Editorial - oh brave new world

'The world is now in equilibrium. People are happy because they get what they desire and desire nothing they cannot get. They are well sheltered, always in good health and without fear of death'(1)

We went to press in the last issue with optimism. A Labour landslide might encourage demands to improve official statistics. Manipulation of claimant count figures could be ended, for instance, and the national accounts might become a little more honest. During the campaign Tony Blair was asked whether Labour would reverse the thirty-odd adjustments made to counting the unemployed since 1979. He gave no comment. A few days after the first Labour budget it appears that the biggest adjustment of all may soon be made. In Labour's brave new world no one will be out of work for more than six months (unless they choose the 'fifth option' and starve). The need for radical statistics to keep a count of what really happens is as strong as ever.

In this issue Ray Thomas addresses the problems of revising the unemployment series head on and proposes an integrated series of the claimant count and the Labour Force Survey. He suggests that in the long term the latter, restructured, will become most useful. The long term appears to have arrived with the budget, giving Ray's comments on improving the survey particular salience. With remarkable forethought Ray ends his article discussing the un-analysed questions on people who say that they have a reason not to want to work.

Schools are to get new roofs and, perhaps, a few new teachers; but 'standards' must rise again in return - so says the new Chancellor. Ian Plewis questions the government and media's priorities in educational measurement. Whether pupil standards have changed and whether some subjects are soft options are not enquiries that lead to improved education for children. It may be easier and more useful to measure the effectiveness of different teaching methods, and how the curriculum fits its purposes. Cecilio Mar Molinero, in a later and highly entertaining article goes on to question the meaning of student questionnaires in higher education assessment. With student fees, the privatisation of universities and ever rising 'standards' the questionnaire business is likely to boom.

More money for the NHS, more doctors, more nurses, less accountants. Would Marx have been happy to see the 'jackles of capitalism' loose their jobs? Nancy Krieger and co. take us away from our small rock and obsession with the present, to a more international agenda for public health based on the 1848 spirit of revolution in Europe and the belief that social justice is the foundation of public health. The Spirit of 1848 committee describe their work to highlight racism and class as determinants of public health and the attacks made upon this work in the United States. Their article in this issue also gives a fascinating summary of events a century and a half ago, compared to meetings today.The Radical Statistics Health Group then bring us right up to date in Britain with an urgent briefing on the Private Finance Bill and the NHS.

The debate about the future of official statistics under the new regime is opened up by an article from Paul Allin on behalf of the Statistics Users' Council. Points for discussion in the Council's November meeting are usefully summarized in advance of the debate with the key issue being the independence of official statistics from government control. Finally, Christine Griffin ends our articles by looking at government interference within the research council that supports most social science research in Britain and, in particular, the implications of the new ruling that qualitative data should be deposited at a central ESRC archive.

This issue concludes with the latest news, comments and reviews and with our last reference to the general election - the wonderful 'reduced crime in Merseyside' graph produced in the manifesto of the Natural Law party. The next AGM, the new Radical Statistics book and dates of conferences and other current events are all included. All contact address are at end of articles or in the news section, please use them. That's what this newsletter is for - use it to enlighten and submit! Deadline for copy for issue 67: 30 November.

Danny Dorling and Ludi Simpson

(1) Aldous Huxley, 1931

NEWS, COMMENT, AND REVIEWS.

Press briefing:

The NHS (Private Finance) Bill and the functions of NHS hospital trusts

Summary

The NHS (Private Finance) Bill confirms that an NHS trust can enter into private finance (PFI) arrangements if the purpose of the arrangement is 'the provision of facilities in connection with the discharge of any of its functions'.

However, last year the Secretary of State changed the defined functions of a number of trusts involved in PFI deals in such a way as to exclude any reference to their role as NHS service providers. This created the possibility that these trusts could eventually operate as commercial operations outside the NHS.

These changes to trusts' functions were intended to facilitate PFI developments, and it is expected that any trust with a major PFI scheme will also have its functions altered. Trusts with PFI schemes will thus no longer be obliged to operate primarily as NHS service providers.

The legislation should be amended to include a statement that NHS trusts exist to provide NHS hospital services, and that any other activity in which they engage should be for the furtherance of that function.

At the same time, section 1 (5) of the bill states that the 'facilities' to be provided under PFI include 'services', without defining services any further. The bill thus allows for the privatisation of any services provided by an NHS trust, including clinical services. The government has reiterated its commitment to keeping all clinical services within the NHS, but has resisted proposals to write that commitment into the legislation.

