attributable to differences in these potential confounding variables. Although we were unable to present the numerical results of these analyses because of space constraints, we do refer to them in the paper.

Although we were concerned about the impact of the low response rate and our chosen comparison population on the interpretation of our data we, like Dr Mindell, were sufficiently convinced by the results to believe that they were worthy of public health concern. What exactly should be done about them, however, needs careful thought and debate. We were struck by the poor mental health of students and the potential implications of this for public health, and therefore made this the focus of our discussion. Dr Mindell suggests that a reinstatement of student grants would solve the problem and, as we indicated in our paper, such action might help. However, we consider it unlikely that this is either the only or the most important solution. There are other approaches to mental health promotion, at present being implemented by some health-promoting universities, which are potentially as valuable and arguably more likely to succeed.

Yours faithfully,

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On health inequality

Sirs,

In his paper on inequalities Oliver\(^1\) highlights the limitations of the evidence base for effective interventions. Social policy measures are often suggested as remedies for inequalities, but these may have to be implemented over lengthy periods and are not usually subject to the sorts of tests of efficacy that are recommended in clinical practice. Furthermore, they are often blunt tools aimed at communities where the genesis and manifestations of inequality, and its associations, for example 'deprivation', are incompletely understood. An improved understanding of inequality is required, based on a new approach to the analysis of public health problems.

Such a new approach could be fostered by two measures. First, public health analysts should be drawn from the communities experiencing inequality. This would provide a coterie of individuals with experience of the health issues in question. Such people would be a valuable repository of intuition relative to the interpretation of problems and possible solutions. Second, analytical processes would be assisted by a greater integration of the behavioural sciences into discussions of causation, effects and ‘treatments’. Such disciplines make useful contributions to the questions of how and why ill health affects communities. However, their contributions to the analytical processes would need to take place at levels of population much smaller than the typical English health authority to allow the necessary fine-tuning of analysis to remedies.

Reference


Yours faithfully,

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Reply

Sirs,

I agree with Donald Coid’s comments on my article ‘On health inequality’\(^1\) in that social policies are often recommended as remedies for alleviating health inequalities without any clear evidence that they work. This is not to say that such social policies are necessarily undesirable. Some argue that waiting for evidence to be collected on all policy measures would lead to an excessively conservative attitude towards alleviating health inequalities. Davey Smith et al.\(^2\) argue that much of the social reform implemented at the beginning of the nineteenth century (e.g. banning young children from working in cotton mills and reducing the number of hours children could work to 10 per day) was introduced without any strong supporting evidence that they would reduce health inequalities.

However, I cannot help thinking that those who call for evidence which shows that policies are effective in reducing health inequalities, and those who claim that this is an excessively conservative attitude, are addressing two different questions. If we as a society accept that prevailing health inequalities are unjust, we should want to reduce very specifically those inequalities. Given that we have limited resources to devote towards health policy generally, we should attempt to ensure that the policies that we implement to address health inequalities are effective (and indeed cost effective). This necessitates the collection of the likely effects of the policy, as without collecting this evidence, a more effective policy may be ignored or replaced. Macintyre et al.\(^3\) list a number of well intentioned and seemingly logical policy recommendations that, when evidence was collected, were found to do more harm than good. Petticrew and Macintyre\(^4\) have recently written a paper that aims to review the available evidence on the effectiveness and cost-effectiveness of addressing health inequalities. They conclude that there is very little available evidence, but that there are signs that more evidence will soon be forthcoming.