



World Health Organization  
Regional Office for Europe  
Scherfigsvej 8, DK-2100 Copenhagen Ø, Denmark

Tel.: +45 39 17 17 17.  
Fax: +45 39 17 18 18.

E-mail: [postmaster@euro.who.int](mailto:postmaster@euro.who.int)  
Web site: [www.euro.who.int](http://www.euro.who.int)

Concepts and principles for tackling social inequities in health: *Levelling up part 1*



# Concepts and principles for tackling social inequities in health:

## *Levelling up Part 1*

Margaret Whitehead  
Göran Dahlgren

WHO Collaborating Centre for  
Policy Research on Social Determinants of Health  
University of Liverpool

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EUROPE

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## **FOREWORD**

*In 1990, the WHO Regional Office for Europe published two technical documents: The concepts and principles of equity and health (Whitehead, 1990), followed by a companion paper on policies and strategies (Dahlgren & Whitehead, 1992). The purpose of both documents was to clarify the concept of equity, in the context of health, and its implications for policy development in this field. These documents were intended for a non-technical audience of policy-makers and practitioners. The outcome was raised awareness and stimulating debate in a wider general audience. The documents were taken up across Europe, North America and Australasia, translated into 20 languages, and incorporated into training materials for a wide spectrum of disciplines.*

*Why then are we undertaking a similar exercise now? First, the European context has changed since the early 1990s, with social divisions across and within European countries widening in many respects. To be effective in tackling social inequities in health, policy-makers and practitioners need a sound understanding of the current evidence about the key determinants and ways in which health systems can confront them in different country contexts. Our **conceptual** understanding of this body of evidence particularly about the social cause of many health inequities has also advanced considerably in the last two decades. Third, we have also developed and begun using more sensitive and reliable measures for assessing inequities in health. Finally, our knowledge about what to do to address these differences has advanced considerably, particularly in terms of: the actions that are required (policy and program); the focus of such actions (levelling up as well as reaching vulnerable groups); and the **principles** to be applied in the design, implementation and evaluation of such actions (e.g. active engagement of all stakeholders from the beginning).*

*The WHO Regional Office for Europe has been at the forefront of advocating policies that promote equity in health. In 2003, it reaffirmed this commitment by opening the WHO European Office for Investment for Health and Development (the WHO Venice Office), which focuses specifically on the social determinants of health and what health systems can do to confront them. Dr Danzon, the Regional Director of the WHO European Region, has identified the reduction of health inequities as one of six key priorities for the work of WHO in the European Region (EUR/RC56/11, Conf.Doc./5)*

*Globally, the WHO reaffirmed its commitment to acting in this area with the establishment of the Commission on Social Determinants of Health. Thus equity in health and social justice solidly remain a firm priority of the work of the WHO globally and regionally. They are at the core of action to strengthen health systems to reduce health inequities and improve population health.*

*It is within this global and European effort to develop useful tools and guidance for countries to tackle social inequities in health, that the WHO Venice Office invited Margaret Whitehead and Göran Dahlgren to prepare this document on the concepts and principles needed to tackle social inequities in health. The document is the result of a wide range of consultations including discussion of earlier versions of this paper at meetings organized by WHO as well as in international fora. This final version has greatly benefited also from two European consultations on how to mainstream the social determinants of health and the reduction of health inequities involving ministries of health, cross-government policy-makers, academia and civil societies from over 30 Member States (Edinburgh 2006 and London 2007). It is also the result of inputs from the WHO Regional Office for Europe technical units and WHO Country Offices. Finally, the document has also built upon comments from a wide range of experts and policy makers working at international, national and sub-national level.*

*Our expectation is that together with European strategies for tackling social inequities in health: Levelling up Part 2 (Dahlgren & Whitehead, 2007), this work will help policy-makers in their efforts to address social inequities in health in a Europe that is rapidly changing.*

Erio Ziglio  
Head,  
*WHO European Office for Investment for Health and Development*



**PART A.**  
**CONCEPTS**

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## Part A. Concepts

### What is the difference between variations in health and social inequities in health?

Social inequities in health are the central focus of this paper. Such inequities concern systematic differences in health status between different socioeconomic groups. But what exactly does that entail? Within any country, differences in health can be observed across the population. Genetic and constitutional variations ensure that the health of individuals varies, as it does for any other physical characteristic. The prevalence of ill health also differs between different age groups, with older people tending to be sicker than younger people, because of the natural ageing process. Biologically, women in older industrialized countries exhibit an advantage in survival over men at every stage of life. Chance also plays a role in everyone's life, with luck deciding which individuals avoid a particular infectious disease or hazard and which succumb.

