


Position Paper on 'Tackling Health Inequalities'

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NICE, National Institute for Health and Clinical Excellence, ENG/ UK
NIHD, National Institute for Health Development, EE
STAKES, National Research and Development Centre for Welfare and Health, FIN
INPES, Institut National de Prévention et d'Education de Santé, F
BZgA, Bundeszentrale für gesundheitliche Aufklärung, D
ISPM, Institute of Social and Preventive Medicine, EL
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Despite prosperity and overall improvements of population health, social variations in health and life expectancy (which are commonly referred to as 'health inequalities'), are observed in all European countries. They pose a great challenge to the field of health promotion and health policy. In the frame of the EU project 'Closing the Gap', European countries are encouraged to exchange policies and practices that meet this challenge successfully.

Before coming to a definition of the concept of health inequalities, it is important to consider why it should be a central aim to 'tackle' health inequalities at all.

First of all, Article 152 (4) of the Treaty establishing the European Community declares that a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities. Also, it has been declared by Health 21 - the health policy framework for WHO's European Region - that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being (WHO European Region, 1999).

Apart from the ethical argument regarding health equalities as such, it must be stressed that health is an important factor for economic development. The cost of disease, disability and premature death (of population groups) puts an enormous economic burden on society and the individual, specifically through mechanisms related to labour. These costs, which have been estimated in a European study soon to be published, go far beyond those which are spent on the treatment of disease (Mortensen et al., 2005).

The aim of this paper is to develop a common understanding of the concept of 'health inequalities', and to help in our further work in the frame of the EU project 'Closing the Gap': It will be the theoretical underpinning for all tasks at the EU, national or local level.

1. The distinction between health inequalities and health inequities

The term 'health inequalities' does not precisely reflect the problem discussed. **Health inequalities** is the generic term used to designate differences, variations, and disparities in the health achievements of individuals and groups. **Health inequities** refer to those inequalities in health that are deemed to be unfair, unacceptable or stemming from some form of injustice (Kawachi, Subramanian & Almeida-Filho, 2002), such as

- health-damaging behaviour where the degree of choice of lifestyles is restricted,
- exposure to unhealthy, stressful living and working conditions,
- inadequate access to essential health and other public services,
- health-related social mobility involving the tendency for sick people to move down the social scale (Whitehead, 1990) (cf. 4).

This does, to date preclude natural, biological variations. As social epidemiological research advances however, we increasingly find that individual characteristics vary or interact with socio-economic status; such as height, which is supposed to be a marker of social disadvantage in early childhood (Power et al., 2003).

In the frame of the project, we refer to health inequities, but **use the technical term of 'health inequalities'**. This term might not be used in all countries. Whether this is so, and why (because it does not translate, because public is not aware of it, or because of other reasons), will be further elaborated in 'Closing the Gap'.

2. Evidence of health inequalities

Evidence on social variations in health and life expectancy in all European countries has accumulated over the last decades (Drever & Whitehead, 1997; Marmot & Wilkinson, 2005; Mackenbach & Bakker, 2002; Marmot & Bobak, 2000), and points to the fact that, despite overall improvements in health and welfare policies, an individual's socio-economic position is strongly associated with health and disease across the life span:

- childhood mortality, morbidity and accidents are more prevalent in socially disadvantaged groups,
- health-damaging behaviours like smoking, bad diet and lack of physical activity are more prevalent among the poorer parts of the population,
- the risk of developing chronic illness in adult life, for example coronary heart disease or depression, is elevated for persons with a low socio-economic background and premature mortality is more frequent.

Furthermore, international studies show that relative mortality differences between high and low socio-economic groups have **increased** within European countries (Mackenbach et al., 2003), pointing to actual differences in life expectancy of four to six years in men and two to four years in women (Mackenbach, 2005).

The Social Gradient

Social epidemiological research indicates that poor health is not simply confined to those at the bottom of the social hierarchy: There is a 'social gradient' of mortality and morbidity that affects all members of society: With each step one moves down the social ladder, the worse one's health (see Figure 1). Marmot and colleagues were the first to show this gradient in their study of British civil servants, known as the Whitehall studies (Marmot, Shipley, & Rose, 1984). Since then the social gradient has been shown for many diseases and health determinants.

