THE PERSISTENCE OF HEALTH INEQUALITIES IN MODERN WELFARE STATES: THE ROLE OF HEALTH BEHAVIOURS

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Summary: Despite the rise of the modern welfare state, health inequalities by socioeconomic position are substantial in all European countries with available data. One reason is that people with a higher socioeconomic position often are the first to abandon behaviours that are found to damage health, such as smoking and high-fat diets, or to adopt behaviours that are found to promote health, such as leisure-time physical activity. As a result, and as shown by recent European studies, inequalities in smoking, excessive alcohol consumption, diet, obesity and other factors are common, contributing importantly to inequalities in morbidity and mortality. Tackling inequalities in health-related behaviours therefore is key to success in reducing health inequalities. Although some examples of effective interventions are available, more research and development is necessary to develop adequate countermeasures.

Keywords: Health Inequalities, Health Outcomes, Health Behaviours, Tobacco, Alcohol

Health inequalities are surprisingly large

It is now widely known that people who have lower socioeconomic positions (indicated by their level of education, occupation or income) have, on average, shorter and less healthy lives than those who are better off. Indeed, life expectancy at birth often varies by five to ten years, with less educated and poorer people also spending ten to twenty more years of life suffering from illness or disability. As Figure 1 indicates, the magnitude of these inequalities varies considerably between European populations, with smaller inequalities in populations in Spain and Italy, and larger inequalities in central and eastern Europe. Nevertheless, inequalities in mortality are substantial everywhere, even in countries with highly developed welfare states like the Nordic countries.
In the nineteenth century, this would not have been surprising, given low average income, widespread poverty and lack of social security. But it is surprising that such large inequalities are commonly found in high-income countries today, including those ranking high on indices of human development. Since the end of World War II, many countries have tried to reduce socioeconomic inequality, or offset its consequences, through progressive taxation, social security programmes, and a wide range of collectively financed provisions, such as public housing, education, health care and cultural facilities.

While there is no doubt that these policies have reduced inequalities in some social and economic outcomes, including income, housing quality and health care access, they have apparently been insufficient to eliminate health inequalities. Long-term time-series data indicate that the socioeconomic mortality gap narrowed in the first half of the twentieth century, but has grown again since the 1950s. Even more puzzling is the fact that, as can be seen in Figure 1, countries with more generous welfare policies, such as the Nordic countries, do not have smaller health disparities than other western European countries.

The explanation of a paradox

Many researchers have struggled to explain this paradox, and what emerges from the scientific literature is that the persistence of health inequalities in modern welfare states results from a combination of three factors. First, and perhaps most importantly, despite increases in average prosperity and some redistribution of income from higher income earners to those with lower incomes, inequalities in access to material resources have not been eliminated. The welfare state does redistribute lifetime income through taxation, cash transfers and non-cash benefits, but what remains of inequalities in material living conditions is still substantial, even where there are relatively small income inequalities as in the Nordic countries.

Second, social mobility, with children ending up in higher social positions than their parents, has been widespread in all high income countries. Due to this process of upward social mobility, the lower socioeconomic groups have not only shrunk in size, but have also probably become more homogeneous in terms of disadvantage. The reason for this is that the more social mobility there is, the more opportunities there are for selection into higher social positions on the basis of personal characteristics like mental health, cognitive ability and personality. We know that these personal characteristics are important for health, e.g. because they determine health-related behaviour, and the increased importance of these selection processes will therefore tend to increase inequalities in health. This may be the case particularly in countries with well-developed welfare policies such as the Nordic countries, which usually also have egalitarian education policies.

Third, people with a higher socioeconomic position often are early adopters of new behaviours, only later to be followed by those with a lower social position. This also applies to health-related behaviours, and thus people with a higher socioeconomic position often are the first to abandon behaviours that are found to damage health, such as smoking and high-fat diets. Over the past decades, these behaviours have been pushed back in many western European countries, partly as a result of health promotion efforts, but during this dynamic phase large and widening inequalities in health behaviours have emerged, which in their turn have led to large and widening inequalities in mortality.

Inequalities in health-related behaviours

Significant disparities in smoking, physical exercise, diet, alcohol consumption, and several other health-related behaviours now afflict many of Western Europe’s welfare states. Their welfare arrangements, which were created to combat poverty, obviously have been less effective against the causes of “diseases of affluence” like heart disease and lung cancer, which are often linked to modern consumption behaviour.

Among men, smoking nowadays is more prevalent among the lower educated in all European countries, with inequalities being particularly large in some of the Nordic countries. Among women, similar international patterns are seen, but in
southern Europe inequalities in smoking sometimes still have a “reverse” pattern, with smoking being more prevalent among the higher educated. Studies have shown that inequalities in smoking explain up to a third of inequalities in all-cause mortality, particularly among men.

Women, overweight and obesity are much more prevalent in lower socioeconomic groups in all countries with available data, and inequalities in overweight and obesity are largest in southern Europe where they make a larger contribution to the explanation of inequalities in mortality among women than smoking.

The systematic nature of differences in health-related behaviour clearly demonstrates that these are not a matter of free choice, but must be determined by conditions which are at least partly beyond the control of the individual. The explanation of inequalities in smoking has been studied in some detail and the results of these studies point to a variety of specific factors that work together to produce a higher prevalence of smoking in lower socioeconomic groups. Because social norms in lower socioeconomic groups are more pro-smoking, adolescents from these groups are more likely to start smoking than their better-off counterparts, and they start at a younger age, leading to more nicotine dependence. Smokers from lower socioeconomic groups also stop less often, and with less success.

