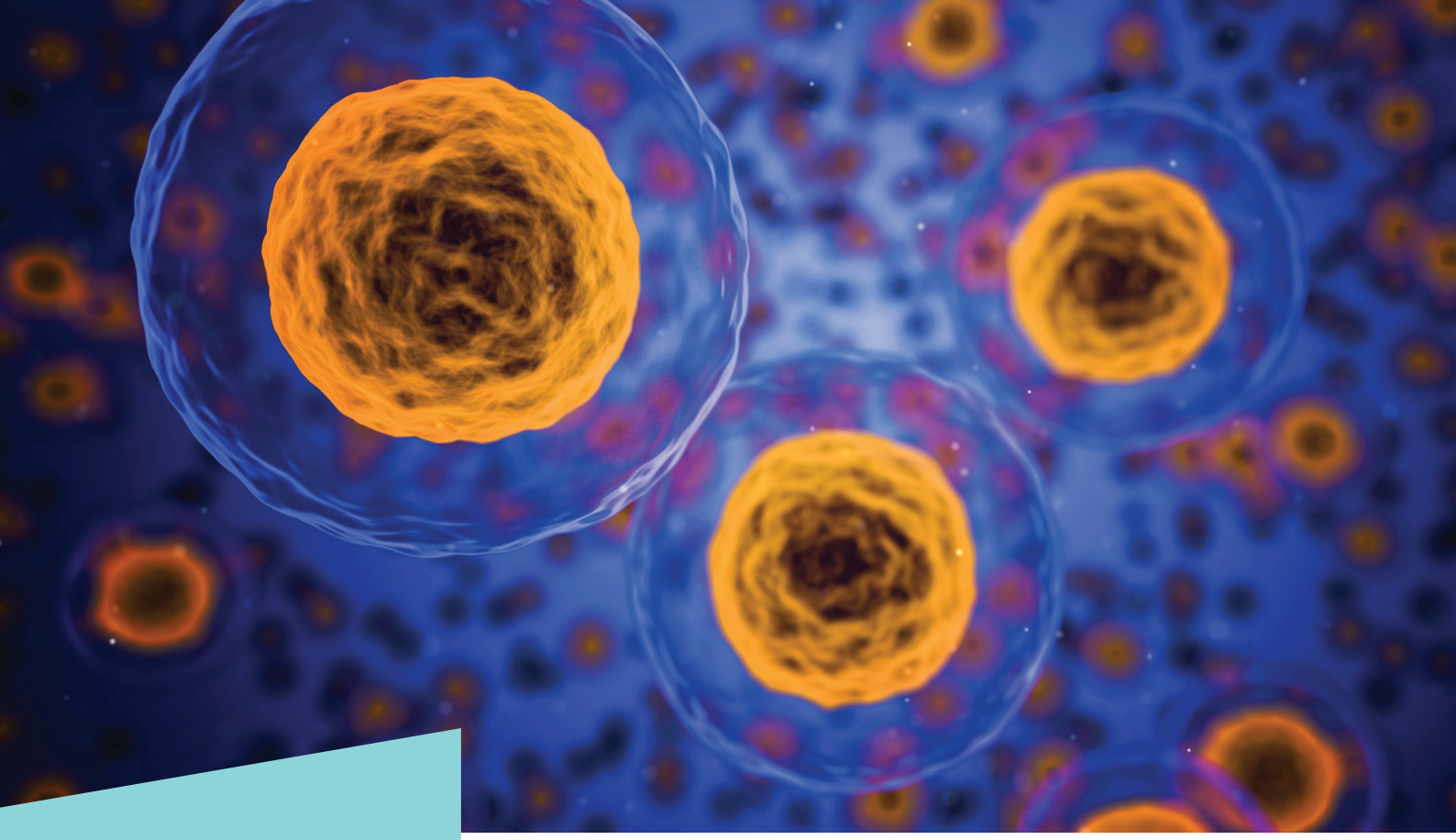

Am I my brother's or sister's keeper?