1 Background

The NHS (Private Finance) Bill, which went to committee stage in the House of Lords on the 19 June, is intended to confirm, for the benefit of banks funding NHS private finance developments, that hospital trusts do indeed have the necessary powers to enter into private finance arrangements. Prospective funders of PFI projects had feared that if these powers were not explicitly established in legislation, trusts might in the future be found to have been acting *ultra vires* in agreeing to the lengthy payment schedules associated with PFI. If that happened, trusts might turn out not to be liable for their PFI payments, and debts might not be recoverable

The bill states that NHS trusts have the power to enter into what are referred to as 'externally financed arrangements'. It gives the Secretary of State for Health the power to issue certificates for PFI schemes confirming that they constitute 'externally

financed' agreements for the purposes of the legislation.

The bill says that the Secretary of State can certify a PFI scheme where it is intended to contribute to the discharging of 'any of the trust's functions'. The implications of this turn on the existing definition of trusts' functions, which derives from the 1990 NHS and Community Care Act.

2 What are the functions of an NHS trust?

The functions of NHS trusts are set out in the *establishing orders* made for individual trusts by the Secretary of State for Health at the time they were given trust status. The 1990 Act set out two alternative sets of functions that the Secretary of state for Health could assign to trusts. Under section 5 (1) trusts could be established *either* '(a) to assume responsibility, in accordance with this Act, for the ownership and management of hospitals or other establishments or facilities which were previously managed or provided by Health Authorities' *or* '(b) to provide and manage hospitals or other establishments or facilities '

Most trusts were established with section 5(1)(a) functions. However, in March 1996, the then Secretary of State amended the establishing orders of 20 trusts which were engaged in major PFI developments These trusts were given the functions set out in section 5 (1)(b)

Orders made under section 5 (1)(b) say nothing about trusts' NHS function: the section could refer just as easily to commercial healthcare provision. The functions of NHS trusts are defined in their establishing orders and nowhere else, so the role of trusts as NHS service providers is not firmly established anywhere in existing legislation.

These amendments to establishing orders were made precisely in order to allow trusts to enter into PFI arrangements. It is expected that similar amendments will be made to the orders for all trusts with PFI schemes.

3 Why does PFI mean changing the functions of NHS trusts?

Section 5(1)(a) orders confine trusts to owning and operating what had previously been health authority hospitals. There are two problems with these establishing orders when it comes to PFI developments.

Firstly, under PFI, trusts will not *own* the facilities they commission, which will be the property of the private sector. Section 5 (1)(b) has the advantage that it gives trusts the functions of providing and managing, but not of owning, hospitals.

Secondly, PFI developments tend to involve extensive changes to the configuration of hospital services, with disposal of hospital sites for commercial development, relocation of services to new sites and the closure of smaller hospitals. They also tend to involve extensive private provision. Section 5(1)(a) effectively confines trusts to providing services on existing NHS sites. However Section 5 (1)(b) does not limit the trust in terms of the sites it may operate on.

Neither of these considerations explains, let alone justifies the failure to specify that trusts are there to provide healthcare free at the point of demand. The introduction of

PFI into the health service, which will lead to the development of unprecedented new relationships between the public and private sectors, makes it all the more urgent that the role of NHS trusts be clarified in legislation.

4 What can be done?

Until the 1990 NHS and Community Care Act, there were legislative restrictions on the extent to which NHS bodies could engage in commercial activity. The 1988 Health and Medicines Act, which gave NHS bodies extended powers to engage in 'income generating activities', nonetheless specified that the purpose of these powers was to 'make income available for improving the Health Service' [section 7(1)]. It also stated that private provision at NHS hospitals was only to be permitted if it did not 'to a significant extent operate to the disadvantage' of NHS patients [section 7(8)]. No such safeguards exist under the current legislative framework.

We suggest that the relationship between commercial and NHS activities of NHS trusts be set out in the current legislation. One way of doing this would be to amend Section 3 of the bill to include a statement of trusts' NHS functions and to specify that 'externally financed arrangements' will only be certified if they are to be entered into for the furtherance of that function.

5 Clinical Services

According to section 1 (3) of the new bill, the Secretary of State may certify a PFI agreement if 'in his opinion the purpose or main purpose of the agreement is the provision of facilities in connection with the discharge by the trust of any of its functions. Section 1 (5) states that 'facilities' includes '(a) works, buildings, plant, equipment or other property and (b) services'.
'Services' is not qualified in any way in order to exclude the possibility of the privatisation of clinical services.

