

The Review

Health inequalities in primary care:

time to face justice

'Don't take offence if we tell you to lose weight or stop smoking or drinking. You need to face facts and take responsibility', asserted Professor Steve Field, then Chair of the Royal College of General Practitioners, in an article published in the *Observer* back in the summer of 2010. He continued: *'every day we [GPs] are confronted with the harm caused by smoking, excessive alcohol consumption, and obesity.'*¹ In the same newspaper the following week Professor Field was upbraided by Professor Sir Michael Marmot, Chair of the World Health Organization's (WHO's) Commission on Social Determinants of Health:

*'Simply telling people to behave more responsibly is no more likely to be effective than telling someone who is depressed to pull his socks up ... smoking, obesity, and heavy drinking are causes of ill-health, but what are the causes of these behaviours?'*²

Marmot was alluding to the social determinants of health, the 'poverty, exploitation, oppression, and injustice' described in his influential WHO report.³ It is these determinants that result in health inequalities; causing for instance, male life expectancy in the poorest parts of Glasgow to be just 54 years, while in affluent areas of the same city it is 82 years.⁴ Acknowledging that people with less money and less education are likely to have less control over their lives and their health behaviour will help us to avoid blaming victims and thereby contributing to injustices in practice. But other than aiming to empower, not admonish, patients to change unhealthy behaviours, and treating their physical consequences, what is the role for GPs (and GP leaders) in tackling health inequalities?

DISTINGUISHING INEQUITIES FROM INEQUALITIES

'Inequalities that are preventable by reasonable means are unfair. Putting them right is a matter of social justice.'

Michael Marmot again, in his review of health inequalities in England:

*'A debate about how to close the health gap has to be a debate about what sort of society people want.'*⁵

Perhaps the most influential argument in

that debate so far has been the utilitarian position, convincingly put forward by authors of *The Spirit Level*, and utilised subsequently by David Cameron in his promotion of the Big Society,⁶ that 'equality is better for everyone'.⁷ Yet Marmot's allusions to fairness and social justice prompt consideration of another debate that has not yet occurred: a debate in terms of rights, opportunities, and justice.⁸ That we are still limited to talking about 'health inequalities' in the UK signifies a key deficiency in our discussions. An important distinction exists between health *inequalities* and health *inequities*.⁹ That is, between those differences in health outcomes attributable to biological variation or free will (inequalities), and those determined by the external environment and factors beyond an individual's control (inequities).¹⁰ Inequities are deemed unjust or unfair by most definitions; inequalities are not necessarily so.¹¹ The distinction is more than words: we need not worry about health inequalities if we know they are inevitable or not unfair (for example, the health inequality between young and old), but it is imperative that we acknowledge and address unequal health distributions that are avoidable and unjust (such as between richer and poorer members of our society).

POLITICAL AVOIDANCE OF HEALTH EQUITY

Acknowledging this might have enabled us to immediately perceive the ill-judgement in Health Secretary Andrew Lansley's announcement earlier this year that regional healthcare funding should be based upon the age of the local population, rather than indices of deprivation.¹² The announcement elicited little controversy and one medical writer was 'struck by the absence of reaction to Andrew Lansley's claim. He seems to have got clean away with it'.¹³ A Department of Health

spokesperson subsequently denied suggestions that concerns for the politics of winning votes among older people might be acting as a greater influence upon social policy than concerns for social justice.

The same Department of Health spokesperson asserted that 'the Health Act has given the NHS its first ever duty to reduce health inequalities'.¹⁴ But the Health and Social Care Act in fact only ever refers to 'inequalities between patients with respect to their ability to access health services' and/or 'the outcomes achieved for them by the provision of health services'. Equality in service access and outcomes is not at all the same as equity or equality in health: the Health Act permits health inequities to persist. No surprise perhaps. Recall *Equity and excellence: Liberating the NHS*, the government white paper that eventually became the Health and Social Care Act. Despite its prominent appearance in the title, 'equity' was never cited in the white paper as an aspiration and no mention was ever made of strategies that might improve equity in wealth or health. 'Inequity' was never mentioned, nor, unsurprisingly, were 'justice', 'injustice', 'fairness', or 'unfairness'.¹⁵

THE ROLE OF HEALTH CARE IN HEALTH INEQUITIES

We should be concerned by the ease with which equity is shifted to the fore when it is useful for justifying healthcare policy, then allowed to slip away when it becomes a prospect too challenging to confront. And we should be concerned by the failure to adequately account for health inequities in healthcare planning and provision.

Over 40 years ago Julian Tudor Hart described the inverse care law. It states that the availability of health care tends to vary inversely according to a population's health needs. This is a sorry reflection of social injustice, but not necessarily a major determinant of health inequity: breaking

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"As GPs we hold a unique position as witnesses to unjust health outcomes ... Initiating and impelling the justice debate about health inequities and their determinants is an urgent and important role ..."

Hart's law will not resolve the 'poverty, exploitation, oppression, and injustice' that constitute the principle social determinants of health. Yet the law does not describe a static system: as (socially-determined) population health declines and availability of health care reduces, the strength of health care as a health determinant increases. As the situation of social injustice deteriorates, Hart's law becomes increasingly important. And the situation in Britain is deteriorating: health inequities have worsened since Hart's original work and they continue to get worse.¹⁶

In the long term, the greatest impact of the NHS upon health inequities should be by way of funding through more progressive taxation; leading to greater wealth equity with consequent health benefits. Here again Julian Tudor Hart has exposed the ease with which social justice is overlooked. Discussing the perceived problem of 'how to fund a just healthcare system' recently he dismissed recourse to the proposed means-tested direct charges to patients (co-payments) and reminded us that funding from properly progressive taxation would already be means-tested, would avoid an added tax upon the sick, and would have the further benefit of reducing wealth (and consequently health) inequities.¹⁷

IF NOT US, WHO?

Justice-based discussion about the health consequences of social processes and resource distributions is a necessary companion to the argument that equality is better for everyone. It has the potential to ensure that health inequities are neither inappropriately exploited nor discounted in health policy proposals. And it could drive a vital moral imperative into tackling social determinants of health that lie beyond the remit of the health services such as education, employment, housing and — most crucially — taxation. Justice is a powerful concept, but one that governments will only confront if it is part of a public agenda with which they can align. As GPs, whether we like it or not, we hold a unique position as witnesses to unjust health outcomes. Failure to acknowledge

the injustices and to engage in meaningful debate about how they might be redressed is itself a decision of dubious morality. Initiating and impelling the justice debate about health inequities and their determinants is an urgent and important role that GPs (and GP leaders) surely have an obligation to take on.

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