Three distinguishing features, when combined, turn mere variations or differences in health into a social inequity in health. They are *systematic*, *socially produced* (and therefore modifiable) and *unfair*.

The first feature is the systematic pattern of the differences in health. These differences are not distributed randomly, but show a consistent pattern across the population. One of the most striking examples is the systematic differences in health between different socioeconomic groups. Mortality and morbidity increase with declining social position, as illustrated in subsequent sections. This social pattern of disease is universal, though its magnitude and extent vary among countries.

The second feature is the social processes that produce health differences, rather than these differences being determined biologically. No Law of Nature, for instance, decrees that the children of poor families should die at twice the rate as that of children born into rich families (Blane et al., 1993), so this health inequity

is not fixed or inevitable. Theoretically, at least, if social processes generate these differences in a country, then these differences should be amenable to alteration by a concerted effort by that country.

The third feature is that social inequities are differences widely considered to be unfair, because they are generated and maintained by what Evans & Peters (2001) have termed “unjust social arrangements” that offend common notions of fairness. Of course, this depends on the meaning attributed by different people to the idea of *unfair*. Although ideas about what is unfair may differ to a certain degree from place to place, there is much common ground. For example, most (if not all) people in European countries share the view that all children, regardless of social group, should have the same chance of survival. It would be widely considered unfair if the chance of survival was much poorer for the children of some socioeconomic groups, compared with that of others. This is but one illustration of an all-embracing concern across Europe for linking fairness to human rights.

### **Fairness and human rights**

The bias and discrimination that lead to differences in access to the resources and opportunities for health between social groups is unfair. This touches on the special place that health holds in *human rights*: everyone has the right to enjoy the highest attainable standard of health in their society (WHO, 1946). Health is also a unique resource for achieving other objectives in life, such as better education and employment. Health is therefore a way of promoting the freedom of individuals and societies (Sen, 2000).

It is therefore important for a society to organize its health resources equitably, so that access to those resources are open to everybody. The existence of clear social differentials in health and in their determinants (illustrated in subsequent sections) goes against accepted values of fairness and justice (Daniels, Kennedy & Kawachi, 2000).

In today's Europe, working out what social differences in health are *fair* and *unfair* is unnecessary. Essentially, all systematic differences in health between different socioeconomic groups within a country can be considered unfair and, therefore, classed as *health inequities*. There is no biological reason for their existence, and it is clear that even systematic differences in lifestyles between socioeconomic groups are to a large extent shaped by structural factors. Summing up briefly, social inequities in health are directly or indirectly generated by social, economic and environmental factors and structurally influenced lifestyles. These determinants of social inequities are all amenable to change.

In the International Covenant on Economic, Social and Cultural Rights, the wording deliberately sets health in the context in which people live (Kälin et al., 2004). For the purpose of taking action, the health status of groups of people who are better off can be used as a practical indicator of the standard of health *attainable* in any given society and as the standard to which policies that address inequities in health should strive.

### **Inequality and inequity are synonymous**

Earlier papers by the present authors, adopted the phrase *inequities in health* throughout, while explaining that in some countries, notably the United Kingdom, the phrase *inequalities in health* was used and had the same meaning. In the intervening years, more European countries have adopted the British terminology, as illustrated by the title of the 2005 EU Summit on Tackling Inequalities in Health. For consistency with other WHO documents, however, the phrase *social inequities in health* has been retained in this paper. The authors would still like to emphasize, though, that in the public health community the phrase *social inequalities in health* carries the same connotation of health differences that are *unfair* and *unjust*. Indeed, as some European languages have only one word for the two terms, there is no distinction between the two when they are translated.

## So what is equity in health?

If inequity in health is unfair and unjust, what then is the converse: *equity in health*? The concept is related intimately to the central *human rights thread* that has run right through the key articles of WHO, from its inception in the 1940s to the resolutions of the 21<sup>st</sup> century. The WHO Constitution (WHO, 1946) 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”.

Echoing these sentiments nearly 60 years later, 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.

