

**THE IMPACT OF THATCHERISM ON HEALTH
AND WELL-BEING IN BRITAIN**

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Margaret Thatcher (1925–2013) was the United Kingdom’s prime minister from 1979 to 1990. Her informal transatlantic alliance with U.S. President Ronald Reagan from 1981 to 1989 played an important role in the promotion of an international neoliberal policy agenda that remains influential today. Her critique of UK social democracy during the 1970s and her adoption of key neoliberal strategies, such as financial deregulation, trade liberalization, and the privatization of public goods and services, were popularly labeled Thatcherism. In this article, we consider the nature of Thatcherism and its impact on health and well-being during her period as prime minister and, to a lesser extent, in the years that follow; we focus mainly on Great Britain (England, Scotland, and Wales). Thatcher’s policies were associated with substantial increases in socioeconomic and health inequalities: these issues were actively marginalized and ignored by her governments. In addition, her public-sector reforms applied business principles to the welfare state and prepared the National Health Service for subsequent privatization.

... with Thatcherism, she set out to save the soul of the nation and ended up selling it off to the cheapest bidder. . . . People who didn’t agree with Mrs. Thatcher were just not ‘one of us,’ they deserved no empathy, had to be beaten, and Britain for a while found her drama of certainty addictive. . . . Spite came to live in Britain during her time and we became partisan to the point of psychosis. . . . Margaret Thatcher’s greatest legacy will be to have made Britain a place more out of love with the idea of tolerance.

—Andrew O’Hagan, Maggie (1)

Margaret Thatcher (1925–2013) was the United Kingdom’s prime minister from 1979 to 1990. Her informal transatlantic alliance with U.S. President Ronald Reagan from 1981 to 1989 played an important role in the promotion of an international neoliberal policy agenda that remains influential today. Her critique of UK social democracy during the 1970s and her adoption of key neoliberal strategies, such as financial deregulation, trade liberalization, and the privatization of public goods and services, were popularly labeled “Thatcherism.” In this article, we consider the impact of Thatcherism on health and well-being during her period as prime minister and, to a lesser extent, in the years that follow; we focus mainly on Great Britain (England, Scotland, and Wales). Thatcher’s policies were associated with substantial increases in socioeconomic and health inequalities: these issues were actively marginalized and ignored by her governments. In addition, her public-sector reforms applied business principles to the welfare state and prepared the National Health Service for subsequent privatization.

THATCHERISM IN OVERVIEW

Thatcherism has had a fundamental and long-term impact on public health and health inequalities in Britain because of the way it affected the social determinants of health and made socioeconomic position an ever more important factor in health and well-being (2). Thatcherism has been described as an ideological project that set out to radically re-cast the relationship between labor and capital and between the state, society, and the individual (3). Thatcherism and the New Right provided a narrative that explained the crisis of British capitalism in the 1970s as a crisis of the welfare state, high wages, and low productivity; of the “undemocratic” power of what in 1984 she called “the enemy within”—the trade unions (4). This was accompanied by a racialized discourse targeting non-whites and immigrants (5). Thatcherism set out to systematically dismantle the structures of the post-war Keynesian consensus around the social wage, full employment, the corporatist state, and the size and role of the public sector. This goal was pursued through the aggressive promotion of the free market alongside the “hollowing out” of the state (6).

Thatcher’s political program included: (a) deregulation of the labor and financial markets (including the “Big Bang” deregulation of the City of London in 1986); (b) privatization and marketization of the main utilities (water, gas, and electricity) and state enterprises (e.g., British Steel, British Rail, and British Airways); (c) promotion of home ownership (including the widespread sale of public housing stock under the “right to buy” scheme); (d) curtailing of workers’ and trade union rights (e.g., bans on the “closed shop”; obligatory membership ballots before any industrial action; restrictions on the right to picket, including a ban on secondary picketing; and removal of trade union immunity from damages); (e) promotion of free-market ideology in all areas of public life (including health care and the civil service); (f) significant cuts to the social wage via welfare

state retrenchment (e.g., a 7% reduction in state expenditure on social assistance between 1979–1989; removal of 16- to 18-year-olds from entitlement; reductions in state pensions; abolition of inflation-link for welfare benefits); (g) acceptance of mass unemployment as a price worth paying for the above policies; and (h) large tax cuts for the business sector and the most affluent (e.g., during Thatcher's premiership, the rate of income tax for the top tax bracket was reduced from 83% to 40%) (7, 8).

This article considers how these and other policy changes shaped the health and well-being of the British population and altered the subsequent policy landscape. We first review the political economy of Thatcherism and then outline health-relevant social policy reforms. We consider Thatcher's denial of health inequality as a policy concern, including the rejection of the Black report. We discuss how Thatcher's governments began the application of private-sector management principles to one of Britain's most popular socialist creations, the National Health Service (NHS)—and in doing so, paved the way for subsequent NHS privatization by the governments of Blair, Brown, and Cameron (9). Finally, we draw on a range of data to summarize the impacts of Thatcher's policy reforms on social determinants of health and health inequalities. The concluding section argues that Thatcherism bears historical and contemporary responsibility for making Britain a less healthy and more unequal place than it might otherwise be.

