What is Poverty?

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What do we mean by poverty? Not what Dickens or Blake or Mayhew meant. Today, no one seriously expects to go hungry in England or to live without running water or medical care or even TV. Poverty has been redefined in industrial countries, so that anyone at the lower end of the income distribution is poor *ex officio*, as it were—poor by virtue of having less than the rich. And of course by this logic, the only way of eliminating poverty is by an egalitarian redistribution of wealth—even if the society as a whole were to become poorer as a result.

Such redistribution was the goal of the welfare state. But it has not eliminated poverty, despite the vast sums expended, and despite the fact that the poor are now substantially richer—indeed are not, by traditional standards, poor at all. As long as the rich exist, so must the poor, as we now define them.

Certainly they are in squalor—a far more accurate description of their condition than poverty—despite a threefold increase in per-capita income, including that of the poor, since the end of the last war. Why they should be in this condition requires an explanation—and to call that condition poverty, using a word more appropriate to Mayhew's London than to today's reality, prevents us from grasping how fundamentally the lot of "the poor" has changed since then. The poor we shall always have with us, no doubt: but today they are not poor in the traditional way.

The English poor live shorter and less healthy lives than their more prosperous compatriots. Even if u didn't know the statistics, their comparative ill health would be obvious on the most casual observation of rich and slum areas, just as Victorian observers noted that the poor were on average a head shorter than the rich, due to generations of inferior nourishment and hard living conditions. But the reasons for today's difference in health are not economic. It is by no means the case that the poor can't afford medicine or a nourishing diet; nor do they live in overcrowded houses lacking proper sanitation, as in Mayhew's time, or work 14 backbreaking hours a day in the foul air of mines or mills. Epidemiologists estimate that the higher rate of cigarette consumption among the poor accounts for half the difference in life expectancy between the richest and poorest classes in England—and to smoke that much takes money.

Notoriously, too, the infant mortality rate is twice as high in the lowest social class as in the highest. But the infant mortality rate of illegitimate births is twice that of legitimate ones, and the illegitimacy rate rises steeply as you descend the social scale: so the decline of marriage almost to the vanishing point in the lowest social class might well be responsible for most of its excess infant mortality. It is a way of life, not poverty *per se*, that kills. The commonest cause of death between the ages of 15 and 44 is now suicide, which has increased most precipitously precisely among those who live in the underclass world of temporary step-parenthood and of conduct unrestrained either by law or convention.

Just as it is easier to recognize ill health in someone you haven't seen for some time rather than in someone you meet daily, so a visitor coming into a society from elsewhere often can see its character more clearly than those who live in it. Every few months, doctors from countries like the Philippines and India arrive fresh from the airport to work for a year's stint at my hospital. It is fascinating to observe their evolving response to British squalor.

At the start, they are uniformly enthusiastic about the care that we unsparingly and unhesitatingly give to everyone, regardless of economic status. They themselves come from cities—Manila, Bombay, Madras—where many of the cases we see in our hospital would simply be left to die, often without

succor of any kind. And they are impressed that our care extends beyond the merely medical: that no one goes without food or clothing or shelter, or even entertainment. There seems to be a public agency to deal with every conceivable problem. For a couple of weeks, they think this all represents the acme of civilization, especially when they recall the horrors at home. Poverty—as they know it— has been abolished.

Before very long, though, they start to feel a vague unease. A Filipina doctor, for example, asked me why so few people seemed grateful for what was done for them. What prompted her question was an addict who, having collapsed from an accidental overdose of heroin, was brought to our hospital. He required intensive care to revive him, with doctors and nurses tending him all night. His first words to the doctor when he suddenly regained consciousness were, "Get me a fucking roll-up" (a hand-rolled cigarette). His imperious rudeness didn't arise from mere confusion: he continued to treat the staff as if they had kidnapped him and held him in the hospital against his will to perform experiments upon him. "Get me the fuck out of here!" There was no acknowledgment of what had been done for him, let alone gratitude for it. If he considered that he had received any benefit from his stay at all, well, it was simply his due.

My doctors from Bombay, Madras, or Manila observe this kind of conduct open- mouthed. At first they assume that the cases they see are a statistical quirk, a kind of sampling error, and that given time they will encounter a better, more representative cross section of the population. Gradually, however, it dawns upon them that what they have seen *is* representative. When every benefit received is a right, there is no place for good manners, let alone for gratitude.

Case after case causes them to revise their initial favorable opinion. Before long, they have had experience of hundreds, and their view has changed entirely. Last week, for example, to the amazement of a doctor recently arrived from Madras, a woman in her late twenties entered our hospital with the most common condition that brings patients to us: a deliberate overdose. At first she would say nothing more than that she wanted to depart this world, that she had had enough of it.

I inquired further. Just before she took the overdose, her ex-boyfriend, the father of her eight-month-old youngest child (now staying with her ex-boyfriend's mother), had broken into her apartment by smashing down the front door. He wrecked the apartment's contents, broke every window, stole $110 in cash, and ripped out her telephone.