This refers to *everyone* and not just to a particularly disadvantaged segment of the population. Efforts to promote social equity in health are therefore aimed at creating opportunities and removing barriers to achieving the health potential of *all* people. It involves the fair distribution of resources needed for health, fair access to the opportunities available, and fairness in the support offered to people when ill.

The outcome of these efforts would be a gradual reduction of all systematic differences in health between different socioeconomic groups. The ultimate vision is the elimination of such inequities, by *levelling up* to the health of the most advantaged.

## Widespread inequities throughout Europe

### A widening health divide

Within the countries of Europe, there are many examples of systematic differences in health between different social groups. In all European countries,



most disadvantaged groups have worse health and higher mortality. This manifests itself in large differences in life expectancy between the extremes of the social scale. 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 et al., 1998). 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, Vagero & Kunst, 2003).

Examples from the northern and southern parts of the Region are also evident. 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, Boshuizen & Perenboom, 1996). Also, women in Finland from the group with the lowest level of education have eight fewer years of disability-free life expectancy than women from the group with the highest level of education (Valkonen et al., 1994). Moreover, in the south, studies in Turin, Italy, have shown that although mortality decreased for all socioeconomic groups over the past 30 years, the decrease was less pronounced among men and women with a lower level of education and among men with poorer housing conditions (Marinacci et al., 2004).

In France, two examples are striking. Between a 35-year-old unskilled manual worker and a white-collar (*cadre supérieur*) 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, 1999; Jouglu et al., 2000).

The health situation in central and eastern European countries is of grave concern. The Russian Federation had a drastic, indeed unprecedented, deterioration in life expectancy after the economic and political shocks of the early 1990s. This deterioration did not affect all segments of the population equally. The hardest hit were the least educated groups. In fact, between 1990 and 1994, the chances

of survival for men from groups with lower levels of education were poorer than in the 1970s and 1980s. Mortality rates among people with a university education, however, were closer to mortality rates for general western populations (Shkolnikov, Field & Andreev, 2001).

### **The phenomenon of the social gradient**

Typically, a stepwise, or linear, decrease in health – and not just an extreme group in poor health and the rest in reasonably good health – is seen with decreasing social position and is referred to as the *social gradient* (Marmot, 2004). For example, the health of the populations of Florence, Leghorn and Turin has been followed over a number of years, and the findings clearly show that mortality increases linearly with increasing degree of social disadvantage. This is so both when social disadvantage is measured by the characteristics of individuals, such as education, employment or social class, and when it is measured by deprivation of the area in which people live (Costa, Spadea & Dirindin, 2002).

The impact of the social gradient on health is sometimes expressed as a *shortfall* in health – that is, the number of lives that would have been saved if all groups in society had the same high level of health as the most advantaged group. As an example of a shortfall, it has been estimated that if all working men 20–64 years of age in England and Wales had the same mortality rates as men of the same age in professional and managerial positions, then over 17 000 fewer deaths would have occurred each year in the early 1990s (Acheson et al., 1998). Excess mortality in the more deprived areas of Spain, compared with the most affluent, has been estimated at 35 000 deaths a year (Benach & Yasui, 1999). A similar shortfall calculation for the Netherlands estimated that average morbidity and mortality in the Dutch population would be reduced by 25–50% if men with lower levels of education had the morbidity and mortality levels of men with a university education (Mackenbach, 1994).

The existence of these social inequities in almost all countries poses the most serious challenge to improving the health of the Region's population, in general. Advances in life expectancy for a country as a whole, for example, are held back by the magnitude of the inequity experienced within that country.

Inequity does, however, indicate the scale of the improvement possible. It demonstrates, for example, what groups with the greatest advantages have already achieved and, therefore, what is feasible for others to attain in a particular country at a particular time. Social inequities in health among babies and children provide the starkest examples of injustice. Evidence of large differences in infant mortality between rich and poor babies in Stockholm as far back as the 1930s was a source of political concern, which led to a programme of maternal health care reforms. When combined with more general social security and housing reforms, to improve the living conditions of families in the city, these programmes and reforms brought about a reduction in the social inequity in infant mortality (Burström, 2004). Today, in Sweden, the inequity in infant mortality is almost eliminated, which is not always the case in other high-income countries.

