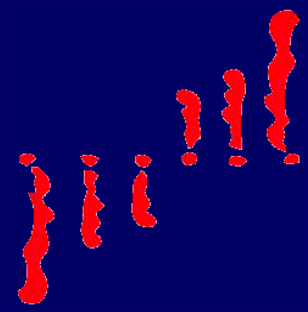
Social inequalities in health: reflections on the role of policies and political context

Léa-Roback Research Centre launch
7th October 2004, Montréal

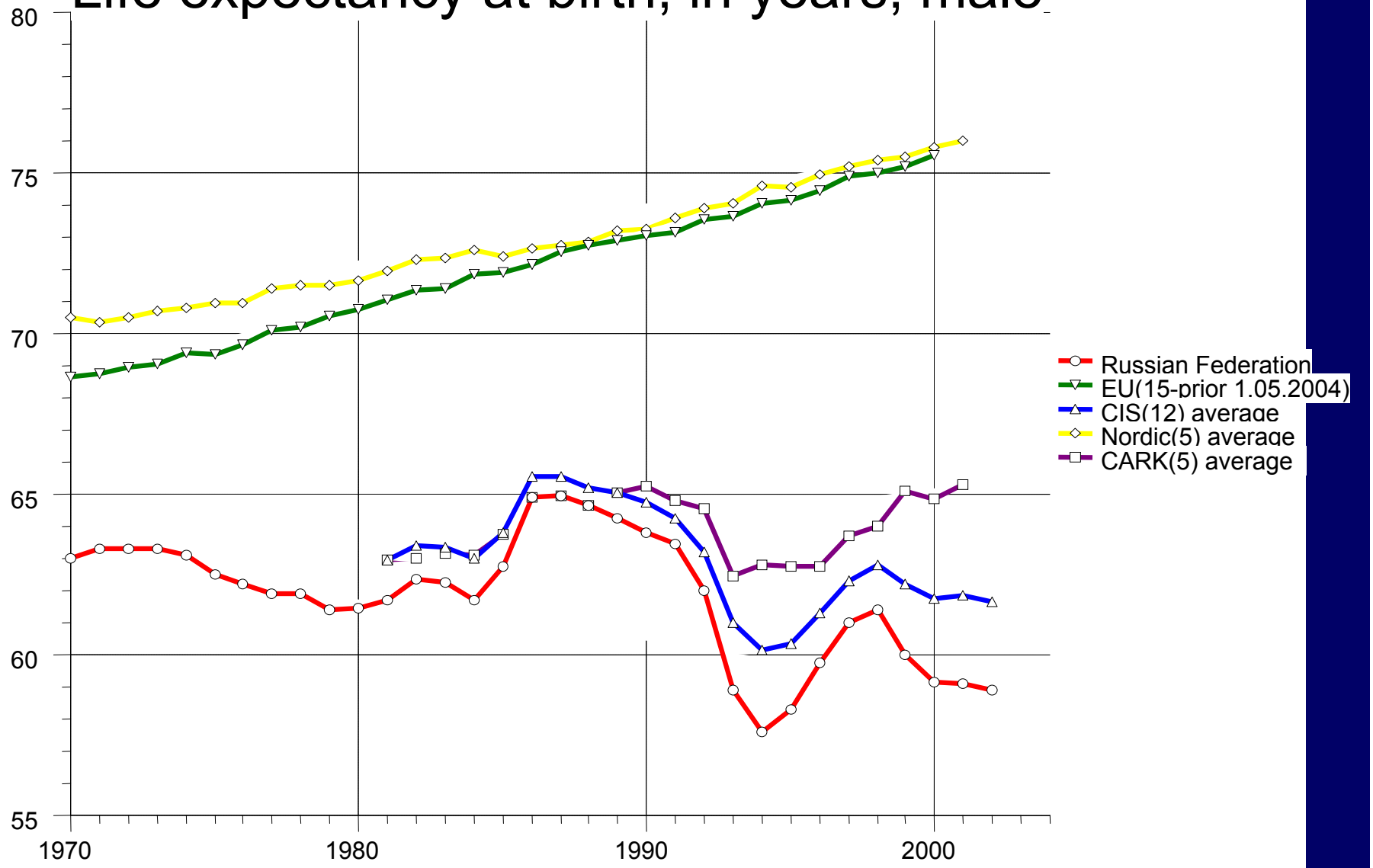
Professor Margaret Whitehead
University of Liverpool