In response to concerns about which elements of NHS provision are open to privatisation under PFI, the Department of Health is currently undertaking a review in order to arrive at a satisfactory definition of clinical services, and has stated that none of the services falling within that definition will be the subject of PFI arrangements.

Unfortunately, however strong the current government's commitment may be, it cannot guarantee the policies and actions of any future administration. The work on defining clinical services should be backed up by legislation firmly establishing that those services will continue to be publicly provided.

The NHS (Private Finance) Bill provides an opportunity to do this. Section 1(5) (b) should be amended to exclude clinical services from PFI arrangements.

Politics, Race and the US Census

David Gordon

Careful readers of the inside pages of the British newspapers may have noticed that last month the Republicans in the US Congress delayed an emergency bill to help victims of recent floods in the Midwest by attaching an amendment that would have outlawed the use of statistical sampling in the census. After President Bill Clinton vetoed the amended bill, the Republicans removed the amendment and let the bill pass.

The next US census will be carried out in 2000 so this is probably just the start of the bitter political fights that usually occur before any decennial census in the United States.

The expert panel convened by the National Academy of Sciences argued that the 2000 census would be flawed if statistical sampling was not used. The census tries to enumerate the US population by first mailing questionnaires to every household, and then by follow-up visits to those who fail to reply. However, about one-third of the population either fails to return a census form without a folow-up or never receives one. In 1990 the eventual undercount was estimated to be 1.76%, or about 4 million people. The number of blacks and Hispanics and other 'poor' groups excluded from the count was especially high at about 5% (Kleiner 1997).

Statistical sampling would reduce the bias of the census and also save money. The census bureau plans to stop its door-to-door surveys when it has contacted 90 percent of American households. Census officials would then use the information from the population already counted - checked for accuracy against data from a separate, intensive survey of 750,000 people - to fill in the blanks.

Regions in the US with concentrations of poor people have in the past been systematically undercounted in censuses. There is virtually no research in the US on the geography of deprivation and need (see Mayer & Jencks 1989, Krieger et al 1997, for the few exceptions), however, poor regions are not evenly spread across America but are concentrated in the inner cities and remote rural areas. Both, the number of representatives to the US Congress and the apportionment of direct taxes are distributed according to the census count. So an undercount will result in under representation.

Republican members of Congress fear the use of statistical sampling, since the resulting corrections would give higher counts for black and Hispanic and other poor groups of people, and that could lead to a redrawing of Congressional districts which would favour the Democrats.

US censuses have a long history of under enumerating poor people, the section of the US constitution that prescribes a census every 10 years also includes the statement that slaves shall be counted as three-fifths of a person. The only time that black people were ever over counted was in the sixth census of 1840. This was the first census to include counts of the mentally ill and deficient, enumerated by race (see

Stanton 1960, Gould 1980, Krieger 1987, Anderson 1988 for discussion).

The census fell under the jurisdiction of Secretary of State John C. Calhoun, who was a vigorous defender of slavery. The published census tables purportedly showed that one in 162 'blacks' were insane in the free northern states compared with only one in 1,558 in slave states. Calhoun used these census results to argue that in the north 'blacks' had "inevitably sunk into vice and pauperism, accompanied by the bodily and mental afflictions incident thereto" whereas in the slave states the black population had "improved greatly in every respect - in number, comfort, intelligence and morals" (quoted in Gould 1980).

These arguments were made at a time when slavery was facing increasing opposition and the slaveholding South was feeling under increasing threat, partially as a result of Nat Turner's rebellion in Virginia (see Wiltse 1965, Aptheker 1969, Tragle 1971, Zinn 1980).

The 1840 census results were of course fraudulent, Dr Edward Jarvis - one of the pioneers of medical statistics in the US - found that the numbers of insane black people had been absurdly inflated in the northern states. Jarvis found that in 135 northern towns the number of 'insane blacks' was greater than the total number of 'blacks', both 'sane' and 'insane'. Similarly, in a further 25 towns in 12 free states there was not a single black person of sound mind, the figure for 'All Blacks' had been copied into the column for 'Insane Blacks'. Despite a life long campaign by Jarvis to get the census results amended, the fraudulent data has never been officially rectified (Gould 1980).

