

# IS EQUITY IN HEALTH POSSIBLE IN EUROPE?

## SOME CHALLENGES AND INEQUALITIES

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### BACKGROUND

Historical evidence suggests that socio-economic inequalities in health are not a recent phenomenon. Approaches to tackling health inequalities date back to the 1840s. During that period 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, also emphasized the importance of the relationship between social class and mortality and morbidity in the 19th century.

However, while life expectancies may have increased dramatically in Europe and in the world over the last century, so have inequities in health status. Therefore, significant body of research, especially since 1990, documents that socioeconomic inequality, including institutional racism, sexism; even ageism, poor quality of life, and low socioeconomic (educational and income level) status are principal causes of morbidity and mortality [Gwatkin DR. (2007). "10 best resources on .... health equity", Health Policy and Planning; 22:348–351. Accessed 5 September 2007].

Due to the more economic and social opportunities for people than 10 or 100 years, the magnitude of socio-economic inequalities in health in Europe has certainly declined in absolute terms. On the other hand, this situation can easily mask great inequalities in public's health. However, the greatest improvements in people's health have resulted not from health services but from social and economic changes and it remain high opportunities to do even better. Despite the dramatic improvements in health in general, significant inequalities in health among citizens still persist in European nations.

At the start of the 21st century, all European countries are faced with substantial inequalities in health within their populations. People with a lower level of education, a lower occupational class, or a lower level of income tend to die at a younger age, and to have a higher prevalence of most types of health problems resulting high morbidity and mortality. As a result, people with lower socio-economic positions not only live shorter lives, but also spend a larger number of years in ill-health.

## **AIM**

The aim of this paper is to discuss the health inequalities and their reasons in Europe and make some recommendations within the concept of unified Europe.

## **METHOD**

Available published data is employed to show the health inequalities of countries in Europe.

## **WHY MEASURE HEALTH EQUITY?**

“to improve something, first measure it”

Lets start with terminology on health inequality and then present examples. “Health equity” is described as the absence of health differences between more and less socially advantaged groups [Braveman P, Gruskin S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*. 57:254-8.]. In another study, [Sen A. (2002). Why health equity? *Health Economics*. 11:659-66] Sen 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. Without specific attention to equity issues, societies tend towards inequity, as social advantage and disadvantage started to be seen as natural and inevitable, while socially disadvantaged groups and individuals generally lack the political voice to challenge the status quo. Societies that wish to increase equity in health must therefore be able to identify health inequalities; and differentiate health inequalities reflecting random variation or immutable biological differences from those that could be decreased through medical, public health or social policy interventions feasible for a given context [Nolen LB. et al, (2005). Strengthening health information systems to address health equity challenges. *Bulletin of the World Health Organization* August, 83 (8).]

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. The WHO Constitution asserted back in 1946 that “the highest standards of health should be within reach of all, without distinction of race, religion, political belief, economic or social condition”. 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). Leveling up (Part 1): a discussion paper on concepts and principles for tackling social inequities in health. WHO Collaborating Centre for Policy Research on Social Determinants of Health. University of Liverpool, Studies on social and economic determinants of population health, No.2. <http://www.euro.who.int/document/e89383.pdf>. Accessed 15 May 2007.]

“Inequalities in health” refer to a broad range of differences in health experience and health status between countries, regions, and social groups. Health inequities are avoidable inequalities that are unfair and unjust [Leon DA, Walt G, Gilson L. (2001). International perspectives on health inequalities and policy. *BMJ*;322: 591-4.].

“Health equity” is described as the absence of systematic health differences between more and less socially advantaged groups; it is based on principles of justice, reflecting equal opportunity for all people (individuals and groups) to be as healthy as possible [Braveman P, Gruskin S. (2003). Defining equity in health. *Journal of Epidemiology and Community Health*. 57:254-8.]. To document the existence or magnitude of health inequities, data are required on a measure of health; and a measure of social position or advantage (an “equity stratifier”) that defines strata in a social hierarchy.

