EDITORIAL

The Black Report

THE report on 'Inequalities of Health' (DHSS, 1980) by professors Black, Morris and Townsend and Dr Cyril Smith, stands as a grim indictment: in 30 years the NHS has failed to meet its declared objective of providing effective health care to all members of our society according to their needs rather than their resources. The authors have collected, evaluated and arrayed a large volume of data (most of which were previously available) which not only establishes that there are gross inequalities of health, but quantifies them. It is important that we recognize that inequalities of health mean inequalities of suffering, of risk, and of premature death. Perhaps the most chilling statistic quoted is the statement in the introduction:

> "If the mortality rates of Class I (professional workers and their families) had applied to Classes IV and V (partly skilled and unskilled manual workers and their families) during 1970 to 1972 (the dates of the latest review of mortality experience), 74,000 lives of people under 75 would not have been lost. This estimate includes nearly 10,000 children, and 32,000 men between 15 and 64."

Deaths and differences between expected and actual death rates are easy to measure. Suffering, from avoidable or undertreated disease, whether acute or chronic, is less easy to measure and compare, but, where the working party could adduce such information, the trend holds. Social class alone does not account for the whole of the difference: there are significant geographical differences. Even when standardized for age and social class, the North, North West, East Midlands and Wales experience a significantly higher mortality than the South East, South West, and West Midlands. Not for the first time, the spectre of "two nations" (or more) emerges. No comfort can be got by studying trends in time; there is a wider gap between the death rates for men aged 15 to 64 in Social Class I and V in 1971 than there was in 1951. Similarly, the percentage improvement in stillbirths and neonatal deaths is greater for Social Classes I and II than for III, and greater for III than for IV and V.

Three institutions stand indicted by these findings, and must carefully examine their roles.

First, politicians, who in their administration of the National Health Service have seemed unable to understand the complex relationship between health services and health, or between health and other areas of concern such as poverty, housing and education. Health services alone cannot heal the damage done by deprivation. Even though joint committees of local departments of health, housing and social services have been established, they have been given too little money and power to effect the kind of change which is needed.

Secondly, civil servants, and advisory bodies such as the Standing Medical Advisory Committee (once part of the Central Council for Health Services, now of the DHSS), have not recognized, or focused their political masters' attention, on the failure of a mere technological approach to provide health care.

Thirdly, the profession itself, and in particular its educational establishment, has become ever more enamoured of technical solutions which, brilliant as they may be for individuals, contribute little to the health of populations. The authors say "our understanding of health will always be evolving and we must be prepared to absorb new knowledge about health and social conditions." However, they go on to say that "once a conception of a disease finds embodiment in a structure of service, major changes become difficult to introduce." All professions tend to become over-committed to existing practice, and their receptivity to the need for change is liable to become weak. This preoccupation with technology is compounded by the traditional aversion to involvement with politics (in the sense of social policy or social action) by the most political of the learned professions.

The Secretary of State, in his preface, costs the Working Party's proposals at £2 billion and on that basis briefly dismisses them. This sad response must be challenged for three reasons: first, several of the recommendations could be undertaken with little or no financial implication; secondly, because against that £2 billion could be offset considerable savings in medical care costs, sickness benefit and social security support for the families of workers who die prematurely; and thirdly, because even if the present government, in the present economic crisis, cannot enter into such activity, the Working Party's findings and the recommendations that stem from them must be the basis for an immediate surge of educational and research development if the

gaps, and widening gaps, are not to be perpetuated by yet more generations of doctors equally misled as to the realities of health in populations.

Here then is a new role for our College. It has achieved most of its early objectives. It has become a recognized authority on general practice. It has acquired formidable expertise in education, and in population-based research. If, for the 20 years to the end of this century, the College's goal was to tackle inequalities in health on every front—political, educational, clinical and environmental—it would go far to justifying its continuing existence. To evade the issue placed before us by the Working Party is to collude with those institutions who have failed the people of Great Britain. As they say:

> "Social inequalities in health in a country like Britain are unacceptable, and deserve so to be declared by every section of public opinion."

Where does the College stand?

Inequalities in Health Care costs £8·50 (including postage and packaging) and is available from the DHSS, Alexander Fleming House, The Elephant and Castle, London SE1. Please address your enquiries to Mr C. Muir.

Mortality and the national economy

The long-term upward trend in real per caput incomes is associated with better health, but the smoothed curve disguises cyclic fluctuations, recessions followed by periods of rapid economic growth, which may be stressful to certain groups in the workforce and, by extension, to their families. Especially vulnerable in recessions are those in industries whose goods or services are not essential, the less skilled who are the first to lose their jobs and the last to get their jobs back when the economy improves, and those who find that over one turn in the business cycle their skills are no longer needed. For these groups, most often to be found in the lower socio-economic classes, this lack of economic security is stressful: social and family structures break down and habits that are harmful to health are adopted. Acutely, if the effect manifests as a psychopathological event (e.g., suicide), or after a time lag of a few years or even one or more turns of the business cycle for chronic diseases, economic recessions and subsequent periods of rapid economic growth are associated with a deceleration in the normally declining curve of mortality against time. This model, tested previously on US data, has now been confirmed on data for England and Wales.

Source: Brenner, M. H. (1979). Mortality and the national economy: a review, and the experience of England and Wales, 1936-76. *Lancet*, 2, 568-573.

Role of the Health Service

We are told that for every quarter million people in this country there will be 7,000 with severe physical handicap and 700 with severe mental handicap. This at least gives a scale of disadvantage. Each year the quarter million will have 19,000 acute medical or surgical admissions to hospital and 925,000 consultations with their general practitioners. This gives proportion to the contribution of hospital and primary care. In big cities many will visit hospital emergency departments with non-urgent complaints, claiming that they cannot find a general practitioner. But the figures cannot tell us whether the care used could be better or should be different. At least there are a lot of data on the efficiency with which patients are dealt with by their doctors in surgeries and hospitals. Those who have made such operational analyses find that many clinicians are hard to convince and continue their old ways even when they have been shown to be inefficient.

In the end, it is the individual who decides when he is a patient. Granted that the decision is forced upon him by any obvious disaster such as a stroke or an acute abdomen, but the sociologists are right in saying that there is a wide spectrum of human distress that may or may not prompt the person to seek a doctor. The individual's decision is an amalgam of his own concepts of disease, of the availability of medical aid, and of his anticipation of relief. Given that muddle of feelings, it is difficult to lay down criteria for a necessary visit to the doctor. It cannot be the presence of a disease entity, a formal diagnosis used as a badge of respectability. Every general practitioner spends his time with unsorted psychosomatic problems. The skills needed to handle these are as hard to acquire as any technical manoeuvre. In a sense, each decision to see a doctor is self-justifying. The climate of public opinion may well play a large part in such decisions, so there is an obvious role for health education to inform people what medicine can do and where it is inappropriate, and that the Health Service is not obliged to provide instant contentment for all.

Source: *Journal of the Royal College of Physicians of London* (1980). Editorial, **14**, 67-68.