The European backdrop: two turbulent decades

- Breakup of USSR: 50+ countries in WHO EURO
- Armed conflict/ethnic tension/insecurity
- Migration/asylum/entitlements/human rights
- Precipitous transition to market economies/market reforms
- Collapse in life expectancies/new diseases
- Concern about high unemployment, growing poverty, widening social inequalities

Life expectancy at birth, in years, male



Inequalities Action Spectrum

Whitehead 1998

Healthy Life Expectancy by Socio-economic Status (SES), The Netherlands

	Low SES	High SES	Difference
Life expectancy in years	72	77	5
Healthy life expectancy in years	52	64	12

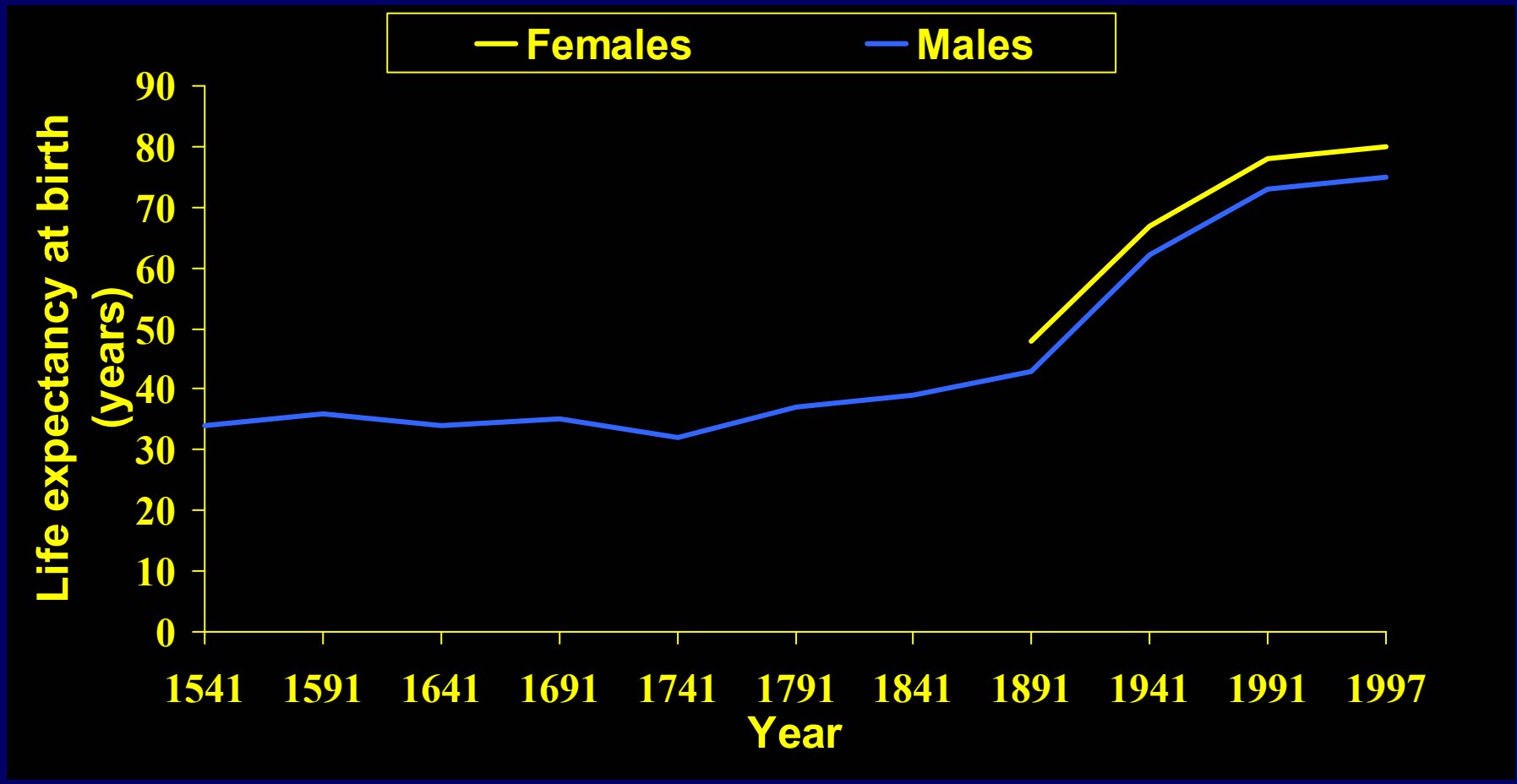
Consensus approach in The Netherlands

- 1970s: health inequalities a non-issue
- 1980: New evidence - no political follow-up
- 1985: Test country for European HFA Strategy + Dutch "Black Report"
- 1987 - coalition government (centre right) calls national conference, broad plan of action adopted, 5-year research programme funded
