

In deprived areas general practitioners need to work in the community with community health workers, benefits rights workers, health promotion officers, and housing officers to ameliorate the multifactorial problems caused by socioeconomic, educational, and health deprivation. Social policies aimed at a more equitable distribution of wealth—by empowering deprived people through educational and employment opportunities—are needed to reverse the dramatic widening of the health-wealth gap.⁵

The message is clear. To reverse the marginalisation of disadvantaged areas additional resources must be targeted in health, education, and employment if the targets of *The Health of the Nation* are to have any chance of being met. Disproportionately greater resources are needed to give deprived people an average chance of health.

JOY A MAIN
PAUL MAIN

Bristol BS13 0JP

- 1 Eames M, Ben-Shlomo Y, Marmot MG. Social deprivation and premature mortality: regional comparison across England. *BMJ* 1993;307:1097-102. (30 October.)
- 2 Main JA, Main PGN. Allocating resources to doctors in deprived areas. *BMJ* 1990;299:1528.
- 3 Main JA, Main PGN. *The health divide*. *BMJ* 1993;306:273.
- 4 Marsh GH, Channing DM. Narrowing of the health gap between a deprived and an endowed community. *BMJ* 1988;296:173-6.
- 5 Smith GD, Egger M. Socioeconomic differentials in wealth and health. *BMJ* 1993;307:1085-6.

Wealth redistribution has its price

EDITOR,—Margaret Eames and colleagues have added weight to widespread observations of a positive and progressive association between higher socioeconomic position and improved health.¹ It seems that more income, wealth, and education and higher status occupations are all correlated with less illness and a lower mortality, and such improvements continue right to the top of the social scale.² So far, there seems to be no limit to the ability of social advantage to add to health and life expectancy.²

It is time that we changed our way of conceptualizing socioeconomic inequalities in health. Instead of continually harping on deprivation as a cause of sickness—where deprivation is defined as a “comparative” concept with “no specific threshold”—perhaps it would be more reasonable to stop using the word deprivation when talking about some of the most privileged and prosperous people in the history of the world. Otherwise we are put into the absurd position of asserting that (to misquote Orwell) everybody is deprived, but some of us are more deprived than others.

We might consider the reciprocal view that, instead of deprivation causing sickness, advantage causes health. This is the salutogenic model of health as outlined by Antonovsky and elaborated by M P Kelly and myself.⁴ The salutogenic perspective highlights several points not mentioned anywhere in the 20 October issue of the *BMJ*.

For instance, one consequence of the finding that “premature mortality increases linearly with increasing deprivation”¹ is that a policy to produce “a reversal in the dramatic upwards redistribution in wealth”⁵ would surely damage the health of the higher social classes even as it improved the health of the lower social classes. This may, indeed, be a price worth paying; but we should not ignore the fact that there is a price to pay. Redistribution removes advantage at the same time as it addresses deprivation. Wealth redistribution would not give us something for nothing: there would be health losers as well as health gainers—a situation which would not promote the Utopian goal of “allowing everyone the opportunity of achieving the maximum health.”⁵ Neither can we assume that “one way of achieving national targets would be to reduce geographical and social variations.”¹

It is unhelpful to become fixated on “differen-

tials” and “inequalities” while downplaying the massive improvements in public health over the past decades. A more practical policy would be to concentrate on improving health wherever possible. “Everyone” will never achieve maximum health, and we should be careful not to throw away actual achievements in pursuit of unattainable ideals.

BRUCE G CHARLTON

Department of Epidemiology and Public Health,
University of Newcastle upon Tyne,
Newcastle upon Tyne NE2 4HH

- 1 Eames M, Ben-Shlomo Y, Marmot M. Social deprivation and premature mortality: regional comparison across England. *BMJ* 1993;307:1097-102. (30 October.)
- 2 Charlton BG. Is inequality bad for the national health? A reinterpretation of the evidence. *Lancet* (in press).
- 3 Antonovsky A. *Health, stress and coping*. San Francisco: Jossey Bass, 1985.
- 4 Kelly MP, Charlton BG. A scientific basis for health promotion: time for a new philosophy? *Br J Gen Pract* 1992;42:223-4.
- 5 Davey Smith G, Eggar M. Socioeconomic differentials in wealth and health. *BMJ* 1993;307:1085-6. (30 October.)