Health poverty in the UK

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Poverty increases the chances of poor health. Poor health in turn traps communities in poverty[1]

Universal dignity: a biblical mandate

Am I my brother's or sister's keeper? The original story of Cain and Abel told in Genesis 4.9 suggests no responsibility for each other from Cain's perspective, yet this lack of care is condemned throughout the Bible. The development of a social conscience is developed early on, it forms a key aspect of the prophetic tradition and reaches its climax in Jesus' teachings and parables, not least in the story of the Good Samaritan where the framework becomes international.

The Pentateuch challenges us to identify, in our own communities and time, just who is the orphan, the widow and the stranger today (cf. Exodus 22.21–24; Leviticus 19 and 25; Deuteronomy 10.18; 14–15; 24; 26; 27 and 31). In turn, all communities of the Word then face the question: 'Am I my brother's and sister's keepers?'

Such a biblical mandate will inevitably shape our understanding of, and response to, health poverty and its disturbing increase throughout our communities.

The Young Christian Worker movement is one model that enables thoughtful thinking and acting in this area. The movement was established by Josef Cardijn, later Cardinal, in Belgium in 1924. A Catholic priest dedicated to lifelong social activism, Cardijn developed a dialectic of three truths: the truth of experience, the truth of faith, and the truth of method – how to see, judge and act. 'The Truth of Faith' sought to impress upon young workers that they had a God-given dignity.[2] Created in God's likeness, they were not machines, animals or slaves. They were God's sons and daughters, equal collaborators and heirs to the Kingdom of God on earth. As such, they had a vocation to form and transform the realities of life being experienced by themselves and others.

There have been enormous changes between the worlds of work today and the late industrialisation of Cardijn's times; but the contradiction between the universal dignity of all those created in the image and likeness of God and the terrible impoverished reality of millions has not. What may have altered is the circle of those who are now encompassed within our sense of brothers and sisters, as the world seems to become smaller and our awareness of what Pope Francis

calls our human ecology increases. 'The Truth of Faith' continues to provoke us to connect what is happening today with the challenges of the gospel of Jesus Christ.

poverty increases the chances of poor health

What is health?

But to return to our specific focus: what is health? Is it simply the absence of illness and disease or a more positive sense of well-being?

The World Health Organisation states:

> 'Health for all' means simply the attainment by all peoples of the highest possible level of health; and that as a minimum all people in all countries should have at least such a level of health that they are capable of working productively and of participating actively in the social life of the community in which they live.[3]

This begs the question: what is ill-health and why are there so many inequalities of health? The quality of life and the kind of life we can live matters in any measure of a healthy life.

The NHS broader social analysis helpfully defines inequality of health as, 'avoidable, unfair and systematic differences between different groups of people'.

Inequalities in UK health

Health inequalities are not inevitable but a more comprehensive approach to tackling them is essential. Only systematic action across multiple fronts can address the root causes. This includes, but goes well beyond, simply defending and improving our health care systems. Just as critical for our general health and wellbeing are improvements in income, employment conditions, education and housing, all of which are key drivers in health inequity that need to be addressed if we are to reduce and eliminate the disparities in health outcomes.[4]

Over decades in the UK, there have been clear observable divides between the health outcomes of different social classes and their access to resources and preventative services. The Black Report, commissioned in 1977 by a Labour government and published in August 1980, highlighted the inequalities in health and the need for government intervention and spending.[5] The Black committee made 37 recommendations. It also identified the necessity for other social policies to be revisited/tackled because of the interlocking effects they had on people's health. The requirement to increase child benefit, improve housing and agree 'minimum working conditions with unions' were examples of what was identified. When the report was published the then Conservative Government did not carry out the recommendations on the basis of the amount of money it would cost.

Another report produced by a committee chaired by Sir Donald Acheson was to inform the white paper 'Our Healthier Nation', which focused on public health policy. Published in 1998 the Acheson Report again linked health, environment and social factors.[6] The cost of the 39 recommendations in this report was not established.

Some areas covered were the 'disproportionate effect' of poverty on children, the need for more funding for schools in deprived areas, smoking and drinking restrictions. It was noted that policies which were expected to have an impact on health also required consideration about their impact on health inequalities; reducing income inequalities and improving the living standards of poor households was necessary if general health was to be improved.

