Years apart

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Michael Marmot

THE HEALTH GAP
The challenge of an unequal world
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We live in an age that fetishizes the idea that health is personal. Marketers sell us devices that track the steps we take each day, the calories we consume, the hours and quality of our sleep, as if each tiny variation were something fascinating and revealing of our true selves. The NHS has recently embraced "genomics", a form of personalized medicine that tailors cancer treatment to genes. Likewise, "nutrigenomics" is a new fad devoted to matching the foods we eat to our particular genetic make-up. What all of these trends imply is that each person's health is something special and unique, an expression of individuality. Sir Michael Marmot, a professor of public health at UCL, sees things very differently. He does not deny the importance of individual genetic variation. But for Marmot, the overall state of your health says less about your DNA, or your inner being, and more about the society you happen to find yourself living in, and your status within it.

Meet Jimmy, a resident of Calton in Glasgow. Jimmy's family environment was unstable – his mother had a succession of partners, some of whom abused him – and he was often in trouble at school. He failed to stick at an apprenticeship and has never had a full-time job. Jimmy drinks too much, takes drugs and his diet consists mainly of fast food and alcohol. He does not eat his five-a-day. When drunk, he beats up his girlfriends; the relationships don't last long. The police have questioned him on several occasions, for gang-related violence. Jimmy's health prospects, needless to say, are poor.

There are various ways we could think about Jimmy's health. The conventional view from one side of the political spectrum might say that he is an irresponsible person who needs to take charge of his life. Jimmy should smarten up his act, eat some greens, stop being so vile to women, quit brawling and boozing, get a job. All good plans – but how do you get Jimmy to follow any of them? A conventional view from another side of the spectrum might suggest

are the *causes* of avoidable ill health – poor diet, smoking, pollution, stress, risky behaviours and so on – and by implication the environmental factors behind those causes. The "causes of the causes" – as Marmot and his public health colleagues refer to them – include absolute poverty. If the people of Calton had more money "their lives would change". But Marmot also argues – through numerous telling examples and statistics – that, above a certain level of income (around $10,000 a year), what matters even more for health is inequality and the "nature of society". Calton, as Marmot describes it, is a place where people feel ground down and disempowered, where the few green spaces are colonized by prostitutes and drug users, where residents feel too scared to let their children play outside. Jimmy may not sound like someone you would want to spend time with, but he comes from a place where it would be hard for anyone to feel good about themselves.

As a young doctor, Marmot worked at a hospital in Sydney. He was struck by the absurdity of treating people with a "bottle of white mixture" and sending them back "to the conditions that made them sick". Many of those he saw were poor immigrants from Greece and Yugoslavia. One woman arrived at the clinic complaining of crying, having no energy, not sleeping, feeling suicidal. She also mentioned that her husband was drinking again and beat-

gathering further examples of patterns in the social causes of ill health. Many of them, as with the Calton example, are jaw-dropping, and force the reader, whatever his or her political persuasion, to question many of our unthinking assumptions about health. "I hear people talk about investing in health when they mean investing in health care", writes Marmot. Yet the United States, which spends 17 per cent of its gross domestic product on health care, more than any other country, ranks fiftieth in the world for the chances of a fifteen-year-old boy surviving to sixty. Out of 1,800 American fifteen-year-old girls, one will die in childbirth. This may be better than in Sierra Leone (where the figure is one in twenty-one) but Marmot notes that it is significantly worse than in Italy, at one in 17,100. Marmot shows that this is not just because of the well-documented flaws in the American health care system itself (including the unjustifiably high cost of health insurance and the fact that even post Obamacare so many citizens still have no cover at all). It is also because of inequalities in society itself.

