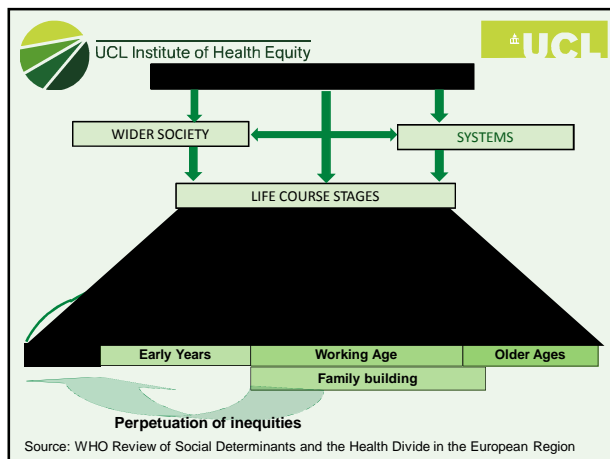


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**Health inequality: causes and responses: action on the social determinants of health**

Professor Sir Michael Marmot  
<http://www.instituteofhealthequity.org>

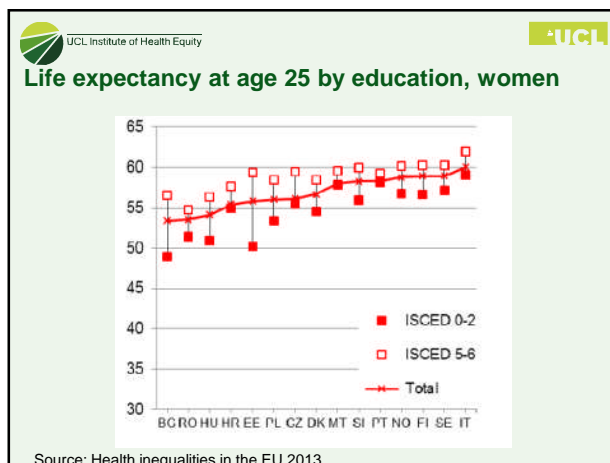
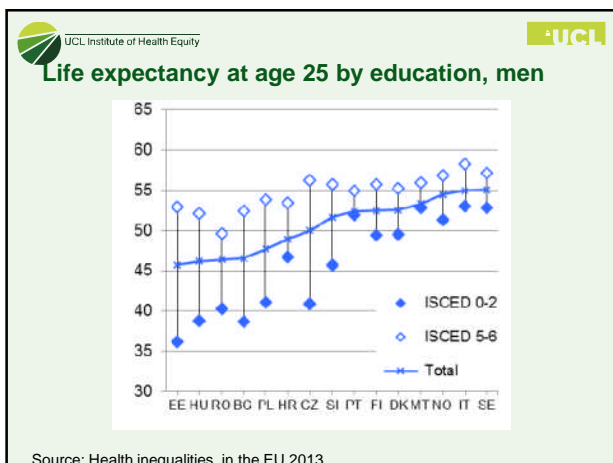
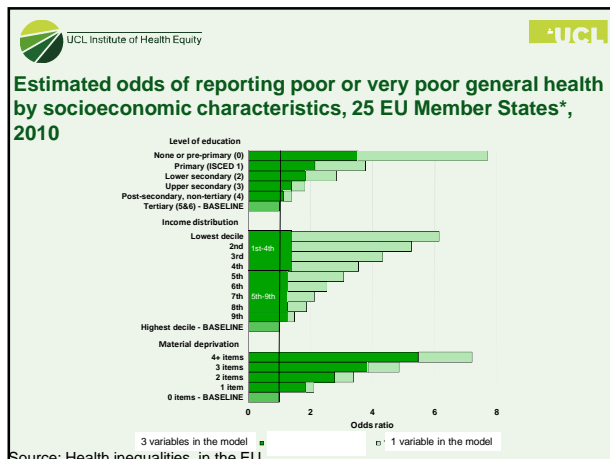
November 2014

