Commentary

The challenge of prevention: A response to Starfield’s “Commentary: Pathways of influence on equity in health”

Richard Wilkinson*

University of Nottingham, Nottingham, UK

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Policy that doesn’t work

As Mackenbach (2006, p. 231) has pointed out, Britain “is now ahead of Continental Europe in developing and implementing policies to reduce socio-economic inequalities in health”. However, after almost 10 years of initiatives from a Labour Government there are still no clear signs of a diminution of health inequalities (Department of Health, 2005). This is likely to be because it took the Blair government 4 years in office to start to reverse the widening trend in income differences and a further 4 years just to get back to the levels of inequality when they came to power (Brewer, Goodman, Shaw, & Sibieta, 2006). None of the dramatic increase in inequality during the 1980s and earlier 90s has yet been undone.

Instead of reducing the underlying inequalities themselves, many policy initiatives have attempted to separate social and economic inequalities from their health consequences. But it has been a mistake to think that health inequalities can be substantially reduced even by well designed and targeted changes in policy which leave most of the society untouched. It would be nice to think that other countries could learn from these mistakes rather than repeating them.

In her commentary, Starfield has provided a useful outline of the issues facing research and policy aimed at reducing health inequalities (Starfield, 2007). She is right to emphasise our lack of knowledge of causal pathways. However, the need to know the detailed pathways may be more important in a political climate inhospitable to the major social and political changes which major reductions in health inequalities require. Perhaps it takes cleverer policies to make any difference in the context of “business as usual”. But one of the duties of researchers in a democracy is to inform public opinion, and in doing so point out that what technocratic solutions can achieve is very limited. Healing the social wounds of our societies requires more fundamental social change, for which what is lacking is widespread political will rather than a more detailed knowledge of pathways.

The policy dilemma

We know that health is influenced by hundreds of different things: by health-related behaviour, by pre-natal factors and by early childhood, by social status, by friendship, by living conditions, by education, by health services, by diet, by depression, and by stress. And the lower you are on the social ladder, the worse all these things tend to be. So should we try and do a little about each of them?
Try to stop poorer people buying less healthy food? Make sure their children do better at school? Stop people drowning their sorrows with whatever comes to hand? Reduce hostility, violence, and risky behaviour? Make sure less well-off young women have well-supported and stress-free pregnancies? And if so, how—if not by reducing the socioeconomic disadvantage which underlies them?

Almost by definition the causes of health inequalities increase with increasing socioeconomic disadvantage and might be expected to be responsive to changes in the burden of disadvantage. Can we expect to make a substantial impact on health inequalities without reducing disadvantage? And if we give the impression that it may be possible if it is not, do we risk weakening the demand to reduce deprivation itself? Too often other forms of prevention actually widen health inequalities (Pickett, Kelly, Brunner, Lobstein, & Wilkinson, 2005).

Social gradients in other social problems

Ill health shares its social distribution with many other social problems—including violence, teenage births, educational failure of school children, drug abuse, obesity...the list goes on. If, instead of focusing on health inequalities we were trying to tackle educational failure, what causal factors would we be concerned with then? Presumably attention would focus on the many things which differ between poorer homes and middle-class homes, differences in child rearing, in self esteem, in expectations and opportunities, in schools, and in the teachers they are able to attract. If instead we were working on violence, or drugs, or teenage births, many of the same factors would come up.

The causes of social “inequalities” in problems such as these spring, like health inequalities, from many different factors about which the only certainty is that they are related to underlying socioeconomic circumstances. Whatever the problem is, the dilemma is the same: do we reduce social disadvantage or try to reduce its effects? Almost inevitably, trying to reduce its effects means demanding additional services: more medical care, more drug rehabilitation units, more social workers, more police, more cognitive behavioural therapy, and more educational psychologists. The result is a widening range of expensive and only partially effective services trying to cope with damage our society goes on creating.

