Editorials

Inequality, austerity, Brexit, and health care

INTRODUCTION

When Julian Tudor Hart published his iconic paper 'The inverse care law',[1] it stimulated much interest and research into how poverty adversely affected health and access to health care. Although it is reasonable that resource allocation should match need, my observation is that increasing socioeconomic polarisation and ageing have caused unexpected, and underrated, pressures on health care in affluent areas. The four interlinked issues of morbidity patterns, attitudes to health, social interaction, and staff recruitment are worthy of consideration in planning future service configuration.

THE RICH MAN'S BURDEN

My observations stem from two decades as a GP in an affluent commuter town near London. The main driver is chronic disease in an older population, at the apex of which is demand generated by care homes. The working-age population overwhelmingly comprises affluent Londoners who have taken the well-trodden path into the Home Counties, but whose quest for a gentler pace of life is dashed by the reality of an exhausting daily commute on crowded trains back into the capital, atop a long working day. Stress-related presentations are frequent, as is health-related anxiety of the 'worried well'. My experience tallies with what Des Spence explored in these pages recently:[2] a severely disabling state and a significant burden on health care, which has attracted less public and academic interest than it should.

THE EPIDEMIC OF YOUTH DEPRESSION

Sadly, it is among older children and young adults that I have noted a veritable epidemic of anxiety, depression, self-harm, and eating disorders. Many appear to have given up on any hope of matching the social mobility of their parents, and a frequent trend for Generation Y is that the gap year becomes an alternative lifestyle through their 30s and 40s. When the UK's economic divisions are discussed, an under-appreciated trend has been how the middle class has been split asunder into the 'have lots' in finance, real estate, and the higher echelons of entertainment, and the rest of us. When I first arrived here there were doctors, dentists, nurses, teachers, and vicars, many of whom worked and lived in the community. Today, they have imperceptibly vanished; the working-age population is virtually confined to City workers, hardly anyone who lives here works locally, and vice versa. Had this occupational homogenisation bolstered the social fabric, I would not have been moved to write this article. However, the opposite is true: as the area has become richer financially, so it has become poorer in spirit and public engagement. One of the follies I recognise is how parents — many ambitious people from modest backgrounds — cosset their children to avoid contact with 'the Other', their world lens confined to the tinted windows of the family 4×4. If anyone suggested that a young adult who grew up in a tough neighbourhood mixing only with similar peers might struggle, nobody would be surprised. I believe, however, that social apartheid and materialism often exert a malign influence on affluent youngsters. What worldliness can result from attending a school where every father is a banker, and girls have limited exposure to working mothers as role models? Factors, I aver, why many enter adulthood woefully bereft of vital life skills such as ambition, stoicism, empathy, and intellectual curiosity. It is a phenomenon starting to interest psychologists;[3] the parallels, if you wish, between the council estate and the gated estate.

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THE MYTHS OF LEAFY SUBURBIA AND IDYLLIC RURALITY

Our cultural adherence to ingrained stereotypes has impeded the in-depth analysis that demographic change, and its effect on health care, merits. The belief that the inner city is 'tough', that suburbia is 'leafy', and that anything rural is 'idyllic' remains pervasive even if, certainly around London, the opposite is true. Prime Central and West London is now affordable only to the migratory global super-rich. Gentrification of several once-edgy districts in zones 2 and 3 has pushed swathes of the urban working class to the outer suburbs, where they and migrant workers typically form the tenants in former family homes that are now multi-occupancy buy-to-lets.[4] Further afield is the sterile affluence of the Home Counties, while truly rural areas contend with much of the worst poverty and social exclusion in the country.[5] This matters because of how it affects funding, via the weighted list size, which financially penalises practices in affluent non-metropolitan areas such as mine. These expensive areas now also contend with a recruitment and retention crisis. I have chronicled how district nursing has virtually disintegrated in my area, and how no consultant or GP can settle here independently without a substantial private practice.[6]

A POLITICAL CLASS OUT OF TOUCH

None of this can be separated from the wider political landscape, now dominated by Brexit to an unhealthy degree. Yet Brexit was no more an anti-European vote than the rise of Scottish nationalism is a rational response to escalating Sassenach oppression. Rather, both reflect the rise of protest politics. The Conservative government is suffering an unprecedented rift with Middle England, for it cannot ideologically champion the free market while being ideologically opposed to the migrant foot-soldiers vital to the economy. Public services are, if anything, even more dependent on migrant labour, and Brexit, especially the 'hard' version, will be disastrous for health care. The fact is that 10% of England's medical workforce is made up of EU nationals, more than twice the 4.9% comprising the resident population.[7] In a survey of attitudes conducted by the BMA, 42% of EU doctors were considering leaving, an understandable response to

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uncertainty and to the perception of feeling unwelcome.[8]

Academic medicine will also suffer, for the UK has been the beneficiary of a €120 billion Research and Innovation Budget grant likely to be withdrawn.[9] Our professional discourse with government and the wider public should encompass these concerns, and criticise policies such as allowing big multinationals to trade in the UK but pay minimal tax, while continuing the public sector pay freeze beyond a decade, which worsen inequalities.

On a range of issues, my observations challenge the assumption that inequalities never harm the wealthy, and when a retired CEO cannot access a district nurse because she cannot afford to live within a two-county radius of where he does, he too might wish we could narrow the gap.

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REFERENCES

1. Hart JT. The inverse care law. *Lancet* 1971; **i:** 405–412.
2. Spence D. Bad Medicine: The worried hell. *Br J Gen Pract* 2016; DOI: https://doi.org/10.3399/bjgp16X687361.
3. Luthar SS. The problem with rich kids. *Psychology Today* 2013; **5 Nov:** https://www.psychologytoday.com/articles/201311/the-problem-rich-kids (accessed 12 Oct 2017).
4. Prynn J, Roberts G. The dispossessed: London's worst poverty is moving out to leafy suburbs. *Evening Standard* 2010; **27 Jul:** https://www.standard.co.uk/news/the-dispossessed-london-s-worst-poverty-is-moving-out-to-leafy-suburbs-6496565.html (accessed 12 Oct 2017).
5. Department for Environment, Food & Rural Affairs. *Rural living — statistical indicators and rural economy and community.* DEFRA, 2013 (updated 2017). https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/597383/DefraRuralPovertyStats_March_2017.pdf (accessed 12 Oct 2017).
6. Lakasing E. Please can we have our nursing teams back? *Br J Gen Pract* 2017; DOI: https://doi.org/10.3399/bjgp17X688633.
7. Dayan M. *Fact check: migration and NHS staff.* London: Nuffield Trust, 2016. https://www.nuffieldtrust.org.uk/resource/fact-check-migration-and-nhs-staff (accessed 12 Oct 2017).
8. Torjesen I. Four in 10 European doctors may leave UK after Brexit vote, BMA survey finds. *BMJ* 2017; **356:** j988.
9. Royal College of Physicians. *Brexit: what does it mean for medical research?* London: RCP, 2017. https://www.rcplondon.ac.uk/projects/outputs/brexit-what-does-it-mean-medical-research (accessed 12 Oct 2017).