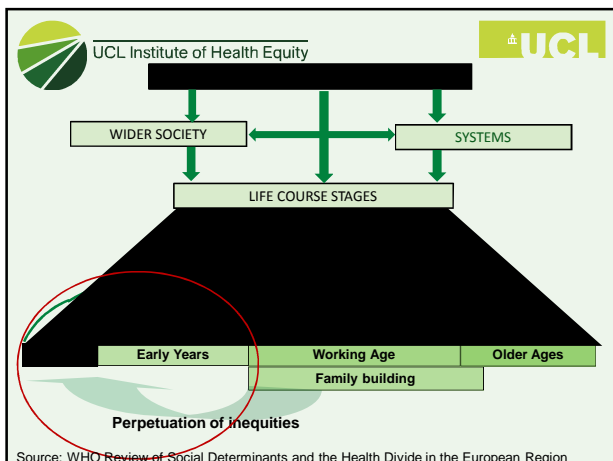


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**Why we need to tackle health inequalities**

- Moral responsibility
- Much can be done in countries at all levels
- Financial difficulties are not a barrier

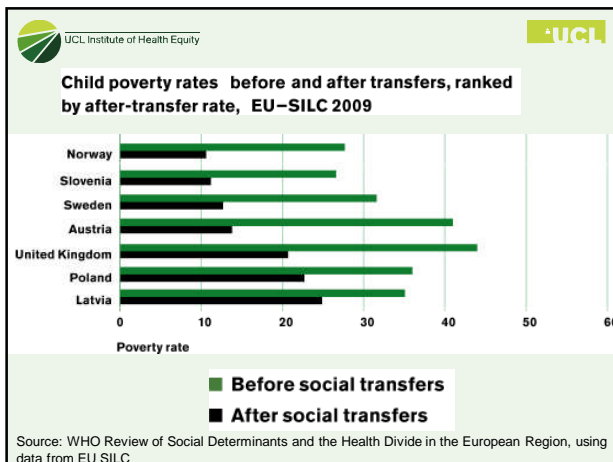




### Early child care and education

- Parenting and family support
  - Perinatal services
  - Care before and during pregnancy
  - Help for new mothers
- Pre-school education and care
- Primary, secondary and tertiary education and training

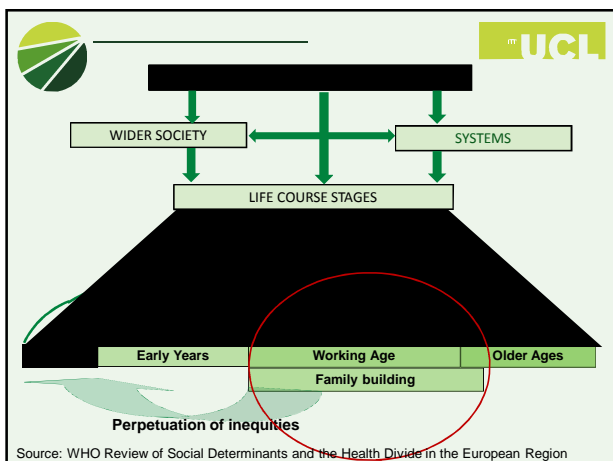
Source: WHO Review of Social Determinants and the Health Divide in the European Region



### Integrated approach across the social determinants

- Family income
- Parental leave arrangements,
- Availability & affordability of childcare at particular ages and stages
- Aligning policy - child care and education, employment, housing and transport

Source: WHO Review of Social Determinants and the Health Divide in the European Region



