

## Guest editorial

### Are we sufficiently aware of poverty?

When I received the invitation to write this guest editorial, it seemed reasonable to look back at its predecessors to see if there was any particular aspect of injury prevention which had somehow not been given the prominence I felt it deserved. One such—and one that we are all aware of—is the socioeconomic background of the families and the children who are injured. Incidentally, this is a facet which has concerned me for many years. Nearly 50 years ago I was a research worker on the 1000 Family Study in Newcastle upon Tyne,<sup>1</sup> and part of my role was to visit the houses of the families. One family of parents and four children lived in a two roomed upstairs flat. The stairway to it was in total darkness, and two of the stairs were missing so that the health visitor and I had to crawl up on hands and knees to avoid falling through to the ground floor. The fireplace in the living room-cum-kitchen had fallen out and had been put back up on bricks. The window was so rotten that of the four places for glass, only one had glass, two were covered with brown paper and one was permanently open to the air. The bedroom window was the same, and the outside wall bulged out so that I could put my arm through the gap between the party wall and the outer wall from one room to the other. Such were the living conditions of one of our survey families in Newcastle in 1948, and many were almost as bad, and yet the baby was kept injury free by his mother, and because he lived permanently in fresh air he was reasonably free from respiratory infections as well. It is not surprising that these visits have remained indelibly imprinted on my mind.

Studies on the inter-relationship of social conditions with health go back a long way—over 150 years ago Chadwick looked at the social background of labourers,<sup>2</sup> but in recent years in the UK the main stimulus was the Black report of 1982, *Inequalities in Health*.<sup>3</sup> Although it had been commissioned by the government of the day, the demonstration of the inverse relationship of poverty and deprivation with health was something that did not please those politicians. An attempt was made to play down the importance of the report by arranging for only 260 duplicated copies to be made available, and major organisations in the National Health Service, including health authorities, did not receive copies. Fortunately, there was a strong backlash to this, and in due course considerably more publicity was generated than would have occurred if the down playing of the report had not taken place.

In the Black report, due prominence is given to the social background of children's accidents. 'Among 1-14 year-olds, and this we wish to stress, almost all the differences in mortality between occupational classes I (professional) and V (unskilled manual) are due to accidents, respiratory disease, and to a much lesser extent congenital abnormality' and 'while the death of an individual child (from an accident) may appear as a random misfortune, the overall distribution clearly indicates the social nature of the phenomenon'. Many of the conclusions are still pertinent today: ...'the only reliable long-term answer is to give children safe areas in which to play'—a conclusion supported 10 years later by Sharples *et al*,<sup>4</sup> and 'Moreover, if there is a need to step up safety education it is the motorists, especially young drivers, who should be the target'.

Since the Black report there has been no let-up in publications in the UK about health and socioeconomic factors. The development of indices of deprivation such as the Townsend score which takes into account unemployment, car ownership, home ownership and overcrowding,<sup>5</sup> have proved valuable in examining the relationship more clearly than was possible with the use of the Registrar General's occupational classification which, over the course of time came to include a significant number of uncategorised unoccupied people including single parents<sup>6</sup> whose children have been shown to have injury rates that are twice those of children in two parent families.<sup>7</sup> Poverty *per se* is also indicated as being related to life expectancy by Wilkinson.<sup>8</sup> The importance of the socioeconomic background in relation to injury prevention is of course recognised internationally: Klein in the USA pointed out its importance as far back as 1981.<sup>9</sup>

What is now of importance is the fact that the inequality between the better off families and the poorer ones in the UK and doubtless elsewhere, is increasing rather than decreasing. Wilkinson, in the first of a series of articles examining factors that affect the relation between deprivation and health, points out that mortality in developed countries is affected more by relative than absolute living standards.<sup>10</sup> It is interesting to note that countries that have smaller income differences and thus lower levels of relative deprivation, tend to have lower national mortality rates. In a leading article introducing this series Haines and Smith present the grotesque fact that the net worth of the world's 358 richest individuals is equal to the combined income of the poorest 45% of the world's population—2.3 billion people.<sup>11</sup>

How is this reflected in child injury mortality rates? Roberts and Power have shown that although these rates have fallen in all social classes between 1981 and 1991, the decline in social classes IV and V (21% and 2% respectively) has been much smaller than for social classes I and II (32% and 37%).<sup>12</sup> Thus the socioeconomic mortality differential noted by Black has continued to increase during this period.

