Conference Report

Poverty in the cradle

RICHARD SMITH

Not often can a whole conference be sparked off by an obtuse remark, but it was Kenneth Clarke, Minister of Health, questioning the link between poverty and infant mortality that led to the Maternity Alliance's conference "Poverty—a Crisis for Babies." Sadly Mr Clarke was not there to hear the speakers spell out the statistics of deepening poverty in Britain and explore the complicated but usually undisputed connections between poverty and the death of babies, but he and his government colleagues could be said to have haunted the meeting. This was because of a report that appeared on the front page of the *Guardian* on the morning of the conference announcing that the government was considering abolishing the maternity grant except for the poorest families and introducing a means test for maternity benefit.¹

Images and statistics of poverty

If the ministers had been there then it might have been the images of poverty that were scattered through the meeting that would most have impressed—or even shocked—them. They may be used to the statistics, but for them, as for much of the electorate, poverty in Britain is mostly invisible. But it isn't invisible to many of the health workers who attended the conference. Wendy Savage, an obstetrician who works at the London Hospital Medical College, described how she had visited a mother and her children in Tower Hamlets, one of London's poorest boroughs, on a Monday morning and discovered that they hadn't eaten since Friday lunchtime—their social security cheque had not arrived. Shirley Goodwin, general secretary of the Health Visitors' Association, told the conference how she had visited one of the poorest families on her books and discovered a huge freezer in their small kitchen: they had bought the freezer on hire purchase because it came full of food, but they couldn't keep up the payments and couldn't afford the electricity to keep it going.

Some of the worst poverty is seen among the increasing number of "bed and breakfast" families—those that are kept in hotels because otherwise they would be homeless. Nick Raynsford, director of the London Housing Aid Centre, has come across eight children and two parents staying in one room in one such hotel. Leon Polnay, a senior lecturer in child health in Nottingham, caused the audience to gasp when he showed pictures of slums that he had visited in Nottingham. "Slums," as Nick Raynsford emphasised, "are not a thing of the past."

Peter Townsend, professor of social administration in Bristol and one of the authors of the Black report,² gave the statistics of poverty rather than the images, but he did say that he now saw worse poverty than he had as a researcher in the east end of London in the 1950s. Normally in Britain we talk about relative poverty (not having enough money to live a decent life) rather than absolute poverty (not

having enough money to stay healthy), but absolute poverty is widespread in Britain.

Statistics on poverty are limited, explained Peter Townsend, but all the data show that the number of children living in poverty is increasing while the total numbers of children are decreasing, culminating in the terrible statistic that a third of British children are growing up in poverty. The government's poverty line is set by supplementary benefit, and by this standard 410 000 children in 1975 and 560 000 in 1981 were living in poverty. But most social researchers suggest that the real poverty line should be some 40% higher, which gives figures of 3 170 000 children in 1975 and 3 660 000 in 1981 growing up in poverty.

These are figures for children under 15, and there are no figures specifically for infants. But the assumption must be that a higher proportion of infants live in poor families because income tends to be lower in young families, unemployment rates are higher, and housing costs are higher. Furthermore, it is often, as Lesley Rimmer from the Family Policy Studies Centre explained, the arrival of the first child that plunges families into poverty. These days both partners tend to work until the arrival of the first baby, which means that when the baby comes income drops just as costs increase. Poverty also tends to be more extreme among single parent families (40% of families living on supplementary benefit have only one parent) and among families from ethnic minorities.

The problem of poverty is complicated by many families not claiming the benefits to which they are entitled. Lesley Rimmer described present benefits and discussed their adequacy. The maternity grant of £25 is, for instance, intended to meet the costs incurred in having a baby. It has stayed at £25 since 1969, and just to be as valuable as then it would have to be about £125, but the true cost of having a baby is probably nearer £500. In France the equivalent of the maternity grant is worth £557. But the maternity grant does have the advantage of being universal—like child benefit—whereas the maternity allowance, maternity pay, supplementary benefit, family income supplement, housing benefit, and most other benefits have to be claimed and the rules are usually very complicated. This means that not only may they be inadequate but they don't reach all the people who are entitled to them: for instance, only half of the families entitled to family income supplement make a claim, and only 7% of women eligible for free milk and vitamins on grounds of low income take up the entitlement.

Poverty and child health

Neonatal deaths, postneonatal deaths, stillbirths, and the incidence of low birth weight are all correlated with poverty (fig).³ Infant mortality in social class V is roughly double that in social class I, said Peter Townsend: the gap narrowed towards the end of the '70s but is now widening again. The Black report explains how class differentials reach a peak among infants aged more than a month and less than a year: for every such death in social class I in this age group there are four in social class V. In other countries in Europe this social class difference is not nearly so definite, and Britain is slipping steadily down the league table of international infant mortality.