"Lack of health care is no more a cause of ill-health than aspirin deficiency is the cause of headache", writes Marmot. In 2013, the National Academy of Science compared health in the US with that of sixteen high-income countries. The report found that despite its high spending on health care, the US ranked close to bottom for nine health measures including drug-related mortality, obesity and diabetes, injuries, homicide and heart disease. The authors suggested that the reasons the US had such poor health, relative to its wealth, were its high rates of poverty and income inequality, low social mobility, declining educational performance and scanty safety nets for those who suffer setbacks. Lack of

Take obesity. In the public debate, obesity is often seen as a question of personal responsibility or willpower. Marmot was at a conference where an economist gave a lecture on rational choice theory as applied to obesity. The economist was asked why he himself was obese. "His response was because I choose to be. I have to say: I doubt it." In Marmot's analysis, to treat obesity purely as a form of personal choice is to ignore the vast patterns of a changing food supply in which some countries are so much more obese than others. Are we to suppose that "more and more Americans choose to be obese" and that relatively fewer French people are choosing to be obese? Or is something else going on? In Mexico and Egypt, where sugary sodas are a way of life, 70 per cent of women are now overweight. "Increases in obesity such as these have to be 'nurture', not 'nature'", concludes Marmot. Instead of telling us – yet again – that we should eat less sugar, governments should work towards creating an environment in which it is easier for us to.

If ill health is largely a product of how societies organize themselves, the great hope is that they can be organized differently. In response to the "familiar coda" at the end of scientific papers that *more research is needed*, Marmot declares that "more action is needed". What makes *The Health Gap* so powerful is the way Marmot marshals data to show that both "health and inequalities" can change rapidly with the right interventions. Despite the often shocking state of health across the world – from hunger and pollution in the developing world to obesity and heart disease in the affluent West – he remains "unreasonably optimistic" that "things can improve".

One of the greatest health remedies is education. In demographic surveys of low-income countries, women are sometimes asked if they agree that it is acceptable for a husband to beat his wife if she refuses to have sex with him. As of 2011, 48.9 per cent of women in Ethiopia with no education agreed

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What interests Marmot is that there happen to be so many Jimmies in one particular neighbourhood of Glasgow. "If a man dies in Calton . . . it may be a tragedy, but it's not a surprise." In 2008, the author published data on Calton as part of the report he chaired for the World Health Organization entitled *Closing the Gap in a Generation: Health equity through action on the social determinants of health*. As of 1998–2000, life expectancy for men in Calton was a mere fifty-four – eight years less than the overall figure for men in India – whereas in the genteel area of Lenzie, just a few kilometres away, men could expect to live to eighty-two. This twenty-eight-year gap is the biggest Marmot has been able to uncover anywhere within a single city. It has since fallen a little, to a twenty-year gap, which is, notes Marmot, still "ridiculously large . . . . Twenty years is the gap in life expectancy between women in India and women in the USA".

The argument of this eye-opening and vitally important book is that the health enjoyed by different people is only minimally a question of "health care". What is far more critical than treatment, in Marmot's analysis,

pital in Sydney. He was struck by the absurdity of treating people with a "bottle of white mixture" and sending them back "to the conditions that made them sick". Many of those he saw were poor immigrants from Greece and Yugoslavia. One woman arrived at the clinic complaining of crying, having no energy, not sleeping, feeling suicidal. She also mentioned that her husband was drinking again and beating her, that her son was in prison and her teenage daughter was pregnant. Marmot's boss, the psychiatrist in charge, told her "to stop taking the blue pills and try these red pills". Marmot felt how futile it was to offer such temporary remedies rather than do anything about the problems that had made her – understandably – depressed.

Marmot abandoned clinical medicine and went on to do a PhD at Berkeley in 1975 on the differences in health between Japanese-Americans and Japanese people in Japan. "As Japanese migrate across the Pacific, their rate of heart disease goes up." Marmot set himself the task of studying how "Americanisation leads to heart disease". What he discovered went against conventional wisdom on diet and health. As expected, he found that Japanese-Americans in California were "taller, fatter and more partial to hamburgers" than their equivalents in Japan. Yet, exposed to the same environment, they still had lower rates of heart disease than US-born Americans. Marmot's hypothesis was that "the cohesive nature of Japanese culture was a powerful mechanism for reducing stress", which in turn reduced rates of heart disease. Even when they were eating American food and smoking American cigarettes, these Japanese-Americans had close-knit social relations that protected them somewhat from ill health.