## **EUROPE IS NOT FLAT: THERE ARE HEALTH INEQUALITIES**

For the developed countries of Europe, the 20th century is characterized by the establishment of comprehensive social protection systems and far-reaching medical progress. For entire population groups this had led to an increase in their life expectancy and to a rise in the scope and quality of medical care to an extent up to then unimaginable. Enormous reductions in infant and child mortality as well as the containment of endemic infectious diseases illustrate this development in a special way. In the post-war period, most west European countries thus attached little attention to the topic of 'socio-economic inequalities in health'; their health policy was restricted to the well-directed extension of medical care to reduce inequalities in isolated areas. Then, at the beginning of the 80s, however, this situation changed: almost all European nations, after phases of continuous prosperity, were confronted with phases of economic depression leading to a general deterioration of the socio-economic situation. 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. [Lögd (2003). Report on Socio-Economic Differences in Health Indicators in Europe: Health inequalities in Europe and the situation of disadvantaged groups. Institute of Public Health, NRW. loegd, Bielefeld.]

All systematic differences in health between socioeconomic groups in European countries could be regarded as unfair and avoidable, and therefore regarded as inequities. According to existing studies, there are many examples of systematic differences in health between different social groups. [Marmot M. and Bobak M. (2000). “International comparators and poverty and health in Europe”, *BMJ*. 321(7269):1124 (4 November), doi:10.1136/bmj.321.7269.1124. <http://www.bmj.com/cgi/reprint/321/7269/1124>. Accessed 21 May 2007.]

### **FORMS OF INEQUALITIES: EXAMPLES:**

**a. Geographical Variations: East-West differences:** Overall, the citizens of the central and eastern European countries tend to have poorer health and shorter life expectancy than those in western Europe. Compared to the body of evidence on health inequalities within western European countries, however, the social determinants of health in the transition countries of central and eastern Europe have been researched less.

A widening gap in life expectancy: In the mid-1990s there was a life expectancy gap of six years between eastern and western Europe. Of these six years, 0.9 years were due to differences in infant mortality. The biggest contribution to the gap was in middle age. Cardiovascular disease accounted for more than half of the six year gap,

and external causes of death accounted for another fifth. It is, therefore, appropriate to focus on mortality differences after childhood [Marmot M. and Bobak M. (2000). "International comparators and poverty and health in Europe", *BMJ*. 321(7269):1124 (4 November), doi:10.1136/bmj.321.7269.1124. <http://www.bmj.com/cgi/reprint/321/7269/1124>. Accessed 21 May 2007.]

People in higher socioeconomic groups are living longer, in part because of a focus on fitness and healthy eating. People in lower socioeconomic groups generally continue to smoke, eat badly, and take less exercise. Other factors, such as housing, environment, and work conditions, also contribute.

In 1970, life expectancy was similar in those countries that now form the European Union and in eastern Europe excluding the Soviet Union-- a difference of less than 1.5 years. From 1970, life expectancy at age 15 improved continuously in the EU countries but not in eastern Europe. By 1990 there was a four year gap which, by 1997, in men, had widened to six years; moreover, life expectancy at age 15 in men declined between the mid-1970s and the mid-1990s. The changes in the former Soviet Union countries were more dramatic. In 1970 life expectancy was already four years lower for men and one year lower for women compared with the rest of eastern Europe. In 1997 the gap was more than 10 years for men and more than six years for women. If the reported figures are correct, life expectancy in the former Soviet Union declined by about five years over an eight year period from 1989. [Marmot M. and Bobak M. (2000). "International comparators and poverty and health in Europe", *BMJ*. 321(7269):1124 (4 November), doi:10.1136/bmj.321.7269.1124. <http://www.bmj.com/cgi/reprint/321/7269/1124>. Accessed 21 May 2007.]