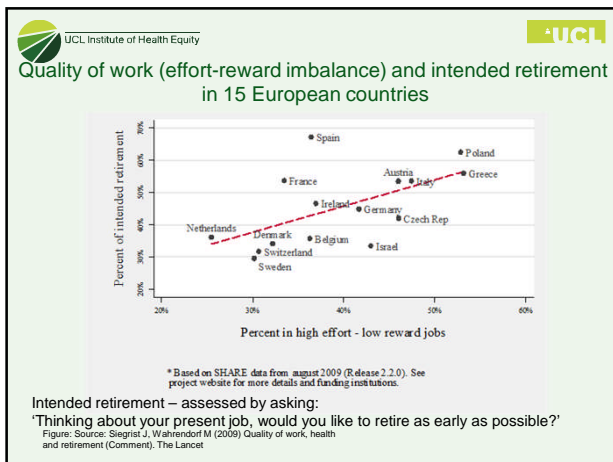
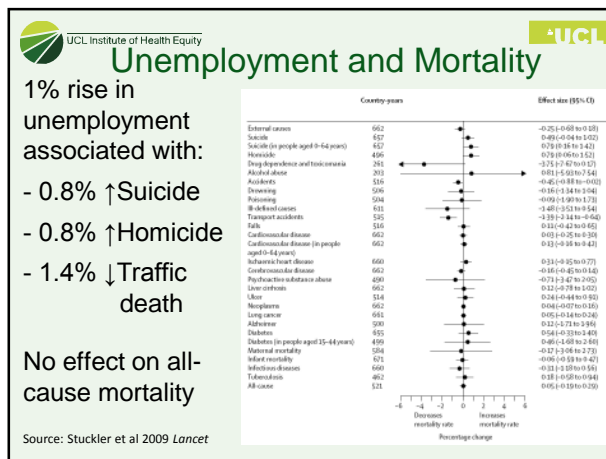
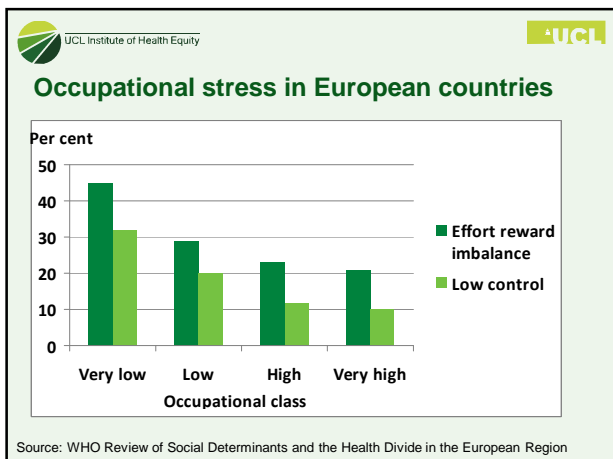
### Employment and working conditions have powerful effects on health and health equity

When these are good they can provide:-

- financial security
- paid holiday
- social protection benefits such as sick pay, maternity leave, pensions
- social status
- personal development
- social relations
- self-esteem
- protection from physical and psychosocial hazards

... all of which have protective and positive effects on health

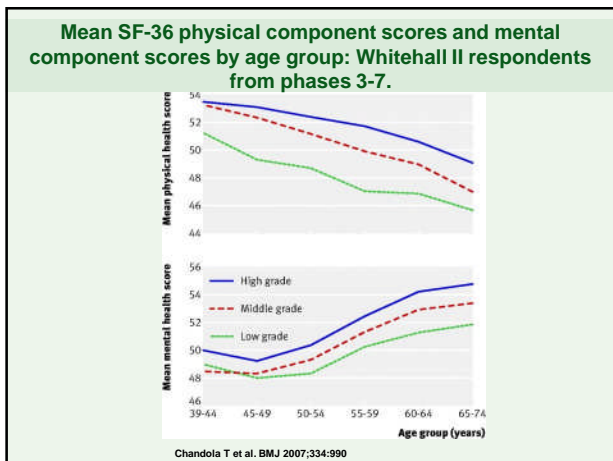
Source: CSDH Final Report, WHO 2008



**Older ages:**  
**3 components of healthy ageing:**

- Staying alive
- Avoiding disease
- Having good positive physical and mental functioning

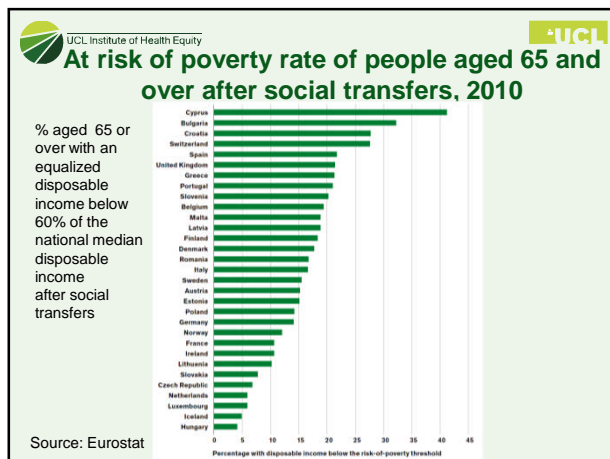
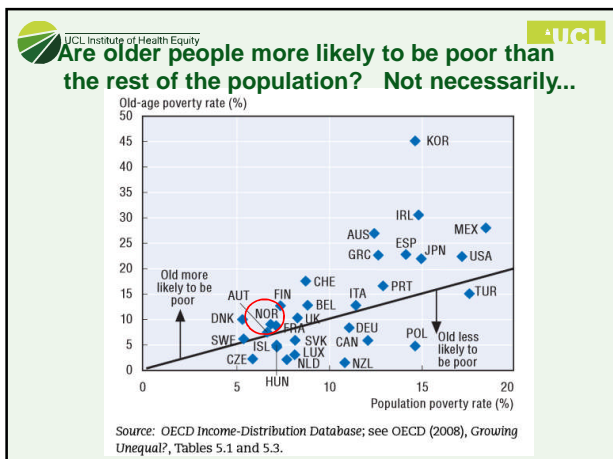
**Each of these is strongly related to the social environment**