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In a state of poverty and social disadvantage, it is far harder to make the good "choices" about our health that governments and doctors so strenuously advise. Some of the sharpest passages of Marmot's book concern the absurd mismatch between official health advice and the realities of the environments in which so much ill health is spawned. When we are advised to keep physically active, to manage our stress or follow a balanced diet, Marmot suggests, the science is sound enough, but we might as well be told to avoid living in a deprived area, to make sure we are not disabled and to ensure we don't take on stressful, poorly paid work. "People cannot take responsibility if they cannot control what happens to them." As many as a third of cancers may be preventable through improved diet, but Marmot claims he has never once met a patient "who lost weight because the doctor told her so". This sounds like an exaggeration; it is not hard to find examples of patients losing weight on medical advice in the short term, for an operation, say. Marmot's broader point stands, however: most avoidable ill health cannot be reduced to poor choices, as if it were something rational, to be cured by better information. He calls this a "grim mockery" because "people have no control over where they are born".

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One of the greatest health remedies is education. In demographic surveys of low-income countries, women are sometimes asked if they agree that it is acceptable for a husband to beat his wife if she refuses to have sex with him. As of 2011, 48.9 per cent of women in Ethiopia with no education agreed it was acceptable. But this fell to 32.8 per cent among women with primary education; and just 11 per cent among those with secondary or higher education. Women's education is also dramatically linked to lower birth rates and, still more starkly, infant mortality rates. In countries such as Mozambique, Marmot writes, the "mother's education is a much stronger predictor of infant mortality than is household income or wealth". The differences are not small. In Mozambique, 140 babies out of every 1,000 die among uneducated mothers; but just sixty out of every 1,000 whose mothers have secondary education. You might think that lack of education here is just a proxy for poverty: the poorest households are less likely to educate daughters, even when schooling is free (whether because of the cost of uniform or the belief that a girl's time should be spent working at home). But Marmot notes that female education still trumps income when it comes to lowering infant mortality. The reason, he suggests, is that educated mothers, whatever their income, understand more about nutrition and sanitation and how to protect their children.

Much of *The Health Gap* describes people living lives of grotesque horror, such as Lalta, a scavenger in India, whose job was once to clean human excrement out of latrines by hand and carry it in a basket on her head to a dumping ground. Lalta's life has been transformed

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by an NGO called Sulabh International which installed low-cost toilets in villages and retrained the scavengers as beauticians, pickle-makers or small-scale entrepreneurs. In cases of such extreme deprivation, it is hardly surprising that improving social conditions would result in better health.

The more surprising and telling aspect of Marmot's argument is that the social gradient affects health even much higher up the scale. It is not just that the worst off in society have worse health than the richest: in a state of what Marmot calls "bone-grinding poverty" it is impossible to enjoy good health. The real surprise is that *everyone* below the very top has worse health prospects. A just society, he suggests, would focus on reducing health inequities for everyone, not just those at the very bottom.

Although punchily written on the whole, *The Health Gap* sometimes suffers from a slight sloppiness of style. Marmot seems so keen to press home his points that he does not always notice when he is repeating himself. A paragraph describing Jimmy from Calton on page 25 is duplicated almost verbatim on page 81. Sometimes, the book feels too insiderish, with Marmot spending too long describing people congratulating him for his work, or digressing on the internal politics of the world of high level international public health (such as a long anecdote about having coffee in Japan with a Hungarian colleague and hearing about the affairs and rows that were stalling the progress of some important research).

Yet none of this detracts from the urgency and weight of Marmot's central thesis. He leaves the reader with a sense of the gross injustice of a world where health outcomes are so unevenly distributed. Again and again, he gives the lie to the notion that poor health is personal, or just a question of luck. One of his many startling diagrams is entitled "The Minister of Finance Could Reduce Child Poverty if She Wished". It shows the child poverty rate in different countries before and after taxes and transfers. Ireland, for example, has a child poverty rate of more than 40 per cent before taxes and transfers but just 8 per cent after, if child poverty is taken to mean children living in households on less than 50 per cent of the median national income. In the Czech Republic it is 17 per cent before transfers and 7 per cent after. By contrast, the rate of child poverty in the United States is 25 per cent before taxes and transfers and 24 per cent after: hardly any change at all. Michael Marmot notes that the rate of child poverty – and hence of child health – in any given country is "under a great deal of political control". Finance ministers can actively decide to reduce the number of children living in poverty – or not. The final irony of *The Health Gap* is this: our individual health may not be a matter of choice, but the health of a society – on which so much depends – actually is.