### **Social inequities in access to health services**

Inadequate access to essential health services is one of several determinants of social inequities in health. It may not be the major determinant, but it is an important one for the health sector to tackle directly – to put its own house in order. Furthermore, the burden of payment for health services is a growing *cause* of poverty, particularly for socially vulnerable groups, and is one for which the health sector has special responsibility (and opportunity) to address effectively (Ziglio et al., 2003).

Taking the *human rights approach*, a very basic right for people is that of having access to effective health care that ameliorates their suffering when they become sick, that protects them and prevents them from developing disease in the first place, and that helps them maintain their own health when well. Without the benefits that access to health services can bring, by improving health and providing freedom from pain and suffering, all other human activities are compromised. But for many millions of people around the globe, even across a relatively rich region like Europe, access is inadequate for the needs of some groups or may even be unattainable for all practical purposes. Moreover, those in the greatest need often have the poorest access to care – a striking example of unfairness.

The idea of inequity in access to care was famously captured in the Inverse Care Law (Hart, 1971), which states, “The availability of good medical care tends to vary inversely with the need for it in the population served.” This so-called law came to Tudor Hart when he surveyed the situation in the coal-mining valleys of Wales. The location of health facilities and their quality were much worse in the poorer towns where the miners lived and suffered from occupational disabilities, compared with the facilities available in the more prosperous towns where morbidity rates were lower.

The Welsh example above relates to *geographic access* – that is, the location and, therefore, physical availability of health services in different parts of a country. Studies from around Europe have found large differences in geographic access for different population groups. In northern Europe, for instance, recent studies in Sweden have shown a clustering of publicly-financed private specialists serving the more affluent neighbourhoods in Stockholm and a scarcity in the low-income areas of the same city (Dahlgren, 1994).

Two other types of access, however, are also important: *economic access* and *cultural access*. What use is there in having health services on your doorstep if you cannot afford to use them? This is the situation in which many urban dwellers in some countries find themselves. The starkest 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. In Belgium, for example, 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 (Louckx, 2002).

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. In addition, the emergency safety net system operated in

such a way that, although the very poor could request free medical aid from the local government department each time they needed treatment, the procedure for doing so was stigmatizing. This French system was reformed in 2000, to ensure that previously excluded segments of the population could have improved economic access to care in a less stigmatizing way (Ziglio et al., 2003).

Another aspect and illustration of the problem of economic access is when people do muster the money to pay out-of-pocket fees (including informal payments), but are then pushed into debt as a result. This we have termed the *medical poverty trap* – that is, impoverishment caused by paying for medical care (Whitehead, Dahlgren & Evans, 2001). The most striking examples come from the developing world, but the medical poverty trap is prevalent in the developed world, most notably in the United States and more recently in eastern Europe. The burden of payment for essential health services and drugs should therefore always be analysed, as it might be substantial, even if it does not drive people into poverty (see companion paper: Dahlgren & Whitehead, 2007).

The other type of access, *cultural access*, relates to acceptability and respect. Do some groups experience cultural barriers to available services, rendering them unacceptable? Are there unacceptable shortcomings in the respect and dignity afforded to marginalized groups, such as the homeless or impoverished patients, by health workers? 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. Also, there may be differences in the attention that patients from less advantaged backgrounds receive, which leads to differences in the quality of care and the respect they are afforded.

Also, *differences in treatment outcome* between different socioeconomic groups may be observed – for example, when recovery after an operation is slower for poorer patients, or when drug treatment to control a chronic disease is less successful for

people living in inadequate housing. Such differences may occur even when the treatment has been provided in an equitable way, because of the socioeconomic conditions under which patients live. These differences in treatment outcome are the result of inequities in the wider social determinants of health, over which the health services may have little or no control. For this reason, striving for equity in treatment outcome is not always a feasible option for a health service.

### **What does equitable health care look like?**

In consideration of these potential inequities in access, the converse – equity in health care – can be seen as being multifaceted and incorporating ideas about *fair arrangements that allow equal geographic, economic and cultural access to available services for all in equal need of care.*

The idea of allowing for differences in *need for health services* across different socioeconomic groups is of critical importance in definitions of equity in health care. This is most easily illustrated by the use of health services by different socioeconomic groups, where service use is taken as an indirect indicator of the wider issues of access. If utilization rates were found to be similar for each socioeconomic group, it would not necessarily signify equitable service. On the contrary, it would most probably indicate an inequitable situation. This is because, given the social gradient in health status, the underlying need for care tends to be greater among lower socioeconomic groups and, therefore, correspondingly greater use of services by them than by more advantaged groups would be expected if their increased need was being met.