Disease registers valuable if geographically defined

EDITOR,—William F Kelly and colleagues’ analysis of data held on a hospital diabetes register illustrates the potential for using a chronic disease register to explore associations such as that between ill health and deprivation.¹ The authors analysed data relating to patients who attended a hospital diabetes centre during one year. The study, however, is flawed. The sample studied made up approximately 0.5% of the district’s population, with half of the sample being treated with insulin. Comparison with population based studies shows that the data refer to only a subset of people with diabetes in the district.²

Only with a geographically defined population register might it be possible to investigate the associations with deprivation that the authors describe. Results suggesting that diabetic patients from deprived wards were older and less likely to use insulin probably reflect nothing more than different patterns of care in general practice, with general practitioners in the least deprived wards caring for more of their older, non-insulin treated patients, who will consequently not be recorded as attending hospital. The presence of complications may be a factor in the decision to refer to hospital care, and this referral pattern may also vary among general practitioners in different areas.

The potential for research using disease registers is considerable but may be fully realised only when comprehensive, valid registers based on geographically defined populations are developed.

DAN KILLALEA
ALWYN DAVIS
GAIL HANSTOCK
JANE HANSON

Department of Public Health Medicine,
Dudley Health Authority,
Dudley DY1 2DD

- 1 Kelly WF, Mahmood R, Kelly MJ, Turner S, Elliot K. Influence of social deprivation on illness in diabetic patients. *BMJ* 1993;307:1115-6. (30 October.)
- 2 Neil AW, Gatling W, Mather HM, Thompson AV, Thorogood M, Fowler GH, et al. The Oxford community diabetes study: evidence for an increase in the prevalence of known diabetes in Great Britain. *Diabetic Med* 1987;4:539-43.

Clinical research in trust hospitals

Threatened by liability for negligence

EDITOR,—For many years our local ethics committee has accepted research proposals from NHS staff within the district on the grounds that, although the NHS had no formal indemnity for its staff who might cause injury through negligence

while undertaking research, an ex gratia payment would be most likely in the event of a claim being made.

We were aware that responsibility for such indemnity had been devolved, first to regions and then districts. We were also aware that Crown immunity had been withdrawn from hospitals. But the consequences had escaped us and they became clear only when our local trust refused to sign any agreements with external manufacturers, who were willing to cover non-negligent injury. Legal opinion had been sought and was to the effect that a trust, under its existing funding and rules of constitution, might not accept so great a liability for research, similar though it is to what happens in ordinary clinical practice.

Trusts therefore seem to have responsibility for something that they are neither funded for nor allowed to undertake—the provision of cover for negligent injury arising from research, whether alongside or outside ordinary clinical practice.

The entailments of this are now clear. As local research ethics committees cannot accept protocols without cover for both negligent and non-negligent injury, this means an effective end to clinical research of any kind which may incur risks of negligence within an NHS trust. And, when all the world’s a trust, that implies within the NHS as a whole.

The Department of Health was asked some time ago for guidance about this, but none has emerged in writing. We have been advised to buy insurance privately. The situation contrasts oddly with the brochure entitled *Research for Health*, published recently by the Department of Health.

D W VERE

Department of Pharmacology and Therapeutics,
London Hospital Medical College,
London E1 2AD

*We sent the above letter to the Department of Health for their response.

Pharmaceutical companies should indemnify trusts

EDITOR,—NHS bodies are not allowed to offer advance indemnity to subjects in research projects. This applies equally to directly managed units and NHS trusts. Any liability of the NHS is carried by the district health authority for directly managed units or by the NHS trust for patients participating in clinical studies in the same way as those NHS bodies carry liability for negligence arising out of normal clinical activity.

The Association of the British Pharmaceutical Industry and this department have agreed the terms of a standard form of indemnity for use in clinical trials sponsored by the pharmaceutical industry. This provides for the sponsoring company to indemnify the district health authority or trust against claims arising out of the administration of the product under investigation and associated procedures. The indemnity extends to employees of the health authority or trust but does not include an indemnity for their negligent actions. The department will be issuing guidance on the use of a clinical trial indemnity form in due course.

We are of course aware of more general concerns about the way risks arising from clinical negligence should be dealt with by NHS trusts. We have for that reason set up a joint departmental-NHS group (which includes representation from the royal colleges) to look at the possibility of establishing a mutual insurance scheme for clinical negligence claims and to consider how to manage risks and claims. We will certainly ensure that the specific concern raised by D W Vere is examined by the group.

J S METTERS

Department of Health,
London SW1A 2NS