THE POLITICAL ECONOMY OF THATCHERISM

The political economy of Thatcherism was expressed succinctly in Thatcher's description of her intentions at the 1980 Conservative Party conference: "the lady's not for turning" (10), a reference to the infamous U-turn of the 1970–1974 Conservative government of Edward Heath. Heath had come to power on the basis of what we might now call a proto-neoliberal agenda, quite radically challenging the post-war social democratic settlement—the "Keynesian welfare state." His agenda attempted to undermine the power of organized labor by disengaging the state from failing ("lame duck") industries, using deflation to increase unemployment and changing trade union laws, while also attacking collective social welfare—notably the provision of social ("council") housing by elected local authorities (11). But Heath's attack was defeated by the industrial action of the British labor movement—by miners, dockers, shipyard and building workers, by Labor local authorities opposing his housing policy, and by a wide range of grassroots and community organizations that sprung up around the issues of unemployment and defending collective welfare provision (12).

Heath's about-turn was very clear: within two years of election, "Heath rediscovered Keynes, turned reflationist, [and] turned 'lame ducks' into golden geese" (12). For a further two years, the government limped on before Heath, against the background of a national miners' strike and posing the question of who

should govern Britain, called an election—which he lost. For the right wing of the Conservative Party, this was a humiliation. It began organizing to take leadership of the party to be in a position to pursue a more tenacious implementation of its vision for Britain, which it did when Margaret Thatcher defeated Heath in the 1975 party leadership contest.

In the years between 1975 and 1979, those around Thatcher—in particular, Keith Joseph and Nicholas Ridley—developed detailed proposals for government (13). Their view was that defeat of the movement that had forced Heath's U-turn would require, not simply the disengagement of the state from industry, but the substantial destruction of Britain's remaining industrial base. The full employment that had been sustained across most of the post-war period was seen, together with the broader security offered by the welfare state, to be at the root of an unprecedented self-confidence among working-class communities (14, 15). In particular, large-scale manufacturing and extraction industries, generally strongly unionized and often linked to the large-scale provision of social housing at subsidized rents by local government, were seen to underpin a working-class solidarity that gave this confidence a potent political expression (16). The windfall from the discovery of oil under the North Sea in the late 1970s became central to these New Right plans. Following Thatcher's election in 1979, highly permissive deals were struck with U.S. firms to allow for rapid extraction. Thereupon, as Foster puts it: "As the pound became a petro currency, it would be allowed to rise in international value. Capital would be exported on preferential terms. Very large-scale unemployment would end the 'cycle of rising expectations,' permit the historic defeat of the trade union movement and then allow the repatriation of capital on its own terms" (17, p. 65). These were, in the phrase of Rodolfo Walsh, the economics of "planned misery"—a "greater atrocity" than even the many human rights violations that accompanied their implementation in Latin America (18, pp. 95–96). This was fully understood by those who developed the plan for their implementation in Britain. Whole towns—indeed, entire regions—would see the decimation of their economic bases and would become "severely deprived." But, as Ridley himself put it: "there is no point in undertaking it if we are not prepared to go through with it" (19, p. 4).

In 1978–1979, the "winter of discontent" arose when working people, via the trade unions, reacted with sustained industrial action to the Callaghan Labor government's attempt to impose an International Monetary Fund-dictated incomes policy alongside public-sector cuts. The Thatcherite New Right used its anti-union narrative to convince the public that the "sick man of Europe" status of the British economy was a result of our social democracy and working-class "power" (4).

Shortly after the 1979 election that brought Thatcher to power, exchange controls were removed to allow an outflow of capital. Interest rates were increased from 12 percent to 14 percent and then again, by the end of the election year, to 17 percent. A "veritable bloodbath" ensued (20). "The depth of the recession had not been anticipated but those . . . who were strongly influenced by monetarist

thinking seized on it as an opportunity for forcing through . . . radical changes” (21, pp. 101–102).

The oil windfall was of further importance in both paying for the costs of the ensuing mass unemployment among the social groups and geographical regions worst affected, while also allowing for starkly regressive tax cuts for the better-off social groups and geographical areas least affected—thus helping to ensure a sufficient electoral base for the government (22). The government also implemented severe cuts in key areas of public expenditure. In housing, funding cuts forced sharp rent increases and undermined repair and improvement programs in the council (public housing) sector. At the same time, council tenants were given a legal “right to buy” their homes (23).