What can be done? In 1993 an important seminar was held in London on 'Tackling inequalities in health—an agenda for action'. The report, with some additions, was published by Benzeval, Judge, and Whitehead in 1995.<sup>13</sup> Initiatives which would have a positive influence at four degrees of proximity to the individual were put forward by Whitehead: strengthening individuals, strengthening communities, improving access to essential facilities and services, and encouraging macroeconomic and cultural change. (Some of these were touched on in an editorial in a previous issue.) The report was drawn up with the forthcoming general election in mind, and is in accordance with the general tenet that health is not merely a matter of curing illness, but of establishing a healthy environment and ensuring that people can lead satisfying and happy lives.

It has been commented on and for the life of me I cannot remember by whom—that 'the Chancellor of the Exchequer has more effect upon the country's health than does the Minister for Health, and that neither of them recognise it'.

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However, the newly elected government is rightly taking this broad view of health by appointing, for the first time, a Minister for Public Health, and one of her first actions has been to appoint Sir Donald Acheson, who chaired the inequalities in health seminar in 1993, to examine how and to what extent the Black report can be implemented. Evidence relating to the socioeconomic background to children's accidents has already been presented to Acheson's group by Ian Roberts and by Carol Sherriff, the Director of the Child Accident Prevention Trust. If the inequalities can indeed be reduced, we should see a major reduction in the child injury rate—an achievement equivalent in lives saved to the discovery of polio vaccine.

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## ISCAIP report

# Injuries in less industrialised countries: what do we know?

One of the serious problems faced by most of the researchers in the less industrialised countries (LICs) is the non-availability of reliable injury and health statistics. Priorities for injury control have to be based on intelligent assessments of official statistics and on specific epidemiological studies conducted by researchers in hospitals and research institutions. In this context we welcomed the publication of *The Global Burden of Disease*.<sup>1</sup> This publication, and the accompanying volume *Global Health Statistics*,<sup>2</sup> are the result of a worldwide collaboration of over a 100 researchers, sponsored by the World Bank and the World Health Organisation and based at the Harvard School of Public Health. These publications quantify the burdens of 483 sequelae of 109 major causes of death and disability (including injury) disaggregated by eight geographic regions and 10 age sex groups. Because such information is not available locally, I decided to base this column on data from these two sources.

A distribution of deaths as a percentage of the regional total is given in table 1.<sup>1</sup> These data indicate that injuries as a cause of death have the lowest proportion in the highly industrialised countries (HICs). These countries are designated as established market economies in the table. The proportions of estimated deaths due to injuries in sub-Saharan countries, Latin American, and China are almost double that in countries with established market economies. What surprised me is that the rate in India (8.6) is relatively much lower than those in the other LICs. Therefore, I decided to compare the years of life lost due to injuries for different age groups. Table 2 has been adapted from data contained in *Global Health Statistics*.<sup>2</sup> These statistics indicate that the proportion of years of life lost due to injuries for all ages in India (11) is almost half that in China (20) and that the statistics for countries with established market economies lies between the two. When we look at estimates for the proportion of years of life lost due to injuries in the age group 15–59 years, we find that India has the lowest proportion and the rest of the regions are quite similar.

None of these statistics made sense to me. Why should India be so different? Why should these estimates make the

Chinese rates look so high? I had no theoretical answers to these questions. So I decided to look at the sources of data and the methodology used to arrive at these estimates. This was not easy as the details of all sources are not given and data for all countries, except China and India, are clubbed into regions. However, the estimates for road accident fatalities for India and China provided the answer: the methods used to arrive at these estimates are based on highly questionable procedures.

Tables 210c and 210d in *Global Health Statistics* show that in 1990 India and China had 174 000 and 135 000 road traffic accident fatalities, respectively. But official statistics report 54 058 fatalities in India and 49 243 in

Table 1 Distribution of deaths as a percentage of regional total<sup>1</sup>

	Group I	Group II	Group III
Established market economies	6.4	87.4	6.3
Formerly socialist economies of			
Europe	5.6	84.1	10.3
India	50.9	40.4	8.6
China	15.8	72.7	11.5
Other Asia and islands	39.6	50.3	10.1
Sub-Saharan Africa	64.8	22.7	12.5
Latin America and Caribbean	31.3	55.7	12.9
Middle Eastern crescent	42.7	47.4	9.9
World	34.2	55.8	10.1
Developed	6.1	86.2	7.6
Developing	41.9	47.4	10.7

Notes: group I: communicable, maternal, perinatal, and nutritional conditions; group II: non-communicable diseases; group III: injuries.

Table 2 Percentage of total years of life lost due to injuries in different regions, 1990<sup>2</sup>

	15–59 years	All ages
Established market economies	29	16
Formerly socialist economies of Europe	36	23
India	23	11
China	31	20
Other Asia and islands	27	14
Sub-Saharan Africa	33	14
Latin America and Caribbean	34	19
Middle Eastern crescent	31	13