The Marmot Review, 'Fair Society, Healthy Lives', published in 2010, described how the social gradient on health inequalities is reflected in the social gradient on educational attainment, employment, income, quality of neighbourhood', and so on.[7] These social determinants, 'the conditions in which people are born, grow, live, work and age which can lead to health inequalities' needed to be addressed if overall health across the population was to be improved. The report identified the importance of local government as a partner along with national government in taking action to address 'the social determinants of health inequalities'.

There followed from this report the white paper 'Health Equity in England: The Marmot Review 10 years on' (February 2020).[8] Some of the findings highlighted that people can expect to spend more of their lives in poor health. Life expectancy 'had stalled' with 'a decline for the poorest 10% of women' and there was an increase in the health divide between wealthy and deprived areas.[9]

In 2021, at the Christian Workers Movement AGM, Steve Gilvin highlighted some of the inequalities that contiune to exist within UK society. For example, males living in the least deprived areas of the UK can, at birth,

NOTES

1. www.healthpovertyaction.org
2. www.cijoc.org/joseph-cardijn-and-the-three-truths/
3. www.who.int/
4. www.cdc.gov/visionhealth/determinants/index.html
5. https://navigator.health.org.uk/theme/black-report-health-inequalities
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7. Marmot Review | Policy Navigator (health.org.uk)
8. 'Healthy lives, healthy people' white paper | Policy Navigator
9. www.health.org.uk
10. www.vatican.va/content/francesco/en/encyclicals/documents/papa-francesco_20150524_enciclica-laudato-si.html
11. L White, 'The Historical Roots of Our Ecological Crisis', in *Science* (1967), pp.1203–7.
12. C de Witt, 'Creation's Environmental Challenge to Evangelical Christianity' in *The Care of Creation.* Leicester: Inter-Varsity. 2000), pp. 60–73.

expect to live 9.4 years longer than men in the most deprived areas; for women, the gap is 7.4 years. People in the most deprived areas spend approximately a third of their lives in poor health, twice the proportion spent by those in the least deprived areas. Healthy life expectancy at birth for males in North East England is 59.5 years, compared with 66.1 years for men in the South East, a gap of 6.6 years; for women, the gap is 5.8 years.

These differences in health exist for many groups in our UK society:

- Poverty – social class which perpetuates inequalities through successive generations.
- Early childhood development.
- Protected characteristics and social inclusion (e.g. gender, BAME, disability, age, et al.).
- Geography – particular areas of UK.
- Excluded groups (e.g. homeless people).

This can also be expressed in a number of other ways:

- Health status – living with long-term condition or disability.
- Experience of care – how people feel they have been treated or mistreated.
- Access – ease of access to a GP, understanding of how the NHS works.
- Wider determinants of care and discrepancies in what defines 'good care'
- Behavioural aspects (e.g. smoking, drinking, healthy eating) which are not about 'individual lifestyles' but are driven by social and economic positions.
- Structural conflict.

Whilst we all need access to quality care when we need it, it is the wider determinants of health that are the fundamental causes of health inequalities:

- Income and social protection.
- Quality of education.
- The housing we live in.
- The work we do.
- The community we live in, e.g. access to green space, food shops, transport, air quality.

The world of work also drives ill health and health inequalities:

- Income – a decent living wage or unemployment and job insecurity.
- Working conditions (physical, emotional and mental) – particularly with what we now know about how exposure to stress affects our health long-term.
- Tackling discrimination – across all of the protected characteristics, gender, ethnicity, disability, belief, age, etc.
- Maintaining our mental health.

Considering these government reports and reviews in our current climate it appears that whilst progress has been made in defining determinants, this progress has been in great part negated by successive governments' different economic philosophies and their effects on existing policies.

the planet is becoming impoverished with clear consequences for its and our health

Why Covid-19 was inevitable

The experience of working people of the current Covid-19 pandemic and its variants, has awoken many to the effects of the so-called austerity policies that had gone before. Increasingly, people have seen and realised, along with the differing inequalities, a greater sense of poverty and vulnerability within and between communities.

The fear of illness and early death, although new to most of the UK population, was not necessarily new to the older generation who experienced life before the creation of the NHS. But the pandemic certainly re-established in our minds how important the NHS and Care Services are for us and of how crucial Public Health is as well. When the pandemic is put into context, we are reminded of how new diseases continue to emerge as viruses cross the divide from animals to humans with examples such as Ebola, SARS and Swine Flu. It was only a matter of time before the arrival of the Covid virus.