- 1989: Labour Government - support continues
- 1991:Conference of all political parties - agree coordinated action on HI
- 1994: results of 1st research prog.reported
- 1995-2000: second 5-year R&D prog:evaluations
- 2001: National Programme Committee on HI issues 26 recs, with health policy targets

Social justice approach in Sweden

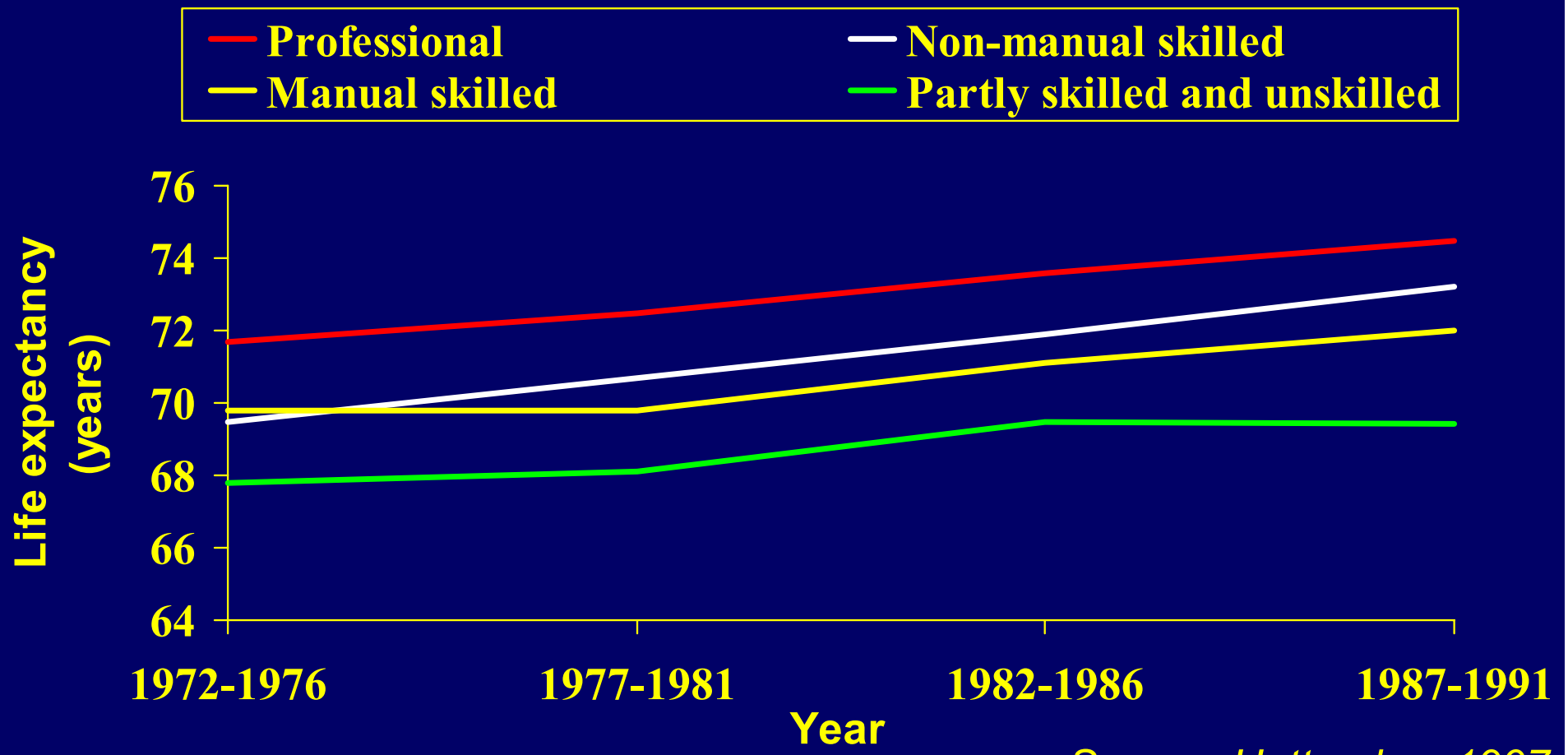
- 1930s: Hot political issue, triggered by large poor-rich inequalities in infant mortality. Goals set, plus raft of maternal health policies
- 1950s/1960s:Interest subsides/problem"solved"
- mid-1970s: new evidence, but ignored
- mid-1980s: Evidence of HI accepted, 1st policy bill, with "reducing inequities" a major objective
- 1991: 2nd bill - equity in health a priority, but then new centre right government plays it down
- 1992: economic recession
- 1995: Soc Dem govn. Sets up parliamentary committee plus commission for national health objectives, focusing on HI
- 2000: Commission makes 19 recs. Based on social justice, focus on social determinants

