

Testimonies from the field

The case of Socio-Economic Inequalities in Health by EuroHealthNet

The key issues for this target group when exercising their right to health

Inequalities in health amongst different socio-economic income groups are a pervasive feature in all EU Member States. Specifically, health inequalities refers to:

- The systematic and avoidable differences in health outcomes between social groups such that poorer and/or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent.¹ (Mackenback, 2005)
- An important feature of health inequalities is that it is not simply the poorest that experience less than optimal health; there is a gradient of risk across the whole population. Health inequalities can therefore be categorised in three ways: 1) the poor health of socio-economically disadvantaged people vis-a-vis the rest of the population 2) health gaps between different groups and 3) social gradients across whole populations.²

The systematic differences in health status across social class is contrary to the fundamental values of equity, universality and solidarity that underpin health systems throughout the EU.

Real life examples of challenges faced

The following are some examples of how health inequalities manifest themselves in different EU Member States:

- Death rates from Coronary Heart Disease in England are three times higher among low skilled than among highly skilled men.
- Health damaging behaviours such as smoking are two to three times higher among low-income than among high-income women in Northern European Countries.
- In the Netherlands, there is a 14-year difference in healthy life expectancy among the

¹Mackenback, J.P. Health Inequalities in Europe: Overview of Patterns and Trends, Erasmus MC, Rotterdam, 2005

² Graham, H. Tackling Inequalities in Health in England: Remedying health Disadvantages, Narrowing Health Gaps or Reducing Health Gradients? Journal of Social Policy, 33:1, p.115-131, 2004

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highest and the lowest socio-economic groups.

- In countries of Central and Eastern Europe, mortality rates have since 1989 been correlated with changes in income inequalities.

Such inequalities result from the varying degrees and quality of exposure amongst different social groups to the factors that affect health. Access and availability of health care is but one, although very important, such health determinant. Evidence indicates that richer, better-educated people find their way to medical specialists and dentists more easily and more frequently, while people with less income tend to use more GP and emergency services. Lower socio-economic groups also tend to postpone preventative and curative care, affecting their perspective of receiving adequate health services, their prognosis for recovery and ultimately their overall health.

These findings reflect that inequity in access to and the affordability of health care continues to be a feature across EU health systems, in spite of the fact that most countries have long achieved rather universal and comprehensive degrees of health insurance coverage. Such inequities in access to health care can contribute to the overall, systematic differences in health status amongst people from different social classes.³

What improvements or developments are needed?

Meeting the challenges posed by health inequalities requires a range of cross-sector actions to address the social and economic determinants of health. Since health inequality is the product of many different factors, governments have a wide array of choice about how to address these. Of importance is that the actions taken involve the redistribution of resources and opportunities in ways that are relevant to the nature of health inequality in a particular context.

Tackling health inequalities is currently high on the political agenda in the UK, leading England's Chief Medical Officer, Sir Liam Donaldson to share his ideas on what is needed to address them: a cross governmental plan, with clear, measurable objectives; belief, or

³ Tamsma N, and Berman B.C. The Role of the Health Care Sector in Tackling Poverty and Social Exclusion in Europe. European Health Management Association (EHMA), 2004

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the conviction that you can do something about it; and 'joined-up government'.

Currently, many EU countries seek to improve the health of the most socio-economically disadvantaged groups, most commonly through a socio-inclusion focus. Others are attempting to narrow the health gap between the most and the least socio-economically disadvantaged. No EU member state has yet, however, made a concerted effort to implement the most radical approach to health inequalities, namely a reduction in the health gradient, whereby health is related to the position of social groups (and individuals within these groups) at every level of society.⁴ (Judge, Platt, Costongs, Jurczak, 2005)

Such an approach would imply focussing on socio-economic differentials (the systematic relationship between socio-economic position and health) in order to address 'systematic differences in life chances, living standards and lifestyles associated with people's unequal positions in the socio-economic hierarchy'. (Graham, 2004)

Additional information on health inequalities is also available in the following reports:

Stegeman, I and Costongs, C. Health, Poverty and Social Inclusion in Europe. Literature review on concepts, relations and solutions, EuroHealthNet, 2003

Stegeman I and Costongs, C. Promoting Social Inclusion and Tackling Health Inequalities in Europe. An overview of good practices from the Health Field, EuroHealthNet, 2004

⁴ Judge, K. Platt, S. Costongs, C. and Jurczak, K. Health Inequality Policies in Europe: Overview of National Strategies. Interim Report (in press) for UK Presidency Summit, 17-18 November, 2005 "Tackling Health Inequalities, governing for health"