SOCIOECONOMIC INEQUALITIES IN HEALTH IN EUROPE

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Erasmus MC
ECONOMIC PROSPERITY
average income per inhabitant, 2002

World Bank 2004
LIFE EXPECTANCY
at birth, in years, men 2003

Legend:
- 32.4 - 41.9
- 42.0 - 46.9
- 47.0 - 53.9
- 54.0 - 60.9
- 61.0 - 64.9
- 65.0 - 67.9
- 68.0 - 69.9
- 70.0 - 73.9
- 74.0 - 78.4
- No Data

WHO 2005
GDP AND LIFE EXPECTANCY

rich countries only

GDP still predicts life expectancy, even among richer countries

Glei et al 2009
HEALTH EXPECTANCY
inequalities by level of education, Netherlands, 1999

RIVM 2002
HEALTH INEQUALITIES IN EUROPE
by level of education or income, ca. 2000

Inequalities in self-reported health or mortality documented

Mackenbach 2005
The paradox of public health:

despite prosperity, more equal income distribution, welfare state, equal access to health care, ...

persisting, even widening health inequalities
TWO RESEARCH STRATEGIES

• Zooming in: **individuals**, and how they differ in socioeconomic position, specific risk factors, and health outcomes

• Zooming out: **societies**, and how they differ in social structure, risk factor distribution, and health inequalities
OUTLINE

• Cross-country comparisons of health inequalities within Europe (and with the US)

• The welfare state and health inequalities: explanations of a paradox

• National policies to tackle health inequalities in Europe
EUROTHINE
“TACKLING HEALTH INEQUALITIES IN EUROPE”

Data on inequalities in mortality or self-reported available

Supported by a grant from the European Commission
Relative inequalities in total mortality by level of education among men in 18 populations

Mackenbach et al. 2008
ABSOLUTE INEQUALITIES BY EDUCATION TOTAL AND CVD MORTALITY, 1990s, MEN

Mackenbach et al. 2008
ABSOLUTE INEQUALITIES BY EDUCATION TOTAL AND CVD MORTALITY, 1990s, WOMEN

Mackenbach et al 2008
ABSOLUTE INEQUALITIES BY EDUCATION TOTAL AND INJURY MORTALITY, 1990s, MEN

Mackenbach et al 2008
(b) Inequalities in current daily smoking by level of education in 11 European countries, 1998.

Smoking by educational level

Huisman et al 2005
RELATIVE INEQUALITIES BY EDUCATION
SMOKING-RELATED MORTALITY, 1990s

Relative inequalities in smoking related causes of death

- Men
- Women
RELATIVE INEQUALITIES BY EDUCATION
ALCOHOL-RELATED MORTALITY, 1990s

Relative inequalities in alcohol related causes of death

RII

FIN  SWE  NOR  DEU  ENG  BEL  SWZ  ITA  BAR  MAD  BGR  SLO  HUN  CZE  POL  LIT  EST  EUR

Men   Women
RELATIVE INEQUALITIES BY EDUCATION
OBESITY (BMI >30)
CORRELATION BETWEEN INEQUALITIES IN OBESITY AND IN DIABETES

The relationship between educational inequalities in diabetes (y-axis) and obesity (x-axis) across Europe for women.
Relative inequalities in amenable mortality

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</table>

Legend: □ Men ■ Women
INEQUALITIES IN MORTALITY
by education (US vs. Europe)

Kok et al 2009
INEQUALITIES IN MORTALITY by education (US vs. Europe)

Kok et al 2009
CONCLUSIONS (1)

- Health inequalities are omnipresent throughout Europe, but magnitude varies substantially, which suggests great potential for reduction

- Smaller health inequalities in Southern Europe are probably partly mediated by smaller inequalities in smoking

- Larger health inequalities in Eastern Europe are probably partly mediated by larger inequalities in smoking, alcohol, and health care deficiencies
WHY HEALTH INEQUALITIES PERSIST DESPITE THE WELFARE STATE: HYPOTHESES

• Welfare state has not eliminated social inequality (material, immaterial)

• Welfare state has increased social mobility, and health-related selection

• Welfare state does not protect against prosperity-related diseases
ADULT MORTALITY
men by occupational class, England

Deaths per 100000 py (standardised)

