Institute for FUTURES STUDIES

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Policies and strategies to promote social equity in health

Background document to WHO – Strategy paper for Europe

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1. INTRODUCTION

This is the second in a series of discussion papers from the WHO Regional Office for Europe. The first covers concepts and principes of equity in relation to health, and should be read in conjunction with this paper (Whitehead 1990)

The present paper sets out to develop the discussion further by outlining a strategic approach to promote greater equity in health between different social and occupational groups. This draws on the work of WHO advisory groups and associated litteratur listed at the back, together with practical examples from industrialized countries where strategies have been put into action.

The first part (section 1-9) of the paper outlines why equity is seen as a priority and distinguishes different policy levels for interventions. Specific equity aspects related to each policy level are then highlighted as well as some case studies.

The second part of the paper (section 10-14) deals with putting policy into practice. Special attention is then paid to the need for comprehensive approaches to combat social and occupational inequities in health as illustrated in terms of a strategy matrix.

Furthermore the democratice process within which healthy public policies are to be discussed and determined is discussed as well as organizational aspects as regards the implementation of an equity oriented health policy. Finally checklists are presented focusing upon how to make things happen.

2. WHY MAKE EQUITY IN HEALTH A PRIORITY

2.1. The health divide

To understand the importance of making equity in health a priority it is necessary to grasp the magnitude of the health divide as experienced by different socio-economic and occupational groups and how these inequities have changed during the last decades.

The general pattern of health development - measured as an average for the total population - has been different in West and East Europe. While life expectancy increased in West European countries during the last decades countries in Eastern Europe such as Bulgaria and Hungary experienced a fall in life expectancy.

The general improvements of the health status in the west masks - however - considerable inequities in health between different socio-economic and occupational groups. The less priviliged groups thus experience an excess risk as regards almost all diseases within each age group and among both men and women.

This social gradient run right through society in a graded fashion. Groups at particular risk are e.g. children to single parents with limited education and low incomes, lonely elderly, migrant workers, long terms unemployed and those working in high risk occupations from a physical and/or psycho-social point of view.

An increasing health divide during a period when the health of the population as a whole is improving faster than ever is thus the tragic paradigm of most west european countries.

Equally tradic and even more serious is the trend in East European countries where the least priviliged groups experience the greatest reductions of their possibilities to live a healthy life within the context of a general decline in terms of social and health development.

The evidence documenting these socio-economic inequities in health is reviewed in several references listed back and include facts such as these:

Infants: (0-1 year): Class differences in terms of infant mortality still exist but impressive reductions as regards this health divide have been achieved during the last 20 to 30 years in many European countries.

Substantial inequities exist - however - still as regards the risk of giving birth to a low-weight baby.

The social gradient among infants increases during the latter part of the first year of life due to poor social environment.

Children and adolescents (1-19 years): The risk of being killed in accidents, by poisoning or due to violance is far greater among children in families living close or under the poverty line. The risk of a fatal accident for a child aged 1-19 also varies substantially according to the parents occupations. Children from less priviliged families also experience a substantial excess risk as regards psycho-social problems.

Men (20-65 years): Life expectancy at birth in West European countries is often five to seven years shorter among men with a working class background as compared with men belonging to the highest socio-economic groups. Behind these figures is a substantial excess risk in terms of early deaths caused by cardio-vascular diseases. This health gap seems to widen.

Considerable social inequities in health are also experienced e.g. among young adults in Eastern Europe. The mortality rate among male agricultural workers (20-39 years) was for example in Hungary (1984-85) 3,2 times higher than that of white collar workers.

Women (20-65 years): Inequities in health between women from different socio-economic groups are usually less than the corresponding differences among men.

Recent trends e.g. as regards lung cancer and diseases in the locomotive organs seem to indicate - however - that the health divide among women is increasing. Women employed in manufacturing industries or service occupations are for example in Sweden two to three times as prone to prolonged illness as women in scientific or technical occupations.

It should also be noted that breast cancer - contrary to almost all other diseases - is more common among women with a middle or upper class background than among working class women.

Elderly (65+): Chronic diseases and other age related diseases tend to set in much earlier among unskilled workers as compared with professional groups.

2.2. Lives lost

The magnitude of existing social inequities in health can also been described in terms of potential reductions in mortality and morbidity if the less priviliged groups reached the health status at present experienced by the more priviliged groups.

In Sweden with fairly small inequities in health it has for example been estimated that physical morbidity would decline by no less than 60 percent if the physical health for the whole population could be brought to the level experienced today by the healthiest socio-economic group (senior salaried employees).

A similar type of calculation in the United Kingdom indicate that if all children enjoyed the same survival chances as the children of professionals and managers then over 3000 lives per year would be saved.

Against this background it is obvious that one of the greatest challanges for the 90s is to improve the possibilities for less priviliged groups to live a healthy life. The social inequities in health not only urge to actions but also indicate the possibilities to improve health conditions for groups at particular risk. The reason being that there are no biological or otherwise predetermined factors causing these inequities in health as they are related to social, economic and behavioural factors which can be influenced e.g. within the context of an equity oriented health policy.

Consequently the very heart of an equity oriented health policy must be to facilitate for less priviliged groups to avoid avoidable health hazards and make the healthy choice as easy for them as it already is among more priviliged groups.

A comprehensive health policy which has not considered these important and systematic differences is both ethically unsound and inefficient in a health development perspective.

It can also be argued that a health policy not giving highest priorityto socio-economic groups at greatest risk for early deaths and poor health must be rejected on ethical grounds.

Consequently the WHO Health For All strategy has equity as a major theme, with Target 1 stating:

"By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25% by improving the level of health of disadvantaged nations and groups."

But, of all the Health For All targets, this is the one where there is greatest concern about lack of progress. While many of the other targets have been achieved or look as though they may be achievable in Western Europe, no country has reported to WHO a reduction in the health gap between different social groups.