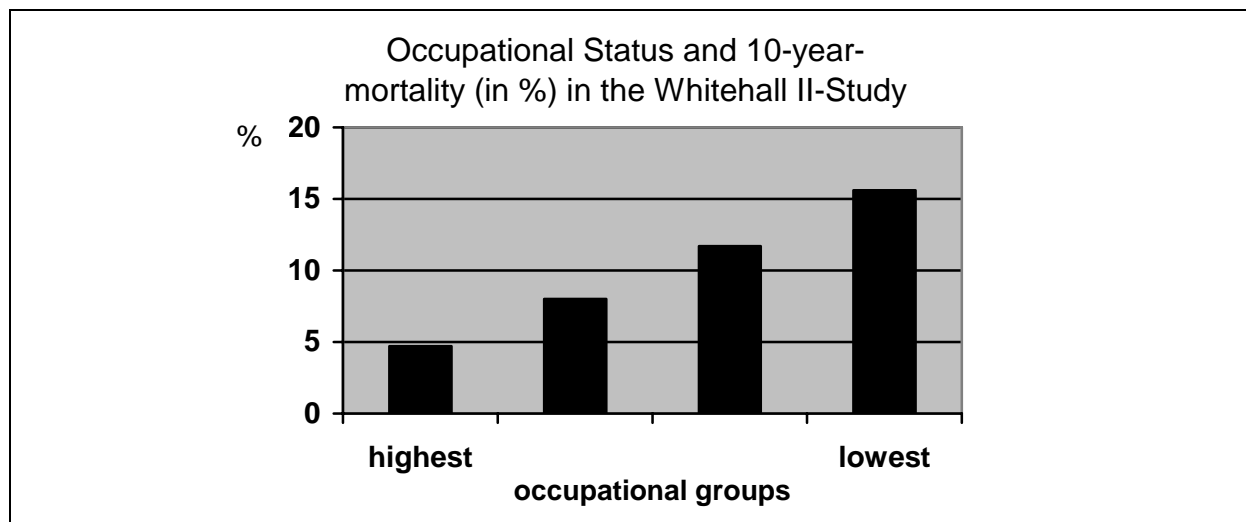


Figure 1: The health gradient in the Whitehall II-Study, UK

In other words: there are 'systematic differences in the health of groups and communities that occupy unequal positions in society' (Graham, 2004a, p. 101). 'Social position' is understood as the individual location in social strata, either in vertical ones such as educational, occupational or income groups; or in horizontal ones, such as age, gender, ethnicity groups

etc. Regardless of individuality, a given social position is associated with specific material, behavioural and psychosocial resources and risk factors - a phenomenon which is termed 'social inequalities' – and thereby with health. Over and above material factors, social position determines the amount of control over life, and opportunities for full social engagement and participation, which are considered to play a crucial role for health and well-being (Marmot, 2004).

In the frame of the project, we mainly focus on the above mentioned vertical inequalities as measured by education, occupational status and income. However, other aspects of inequalities that concern parts of the population, e.g. with regard to age, gender, ethnicity, residential area or family status, should also be recognized if they have relevance in respective countries.

3. Societal determinants of health

The aforementioned resources and risk factors associated with social position do reflect the underlying concept of disease causation, which is relevant in the context of health inequalities. It is the concept of societal health determinants (Dahlgren & Whitehead, 1991), where the focus has widened from more proximal factors of disease causation to more distal ones; as it is illustrated in Figure 2.