Chronic diseases: We know that cervical cancer is an avoidable cause of death and a relevant indicator of women's health. Age standardised death certification rates from uterine cancer in women aged 20-44 in the 15 countries of the European Union and in six eastern European countries was analyzed in a study [Levi F. Et al. (2000). "Cervical cancer mortality in young women in Europe: patterns and trends", *Eur J Cancer*. 36: 2266-2271.]. In the European Union, death rates declined from 5.6/100 000 in 1960-4 to 2.0/100 000 in 1995-7. In contrast, after a fall from 8.9 to 5.5/100 000 between 1960-4 and 1975-9, death rates from all uterine cancers in eastern Europe rose to 6.8 in 1995-7. Thus 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.

These increases observed in eastern Europe since the early 1980s are likely to be due to changed sexual habits in younger generations, with increased exposure to herpesvirus, but a minor role of other risk factors for cervical cancer, including tobacco and oral contraceptives, is also feasible. [Schiffman MH, Brinton L, Devesa SS, Fraumeni Jr JF. (1966). Cervical cancer. In: Schottenfeld D, Fraumeni JF, Jr, eds. *Cancer epidemiology and prevention*. New York: Oxford University Press, 1090-1116.]. 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: Although men and women in eastern Europe showed a similar relative disadvantage compared with western Europe, the absolute disadvantage for men was greater: in eastern Europe (excluding the former Soviet

Union) men had six years' shorter life expectancy and women had four; in the former Soviet Union men had 10 years' shorter life expectancy and women had six (1997 figures). The extraordinary nature of the mortality changes in the former Soviet Union raised doubts about the validity of mortality statistics. Careful mortality analyses provide support for the reported data [Leon DA, Chenet L, Shkolnikov V. (1997). Huge variation in Russian mortality rates 1984-94: artefact, alcohol, or what? *Lancet*. 350: 383-388].

Sex ratios among countries also differ: In the United Kingdom, for example, there are 98 men for every 100 women, 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. [Marmot M. and Bobak M. (2000). "International comparators and poverty and health in Europe", *BMJ*. 321(7269):1124 (4 November), doi:10.1136/bmj.321.7269.1124. <http://www.bmj.com/cgi/reprint/321/7269/1124>. Accessed 21 May 2007.].

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. The decrease ranged from 3% in the Czech Republic, 13% in Hungary, 42% in Lithuania and Russia, and 60% in Ukraine. Changes in mortality of middle aged men after 1989 correlate with changes in gross domestic product. [UNICEF. (1998). *Education for all? Florence: UNICEF International Child Development Centre, (The MONEE Project Regional Monitoring Report, No 5.)*] ie. increases in the Gini coefficient are correlated with changes (lower) in life expectancy.

Deaths: If we examine the age standardized death rates in the Czech Republic according to the number of years of education, it is possible to emphasize three points. Firstly, in 1980-1, under communist rule, there were differences in mortality according to social position (measured here by education). Secondly, these differences follow a social gradient (the higher the place in the social hierarchy, the lower the mortality). Thirdly, the magnitude of health inequalities expressed as the slope of the gradient has been increasing, as has the absolute gap in mortality between the top and bottom educational groups. [Blazek J, Dzurova D. (2000). *The decline of mortality in the Czech Republic during the transition: a counterfactual case study*. In: Cornia GA, Panizza R, eds. *The mortality crisis in transitional economies*. Oxford University Press.]

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 [Leinsalu M, Vagero D, Kunst A (2003). *Estonia 1989–2000: enormous increase in mortality differences by education*. *International Journal of Epidemiology*, 32(6):1081–1087.]



- Children: The Table 1 below presents the findings of the UNICEF's study on Innocenti Report Card 7 [UNICEF, (2007). Child poverty in perspective: An overview of child well-being in rich countries, Innocenti Report Card 7. UNICEF Innocenti Research Centre, Florence.] Countries are listed in order of their average rank for the six dimensions of child well-being that have been assessed. A light blue background indicates a place in the top third of the table; mid-blue denotes the middle third and dark blue the bottom third.

