

The art of medicine

Europe: good, bad, and beautiful

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A Phoenician princess, abducted to Crete, then raped by a Greek god who deceived her by appearing as a beautiful white bull has, if you believe the images on the euro banknotes, given her name, Europa, to a continent. An unpromising beginning. Somehow, Titian managed to turn a brutal rape into a painting of great beauty, complete with Cupids pointing their love arrows at Europa's breast. Deception, beauty, violence, terror, love, diversity, forced migration, belief in myths—are good metaphors for Europe. Certainly in the 20th century, we have had unspeakable horrors giving way, in western Europe, to arguably the best conditions in history for living secure, and long, lives. Put simply, bad societies stop people enjoying basic human freedoms, and damage health; good societies foster the freedoms to lead valuable lives, and health thrives.

More analytically, my work has been animated by the view that the health of a population is a reflection of how well a society meets the human needs of its members. Given the striking social, economic, and cultural diversity in Europe, over time, across the Continent, and within countries, one would expect striking diversities in health. So it proves to be. Restricting myself to just the most recent period of this remarkably mixed history, the era after World War 2 saw remarkable divergence in health between countries of the "east" and of the "west"—the east lagging way behind—and, within many countries, first a narrowing and then a widening of health inequalities between socioeconomic groups. The question is why: how do the good, the bad, and the beautiful translate into good and bad health?

One way to think about these inequalities between, and within, countries is to explain them on the basis of differences in access to health care or in lifestyle: smoking, drinking, eating, patterns of physical activity. But focusing on these proximate causes is perhaps to miss the bigger picture, the way social, cultural, economic, political, and environmental circumstances influence people's lives and their health. I have labelled this: the causes of the causes.

The drama of the 20th century, and beyond, means that the causes of the causes abound in Europe. All parts of Europe were affected by events up to and including World War 2, but not equally. The borderland region encompassing modern Poland, the Baltic states, Ukraine, Belarus, and the edge of western Russia, where boundaries shifted, was most subject to what Anne Applebaum has called the "ideological madness" of Hitler and Stalin. Between 1933 and 1945, 14 million non-combatants died as a result of political action. When we add to that the casualties of war, the scale of lost life is staggering. The tragedy of Europe during the war years set the stage for what came later. In the postwar period, both "halves" of Europe had peace, apart from a few

uprisings which were brutally suppressed. But in the west, it was the peace that went with prosperity that funded highly developed welfare states; in the east, it was the peace of the Red Army and its acolytes. Reviewing Anne Applebaum's book, *Iron Curtain*, about the period 1944–56, Louis Menand has written of a Polish man who was executed for possession of an unlicensed radio and of teenagers who were sent to camps or prison for making faces during a lecture on Stalin. By 1954, 6 million people in Poland were registered as criminal or suspicious elements.

That is nasty. Could it damage health? I hold the strong view that depriving people of control over their lives and the possibility to lead lives of dignity is indeed damaging to their health. Banning civil society organisations because they are thought to damage society will make matters worse. If true, I have to explain why life expectancy, at first, improved in countries such as Poland and Czechoslovakia, in the 15–20 years after World War 2. In fact, it improved at about the same rate on both sides of the Iron Curtain. So that in 1965–70, Czechoslovakia and Austria, two components of the former Austro-Hungarian Empire, had equivalent life expectancy. It was only after about 1965 that life expectancy in the countries of central and eastern Europe stopped improving, while it continued to improve in the west. By 1990, when the velvet revolution transformed Czechoslovakia and communism collapsed across Europe, the gap in life expectancy between east and west was 6 years or more; larger in the case of the Soviet Union.

We need then to understand why things improved in the communist countries for 15 years, then failed to improve until communism collapsed. Then, with the signal exception of Russia, improved again. In the postwar years, young people may not have been able to make rude faces and be disrespectful, but they were immunised against major infectious diseases. Adults could become criminals for expressing an opinion, but they were housed and employed. Food may have lacked variety, but people were not hungry. There were declines in infant mortality, in maternal mortality, and in rates of infectious disease. In these respects the health system functioned and delivered good outcomes. What changed was the rise of cardiovascular disease and violent deaths, the two biggest contributors to east-west differences in life expectancy, and life expectancy stopped improving. It is this failure of adult mortality to decline as it did in the west that demands explanation.