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A Study of Immigration from Spain into Venezuela, 1948-1998

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THE ORANGE TREES
MARRAKESH

Ibn Khaldun and the science of

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Why is Ibn Khaldun so difficult to understand? The North African scholar 'Abd al-Rahman ibn Muhammad ibn Khaldun (1332–1406), chiefly famous for his theoretical work on history, the *Muqaddimah*, has been variously described as the world's first sociologist, as a precursor of Arab nationalism, as a traditional *'alim*, or religious scholar, who employed jurisprudential criteria to the interpretation of the past, as an anthropologist *avant la lettre*, and, quite recently, as the deviser of mystically inspired historical methodology. He has been acclaimed as the precursor of Machiavelli, Vico, Montesquieu, Hegel, Comte, Marx, Durkheim, Vilfredo Pareto and Arnold Toynbee. Since most of these epithets or comparisons are mutually incompatible, most of them must be wrong.

The *Muqaddimah* is a difficult book because Ibn Khaldun worked on it over a long period of time and consequently there is a lot of repetition and inconsistency. His style is laboured and one reads him with interest, rather than for pleasure. He gave familiar Arabic words special meanings, but he was not consistent in his terminology or indeed in his methodology. In the conclusion to *The Orange Trees of Marrakesh: Ibn Khaldun and the science of man*, Stephen Dale's quotation from Scott Fitzgerald's short story "The Crack Up" seems most appropriate: "The test of a first-rate intelligence is the ability to hold two opposed ideas in the same mind and still have the ability to function". Moreover, in order to fully understand the context in which the *Muqaddimah* was written, one needs to be familiar with the ins and outs of North African and Andalusian politics, as well as the competing intellectual programmes of the Mut'azilites, 'Asharites, Malikis, Isma'ilis, Sufis and others.

Stephen Dale has previously written *The Garden of Eight Paradises: Babur and the culture of empire in Central Asia, Afghanistan and India (1483–1530)*, published in 2004. The Mughal ruler Babur comes over in his *Baburnama* as a man of immense charm. He was an enthusiast for swimming, melons, poetry, bird life and (guiltily) alcohol. His masterpiece challenges comparison with the self-revelatory masterpieces of Pepys and Boswell. Ibn Khaldun was different. Though his *Ta'rif* ("Introduction" or "Identification") has sometimes been mistakenly described as an autobiography, it is decidedly short on self-revelation. From what little can be deduced of his personality, he comes over as arrogant, puritanical, pessimistic and elitist. I do not think that Dale likes him very much.

There are scores of books, perhaps hundreds, offering a variety of readings of Ibn Khaldun. (Omar Khayyám's "Two and Seventy jarring Sects" comes to mind.) Dale presents Ibn Khaldun as above all a philosopher working in the Greco-Islamic tradition and argues that the methodology underpinning Ibn Khaldun's theoretical introduction to his universal history owed an enormous amount to Aristotle and Galen (mediated through al-Farabi, Ibn Sina, Ibn Rushd and others). Ibn Khaldun

Ibn Khaldun on a Tunisian ba

axiom that is an inductively derived of a generally acknowledged truth" William Lane's *Arabic–English Le* indeed give this as the correct definiti larly *burhan* has been commonly und simply mean "proof", but, as used by dun, Dale argues that it means spec "apodictic proof", one that is necess Moreover, Dale believes that it is because Ibn Khaldun owed so much philosophy that his writings have bee ily acclaimed by Western thinkers comfortable with that intellectual tra

Though Dale's interpretation i argued and plausible, there are s grounds for doubt, for Ibn Khaldun d his methodological cards on the table has had to deduce what was in his hand. Moreover Ibn Khaldun repea explicitly denounced philosophy. Cl of the *Muqaddimah* contains a secti "A Refutation of Philosophy: The cor the students of philosophy". Of co Khaldun may have only intended t himself from certain modes of philos All the same, the book reads very d from the treatises produced by th thinkers who did explicitly work in tradition. Come to that, neither Ari Galen produced anything that came resembling Ibn Khaldun's great absorbed the vocabulary of the phil but did not necessarily apply their me and he does not seem to have thought as working in the Greek philosophic "We became aware of these things w help and without the instruction of . . .". Furthermore, Ibn Khaldun's u