Prevention of health problems at higher ages has less priority for people from lower socioeconomic groups, because they have more urgent problems to deal with – problems that are linked to their less favourable living conditions and higher exposure to psychosocial stress. Finally, tobacco control policies, particularly those relying on health education, have been less effective for smokers with a lower level of education or income.

Dietary behaviours also vary systematically by socioeconomic position. Men and women in lower socioeconomic groups tend to eat fresh vegetables less frequently, particularly in the north of Europe. Differences in fresh vegetable consumption are smallest in the south of Europe, probably because of the larger availability and affordability of fruit and vegetables in Mediterranean countries. A similar north-south gradient has been found for inequalities in the consumption of fruit.

Lack of leisure-time physical activity tends to be more common in the lower socioeconomic groups as well, as are overweight and obesity. Interestingly, this is one of the very few aspects of health where patterns of social variation are clearer for women than for men. Among women, overweight and obesity are much more prevalent in lower socioeconomic groups in all countries with available data, and inequalities in overweight and obesity are largest in southern Europe where they make a larger contribution to the explanation of inequalities in mortality among women than smoking.

In the last few decades, social policy in most Western European countries has moved away from redistribution. This is a mistake, given that the consequences of this shift – rising income inequality, weaker social safety nets and reduced health care access – will aggravate health inequalities in the long run. In fact, more and better-targeted redistributive policies are likely to be crucial to improving health outcomes in lower socioeconomic groups. For example, income support should be complemented by preventive health programmes, while health literacy programmes could help to diminish the link between low cognitive ability and bad health. Equal access to health care – still the main focus of health inequality reduction in many countries – is certainly not enough. Reducing inequalities in health outcomes requires more intensive health care for patients in lower socioeconomic groups, tailored to their specific needs and challenges.

Tackling inequalities in health-related behaviours probably is the key to success in reducing health inequalities. Unfortunately, we know very little about how to do this. Systematic reviews of smoking interventions covering price increases, access restrictions and smoking bans only found evidence for an inequalities-reducing effect of price increases. Whereas raising excise taxes may be effective, its regressive impact on the poorest smokers who cannot stop should be counteracted by active promotion of the use of nicotine replacement therapy and other forms of smoking cessation support. Revenues from tobacco taxation could be used to fund cessation-support programmes that target disadvantaged smokers. A national programme which created smoking cessation services in disadvantaged areas in England has effectively reached disadvantaged smokers and has somewhat reduced the gap in smoking.

While smoking is clearly bad for health, alcohol is a more complex risk factor: both abstinence and excessive alcohol consumption are bad for health (as compared to moderate drinking). Abstinence usually is more common in the lower socioeconomic groups but the pattern for excessive alcohol consumption is more variable. The clearest evidence comes from countries, such as some of the Nordic countries and central and eastern European countries, where ‘binge drinking’ is a major source of health problems. Binge drinking usually is more common in lower socioeconomic groups, and then makes an important contribution to the explanation of health inequalities, e.g. through a higher rate of cardiovascular disease and injury mortality.

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Partly different but equally complex explanations apply to inequalities in other health-related behaviours, and all of this highlights the need for creative solutions.

What to do about health inequalities?

This article has shown that modern European welfare states have been unable to stop the re-emergence of health inequalities, partly because of a failure to implement more radical redistribution measures, and partly because of concurrent developments which have changed the composition of socioeconomic groups and have made the reduction of health inequalities dependent on changes in consumption behaviour. It follows that a substantial reduction of health inequalities can only be achieved by more radical redistribution measures, and/or a direct attack on the personal, psychosocial and cultural determinants of modern health inequalities.

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Generally speaking, supply-side interventions are likely to be more effective in reducing inequalities in health-related behaviours than demand-side interventions. For example, Finnish nutrition policies have followed the Nordic welfare ideology where universalism has been the general principle. School children, students and employees in Finland receive free or subsidised meals at school or in the workplace, and special dietary guidelines have been implemented to ensure the use of low-fat food products. This has contributed to a favourable trend in the use of butter and high-fat milk in Finland.

As these examples show, tackling inequalities in health-related behaviours is possible, but it will require sustained efforts underpinned by systematic evaluation.

References


New Policy Summary on Addressing needs in the public health workplace in Europe

By: Vesna Bjegovic-Mikanovic, Katarzyna Czabanowska, Antoine Flahault, Robert Otok, Stephen Shortell, Wendy Wisbaum and Ulrich Laaser


Number of pages: 48, ISSN: 2077-1584, Policy Summary 10

Available at: http://www.euro.who.int/__data/assets/pdf_file/0003/248304/Addressing-needs-in-the-public-health-workforce-in-Europe.pdf?ua=1

One of the primary challenges facing European health systems is the need for a multidisciplinary public health workforce supported by new skills and expertise. This policy summary aims to outline these needs and to consider measures and options towards meeting them.

Starting off with a snapshot of the current workforce and training provisions in different European health systems, the policy summary goes on to discuss positive efforts to promote public health training and education such as the Bologna Process and the WHO Regional Office for Europe’s Health 2020 policy. However, large gaps are apparent in both the numbers of professionals trained and the kind of training that exists. The discussion then turns to the need to agree upon core and emerging competences for a well-equipped workforce, including the important role of employers in determining these competences. In addition, public health education needs to include a wider range of health-related professionals, including managers, health promotion specialists, health economists, lawyers and pharmacists.

Identified and agreed-upon competences can, in turn, be translated into competency-based training and education, necessary to equip current public health professionals with the skills required in today’s competitive job market.

New developments in public health training, include flexible academic programmes, lifelong learning (LLL) which is vital for employability, and accreditation. Seven case studies present examples of current developments and practices.