The simple answer is that prosperity and social democracy, including high levels of social protection—unemployment benefits, maternity leave, state pensions, subsidised health care, child support—are good for health; economic stagnation, lack of democracy, and restrictions on human

agency are health-damaging. We are now able to go beyond the Cold War argument of communism versus capitalism and ask how the nature of society influences health. Capitalism leads to more freedom and prosperity, and to better health, than the dead hand of totalitarian state control, but that is no longer the appropriate contrast. The debate now, even in communist China, is about the way we want to manage our capitalist economies. Do we want free market fundamentalism, be content to let inequality rip, erode the welfare state, and blame the poor for their poverty; or can we recognise what was good about the late 20th century in western Europe that delivered such remarkably good health. It is of great relevance that, in central and eastern Europe after 1990, the largest decreases in life expectancy were seen in dysfunctional societies; the greatest improvements were in those societies with income growth, narrow(ish) income inequalities, and reasonable welfare.

As countries consider their response to the financial crisis, it is well to keep in mind that there should not be a trade-off between a successful capitalism and a well-developed welfare state. We need both, whether on the Continental European model of Germany and the Netherlands, or the Nordic model. Many countries are debating the right level of state spending and whether we can continue to afford generous pensions, unemployment benefits, and support to families with children. In the European Review of Social Determinants of Health and the Health Divide, we made the recommendation to do something, do more, do better. Evidence suggests that countries that have made the decision that they can afford generous social protection have lower levels of child poverty and better health. But if countries can afford little, doing something will improve health. If countries are doing a little, do more. And if social protection is already generous, evidence shows that there is scope for doing it better.

Protecting people in times of need contributes to, and is part of, social cohesion. An important lesson from the Nordic experience of welfare states is that of universalism as a component of social cohesion. A health system for the poor is a poor health system; an education system for the poor is a poor education system. Targeting the poor as needing special treatment damages social cohesion. It also ignores the social gradient in health. Inequalities in health, within countries, are not confined to poor health for the poor and good health for everyone else; it is a socially graded phenomenon. The clear implication is that we need to address health inequalities across the whole socioeconomic spectrum, not only the parlous condition of the poor.

Growing income inequality is a threat to social cohesion. Increasingly the gap is not simply between rich and poor, but between the top 1% and the middle. This argues further for recognising that we need not only to deal with poverty but to examine the whole distribution. Hence the need for universalist policies with effort proportionate to need, what we have called proportionate universalism. To tackle both the



Europa (1559–62) by Titian (Tiziano Vecellio)

health divide between countries and the growing inequalities within countries, we need to address the conditions in which people are born, grow, live, work, and age—the social determinants of health. This is not to ignore action on proximate causes: reduce smoking and dangerous drinking, and get people to lose weight.

We need to think about population health in two ways. First, we value health for its own sake. So, if attempts at behaviour change are effective, if pharmacological remedies improve health, they are desirable. Evidence shows, however, that such attempts are more likely to be effective, and equitable in their impact, if we address the causes of the causes. Second, I am arguing that health is an indicator, a measure of how well we are doing as a society. Meeting human needs will achieve desirable goals in addition to better health: improving life chances for individuals, promoting social cohesion are desirable goals quite apart from a positive effect on health. For long periods of its history the European continent seemed to be following the negative lessons of Europa's mythological story—terror, deception, forced migration, violence. But we have a choice. Perhaps it is pushing the metaphor to describe a healthy productive economy and a well developed welfare state as a thing of beauty, but they are ways of delivering considerable levels of health and wellbeing to its population. The challenge is to ensure that is done equitably.

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Further reading

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Menand L. Bloc heads: life behind the Iron Curtain. *New Yorker* Nov 12, 2012