EUROPE

European Committee for Health Promotion Development

Reducing inequalities in health – proposals for health promotion policy and action

World Health Organization Regional Office For Europe

Consensus Statement

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Reducing inequalities in health – proposals for health promotion policy and action

contents

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Background

section I

The implications of the growing body of evidence about social inequalities in health are profound, not least for the field of health promotion. Arguments for taking action on social inequalities in health are now being put forward in the literature on grounds of effectiveness, efficiency, social solidarity, social cohesion and human rights.

In terms of effectiveness of health promotion policies, for instance, it has been argued that it would be difficult, perhaps impossible, to meet countrywide or local health targets if the heavier burden of illhealth in the disadvantaged sections of the population was not specifically addressed.

On economic grounds, it has been observed that these inequalities in health represent a huge wastage of human (and economic) resources, which, if tapped, could be used to the benefit of individuals and society as a whole.

The social solidarity argument notes that inequalities in health are one manifestation of a more general disintegration of society. Action to tackle health inequalities could be one focus for rebuilding social cohesion.

The human rights case is that the existence of inequalities in health demonstrates that substantial sections of the population are prevented from achieving their full health potential, and that this prevents them from gaining access to other basic human rights. It follows that societies should organize their resources for health equitably, so as to make them accessible to everybody.

The ECHPD process

section II

The issue of social inequalities in health was discussed by the European Committee for Health Promotion Development (ECHPD) at its third meeting, held in Brighton, England, 1–3 April 1998. For this purpose, an international review of the evidence on social inequalities in health had been commissioned by the WHO Regional Office for Europe (Health Promotion and Investment for Health programme). The review, based mainly on European studies, has provided the scientific backbone of this consensus document.[1]

At and after the Brighton meeting, many comments were received from ECHPD members. Furthermore, an earlier draft of this consensus document was presented on behalf of the ECHPD to a workshop at the XVIth World Conference on Health Promotion and Health Education, San Juan, Puerto Rico, 21–26 June 1998. Thus, the present document is the outcome of a widespread participatory process.

[1] Whitehead, M. et al. *Social inequalities in health:what are the issues for health promotion?* WHO Regional Office for Europe, 1998. Health Promotion and Investment programme.

Aims and expected impact

section III

Through a Europe-wide dissemination of this consensus document, the ECHPD aims to:

i. increase awareness among policy-makers, health professionals, intergovernmental and nongovernmental organizations and other interested parties, of the negative effects of persisting inequalities in health within and among countries;

ii. clarify the implications of these inequalities for health promotion policies and programmes; and

iii. provide a focus for action on a number of key issues that health promotion should address in order to make the reduction of inequalities in health a major target.

It is expected that this document will be translated into all the languages of the Member States of the WHO European Region. Its impact will be judged by its usefulness to direct debate and health promotion action at all levels of decision-making.

Summary of European trends

section IV

This section provides a short overview of relevant European trends related to social inequalities in health. The implications of these trends for health promotion policy and programmes are briefly outlined.[2]

[2] A comprehensive analysis of these trends may be obtained from the WHO European Office for Investment for Health and Development, Venice, Italy.

Evidence of substantial health divides

The international evidence points to an uneven distribution of health and disease, favouring those in socially advantaged positions, whether position is measured by income, education, occupation or other indicator of socioeconomic status. The magnitude of the differentials is substantial, not trivial. For example, mortality rates are commonly two-to three-fold greater for people at the bottom than at the top of the social scale; life expectancy is five years less for unskilled workers than for professionals; there is a gap of between nine to twelve years in disability-free life expectancy between poor and rich people.

Raised concern in Europe about this issue has in part been triggered by greater awareness, which has arisen from better measurement and monitoring in the growing number of countries which have set out to assess the scale of the problem. In several countries there is the added concern that these inequalities have been widening. This is most evident in central and eastern Europe and has been unparalleled in scale among industrialized nations this century. In some countries, such as the Russian Federation, where the overall health of the population has declined, increasing inequalities indicate the dramatic effects of social and economic upheaval. But countries with favourable health profiles, such as Denmark, the Netherlands and Sweden are also signalling persisting or growing inequalities, and these are emerging as prime public health concerns.

