Despite its limitations, the Dutch experience contrasts starkly with Britain's. The *Health of the Nation* devoted only one page to what are referred to as "variations" (not "inequalities") in health among socioeconomic groups.⁴ These are said to be the result of "a complex interplay of genetic, biological, social, environmental, cultural and behavioural factors." The same list of factors was given by Mrs Bottomley in her message to the BMA's conference on inequalities in health,³ with the rider that "there are no easy answers" in this area.

Yet surely there is some obfuscation here: it is inconceivable, for example, that changes in the genetic make up of different socioeconomic groups have occurred over the past 15 years to produce the increases in differences in mortality in Britain discussed above. Although behaviour related to health is regarded as the appropriate target for health promotion activity, it must be recognised that eating, smoking, drinking, and participating in exercise do not occur in a social vacuum. In poorer areas less healthy food is available and is often more expensive than in affluent areas.¹⁸ Similarly, the reason why smoking breaks the rule that households with low incomes cope by decreasing the personal expenditure of adults cannot be reduced to personal failure. Thus for women caring for children in adverse socioeconomic circumstances smoking may be one of the few activities undertaken solely for themselves and one that provides some respite from the strain of coping with the consequences of material deprivation.¹⁹

Policies that ignore the social and economic constraints on behavioural change may produce increases, rather than decreases, in inequalities in health. A more fundamental approach than oversimplifying the origins of behaviours related to health would be to recognise the close association between the size of income and differences in mortality between 1921 and 1981,^{7,20} with the recent widening of inequalities in health mirroring the gross upwards redistribution of wealth since 1979.²¹ If progress is to be made it is necessary at least to start addressing the fact that increasing inequalities in health are a consequence of our increasingly polarised society.

The government's new working party will be judged by its efforts to move the national debate forward to remedying and preventing inequalities in health, with measures that can be started now. The NHS has its part to play—for example, in the allocation of resources to primary health care in inner cities.²² Research shows, however, that the

main agenda lies elsewhere and should focus on child and family poverty, on housing (which will also create employment), on the provision of nursery education, and the like. The recommendations of the working party on such issues are awaited. "Interdepartmental" commitment, which is central to the *Health of the Nation* and its credibility, will be tested here. Any such measures will, of course, be costly. But then so is the waste of human capital in the premature death that the multiplying statistics represent—not to mention the burden of disability and mass of human misery that are entailed.

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Beyond health care

Attention should be directed at the social determinants of ill health

The aims of health policy ought not to be contentious. Topping the list should be a commitment to improve the length and quality of life of everyone and to minimise avoidable differences in health status among social groups. The corollaries of such goals include improving our understanding of the determinants of health and intervening in public policy to deliver the required outcomes. Unfortunately, no evidence exists that any political party in Britain has grasped the extent to which thinking must change. Debates about the financing, governance, and structure of the NHS remain as dominant as they are largely unconstructive. What is needed now is a radical change of direction away from tinkering with the organisa-

tion of health care towards developing new approaches to health policy.

The importance of this proposition is illustrated in a new book produced under the auspices of the population health programme of the Canadian Institute for Advanced Research. *Why are Some People Healthy and Others Not?* contains contributions from internationally renowned analysts, including economists, epidemiologists, and political scientists.¹

The book's central argument is based on a synthesis of evidence—both familiar and newly emerging—suggesting that "factors in the social environment, external to the health care system, exert a major and potentially modifi-

able influence on the health of populations, through biological channels that are just now beginning to be understood."²

Recent scientific advances show ways in which people's perceptions of their social environments can stimulate chemical and electrical responses in their body's endocrine, immune, and neural systems. These new studies lend credence to older ones that have emphasised the health promoting qualities of social support. A key determinant of health turns out to be the extent to which humans and other primates are able to rely on their own resources, or the support of others, to overcome the pressures associated with social and environmental factors.