An economic system that prioritises growth at the expense of everything else, which results in humans across the globe increasingly working and living closer to wild animals and actively participating in the destruction of their habitats, means increasing risks to human life. All of these factors were outlined in Pope Francis' *Laudato Si: On Care for our Common Home* in 2015, well before the pandemic.[10] There Pope Francis expanded the traditional use of 'the poor' to the whole 'poor planet'. The

planet is becoming impoverished with clear consequences for its and our health.

Some of this thinking had been anticipated in more critical readings of traditional interpretations of Genesis 1.26–27 where God creates humans in the divine image and shares dominion of creation with them. Dominion has gone through many interpretations across the ages linked to very different systems of social organisation and economics. Early critics, like historian Lynn White, laid the blame for the ecological crisis on Christianity's reading of dominion, which led to the development of science and technology and its now out-of-control manipulation of the planet and all its lifeforms.[11] It is therefore not an unfortunate accident but a consequence of human economic systems and the misinterpretation of the Genesis texts that puts all creatures at risk, and increases the numbers of people who experience inequalities of health.

Jewish scholars point out that the word 'Adam', created at the same time as other animals, means 'of the earth' and the word 'Eve' means 'daughter of life'. So if they, and we after them, are to image the creator God, then our role, rather than dominion, is more akin to attentive service of the earth.

Solidarity with the earth makes us more healthy

Calvin de Witt suggests this means we are to keep the creation as God keeps us, we are to exercise a tenacious solidarity with the earth.[12] As such we are also disciples of the Second Adam (Colossians 1.19–20) helping with the restoration and reconciliation of all things. Like Francis with the poor, we are to extend the biblical sabbath (Exodus 20.8–11; 23.8–12) to the Land and all species. Called to enjoy the graciousness of God's good creation, we are not called to posses it out of self-interest. Rather, we are to see it in its vulnerability, and in discerning and judging its threats we are to act for its common good.

The 2020 measures put in place to control the spread of Covid-19 were all components of public health: physical distancing, masks, lockdowns, border controls. These components, and the swift development and implementation of vaccines, provided us with the better conditions that we enjoy in Europe today. Yet the absence of these vaccines in the rest of the world puts the whole planet at risk in the future. The WHO estimates that more than 13 million deaths around the world each year are due to avoidable environmental causes – avoidable only if all our brothers and sisters work together in solidarity for the common good.

Whilst thankful for the number of people immunised in the UK (England, Scotland, Wales and Northern Ireland – the highest number in Europe) we cannot forget the number of deaths. We also buried the highest number of people in Europe. In January 2021, our third 'lockdown' period, it was estimated that the death rate in the UK was the highest rate in Europe. Each death is and has been an individual tragedy and it is also a societal and shared tragedy for us all.

In Mark 3.35 (with parallels in Matthew and Luke), Jesus defines his 'brother and sister and mother' simply as 'whoever does the will of God'. This idea of extending the family network beyond one's direct relatives is mentioned more than 50 times in Acts, over 130 times in Paul's letters, and in nearly every other epistle. In this sense, we are expected to love one another as Jesus loves everyone, and to care for each other equally since we are children of the one God, through our common creation (Acts 17.28–29) and through our belief in God in the Spirit (Romans 8.14–17; John 1.12). It is this spiritual communion and kinship in Christ that should lead us to treat each other with 'brotherly and sisterly' love and care highlighted in 1 Thessalonians 4.9 and 1 Peter 1.22.

Conclusion

Jesus' identification of the poor, the sick and the needy as our 'neighbours' regardless of their age, gender, tribe, race or background history, combined with his own consistent engagement with all peoples, led to his disciples caring for the vulnerable right from the beginning of the church. This ancient model is still appropriate for all our societies, whether we are living in a pandemic or not.

As disciples of the Second Adam, pilgrim people of the Word, we are challenged, as in every previous era, to provoke our governments and fellow citizens to see what is before us, to discern as wisely as we can in the light of our faith and to act together with all who will join us for the common good.

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This article has been adapted from ongoing Movement for Chrisian Workers (MCW) work on Health Poverty in conversation with Fleur Dorrell.