Professor Marmot's lectures in Australia chart extent of health inequality

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The establishment media invariably reports social crises, human disasters or crimes by focussing on the individuals involved, often with howls of condemnation branding them as responsible. Well-heeled news anchors and media owners generally ignore or deny any relationship between such events and the deteriorating conditions of life of broad layers of people.

Therefore four lectures delivered by Professor Sir Michael Marmot in Sydney during September provided a refreshing antidote to these prevailing winds. Ill health, quality of life and life expectancy are directly related to socio-economic status. Marmot's lectures, *Fair Australia: Social Justice and the Health Gap*, presented a wealth of data charting health inequality and its underlying social causes.

As an epidemiologist for 40 years, president of the World Medical Association, director of the University College London's Institute of Health Equity and author of *The Health Gap—The Challenge of an Unequal World*, Marmot was well qualified to present the annual Boyer lectures, commissioned by the Australian Broadcasting Corporation (ABC).

He presented critical statistics that establish the clear connection between social inequality, its impact on the living and working conditions of the poor, and the subsequent deterioration in their health outcomes.

In *The Health Gap*, Marmot documented "a remarkable gradient in health and life expectancy: the higher the grade of employment the longer the life and the healthier the life." This "social gradient" showed that: "People in the middle of the hierarchy have worse health than those above them and better than those lower than them. It is as true in supposedly egalitarian Australia as it is in class-bound England."

Marmot's book, which explained how his research originated from his experience as a medical student at Sydney's Royal Prince Alfred Hospital, noted that "in Australia ... we see a clear gradient: the fewer the years of education, the higher the risk of death. Men and women in their 40s with fewer than 12 years of education, have 70 percent higher mortality risk than the most educated."

In an interview with the ABC, Marmot explained that "his key insight is that health is not simply a matter of lifestyle, or access to healthcare, but is instead related to the inequality of economic and social conditions that affect all of us."

He continued: "There is a tendency to see health inequalities as confined to the shockingly poor health of indigenous Australians. There is a life expectancy gap of 14 years between indigenous and non-indigenous men and women. But in Australia's general population, as elsewhere, the more years of education or the higher the income, the better the health. Health inequalities arise from inequalities in the conditions in which people are born, grow, live, work and age; and inequities in power, money and resources—the social determinants of health."

Marmot began his first lecture, *Health Inequality: The Causes of the Causes,* with a question: "What good does it do to treat people and send them back to the conditions that made them sick?" Answering the question, he turned to a riot that erupted in 2015 in the US city of Baltimore following the killing of a black man in police custody.

In an earlier period, Marmot had studied the social conditions in Baltimore. He explained that not all areas of Baltimore participated in the protests, only the poorer areas, because while the trigger was yet another police murder, in fact "the underlying cause of the riot was inequality of social and economic conditions."

The poorer areas of Baltimore where the unrest erupted had an average male life expectancy of 63 years—equal to that of Ethiopia and two years less than the average in India. By contrast, a male living in the richest area of Baltimore could expect to live to 83 years and, in those extra 20 years, would experience a far higher quality of life.

Marmot's research found startling divergences in Baltimore. In 2010, a poor suburb, Upton Druid, recorded median family income of $17,000; in Roland Park, a wealthy suburb, it was $90,000. In Upton Druid, half the households were single-parent families, but only 7 percent were in Roland Park. Of the children in Upton Druid, 90 percent did not progress to college, compared to 25 percent in Roland Park, and the disparity continued in every aspect of living conditions.

Remarkably similar results could be found in every major city of any country in the world, including Australia.

In the second lecture, *Give Every Child the Best Start,* Marmot examined the impact of poverty and deprivation on the intellectual, physical and psychological development of children. He noted a stark contrast in Australia. The suicide rate of Aboriginal children aged 15–19 is four times higher in boys and six times higher in girls than in the same non-indigenous age group. But, he explained, the situation facing Aboriginal people is only the sharpest example of inequality in the entire population.

The lecture highlighted how poverty directly impacts on the nature and quality of parenting and therefore the health and intellectual outcomes of children. "We have been monitoring early child development in Britain and find that the more economically deprived a neighbourhood is, the lower the proportion of children, at age 5, that have a good level of development: cognitive, linguistic, social, emotional and behavioural."

Around 20 percent of mothers did not understand the significance of talking, reading and cuddling their children, and the lower the household income, the higher the incidence of this trend.