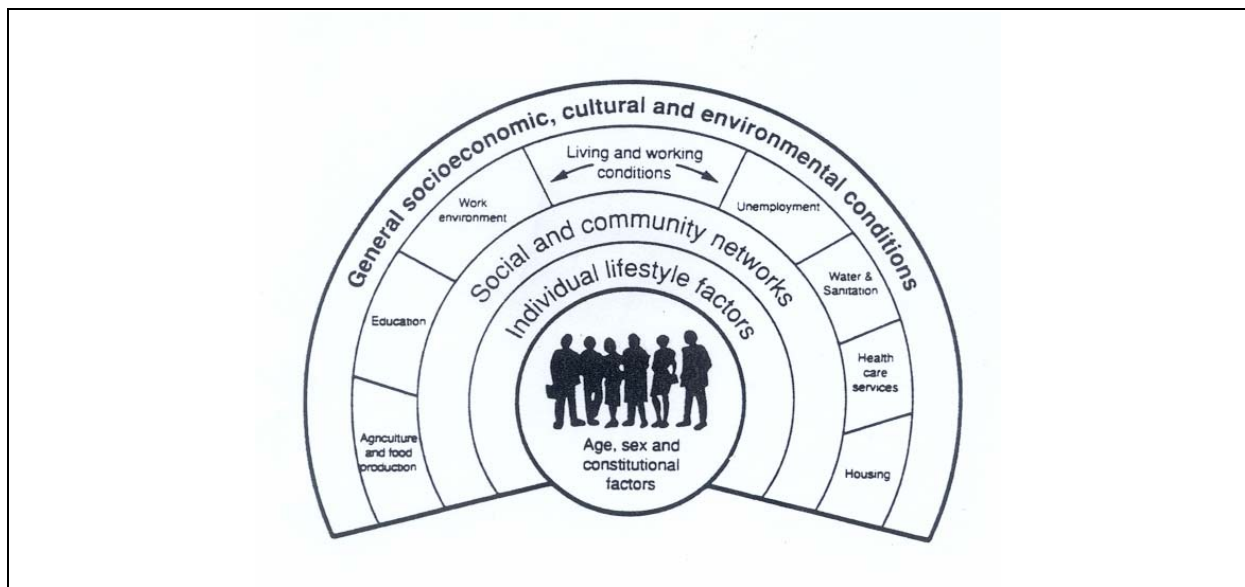


Figure 2: societal health determinants

Concepts of societal health determinants differ in style and complexity but in general they comprise the following factors (from upstream to downstream):

- Social, cultural, economic and environmental context (in which the)
- individual social position (is embedded which connects the individual to)
- intermediate factors such as material, psychosocial and psychological factors, health behaviour, health care accession, quality and utilisation (which mediate or moderate)
- biological and genetic factors (which, in turn, affect people's vulnerability to)
- illness and injury (which feed back into the causal chain by weakening one's social position)
- i.e. social selection (cf. 4).

There are multiple pathways running from the social structure through living and working conditions to health-related beliefs and behaviours. 'Closing the Gap' will embrace this holistic approach to health and integrate public health and health promotion policies and interventions with a link to these 'layers'.

4. Explanations of health inequalities

Apart from the different layers of influence on health as explained above, it is crucial to ask what brings about *inequalities* in health. There are different explanations discussed in social epidemiology, referring to the spectrum of upstream and downstream factors mentioned above, and also considering the time perspective:

With regard to society as a whole, there are processes and policies that influence the unequal distribution of societal health determinants; like income distribution, educational policies or housing standards.

Also, there are inequalities in access to, and quality of the health care system. However, the social gradient in health is also found in welfare states with a relatively free access to medical treatment, such as the Scandinavian countries or Germany.

Aggregate deprivation, i.e. living in areas characterized by low income, high percentage of unemployment, poor infrastructure etc., increases the risk of poor health above and beyond factors on individual level. This is called 'context effect'.

Concerning the more proximal health determinants, there are different phases in the life course which are crucial for health inequalities: (1) Exposure to adverse material and psychosocial circumstances in early childhood have a negative influence on cognitive ability, socio-emotional adjustment and physical development in childhood and later life. (2) Health-related behaviour is shaped in adolescence. Boys and girls who suffer from social disadvantage and conflict are more likely to smoke, drink and have a poor diet than their peers. (3) In adult age, a lack of material resources and psychosocial stress at work or home is more common in socially disadvantaged persons. Some of the most prevalent diseases such as coronary heart disease and depression are, among others, elicited through chronic stress.

The resulting health inequalities are likely to be caused both by a differential **exposure** to, and a differential **vulnerability** towards health determinants: It has been shown that risk factors such as adverse childhood circumstances, adolescent health behaviour or psychosocial stress, are more prevalent in persons with a lower socio-economic status (cf. 2). In this case, low socio-economic status mediates the risk factor which is relevant to disease (mediation hypothesis). But it is also obvious that the effects of these factors on health are more pronounced in low socio-economic groups, e.g. due to a lack of resources or

due to concomitant risk factors. Here, low socio-economic status modifies the effect of risk factors on health (modification hypothesis) (see Figure 3).