All of this had a growing impact on the nature of working-class communities. The better-off council tenants bought the best of the housing, while the younger people who were economically active in the communities were forced out of the sector, leaving the oldest and poorest in the least desirable and often degenerating housing. As the relative value of benefits fell, and as wage rates for increasingly insecure and feminized, unskilled work were held down, the poorest were becoming poorer and increasingly “socially excluded,” blamed, and stigmatized for policy outcomes that the government had in fact fully anticipated in resolving to “go through with it” (24).

“Going through with it,” as Ridley put it, also required the aforementioned changes to trade union law and policing strategies for industrial disputes, together with a range of other preparations, to ensure the defeat of trade unions in specific industries selected, at times, by the government and employers (19). “These plans were in due course faithfully followed” (21, p. 103)—most infamously in the case of the 1984–1985 miners’ strike, which allowed the government to “scare most other unions into acquiescence” (25, p. 193).

But the “repatriation of capital on its own terms” proved rather more problematic than had been anticipated. The new economy that emerged in the 1980s was of a seriously unbalanced kind. Manufacturing and extraction industries, public utilities, and collective housing provision were displaced by finance and banking industries, privatized utilities, and rampant property speculation. The “big bang” of 1986 saw the deregulation of the City of London and, with that, the unleashing of hitherto unimaginable forms of financial speculation. The ostensible “giving power back to the people” through privatization in fact led to the radical de-democratization of the power industry—now largely externally owned—and other utilities. And the ambition to create “a nation of homeowners” produced a mushrooming of homelessness due to a chronic shortage of affordable social housing—creating the preconditions for the more recent emergence of a new breed of “buy-to-let” landlords charging “market rents.” It also underpinned a new culture of speculation and chronic indebtedness—on which a new breed of amoral “entrepreneurs” in banking and finance would be able to prey. All of this generated—and was designed to generate—sharply increased inequalities of

income and wealth across Britain and a dramatic increase in poverty. It also put in place most of the prerequisites for the great banking and finance crisis of 2008.

In this way, Thatcher's governments willfully engineered an economic catastrophe across large parts of Britain and sowed the seeds, later nurtured by Blair's New Labor governments, of a subsequent collapse—which ironically has provided the highly spurious legitimation for a new generation of “uber-Thatcherites” in the current Conservative-Liberal Democrat coalition government to go where Thatcher herself had hesitated to tread—a complete dismantling of the welfare state, including privatization of the NHS in England (9, 26).

THATCHERISM, “BIG BUSINESS,” AND THE SOCIAL DETERMINANTS OF HEALTH

Many of the changes outlined above were supported and promoted by the business community and occurred alongside the increasing incorporation of business interests into the management of the welfare state (27, p. 473). In education, for example, state funding was cut and City Technology Colleges were established with a view toward involving business interests in establishing and funding secondary education (28). The private sector was also encouraged to get involved in tackling youth unemployment and tendering for key government services (29).

The health impacts of the commercial sector's policy influence, and the close connections between senior politicians and commercial interests, were perhaps most overt in relation to tobacco. Under Thatcher's leadership, despite growing evidence of the negative health impacts of smoking (30), the tobacco industry remained influential and only very limited measures to control the marketing of tobacco were introduced (31). Subsequently, both Thatcher herself and one of her ministers, Ken Clarke (who held various high-level positions under Thatcher, including Secretary of State for Health), went on to work for large transnational tobacco companies; in 1992, ex-prime minister Thatcher signed up to work as a consultant for Philip Morris, while Ken Clarke became the chair of British American Tobacco in 1998 (32).

Thatcherism was not only about the free market and the dominance of private interests, but also the “strong state” (3). It was an “authoritarian populist” project in which economic liberalism was accompanied by social conservatism and the reassertion of 19th-century (Victorian) moral values (4). Social and ethnic minorities were subject to increased “moral” and actual surveillance, for example, as a result of the “stop and search” laws, which were disproportionately used by the police against young black men and were implicated in the 1981 inner-city riots in Brixton, London, and Toxteth, Liverpool (33). Reforms to social assistance tended to be disciplinarian in nature, including the abolition of the earnings-related unemployment benefit supplement in 1982. Additionally, control over what was taught in schools was increasingly centralized; examples included the Education Reform Act in 1988, which introduced

the National Curriculum, and Section 28 of the 1988 Local Government Act—the infamous clause that forbade the circulation of materials about, or the teaching of, the “acceptability of homosexuality as a pretended family relationship” in state schools.

These changes all led to a fundamental rebalancing of British economic and social life that saw a reassertion of social class divisions. The growing economic equality experienced as a result of UK social reforms since 1945 was reversed, with income inequality increasing significantly (e.g., the richest 0.01% had 28 times the mean national average income in 1978, but this increased under Thatcher’s tenure to 70 times in 1990) (34). Additionally, as a result of welfare state retrenchment, high unemployment, and falling wages for many poorer workers (due to the decreased bargaining power of trade unions), there was a near doubling of poverty rates in the United Kingdom from 6.7 percent in 1975 to 12.0 percent in 1985 (7). Social mobility gains were also stalled via changes to the education system, as well as the “lost generation” of young people who left school and went straight onto “the dole” in the early 1980s.