Pamuk 1985
TREND IN MORTALITY BY OCCUPATIONAL CLASS
MEN 30-59 YEARS

Mackenbach et al 2003
CONTRIBUTION OF CVD TO WIDENING INEQUALITIES IN MORTALITY

Mackenbach et al 2003
ISCHEMIC HEART DISEASE mortality by occupational class, England

Mackenbach 1988
OBESITY
by level of education, women 1992-2002

Monteiro et al 2004
Social inequality persists despite the welfare state

Material factors now replaced by lifestyle and psychosocial factors

Does this make health inequalities less unfair?
• Generous and universal welfare policies may be necessary for eliminating health inequalities, but they are not sufficient

• To (further) reduce health inequalities, welfare policies should be redirected to achieve larger health gains in lower socioeconomic groups

• Specific interventions should focus on changing health-related behaviour in lower socioeconomic groups
NATIONAL POLICY DEVELOPMENTS IN EUROPE

Four common milestones in policy development:

• High-profile independent reports
• National research programs
• Government advisory committees
• Coordinated government action

Mackenbach & Bakker 2003
INNOVATIVE APPROACHES

• Policy steering mechanisms (e.g. target setting)
• Labour market and working conditions (e.g. restructure demanding jobs)
• Consumption and health-related behaviour (e.g. tailored stop-smoking)
• Health care (e.g. strengthening primary care in disadvantaged settings)
• Territorial approaches (comprehensive packages for deprived neighbourhoods)

Mackenbach & Bakker 2003
COMPREHENSIVE STRATEGIES

• Britain: Independent Inquiry (1998)

• Netherlands: Albeda committee (2001)


• Norway: National strategy (2006)
STRATEGY RECOMMENDED
BY ALBEDA COMMITTEE

26 recommendations

4 specific strategies

11 quantitative targets for intermediate outcomes
EXAMPLES OF POLICY RECOMMENDATIONS

Poverty reduction
School health programs
Physical work load
Primary care
CURRENT SITUATION IN THE NETHERLANDS

2001 -- Government adopts Albeda report
2002 – New elections, new government
2004 -- Monitoring scheme, White paper
2007 – New elections, new priorities?
Echte minister van Gezondheid gezocht

Nederland raakt steeds verder achterdocht met zijn gezondheid. Een echte minister zou dan in actie komen, preziet John Mackebach.

Er was eens een tijd dat Nederland de wereldkampioen was op het terrein van gezondheid. Rond het midden van de twintigste eeuw was de levensverwachting in Nederland hoger dan waar ook ter wereld. De publieke gezondheidssector was ondertussen een hoog gepolitiseerd en vragende om een heilig lage zorgbeginscherm. Het was de tijd van de verbeteringsmomenten, die op de fiets bij de gezondheidszorg lagen, in zo moderne opstellingen over te dragen van de seks die bij dit alles in het achtervolgens is Nederland.

Studieën is gebrekken: bijv. als ziektebestrijdingssegment door sigarettenrook en andere risicobezorging, en zijn instructieverkeer als douchemaken dat vertragen bij het actie. Het is de tijd van de volksgezondheidszorg aan de klinkende gezondheid. Het werkende moment dringt aan in de toekomst, maar dat is een ander verhaal.

De gezondheidszorg ligt voor het grijpen, maar die vereist inzet.

Illustratie: Siegfried Woldhek.
National strategy to reduce social inequalities in health
• Reduce social inequalities:  
  -- income inequalities, (pre)schooling, labour conditions

• Reduce social inequalities in health behaviour:  
  -- diet, physical activity, smoking, cost-sharing in health care
PRIORITIZED AREAS IN NORWEGIAN STRATEGY (2)

- Promote social inclusion
  -- education, employment, homelessness, geographical areas

- Develop knowledge and cross-sectoral tools
  -- policy reviews, health inequalities impact assessment, monitoring, research
CONCLUSIONS (3)

• Health inequalities field in Europe has moved from description, to explanation, to intervention development

• Some countries in Europe have started systematic policy implementation – will these policies work?

• Look at historical successes: we can reduce health inequalities if we really want
HISTORICAL SUCCESSES
reduction of inequalities in tuberculosis mortality

Deaths per 100000 py (standardised)

1931 1961

Low men
High men
Low women
High women

Mackenbach 2003