Table 1. An overview of child well-being in rich countries

		Dimension 1	Dimension 2	Dimension 3	Dimension 4	Dimension 5	Dimension 6
Dimensions of child well-being	Average ranking position (for all 6 dimensions)	Material well-being	Health and safety	Educational well-being	Family and peer relationships	Behaviours and risks	Subjective well-being
Netherlands	4.2	10	2	6	3	3	1
Sweden	5.0	1	1	5	15	1	7
Denmark	7.2	4	4	8	9	6	12
Finland	7.5	3	3	4	17	7	11
Spain	8.0	12	6	15	8	5	2
Switzerland	8.3	5	9	14	4	12	6
Norway	8.7	2	8	11	10	13	8
Italy	10.0	14	5	20	1	10	10
Ireland	10.2	19	19	7	7	4	5
Belgium	10.7	7	16	1	5	19	16
Germany	11.2	13	11	10	13	11	9
Canada	11.8	6	13	2	18	17	15
Greece	11.8	15	18	16	11	8	3
Poland	12.3	21	15	3	14	2	19
Czech Republic	12.5	11	10	9	19	9	17
France	13.0	9	7	18	12	14	18
Portugal	13.7	16	14	21	2	15	14
Austria	13.8	8	20	19	16	16	4
Hungary	14.5	20	17	13	6	18	13
United States	18.0	17	21	12	20	20	–
United Kingdom	18.2	18	12	17	21	21	20

Source: [UNICEF, (2007). Child poverty in perspective: An overview of child well-being in rich countries, Innocenti Report Card 7. UNICEF Innocenti Research Centre, Florence.]

In summary:

- The Netherlands heads the table of overall child wellbeing, ranking in the top 10 for all six dimensions of child well-being covered by this report.
- European countries dominate the top half of the overall league table, with Northern European countries claiming the top four places.
- All countries have weaknesses that need to be addressed and no country features in the top third of the rankings for all six dimensions of child well-being (though the Netherlands and Sweden come close to doing so).
- The United Kingdom and the United States find themselves in the bottom third of the rankings for five of the six dimensions reviewed.

- No single dimension of well-being stands as a reliable proxy for child well-being as a whole and several OECD countries find themselves with widely differing rankings for different dimensions of child well-being.

There is no obvious relationship between levels of child well-being and GDP per capita. The Czech Republic, for example, achieves a higher overall rank for child well-being than several much wealthier countries including France, Austria, the United States and the United Kingdom. Evidence on long term effects of early life environment, intergenerational mechanisms in transfer of health and social disadvantage, and the availability of "life course" methodological approaches [Kuh D, Power C, Blane D, Bartley M. (2004). Socioeconomic pathways between childhood and adult health. In: Kuh D, Ben-Shlomo Y, eds. A life course approach to chronic disease epidemiology. 2nd ed. New York: Oxford University Press, 371-95.] open yet further possibilities for better understanding the aetiology of health inequalities between and within countries.

### **b. Health disparities within countries:**

The Research Working Group on Inequalities in Health set up on instruction by the British government submitted the 'Black Report', which documented significant social class-related differences in the mortality of the British population both for men and for women. This report published over the Bank Holiday Weekend of 1980 by the Thatcher Government signalled the end of the hopes of improvement in public health for twenty years. It was clear that the Government would have preferred to suppress the whole thing, and it is greatly to the authors' credit that this did not happen. Fifteen years later, evidence showed that the situation has not been improved well enough not only in England but for the rest of the European countries also.

Social class and education: The class gap in health has actually been growing in England. In 2001-3 infant mortality among the families of "routine and manual" workers was 19% higher—at six deaths in every 1000 live births—than the national average. In 1997-9 infant mortality in this social group had been 13% higher than the national average and in 1999-2001 it had been 17% higher. Infant mortality in this group in 2001-3 was 69% higher than that in the "managerial and professional" group. The difference in life expectancy between the most deprived areas and the national average also grew in these years. In 2001-3 the average life expectancy in the fifth of local authorities with the worst figures was 74.17 years for men, 2.07 years less than the English average for men of 76.24, and 79.09 for women, 1.63 years less than the English average of 80.72. The differences at baseline were 2.00 years for men 1.54 years for women. [Dyer O. (2005). "Disparities in health widen between rich and poor in England", *BMJ*. 331(7514):419 (20 August), doi:10.1136/bmj.331.7514.419.].