A pragmatic goal for equity in health care in the case just mentioned would include striving for *equal use for equal need.* The need for care, however, has to be taken into account when assessing progress towards this goal. A segment of the population with full eligibility to use a service may exercise their right not to use it, resulting in lower utilization rates for this group than the level of need indicates (Whitehead, 1990). Preventive screening and health checks provided nationally are cases in point, where some people may be reluctant to take up the

service offered. In this situation, pressuring people to use a service against their will would be inequitable. Where further investigation reveals, however, that the reason for not using the services is poor geographic access or social or economic barriers, so that people who wished to use the service could not, this would be considered unacceptable and unfair.

### **Different goals for equity in health and in health care**

In practical terms, it is important to understand that the goals for equity in *health* and equity in *health care* are very different. With equity in health, the ultimate goal would be the elimination of all systematic differences in health status between socioeconomic groups, as stated in the section on “So what is equity in health?” 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.







**PART B.**  
**TEN PRINCIPLES FOR POLICY ACTION**

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## **Part B. Ten principles for policy action**

The concepts of health equity imply certain pragmatic principles of action when striving to reduce social inequities in health status. These are set out below as 10 principles for general guidance. A framework for analysing causes of social inequities in health, and for highlighting policy options and strategies for reducing them, is contained in the companion paper (Dahlgren & Whitehead, 2007).

### **1. Polices should strive to level up, not level down**

Nobody would seriously suggest trying to close the health gap by bringing healthier people down to the level of the least healthy. A worsening in the infant mortality rate of the babies of rich parents, for example, with no change in the mortality rate of poor babies, would not be seen as a success, but would rather be seen as a tragedy – even if it led to a narrowing of the differences between the two groups, purely in terms of measurement. Yet, opponents of an equity policy have warned of this danger. Therefore, to make it absolutely clear, the principle set out in this paper emphasizes that 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. Levelling-down is not an option.

### **2. The three main approaches to reducing social inequities in health are interdependent and should build on one another**

The relative merits of different ways of addressing social inequities in health have been debated recently (Mackenbach et al., 2002; Graham, 2004a). Essentially, the three main approaches being applied to measure and tackle social inequities in health are: focusing on people in poverty only, narrowing the health divide and reducing social inequities throughout the whole population.

- i. **Focusing on people in poverty only.** This is a so-called targeting approach, which measures progress in terms of an improvement in health for the targeted group only, without any reference to improvements in health taking place in the population as a whole or among the most privileged group. From this perspective, any improvement in the health status of disadvantaged groups can be considered a success, even if the health divide between rich and poor is increasing.
- ii. **Narrowing the health divide.** This approach takes as its starting point the health of disadvantaged groups *relative to* the rest of the population. The focus of action in this category is to reduce the gap between the worst off in society and the best off – the disparity in health status between the extremes of the social scale.
- iii. **Reducing social inequities throughout the whole population.** This approach recognizes that morbidity and premature mortality tend to increase with declining socioeconomic status and that they are not just an issue of a gap in health between rich and poor. This approach therefore takes in the whole population, including middle-income groups, and seeks to reduce the differences in health between high-, middle- and low-income groups, by equalizing health opportunities across the socioeconomic spectrum.

The definition of equity in health adopted in this paper encourages seeing these three approaches as not only complementary to one another, but also seeing them as interdependent. They must build on one another. The logical sequence is therefore to make sure that the health of disadvantaged groups is improving, as an essential first step. We are not, however, recommending an isolated targeted approach here, but a general approach which may include specific actions aimed at improving the health of disadvantaged groups at a rate that reduces existing social inequities in health. The second step, narrowing the health divide, has the more ambitious aim of improving the health of people in poverty at a faster rate than that among the rich. The third step is to reduce health inequities between all groups, not just between the extremes of the social scale. The third approach, however, cannot be isolated from the other two, as reduced differences can technically be achieved by reducing the health divide between middle and higher

socioeconomic groups, while neglecting people in poverty and leaving their health even further behind. The only valid indicator of reduced social inequities throughout the whole population is when the health of the most disadvantaged groups has improved faster than that of the middle- and high-income groups, as explained in Principle 1 above.

