Concerns with the differences in health status and the use of health services associated with the differences in socioeconomic status have been increasing in most European countries. Many reviews are concerned with action which can be taken to reduce health inequalities.

A recent review searched for studies from published and unpublished sources. However, of the 140 references none dates back to before 1969. Similarly a British report also only deals with more recent literature. Gepkens and Gunning-Schepers stated that they used Medline for their search. It is most unfortunate that so many researchers restrict their consideration to material listed in Medline or other computerised literature databases. These are incomplete as they only contain literature published since 1964. Proponents of structured literature reviews emphasise the deficiencies of the current methods of data retrieval and the need to do hand-based searches, but there is little reference to the need to review older literature. This is of particular importance in the reviews of the health effects of poverty and the means to counteract these.

Poverty and ill-health were more evident in the past. We neglect the consideration of the measures developed. For example, before the Second World War, much ill-health could be attributed to poor nutrition. Between the wars school meals and free milk were dispensed to help alleviate the problems of undernutrition. The need for these has gradually disappeared. However, we now have the problem of obesity, particularly amongst the poorer schoolgirls. There is little consideration of the need to provide properly balanced, nutritious, attractive school meals. Instead children are provided with access to sandwiches, crisps, chocolates and hamburgers - foods which are cheap to prepare.

Between the wars community services for pregnant mothers, babies and small children were developed through health visitors and other community outreach services. These helped to improve antenatal care and child care. After the Second World War, these services were further developed. Unfortunately few were formally evaluated. However, evidence accumulated that they were effective, particularly in inner-city deprived areas. Since the early 1970s the NHS has witnessed many reorganizations and continuing pressure for improving its efficiency. Advocates for these services were uniformly at a disadvantage, compared to those pressing for more acute services. So now abortion is common, family planning advice has been cut back and domiciliary preventive services are the Cinderella of health service provision.

Although we believe in 'evidence-based medicine and health' we tend to restrict this to studies based on randomised controlled trials and neglect other studies based on alternative models of evaluation. For public health this is unfortunate. Most of the measures that led to improvements in our health were based on policies developed after observational studies - e.g. clean water, safe unadulterated food and clean air policies. Randomised controlled trials may be essential for determining the effectiveness of some drugs, but, as Sir Austin Bradford Hill (the major advocate of these trials) taught, they are not always necessary or appropriate. This can be taken further - the need for 'interventional effectiveness' before a policy is introduced into a public health measure is spurious and unnecessary. For example, the Broad Street outbreak of cholera investigated by John Snow did not depend on the removal of the pump handle to demonstrate that the water supply was contaminated. As Bradford Hill and others showed, the epidemic was already on the wane before the pump handle was removed.

To correct social and environmental inequalities measures need to be taken in employment, housing, education, etc., which are far more expensive - and are the underlying causes of ill-health - rather than spending money on health services. Thus, to spend money on health services is merely to provide a sticking-plaster to correct inequalities in health. This was recognised by the Resource Allocation Working Party which developed a method for the equitable distribution of finance for health services.

Thus, there are 3 major problems with recent publications.

- Restrictions to the literature published and referenced in computerised databases, which have only existed for the past 30 years, thus neglecting the examination and promotion of services which were effective in earlier years.
- Restriction of the proposals for the introduction of services to correct inequalities in health to those that satisfy criteria appropriate for the assessment of drugs, technology, etc., but impossible to satisfy in public...
health programmes which are based on changes of the environment by, for example, legislation, taxation or behavioural incentives.

- The problems of influencing inequalities in health when the major determinant is poverty. Although there has been an undoubted improvement in the health of all socioeconomic groups, nonetheless, the proportional gap, between the poorest and wealthiest, has not diminished much. Although structural changes to society, e.g. communism, have failed and the provisions of monetary benefits to individuals considered to be poor is used in most of the developed countries, we have not continued to provide the additional services which were used in the past to alleviate the problems of the poor. In our attempt to cope with both the problems of cost-containment as well as evidence-based practice we have usually 'thrown the baby out with the bath water'.

REFERENCES


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A reply

LOUISE J. GUNNING-SCHEPERS, ANNEMIEK GEPKENS

We would like to thank Professor Holland for his comments on our paper and we quite agree with most of his points. It is true that by restricting literature searches to computerized databases one might miss valuable older publications. We also quite agree that RCTs (randomized controlled trials) or other experimental designs may not be the best suited evaluation mode for some of the possible interventions that might help to reduce social inequalities in health. This is true for example for interventions that require legislation or structural financial measures such as taxation or benefit schemes. This does, however, not necessarily apply to some of the health promotion interventions. We did not limit our search to RCTs though, but we have to admit that outside RCTs the designs of the evaluation studies were often less rigorous than we could have hoped. They are often observational rather than experimental designs, controls may be missing completely and very often no attempt is made to control for autonomous trends or time intervals. More structural measures are seldom evaluated in terms of health benefits, let alone health differentials. To reduce social inequalities requires probably quite powerful interventions. To show a beneficial effect in the lower social groups is not sufficient evidence for such a reduction, which does not mean it is an unimportant public health intervention. Policy makers should be aware of the formidable task they take on when they announce policies to reduce inequalities. At the same time one would not wish to discourage such policy actions. With our review we hoped at least to show what has been done and encourage those who are involved in programmes aimed at the reduction of inequalities to evaluate their efforts so that others may benefit from their experience. Although we may not be able to base all of our decisions on scientific evidence, it is wise to spend scarce resources as rationally as possible, especially in an area in which political views may differ so strongly.

Finally, we quite agree with Professor Holland that one need not to wait for a controlled experiment in order to continue a long-standing public health tradition to support policies combatting the consequences of poverty. In this area we may find more differences between European countries than we realize. The current debates on the future of the welfare state seldom involve public health professionals, and we may be so concerned with our own problems in dealing with scarce resources for health care that insufficient attention is paid to some of the policy changes occurring in the broader field of social health determinants. Each of those measures may individually seem quite trivial, but the cumulation of the effects in some groups in our population may well threaten their health in a way we should not tolerate.

We hope that our article and this exchange will start a long series of publication in the European Journal of Public Health reporting on the evaluation of interventions to reduce inequalities in health.

REFERENCES