HEALTH INEQUALITIES:
LEARNING HOW TO “MIND THE GAP”

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Summary: Recent years have seen progress on tackling inequalities in health between socioeconomic groups in Europe on two fronts: several studies exploiting natural policy experiments have generated new knowledge on the effectiveness of interventions and policies to reduce health inequalities; and trend data on health inequalities show that some inequalities, particularly absolute inequalities in mortality among men, are becoming smaller instead of larger. Nevertheless, health inequalities remain unacceptably large, and it will require “all hands on deck” to close the health inequalities gap.

Keywords: Health Inequalities, Natural Policy Experiments, Trends, Research

Introduction

“Minding the gap” in health between socioeconomic groups in our societies is one of the main challenges for public health throughout Europe, and the European Public Health conference in Glasgow has shown that we are making progress – slowly, too slowly perhaps, but steadily.

There is progress on two fronts. First, there is progress in knowing what to do to reduce health inequalities. Thanks to serious investments in cutting-edge research by the European Commission (EC), lots of new knowledge on the effectiveness of interventions and policies to reduce health inequalities has recently been generated. Second, evidence is emerging that some inequalities in health are becoming smaller instead of larger. Although this narrowing of health inequalities is somewhat dependent on the perspective chosen, and largely limited to men, it is encouraging news that lends support to the idea that health inequalities are indeed remediable.

Progress in knowing what to do

Gradually, research on health inequalities in Europe has moved from description to explanation (in the 1990s) and then from explanation to intervention (in the 2000s). Whereas research efforts in the 1990s were largely focused on finding out what the determinants of health inequalities are, recent years have seen a surge of studies looking at the impact of interventions and policies to reduce health inequalities. This was also evident at the Glasgow conference where four large projects funded by the ECs Seventh Framework Programme for Research presented their main results.

Evaluating interventions and policies to reduce health inequalities is far from easy. Randomised Controlled Trials, the “gold standard” for evaluation in the health care field, are generally unsuitable for evaluating the large-scale and complex interventions and policies that are needed for achieving population-level effects. The four EC-funded projects have therefore tried to exploit “natural policy
experiments”, in which interventions and policies happened to have been implemented in one setting and not in another, allowing comparisons to be made. These four projects are known under the following acronyms: DEMETRIQ (www.demetriq.eu), DRIVERS (www.healthgradient.eu), SILNE (www.silne.ensp.org), and SOPHIE (www.sophie-project.eu).

One general finding of these four projects is that it is often easier to find natural experiments, in which interventions and policies happened to have been implemented in one setting and not in another, allowing comparisons to be made. These four projects are known under the following acronyms: DEMETRIQ (www.demetriq.eu), DRIVERS (www.healthgradient.eu), SILNE (www.silne.ensp.org), and SOPHIE (www.sophie-project.eu).

travellers from the European Union. As a result, alcohol-related hospitalisations and mortality rose, particularly in low income groups. While these results clearly illustrate that the evidence base is slowly growing, there is an urgent need to continue research into what works to reduce health inequalities. Europe, with its variations in policy, offers excellent opportunities for generating more evidence, and the EC would do well to allocate funds from the Horizon 2020 programme to support further work in this area.

**Progress in actually reducing health inequalities**

There is also some progress in actually reducing health inequalities, but in order to see it one must first carefully define what “progress” means. Let’s look at a numerical example. Suppose that in country X the mortality rate declines from 100 to 50 among the rich, and from 200 to 120 among the poor. While the decline in mortality will be seen as progress by everyone, the resulting change in magnitude of inequalities between rich and poor will not. Some will see a deterioration of health inequalities, because the Rate Ratio has increased from 2.0 (200/100) to 2.4 (120/50). Others will see progress, because the Rate Difference has fallen from 100 (200–100) to 70 (120–50).

Such opposing trends for relative and absolute inequalities are quite common, as recent studies of trends in inequalities in mortality have shown (see Figure 1). Trends have been very unfavourable in Hungary, Lithuania and Estonia, where mortality has increased among the low educated, and declined or remained stable among the high educated, and both relative and absolute inequalities in mortality have risen dramatically.