This lack of progress is not primarily due to lack of knowledge as regards the causes of the observed inequities in health. It has to be analyzed in terms of professional and political priorities.

There are however good reasons to believe that inequities in health soon will be much higher on the professional and - even more important - the political agenda.

This assumption is based on the fact that the existence of a health divide within countries is increasingly recognized by those at greatest risk, their organizations (e.g. labour unions) and other groups striving to obtain a more equitable society.

It is against this background for example the Swedish parliament approved a health policy bill 1990/91:175 stating that the reductions of social inequities in health "is the most important objective when setting priorities in the field of public health"

Corner stones in this equity oriented health strategy are periodic reports to parliament focusing upon social inequities in health, active labour unions and a newly established institute for action oriented research and financial support to local health programmes e.g. for women and children at particular risk for early deaths and poor health. In the above mentioned health policy bill it is also stated that all national agencies in different health related sectors should develop an explicit equity oriented health policy within their sphere of competence and responsibility.

These sector specific health strategies shall "include goals and guidelines focusing upon possibilities for each agency to reduce inequities in health as related to different social and occupational groups. The government finds it of partucular importance that such equity oriented health targets are developed for those agencies responsible for housing and local environment, education health care and social services."

Other countries such as the Netherlands have - as illustrated by the case study presented below - recognized that strategies to combat inequities in health also are likely to be the most cost-efficient strategies in terms of improved health.

Case-study 1: Putting equity in health on the political agenda in the Netherlands.

The debate on equity in health in the Netherlands has been transformed from a non-issue in the 1970's. This was brought about by careful planning initiated by the Staff Bureau (a think tank) of the Department of Health, Welfare and Cultural Affaires, which began work in 1986 on raising awareness of the issue. The success of the venture is attributed to five main strategic points (Gunning-Schepers 1989):

1. Politically neutral definition The problem was defined in politically neutral terms, so that equity did not become a topic for just one political party, but had all-party support. The social justice aspect of reducing differences in health was therefore played down. Instead, the efficiency argument was stressed: that greatest improvement in the health of the population would be achieved by concentrating the health policy on the groups lagging behind in health.

2.Raising awareness Key policy-makers including politicians from all parties, trade unions, employers organisations and medical associations were brought together for a two-day conference at which leading academics presented the evidence,with time for wide-ranging discussion without the presence of the media. Major press coverage was arranged for the report coming out of the conference.

3. Feeding the facts into the policy-making process. The publication of the conference report was speeded up to coincide with a major parliamentary debate on a new health insurance scheme in the Netherlands. The facts in the report were widely quoted and contributed to the public debate on health care.

4. Involving all parties in the process of reducing inequities. The causes and solutions for inequities in health are highly complex, and there was a danger that no-one would feel able or willing to act to reduce them. The conference was designed to get all parties involved in the process of attacking the issue and great stress was put on the fact that everyone had a contribution to make, however small.

5. Having follow-up action ready. At the end of the first conference, a broad plan of action was presented for discussion and an appeal made for information from each participant on how their organization could help.

No-one could leave the conference believing that someone else was to do the work. The participants agreed on a five-year research and development programme.

A follow-up conference has been called for 1991, for participants to report on the action they could take to reduce inequities in health and for the government to report on the progress of planned intervention projects in the field.