The impact of these changes on other key social determinants of health was, in many cases, dramatic. Inequalities in educational outcomes (35) and in access to health care (36), for example, both increased following policies implemented under Thatcher’s leadership. In housing, Thatcher’s government quickly implemented a “right to buy” initiative, which as previously stated gave council tenants the right to purchase the homes they occupied, often at greatly discounted rates. This policy reflected the ideological belief in the superiority of the market and was popular among many of those it helped move into the housing market. However, it contributed to growing wealth inequalities (37) and, more broadly, the policies of Thatcherism sowed the seeds of the housing market crash in 1989, which left many homeowners trapped by “negative equity.” Meanwhile, as the better quality houses were sold off, local councils were left with responsibility for a far smaller and increasingly poor quality housing stock (37). All of this contributed to growing levels of homelessness (38).

HEALTH INEQUALITIES POLICY

During Thatcher’s period of governance, concern about health inequalities focused on two areas: specific social determinants of health and the Black report and its legacy. Our present-day understanding of the dynamics of health inequality largely post-dates Thatcher: it was only in the 1980s that many key material and psychosocial causes of health inequality—such as unemployment, income inequality, and social isolation—were first established (39–41). Thus, the primary focus in the 1980s was on these and other known, specific causes of health inequality. Causes that had been exacerbated by Thatcher’s public policies, such as unemployment and poor nutrition, were often the subject of heated debate and government denial as to their health equity implications (42–44), since Thatcher

would not permit “the nanny state” to “interfere” in what she regarded as individual decisions about people’s health.

The 1980 Black report (45, 46) that had been commissioned in 1978 by Labor and its 1987 successor The Health Divide (46, 47) were critical and comprehensive reviews of health inequalities research and policy in the United Kingdom and overseas. Both were famously marginalized and suppressed by Thatcher’s government—and both achieved wide and immediate attention as a result (48). Both carried unpalatable messages for Thatcher. The Black report reviewed long-term trends in mortality inequalities by occupational social class. It considered alternative causal explanations, including artifact, selection, and culture, concluding that structural/material inequalities were undoubtedly the main cause of health inequality. It made wide-ranging recommendations, including child poverty reduction policies and increases in welfare benefits, and it was no surprise that its findings were immediately rejected by Thatcher’s government (49, 50).

The Health Divide reviewed progress in the seven years since the Black report and concluded that health inequalities had steadily increased during the 1980s. Its wide-ranging recommendations for public policy were similarly rejected. Despite this negative scenario, much local action around health inequalities was promoted by Labor local authorities and nongovernment organizations (51). Academics and activists were also legitimated in their health equity activities by the World Health Organization’s Health for All Strategy, the first of whose 38 European targets was a 25 percent reduction in health inequalities by the year 2000 (52). While the United Kingdom was a signatory to the strategy, its health inequalities aspects continued to be disregarded throughout Thatcher’s period of office.

A typical example of this relates to the 1986 publication of the decennial Occupational Mortality Supplement to the 1981 national census (53). For the first time, virtually all of the data on social class were made available only in microfiche and hence were effectively unavailable to the general public. The official reason given related to changes in the social class classification—even though this could have been overcome by aggregating and then comparing data from non-manual and manual occupational classes. Indeed, the lead author of the supplement did precisely this in a research paper published simultaneously with the supplement’s release (54), which demonstrated significantly widening class inequalities in Britain. The *British Medical Journal* was so incensed by the effective suppression of the inequalities data that it published these allegations in an editorial provocatively entitled “Lies, damned lies and suppressed statistics” (55).

THE RISE OF MANAGERIALISM AND MARKETS IN THE NHS

Thatcher’s approach to the NHS “problem” was highly contradictory. Despite commissioning radical proposals from the government’s Central Policy Review Staff in 1982 that would have led to a dismantling of the welfare state and the

replacement of the NHS by a health insurance system, in the end the NHS remained remarkably untouched during her time in office. In her memoirs, Thatcher admitted that, in most areas, the NHS delivered high-quality care at reasonable cost. She also acknowledged that the service commanded “as much affection as exasperation” (56). But while Thatcher backed off any wholesale reform of the NHS, allegedly fearful of an adverse public reaction to such a move, her government did introduce a number of policy initiatives that set the NHS on a course from which it has not deviated since. That course might be characterized as a shift from a welfare state to a market state (57).

The two most significant NHS developments that took place under her premiership were linked and involved, first, subjecting the NHS to a particular form of managerialism that in turn led directly to the introduction of a quasi-market in health care centered around competition and choice (58).

