

THE POLITICAL AND THE PERSONAL

Deprivation and health

Douglas Black

Above all, a nation cannot last as a money-making mob: it cannot with impunity,—it cannot with existence,—go on despising literature, despising science, despising art, despising nature, despising compassion, and concentrating its soul on Pence.¹

These words were wrung from John Ruskin as he contemplated the monetarism of Victorian England, with its great gulf fixed between Disraeli's "two nations." In the end, Ruskin went mad. A little over a century later, even though the clock has been determinedly put back in the past decade, we are more fortunate in one respect. Surveying a similar problem with equal compassion, but also with a wealth of scientifically based understanding, Peter Townsend has remained eminently sane. This distinguished sociologist has recently retired from his chair in Bristol; and in September a celebration of his work took place at Dartington Hall. I was pleased and honoured to take part in this tribute to a man who has contributed more than any other to the recognition of socioeconomic deprivation as a great and growing evil with grim effects on health.

Before I turn to the report whose preparation brought the celebrants together, I would like to lay open the roots of my own concern with these matters. As a medical student and young doctor I saw barefoot children in Dundee, and after doing a clinic in Manchester I would bring home a flea several times each year. Even in the lean years after the war, the welfare state improved matters considerably, but by no means completely; but the recurrence of monetarism over the past dozen years has again created evils that should have been relegated to history. In Britain we have homelessness and massive unemployment, potent causes of illness, and we have a health service which is being covertly denationalised, at great expense occasioned by the unnecessary creation of an artificial "internal market." (There has been even more rapid regress in the United States—under Ronald Reagan's brand of monetarism it took only eight years for tuberculosis to be re-established as a health hazard on the streets of New York.) In 1974 Peter Townsend was already aware of the dangers inherent in hierarchical corporate management, regarding it as "the largest single threat to free access to health care and the aim of a healthy society."² After a lifetime of professional detachment, I am both sad and angry to see the attempted destruction of a system of health care which was as comprehensive as any in the world, and at a lower cost than any other comparable system.

The Black Report . . .

What was so special about the 1980 so called "Black Report" on inequalities in health related to social class? It was certainly not the discovery of a new phenomenon—the association between social deprivation and ill health had been stressed by John Brotherston, chief medical officer in the Scottish Home and Health Department 1964-77, in a Galton lecture³ and by Peter Townsend himself in his Geoffrey Vickers lecture in



Some of the greatest effects of socioeconomic deprivation are evident in children—now as in Victorian times

1974.² And it was in full awareness of the problem that David Ennals, secretary of state for social services 1976-9 commissioned the study which led to the report. Each member of the group might pick out different reasons to explain the impact of the report. I would like to suggest a couple.

Firstly, the group, having met at fairly frequent intervals over a three year period and enjoying the services of two qualified research assistants and the back up of a large Department of State, was able to assemble a mass of relevant statistical information, which compelled attention. In this, we were greatly assisted by the comprehensive information on health status compiled by the Office of Population Censuses and Surveys. It is also much to the credit of the departmental civil servants that we enjoyed the same support, even after a change of government to one which did not find our activities or conclusions especially palatable.

Secondly, we were able to identify a number of questions that were both important and open to research. We drew attention to several imperfections in the then available indices of health and of social status;

Whitchurch-on-Thames,
Reading RG8 7EN
Douglas Black, past
president, Royal College of
Physicians

BMJ 1993;307:1630-1

much better indices have now been developed, and the search for causal mechanisms (which must surely be multiple) has been made easier by the study, using the newer indices, of subnational populations defined by postcode or municipal wards. Such studies confirm the constancy of the association between deprivation and ill health; and they may also bring to light potentially causal factors which might not appear so clearly in national statistics. In all this work, conveniently brought together in the 1992 edition of *The Health Divide*,⁴ Peter Townsend has been a major worker, and a stimulant of work in others.

... and after

The differences in mortality associated with social deprivation are considerable, and they are at their greatest in the very early stages of life. One of our prime recommendations was that children be given a better start in life. We based this on the long term duration of any improvement in health which could be achieved by better maternity or infant care; but that is not the whole story. More recent studies by Marmot in relation to heart disease⁵ and by Barker more generally⁶ support the generalisation in the Court report that childhood illness casts long shadows ahead, producing impairment of health years in the future.⁷

In seeking for an explanation of the association between social deprivation and ill health we recognised that on occasion the onset of ill health could lead to impoverishment, and also that shifts of individuals between classes could be statistically confounding. We did, however, adopt the position that in the main it was social deprivation which was the independent variable, damaging health in a variety of ways, acting differently at different stages of life. For children, important factors were lack of safe play areas, domestic overcrowding, and lack appropriate stimulation. For workers, inappropriate living conditions and deleterious lifestyles (some of which are shamefully stimulated by advertising) may have their effects made worse by specific hazards of particular occupations, which may be both poorly paid and intrinsically hazardous. The accumulated burden of a socially

deprived life continues to oppress the diminished band of those who survive into old age. Many details have since been added to the picture, but they have in general strengthened its outlines, rather than demanded any radical revision.