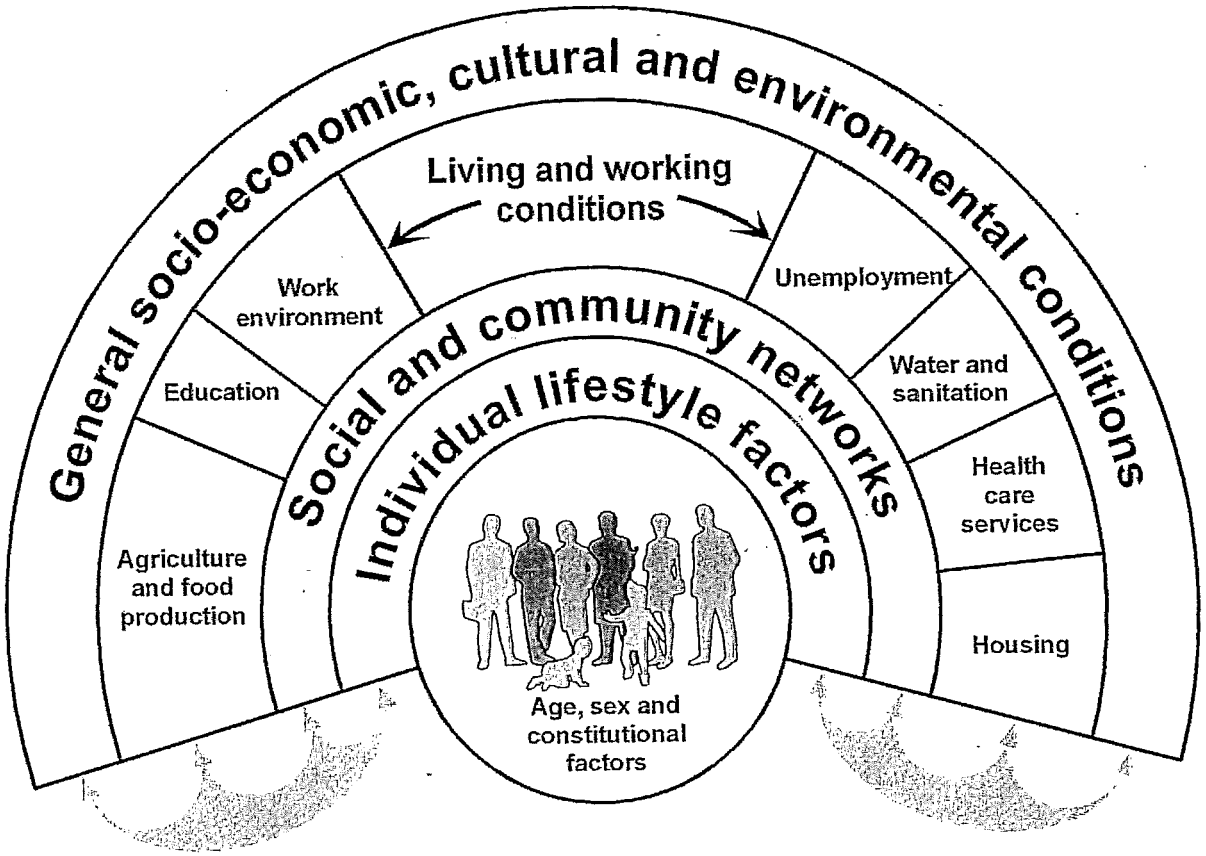
3. UNDERSTANDING THE DIFFERENT POLICY LEVELS

Policies and strategies have to be based on an understanding of what the main influences on health are. They can be described in terms of factors threatening health, promoting health and protecting health. It can then be useful to start by grouping these influences into categories, because these then suggest quite distinct levels of intervention for health policy-making.

Figure 1 illustrates the main influences on health. They can be thought of as a series of layers, one on top of the other. Overall, there are the major structural environment. Then there are the material and social conditions in which people live and work, determined by various sectors such as housing, education, health care, agriculture and so on. Mutual support from family, friends, neighbours and the local community comes next. Finally, there are actions taken by individuals, such as the food they chose to eat, their smoking and drinking habits.

The age, sex and genetic make-up of each individual also plays a part, of course, but these are fixed factors over which we have little control.

Figure 1: **The main determinants of health**



These four layers of influence translate into four levels for policy intervention:

Policy Level 1 - aimed at bringing about long term structural changes . This would include e.g. economic strategies, tax policies, trade and environmental agreements between countries.

These structural changes usually require political actions at national or international levels.

Policy Level 2 - aimed at improving living and working conditions through healthy public or business strategies, within the framework of one or more sectors. At a national, regional or local level, this would cover e.g. the provision of welfare benefits through the social security sector, health services through the health care sector, food and nutrition policies through the agricultural sector, and employment policies through the labour sector.

All are focused on improving the material and social conditions in which people live and work, through the political process in relation to public policies and through decisions by business entreprises, labour unions and voluntary organisations.

Policy level 3 - aimed at strengthening social and community support to individuals as well as families. This is focused on how people can join together for mutual support and in so doing strengthen their defense against health hazards. These strategies recognise the intrinsic strengths that families, relatives, friends, volunteer organizations and communities have, over and above the capabilities of individuals working in isolation.

Policy Level 4 - aimed at influencing individual lifestyles and attitudes. The focus of attention is on the areas where it is recognised that individuals have a certain degree of choice, and would include health education and support aimed at groups with the unhealthiest lifestyles.

It is important to realise that for any health policy goal or target, strategies can be devised at any of the four policy levels. For example, taking the general goal of "increasing access to a nutritious diet", strategies could operate:

At level 1, through economic adjustment programmes maintaining nutrition of vulnerable groups;

At level 2, through national pricing policies and incentives to farmers in the agricultural sector to make cheap, nutritious food more readily availabe;

At level 3, through the stimulation of neighbourhood food co-ops and lunch clubs for elderly people;

At level 4, through better food labelling and nutrition education to influence individual eating habits.

Similarly, with the goal of controlling tobacco consumption, strategies could involve cigarette taxation (level 1); bans on cigarette advertising and the creation of smoke-free public places (level 2); helping communities join together to press for tighter controls on sales of cigarettes to children in local shops (level 3); and the education of the general public about the dangers of smoking (level 4).

All too often, strategies are only considered at one policy level, yet concerted effort at several levels would in many cases be far more effective. The reinforcing - synergetic - effects of this type of vertical health policy is in fact the very key for improving the impact of health policies in general and strategies to reduce social inequities in particular.

Equally evident is the fact that positive actions for health at one level (e.g. health education among young people) can be offset by negative actions at other levels. (e.g. reduced funds for school lunches).

Consequently the conceptual framework presented should be viewed as an interdependent system for improving health and reducing health hazards.

This general framework for health development can also be used in relation to equity. Below, each policy level is examined in more detail, to pick out the important equity aspects of each.

4. Equity aspects of structural policies (policy level 1)

4.1. Economic strategies and health

The relationships between economic development and health can be described in terms of "the economics of health" and "the health of economics".

The "economics of health" perspective is focusing upon how changes in the health status of the population - or within different groups of the total population - affects economic growth and the general level of public expenditures.

Using social cost-benefit methods the costs of different diseases can be estimated as related to e.g. expenditures for medical services provided as well as productive working days lost.

The total costs for e.g.mental problems, cardio-vascular diseases, diseases in the locomotive organs and accidents constitute a major economic and financial issue both in terms of production capacity lost and financial transfers incurred due to sick leave and early retirements.

It has also become increasingly evident that the costs of sick leave and high turn over rates among the personel due to unhealthy working conditions constitute a major factor in the social book keeping both in the private and public sector.

Calculations such as these can not - however - be used as a base for determining priorities between different public health actions. The reason being that they reflect the market value of individuals rather than the objectives for public health strategies which in most if not all countries are explicitly based on an ideology of equal right to health regardless of income and social status.

The other perspective focusing upon the health effects of different economic strategies is - however - of critical importance for any equity oriented health policy.

This can be illustrated by the fact that some very rich countries such as the United States of America have a general health status far below what one could expect considering their high GNP per capita. The main reason for this poor performance in terms of health is a highly skewed distribution of available economic resources keeping some 30 million people below the poverty line.