The way in which poverty leads to ill health cannot be neatly explained. The Social Services Committee classified the factors causing infant deaths into two groups—socioeconomic (lack of education, poor housing, poor nutrition, unplanned pregnancy, smoking, drinking alcohol to excess) and medical (lack of antenatal care, low birth weight, asphyxia, congenital malformations, cerebral haemorrhage).⁴ Any such classification is inadequate, however, and Leon Polnay and Shirley Goodwin gave good examples of the myriad ways in which poverty can lead to infant deaths.

Outcome of pregnancy by social class of father and legitimacy, England and Wales, 1980 (taken from *Birth counts* by Alison Macfarlane and Miranda Mugford³). Social class: I professional occupations; II intermediate occupations; IIIN skilled non-manual occupations; IIIM skilled manual occupations; IV semiskilled occupations; V unskilled occupations; "other" means students, members of the armed forces, and inadequately described occupations.

As the Black report says, one of the causes of death that shows the steepest social gradient is accidents.² Imagine a mother living in a bed and breakfast hotel with her children: not only is the accommodation poor so that there are broken bannisters and broken glass but also the primitive cooking facilities may be a couple of floors away, meaning that a mother may have to leave her older child while she takes the baby to fill his bottle. Perhaps while she is away the toddler falls or burns himself. Similarly, as Shirley Goodwin explained, cooker and fire guards are expensive and mothers will naturally not choose to leave their children without food in order to buy them.

(This discussion of accidents and poverty gave me qualms of guilt because I had the day before been talking on television about children burning themselves in the home—and yet I had not considered poverty. This is one small illustration of how many doctors don't consider poverty when they should, but it also shows how health professionals when intending to be helpful can actually undermine the parental esteem of a mother who is unable to afford to follow their advice.)

Leon Polnay also considered the many ways in which deprivation can lead to poor access to health care. Consider, for instance, when a child in a poor family becomes ill. The parents may be less likely than middle class parents to recognise the problem and when they do they may not respond appropriately. Then even if they do want to contact the doctor they probably have no phone, and the phones outside on the estate are broken. When they get through to the doctor what do they say? If they say just that the baby is ill they are less likely to get the doctor out than if they say he is blue all over and breathing noisily.

When the link between poverty and ill health is discussed there is a tendency to blame either the poor themselves or the services: Leon Polnay thought that the truth lay between these two extreme interpretations. The important point to me was that the link between poverty and ill health is to be found in detail rather than in sweeping generalities.

Housing problems

But one generality which is closely related to both poverty and health, and yet which is often ignored, is housing. And it has suffered more from government cuts than any other sector: expenditure on housing has been cut by two thirds since 1979, and only 38 000 new houses were started last year compared with 170 000 ten years ago. This fall in new building is nothing to do with the country having enough houses because, according to Nick Raynsford, the condition of the housing stock is deteriorating rapidly. There are now three categories of slums: the traditional one of privately rented housing and two newer ones—structurally defective council houses built in the '60s, and owner occupied houses where the owners (usually elderly people) are unable to afford to maintain the house.

About 1.2m families are on housing waiting lists, and most of these have little or no chance of being rehoused in the foreseeable future. More and more families are becoming homeless, and many are ending up in bed and breakfast hotels, which are both expensive for the local authorities and sordid for the people who have to live in them. Housing benefits are even more complicated than most other parts of the social security system—Nick Raynsford described them as being byzantine—and consequently the take up rate is less than a third. Nick Raynsford ended his chilling talk by pointing out that while only £4m a year is paid out in housing benefits to poorer families about £3½ billion is handed out in income tax relief on mortgages.

What can be done about poverty and the poor health it causes?

Statistics like that last one quoted by Nick Raynsford led some people at the conference to take the line that redistribution of wealth was the only way forward and that all other proposals were idle chatter. "While there are stinking rich people there will be stinking poor people," said one community physician angrily, implying that it was time the rich were put up against the wall; while another speaker took the line that the poor needed money, not advice from health visitors, or booklets from general practitioners, or more considerate antenatal care from obstetricians.

Most of those at the conference thought that some sort of political action was right, but most also thought that they had to try and find ways in their daily work of helping those families in poverty. One way of helping is by encouraging the poor to take up the benefits to which they are entitled, and Brian Jarman, professor of general practice at St Mary's Hospital Medical School, described the computer programme that he operates in his health centre to tell people about benefits.⁵ Many health workers have not seen it as part of their job to encourage the uptake of benefits, but Shirley Goodwin suggested that they should all take on such work. This message was particularly directed at general practitioners, who see about three quarters of all their patients each year and so would be well placed to give such advice.

Leon Polnay discussed ways in which health services could be

made more acceptable to the poor. Health workers should be as unauthoritarian as possible, and both he and Shirley Goodwin emphasised the importance of building up the personal esteem, confidence, and responsibility of poor parents: it is all too easy to make them feel inadequate.