As noted above, the business sector was held in high regard by Thatcher’s governments, and Thatcher often invited prominent businessmen into government to conduct reviews of efficiency in order to demonstrate how public services could learn from what she instinctively believed to be a leaner and fitter private sector. Roy Griffiths, a former chair of the Sainsbury’s supermarket chain, was among the first to fulfill this role: his 23-page “letter” to ministers in 1981 led to the introduction into the NHS of general management, accompanied by a cadre of health authority chief executives (59). Although Griffiths had expected existing managers and clinicians to take on this role, many of those initially recruited were drawn from business and the armed forces: few survived.

The tension between management and medicine has been a long-standing one, with successive NHS reorganizations from 1974 onward seeking to limit clinical freedom and power while strengthening the grip of management over resources and priorities (59). While management of any type may be anathema to some clinicians, what has dismayed many is the particular brand of managerialism that the Thatcher government, and others since, endorsed and what it has led to.

The British NHS was an early pioneer of management reforms following its first major reorganization in 1974, which was largely based on work and concepts developed by a combination of the management consultancy McKinsey (whose close association with the NHS remains to the present day) and a team from Brunel University. But arguably, the managerial revolution in health care did not really get underway until the 1980s and 1990s under the banner of “new public management” (NPM). NPM became an international trend in public administration and proved attractive to policymakers in many health systems other than the United Kingdom’s. Hood (60) describes NPM as comprising seven doctrines:

- A focus on hands-on and entrepreneurial management, as opposed to the traditional bureaucratic focus of the public administrator
- Explicit standards and measures of performance
- An emphasis on output controls

- The importance of disaggregation and decentralization of public services
- A shift to the promotion of competition in the provision of public services
- A stress on private-sector styles of management and their superiority
- The promotion of discipline and economy in resource allocation

Conceivably, NPM would have been introduced regardless of who held power in Britain at the time, since its market-based thinking enjoyed wide appeal across the political spectrum and health system reform had become something of a global industry. Nonetheless, what happened in the United Kingdom occurred during Thatcher's tenure and, as it happens, chimed perfectly with her values and ideology, which viewed public services as bloated, inefficient, unresponsive to user (or, increasingly, consumer) preferences, and often ineffective and poorly performing. She may have felt unable to go further in subjecting the NHS to the full rigors of the marketplace, for reasons that were not always consistent or clear—but she did enough to allow her legacy to be built on and taken further by her successors from both main political parties.

Among the most controversial changes Thatcher introduced was the policy of contracting out or outsourcing, introduced in 1983, whereby health authorities were required to set up competitive tendering arrangements for their cleaning, catering, and laundry services. Additional non-clinical services were later added to the list. The main significance of this development was the establishment of the principle that the core responsibility of health authorities was no longer to directly provide non-clinical services, but merely to ensure they were in place at least cost. A key negative impact was a loss to the public-sector ethos of the NHS in which, for example, cleaners were perceived as members of the ward team whose friendly, reassuring presence made important contributions to patients' well-being. This contribution disappeared once the tight schedules of competitive contract cleaning took over. Equally important was the perception that ward cleaning became substantially less thorough, leading over time to the current high prevalence of hospital-acquired infections (61).

The managerial grip was further tightened with the appearance in 1989 of the government's plan for NHS reform, *Working for Patients* (62), which led to the NHS and Community Care Act 1990. Its proposals drew directly on NPM-type thinking and introduced market-style mechanisms into the NHS, notably the purchaser-provider separation and general practitioner (GP) fundholding, whereby GPs were allocated budgets they were free to spend as they saw fit to meet their patients' needs. Such proposals may seem rather timid and insubstantial in retrospect, especially as the purchaser-provider separation failed to confront entrenched provider power as was intended (and as remains the case under present-day commissioning), and GP fundholding fizzled out as most GPs did not warm to it. But at the time, the Conservative government's NHS changes were regarded as marking a break with the past and opening the NHS up to market forces. The use of the term "internal market" may have given the impression that

the creation of a market would be confined to the public sector and off-limits to the private sector, but this was misleading—although the government was nervous about allowing market forces to take off.

The real significance of Thatcher's NHS reforms lay not in what they themselves achieved, but in putting in place key system changes that positioned the NHS for subsequent developments under New Labor (1997–2010) and under the UK Coalition Government from mid-2010. The basic architecture evident in many of the controversial changes contained in the Health and Social Care Act 2012 (9) clearly has its origins in the changes implemented by Thatcher and in the work of New Right think tanks that shared her ideology and politics (63, 64).

MORTALITY, HEALTH, AND WELL-BEING IN THE THATCHER YEARS

Mortality rates in the United Kingdom, and across Western and Central Europe, have been improving for approximately 150 years (65). This long-run improvement continued throughout the period of the Thatcher government, with all-cause mortality rates declining at a rate similar to those in other countries and compared to the time periods before and after (Figure 1). However, underlying the overall improvement in mortality rates, some specific causes of mortality increased markedly either during the period of the Thatcher government or immediately afterward. For example, alcohol-related mortality increased dramatically during the late 1980s and early 1990s in the United Kingdom in contrast to the improving trends in other parts of Europe. Increases were also seen at this time in drug-related mortality, suicide, and violence (66–68), all causes of death that are clearly socially produced rather than due to biological or physiological mechanisms.

