health secretary. It will therefore be less easy to arrange a quick burial for the report in a departmental silo.

An unexpected champion of public health, Wanless is critical of the government's short term preoccupation with acute care and hospital beds. His update on progress offers the public health community an unprecedented opportunity to influence and shape future health policy. He wants to engage in an active dialogue with public health practitioners and others with important things to say. Whether those working in public health are up to the challenge may be more of a problem. Public health practitioners are still coming to terms with the latest NHS reorganisation. Split between the regional government offices, strategic health authorities, and primary care trusts they are struggling to keep the spirit of public health alive. Networks to overcome isolation and fragmentation are patchy and uneven.

Wanless will wish to satisfy himself that the present decision making structures for producing and implementing plans to improve health and tackle inequalities are "fit for purpose" and that sufficient resources are available in terms of capacity and capability. Whether the Department of Health is the best location to provide leadership for public health—an issue that exercised the House of Commons health committee in its review of public health—is something Wanless will wish to explore.[6] He will also want to be sure that the evidence for public health interventions exists and is robust. He felt hampered in his first review by the poor state of evidence in public health. Concern about weaknesses in the evidence base could become counterproductive and an excuse for inaction.[7] Lack of evidence is not the central issue. As the *World Health Report 2002* of the World Health Organization makes clear, deaths from cardiovascular disease could be cut by 50% if the political will to act was there.[8] Only when governments cease to worry about being labelled the "nanny state" will they stand any chance of providing much needed leadership. In the United Kingdom this seems even less likely at a time when devolution (the "real localism") and individual choice are dominant themes.[9]

David J Hunter *professor of health policy and management*

School for Health, Wolfson Research Institute, University of Durham, Queen's Campus, Stockton on Tees TS17 6BH

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Self esteem and health

Autonomy, self esteem, and health are linked together

The starting point for Richard Sennett's recent book, *Respect in a World of Inequality*, is that society is riddled with inequality: of natural endowment and talent, of opportunities and life chances, and of achievement.[1] We respect achievement. Hence these inequalities will be accompanied by inequality of respect. This, in turn, will be accompanied by inequalities in self esteem. Do such inequalities in self esteem matter? And if they do, is there anything to be done given that there will always be individual differences in earned respect?

The answer to both questions is probably yes—they do matter, and something can be done. There is a view that human needs form a hierarchy: keeping life and limb together takes precedence over such concerns as self esteem and respect. Doyal and Gough criticise this concept of hierarchy of needs and replace it with the idea that there are two basic human needs—health and autonomy.[2] Autonomy is closely linked with self esteem and the earning of respect.[1] Individuals do not worry about the means of achieving good health and only then concern themselves with autonomy. Both are basic and, I would argue, linked. Low levels of autonomy and low self esteem are likely to be related to worse health.

One way this can operate is through people's behaviour. Consider this example. The levels of obesity and diabetes among the Pima Indians of Arizona have long been recognised to be high. A small study tested the efficacy of lifestyle interventions. Two groups were identified. The Pima action group had a familiar mix of interventions on nutrition and physical activity. The Pima pride group looked remarkably like a control group for a health education trial—they received printed leaflets about activity and nutrition—but in addition they had regular discussions with local leaders on Pima culture and history. At the end of 12 months, much was going in the wrong direction for the action group, but the pride group had either less deterioration of risk factors or improvements. Compared with the action group the pride group looked favourable on weight, waist circumference, and blood glucose and insulin levels two hours after a glucose load.[3] A tentative conclusion was that increasing pride in their identity had a more favourable impact on health behaviours and risk than focusing on how to change diet and exercise.

Turning to more direct pathways between psychosocial influences and ill health, ample data show the link between low self esteem and depression.[4] The problem here, of course, is distinguishing causes from consequences. Low self esteem may be part of depressive illness rather than a step on the way.

Where the results are fatal, it is harder to argue that low self esteem was a consequence rather than a cause, especially if challenges to self esteem have dramatic

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results on the health of others. This is one interpretation of the close link between income inequality and homicide that has been noted internationally and among American states. Even in one city, Chicago, among 77 neighbourhoods a close relation was found between the degree of income inequality and rates of homicide.[5] What is the link with self esteem? Accounts of life in the inner city emphasise the salience of respect and self esteem. "No small amount of mayhem is committed every year in the name of injured pride."[6] Putting this together with income inequality, the hypothesis is that unequal distribution of resources leads to increased competition for status among young men who have little to lose other than their self esteem and the respect of others. The results are violent confrontation and homicide.

If we link, as Sennett does, the concepts of respect, self esteem, and autonomy the theory implies that all people have a basic need for autonomy and self esteem. The effects of self esteem on health will depend on context. Where inequality is high people at the bottom of the scale may express their response to threats to their self esteem in violent ways. At the other end of the income scale the effects may also be dramatic. How else are we to interpret the finding that actors who have won an Oscar have a life expectancy that is four years longer than that of those who were nominated and did not win?[7]

Several studies have shown the links to increased coronary risk of low control in the work place and imbalance between efforts and rewards.[8–10] This has been elaborated into a general framework.[11] Appropriate reward for efforts expended and control over life circumstances are crucial, among other things, for the enhancement of self esteem. Threats lead to health damaging behaviours and to activation of biological stress mechanisms that increase risk of diseases such as coronary heart disease. These threats are unequally distributed in society and hence may contribute to inequalities in health.

But if inequalities are part of the human condition, what is to be done? Tawney wrote that "to criticise inequality and to desire equality is not, as is sometimes suggested, to cherish the romantic illusion that men are equal in character and intelligence. It is to hold that, while their natural endowments differ profoundly, it is the mark of a civilised society to aim at eliminating such inequalities as have their source not in individual differences but in (social) organisation."[12] The UK government has set targets for reduction in health inequalities. Achievement of these will require changes in social organisation, but changes that are sensitive to the issue of self esteem. Encouraging people off welfare and into work sounds like a step in the right direction. But the quality of jobs matters. No one can read Polly Toynbee's demeaning experiences of low paid jobs in the contracted out workforce that serves the public sector and relax with the comfortable nostrum that any job is better than none.[13]

Michael Marmot *director*

International Centre for Health and Society, Department of Epidemiology and Public Health, University College London, London WC1E 6BT

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Treatment of multiple myeloma

New drugs raise hope for the future

Multiple myeloma is a malignant disease of plasma cells that is characterised by secretion of paraprotein, humoral immunodeficiency, anaemia, lytic bone lesions, and kidney dysfunction. Although the median survival of patients with multiple myeloma has improved from seven months to five years with treatment, the disease remains largely incurable.[1]

Conventional treatment includes melphalan and prednisone, now used sparingly because of its propensity to compromise collection of haematopoietic stem cells, other combinations, and regimens containing high dose corticosteroids. The latter—including dexamethasone; vincristine, doxorubicin, and dexamethasone; and cyclophosphamide, vincristine, doxorubicin, and methylprednisolone—are preferred for induction because of their excellent anti-myeloma activity and lack of marrow toxicity.

High dose chemotherapy, particularly melphalan, with autologous haematopoietic stem cell transplantation improves response rates and their duration and survival compared with conventional chemotherapy. It is now commonly used as consolidation treatment.[1] The superiority of consolidation with haematopoietic stem cell transplantation over continued conventional treatment has been confirmed in two randomised studies with a 12 month increase in median overall survival.[2 3] Another study has shown that the overall survival of patients who received haematopoietic stem cell transplants after relapse was

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