Equally evident is that rich countries with a fairly equal distribution of economic resources - such as Japan and Sweden -

have a very good health status as well as less marked differences in terms of health between different socio-economic groups.

The distributive policies linked to various economic growth strategies are thus of critical importance in any equity oriented health policy. It has even been estimated (Wilkinsson) that up to three quarters of observed inequities in health between rich countries are related to existing inequities in income.

Consequently policies and actions of importance for income distribution and reduction of poverty constitute the very heart of an equity oriented health policy.

Mechanism for income redistribution exist in all industrialized countries. Citizenship thus include a notion that the real income can not be the same as the market value of an individual. The strategies and tools to be analyzed from an equity point of view include:

1. Actions to reduce differences in gross income by e.g. compressed income scales and priority to low income groups in terms of increased wages.

2. Reductions of differences in net income by progressive taxsystems and transfer of resources e.g. to specific age groups (children, elderly) and to low income families (housing allowances, social benefits)

3. Labour market policies reducing the risk of being unemployed thus securing a steady income among those with a weak position on the labour market

4. Policies securing good economic and geographical access to e.g. health care and higher education

Considering that poverty is a major riskfactor for poor health and early deaths particular attention must also within a European context be paid to the groups living at or below the poverty line. The size of this group - and how it changes over time - is in fact a titmuss-test for an equity oriented health policy in many industrialized countries.

4.2. A sustainable development from a health point of view

Economic development strategies reviewed from an environmental point of view are described as "substainable" when they support or do not constitute a threat to any vital part of the ecological system.

Economic growth strategies not meeting these criteria are increasingly often considered non-viable.

Equally important is to secure a sustainable development from a health point of view. Development processes preserving or increasing substantial social inequities in health must thus be defined as non-sustainable as they are a threat to the health of disadvantaged groups.

The health status among less priviliged groups and how it changes over time is also a valid indicator for social progress and quality of life.

This is reflected in a resolution unanimously adopted by the World Health Assembly 1986 (WHA 39:22)calling on all member states "to use the health status within the population and in particular its changes over time among disadvantaged groups as an indicator for assessing the quality of development..."

Another interesting example of measuring human development has recently been presented by UNDP. Their Human Development Index is based on the following three indicators; income (level and distribution), life expectancy and educational level.

Comparing the indicators suggested by WHO and UNDP respectively the latter is likely to be more robust for international comparisons while the former is more sensitive to changes in a country specific context.

The introduction of these two health related indicators for social progress as well is the concept of sustainable development from a health point of view would consitute a major step toward a more equity oriented health policy. The reason being that the roots of poor health in terms of poor living and working conditions are likely to be given greater attention when directly related to a specific indicator for social development. Furthermore criteria to define a sustainable development not only from an environmental but also human health point of view reinforces a holistic view of the development process where the right to health is the same regardless of income or social status.

4.3. Environmental policies and health

The green house effect, acid rains, pollution of air and water as well as many other environmental issues are high on the political agenda in most - if not all - European countries.

The effects of these environmental health hazards on human health are increasingly focused upon and new disciplines such as medical ecology have been developed for tracing early warning signals.

This is of importance also from an equity point of view as the exposure of various environmental health hazards often vary between different areas. Noise and air pollution make certain areas of a city less attractive as a residential area. The same is true for houses located near industries known to pollute air and/or water or in inner city slums with poor hygienic conditions. The lower prices of apartements and houses in these areas make them accessible for low income groups who thus become at particual risk also as regards certain environmental health hazards.

An equity oriented health policy must thus include special efforts to reduce and whenever possible eliminate these excess risks experienced by those who can not afford living in a more healthy environment.

A point of departure for such an equity oriented environmental health policy can be a map indicating streets and houses exposed to unacceptable levels of air pollution and noise as well as estimates of financial allocations - and reallocations - necessary to operate according to need also from a health point of view.

4.4. War, military expeditures and health

Conventional wars and even more so nuclear wars constitute major threats to human survival and health.

It is even within this context of war and military expenditures important to recall the following issues related to equity and health:

1. There are very few - if any - examples of wars where the middle and upper classes suffered more than the working class on the battlefields. This can be useful to recall when the need for military interventions are discussed by the political and economic elite.

2. The underpriviliged groups are far more likely to suffer from the hard times created by war in terms of e.g. diseases, poor housing and lack of food.

3. There is a direct trade off between using tax money for military and social purposes. Thus the present very postivie trends towards disarmament provide a unique opportunity to discuss how to reallocate investments in arms to investments for improved living conditions and thus health among disadvantaged groups. The magnitude of the financial resources released within the industrialized countries can be illustrated by the following facts presented at the so called Stockholm Initiative on Global Security and Governance (April 1991):"

> "Considerable annual reductions in military spending are quite possible. Based on calculations by SIPRI the potential peace dividend in the North can be estimated at around $ 100 billion a year, possibly rising to between $ 200 and $ 300 billion a year by the year 2000. Total potential savings would then be between $1.500 and $ 2.000 billion during the course of the 1990's."

Considering the magnitude of these savings there are - theoretically - a tremendous potential for increasing investments in human development.

A major objective for an equity oriented health policy must be to support efforts to transform these theoretical options into political will by presenting viable and sustainable strategies for improving health conditions among disadvantaged groups.

Case-study 2: Structural change and the European community

Policies adopted by the European Community (EC) have the power, through structural changes, to influence equity in relation to many different risk factors, including pollution, food and nutritional standards, tobacco and alcohol consumption, and the staffing of health services on an equitable basis.

The EC has already taken action on the issue of pollution based on the equity principle of mutual concern and control at an international level. For example, in June 1990 EC ministers agreed to help Eastern Europe tackle its severe environmental problems and promoted a code of conduct to ensure that Western companies investing in the East adhere to EC standards.