Within the United Kingdom, mortality rates improved much more slowly in Northern and inner-city areas than in the more affluent Southern England (69), to the extent that in some areas, mortality rates actually worsened (70). Indeed, for young adults in Scotland, there has been no improvement over the last 30 years (71).

The rise in spatial inequalities in health during the 1980s (72) was also reflected in a rapid rise in mortality inequalities by occupational social class in England and Wales and by area deprivation in Scotland (73). Figure 2 shows that the absolute gap in mortality (as measured by the Slope Index of Inequality) between the least and most deprived postcode areas in Scotland remained high but stable between 1981 and 2001; relative inequalities (as measured by the Relative Index of Inequality) increased rapidly, leaving Scotland with the highest inequalities in Western and Central Europe (74, 75). In England and Wales, life expectancy increased for all social class groups among males and females over time, but the increase was more rapid among social classes I+II than in social classes IV+V, such that the inequalities increased.

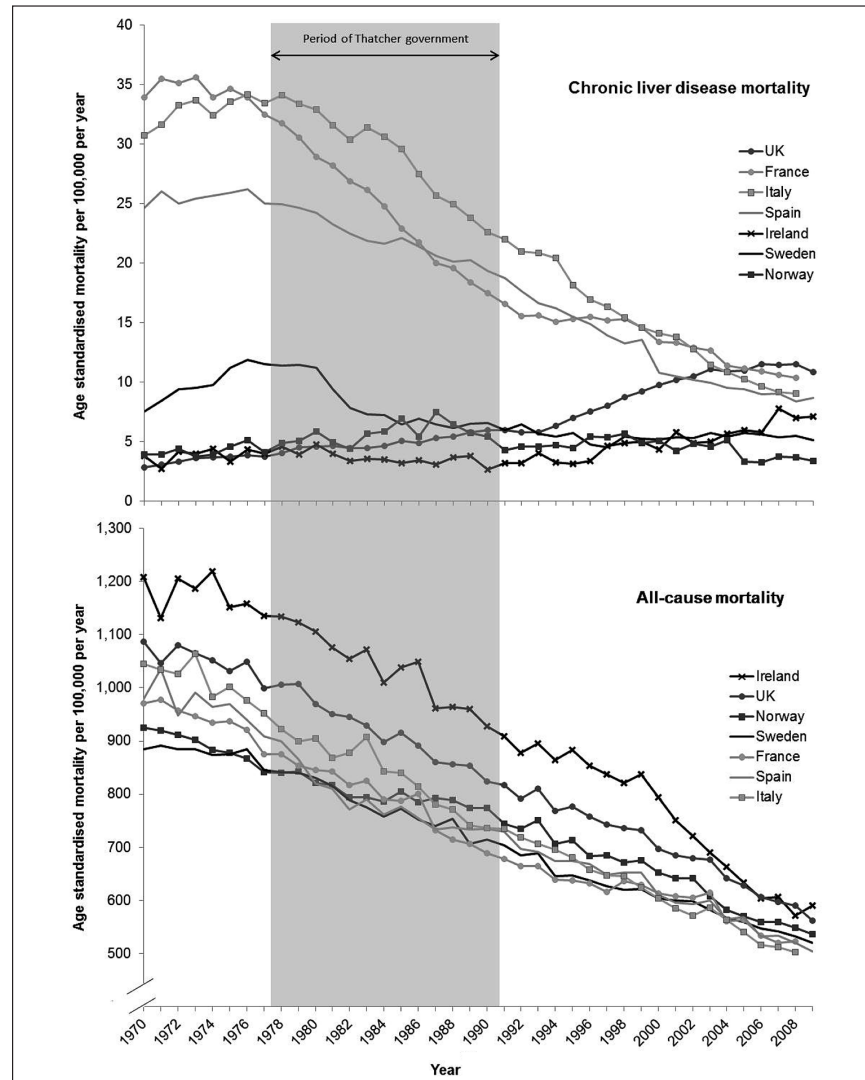


Figure 1. Trends in all-cause and chronic liver disease mortality in United Kingdom compared to selected European countries, 1970–2009. *Source:* European Health for All Database, World Health Organization.