"He's very violent, doctor." She told me that he had broken her thumb, her ribs, and her jaw during the four years she was with him, and her face had needed stitching many times. "Last year I had to have the police out to him."

"What happened?"

"I dropped the charges. His mother said he would change."

Another of her problems was that she was now five weeks pregnant and she didn't want the baby.

"I want to get rid of it, doctor."

"Who's the father?"

It was her violent ex-boyfriend, of course.

"Did he rape you, then?"

"No."

"So you agreed to have sex with him?"

"I was drunk; there was no love in it. This baby is like a bolt out of the blue: I don't know how it happened."

I asked her if she thought it was a good idea to have sex with a man who had repeatedly beaten her up, and from whom she said she wished to separate.

"It's complicated, doctor. That's the way life goes sometimes."

What had she known of this man before she took up with him? She met him in a club; he moved in at once, because he had nowhere else to stay. He had a child by another woman, neither of whom he supported. He had been in prison for burglary. He took drugs. He had never worked, except for cash on the side. Of course he never gave her any of his money, instead running up her telephone bills vertiginously.

She had never married, but had two other children. The first, a daughter aged eight, still lived with her. The father was a man whom she left because she found he was having sex with 12-year-old girls. Her second child was a son, whose father was "an idiot" with whom she had slept one night. That child, now six, lived with the "idiot," and she never saw him.

What had her experience taught her?

"I don't want to think about it. The Housing'll charge me for the damage, and I ain't got the money. I'm depressed, doctor; I'm not happy. I want to move away, to get away from him."

Later in the day, feeling a little lonely, she telephoned her ex-boyfriend, and he visited her.

I discussed the case with the doctor who had recently arrived from Madras, and who felt he had entered an insane world. Not in his wildest dreams had he imagined it could be like this. There was nothing to compare with it in Madras. He asked me what would happen next to the happy couple.

"They'll find her a new flat. They'll buy her new furniture, television, and refrigerator, because it's unacceptable poverty in this day and age to live without them. They'll charge her nothing for the damage to her old flat, because she can't pay anyway, and it wasn't she who did it. He will get away scot-free. Once she's installed in her new flat to escape from him, she'll invite him there, he'll smash it up again, and then they'll find her somewhere else to live. There is, in fact, nothing she can do that will deprive her of the state's obligation to house, feed, and entertain her."

I asked the doctor from Madras if poverty was the word he would use to describe this woman's situation. He said it was not: that her problem was that she accepted no limits to her own behavior, that she did not fear the possibility of hunger, the condemnation of her own parents or neighbors, or God. In other words, the squalor of England was not economic but spiritual, moral, and cultural.

I often take my doctors from the Third World on the short walk from the hospital to the prison nearby. It is a most instructive 800 yards. On a good day—good for didactic purposes, that is—there are seven or eight puddles of glass shattered into fragments lying in the gutter en route (there are never none, except during the most inclement weather, when even those most addicted to car theft control their impulses).

"Each of these little piles of smashed glass represents a car that has been broken into," I tell them. "There will be more tomorrow, weather permitting." The houses along the way are, as public housing goes, quite decent. The local authorities have at last accepted that herding people into giant, featureless, Le Corbusian concrete blocks was a mistake, and they have switched to the construction of individual houses. Only a few of their windows are boarded up. Certainly by comparison with housing for the poor in Bombay, Madras, or Manila they are spacious and luxurious indeed. Each has a little front yard of grass, surrounded by a hedge, and a much larger back yard; about half have satellite dishes. Unfortunately, the yards are almost as full of litter as municipal garbage dumps.

I tell my doctors that in nearly nine years of taking this walk four times a week, I have never seen a single instance of anyone attempting to clean his yard. But I have seen much litter dropped; on a good day, I can even watch someone standing at the bus stop dropping something on the ground no farther than two feet from the bin.

"Why don't they tidy up their gardens?" asks a doctor from Bombay.

A good question: after all, most of the houses contain at least one person with time on his or her hands. Whenever I have been able to ask the question, however, the answer has always been the same: I've told the council [the local government] about it, but they haven't come. As tenants, they feel it is the landlord's responsibility to keep their yards clean, and they are not prepared to do the council's work for it, even if it means wading through garbage—as it quite literally does. On the one hand, authority cannot tell them what to do; on the other, it has an infinitude of responsibilities towards them.

I ask my Third World doctors to examine the litter closely. It gives them the impression that no Briton is able to walk farther than ten yards or so without consuming junk food. Every bush, every lawn, even every tree, is festooned with chocolate wrappers or fast- food packaging. Empty cans of beer and soft drinks lie in the gutter, on the flower beds, or on top of the hedges. Again, on a good day we actually see someone toss aside the can whose contents he has just consumed, as a Russian vodka drinker throws down his glass.

Apart from the antisocial disregard of the common good that each little such act of littering implies (hundreds a week in the space of 800 yards alone), the vast quantity of food consumed in the street has deeper implications. I tell the doctors that in all my visits to the white households in the area, of which I've made hundreds, never—not once—have I seen any evidence of cooking. The nearest to this activity that I have witnessed is the reheating of prepared and packaged food, usually in a microwave. And by the same token, I have never seen any evidence of meals taken in common as a social activity—unless two people eating hamburgers together in the street as they walk along be counted as social.