In the last analysis doctors probably cannot do very much to counteract the powerful effects of poverty on health, but something they can do is to recognise its importance. The conference was held at the Royal College of Obstetricians and Gynaecologists, which generously gave the facilities free, but Wendy Savage pointed out that as far as she knew apart from herself only one other obstetrician was at the meeting. This was an indictment of obstetricians, she thought, because as Ann Oakley has said: "Reducing social

disadvantage—whether in the form of poor housing, inadequate disposable income deficient diet, or whatever—is not a different issue from the issue of improving perinatal mortality and morbidity, but the same issue."

References

- 1 Hencke D. Thatcher supports pensions cutback. *Guardian* 1985 April 19:1.
- 2 Black D, Morris JN, Smith C, Townsend P. *Inequalities in health*. Harmondsworth: Penguin, 1982. (Black report.)
- 3 Macfarlane A, Mugford M. *Birth counts*. London: HMSO, 1984.
- 4 House of Commons Social Services Committee. *Perinatal and neonatal mortality*. London: HMSO, 1980.
- 5 Jarman B. Giving advice about welfare benefits in general practice. *Br Med J* 1985;290:522-4.

Medicolegal

Doctors and defamation

BY OUR LEGAL CORRESPONDENT

Doctors may get involved in defamation actions either as plaintiff or defendant. As potential litigants it is as well for them to have a rudimentary knowledge of a complex subject.

The two most important things to know about defamation actions are matters of practice, not law.

Firstly, the defendant to an action which is fought out to judgment is bound to lose financially. If judgment is given against him he will be liable to pay damages and costs to the plaintiff. If judgment is given against the plaintiff he will be ordered to pay the defendant's "party and party" costs, which will not be more than two thirds of the costs the defendant has to pay to his own solicitor (the "solicitor and own client" costs) and may be as little as half those costs. The plaintiff will also have a shortfall on costs but he may be able to make up that shortfall with his (tax free) damages if they are sufficiently substantial. Any judgment, whether for defendant or plaintiff, may remain unsatisfied in whole or in part if the loser of the action lacks the means to pay. The costs of a libel action will average up to about £1000 to £2000 per party a day (including expert's fees and general expenses) depending on the length and complexity of the case.

Secondly, a good claim or defence may be spoilt and a bad one made worse by the first letter written by or on behalf of a party. Before complaining about a defamation or before answering a letter of complaint specialist advice must be obtained.

Defamation is a word used to refer to both libel and slander. In general, libel consists of an actionable publication in writing or some other permanent form, and slander consists of actionable spoken words or gestures. But sound and television broadcasts and theatrical performances, if actionable, would be libel.

The object of both libel and slander actions is to redress injury to reputation. Words are defamatory if they tend to lower a person in the estimation of right thinking people. The reputation protected is not only moral reputation. In an action against the *BMJ* Lord Pearson said, "Words may be defamatory of a trader or businessman or professional man, though they do not impute any moral fault or defect of personal character. They can be defamatory of him if they impute lack of qualification, knowledge, skill, capacity, judgment or efficiency in the conduct of his trade or business or professional activity."¹ In the same case it was also stressed that it is perfectly possible for scientific and professional men to criticise each other's views, theories, and techniques even

in strong terms without saying anything capable of being construed as defamatory.

If words are defamatory and they are published to someone other than the complainant an action may be brought to complain of the publication subject to certain defences which may be available to the person who spoke or wrote the words. In allowing those defences the law seeks to strike a balance between freedom of speech and protection of the individual's reputation.

Mistakes and defamation

Not all damaging publications are defamatory. A mistaken publication of the obituary of a living doctor could have disastrous effects on his practice, but a false report of a man's death does not make the right thinking individual think less of him. Such a report would be actionable only if the elements required to make up the tort of malicious falsehood were present. Equally, not all offensive publications are defamatory. A doctor whose name has been used without his authority in an advertisement to puff the sale of a medicine has no cause of action based simply on the affront that his name has been used without authority.² But if the advertisement carried the false implication that the doctor had consented to the use of his name the innuendo that he was in breach of the ethical rules of his profession would be actionable.³

If a plaintiff can show publication of defamatory words in a form amounting to libel it is unnecessary for him to show more to get his action on foot. He does not have to prove that he has suffered any specific injury or that the defendant intended to defame him or even to refer to him, nor does he have to show that the defendant was malicious. Even the defendant who publishes defamatory written words with wholly innocent intent may be put to the burden of either apologising or defending himself with one of the standard defences.

Slander

But where the cause of action is slander, in respect of spoken words, the plaintiff must show more to bring his action. To succeed in a slander action a plaintiff must either prove special