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 [Acheson D et al. (1998). Independent inquiry into inequalities in health report. London, The Stationery Office.]

In France, two 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. When looking at rates of premature death (before 54 years of age), four

times more unskilled manual workers die prematurely of diabetes than do white collar workers, and the difference is tenfold when it comes to cirrhosis and alcohol psychosis [Mesrine A. (1999). Les differences de mortalité par milieu social restent fortes [Differences in mortality according to social class are still important]. Données Sociales, 228–235] and [Jouglu E et al. (2000). Chapitre de :Les inégalités sociales de santé.[Social inequalities in health] In: de Leclerc A et al., eds. La découverte. Paris, Inserm ([http://www.inserm.fr/fr/questionsdesante/dossiers/sante\\_environnement/att00000579/12septembre2000.pdf](http://www.inserm.fr/fr/questionsdesante/dossiers/sante_environnement/att00000579/12septembre2000.pdf), accessed 15 May 2007) (in French).].

In the Netherlands, for example, there is a 5-year gap in life expectancy, and a 13-year gap in disability-free life expectancy, between men from groups with low and high levels of education [Van de Water HPA, Boshuizen HC, Perenboom RJM (1996). Health expectancy in the Netherlands 1983–1990. *European Journal of Public Health*, 6:21–28.].

Excess mortality in the more deprived areas of Spain, compared with the most affluent, has been estimated at 35 000 deaths a year [Benach J, Yasui Y (1999). Geographical patterns of excess mortality in Spain explained by two indices of deprivation. *Journal of Epidemiology and Community Health*, 53:423–431.].

Cause-specific mortality: [Mackenbach JP (2005). *Health Inequalities: Europe in Profile*. An independent, expert report commissioned by the UK Presidency of the EU. [http://www.fco.gov.uk/Files/kfile/HI\\_EU\\_Profile,0.pdf](http://www.fco.gov.uk/Files/kfile/HI_EU_Profile,0.pdf)] Accessed 4 June 2007].

- Cardiovascular disease mortality is higher in lower socio-economic groups and also one of the main contributors to widening inequalities in total mortality in many Eastern European countries.
- 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)
- Inequalities in stroke mortality are largely similar in the North and in the South of Europe: mortality is higher in the lower socio-economic groups in all countries with available data
- Inequalities in cancer mortality tend to be smaller than those for cardiovascular disease mortality, both in Western and in Eastern Europe
- Injuries are also a major cause of death in all European countries. However, as with other causes of death, the injury burden is not shared equally among all groups in society.

Morbidity: As was the case with mortality, rates of morbidity are usually higher among those with a lower educational level, occupational class or income level. [Mackenbach JP (2005). *Health Inequalities: Europe in Profile*. An independent, expert report commissioned by the UK Presidency of the EU. [http://www.fco.gov.uk/Files/kfile/HI\\_EU\\_Profile,0.pdf](http://www.fco.gov.uk/Files/kfile/HI_EU_Profile,0.pdf)] Accessed 4 June 2007].

Table 2 presents the ratios of mortality according to some selected socio economic position in some European countries.