### **3. Population health policies should have the dual purpose of promoting health gains in the population as a whole and reducing health inequities**

Some portray these twin goals as conflicting, presenting a trade-off between improved health for the population as a whole and even faster improvement in health among the worse off in society – that is, between overall gains in population health and reducing social inequities in health. This is a false trade-off. The objective of reducing health inequities constitutes an integral part of a comprehensive strategy for health development, not an alternative option. In reality, no national strategy in Europe, or elsewhere, abandons attempts to improve the health of the population as a whole in favour of concentrating solely on reducing health inequities. Also, it is increasingly recognized that national health targets for the population as a whole stand little chance of being met without attention to the health of the worst off in society. The two goals typically go hand in hand.

### **4. Actions should be concerned with tackling the social determinants of health inequities**

This principle focuses not only on the social determinants of health in general (the social conditions that can affect people's health), but also focuses on the main determinants of the systematic differences in opportunities, living standards and lifestyles associated with different positions in society (Graham, 2004b). Working conditions are a good illustration of this point. In post-industrial Europe, exposure to poor working conditions has ceased to be a major determinant of

ill health in the population overall. However, a study in Sweden found that differences in exposure to poor working conditions across the social spectrum explained a considerable proportion of the observed inequities in health between socioeconomic groups in the country (Lundberg, 1991). Tackling such social determinants, therefore requires a greater understanding of the processes that generate and maintain social inequities and then intervening in these processes at the most effective points (see companion paper: Dahlgren & Whitehead, 2007).

##### **5. Stated policy intentions are not enough: the possibility of actions doing harm must be monitored**

This principle requires an assessment of differential impacts, not just average effects. The classic example in the field of health equity is that of the adverse effects of some health sector reforms of recent decades, which have created a *medical poverty trap* (Whitehead, Dahlgren & Evans, 2001), where the increasing necessity to pay for care when sick pushes more people into poverty. In this case, the welfare system, which originally intended to support the sick, is turned into a poverty-generating system. This trap developed at a pace that required vigilance to catch it in time. Similarly, interventions designed to help people in poverty may be implemented in such a way as to stigmatize the very people the programme was designed to help and, in so doing, push them to avoid the help on offer.

This principle of carrying out health inequity impact assessments applies to a variety of policies outside and inside the health sector. Indeed, the greatest danger may lie in wider macro-policies that *hide* the negative health impacts, because they are not seen as health related (see companion paper: Dahlgren & Whitehead, 2007).

## **6. Select appropriate tools to measure the extent of inequities and the progress towards goals**

This principle may seem obvious, but as principles 1–5 illustrate, interventions intended to reduce inequities can be focused on one of several distinct goals or targets, and each one may require a separate indicator. Measures that only monitor changes in health of the poor, for example, will not be able to contribute anything about how poorer groups are faring relative to more advantaged groups. This requires measuring progress at both the top and bottom of the social scale and then comparing these two measurements. This comparison between the extremes of the social scale will not be able to assess the impact across the whole of society. This may require indicators of the so-called shortfall – that is, the cumulative difference between the most advantaged group and each successive social group for each specific factor.

It is important to monitor both *relative* and *absolute* changes in social inequities in health, because they give different information about the magnitude and direction of change. An example of a relative measure is the *ratio* of the mortality rate of the most disadvantaged group to the mortality rate of the most privileged group. An absolute measure in this case would be the *difference between* mortality rates of the disadvantaged and privileged groups. Table 1 in the Appendix gives a numerical example, using English data on trends in circulatory diseases by deprivation category. Using the absolute measure in this example, inequities in mortality show a decrease, while using the relative measure they show an increase.

## **7. Make concerted efforts to give a voice to the voiceless**

This principle entails, for example, seeking the views of marginalized groups and increasing their genuine participation (as opposed to token consultation). The more articulate members of the population and those with the most powerful representation tend to have more influence than those in a weaker position. To address this, administrators and professionals need to make a determined effort to provide administrative systems and information to make it easier for lay people to participate in decisions that affect their health.

## **8. Wherever possible, social inequities in health should be described and analysed separately for men and women**

This separate description and analysis is needed because both the magnitude and the causes of observed social inequities in health are sometimes different for the two sexes. It is therefore of critical importance that these differences are known and taken into consideration when developing strategies to combat inequities in health.