Radical Statistics readers do not need convincing of the political nature of seemingly 'objective' statistics. Many previous issues of the newsletter have contained articles detailing the political manipulation of British health, poverty, unemployment and pension statistics. However, this practice is not confined to the UK, there can be few better examples of the attempted political manipulation and fraudulent production of statistics than the long history of the US census.

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Official statistics

Health inequalities

As readers of Radstats e-mail discussion group will know, on the 21 May Sir Donald Acheson (the recently retired Chief Medical Officer) wrote to a number of people stating that there was a possibility that the new Labour government would update the Black Report into Inequalities in Health in England. The new report will need to be ready by March 1998 with an interim report by the end of 1997 and assurances have been given that that the report will be "in scientific terms completely independent" and will produce a "state of the art review of the science together with the provision of a list of evidence based points of intervention and options" However the proposed draft structure of the report was far from ideal, with eight sections on,

- The foetus
- The family, infancy, childhood, adolescence
- The workplace, unemployment, social hierarchies
- The 'third age' (active life after retirement from full-time work) dependent old age
- The material environment - housing, pollution, etc
- The social environment
- The economic dimension
- The national health service

The idea of trying to look at the health of the foetus, without considering the health of the mother is perverse, indeed the lack of any explicit gender dimension in the suggested draft structure is worrying. Hopefully, the draft structure will have been amended by now.

On the 11th June the Prime Minister announced approval for a new 'Black Report' at Prime Minister's Question time (see extract from Hansard Below), so Radstats readers now need to move rapidly to put together evidence and policy responses.

Commons Hansard (11 Jun 1997) (Engagements) The Prime Minister

Q7 Mr Home Robertson
Does my right hon Friend share my concern about the wider effects of the division and inequality that we have inherited from the previous Administration? Will he consider the position of people on low incomes in this country? Surely it is bad enough that they have a low standard of living. Is it not worse still that a disproportionate number of them also suffer from bad health, which

often leads to early death? After all the years of procrastination and neglect by the outgoing Administration - starting with the cover-up of the Black report on health and inequality in Britain in 1980 - what will the new Labour Government do to make things better for people on low incomes? [1413]

The Prime Minister:
My hon. Friend is right to raise that concern. It is for that reason that the Secretary of State for Health has asked Sir Donald Acheson to conduct a further review into inequality and the link between wealth and health. It is important to do that because the Black report, which was commissioned by a Labour Government, was effectively buried by the last

Conservative Government. These inequalities do matter and there is no doubt that the published statistics show a link between income, inequality and poor health. It is important to address that issue, and we are doing so. The purpose of the windfall tax is to address that matter on behalf of young people and the long-term unemployed. We are also addressing the issue by introducing the minimum wage, which will help those on low incomes, and with welfare measures, particularly those designed to get single parents back to work. [Hon. Members: "Boring."] Conservative Members may shout "boring" but most people in this country want those issues to be tackled.

Shooting up NHS policy

Those who don't proof-read The Observer might have missed the following extract from the back page which sheds some new and interesting light on the thinking behind the NHS internal market

"Dr Clive Froggatt advised Margaret Thatcher and dealt with every Health Secretary from Norman Fowler to Virginia Bottomley. Understandably he turned to drugs for comfort

Heroin was his favourite prop. "I was taking it every day" he said, "and shooting up before meetings with Ministers. I don't know if you want to call it an addiction, but no one in Whitehall noticed anything wrong".

Although the revelation that the man who created the NHS Internal market was high as a kite at the time did not surprise doctors, Froggatt was not the stereotypical addict. He was and remains jaunty and charming - the antithesis of a wonk.

Froggatt was disgraced in 1994 when he was convicted of forging prescriptions for heroin. ..."

(Source: Observer 6/4/97 p. 30)

Surveys and official statistics

Health Minister Tessa Jowell's close contact with survey methods - as wife of a director of survey centre SCPR - may give some hope for the re-opening of the General Household Survey, but don't throw out the baby with the bath-water, Tessa.

The last two issues of *Radical Statistics* have warned against uncritical replacement of administrative statistics with surveys. Statistics of unemployment and of local services would suffer from reliance on

surveys with small local samples or large biases from non-respondents.

Religion in the Census

The working party backing Religious affiliation as a question in the next (2001) Census throughout Britain has provided a paper to support its case. It is a lengthy argument that the prevalence of religion should be measured in order to implement educational policy, and to design services sensitive to religious preferences from cradle to grave, urn or flight to country of birth.

