Editorial

Politics and the common good

One of the most thought-provoking discoveries to come out of the dusty corners of health services research is the increasingly consistent correlation between inequities of income and rates of illness and death.[1] For example, in Western countries where the gap is smaller between average annual incomes in the bottom 20% and those in the top 20%, the health status of the population overall is higher. Likewise, when the income gap is larger, overall health status is worse. These relationships seem to hold regardless of average per capita income.

But it is equally evident that health status is strongly correlated both with a population's overall economic prosperity and with individual income.[2] Even within a single employee group, such as British civil servants,[3] the higher the income, the healthier the individual. Thus politicians and government must take into account both the deleterious effect of income disparity and the beneficial effect, for individuals and for society as a whole, of individual prosperity.

Shaking off the dust, a variety of health services researchers and policymakers met in Havana, Cuba, in June for the inaugural conference of the International Society for Equity in Health (www.iseqh.org). In a keynote address, Sudhir Anand maintained that income disparity is less problematic than health inequity. As he pointed out, income incentives are a powerful motor of productivity and are in any case unlikely to go away. Thus we can only expect greater inequities of income as economies develop. In this view, reducing economic disparity is not a realistic policy option for any government.

But what about the income gap and its detrimental effect on health? Barbara Starfield[4] and others argue that the relation between the distribution of incomes and health holds because of the availability of comprehensive universal primary health care services: the relation, therefore, may not be between income disparity and health but between primary care *availability* and health. Regions where the income gap is smaller have more highly developed primary health care services.

In Canada, as we approach a national election the federal parties are positioning themselves and debating short-term fixes to medicare — pharmacare, CT scanners, home care and waiting lists (see pages 1323–4). But, in reality, the role of the federal government in health is to organize (and implement) through legislation and leadership the various components of our world that are the *determinants* of health: particularly education and primary health care, but also jobs, security, a decent income, housing, etc. We need to elect a government that is prepared and able to articulate through its policies the competing values of capitalism (not just lower taxes and greater personal advantage) and those of the common good. The Canadian electorate needs a government that, while promoting and encouraging economic growth, will not only defend but also promote the ideals of fairness in the key domains of access to primary health care and to all levels of education. — *CMAJ*

References

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3. Hemingway H, Shipley M, Macfarlane P, Marmot M. Impact of socioeconomic status on coronary mortality in people with symptoms, electrocardiographic abnormalities, both or neither: the original Whitehall study 25 year follow up. *J Epidemiol Community Health* 2000;54(7):510-6.
4. Starfield B. Is US health really the best in the world? *JAMA* 2000;284(4):483-5.