% a year, despite the population increasing and getting older. Cutting taxes would surely result in an even bigger shortage of the health workforce and longer waiting lists.

Why, on earth, are these worthy goals? We know what cuts in public expenditure in the UK have achieved. Plausibly, regressive cuts in public spending after 2010 were responsible for an increase in health inequity and life expectancy falling for the poorest people. I want to ask ideological tax cutters: why are they not prepared to come out and say that damaging the public health and creating greater inequities of health and wellbeing is the price society has to pay to meet this obsession? The tax-cutting zealot might note that the UK is not a high-tax country. Data from the International Monetary Fund show government revenue as a share of GDP to be 52% in Finland and France, 50% in Sweden, 46% in Germany, and only 36% in the UK. The USA lags at 31%.

It was as relatively low-taxed countries, with high levels of social and economic inequality, and threadbare public services that the UK and USA faced the COVID-19 pandemic. And these two countries did really badly. In England, a comparison of life expectancy in 2018–20 with the previous triennium showed a fall in the most deprived 40% of areas. A reasonable interpretation is that the pandemic led to worse health overall and increased health inequality. Among 20 high-income countries, the USA had the biggest fall in life expectancy in 2020 and 2021, followed by Scotland, Northern Ireland, Germany, and England and Wales. My speculation is that the link between poor health performance pre-pandemic and poor management of the pandemic works at four levels: poor governance and political culture, high levels of social and economic inequalities, low and diminished spending on public services, and poor health that predisposes some people to more severe COVID-19.

All this was inadequate preparation to meet a cost-of-living crisis. With the UK Government shifting to its living with COVID-19 strategy, the former UK Chancellor of the Exchequer first removed a pandemic boost to welfare payments to poorer families of £1040 a year, and then raised benefit levels by 3% with inflation running at 9%. The Resolution Foundation calculates that a further 500 000 children in the UK will fall below the poverty line in 2023. Public sector workers will see their pay eroded further, and, as reported by the Food Foundation, one in seven UK households was food insecure in April, 2022.

Suppose that we agreed that equity of health and wellbeing is a worthwhile social goal that our political and social arrangements should deliver. The UK and the USA are rich countries with relatively low levels of taxation and relatively high social and economic inequalities. Evidence on the social determinants of health provides ready explanations for why their population health has been relatively poor and health inequities have increased. A degraded discussion about taxation levels should not be the currency of political debate. Surely, a more worthwhile debate is how to increase and sustain health equity and wellbeing. In short, to build back fairer.

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