It also claims that religion will be a good indicator of service need: "International empirical research indicates the different pattern of social support required by the religious elderly, the speedier recovery rate from certain illnesses among some religious subjects, the different pattern of substance abuse among religious teenagers, and so on."

Any comment from ill and elderly believers?

Unemployment rates

Cuban statistician Armando Medina Mill contributes the following in correspondence, "You talked about a debate over how to measure employment and unemployment. We have also studied that problem and have created two types of unemployment rate, the one that has always been used and is accepted internationally, and the rate of potential unemployment. Potential unemployment equals those without work (who are looking for a job) plus discouraged workers both within and outside the workforce. Although this rate is not recognised internationally, and it clearly is inconvenient to the capitalists, it does solve the situation in part, and if you agree you can introduce this variant in the debate as a modest contribution to it."

Psychology Politics Resistance

Readers may be interested in the latest issue of the newsletter of PPR, "a network of people - both psychologists and non-psychologists - who are prepared to oppose the abusive uses of psychology. This means challenging the ideas within psychology that lead to oppressive practices, supporting those who are on the receiving end, and using psychological knowledge positively to help those engaged in struggles for social justice"

Contents of the eighteen-page issue 4 are: PPR so far, Isabel Rodriguez released! North West right to refuse electroshock campaign, Support Coalition and Dendron, the politics of control, Critical Psychology journal what next? Marxism? International contact points.

Subscribe to PPR by sending £5 (£1 unwaged/low-waged) to Ian Parker, PPR Psychology, Bolton Institute, Deane Road, Bolton, BL3 5AB

BOOK REVIEW

'Analyzing Tabular Data' by Nigel Gilbert.

The book sets out to introduce the reader to a range of quantitative methods which can be used to analyse tables of data. As social research often requires this skill, the objective is an extremely useful one. Nigel Gilbert uses a number of social research datasets on topics such as housing or voting patterns to illustrate how the techniques he is describing can be applied by researchers working in a range of fields.

The book begins with two important chapters to set the context for the analysis to follow. Chapter One, entitled 'Real and Imaginary Worlds', explains to the reader how quantitative models can be used to explore possible patterns in datasets. Chapter Two, entitled 'Classification and Measurement', introduces readers to the kinds of data that they are likely to meet in their research. These two chapters provide a vital backdrop for what follows.

The remaining chapters (there are thirteen in total) introduce the quantitative methods themselves. The book begins gently, with cross tabulations and associations, but leads rapidly into more advanced topics such as loglinear models (Chapter Five) and logistic regression (Chapter Ten). Nigel Gilbert's stated aim is to write a book "for those who have little prior knowledge of quantitative analysis or statistics", but I feel that it may be too fast-moving for some people who meet this description. Some of the more basic tools, such as Chi-Squared in Chapter Four, have been covered more simply and clearly elsewhere for students new to (or with a fear of) statistics. The book could make greater use of graphs and charts to make it an easier and more accessible read for such people.

Nevertheless, the book has a clear flow, and each chapter takes a logical step forward, for example from two and three dimensional tables to high-dimension tables. Its main topics (logistic and loglinear models) are covered well. Loglinear analysis, for example, is introduced by exploring the links between occupational class, housing tenure and voting behaviour. Each chapter ends with a summary, and computer analysis of a "real" dataset. The software packages used are SPSS and GLIM, and these sections are likely to be of great interest and practical use to many readers. In conclusion, if your research is generating more and more data, perhaps from a survey exercise, and you are wondering how to get the most out of it, you will welcome this book which deals with the practical skills needed to handle tabular data.

The book was first published in 1993 by UCL Press, 186 pages
(ISBN 1-85728-090-3 HB, 1-85728-091-1 PB).*Maureen Meadows, Warwick Business School, University of Warwick*

HEALTH AND SOCIAL ORGANISATION: Towards a Health Policy for the 21st Century
David Blane, Eric Brunner and Richard Wilkinson Routledge 1996

UNHEALTHY SOCIETIES : The afflictions of Inequality
Richard Wilkinson Routledge 1996

These two contrasting books are very welcome as they bring together the vast amount of research recently undertaken which has began, with ever finer detail, to draw a picture of mechanisms through social and economic factors act on the health of individuals
Published to mark the launch of the International Centre for Health and Society at University College London, *Health and Social Organisation* is an edited collection of articles by experts from the UK, Canada and USA It is sophisticated, detailed and concentrates on presenting the evidence from the different disciplines of sociology, epidemiology and psychology in rigorous manner. Some of the chapters are reviews and other are reports of original work. Cohesion is provided by an attempt to build a theoretical framework which links individual biology with social and economic forces, and societal health. Both sociologists and epidemiologists will find much to reflect on, and the book will undoubtedly become a major source of reference for those interested in the relationship between health and the individual and society.

