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Editorial

Reaching across the political divide to address health inequalities

In our previous editorial we discussed the value judgements of fairness and avoidability that are inherent in the concept of health inequalities and how the general public view fairness as deservedness [1]. Here we take this a step further to argue public health needs to engage more with arguments of meritocracy and personal responsibility to make progress on health inequalities.

There is a well-rehearsed pattern of those on the political left becoming frustrated with the cold and callous right who enact policies such as reducing and restricting welfare payments or creating hostile environments for people from war-torn countries seeking refuge abroad. While the political right become exasperated at the left who seemingly want to bankrupt the country by rewarding inactivity and giving handouts to people who should be able to help themselves. These arguments play out in the national media but are also replicated across the country at regional and local levels.

While public health is generally considered a more comfortable bedfellow with the political left, it is fundamental that public health can make objective and clear arguments across the political spectrum. That is not to say public health should not be political, rather it needs to engage with and understand different political ideologies and avoid any perceived political affiliation. In fact, public health should become skilled in leveraging the most relevant arguments to promote a healthier and fairer society.

For the political right, deservedness or meritocracy is the ideological driver of much policy. The logic is that incentivised structures within society increase productivity, civic obedience and economic and technological advancement; if an individual works hard and makes good choices, they will be rewarded, and society will benefit. While there is a carrot, there is also a stick. The most obvious example is the existence of a punitive welfare system that seeks to make being out of work so unpleasant to force people into the employment market. This is not a new concept and can be seen in the English Victorian workhouses of the 17th century which sought to punish people who were judged to be capable of working but unwilling [2].

Meritocracy and deservedness rely on a proportionate reward and equal opportunity. Few would argue that there should be no reward for greater productivity or compliance with the rules of the land. Inevitably social and political structures based on meritocracy or deservedness lead to differences in income, and subsequently wealth, housing, educational opportunities and family circumstances, all of which influence health. Therefore, for some, a degree of differences in health are fundamentally unavoidable and fair when we design structures within society to reward positive choices. Rawls argues that inequality is acceptable as along as policy overall benefits the most disadvantaged [3].

The question is how rewards are distributed, what is reasonable recompense for productivity and compliance, what safeguards are in place for those who cannot be productive and how do we ensure that every individual has equal access to the opportunities to gain these rewards. Arguably rewards are not proportionate to effort when in the UK one individual can be paid more than £200 m per year while one in ten full time workers live in poverty [4]. There is little evidence of equal opportunities when wealth is amassed, passing down generations and parental background is the biggest factor in educational attainment [5].

To make progress, we need to engage and debate with the ideology of meritocracy and deservedness. To do this we should build the evidence base to shape political arguments which clearly articulate; the links between poor health and low productivity, that equal opportunities across society remain a distant aspiration, that societal rewards do not reflect the skills, effort and labour involved, and that a punitive welfare state does not incentivise work and can plunge people further into poverty. We also need to demonstrate where the structures and systems in society reduce opportunities and highlight the root causes of a lack of opportunities. For example, we know that children growing up in low-income families have reduced educational and employment opportunities and this will affect their future life chances [6]. What changes are needed to education policy if we are serious about using education's full potential as a lever to improve public health? [7] And the bigger question, what changes do we need across government to have fewer individuals, families and communities living in poverty?

In a previous editorial we argued that we needed to understand when health inequalities is helpful as a concept and when it is not. Health inequalities may be a useful rallying cry to left leaning researchers, policymakers and practitioners, but it risks remaining only that and may continue to be dismissed by the political right. To build consensus it may be more useful to use positive visionary language, such as health-for-all. Our language also needs to articulate more clearly, specifically and strongly about what policy changes are needed in specific sectors and across sectors if we are serious about reducing inequalities.

It is easy for public health to remain in its comfort-zone of describing inequalities and arguing for an equal distribution of the social determinants of health, however to engage across the political divide and take a chance at progress we also need to also engage in the public discourse of meritocracy and deservedness.

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