**Table 2.** Inequalities in mortality by socio-economic position in 21 European countries.

Country	Indicator of socio-economic position	Period	Age-group	Rate Ratio <sup>b</sup>		Source
				Men	Women	
Austria	Education <sup>2</sup>	1991–1992	45+	1.43*	1.32*	National census-linked mortality follow-up
Belgium	Education <sup>2</sup> Housing tenure <sup>1</sup>	1991–1995	45+	1.34*	1.29*	National census-linked mortality follow-up
		1991–1995	60–69	1.44*	1.43*	
Czech Republic	Education <sup>6</sup>	End 1990s	20–64	1.66*	1.09*	Unlinked cross-sectional study
Denmark	Education <sup>1</sup> Housing tenure <sup>1</sup> Occupation <sup>3</sup>	1991–1995	60–69	1.28*	1.26*	National census-linked mortality follow-up National census-linked mortality follow-up
		1991–1995	60–69	1.64*	1.47*	
		1981–1990	45–59	1.33*	n.a.	
England/Wales	Education <sup>2</sup> Housing tenure <sup>1</sup> Occupation <sup>3</sup>	1991–1996	45+	1.35*	1.22*	National census-linked mortality follow-up National census-linked mortality follow-up; representative sample
		1991–1996	60–69	1.65*	1.58*	
		1981–1989	45–59	1.61*	n.a.	
Estonia	Education <sup>11</sup> Education <sup>6</sup>	2000	20+	2.38*	2.23*	National cross-sectional study National cross-sectional study
		1988	20–74	1.50*	1.31*	
Finland	Education <sup>2</sup> Housing tenure <sup>1</sup>	1991–1995	45+	1.33*	1.24*	National census-linked mortality follow-up
		1991–1995	60–69	1.90*	1.73*	
France	Education <sup>1</sup> Housing tenure <sup>1</sup> Occupation <sup>3</sup>	1990–1994	60–69	1.31*	1.14	National census-linked mortality follow-up National census-linked mortality follow-up; representative sample
		1990–1994	60–69	1.27*	1.25*	
		1980–1989	45–59	2.15*	n.a.	
Hungary	Education <sup>9</sup> Occupation <sup>10</sup>	2002	45–64	1.97*	1.58*	Cross-sectional ecological analysis National cross-sectional study
		1984–1985	45–64	1.61	1.33	
Ireland	Occupation <sup>3</sup>	1980–1982	45–59	1.38*	n.a.	National cross-sectional study
Italy	Education <sup>2</sup> Housing tenure <sup>1</sup> Education <sup>4</sup>	1991–1996	45+	1.22*	1.20*	Urban census-linked mortality follow-up (Turin) National census-linked mortality follow-up National census-linked mortality follow-up
		1991–1996	60–69	1.37*	1.33*	
		1981–1982	18–54	1.85*	n.a.	
	Occupation <sup>3</sup>	1981–1982	45–59	1.35*	n.a.	National census-linked mortality follow-up
Latvia	Education <sup>7</sup>	1988–1989		1.50	1.20	National cross-sectional study
Lithuania	Education <sup>5</sup>	2001	25+	2.40*	2.90*	Unlinked cross-sectional analysis
Netherlands	Education <sup>23</sup>	1991–1997	25–74	1.92*	1.28	GLOBE Longitudinal study (Eindhoven)
Norway	Education <sup>2</sup> Housing tenure <sup>1</sup> Occupation <sup>3</sup>	1990–1995	45+	1.36*	1.27*	National census-linked mortality follow-up National census-linked mortality follow-up
		1990–1995	60–69	1.44*	1.36*	
		1980–1990	45–59	1.47*	n.a.	
Poland	Education <sup>8</sup>	1988–1989	50–64	2.24	1.78	National cross-sectional study
Portugal	Occupation <sup>3</sup>	1980–1982	45–59	1.36*	n.a.	National cross-sectional study
Slovenia	Education	1991 & 2002	25–64	2.44	2.66	Unlinked cross-sectional study
Spain	Education <sup>2</sup>	1992–1996	45+	1.24*	1.27*	Urban and regional census-linked mortality follow-up (Barcelona & Madrid) National cross-sectional study
		1980–1982	45–59	1.37*	n.a.	
Sweden	Occupation <sup>3</sup>	1980–1986	45–59	1.59*	n.a.	National census-linked mortality follow-up
Switzerland	Education <sup>2</sup>	1991–1995	45+	1.33*	1.27*	National census-linked mortality follow-up
		1979–1982	45–59	1.37*	n.a.	

a Because of differences in data collection and classification, the magnitude of inequalities in health cannot always directly be compared between countries.

b Rate Ratio: ratio of mortality rate in lower socio-economic groups as compared to that in higher socio-economic groups. Asterisk (\*) indicates that difference in mortality between socio-economic groups is statistically significant. Notes refer to references given in the back of this report. N.a. indicates 'not available'.

