IS EQUITY IN HEALTH POSSIBLE IN EUROPE ? SOME CHALLENGES AND INEQUALITIES

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Goals of the presentation

- Historical evidence on inequality
- Definitions
- The concept
- Europe; some examples
- Recommendations according to problem areas

Historical evidence

- Historical evidence suggests that socioeconomic inequalities in health are not a recent phenomenon. Approaches to tackling health inequalities date back to the **1840**s literally.
- Both **Edwin Chadwick** “Sanitary Conditions of the Labouring Population of Great Britain” and **Friedrich Engels** “The Condition of the Working Class in England “ described the dreadful conditions of poor people in 19th century Britain. **Rudolf Virchow**, a public health pathologist and **Villermé** in France, also emphasized the importance of the relationship between social class and mortality and morbidity in the same period.

Why Measure Health Equity?

- “To improve something, first measure it”

Definitions

- **“Health equity”** is described as the absence of health differences between more and less socially advantaged groups [Braveman P, Gruskin S. (2003).
- Sen (2002) have argued that **“health equity”** is a central dimension of overall social equity or justice, as it conditions the capabilities of individuals and groups to participate in and benefit from social and economic development.

Recent Definition

- Today, **equity in health** implies that ideally everyone could attain their full health potential and that no one should be disadvantaged from achieving this potential because of their social position or other socially determined circumstance. [Whitehead M. Dahlgren G. (2006).

What is meant by health inequalities may vary

- In the USA, it has not been widely taken up by either researchers or policy-makers, with the term 'health disparities' preferred instead.
- In the UK, concept of health inequalities fell out of favour with government in the 1980s and early 1990s but currently occupies a pivotal place in the policy discourse and health inequalities are more likely to refer to inequalities in the health of socio-economic groups as in Europe.
- In New Zealand, ethnic inequalities are described as health inequalities

The concept

- The concept can be used to draw attention to
  - health differences between individuals,
  - health differences between population groups, and
  - health differences between groups occupying unequal positions in society.

Europe Is Not Flat: There Are Health Inequalities

- During the 20th century, the relative risks of dying for whose with a low socio-economic status (SES) compared to those with a high SES seem to have remained stable, and they even seem to have increased during the second half of the 20th century in many European countries.

- At the beginning of the 80s, almost all European nations, after phases of continuous prosperity, were confronted with phases of economic depression leading to a general deterioration of the SES.
- These changes have led to a relative deterioration of the health status of the population of individual countries particularly in east Europe and to an increasing differentiation among individual groups also within prosperous European countries.

- At the start of the 21st century, most of the European states are faced with substantial inequalities in health within their populations. People from disadvantaged socioeconomic groups not only live shorter lives, they in addition more often suffer from physical and psychological problems during their shorter lives. Health inequalities have been found in countries in all European regions, and even if data for a particular country are not available, one can confidently expect large socioeconomic inequalities in health to exist there as well.

International arena

- The “equity in health” concept is related intimately to the central human rights thread that has run right through the key articles of World Health Organization (WHO), from its inception in the 1940s to the resolutions of the 21st century.
- AND, For the developed countries of Europe, the 20th century is characterized by the establishment of comprehensive social protection systems and far-reaching medical progress.
- NEVERTHELESS, **Europe Is Not Flat: There Are Health Inequalities**

Examples on Inequality

- **A widening gap in life expectancy**

  Overall, the citizens of the central and eastern European countries tend to have poorer health and shorter life expectancy than those in western Europe.

- **Chronic diseases (Unsafe sex related, cervical cancer etc.)**

In recent years the difference in mortality from cervical cancer between the European Union and selected east European countries was over threefold. In Russia mortality from cervical cancer in young women rose from 3.1/100 000 in 1980-4 to 4.2/100 000 in 1995-7.

Cervical cancer represents a relevant indicator of the worsening women's health conditions in eastern Europe and an important avoidable cause of death.

- **Gender biasness: disadvantaged men**

  In Russia there are 84 men for every 100 women (1995,. 45-64 age group). This fact shows that factors other than "current" mortality in middle aged people will affect the sex ratio. In eastern Europe men is missing because of the high toll of premature mortality from cardiovascular disease and external causes of death.

- **Income distribution**

Newly independent states show that the Soviet Union had a worse life expectancy record than the rest of Eastern Europe. This divergence of mortality and consequently of life expectancy may be related to economic fortunes. The gross domestic product increased by 5% in Poland and decreased in all other eastern European countries. Changes in mortality of middle aged men after 1989 correlate with changes in gross domestic product.

- **Education**

In Estonia, the gap in mortality between the groups with the highest and lowest levels of education increased tremendously from 1989–2000, the transition period after the cessation of Soviet rule. By 2000, a male graduate 25 years of age could expect to live 13 years longer than men the same age with the lowest level of education

- **Social class: Variations within a country**

In Scotland, for instance, a baby born in the most disadvantaged neighbourhood in Glasgow can expect to live 10 fewer years than a baby living in the most affluent neighbourhood.

In France, examples are striking. Between a 35-year-old unskilled manual worker and a white-collar worker of the same age, the difference in life expectancy is about nine years.

- **<u>Cause-specific mortality</u>**

  For ischemic heart disease, a North-South gradient has been found, with relative and absolute inequalities being larger in the North of Europe (e.g. the Nordic countries and the United Kingdom) than in the South (e.g. Portugal, Spain and Italy)

Health service access

There are an increasing number of instances of patients delaying seeking non-urgent care for financial reasons among aged people and low socioeconomic groups. For example in Belgium, recent surveys found that patients with chronic illnesses spent an average of 23% of their disposable income on care. Also, about a third of the Belgian population reported that they experienced difficulty in paying for medical care, and 8% of families postponed seeking medical care because of the cost.