**Older ages**

- People in professional and managerial classes reach the same level of disability as those in routine and manual classes about 15 years later.
- Professional and managerial classes have less illness in their 70s than 'routine and manual' classes 15 years earlier

Source: English Longitudinal Study of Ageing (ELSA)

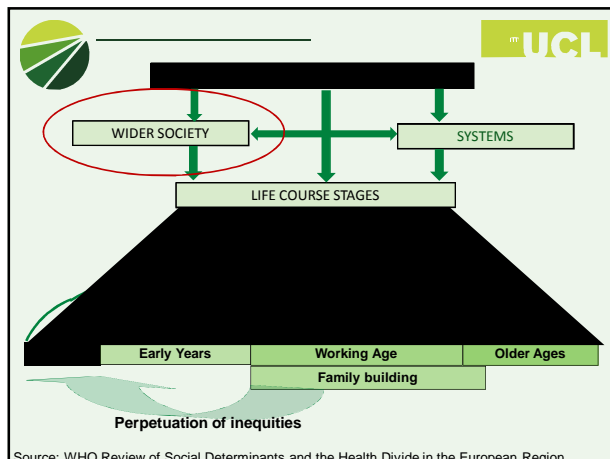


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### Spending on basics as % of income rises steeply among poorer groups

	Spending on basics as % of income	
	2008/9	Percentage point change in spending as % of income 2004/5-2008/9
Poorest	48.3	12.5
2 <sup>nd</sup>	34.4	2.2
3 <sup>rd</sup>	27.6	-1.5
4 <sup>th</sup>	22.6	-4.1
Richest	16.4	-7.1
All	29.7	0.7

Source: English Longitudinal Study of Ageing (ELSA)

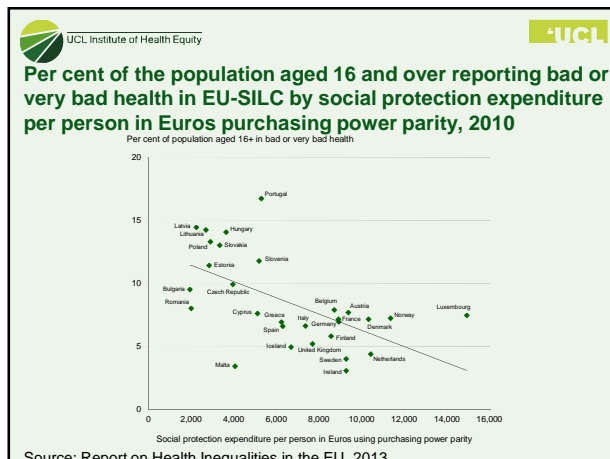


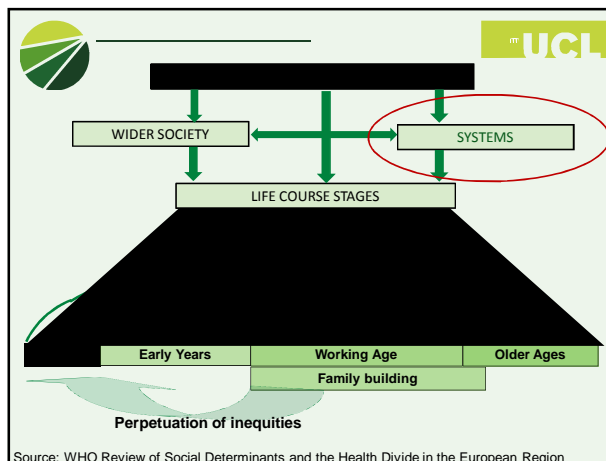
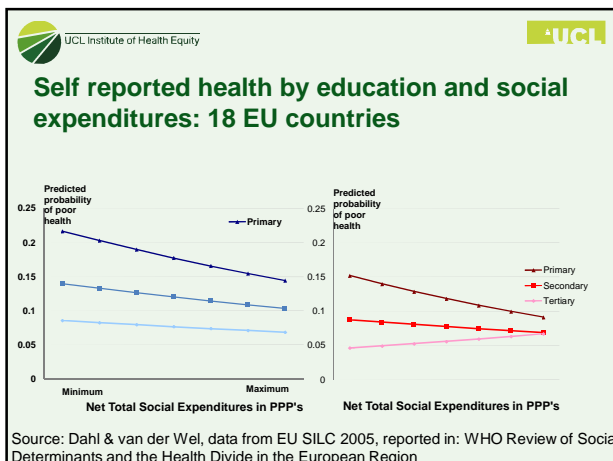
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### Wider Society