It has also been predicted that if current EC initiatives to reduce poverty were successful, then one likely outcome would be a reduction in the incidence of coronary heart disease in disadvantaged groups, and such policies should be encouraged on health grounds.

Recent legislation, notably the Single European Act, has immense potential influence on equity and indicates the pressing need to assess all economic policies for their impact on the health of disadvantaged groups. The Single European Act came into force in July 1987 with the aim of establishing a single internal market in the EC by the end of 1992. Although aimed at increasing economic prosperity, its effects on inequities in health cannot be ignored.

The proposals in the Act for tax harmonisation, for example, have immediate implications for consumtion levels of tobacco and alcohol. Tobacco consumption is known to be higher in many disadvantaged groups, and although the pattern of alcohol consumption is much more complex, it is true to say that the effects of alcohol abuse are felt more severely in disadvantaged groups due to lack of social support and increased likelihood of job loss and unemployement. The first set of proposals for tax harmonisation, put forward in 1987, would have resulted in a large drop in tax rates for alcohol in some countries and a smaller but still important drop in cigarette duties. It was predicted that the consequent fall in prices would lead to increased consumption with resulting increases in associated health problems, particularly in low-income groups most sensitive to price changes. Fortunately, this effect was acknowledged and the search is still on for an alternative solution that will not be detrimental to health.

As restrictions on the employment of health care professions in different EC countries are lifted after 1992, some control has to be built into the system so that richer countries in Europe do not solve their staffing problems by serously depleting the health care systems of poorer countries. All these equity implications of economic policies need to be widely debated and researched.

5. Healthy public sector policies in an equity perspective (policy level 2)

Strategies to improve living and working conditions form a major part of any comprehensive health policy. In relation to the issue of equity, such strategies are crucial because differences in living and working conditions are the main determinants of social inequities in health in most countries.

These differences need to be addressed as a matter of urgency. Here, equity aspects are singled out in relation to strategies concerned with the sectors governing work, unemployment, food and agriculture, housing, education and health care services, though the issue extends beyond these confines, to all the sectors illustrated in Figure 1.

5.1. Work environment

Differences in the physical and psycho-social work environment constitute one of the main determinants of socio-economic inequities in health. In addition to occupational accidents and diseases a combination of heavy uncomfortable and monotorious work couple with stress and very limited control over the situation increases the risk of many diseases.

Working conditions are often closely related to educational background and salary levels. The more limited the educational background and the lower the salary the higher are usually the risks for excess mortality and morbidity due to unhealthy working conditions. This is particularily true for the increasing proportion of women working outside the home.

Efforts to improve working conditions during centuries have - no doubt - been of critical importance for e.g. reducing serious accidents at work and the threat of chemical health hazards. A driving force for these improvements has often been labour unions.

Looking ahead great challanges remain in particular as regards policies and actions improving the working conditions for those at greatest risk. An occupational health strategy "putting the last first" should include e.g.:

*special action programmes to improve working conditions in service and care sectors where the majority of the employed are low paid women experiencing very high excess risks for e.g. pain in back and joints.

Considering the overall objectives for the health care sector it would be logical if comprehensive action programmes were

inititated to improve working conditions for e.g. assistant nurses, cleaners and laundry workers. This type of healthy health sector policy in terms of improved working conditions could serve as an example for other sectors experiencing great differences in health status between different occupational groups. Furthermore such in-house programmes could be very useful from a professional point of view as they focus on possibilities and constraints to reduce occupational inequities in health from a workplace perspective.

*management reforms increasing the possibilities to control and influence the work to be carried out. Priority groups could be occupational cathegories at present experiencing an excess risk for cardio-vascular diseases and mental problems due to monotonous and stressful jobs.

*legislative actions reducing and where ever possible eliminate chemical and other specific health hazards at work. Particular attention should then be given groups experiencing excess mortality and/or morbidity rates due to e.g. the chemicalization of farming.

*flexible working hours and a continued gradual decrease in total hours of work per week which would facilitate an improved balance between paid work and work at home. This would be of particular importance for disadvantaged women often carrying a double burden of poor conditions in both situation.

*international agreements preventing multinational companies to apply different standards as regards e.g. safety regulations in different countries.

*improved control and wherever necessary legislative actions to prohibit child labour. This is an issue of renewed concern - and of great importance also in an equity perspective - in many European countries as migration accelerate across regions and disadvantaged children increasingly are found working in substandard conditions.

Case study no 3 The Swedish "Work life fund"

In Sweden a special "Work life fund" was created by the government by placing a short-term tax on business from september to december 1990. The sum of money raised - £ 1.500 million - will be used during a five year period for improvements of working conditions. Applicants - public as well as private enterprises - have to match the funds provided with their own funds.

Programmes initiated include for example:

- improved possibilities for cleaners employed by the municipality of Ronneby to control their own working situation, use better and healthier techniques and participate in training on how to reduce various work-related health hazards. Annual savings from this programme as achieved by reductions in sick leave, early pensions and expences for extra personnell for replacement have been estimated to £ 100.000 which is twice the total budget for the whole programme.

- increased control, and responsibility as well as direct contact with the customer were key areas of concern when reorganizing the workshop of Bilia with 400 employed. This reduced short term sick leave by more than ten percent.

- excercize as part of work for cleaners employed by the municipality of Arvika reduced the number of sickdays during a year by more than 50 percent.

5.2. Unemployment

There is increasing evidence that unemployment can cause ill health and premature death. The risk of long-term unemployment is highest among under-priviledged groups such as single mothers, low-income families, unskilled workers, and people with few years of schooling. Furthermore, the effects of unemployment can be more devastating for these groups because they are less likely to have a supportive social environment and, if pushed close to or below the poverty line by unemployment, they are also more likely to experience a decline in access to decent housing, nutrition and health care.