This is not to say that I haven't seen people eating at home; on the contrary, they are often eating when I arrive. They eat alone, even if other members of the household are present, and never at table; they slump on a sofa in front of the television. Everyone in the household eats according to his own whim and timetable. Even in so elementary a matter as eating, therefore, there is no self-discipline but rather an imperative obedience to impulse. Needless to say, the opportunity for conversation or sociality that a meal taken together provides is lost. English meals are thus solitary, poor, nasty, brutish, and short.

I ask the doctors to compare the shops in areas inhabited by poor whites and those where poor Indian immigrants live. It is an instructive comparison. The shops the Indians frequent are piled high with all kinds of attractive fresh produce that, by supermarket standards, is astonishingly cheap. The women take immense trouble over their purchases and make subtle discriminations. There are no pre-cooked

meals for them. By contrast, a shop that poor whites patronize offers a restricted choice, largely of relatively expensive prepared foods that at most require only the addition of hot water.

The difference between the two groups cannot be explained by differences in income, for they are insignificant. Poverty isn't the issue. And the willingness of Indians to take trouble over what they eat and to treat meals as important social occasions that impose obligations and at times require the subordination of personal desire is indicative of an entire attitude to life that often permits them, despite their current low incomes, to advance up the social scale. Alarmingly, though, the natural urge of the children of immigrants to belong to the predominant local culture is beginning to create an Indian underclass (at least among young males): and the taste for fast food and all that such a taste implies is swiftly developing among them.

When such slovenliness about food extends to all other spheres of life, when people satisfy every appetite with the same minimal effort and commitment, no wonder they trap themselves in squalor. I have little trouble showing my doctors from India and the Philippines that most of our patients take a fast-food approach to all their pleasures, obtaining them no less fleetingly and unstrenuously. They have no cultural activity they can call their own, and their lives seem, even to them, empty of purpose. In the welfare state, mere survival is not the achievement that it is, say, in the cities of Africa, and therefore it cannot confer the self-respect that is the precondition of self-improvement.

By the end of three months my doctors have, without exception, reversed their original opinion that the welfare state, as exemplified by England, represents the acme of civilization. On the contrary, they see it now as creating a miasma of subsidized apathy that blights the lives of its supposed beneficiaries. They come to realize that a system of welfare that makes no moral judgments in allocating economic rewards promotes antisocial egotism. The spiritual impoverishment of the population seems to them worse than anything they have ever known in their own countries. And what they see is all the worse, of course, because it should be so much better. The wealth that enables everyone effortlessly to have enough food should be liberating, not imprisoning. Instead, it has created a large caste of people for whom life is, in effect, a limbo in which they have nothing to hope for and nothing to fear, nothing to gain and nothing to lose. It is a life emptied of meaning.

"On the whole," said one Filipino doctor to me, "life is preferable in the slums of Manila." He said it without any illusions as to the quality of life in Manila.

These doctors have made the same journey as I, but in the reverse direction. Arriving as a young doctor in Africa 25 years ago, I was horrified at first by the physical conditions, the like of which I had never experienced before. Patients with heart failure walked 50 miles in the broiling sun, with panting breath and swollen legs, to obtain treatment—and then walked home again. Ulcerating and suppurating cancers were common. Barefoot men contracted tetanus from the wounds inflicted by a sand flea that laid its eggs between their toes. Tuberculosis reduced people to animated skeletons. Children were bitten by puff adders and adults mauled by leopards. I saw lepers with noses that had rotted away and madmen who wandered naked in the torrential rains.

Even the accidents were spectacular. I treated the survivors of one in Tanzania in which a truck—having no brakes, as was perfectly normal and expected in the circumstances— began to slide backward down a hill it had been climbing. It was laden with bags of corn, upon which 20 passengers, including many children, were riding. As the truck slid backward, first the passengers, then the corn, fell off. By the time I arrived, ten dead children were lined up by the side of the road, arranged in ascending order as neatly

as organ pipes. They had been crushed or suffocated by the bags of corn that fell on top of them: a grimly ironic death in a country chronically short of food.

Moreover, political authority in the countries in which I worked was arbitrary, capricious, and corrupt. In Tanzania, for example, you could tell the representative of the sole and omnipotent political party, the Party of the Revolution, by his girth alone. Tanzanians were thin, but party men were fat. The party representative in my village sent a man to prison because the man's wife refused to sleep with him. In Nigeria the police hired out their guns by night to the armed robbers.

Yet nothing I saw—neither the poverty nor the overt oppression—ever had the same devastating effect on the human personality as the undiscriminating welfare state. I never saw the loss of dignity, the self-centeredness, the spiritual and emotional vacuity, or the sheer ignorance of how to live, that I see daily in England. In a kind of pincer movement, therefore, I and the doctors from India and the Philippines have come to the same terrible conclusion: that the worst poverty is in England—and it is not material poverty but poverty of soul.