However, trends have been much more favourable in Western Europe, where mortality has declined among both the low and high educated, albeit at different speeds. Whereas relative inequalities in mortality have nearly uniformly gone up, absolute inequalities have not, particularly among men. Due to greater absolute declines among lower educated men, Rate Differences of mortality have gone down among men in Finland, Sweden, Norway, England & Wales, France, Switzerland, Spain and Italy (Figure 1b), and among women in Sweden, Norway, France, Switzerland, and Italy (Figure 1d). Rate Ratios, on the other hand, have gone up in almost all countries (Figures 1a and 1c).

How to choose between these two perspectives? Embedded in quantitative measures of relative and absolute inequalities are value judgements. Regrettting the rise of Rate Ratios despite declining Rate Differences implies a strictly egalitarian position, in which what matters is equality in itself, independent of other considerations such as the absolute rates of mortality for each group. Welcoming the decline of Rate Differences despite rising Rate Ratios implies the pragmatic view that absolute rates matter most for people in lower socioeconomic groups, and that a smaller absolute mortality excess is thus to be preferred even if it goes together with a larger relative mortality excess, as in many European countries over the past decades.

In my view, there is a strong case to be made for the ‘Realpolitik’ of aiming to reduce absolute inequalities in mortality. In a context of rapidly declining mortality rates, it is extremely difficult to reduce relative inequalities in mortality. This is not only suggested by the near-absence of empirically observed reductions of relative inequalities (see Figure 1), but can also be underpinned by theoretical reasons. To achieve a reduction of relative inequalities in mortality one would need to create greater reach and/or greater effectiveness of interventions and policies among people with a lower socioeconomic position, and therefore spend considerably larger efforts on people with a lower socioeconomic position. While this is not impossible, it would necessitate a massive shift of resources that has so far not been politically feasible.

**Conclusions**

In conclusion, there is progress, both in “knowing what to do” and in actually reducing health inequalities, but these two forms of progress probably have
little to do with each other. The decline of absolute inequalities in mortality seen in some countries was not due to the implementation of policies aiming to reduce health inequalities, but represents general progress in reducing mortality which was shared more or less equally between socioeconomic groups.

One example is the decline in mortality from cardiovascular disease which has been larger, in absolute terms, among the low than among the high educated in many Western European countries, probably as a result of advances in prevention and treatment of these conditions which have benefitted all social strata. Such benefits to lower socioeconomic groups do not come automatically but represent an enormous achievement of many Western European countries, which would not have been possible without, some degree of equality of access to health care.

Nevertheless, much remains to be done, particularly if we aim at reducing relative inequalities in health. Health inequalities remain unacceptably large, both in absolute and relative terms, and while evidence on the (in)effectiveness of policies and interventions to reduce health inequalities is accumulating, the political will to implement these policies, and to allocate the resources necessary to achieve population-level effects is often lacking. As the Glasgow declaration rightly states, it is “all hands on deck” to close the health inequalities gap.

References


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**Figure 1:** Changes in educational inequalities in mortality between the 1990s and 2000s, by country/region and sex

**a. Relative inequalities, men**

**b. Absolute inequalities, men**

**c. Relative inequalities, women**

**d. Absolute inequalities, women**

Rate Ratios and Rate Differences calculated from age-standardised all-cause mortality rates of those with no, primary or lower secondary education versus those with tertiary education.

Source: Eurohealth OBSERVER


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**Some tweets from the Conference #ephglasgow**

- Prof Whitehead: governments should invest in social protection over austerity measures that hit hard the more disadvantaged #ephglasgow

- Access to care key in decreasing mortality among lower socio-economic groups #ephglasgow

- #KarlEkdahl is warning that health politicians are not aware of lower access to #healthcare for vulnerable groups #ephglasgow

- Marc Sprenger: “public health is a clockwork” – all measures should interlock #ephglasgow #phealth

- Policies more effective than pills against non-communicable diseases #ephglasgow #NCD