Although unemployment is a risk to health,the solutions can differ from country to country depending on the trade-offs that have to be made in that country.

* Ideally, the first priority for a health-oriented employment policy is to keep unemployment at the lowest possible level, particularly long-term unemployment. This calls for policies to promote employment in general, but also in-depth knowledge of the labour market for poorly educated people; single, elderly men; disabled people; and immigrants, with intensified efforts to find suitable jobs for them. When economic arguments concerned with keeping inflation down are used to defend a certain level of unemployment, the damaging effects on health must be made explicit and alternative methods of development fostered.

* Long-term job security needs to be promoted, as the threat of unemployment can be almost as damaging as the state itself. Active employment policies offering temporary jobs and relief works and labour market training are from a health point of view far better than financial support only.

* The risk of medicalising unemployment, by labelling the unemployed as "sick" for social security and pension purposes, should be avoided, as focussing on the sick role can aggrevate the adverse effects on health. Instead, the aim should be to provide training for those experiencing long-term unemployment.

* Action among the unemployed themselves to influence decision-makers and to develop work alternatives can help to preserve self-esteem and create positive social networks to ward off loneliness and guilt.

* Health workers can develop appropriate and sensitive advice and care for people suffering the ill-effects of unemployment, as well as raising policy-makers' awareness of the effects of unemployment on health.

5.3. Food and agricultural sector

Hunger is reapperaring as a problem in several European countries today. Where that is the case, the provision of basic foodstuffs to all the population - another pre-requisite for health - has to be of highest priority.

The main food related problem in most European countries is however that many - particularly within the less priviliged groups - have a diet far from what is recommended from a health point of view. With an increasing knowledge of the linkages between dietary factors and major diseases such as cardio-vascular diseases and cancer this malnutrition is a major health hazard both from a general and equity point of view.

Few countries have - however - adopted explicit health policies within the food and agricultural sector.

Agricultural policies are mostly concerned with helping domestic farmers achieve and maintain a reasonable income at a controlled level of production, and protect their home markets by using tariffs etc. From a health point of view this often leads to a price structure stimulating unhealthy habits, by subsidizing high-fat products and discouraging the consumption of fish, fruit and vegetables. The negative effects of such a price structure are of course greatest among low-income groups, who are very sensitive to cost. This also applies to tobacco and alcohol, where pricing and marketing policies have a great influence on consumption.

* An equity-oriented food and nutrition policy would therefore pay special attention to the production of cheap, nutritious food, with the use of subsidies and incentives to producers where necessary.

The importance of such a price policy from an equity point of view can be illustrated by a calculation made (1986)by the National Advisory Committee on Nutrition Education in Britain showing that the healthy diet they recommended would cost up to 35 percent more than the typical diet of a low income family. The healthy choice is thus not a very easy choice for these economically less priviliged groups. Furthermore the Health Education Authority has shown (1986) that the price on healthy food such as fish, whole meal bread and fruit have risen faster than less healthy items.

* Such a policy would also aim to improve distribution networks for food, so that adequate supplies of fresh produce get throgh to every area of the country on an equitable basis, and producers and retailers package food in quantities to suit those living alone, which includes many of the elderly.

* Strategies to improve the nutrition of pregnant women and disadvantaged children would be of great benefit. For example the provision of school meals of high nutritional standard would help to compensate for the inadequate diet of disadvantaged children at other times of the day. At the same time healthy eating habits are promoted within the young generation.

Case-study 4. Increasing access to a nutritous diet - Norway's experience

Access to a nutritious diet can be hindered by many factors including lack of money, poor food distribution networks and lack of information on which to base an informed choice.

In the wake of the world food crises of 1973-74, the Norwegian parliament passed a national nutrition and food policy in 1975 - the first of its kind in the world and outstanding in its vision. It had four inter-related goals:

1. To encourage healthy dietary habits, by education, pricing policies and improvement in the food distribution network to outlying areas.

2. To help stabilize the world food supply by food-related aid to the third world and decreasing reliance on imported food into Norway.

3. To promote consumption of domestically produced food.

4. To strengthen and stabilize the rural economy, stopping the decline of small farms by making farming more profitable and attractive.

National dietary goals were set and structural changes through the agricultural sector proposed including differential food pricing and incentives for the production of selected foods, with the whole policy co-ordinated across nine government departments with an influence on the issue. The aim was to provide reasonably priced, nutritious food accessible to all.

After 15 years of the policy, evaluations show mixed progress. Most progress has been made on a wide variety of health education programmes, on aid to the Third World, and in increasing the area of cultivated land. However, it has proved very difficult to change existing farming and pricing policies in the face of a strong lobby from the agricultural sector, which has acted to protect the producers rather that the consumers. There was an additional set back as food prices between 1979 and 1987 rose faster than the consumer price index overall, with fish and grain products well above average, creating a disincentive to change eating habits for those on low incomes (Milio 1989).

The general principles of the food and nutrition policy are still supported, but more effort is now going into the implimentation problems of how to change pricing policy and build on the successes so far.

Case-study 5. The special supplementary Food Programme for women, infants and children (WIC) in the United States.

The WIC programme in the United States provides packages of highly nutritious food to low income nutritionally at risk women who are pregnant or breast feeding as well as to infants and children at risk up to the age of five. Health education as well as health care constitute an integrated part of this programme which 1986 served 3.3 million participants at a cost of US$ 1.56 billion.

An evaluation of the WIC programme financed by the Dept. of Agriculture (1985) showed that WIC participation reduced premature births among high risk mothers by 15 to 25 percent.

It was also found that - as a result of the health education programmes - WIC-families purchased and consumed more nutritious foods than comparable non WIC families.

