LIFE AND DEATH **Iona Heath**

R-E-S-P-E-C-T—find out what it means

What reasons underlie the increase in killings by some children and young adults in Britain?

"All I'm asking is for a little respect" sang Otis Redding in 1965 and Aretha Franklin two years later with her magnificent cover version. Respect is crucial to human dignity and is central to both the understanding and the mitigation of health inequalities. In the UK at the beginning of the 21st century, the prefix from disrespect has become a powerfully insulting verb. Children and young adults, born into families and homes that are offered scant regard by the rest of society, are killing others at a terrible rate and often in revenge for a perceived lack of respect. The activity of dissing has come to encapsulate the marginalisation of young people deprived of richer opportunity.

The evidence that poverty undermines health is now overwhelming, and the task for every member of any society worthy of the name is to transform that knowledge into some form of redress. Each of the dimensions of poverty—low income, inadequate education, unemployment, poor housing, social isolation, and even the carrying of knives—have a common core, which is the attrition of hope, opportunity, dignity, and respect. All four are intimately related, and the erosion of one damages each of the others.

It seems increasingly likely that the hopelessness of poverty undermines health through the destruction of an individual's sense of agency and so of being even partially in control of their own destiny. Poverty affects health not only through the direct effects of lower absolute material standards of, for example, nutrition, housing, and heating, but also through chronic psychosocial strain caused by increased exposure to violence and chronic emotional stress, and to the compensatory behavioural risks such as smoking, drinking, and drug misuse. Evidence indicates that it is the psychosocial effects of social status, both positive and negative, that explain the larger part of health inequalities in affluent countries. The stress associated with low social status produces physiological change, including higher blood pressure, increased secretion of cortisol, suppressed immune function, central obesity, and adverse serum lipid ratios. By these means we can begin to understand how poverty, by eroding control and agency and by producing insecurity and loss of self esteem, creates chronic psychosocial stress and, through the associated physiological changes, is transformed into disease.

The challenge of attempting to reverse this process is daunting, but it seems clear that the earlier in this sequence we can intervene the more likely we are to be effective. A primary task of frontline healthcare workers becomes one of trying to locate and foster hope, opportunity, dignity, and respect within the patient's life story and its context. Recognition, advocacy, and signposting are key roles for general practice—but too often there seems to be no one to advocate to and nowhere for people to go. Too many interventions are stigmatising and demeaning, and there seems always to be insufficient recognition of the enormous reserves of courage and resilience and survival skill hidden within the bald statistics of health inequalities.

If health professionals are to contribute in any substantive way to the redress of health inequalities, it will be necessary to recognise that organisational change and epidemiological evidence are necessary but not sufficient. A different and much broader approach is required, accommodating not only the importance of genuine respect and dignity but also a commitment to the more equitable distribution of hope and opportunity and the money that underpins them. The government seems to want to deliver respect in the form of choice, but there is neither respect nor much hope in a version of choice that seeks to combine promotional window dressing and ideologically driven manipulation in the commercial interests of privatisation.

Health service professionals find themselves being held responsible for health inequalities, and indeed the existence of health inequalities was presented as the justification for the Darzi proposals for London. However, health inequalities cannot be detached from their social and economic equivalents, and when politicians allow these to continue to widen while expecting the health service to contain and even reverse the inevitable health consequences it becomes deeply demoralising not only for those whose health suffers on the losing side of inequality but also for those in the frontline of clinical care, particularly in deprived areas. There is a desperate need to distribute health services resources according to need, but this does not fit with the contemporary rhetoric of choice. Poorer people have more illness and more disease, and they need commensurately more access—not less as now; not even the same—to the services of doctors, nurses, and other healthcare professionals. This is the choice that poorer people do not have.

"Respect means facing the reality and the effects of inequality and injustice, both within society as a whole and within the health service, rather than believing that they can simply be managed away"

Why is Julian Tudor Hart's inverse care law so pervasive even in the NHS, and why are the greater needs for health care in some areas not more accurately reflected in more intensive and focused provision? Is the apparent political commitment mere rhetoric? Are wealthier citizens simply not prepared to invest in services for those less fortunate? Are we stuck with Nabokov's polarity of "fatal poverty and fatalistic wealth"?