Another matter on which we had some discussion within the group was the relative importance, in alleviating the health effects of social deprivation, of measures which could be broadly called social, and of measures directly related to health services. Our view, that poverty and its effects was the root cause of the ill health associated with it, naturally led us to advocate a wider strategy of social measures. After all, the surest way to alleviate the effects of poverty must be to alleviate poverty itself. But since the millennium is not at hand, except perhaps in the most formal sense, it is also worth considering the value of improving health care, even if only as a palliative. At the time of the report there was little quantitative evidence to suggest that specifically medical measures might appreciably reduce mortality at the population level, though their potential to help in individual episodes of illness was well recognised. It has now, however, been shown in several countries that mortality due to those diseases for which curative measures are available is falling more rapidly than mortality from those diseases which are not yet open to medical intervention.⁸ Common sense might suggest this would be so, but it is nice now to have some figures.

I think that Peter Townsend might agree with me that if we are serious in seeking to diminish morbidity and mortality due to social deprivation, we must return to the values of the welfare state and pursue them with greater determination.

- 1 Ruskin J. *Sesame and lilies*. London: Smith, Elder and Co, 1865.
- 2 Townsend P. Inequality and the health service. *Lancet* 1974;ii:1179-90.
- 3 Brotherson J. Inequality: is it inevitable? In: Peel J, Carter CO, eds. *Equalities and Inequalities in Health*. London: Academic Press, 1976.
- 4 Whitehead M. *The health divide*. 2nd ed. London: Penguin, 1992.
- 5 Marmot MG, Shipley MJ, Rose G. Inequalities in death—specific explanations of a general pattern? *Lancet* 1984;i:1003-6.
- 6 Barker DJP. The fetal and infant origins of adult disease. *BMJ* 1990;301:1111.
- 7 Department of Health and Social Security. *Health Services development: Court report on child health services*. London: HMSO, 1978.
- 8 Boys RJ, Forster DP, Jojan P. Mortality from causes amenable and non-amenable to medical care: the experience of eastern Europe. *BMJ* 1991;303:879-83.

Metachromatic leukodystrophy: two sides of a coin

Robert Jeffery, Alison Jeffery

Like all parents, we dreaded the birth of a handicapped child. We had not realised that our love for that child would both compound and leaven the heartbreak and hard work.

Our story is the typical one of initial concern about her development, the gradual appearance of neurological signs, and eventually the realisation that the disorder was progressive. We were fortunate that a diagnosis was possible: many families have to cope with neurodegenerative diseases that have not yet been characterised. For us the prognosis could be explained, although the timescale in metachromatic leukodystrophy is variable. The deficient enzyme and the gene have been identified and some of the individual mutations are known; relatives can be screened and early antenatal diagnosis performed. Of course, these opportunities bring their own ethical problems.

Soon after diagnosis, we learned of the treatments available, mostly recently developed and with uncertain results. By coincidence, the Royal Manchester Children's Hospital, 3 km from our home, has an international reputation in this field. The specialists'

advice, a literature search, and a phone call to a leading authority in America led us to the conclusion that bone marrow transplantation was more likely to prolong the decline then prevent it in Fiona's case. We were aware of the clinicians' differing opinions and have been at ease with the course we took. Some people insisted we must not give up hope; we found it simpler to accept what we could not change, to take each day as it came and accompany our daughter along her difficult journey as best we could. There is no cure, but there are decisions to be made along the way and the prediction of our physician that each choice would come naturally when the time came has been fulfilled.

Distress and helplessness

It is deeply distressing to watch one's little girl decline from being a late walker at 18 months to become a helpless creature at the age of 3—paralysed, demented, and blind. There have been hints that she might be vaguely aware of her diminishing ability; that the paralysis preceded the dementia and that her senses

Eccles, Manchester M30 9EF

Robert Jeffery, senior orthopaedic registrar
Alison Jeffery, registered midwife

Correspondence to:
Mr R S Jeffery, Department of Orthopaedic Surgery, Clinical Sciences Building, Hope Hospital, Eccles Old Road, Salford M6 8HD.

BMJ 1993;307:1631-2