The rise in health inequalities witnessed in Britain during the 1980s and 1990s was large, but not unprecedented. Other countries that adopted neoliberal policies also saw rises in health inequalities, such as the United States and New Zealand (76). It would be wrong to assume that such rises in health inequalities are in any

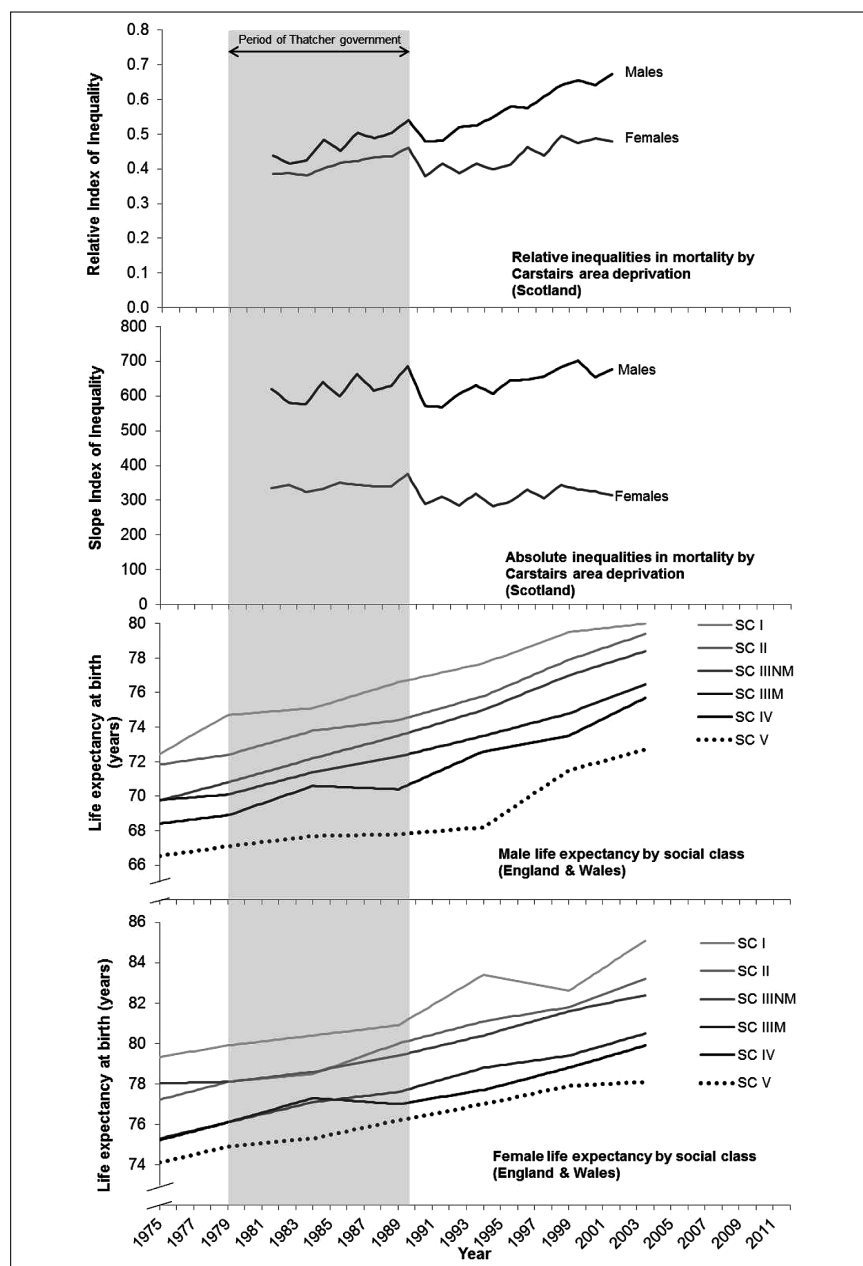


Figure 2. Trends in health inequalities in England and Wales, 1975–2003 (by occupational social class), and Scotland, 1981–2001 (by Carstairs area deprivation). *Source:* National Records for Scotland and Office for National Statistics.

sense inevitable: from the 1920s to the 1970s in both Britain and the United States, inequalities in mortality declined at the same time as income inequalities were reduced and the welfare state was built up (72, 77).

Figure 3 gives some insight into causes of the rises in health inequalities seen in Britain during this time. As outlined above, the combination of policies implemented under Thatcher led to a rapid rise in unemployment rates. Since 1980, the number of unemployment claimants rose from approximately 1 million to 3 million in 1983; a further peak was seen in the early 1990s. Meanwhile, there was a steady rise in the number of claimants of long-term sickness (disability) benefits. The rise in the number of disability benefit claimants has been attributed to a government desire to move people off the unemployment register and to the lack of jobs in the economy (78). Figure 3 also shows that the 1980s saw a rapid increase in income inequalities and poverty rates. By the 1990s and 2000s, these new high levels became normalized.

The rises in cause-specific mortalities such as alcohol- and drug-related deaths, suicide, and violence, and the widening health inequalities, occurred during the same time period in which unemployment, poverty, and income inequality all rose. The antecedents of these types of cause-specific mortality, and of health inequalities, are well-explored in the literature; reviews of this evidence highlight the importance of social and economic determinants of health (79). Given what we know about the impact of Thatcher's neoliberal reforms on the social and economic landscape of Britain, it seems clear that Thatcher's legacy includes the unnecessary and unjust premature death of many British citizens, together with a substantial and continuing burden of suffering and loss of well-being.

