A Black look at the independent inquiry into Inequalities in Health

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On 1 December 1998, at a seminar arranged by the Faculty of Public Health Medicine, Sir Donald Acheson and his colleagues made a series of presentations on their important report, Inequalities in Health. Although commissioned by government, and supported administratively by the Department of Health, the report is the result of an inquiry that was prolonged, thorough and, above all, independent. I was given the opportunity to make the 'opening remarks', and used it to say something of the background to the report: to draw attention to the important common ground between the present report and one published on the same topic in 1980; and, most importantly, to indicate ways in which the new report makes significant advances on earlier work, giving renewed hope for future action.

The background

That the disadvantages of poverty include ill-health and early death must have been suspected from early times; but its explicit recognition and quantitation, based on bills of mortality, we owe largely to Edwin Chadwick. The idea that something should be done about it came more recently, largely through the work of Richard Titmuss and his colleagues; and in his 1976 Galton Lecture, John Brotherston asked the critical question, 'Inequality: is it inevitable?' It may well have been this that led David Ennals, then Secretary of State for Social Services, to set up a Working Group on Inequalities in Health. Convened in 1977, the Working Group reported in August 1980, though it was not until December 1982 that the so-called Black Report was debated by parliament.

Despite the adversarial style of the parliamentary debate (one MP complained: 'One has to read the report to understand the recommendations'), the accumulated evidence of the report was not vulnerable to the rhetoric of those who disliked its recommendations; and John Brotherston's question has not gone away. Research on the socioeconomic determinants of health has burgeoned, giving us better indices of deprivation and of health status; a fuller appreciation of the universality and extent of the problem, including the lack of improvement over time; and many concrete suggestions for reversing this trend. The general picture derived from our necessarily cross-sectional survey has been corroborated by longitudinal studies. A conspectus of related research is given by Margaret Whitehead in The health divide; and the Acheson Report itself has 529 references.

What remains the same?

Not surprisingly, there are many similarities in the findings of the Black Report and the Acheson Report, and in the way in which they are interpreted. After all, little has been done to alleviate poverty in the intervening years, so little has altered - other than for the worse - in its consequences. This is reflected in the objective findings. With regard to interpretation, in the Black Report we opted for a socioeconomic model of the relationship between poverty and health; adopting the same type of model, the Acheson Report (page 5) was able to say, 'This is in line with the weight of scientific evidence'. Both reports conclude that the problem can be tackled only by a strategy wider than measures within the health services, embracing also action on inequalities in disposable income, housing, education and lifestyles in general.

Another important similarity between the two reports is the emphasis laid on the health of children, including those yet to be born. In the Black Report, the first of our three priorities for health and personal social services was, 'Priority for children to have a better start in life'. This is extended and made more explicit in the Acheson Report (page 120): 'We recommend a high priority is given to policies aimed at improving health and reducing health inequalities in women of childbearing age, expectant mothers and young children'. Although the purport of these two recommendations is the same, the interval between them has seen a sea-change in the type of evidence available to support them. Our recommendation was based on clinical pragmatism, the recognition that an improvement in the health of a child would give dividends for years ahead; or, to use Donald Court's phrase, childhood illness casts long shadows forward. But in the years between the two reports, adverse conditions in pregnancy, reflected in low birth-weight, have been firmly linked in epidemiological studies to increased morbidity and mortality in later years.

This is just one example of how research has enriched the evidence base of recommendations previously made on pragmatic grounds, a point which may introduce consideration of differences between the two reports.

What's new?

To start with something that is obvious but not trivial: the original version of the Black Report, cyclostyled within the

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J R Coll Physicians Lond 1999;33:148-9
Department of Health and Social Security, was unappealing; in contrast, the Acheson Report is inviting to read, as was also the Department of Health’s 1995 report on a related subject, *Variations in health*. More substantially, each one of the subsections of the Acheson Report is backed up by a summary of the relevant evidence. Twenty years ago, much of this was not yet available. During the past 20 years, however, the problem of health inequalities has been taken up by official international bodies, most notably perhaps by the World Health Organisation and its European office in Copenhagen. Research into its extent and causation has been world-wide, producing a vast expansion of the knowledge base from which conclusions can be drawn.

A key difference between the two reports lies in the attention paid to the system of taxation. The average income has increased since 1980, but the increase has been much greater in those already affluent than in those already poor. Although their terms of reference included the caveat, ‘within the broad framework of the government’s financial strategy’, the Acheson group felt able to draw attention to the effect of taxation policies in the 1980s on increased differentials in income between rich and poor, and to make the claim (page 33) that ‘a fairer tax system will help the less well-off who are in work’.

In 1980, it was necessary to deploy argument against tendencies to dismiss the evidence of a link between poverty and ill-health as a statistical artefact; as a consequence of cultural and ‘lifestyle’ differences between rich and poor; or even as a manifestation of an inborn ‘failure to cope’, productive both of economic failure and of illness. It was also necessary to marshal substantial statistical evidence of the extent and universality of the influence of poverty on health, simply to show that there was important cause for concern (and as we had hoped, action). These battles have been largely won through the research of the intervening years, enabling the Acheson group to call on a virtual consensus of opinion, rather than attempt to create one. This frees their report from the need to include much of the material that enabled critics of the Black Report to label it as ‘socialist’, ‘polemical’, even ‘turgid’. This freeing allows greater relative scope for recommending what is to be done; and the recommendations that it makes are clear and specific. Particular attention should be given to what are described as ‘general recommendations’. In summary, these enjoin a broad approach to the problem, but with specific priority given to the welfare of children, the citizens of the future.

The future

Large and complex as the problem is, it is also possible to write it off as the inevitable consequence of social stratification. To do so does not demand ill will or lack of intellect, only a lack of vision and a failure to empathise with the lot of others; such was the spirit imposed by the dominant leadership of the 1980s, here and in the USA, though not in Scandinavia or in the Netherlands which, with less inequality, enjoy better health (we in turn do better than the USA, whose inequality is greater than ours). An unequal society is not a good society.

There is always the excuse of difficulty and expense for those who favour neglect. Those who criticised that neglect through long years in opposition to a triumphalist government, now have the opportunity to change things. They have made a decent start by commissioning an in-depth inquiry early in the course of a comprehensive plan of reform. This has now produced a report of great substance, with many recommendations for sensible action. As we said back in 1980, it need not all be done at once; but I cherish the hope that a meaningful start can now be made.

This article is open to the criticism of being ‘political’. My reason is that this is basically a political problem, whose radical solution will require a return to distributive justice. Why write about it in a medical journal? Because doctors are also citizens; they have opportunities to observe and perhaps to mitigate the effects of poverty; and they should be, in Virchow’s words, ‘the natural advocates of the poor’.

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