BRITISH MEDICAL JOURNAL

SATURDAY 23 MAY 1987

LEADING ARTICLES

CLINICAL RESEARCH • PAPERS AND SHORT REPORTS • PRACTICE OBSERVED

MEDICAL PRACTICE

NO 6583 BRITISH MEDICAL JOURNAL 1987 VOLUME 294 1307-1366
BRITISH MEDICAL ASSOCIATION TAVISTOCK SQUARE LONDON WC1H 9JR.

WEEKLY. ISSN 0267-0623
ASTM CODEN: BMJOAE 294 (6583) 1307-1366 (1987)

CORRESPONDENCE

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Inequalities and the new Health Education Authority

SIR,—It would be unfair to dismiss *The Health Divide*[1] because of its political bias (4 April, p 857; 9 May, p 1230). It has brought together much detailed and important research, and many of the issues it raises would, if presented differently, command wide support.

The main problem is that the report is concerned with inequalities rather than actual standards, so anything that improves the level of health in all social classes but which has mainly benefited the higher social classes can be pilloried as increasing inequality. Thus the figures for cigarette smoking show that in 1972-84 there was a progressive reduction in all socioeconomic groups, but, while the prevalence of cigarette smoking in men over 16 in the professions fell from 33% to 17%, in unskilled manual workers it fell less, from 64% to 49%. If the prevalence of smoking related disease follows that of smoking then the inequality in health between socioeconomic groups attributable to these diseases will have increased. In 1972 the ratio was 1·9 while by 1984 it had become 2·9. By this measure the whole effort to reduce cigarette smoking would appear to have been counter-productive, which is manifest nonsense.

The authors base their approach on the World Health Organisation's strategy Health for All by the Year 2000, which aims at reducing the actual difference in health state between groups. This has the advantage of drawing attention to the needs of those with the worst health, but it is oversimplistic and will alienate many who want to improve the health of the whole community, including especially the poor.

The main divide between the political parties in Britain is between those who want to distribute the existing cake more evenly and those who want to enlarge the cake so that each portion can be increased. This report will be warmly welcomed by those whose politics are left of centre and severely criticised by the rest.

The authors pay tribute to the health services in the Netherlands and Sweden; but these are rich countries, and richer countries can and usually do spend more on health than poorer nations. In 1983 the expenditure on health per head was £548 in the UK, £988 in the Netherlands, and £1424 in Sweden.[2]

The report is useful in highlighting specific areas for further research and action. For example, the high mortality from hypertension and stroke among people of Afro-Caribbean descent and the high mortality rates for babies of mothers born in Pakistan should stimulate further research and appropriate provision. Success in reducing these problems is likely to reduce the cost to the health service by reducing the levels of hospital provision required, so the injection of modest sums of money may well produce better health for these groups at little cost.

It is not easy to define health, let alone decide how best to allocate resources to improve it, but we should be developing a strategy for spending the increasing amounts of money likely to be available for health as the country becomes more affluent. This strategy should be based on concepts that are less politically divisive than this report, targeted more precisely, and give priority to measures which will help those most in need.

If the report, with all its inadequacies, stimulates better services, especially for those most in need, then it will have served a useful purpose.

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1 Whitehead M. *The health divide: inequalities in health in the 1980s.* London: Health Education Council, 1987.
2 Office of Health Economics. *Health expenditure in the UK.* London: Office of Health Economics, 1986.

SIR,—Dr P B S Fowler (9 May, p 1230) deplores "emotive utterances . . . misleading statements" as "worrying propaganda tricks" in the debate surrounding the future of health inequalities in Britain.

He appears to take exception to the view that if the less well off do not have a decent diet this may partly be because of insufficient money. His conviction that the poor have no one to blame but themselves (as far as healthy eating is concerned) is based not on an analysis of the research literature of official statistics but on anecdote: "wives (sic) could tell that a stew made of neck of mutton with onions, carrots, and swedes is more nutritious and cheaper than the packaged convenience foods that are bought in such huge quantities."

Eight million people in Britain depend for all or part of their income on supplementary benefit. A study of goods and services that could be afforded by this section of the population conducted in 1986[1] and based on Family Expenditure Survey figures does indeed show that for a couple with two