Life expectancy at birth, England, over 450 years



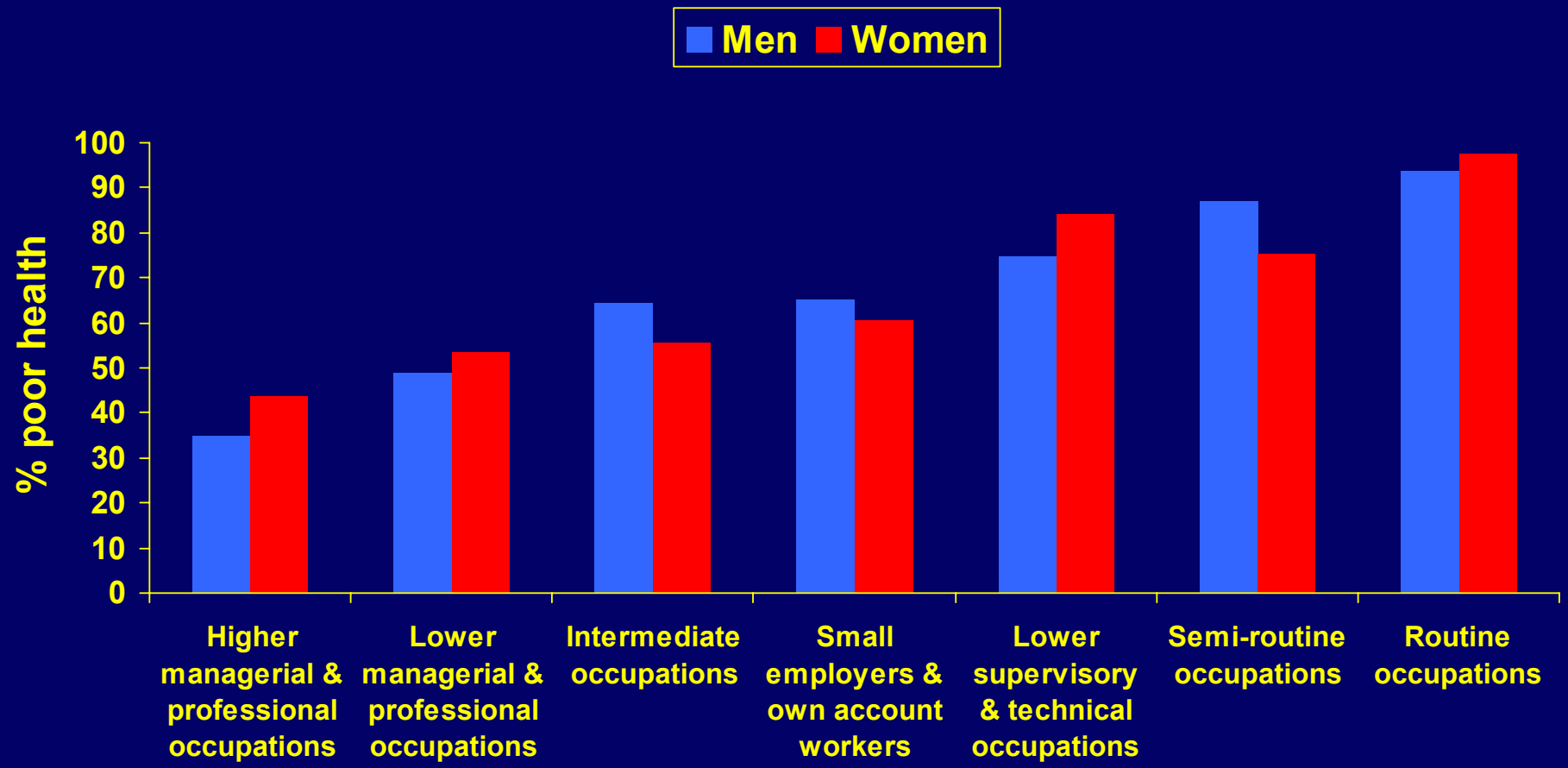
Source: Whitehead, 1997

Trends in life expectancy at birth by social class, men, England and Wales 1972-91