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Differential deterioration in women's health, particularly among women from more disadvantaged social groups, is a development which is becoming the focus of attention of policy-makers and politicians in these countries. In some countries there are clear ethnic inequalities in health. Evidence from the United Kingdom, as well as from other countries, suggests that these are largely a consequence of the disadvantaged socioeconomic position of some ethnic minority groups.

The evidence shows not only that all countries have social differentials in health but, crucially, that the magnitude and nature of these inequalities vary from place to place and time to time – indicating that they are not fixed, but in principle could be changed. The best levels achieved by any country should act as a guide to feasible health promotion goals for other countries.

Differential exposure to risks and health hazards

When considering the underlying reasons for the observed differentials in health, there is a growing consensus that a prominent role is played by systematic differentials in exposure to health hazards and risk conditions in the population. This means that some groups in society have a much poorer chance of achieving their full health potential than others, because of their life circumstances – the physical, psycho–social and socioeconomic conditions of their lives.

the lower the social class, the more likely people are to experience physical strain, serious injury, high noise and air pollution levels

So, for example, considering living and working conditions, there is evidence of differential exposure to health-damaging physical and psychosocial conditions across social groups. In the work environment, for example, the lower the social class, the more likely people are to experience physical strain, serious injury, high noise and air pollution levels, as well as higher levels of psychosocial stress caused by the forced pace of work over which they have little control.

When considering the distribution of behavioural factors that are health-enhancing or health-damaging, there is evidence that poorer socioeconomic groups tend to have poorer nutrition, less physical activity in leisure time, greater prevalence of smoking and more damaging patterns of alcohol use. That is only half the story, though. It is of critical importance to understand *why* this should be so. The growing literature from qualitative studies of

the life circumstances of people experiencing disadvantage highlights the greater restrictions on their choices of healthier lifestyles, by practical constraints of time, space and money, as well as psychosocial mechanisms.

These patterns are compounded by differential access to facilities and services that could help prevent or ameliorate the damage to health caused by socioeconomic factors. For example, differentials can often be found in access to and quality of essential health services for different sections of the population, with the healthier, more affluent groups enjoying greater access. This applies to preventive, curative and health promotion services.

The accumulation of health damage

In many countries, there is an accumulation of health hazards, risk factors, and risk conditions such as unemployment or job insecurity, in less advantaged socioeconomic groups. It is often the case that the people who live in the poorest housing and have the most unsafe working conditions are also the people who have the greatest risk of unemployment, have poor diets, are more likely to be smokers and have restricted access to health care when ill. It is important to view the overall pattern of risk exposure, not just each factor separately. Studies that have looked at the contributions made by the various factors point to the major role played by structural determinants of health and structurally determined lifestyles in the observed social inequalities in health. Taking a life-course perspective – looking at the trajectories of different social groups from birth to old age – this cumulative disadvantage becomes even clearer. In an assessment of the British evidence, for example, a Department of Health report in 1995 concluded:

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It is likely that cumulative differential exposure to health damaging or health promoting physical and social environments is the main explanation for the observed variations in health and life expectancy.

Moreover, the major transformations currently taking place in economic and social life are tending to weaken social solidarity, cohesiveness and inclusion in many societies. The evidence suggests that this is having a disproportionate impact on younger age groups, and especially younger men, for whom traditional paths to security, hope, self-esteem and self-confidence have become eroded. Unless effectively addressed, this seems likely to add to the accumulation of damage in future.

Implications for health promotion

section V

The implications of this growing body of evidence are profound**.** In addressing the problem a good balance must be struck between public and personal commitment to reduce inequalities. The following ten points have been put forward to provide an approach through which inequalities in health can be reduced.