Conclusion

- **Life and death are not primarily biological phenomena, but are closely linked to social circumstances.**
- **However, it is not possible to provide equal health status for everyone. But it is possible provide more opportunity for the risky groups.**

- **Unfortunately, health inequalities are stubborn, persistent and difficult to change although good health is a fundamental resource for social and economic development.**
- **If we consider our old continent, Europe, as the cradle of many civilizations, science and literature, inequalities in any area, but especially in health draw more attention.**
- **On the other hand we have to define the borders of Europe? European Union-27 countries? World Health Organization- 53 members? Council of Europe- 47 member countries? Google- 47 countries?**

Recommended interventions and policy measures

1. **Changing social culture is much harder than improving health services. But social culture is crucial. Therefore, more health behavior and culture related specific studies should be done and results employed since one size does not fit all. Health service utilization, discriminations on gender and age, smoking cessation, educational attainment, vaccination, consumption of fruit and vegetables, and exercise in school and other environments and others should be studied in order to clarify the modes of user and provider behaviors.**

2. **Universal preschool and quality schools, affordable housing, living wage jobs with benefits and career ladders, prevention of an increase of income inequalities through adequate tax and social security policies, universal health care, and an end to any discrimination should be accepted and realized by the governments. MINORITIES. MIGRANT WORKERS**

3. **In disadvantaged areas, relieving the shortage of general practitioners and reinforcing primary health care by employing more practice assistants, nurse practitioners and peer educators, is another policy option.**

4. **Promoting health-related behaviours (suh as smoking, alcohol consumption, diet, obesity), psychosocial factors (such as psychosocial stressors, social support, social integration), material factors (such as housing conditions, working conditions, financial problems), health care factors (such as access to good quality services) should be the integral part of national and international policies.**

5. **As health is unequally distributed “from the cradle to the grave”, policies to tackle inequalities in health should consider people in different phases of the life course, including infants, children, adolescents, young adults, middle-aged people, elderly and the oldest old.**

6. **Preventing teenage pregnancy and supporting teenage parents as well as effective mother and child care anf family planning programs that aims health generations is another important activity.**

7. **The end goal of equity in health care, however, would be to closely match services to the level of need, which may very well result in large differences in access and use of services between different socioeconomic groups, favouring the more disadvantaged groups in greatest need. Therefore need assessment methods should be revized.**

8. **In order to improve access, health service delivery at a local level and meeting national standards through diversity of provision can be employed as a policy tool. Besides, primary health care (PHC) has potential to address the social determinants of health through universal access and through its contribution to empowerment and social cohesion, helth service delivery systems should be PHC oriented.**

9. **Maintaining benefit levels for long-term work disability, particularly for those who are fully work disabled and those who are partly work disabled due to occupational health problems and adaptation of working conditions for the chronically ill and disabled in order to increase their work participation can be adopted as policy options by the governments.**

10. **These health inequalities are one of the main challenges for public health, and there is a great potential for improving average population health by eliminating or reducing the health disadvantage of lower socioeconomic groups. This requires an active engagement of many policy sectors, not only of the public health and health care systems, but also of education, social security, working life, city planning, etcetera.**

11. **more altruism (which we know can be done – will yield a significant pay-off)**

The potential benefits of reducing these inequalities. An example for EU countries:

- RECENT STUDY: Prof. Dr. Johan (J.P.) Mackenbach, Dr. Willem Jan (W.J.) Meerding, Dr Anton (A.E.). Kunst (July 2007). Economic implications of socio-economic inequalities in health in the European Union. Erasmus MC. Department of Public Health, The Netherlands. *Contract Nr: SANCO/2005/C4/Inequality/01*

Estimated costs

- estimates suggest that the economic impact of socioeconomic inequalities in health is likely to be substantial. While the estimates of inequalities-related losses to health as a ‘capital good’ (leading to less labour productivity) seem to be modest in relative terms (1.4% of GDP), they are large in absolute terms (€141 billion). It is valuing health as a ‘consumption good’ which makes clear that the economic impact of socioeconomic inequalities in health is really huge: in the order of about €1,000 billion, or 9.5% of GDP.

- Inequalities-related losses to health account for 15% of the costs of social security systems, and for 20% of the costs of health care systems in the European Union as a whole. It is important to emphasize that all these estimates represent yearly values, and that as long as health inequalities persist, these losses will continue to accumulate over the years.

Conclusion

- Implementing past successful experiences
- Polices should strive to level up, not level down

Remember Alma-Ata:

- The Alma-Ata Declaration of 1978 emerged as a major milestone of the twentieth century in the field of public health, and it identified primary health care as the key to the attainment of the goal of Health for All.
  - The existing gross inequality in the health status of the people, particularly between developed and developing countries as well as within countries, is politically, socially, and economically unacceptable and is, therefore, of common concern to all countries.

WHO ALSO called to return to the Declaration of Alma-Ata

- An acceptable level of health for all the people of the world by the year 2000 can be attained through a fuller and better use of the world's resources, a considerable part of which is now spent on armaments and military conflicts.
- A genuine policy of independence, peace, détente, and disarmament could and should release additional resources that could well be devoted to peaceful aims and in particular to the acceleration of social and economic development of which primary health care, as an essential part, should be allotted its proper share.

- **Of course, it may not be realistic to eliminate the inequalities not only in the short run and also in the foreseeable future, but it is possible to reduce them to levels that are more acceptable. What we need is political will, attainable objectives, effective policies, interventions and implementation, as well as evaluation and monitoring with country specific tailored strategies.**