Source: Hattersley, 1997

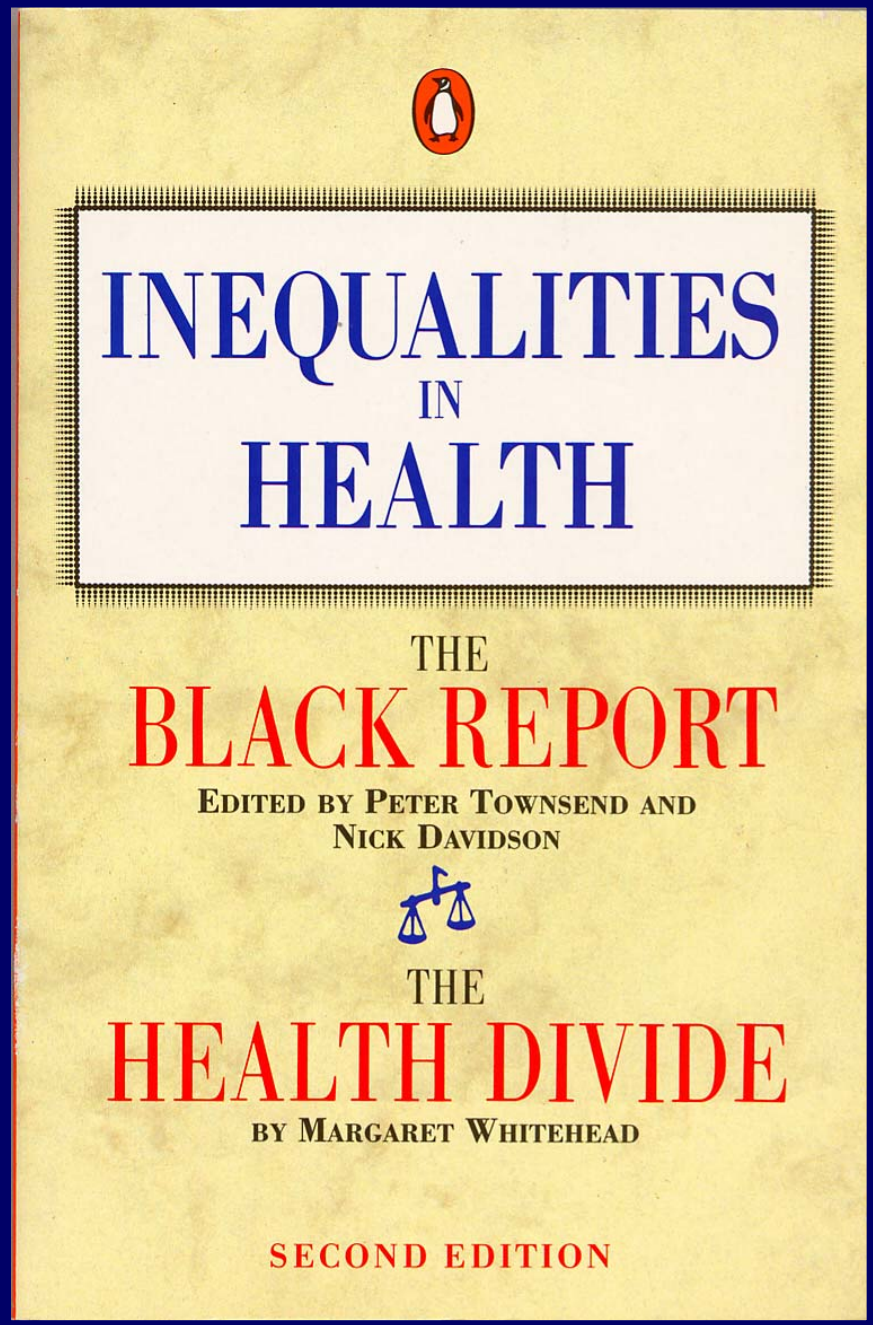
European age standardised rate (per 1000) of self reported poor health by social class: men and women aged 25-64, Great Britain 2001