Lord Darzi and most politicians and policy makers seem to believe that health inequalities can be reversed simply by organisational change within the NHS, underpinned by condescension and exhortation. They need to listen to more soul music. It seems clear that Otis and Aretha know more about inequality than any of them. Respect means facing the reality and the effects of inequality and injustice, both within society as a whole and within the health service, rather than believing that they can simply be managed away.

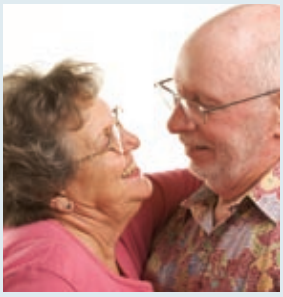
Iona Heath is a general practitioner, London iona.heath@dsl.pipex.com

Cite this as: *BMJ* 2008;337:a672

From the archive: see *BMJ* 2007;335:837 and *BMJ* 2005;330:1221-2

WHAT'S NEW ON BMJ.COM

Our bloggers have had a very active week and, as usual, cover a wide range of subjects, from reflections on individual health and happiness to the healing powers of music and matters of recycling, climate change, and global health. Continuous publication, meanwhile, has meant that lots of new content has been published online every day—check bmj.com for the latest updates.



RESEARCH

Secular trends in self reported sexual activity and satisfaction in Swedish 70 year olds

Over the past three decades (1971-2001) an increasing proportion of these older people have reported having more and better sex, according to this cross sectional survey of four populations. An accompanying editorial says that doctors are well placed to normalise and affirm the value of fulfilling sexual relations for the wellbeing of older patients and should always ask patients, regardless of age, about sex.

FROM THE BLOGS http://blogs.bmj.com/bmj

David Payne explains the *BMJ*'s new publishing model—publishing all journal content online as soon as it's ready—and how this has changed the look of bmj.com (for more information, read our Frequently Asked Questions, http://resources.bmj.com/bmj/about-bmj/the-bmjs-publishing-model). Communication was the key focus for guest blogger Liz Wager, who attended a one day workshop run by Connect, a charity for people with aphasia, culminating in a 20 minute conversation with a trainer who "couldn't say a single word, and her writing skills were limited as she had lost the use of her normal writing hand, but thanks to her skills (definitely not mine) and the techniques and resources recommended by Connect, I found out about her and her family, we exchanged views about US cities we'd both visited, and discovered we share a love of gardening and the same taste in handbags." Her conclusion? "I've had many far less enlightening chats with people who can talk."

Also: Anne Caley: Cycling and recycling

Joe Collier: A stab at future UK drug pricing policy

Domhnall MacAuley: Music of eternal youth

Richard Smith: The end of disease and the beginning of health

CALL FOR ABSTRACTS

International Forum on Quality and Safety in Health Care

The call for abstracts opened this week for the 2009 International Forum, to be held in Berlin, Germany on 17-20 March 2009.

We are interested in hearing from you if you have new work with results to present or you might want to tell us about important cultural or leadership initiatives that have stimulated change (and whether that change was an improvement). Perhaps you have a new tool or method you have employed and you want to share experiences and results. Visit the International Forum website (for more information http://internationalforum.bmj.com/)

BMJ VIDEO : Interview with Lord Darzi

Health minister Lord Ara Darzi talks to Rebecca Coombes about his report, in which he emphasises the need to improve quality of care after a decade of investment in services.

Last week's bmj.com poll

Are international medical conferences an outdated luxury the planet can't afford?

You replied:

YES 471 (59%)

NO 324 (41%)

This week's poll asks

"Should geriatric medicine remain a specialty?"

Where do you stand on this issue? Vote on bmj.com

MOST READ ARTICLES

Cardiovascular risk tables

What is missing from descriptions of treatment in trials and reviews?

Darzi review: Reward hospitals for improving quality, Lord Darzi says

Medical evidence exposes US use of torture

MOST RAPID RESPONSES

Top-ups for cancer drugs: can we kill the zombie for good?

Multiple vaccinations, health, and recall bias within UK armed forces deployed to Iraq: cohort study

WARNER BROS/KOBAL

How clean is your water?

Ten practical actions for doctors to combat climate change

Predicting cardiovascular risk in England and Wales: prospective derivation and validation of QRISK2