CONCLUSIONS

There can be no doubt that Thatcherism had a major impact on the health and well-being of the British population. Although overall population health continued to improve by many measures (e.g., in terms of mean mortality rates and infant mortality), it improved more slowly than in comparable countries (65). Meanwhile, within-country health inequalities increased, in terms of both class and geography. Post-industrial areas, notably in Scotland, fared particularly badly (65).

The aggressive promotion of free-market policies under Thatcher was accompanied by the growing influence of business interests; a commitment to reduce the size of the welfare state; acceptance of widespread, unequally distributed unemployment; and implementation of a range of authoritarian social policies. All of this suggests Thatcherism contributed to ensuring Britain became a less healthy and more unequal place than it might otherwise have been. Thatcher's neoliberal project was subsequently strengthened and more firmly embedded by her successors in Conservative (Major) and Labor (Blair and Brown) governments. Its legacy is especially visible in the policies currently being pursued by the post-2010 Conservative-Liberal Democrat United Kingdom coalition government (26).

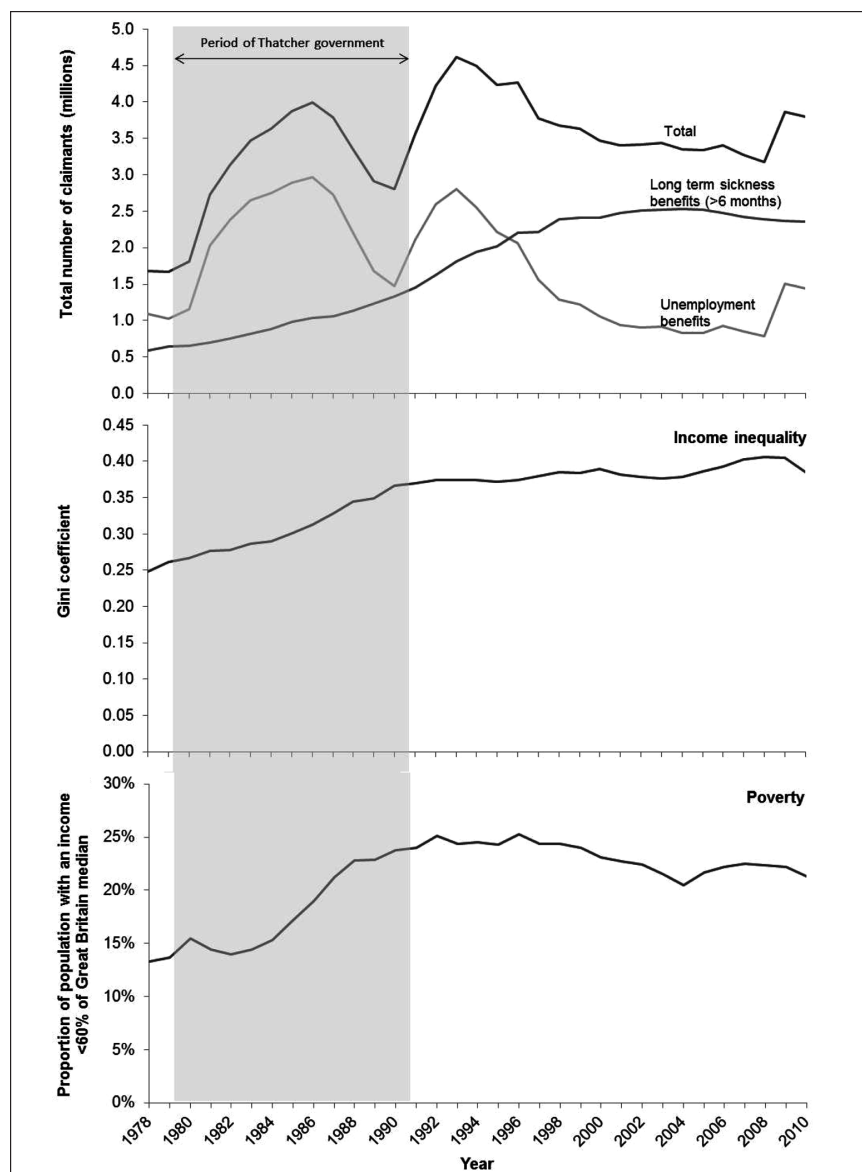


Figure 3. Trends in relative poverty (income < 60% median income), income inequality (measured by the Gini coefficient), and the number of claimants of unemployment and long-term (> six months) sickness benefits in Great Britain (1975–2012). *Note:* Long-term sickness benefits included are Invalidity Benefit, Incapacity Benefit, Severe Disablement Allowance, and Employment Support Allowance. *Source:* Institute of Fiscal Studies, Department for Work and Pensions, Office for National Statistics.

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