Doran, Drever and Whitehead, 2004

The British approach: confrontation

- 1970s: Leading medical researchers raise awareness of emerging evidence
- 1977: Labour sets up (Black)working group
- 1980: Black Report published, but new Tory govn. tries to "bury" it. Public Health bodies object and opposition parties adopt HI issue
- 1980s: A decade of confrontation. Stream of reports published (including "The Health Divide"). Official "denial" of problem
- 1990: Thatcher resigns, softening of official line
- 1995-97: national research progs plus NHS recs.
- 1997: Labour elected, Acheson Inquiry set up
- 1998 onwards: Acheson reports, health equity targets set, national strategy developed


INEQUALITIES
IN
HEALTH
THE
BLACK REPORT
EDITED BY PETER TOWNSEND AND
NICK DAVIDSON
THE
HEALTH DIVIDE
BY MARGARET WHITEHEAD
SECOND EDITION

Health Minister's response to *The Health Divide*

"These issues can be approached from a class bias, a fascination with a class division of society which is basically a Marxist approach… Marxism is entirely based on this class approach and is carefully reflected in the Black Report and *The Health Divide*… the answer is not to impose on society the socialism that everyone else has rejected, and seemingly only the few authors of these reports and a few left-behind diehards on the Opposition Benches still believe in."