Source: Mackenbach JP (2005). Health Inequalities: Europe in Profile. An independent, expert report commissioned by the UK Presidency of the EU. [http://www.fco.gov.uk/Files/kfile/HI\\_EU\\_Profile\\_0.pdf](http://www.fco.gov.uk/Files/kfile/HI_EU_Profile_0.pdf) [Accessed 4 June 2007].

As it will be seen in this table,

- Substantial inequalities are also found in the prevalence of most specific diseases (including mental illness) and most specific forms of disability.
- Over the past decades, inequalities in morbidity by socio-economic position have been rather stable.

- Together with inequalities in mortality, inequalities in morbidity contribute to large inequalities in 'healthy life expectancy' (number of years lived in good health).

**c. Health service access:** WHO defines accessibility as 'a measure of the proportion of the population that reaches appropriate health services'. Although this definition implies many dimensions, two types of access, are important: economic access and cultural. Economic access, is the situation in which many urban dwellers in some countries find themselves. An example of the problem of economic access is when people in need of emergency care are turned away from a clinic or hospital and left to die, because they cannot afford to pay. This is very rare in Europe, but 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. In France, likewise, a study in 1997 found that 600 000 people did not have access to social security to cover medical care costs and that 16% of the population did not have supplementary coverage. Many of them delayed seeking treatment because of the cost. Access. The other type of access, cultural access, relates to acceptability and respect. Language barriers and cultural practices, for example, may prevent minority ethnic groups or recent immigrants from accepting preventive care and benefiting from psychiatric care, even when free. Aside from language barriers, another major barrier is that between professional health workers and less educated patients, where health service providers lack an awareness and understanding of the day-to-day restrictions in the lives of patients living in hardship. [Whitehead M. Dahlgren G. (2006). Levelling up (Part 1): a discussion paper on concepts and principles for tackling social inequities in health. WHO Collaborating Centre for Policy Research on Social Determinants of Health. University of Liverpool, Studies on social and economic determinants of population health, No. 2. <http://www.euro.who.int/document/e89383.pdf>. accessed 15 May 2007].

Other types of health service access barriers are listed below [Wörz M. Foubister T. Busse R. (2006). "Access to health care in the EU Member States", Euro Observer. Summer, Volume 8, Number 2, pp. 1-4.]:

- i. whether health care coverage is extended to the whole population or not- Most notably, for failed asylum seekers and illegal immigrants, coverage for health care may be virtually non-existent (see the case study on illegal immigrants and asylum seekers in this issue). Also for legal residents or citizens, problems may arise from the way in which coverage is organized – coverage for the unemployed, for instance, may require meeting certain administrative requirements- Austria; Poland; Ireland and Germany.
- ii. content of the health benefit package: There appears to be a trend towards increasing explicitness in the definition of benefits packages (particularly in terms of what is excluded from cover), with potential implications for access-. England, The Netherlands,
- iii. Cost-sharing arrangements: About half of EU-10 countries, impose charges for primary and secondary health care.

iv. Geographical barriers to access: Geographical proximity to health services can constitute a significant barrier to access in terms of costs relating to time and transport. In Austria and Hungary, for example, there is significant variation in the provision of hospital beds by region. The Netherlands is among the countries with the highest proportion of people with uniform proximity to hospitals and general practitioners (GPs).

v. Organizational barriers to access: Among the most significant of this type of barrier are waiting lists. Waiting lists are a feature of the English, Irish, Italian, Polish and Dutch health care systems.

vi Utilization of accessible services: Availability constitutes a potential; it is not a proof of access. There is little income-related inequity in the utilization of GPs but that there is pro-rich inequity in the utilization of specialists, particularly in countries where voluntary health insurance or private options are available.

## **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. Unfortunately, health inequalities are stubborn, persistent and difficult to change although good health is a fundamental resource for social and economic development. Unquestionable evidence shows inextricable links between health and sustainable human development and health is also one of the fundamental rights of every human being.