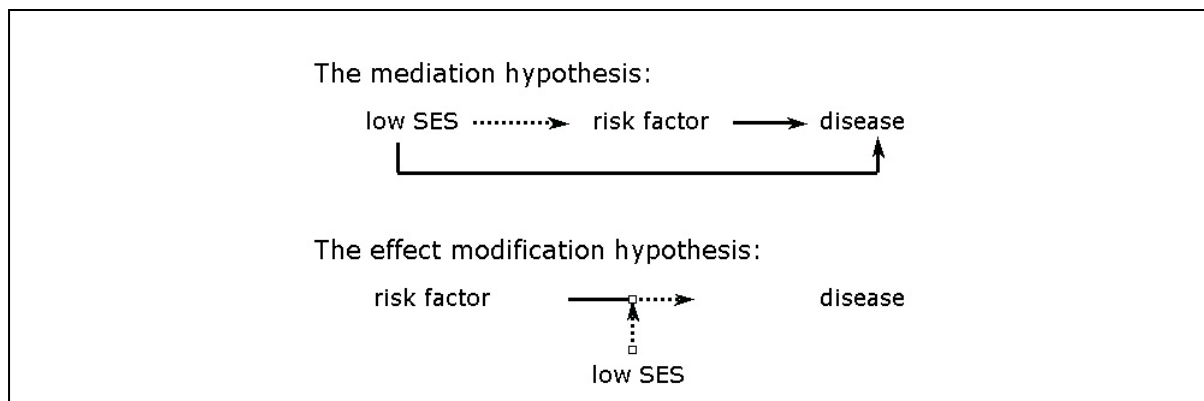


Figure 3: Differential exposure to and differential vulnerability towards risk factors in low social classes

Finally, it is important to note that poor health and disability can lead to low socio-economic status by poor school achievements, loss of job, lack of income etc. This causal pathway, which is called 'downward mobility', also contributes to health inequalities. In the worst case it sets in motion a vicious circle of disease and social disadvantage.

5. Implications for health policy

The understanding of the emergence of health inequalities has thus reached the point where a range of **entry points for policies and interventions** can be defined (Bakker & Mackenbach, 2002). More upstream factors include employment, social and health policies, welfare system, health care system, social and spatial environment, living standard etc. More downstream factors comprise of physical and psychosocial working conditions, health behaviour, health care, etc. Overall, it is important to start targeted prevention and health promotion measures in socially disadvantaged population groups, and as early as possible in the life course.

While much evidence on manifestations and causes of health inequalities exists, and while tackling them is a main goal of public health and health promotion policy, there are multiple understandings of what that goal means and how policies and strategies to tackle health inequalities should be designed and implemented.

In practice, there are different approaches (Graham, 2004b):

- 1) **Improving health of the worst off:** Interventions focus on the poor parts of the population, and may include measures to improve educational performance, housing, health behaviour etc. These interventions do not necessarily have an impact on the health gap between low and high socio-economic groups, because the overall population health may be improving faster. Effectivity would be rated by a comparison of health indicators before and after the intervention. Ideally, there is an absolute improvement in health and determinants. Note that there might be delayed effects of the treatment!
- 2) **Addressing the disparity in health status between rich and poor:** Interventions address the poor and include measures as mentioned above. It is not only important that they change health and its determinants over time, but that improvements are speeded up sufficiently compared to the other groups. Then the gap in health and determinants between the poorest group and the best off, or the average of the population might be

closed. For the evaluation of these interventions, we need information on the health improvements in the target group and the comparison group.

- 3) **Addressing the disparity between social classes & across the spectrum of advantage and disadvantage:** Interventions target the poor and groups in the middle of social stratification, and include measures as mentioned above; But effects must have a higher impact the lower the social class. This can be achieved by a combination of population-based interventions, and additional services for poorer communities, families or individuals. As a result the health gradient flattens. For evaluation, it is important to have information on health improvements in all socio-economic groups.

It is important to note that there is no 'gold standard' in tackling health inequalities. Whether it consists (1) in promoting the health of the worst off, (2) in closing the health gap between the worst and comparison groups, (3) in reducing health gradients across society or a mixture of all three depends on the specific situation and need of populations.

6. Conclusion and next steps

It has become clear that health inequalities are a common problem, and concern everybody in society. Tackling these unjust variations in health and life expectancy is a legally, economically and socially justified aim. Achieving this aim must apply the comprehensive approach of public health and health promotion, as defined by the Ottawa Charter (WHO, 1986), according to which health policy not only entails actions directed at strengthening the skills and capabilities of individuals but also involves actions directed towards changing their social, environmental and economic conditions, so as to alleviate their impact on public and individual health.

This paper is an output of the first project year of 'Closing the Gap', and it is based on research and discussion with project partners and members of the advisory board. It will be further developed in the course of the project, depending on new evidence emerging and new aspects which may be raised in the ongoing discussion. The paper will also provide a basis for a declaration on tackling health inequalities, which will be executed by the European Partners for Equity in Health in spring 2007.

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