All who are involved in planning health promotion policies and programmes, whether at local, national or international level, need to:

Accept the principle that reducing inequality in health means adopting higher levels or standards as the norm

point 1.

There is a risk that as a result of expediency or financial constraints, action will be taken which, while it might raise some people's level of health, might be at the expense of the level of health enjoyed by others. This must be avoided. Health promotion action must ensure that health inequalities are reduced in an equitable, ethical and sustainable manner.

point 2.

Address the uneven distribution of health-related factors across the population, not just averages

Health promotion policy should be based on an understanding of the uneven distribution of:

- health and disease
- exposure to health hazards
- behavioural risk factors
- risk conditions
- opportunities and barriers to adopting a healthier lifestyle
- access to essential goods and services, such as health care.
- health assets

At the very least, the social differentials in these factors need to be taken into consideration in the policy-making process. To do this requires better measurement and monitoring. Information systems need to be examined to see how they can be modified, for example, to identify gender-specific, socioeconomic and ethnic groups at particular risk. The recording of socioeconomic variables needs to be added to health information systems; for example, all data on morbidity and mortality should be related, in addition to age and sex, to socioeconomic background variables. Conversely, more health information could be added to routine socioeconomic data collection.

point 3.

Tackle the root causes of inequalities in health in society, and accept that these causes include broad structural factors in the social and economic environment, beyond individual lifestyles and health care

This requires, among other things, a commitment to carry out heath impact assessments of policies and programmes in a wide range of sectors, so that “unhealthy policies” can be identified and “healthier” ones developed where necessary. The focus of the assessment process should be the impact of policies on the health and circumstances of the most vulnerable sections of society. The means for policy development and

implementation lie in partnership working and much closer intersectoral collaboration than have so far been the case in most societies.

Overcome structural barriers to healthier lifestyles and create supportive environments

point 4.

The research evidence clearly indicates the importance of structurally determined lifestyles rather than freely chosen lifestyles among less privileged socioeconomic groups. In short, the evidence reinforces the need for combining structural changes, related to economic, living and working conditions, with health education efforts, when trying to influence lifestyle factors, such as smoking or eating habits. Furthermore, general policies for health promotion and disease prevention need to take fully into account the reality experienced by socioeconomically less privileged groups.

It is therefore necessary to ensure that health education is combined with broad-based policy action and a range of services and amenities which make it easier for people to take control over their lives and health, and thus to act on health information, education, advice and encouragement. Effectively tackling the underlying causes of inequalities in health will also serve to boost the effectiveness of health education, by lowering the barriers to good health. Conversely, isolated health education campaigns based on reality as experienced mainly by people in middle and upper socioeconomic categories, are likely to be effective primarily among more privileged groups and thus may increase, rather than reduce, the health divide.

Monitor differential effectiveness of interventions and policies on different sections of the population and ensure that interventions are matched more closely to different needs

point 5.

It cannot be assumed that all health promotion interventions will be equally effective for all social groups. The case of tobacco control policies illustrates this point well.

From international studies, there is evidence that when fiscal policy is used to regulate the price of cigarettes, this usually has a greater influence on smoking among teenagers than on the adult population. Furthermore, these studies reveal that price usually has a greater effect on low income adults, with poor smokers more likely to reduce tobacco consumption in response to price increases than the richest smokers. Conversely, anti-smoking publicity is very often most effective with higher socioeconomic groups and least effective with groups experiencing disadvantage.