- Social exclusion
- Social protection across the life course
- Communities

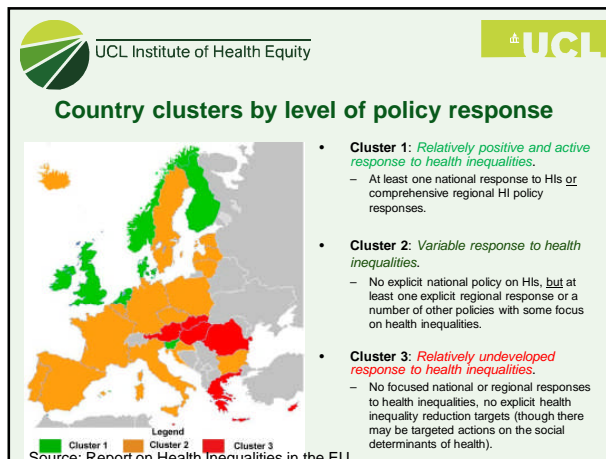
Source: WHO Review of Social Determinants and the Health Divide in the European Region





### Health inequalities and policy strategies

- Health inequalities are not inevitable;
- Not just a responsibility of the health care sector;
- There is no 'magic bullet'
- Whole of society, whole of government



### Widening of policy response between member states since 2006

Level of policy response	Countries by Cluster Group
Intensification of policy response	Cluster 1: Denmark, Finland, Norway, United Kingdom* Cluster 2: Estonia, Latvia, Spain*, Iceland*
Same level of policy response	Cluster 2: Belgium, France, Germany, Italy, Poland, Sweden Cluster 3: Lithuania*
Decrease in intensity of the policy response	Cluster 1: Ireland, Netherlands Cluster 2: Czech Republic Cluster 3: Cyprus, Greece, Hungary

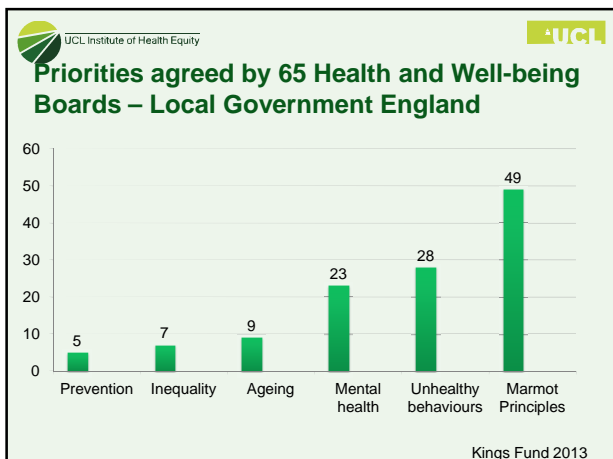
\* Countries where on-going changes to policies (mentioned elsewhere within this report) may affect assessment.

Note: Some countries were not included in the analysis performed in 2006 and are therefore omitted from this table (Austria, Bulgaria, Croatia, Luxembourg, Malta, Portugal, Romania, Slovakia, and Slovenia).

Source: Report on Health Inequalities in the EU

### England: National Health Service duty in reducing inequalities

- **New inequalities legislation 2012** – NHS duty to pay due regard to reducing health inequalities – Trusts, CCGs, NHS England, PHE, DH
- **Secretary of State** – accountable for health inequalities



**Malmö, Sweden**

- Commission for a Socially Sustainable Malmö, chaired by Sven-Olof Isaacson, March 2011
- to translate the findings of the CSDH into a form suitable to address social determinants and health inequalities in Malmö
- Report March 2013

**Malmö: Six areas for action**

- Children and young people’s living conditions
- Living environment and urban planning
- Education
- Income and employment
- Health services’
- Changes in processes for socially sustainable development

**Health is a human right  
Do something  
Do more  
Do better**

Source: WHO Review of Social Determinants and the Health Divide in the European Region