LIFE AND DEATH Iona Heath

Let's get tough on the causes of health inequality

Doctors have a duty to draw public attention to social injustice as a cause of ill health

The UK government has a clearly stated commitment to tackling health inequalities, while perversely allowing disparities in wealth to widen. The problem is that health inequality is directly related to socioeconomic inequality and cannot be separated from its underlying cause or solved independently. It is convenient for governments to believe that this can be done but the medical profession should not collude with them. There has been some attempt to tackle health inequalities by initiatives across government, but the rhetoric has outweighed the substantive achievement considerably and the health service still seems to be expected to make the major contribution.

Two entirely different but potentially complementary approaches to tackling health inequalities date back to the 1840s. During that decade both Edwin Chadwick and Friedrich Engels described the appalling conditions endured by poor people in 19th century Britain. Chadwick published his *Report into the Sanitary Conditions of the Labouring Population of Great Britain* in 1842 and, two years later, Engels followed with *The Condition of the Working Class in England*.

Chadwick laid out a statistical analysis and proposed technical solutions. Engels used a much more polemical argument and advocated political action. Chadwick demonstrated that the poor lived in squalid and overcrowded conditions and that these caused illness and disease, which then made many people too sick to work and trapped them in a downward cycle of worsening poverty and destitution. He also showed that violence, and alcohol and opium abuse, were consequences rather than causes of the conditions of poverty. His principal recommendation was a proper system of drainage and sewage disposal combined with clean water supplies and regular refuse collection. Engels argued for fundamental social change, and in 1848

he collaborated with Karl Marx to write *The Communist Manifesto*.

There is no doubt that Chadwick's interventions were enormously beneficial, saved many lives, and redressed health inequalities to some extent. However, they did nothing about poverty as such or about the unresolved injustice it expresses. In contrast, Engels was primarily concerned with social justice and his work and influence led eventually to profound social upheaval and change in many countries, with enduring benefits for the poorest people. Neither the technical nor the political response is sufficient on its own; both are required.

As a general practitioner working in the same deprived urban area for many years, I find it impossible not to be keenly aware of the lottery of social conditions and the resulting differences between people: differences in their power, their hopes, their opportunities. Many people are obliged by circumstance to live lives leached of dignity and respect and clouded by a sense of having been wronged. Such lives are exacerbated by the arrogance and complacency of those who have the good fortune to find themselves on the winning side of our unequal society. This profound social injustice is untouched by effective sewers or even today's technical expedients, which ostensibly include the financial incentives of the quality and outcomes framework and the ever more extensive prescribing of preventive pharmaceuticals.

Invaluable epidemiological research over the past two decades has documented the extent of health inequalities and has succeeded in turning this form of inequality into a political issue. Democratically elected politicians will always be discomfited by documented evidence of inequality and injustice, although it remains a mystery why governments can be shamed so much more readily by inequalities in health than by those in wealth. The problem is that while epidemiology can

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identify the problem, it cannot provide the answer. Further, we now seem to have developed a health inequalities “industry,” which is rapidly becoming another employment opportunity for the affluent (piggybacking on the distress of the poor becomes a substitute for difficult political effort—opium for the intellectual masses).

Perhaps the British have always favoured technical remedies but here is the impasse—some health problems require a political response. The productive complementarity between Chadwick and Engels has shifted damagingly towards the technical. Does reducing health care to standardised tick-box interventions really address the challenges of health inequalities? Yes, to some meagre extent it does, and the health opportunities of some patients with diabetes and other conditions have been improved as a result, but the fundamental causes of the inequality are left entirely intact. The challenges of ensuring dignity and self efficacy and a sense of justice are ignored.

The UK remains a markedly unequal society, ranked 21st out of the 27 countries of the European Union in terms of the proportion of the population living in relative poverty. In these adverse circumstances, health opportunities will be substantially altered only by genuine political and social change. Disease and disability are caused by biology but also by the ways in which society is organised and in whose interests it operates. Doctors have a clear responsibility to pursue political answers alongside technical ones and to seek out and draw public attention to injustice as a cause of ill health. Once acknowledged, injustice demands redress, and so doctors also have a responsibility for advocacy—to speak to the powerful on behalf of the powerless. Only in these ways can medicine contribute fully to the narrowing of health inequalities.

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