There are further complexities to this issue, though. One issue is that a direct consequence of tobacco price rises is a reduction in the real incomes of those people living in poverty who continue to smoke, pushing them further into hardship. In turn, their state of hardship makes it more and more difficult to quit smoking, because of the psychosocial processes coming into play. In several European countries, the dilemma caused by this clash of policy impacts has generated intense debate among agencies primarily concerned with tobacco control and those primarily concerned with relieving and preventing poverty. There is some consensus that while price increases on tobacco have an important role to play in reducing tobacco consumption in the general population, much more assistance is needed to help the poorest groups to stop, and this assistance would need to take account of their difficult circumstances. At the same time, it is increasingly being recognized that tobacco control policy cannot be seen in isolation from policies to ameliorate the financial and social hardship of people living on low incomes. The tobacco control lobby will need to join forces with social policy advocates in the future if the tobacco epidemic is to be reduced.

point 6. **Establish evaluation and monitoring mechanisms that enable an assessment to be made of the impact of the activity on reducing inequality**

Evaluation and monitoring processes and methodologies must incorporate criteria that will enable an assessment to be made of whether or not the programme has resulted in a reduction in levels of inequality. To do this requires identifying the criteria that will be used to assess the process and outcomes and establishing a monitoring and evaluation framework at an early stage in the planning process.

Establish appropriate accountability mechanisms to ensure that health promoting policies and programmes reduce inequality in health

point 7.

The reduction of inequalities in health needs to be placed on the agenda of key decision-makers, be they senior figures within political organizations, the public and private sectors, or NGOs. Given the involvement of such a wide range of organizations, however, it is imperative that a strategic approach be developed, with clear lines of accountability, to ensure that common goals can be demonstrably achieved.

Ensure professional development is available for those working to reduce inequality through health promotion activity

point 8.

If it is accepted that equity is integral to health promotion policies and programmes, it is essential that the people responsible for implementing those policies and programmes are skilled enough to pursue the goal of reducing inequality. Such policies and programmes will affect groups within society whose support and engagement in the process of health promotion will need to be sensitively gained. To work effectively in this manner requires specific knowledge and skills, or there is a risk of doing more harm than good. This necessitates appropriate training and professional development for health workers and other relevant professional groups.

point 9.

Set equity targets in national and local health promotion strategies in an integrated and coherent manner

The evidence about social inequalities in health has implications for how targets for improving population health are designed and monitored. It is clear that limiting actions only to general targets is likely to be inadequate from both an ethical and practical point of view. General targets cannot acknowledge that some groups in society start from a much worse position and could not be expected to progress as far as others by a specified target date. They therefore risk being unrealistic in predicting the improvements that could reasonably be achieved. Moreover, they may encourage a focus on groups in the population who are quicker and easier to influence, in a bid to reach the specified targets, irrespective of whether other sections of society are neglected as a result. Targets need to be carefully constructed to avoid these pitfalls, while demonstrating an explicit commitment to tackling inequalities in health.

point 10.

Empower the powerless, include the excluded

The evidence about social inequalities in health highlights the issue of social exclusion. Although in principle everyone has the right to participate in decisions affecting their health and to play a contributory role in society, in practice some are denied that right through the powerlessness and exclusion that comes from lack of money, lack of education, lack of influence. Often the most health-damaging effects of inequality are those that exclude people from meaningful participation in society, denying them self-respect and dignity.

The implications for health promotion are numerous. To empower and include groups who are traditionally excluded is a major task for the field of health promotion: helping to open up greater access to information and relevant skills; ensuring the provision of financial resources for self-management, providing more sensitive

channels of communication between decision–makers and socially excluded groups and individuals; and doing so in a way which promotes self-respect, dignity and mutual trust - openly acknowledging mutuality and partnership, and seizing opportunities for mutual learning.

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This embodies major ethical implications for health promotion practice. The ethical principle that "everyone is of equal worth" should underpin policy and practice, whether in one-to-one interactions between a professional and an individual person or in the development of healthy public policy to cover a whole nation. The dilemmas are numerous: for example, how to inform without lecturing and sapping self-confidence; how to open up access and contact without invading privacy; how to make extra efforts to improve the health of people experiencing disadvantage without bullying them to take part in preventive activities against their will. The challenge is to open up opportunities for everyone in the population.

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