Marmot outlined the results of a San Diego study that measured the impact on children of adverse experiences in their first 18 years of life. “The more different types of adverse experience a person had, the greater the risk of depression and attempted suicide. People who had four or more different types of adverse childhood experience had nearly five times the risk of having spent two or more weeks in depressed mood the previous year, and twelve times the risk of having attempted suicide…

“Further, the more adverse experiences, the higher the risk of diabetes, of chronic obstructive pulmonary disease (bronchitis or emphysema), stroke and heart disease.”

Child poverty—children living in households with less than 50 percent of median national income—is widespread. The child poverty rate in the US was 25 percent. In Australia it was 28 percent. After taxes and transfers, which take into account welfare benefits, the US rate reduced slightly to 23 percent, in Australia it was 11 percent. Nevertheless, Australia ranked 16th in the world for child poverty, behind countries such as South Korea and Slovenia.

Health and low-paid, insecure jobs

The third lecture, *Living and Working*, recorded negative impacts on health among workers in low-paid, insecure or casualised and menial jobs—characterised by “high demand/low control, effort reward imbalance, low organisational justice, social isolation, shift work and job insecurity.”

Jobs which imposed a combination of high demand and low control increased the risk of mental illness and coronary heart disease by about 50 percent. Marmot highlighted the “zero hours contract”—an “extreme form of casualised labour” with no guarantee of any hours of work—which is common in the US and UK but also exists in Australia.

Increasingly large proportions of the population in most countries work in low-paid menial jobs, which do not pay enough to provide a family with accommodation, nutrition, clothing, health and education. This impacts heavily on the health of the entire family.

Half the UK households below the minimum income threshold had at least one adult in paid work. In other words, these households were the working poor. In Australia, the proportion was one fifth. In the US, the bottom half of households in paid work had no increase in their income levels in three decades.

Among these social layers, the most sharply negative health indicators were in the US, where the mortality rate of non-Hispanic, white men increased over the past 20 years. The causes for this rise were “one, poisonings due to drugs and alcohol; two, suicide; three, chronic liver disease which is alcohol related; and then there were external causes of death, violence.”

Unemployment also has a major impact on health. David Stuckler from Oxford University compiled data showing that a rise in a country’s unemployment figures correlated with a rise in the level of suicides. In the wake of the 2008 global financial crash, the International Labor Organisation estimated that in 2013, 200 million people were unemployed. Young people were most affected—50 percent in Greece, 43 percent in Spain, and 37 percent in Italy.

Marmot noted: “After the global financial crisis, as the recovery began, for every dollar of economic growth, 92 cents went to the top 1 percent.” The “recovery” was felt only in the very richest, elite layers of society. For the remainder, the conditions of life have deteriorated dramatically since 2008.

The social crisis facing broader layers of the population is set to worsen. The future facing young people is increasingly one of part-time or casual work, low wages, under-employment and unemployment. Hence this generation will be the first whose standard of living and health outcomes will be worse than those of their parent’s generation.

The fourth and final lecture, *Social Justice and Health—Making a Difference*, again began with a question:

“What do Tanzania, Paraguay, Latvia and the top 25 earning hedge fund managers in the US have in common? The answer is that the 48 million people of Tanzania, the 7 million people of Paraguay, the 2 million people of Latvia and the top 25 hedge fund managers each have an annual income of between $US21 and $28 billion.”

Marmot raised the obvious solution—the redistribution of some of the obscene wealth of the top 25 hedge fund managers to the poor in Tanzania, Paraguay and Latvia. Or, in the unlikely event they paid a third of their incomes in tax, this would pay the salaries of 80,000 New York teachers.

The data Marmot has amassed, painstakingly and scientifically, details how the social conditions of life that people confront determine not just *their* physical, mental and social health, but those of their children and grandchildren.

The promotion of his work, both in Australia and internationally, contains an implicit warning to the ruling elite. Unless the widening social chasm that has characterised political and economic life over the past 25 years is halted, the result will be widespread social unrest.

Marmot presents his work in the vain hope that the evidence should, by its sheer volume and substance, convince governments, corporations, communities and individuals to band together to overcome the plight facing increasingly broad sections of the world’s populations. The opposite is in fact the case. The conditions he documents, far from diminishing, are worsening, and engulfing greater numbers of people.

There is a glaring contradiction, however, in Marmot’s argument. He presents statistics which prove that the problems are social, not the result of individuals’ poor behaviour, but of the social conditions in which they live. His perspective, however, is that individuals, including in the governments or businesses that preside over and benefit from social inequality, can be convinced to transform society.

In reality, Marmot’s data amount to a searing indictment of the capitalist system that produced them. The solution is not an appeal to the very ruling elites who have created these conditions, but capitalism’s replacement with a society where production is organised for the benefit of all and not the profits of the super wealthy—in other words, socialism.