If we consider our continent, Europe, as the cradle of many civilizations, science and literature, inequities in any area, but especially in health draw more attention. In this old continent, every intellectual individual is agreed on fair distribution resources and removing inequalities. In contrast with this consideration, their activity radius in terms of geographic borders is a controversial issue. First, who can define the boundary line of the continent today in this globalized world? European Union (27 countries)? World Health Organization (53 members)? Council of Europe (47 member countries) Google (47 countries)? Individuals? People? How are we going to make the comparisons? As it is seen from the above discussions, I did not put the figures from Turkey although there are discrepancies between other European countries and within our country due to the inequalities in health. First of all we have to take into account these variations. Social events like viruses and microbes have transboundary nature. This characteristic is known as globalization.

As a result, health inequalities are increasingly recognized as an important public-health issue throughout Europe. Because of the growing recognition of the problem, many countries are responding by developing public policies in a wide variety of ways.

## **Recommended interventions and policy measures**

- Health inequalities across Europe as a whole are large, with some regions of Europe increasingly lagging behind. This concerns many citizens in Europe and ought to be tackled by European institutions.

- 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.
- 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 integrated communities, universal health care, and an end to any discrimination should be accepted and realized by the governments.
- 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.
- Promoting health-related behaviours (such 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.
- Preventing teenage pregnancy and supporting teenage parents as well as effective mother and child care and family planning programs that aims health generations is another important activity.
- 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 revised.
- Special emphasize should be given to risk groups (children, elderly, low socioeconomic status people etc.).
- 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, health service delivery systems should be PHC oriented.
- 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. [Mackenbach JP. Stronks K. (2004). "The development of a strategy for tackling health inequalities in the Netherlands", International Journal for Equity in Health 2004, 3:11, doi:10.1186/1475-9276-3-11). <http://www.equityhealthj.com/content/3/1/11>. Accessed 1 June 2007].

- Action policies should be defined and revised according to progress. In this context, Whitehead and Dahlgren (2006) suggest ten principles for policy action [Whitehead M. Dahlgren G. (2006). Levelling up (part 1): a discussion paper on European strategies for tackling social inequities in health. Studies on social and economic determinants of population health, No. 3 WHO Collaborating Centre for Policy Research on Social Determinants of Health University of Liverpool. <http://www.euro.who.int/document/e89383.pdf> Accessed 15 May 2007.] and [Dahlgren G. Whitehead M. (2006). Levelling up (part 2): a discussion paper on European strategies for tackling social inequities in health. Studies on social and economic determinants of population health, No. 3 WHO Collaborating Centre for Policy Research on Social Determinants of Health University of Liverpool. <http://www.euro.who.int/document/e89384.pdf> Accessed 15 May 2007].
  - i. Policies should strive to level up, not level down: the only way to narrow the health gap in an equitable way is to bring up the level of health of the groups of people who are worse off to that of the groups who are better off.
  - ii. The three main approaches to reducing social inequities in health are interdependent and should build on one another: focusing on people in poverty only, narrowing the health divide and reducing social inequities throughout the whole population.
  - iii. Population health policies should have the dual purpose of promoting health gains in the population as a whole and reducing health inequities.
  - iv. Actions should be concerned with tackling the social determinants of health inequities.
  - v. Stated policy intentions are not enough: the possibility of actions doing harm must be monitored.
  - vi. Select appropriate tools to measure the extent of inequities and the progress towards goals.
  - vii. Make concerted efforts to give a voice to the voiceless.
  - viii. Wherever possible, social inequities in health should be described and analyzed separately for men and women.
  - ix. Relate differences in health by ethnic background or geography to socioeconomic background.
  - x. Health systems should be built on equity principles: not-for-profit public health services and provided according to need, not ability to pay. The same high standard of care should be offered to everyone, without discrimination with respect to social, ethnic, gender or age profile.

In conclusion, we all have to work hard: Not for generating solutions for unequal situations but for “financial sustainability” of the recommended programs. Otherwise, most of the good will is doomed to failure. Finding new ways for fund raising and sharing the merits of the development is necessary.

Of course, it may not be realistic to eliminate the inequalities not only in the short run but 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.

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