- For Johan Mackenbach major determinants for reducing health inequalities are smoking and alcohol related mortality #ephglasgow

- Ricardo Baptista Leite: health in all policies is the Loch Ness monster of the EU #ephglasgow

- Raj Bhopal: Need to integrate social determinants of health and ethnic disparities agendas. Will help improve health for all #ephglasgow

- Simon Capewell: drug, alcohol and processed food/drink industries care about profit not #publichealth #ephglasgow
GLASGOW DECLARATION

‘ALL HANDS ON DECK’ TO CLOSE THE HEALTH INEQUALITIES GAP

Introduction

Glasgow welcomed Europe and beyond to the 7th European Public Health (EPH) Conference between 19th and 22nd November 2014. Sixty-five countries were represented by over 1500 delegates, who gathered to discuss and debate the knowledge and practice of reducing health inequalities.

Over the course of the conference, which included seven plenary sessions, over 100 parallel sessions, about 300 posters and six films, delegates had the opportunity to share findings from research and experiences with innovation in all fields of public health and health services.

Researchers, educators, policy-makers, community representatives and health managers from Europe and beyond shared new information and insights from their experiences with interventions to reduce health inequalities, the theme of the conference, and developed a deeper understanding of the urgency to address this issue.

This Declaration summarises broad ranging discussions over the three days of the conference, drawing upon rapporteurs’ notes across all the sessions.

The facts

Health inequalities exist not only between countries but also within countries. Health inequalities refer to differences in people’s health and life chances. Health inequalities are strongly related to the conditions in which people live, such as their income, employment status or the area they reside in. In the UK, for example, those living in the richer areas will live, on average, seven years longer than those who live in poor and deprived areas. Priority areas in health inequalities are tobacco, alcohol, addictive drugs and poor diet.

While there are some welcome indications that inequalities have started to narrow in recent years, at least on an absolute scale, they are still unacceptably large.

The evidence presented at the EPH Conference in Glasgow was overwhelming:

- Health inequalities between countries amount to a gap of 8.9 years of life expectancy between Latvia (74.1 years in 2012) and Iceland (83.0 in 2012)
- Health inequalities within countries systematically favour the well off. In Glasgow, for examples, there is a nine-year gap in male life expectancy between neighbourhoods.

At the conference, several promising examples were presented, including:

- Involving peer groups (professional sports clubs willing to “buy in” to health improvement programmes for their fans) has a positive effect on lifestyle changes
- Green spaces in urban environments have a positive effect on mental health
- Regulation by authorities having a positive impact on healthy choices (e.g. Danish fat tax and potential UK sugar tax)
- Organising better access to health care by making ethnic/migration status a routine part of policy.

Even though there have been successes, health inequalities are still unacceptably large. Recent trends, for example in cardiovascular disease mortality, suggest that reducing health inequalities is indeed feasible. National programmes in various European countries to tackle health inequalities have so far been only partly successful, and have shown that we need to re-think what is needed to measurably reduce health inequalities at the population level. The focus going forward should be on a reduction of absolute and relative health inequalities.

The solutions

Glasgow 2014 has made us aware that we not only have to ‘mind the gap’ in health inequalities, we need to go much further than that. It is ALL HANDS ON DECK! The whole public health community and the whole of society needs to get involved in reducing health inequalities.

We need to:

- Increase the available data and also studies on how to achieve population wide impact
- Translate research/evidence to policy consistently and at all levels
- Understand what works to reduce health inequalities, for whom, and why
- Ensure that policies are based on established models of good practice and evaluated both in terms of economic and health benefits
- Exchange best practice (international, national) to learn from each other
- Think outside the box: topics to be covered include poverty reduction, improving employment and working conditions, tobacco and alcohol control and urban renewal
- Foster public engagement and solidarity
- Increase personal engagement
- Develop the commitment of the public health community
- Obtain a commitment from the community

The next steps

At the 8th European Public Health Conference, in October 2015, in Milan, Italy, we will evaluate what processes have been put in place that can reduce health inequalities. We encourage researchers, governments, NGOs and funders to attend Milan 2015 and contribute towards this vision.