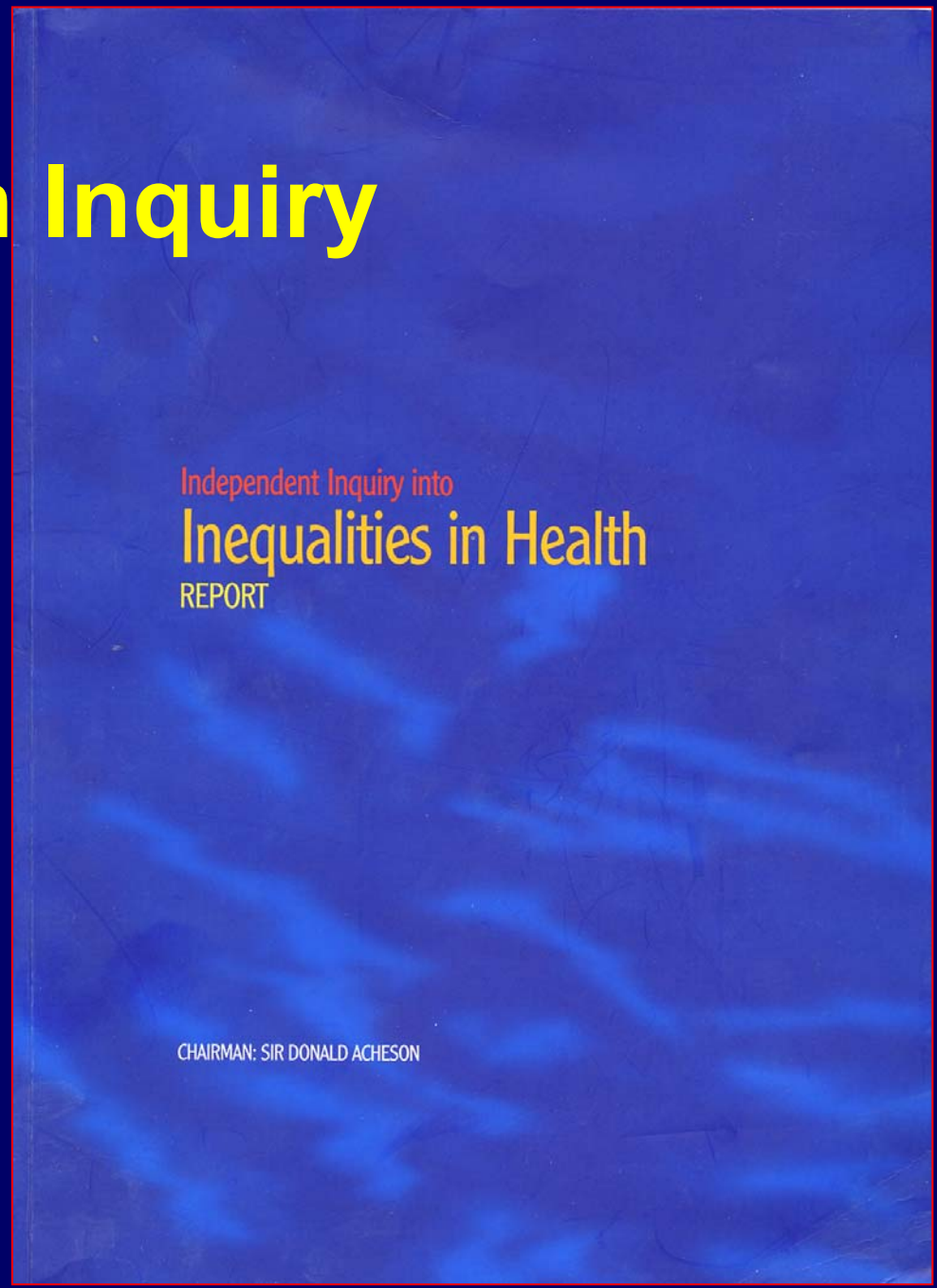
Ray Whitney, Minister of Health, 1987

….but by 1997…..

- "…These inequalities do matter and there is no doubt that the published statistics show a link between income, inequality and poor health. It is important to address that issue, and we are doing so"

  Tony Blair, July 1997

The Acheson Inquiry



Acheson Inquiry: The 3 Priority Areas

- Health inequalities impact assessment of policies
- High priority for families with children
- Reducing income inequalities and improving living standards of poor households

Acheson recommendations for families and children

Reducing poverty in families by:

- removing barriers to work
- adequate financial support for parents
- high quality, affordable day-care

Improving nutrition by:

- adequate benefits
- health-promoting schools and policies
- Review Common Agricultural Policy

Social and emotional support of parents

What factors helped progress in the UK?

- Body of researchers and health practitioners who collected evidence and disseminated it
- Backing of respected medical associations (e.g. RCP) and medical journal editors
- NHS frontline workers bear “witness” to unfairness and health impact – local commitment
- Growing public perceptions of unfairness
- Help from international research and policy community

Wider international initiatives on health inequalities

- WHO European Health Ministers' Resolution (2002): what can the health system do to alleviate/reduce poverty?

- WHO Commission on Social Determinants of Health, 2004; WHO Venice Office "Investment for health"

- EU Network on interventions and policies to Reduce Health Inequalities (Mackenbach)

- EU Network on Health Impact of Policies and Political Context (Navarro)

International networks: what have we learnt?

- No one country has the opportunity or capacity to test and evaluate effective strategies to reduce health inequalities

- We need collaboration to increase learning speed to:
  - pool research capacity
  - exploit "natural policy experiments"
  - show what can be done elsewhere

- Local work helps keep flame alive in cold national climate
- Importance of symbolic targets and international strategies

What can the health sector do?

Using unique position to:

- **Make inequities in health visible**
- **Make the differential effect of policies visible**
- **Advocate for tackling root causes**
- **Reduce the negative consequences of being in poor health**
- **Maintain the value base**