5.3. Housing sector

Homeless

Many European countries still have thousands of homeless people on their streets. Shelter - one of the basic pre-requisites for health - is therefore not available for all citizens and is an extreme form of inequity increasing dramatically also the health divide. This, of course, has to be a priority in any country facing this problem.

Poor physical housing conditions

The link between poor physical housing conditions and ill-health has been recognised for over a century. Equally well-known is the fact that such conditions are primarily a problem for disadvataged groups who cannot afford a good house or apartment.

Although urban renewal programmes have gradually been reducing the number of dwellings with outdated sanitation and heating systems, such programmes can do more harm than good if rents on the improved property are too high for the poor and they are forced to move.

Social segregation and health

Nowadays it is not just the physical condition of housing that is a problem, but the social conditions created by inadequate town planning and uncontrolled market forces. The housing market all over Europe is highly segregated with elegant residential areas for the rich and socially deprived areas in suburbs and inner-cities for the less fortunate.

The health effects of this social segregation are not well known but potentially considerable for those forced by economic realities to live in areas with high rates of drug abuse, crime, social problems, and unemployment. The reason being that the probability for an unhealthy life is far greater in this environment. At the same time the social support system is likely to be much weaker than in a more priviliged neighbourhood.

Furthermore socially deprived areas tend to have fewer social services and amentities for community activity, weaker security arrangements to protect residents from crime, inconvenient or even hazardous lay-outs for children and old people, which in additon encourage isolation and conditions. The prosperous neighbourhoods have the opposite conditions with a social environment more condusive to wellbeing.

* A healthy housing strategy must therefore focus on improving the quality of the social environment as well as the physical structure of buildings. This means, for instance, that urban renewal programmes in deprived areas should be linked to social renewal programmes, with a higher than average allocation of funds in these areas for e.g. schools, day nurseries, sporting facilities, and health services and so on.

Housing subsidies to low income families

A healthy housing policy must also include subsidies to reduce the cost of housing for low income families. In many countries the main subsidies as regards housing are given in the form of interest allowances and tax subsidies primarily benefitting economically priviliged groups. The distributional profile of these subsidies are extremely regressive as the subsidies received increase as the income as well as the loan increase.

Means tested housing allowances usually amount to a very small fraction of what is lost in tax revenue due to housing subsidies to the priviliged groups.

Reallocating part of these subsidies to luxurious apartments and villas to secure a home for those in the growing cardboard towns of many European cities and to increase the possibilities for low income families to avoid socially deprived areas is thus a major task in an equity oriented health policy.

Case-study 6. Improving housing conditions and health in Glasgow and Liverpool

Several initiatives to improve housing conditions have been stimulated by a piece of research springing from a deprived community in Scotland. National and local health agencies funded a community development project in a run-down housing scheme in the early 1980's. The aim was to create channels for people in the community to communicate their health needs and concerns. One over-riding worry identified by the residents was the damp and mouldy housing conditions they had to live in, which they feared were affecting their children's health.

With advice from community development workers, the residents presented their own case, explaining their problems to a seminar at Edinburgh University. This tiggered a research study on the effects of damp housing on health with co-operation between researches and residents. The study found significant links between aches and pains, diarrhoea, headaches and respiratory complaints in children and the presence of mould in houses, even when smoking, unemployment and income were taken into consideration. A larger study in three cities confirmed these findings (Martin et al 1987, Platt et al 1989).

This research was brought to the attention of housing department policy-makers and several experiments in improving housing design are underway. For example, Glasgow District Council (responsible for housing) and the South of Scotland Electricity Board devised a "heat with rent" scheme on a deprived housing estate which had an inefficient and expensive-to-run heating system. The residents were getting into debt with fuel bills and still had damp, cold homes. In some blocks of flats the old heating system was removed and replaced with a cheaper, more efricient system that residents could pay for by a fixed sum each week with their rent - to help prevent fuel debts. Residents were interviewed before and after installation of the new system, and compared with people living in unimproved flats on the same estate. Evaluation showed that children in the warmer, improved falts were protected from symptoms associated with dampness and mould (Hopton and Hunt 1990).

The European Community (EC) Solar Energy Demonstration Project in Glasgow started originally with residents in damp, cold houses requesting teach-ins on how to apply for funding. They secured funds from the local authority and the EC Social Fund for a prototype project to improve their housing conditons. This showed that the modified flats could be kept at a comfortable temperature for 1/10th of cost of unimproved flats. Further funding has now been secured for a larger projet making use of solar energy, and this to be closely monitored over the period 1991 to 1994.

5.4. Education sector

5.4.1 Equality of educational opportunity

The educational system has a tremendous but often very underutilized potential for promoting health in general and reducing social inequities in particular.

At the structural level access to higher education is often perceived as one of the major possibilities to soften class lines. Equality in educational opportunity facilitate eqality in occupational opportunity and thus improve the opportunities to improved living and working conditions in particular for children from less priviliged families. Or as expressed by Horace Mann in a report to the Massachuseths state Board of education 1848: "Education then beyond all other devices of human orgin is a great equalizer of the conditons of men - the balance wheel of the social machinery".

Educational policies based on assumptiones such as these often offer free primary and secondary education open for all on stipends or subsidized loans for higher education. Another feature of these equity oriented schoolsystems is often that they provide a comprehensive education where the pupils study together over a long period of time (9 to 12 years). Special training is often offered children with difficulties.

There is no doubt that these efforts have improved the possibilities to study among children and young people from less priviliged families.

At the same time - however - it must be recognized that the gap to the more priviliged groups in terms of proportion entering higher education often remain the same. In Sweden for example the probability for a child from the highest social class to enter higher education was around five times as great as that of a child with a working class background during the 60's as well as during the 80's. Family background - or what is sometimes referred to as "cultural capital" - thus remained as important as ever.

From an equity oriented health policy point of view findings such as these are of critical importance as they illustrate the difficulties to change the social heritage and thus also inequities in health closely related to this social background.