There seems to be no a priori reason for thinking that the causes of inequalities in different causes of death have more in common with each other than they do with the causes of inequalities in other social problems—whether violence, school failure, or anything else. Although these problems—including health—tend to be approached as if they were completely separate from each other, and required quite different disciplines to understand them, it is likely that in differing degrees they share similar roots in relative deprivation. While we may doubt the extent to which health problems involve psychosocial pathways, there can be much less doubt that social problems which are essentially behavioural involve psychosocial mediation. Indeed, one of the exciting things about our growing knowledge of the psychosocial pathways affecting health is that they may lead us to shared psychosocial pathways which account for social gradients in social problems besides health.

Inequality and other social problems

A recent review of the literature on income inequality and population health showed that where income inequality was measured over whole societies, or over areas large enough to provide a proxy for the scale of material differences across the social class hierarchy, then the evidence was overwhelming that smaller inequalities tend to be associated with better population health (Wilkinson & Pickett, 2006a). This prompts the intuitively plausible hypothesis that the scale of the health burden associated with low socioeconomic status may vary with the scale of socioeconomic inequalities. And if bigger inequalities increase the burden of relative deprivation and of ill health associated with it, might the same not also be true of other social problems rooted in relative deprivation and marked by social gradients?

The evidence suggesting that this may be so is beginning to accumulate. Along with poor health, the prevalence of many other problems has been shown to be lower in less unequal countries. The evidence has recently been summarised (Wilkinson & Pickett, forthcoming). Along with the literature on income inequality and health (Subramanian & Kawachi, 2004; Wilkinson & Pickett, 2006a), there is also substantial evidence on inequality and violence (Hsieh & Pugh, 1993; Fajnzylber, Lederman, & Loayza, 2002; Wilkinson, 2004). In addition, there have been recent papers showing that
obesity (Pickett, Luo, & Lauderdale, 2005), teenage births (Pickett, Mookherjee, & Wilkinson, 2005), and children’s combined literacy and maths scores (Wilkinson & Pickett, 2006b) are related to inequality. This strongly suggests that the processes which account for the greater prevalence of these problems lower down the social scale are exacerbated by greater inequality and greater social differentiation.

Rather than simply involving harmful consequences of fairly superficial social comparisons, the effects of inequality seem more likely to reflect the ways in which people’s personal characteristics are conditioned and constituted by social class and status. What is exciting is that the relationships between the extent of inequality in a society and the prevalence of a number of problems associated with relative deprivation, show us a way to reduce the damage which low social status does to people’s lives. Although in any social hierarchy some people must inevitably be nearer the bottom, we now have evidence that less harm is done where the hierarchy is spread over narrow income differences.

The quality of life at a cross-roads

While the up side of focusing on the underlying material inequalities is that reducing them may result in multiple benefits, the down side is that they are often regarded as hard to change. However, affluent societies have reached a cross-roads in the development of human societies. For thousands of years, the best way of raising the quality of human life has been to raise material living standards. Now the indicators suggest that further economic growth no longer produces increases in well-being—whether measured by health, happiness, or depression. In addition, global warming and other environmental problems mean that the human costs of unrestrained economic growth are likely to rise. If we are to improve the real quality of our lives, we have now, for the first time, to think more fundamentally about how this can be done. Increasingly number of people are concerned with the apparent social failure of many affluent societies, and it is surely to improvements in the social environment that we must turn our attention if we are to make further gains in the real quality of our lives. Via the harm of low social status, weak social affiliations and stress in early life, that is the direction in which much of the social epidemiology points.

Instead of being concerned with the hypothetical extremes of equality and inequality, the evidence comes from comparisons of the effects of the small differences in existing inequality such as those which occur within market democracies and US states. A generation or more ago, governments pretended to do more about poverty and redistribution than they actually did. But more recent governments—including the Clinton administration and Blair’s Labour government with its “stealth taxes”—have hidden what little they have done. Public support for redistributive policies, even for those from which the majority of the population would benefit, appears to have declined and income differences in many countries have widened. However, in a democracy, the job of researchers and teachers concerned with the issues we have been discussing, is surely to inform public opinion. Only when people understand the contribution which differing degrees of inequality make to levels of violence, to school failure, to health, to obesity, to trust, and to a range of other social problems—in short to the quality of our lives, will there be an electorate which will support policies to narrow inequality. Just as the nineteenth century public health movement transformed the physical environment in our cities by introducing sewers and clean water supplies, so an understanding of the social determinants of health has the potential to transform the social environment.

References