Why, given that the importance of social and environmental determinants of the health of populations has been known for many years, has policy taken so little account of it? The short answer is that the combination of economic interests and political influence associated with the health care industry is so powerful that a predominantly biomedical system of beliefs dominates the development and practice of health policy.³

We have been indoctrinated into accepting the superiority of biomedical and disease oriented explanations of the determinants of health to the detriment of socioeconomic ones. For example, probably the dominant lay view in modern industrial societies is that the main causes of premature death are cancer and heart disease. The almost inaudible counterview is that the principal killers are the "lack of social support, poor education, and stagnant economies."⁴ The result of the bias inherent in the prevailing system of beliefs is that enormous effort is put into researching and marketing such fripperies as cholesterol free crisps. On the other hand, serious study of ways of over-coming the stress associated with hierarchies in the workplace or of providing "companionship and support for the widowed elderly"⁴ and other vulnerable social groups is neglected.

Arguing that social sciences should supplant medical ones would, however, be the worst kind of backward thinking. More multidisciplinary research and policy analysis are needed. At present a major bias exists in research funding. Most of the available resources go into the invention of new technologies even though their aggregate contribution to the population's health is modest. Relatively little effort goes into assessing the effectiveness of the existing health care system, and almost nothing is invested in looking at the non-medical influences on health. What's urgently needed is a more systematic programme of research to improve our understanding of the socioenvironmental determinants of health and of how to design public policies that will prevent or ameliorate poor health.

More generally, debate on health policy in countries such as Britain needs a new perspective. A sustained effort should be made to persuade not only politicians and patients but also those who earn their living in the health care industry that it makes economic and social sense to limit spending on health care to free resources for other policies that promote health. Investing in health remains a worthwhile objective, but it means much more than spending on the NHS.

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Liver biopsy: blind or guided?

Benefits of guided biopsy are clear only for focal lesions

Despite advances in imaging techniques and serological investigations percutaneous needle biopsy of the liver is still important in accurately diagnosing hepatic disease. The basic technique, described by Sherlock, has changed little over the past 50 years.¹ It is simple, cheap, and relatively safe and can be carried out at the bedside. In the past few years, however, ultrasonography has been increasingly used to guide the biopsy needle. A recent large survey of consultant gastroenterologists showed that 1 in 8 always used ultrasonography guidance for biopsies.² Some consultants now believe that ultrasonographically guided biopsies are so much safer that blind biopsy can no longer be defended. Before this policy is adopted uncritically, however, it is important to examine the current evidence concerning safety, diagnostic yield, and cost.

Percutaneous liver biopsy has a mortality of 0.01%-0.1%.^{3,4} Death is usually due to bleeding or to biliary peritonitis as a result of puncture from the gall bladder. The incidence of bleeding is probably proportional to the incidence of formation of haematomas, which is not affected by the use of ultrasonographic guidance.⁵ Although, intuitively, guided biopsy might be expected to reduce the risk of puncturing the gall bladder, no ran-

domised controlled trial has been large enough to show reduced mortality with ultrasonography. Identifying deaths related to procedures is not easy. There is an overall mortality of 19% among patients within three months of biopsy, but most deaths are due to underlying disease.⁶ Retrospective reviews may therefore fail to give a true indication of the risks of the procedure.

The 1991 national audit of liver biopsies reviewed 1504 biopsies, of which a third were guided by ultrasonography.⁶ Two deaths definitely related to the procedure occurred, one each from bleeding and from biliary peritonitis. Both biopsies were carried out without ultrasonographic guidance. Surprisingly, postmortem examinations were not performed, but the second death might have been avoided had ultrasonography been used. Data were also collected on pain and bleeding after the biopsy. Pain was experienced by 25% of the patients who had non-guided biopsies and 22% of the patients who had guided biopsies. Serious bleeding occurred in 1.6% of non-guided cases and 2.5% of guided biopsies. These differences were not significant.

The largest single controlled trial is that of Papini and colleagues, who randomised 240 patients to guided or