Health and social organisation begins by charting the develop of study of population health from failure of theory and policies based on individual action or individual risk, to re-emergence of interest in social and economic environments as health determinants.
Following from the introduction there are sections on: The policy problem, Environment and economic growth, The family and the life course and Work and the labour market. A chapter by Hetzman and a separate chapter by Wilkinson introduces a key concept, the notion of social capital which is described as "features of social organisation, such as network, norms and trust that facilitate co-ordination and co-operation for mutual benefit". The evidence suggests that societies with high social capital for given per capita income have better health. Thus countries characterised by increased wealth, a comparatively equitable distribution of income and high investment in education are countries with a better health record. The decline of life expectancy and well being in Eastern Europe in the recent period of turbulence and economic decline are illustrative of how these factors are not fixed.
The following chapters elaborate how social and economic forces are translated within the family and labour market into health. Fonagy reviews the evidence on the important of good parenting and family support on the ability to form attachments in later life. Wadsworth describes the evidence which suggests that in childhood, the family and its social circumstances provide the basis for health in later life. In other words there is a parental or

family inheritance of "social capital". A further chapter by Power, Bartley, Davey Smith and Blane describes how these environmental influences can have a long term effect extending over generations. Blane, White and Morris, using deprivational indices and other routine data, provide an original analysis of the effect of one major area of social policy largely external to the family, education. They conclude that material deprivation is the stronger determinant of health but education retains a residual independent effect.

The influence of the labour market is analysed in relation not only to occupations classified by economics factors but by psychosocial factors such as rewards, lack of control and demands of the job. Marmot and Feeney use data from the two Whitehall studies to analyse the relationship between this occupational classification and health. The chapter by Evandrou on Unpaid work, carers and health, provides an example of how the mutual benefits which may occur in caring can also have beneficial health effects. The mechanism through which social factors produce biological effects in cardiovascular disease is exploring by Brunner using data from the two Whitehall studies.

The last chapter, by Mustard summarises the argument and concludes that the evidence on the effect of the social environment on health, provides an important framework for discussion of policy. The message it provides is that regions which fail to maintain the quality of the social environment will have major problems with stability of their society and the health of their populations

Unhealthy societies is the work of one author and is much more polemical in character. The author draws from the same sources as *Health and Social Organisation* but for me the overall effect is less convincing The book begins by describing the social and economic characteristics of healthy societies The findings that increases in life expectancy begins to tail off at per capita incomes above a certain level is explained by social inequalities within those societies Further chapters develop the argument that inequalities in income distribution are an incomplete explanation for health inequalities Although not unimportant in itself, income distribution provides a marker for a more complex notion that the degree of social cohesion in a society is the key factor in explaining patterns of ill health between societies Wilkinson elaborates how social cohesion appears to be related to health by case studies of a small town

in USA and wartime Britain, with Eastern Europe providing the case where increasing levels of social disintegration are having an effect on health A further section analyses the evidence for social disintegration in Britain and USA and its effect on health The measurable biological effect of social hierarchies on individuals which has been obtained from both studies of baboons and the Whitehall II study, and the biological pathways through which emotional stress in childhood are related to height and social mobility are used by Wilkinson as examples of mechanisms through which, in the authors words, "Society kills".

In the last section Wilkinson argues that increasing public awareness of health inequalities coupled with the fact that the results of inequality effect the health of everyone, not only the poor, give grounds for optimism that polices which improve social cohesion will be implemented.

Unhealthy societies is very readable introduction to the subject. It is packed with interesting arguments, case studies and information. However, readers with a more sociological bent may find much to question here, as some of Wilkinson's arguments, particularly in relation to social cohesion, seem to lack sophistication.

It is ironic that just as evidence is becoming available to elaborate the pathways through which inequalities act on the individuals, the policy trends in recent years have been towards greater social division and bringing about a healthy society seems more remote than ever.

Susan Kerrison

"Best" data graphic of the 1997 General Election