The value of combining gender-specific and socioeconomic analyses has been clearly illustrated recently by the Swedish accident prevention programme. Data on accidents for the population as a whole indicated relatively good progress on injury prevention. When the data were separated by sex and social status, however, very different rates and types of accidents were observed for girls compared with boys, men compared with women, and low-income groups compared with high-income groups. The combined gender and socioeconomic analysis also revealed that working class women, in particular, had very high levels of risk in the home and in the workplace. Once these differences were recognized, the need to tailor prevention strategies by gender and socioeconomic condition became clear (La Flamme, 1998). The same is increasingly true for tobacco control policies (Kunst, Giskes & Mackenbach, 2004).

Another reason for ensuring that systematic differences in health by gender are analysed by socioeconomic background is that the causes may differ by social position. Poor women, for example, may be discriminated against both for being women and for being poor. Tackling the differences in health generated by this so-called double burden may need different strategies from those designed to tackle the gender effects on health experienced by more affluent women. The present trend to neglect gender in analyses of social inequities in health and, conversely, to neglect social position in gender-specific analyses should therefore be replaced by a combined approach that considers both social position and gender.



## **9. Relate differences in health by ethnic background or geography to socioeconomic background**

Analyses of systematic differences in health by ethnic background should, whenever possible, be related to socioeconomic background, as the magnitude and causes of the ethnic differences observed tend to differ by social position. Likewise, ethnic background needs to be included in analyses of social inequities in health in countries with marked ethnic discrimination.

Differences in health between geographical areas should also be analysed, with due consideration to differences in the social structure. Age-adjusted health status in areas with a fairly homogenous population from a socioeconomic perspective can then be used as a proxy for assessing socioeconomic inequities in health, when measures of individual socioeconomic status, such as a person's occupation or income, are not available routinely.

## **10. Health systems should be built on equity principles**

Equity principles include the following.

- Public health services should not be driven by profit, and patients should never be exploited for profit.
- Services should be provided according to need, not ability to pay. This requires a system of health care financing that pools risks across the population, so that those at high risk are subsidized by those at low risk at any given time.
- The same high standard of care should be offered to everyone, without discrimination with respect to social, ethnic, gender or age profile.
- The underlying values and equity objectives of a health system should be explicitly identified, and the monitoring carried out to ensure these objectives are approached in the most efficient way possible.

## Summary

*Social inequities in health* are systematic differences in health status between different socioeconomic groups. These inequities are socially produced (and therefore modifiable) and unfair. In practice, all systematic differences in health between socioeconomic groups in European countries could be regarded as unfair and avoidable, and therefore regarded as inequities. This judgement about unfairness is based on universal human rights principles.

The evidence points to the existence of extensive (and widening) social inequities in health in Europe today, at least in relative terms. The need to take action to reduce these inequities and their root causes is becoming ever more pressing as a major public health challenge. This calls for a new way of thinking about the direction of policy and also calls for renewed vigilance in monitoring impacts, to make sure that no segment of the population is excluded or loses out.

Increasing numbers of countries across Europe have been striving to face the challenge of social inequities in health and are working out what practical action can be taken in their own country to improve the situation. The aim of this paper is to help promote a common understanding of the concepts and principles on which actions for tackling health inequities can be based.

Strategies for reducing social inequities in health are presented in a companion paper “European strategies for tackling social inequities in health: Levelling up Part 2” by Dahlgren and Whitehead (2007).



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**ANNEX:**  
**ILLUSTRATION OF THE DIFFERENCE BETWEEN  
RELATIVE AND ABSOLUTE MEASURES OF SOCIAL  
INEQUITIES IN HEALTH**

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## Annex: Illustration of the difference between relative and absolute measures of social inequities in health

**Table 1. Absolute and relative changes in age-standardized death rates (per 100 000 population) for circulatory diseases in people less than 75 years of age, by deprivation area, in England, 1995–1997 and 2001–2003**

Rates and gaps	1995–1997	2001–2003	Change in inequity
Death rate for the 20% most deprived local authorities (in deaths per 100 000 population)	173	129	--
Death rate for England as a whole (in deaths per 100 000 population)	141	103	--
Absolute gap (difference) between disadvantaged and England as a whole (in deaths per 100 000 population)	$173-141 = 32$	$129-103 = 26$	Reduction
Relative gap (ratio) between disadvantaged and England as a whole	$173/141 = 1.22$	$129/103 = 1.25$	Increase

*Source:* Adapted from British Department of Health (2005): 32–33.