Against this background it seems even more important to focus on the health potential as related to the school environment and content of the education offerred.

5.4.2. Work environment in the school

The work environment as expecienced by pupils and teachers is in many schools far from ideal from a health point of view.

Main problems are often excess risks for accidents, indoor climate generating allergies and very limited possibilities for the pupils to influence the work at school. Furthermore it is a wellknown fact that mobbing and tensions between pupils and teachers often adds to the unhealthy climate.

The likelyhood of having to attend this type of unhealthy school is usually greater in deprived areas with less funds, greater needs and more social tensions than schools in middle and upper-class areas.

An equity oriented health policy should thus include efforts to reallocate funds according to need also within the educational sector. Furthermore it is of critical importance to secure efficent occupational health services - with a strong element of preventive services and direct involment by both teachers and pupils - also within the school system.

5.4.3 Attitudes and values related to life style factors

The school selting can provide an ideal setting for discussing life style issues as related to eg smoking, alcohol and sex.

Attitudes and values are - however - often considered less important than facts and skills by educational planners and teachers.

Striking the balance between these two main components of the educational system is of particular importance for pupils coming from less priviliged families. The reason for this being that they are less likely to get the same opportunities to discuss these vital life style issues at home than pupils from better off families. They may also be more exposed to unhealthy lifestyles at home and among friends which - of course - increases the importance of a school promoting also positive attitudes towards a healthy lifestyle.

5.4.4 Knowledge about the main determinants of health

Facts about the main determinants of health should constitute an integrated part of the curriculum not only in biology but also in social and political sciences. Socio-economic roots of poor health are as important to understand as the role of life style and genetic factors. Without this broader perspective on health development it is difficult to understand and support a sustainable development in terms of health.

5.4.5 School lunches

The positive effects of healthy school lunches are obvious as a good diet is a foundation not only for a healthy life but also is related to the capacity to follow the education provided.

Pupils coming from families with irregular and unhealthy eating habits are those most in need of the good midday meal both from a health and educational point of view.

Consequently free school lunches should be high on the priority list in an equity oriented health policy within the educational sector.

Case study nr 6 Head start - Preschool programmes for disadvantaged children, USA

Head start programmes in the United States Provide young children from disadvantaged families with preschool education usually in combination with health and social services. In addition they also offer follow up courses during the first years in school.

The results have been remarkable in terms of breaking the evil circle of social and health related problems.

An evaluation of the early training programme in Tennessee showed that at the age of twenty the drop out rate was one third higher in the control-group not participating in this head start programme.

A smilar evaluation of the Perry pre-school programme in Michigan revealed that twice as many programme participants as in the control-groups - at the age of 19 - were employed, attended college or received further training.

A preschool programme for children coming from the slum areas of Harlem in New York with extremly high incidence of drug addiction, low employment, inadequate and income also benefitted very much from a special preschool programme including school lunches and involvment of the parents.

At the age of 21 twice as many of the participants in this programme were employed as compared with a similar control-group and one third more had obtained high school (or equivalent) diplomas.

5.5 **The health care sector**

Few attempts have - however - been made to assess the over all health impact of medical services. Some studies estimate however that medical interventions may have contributed to around 10 to 20 percent of the improvements observed in health status in industrialized countries during this century. In addition the quality of life can be greatly improved by appropriate health care.

Equal access to good quality health care is therefore of strategic importance for reducing existing inequities in health. However, at present, the "inverse care law" seems to operate in most countries, with those most in need of care least likely to receive high standard services. The magnitude of the differences in access to care varies from country to country. A country-specific assessment is needed not only in terms of geographical access, but also in terms of economic and cultural factors.

Areas for actions to secure access to good care according to need could then include:

5.5.1. Special outreach services increasing the utilization of preventive health services among socially disadvantaged groups at particular risk. Ensuring that all sections of the community had access to contraceptive and abortion services would, for instance have a vital influence on reducing risk factors such as early and unwanted pregnancies, high parily and insufficient spacing between births. Similarity ensuring that immunization services reached every child would play a part in reducing not only death but also disability from infections diseases which at present fall most heavily on infants living in the poorest circumstances.

The point to be stressed is that special targets as regards coverage - and outreach services - must be formulated for groups at particular risk.

Case study 7. Prenatal outreach health services - California USA

The importance of good access to prenatal care in particular for economically less priviliged women has been illustrated e.g. in an outreach programme carried out in California.

This programme provided some one thousand poor and socially disadvantaged women with free preventive and medical services, vitamin supplements, health education and family planning services. The services were provided both in homes and clinics and special efforts were made to reach also women unable to attend certain classes due to medical, transportation, language or other problems.

The results achieved in this outreach programme were remarkable. The percentage of babies who were on low birth weight was one third lower among the participants in this programme than in a matched comparison group. (4.7 percent versus 7 percent)

The impact in terms of reduced costs are also very interesting. The comprehensive services provided in this outreach programme was around 5 percent higher than the average cost of prenatal care. But every additional dollar spent on this special programme saved an estimated $ 1.70to 2.60 just in neonatal intensive care for low birth babies

Source: Schorr, Within our reach.

Case study 8. Prenatal plus services to very young mothers, John Hopkins, University Hospital, USA

John Hopkins University Hospital provided prenatal plus services to all seventeen and younger expecting girls most of whom were black, single and poor.

The "plus" element in addition to regular prenatal services included health education, and social support to maintain "self esteem".

An evaluation of the programme (1979-81) with a control group receiving basic medical care but not added educational, social and support services showed marked differences in outcome e.g. as regards the proportion of low birth babies.

The rate of low birth weight was 60 percent greater in the control group and very low birth weight was twice as great among the controls as in the experimental group.

Sourc: Schorr "Within our reach"

5.5.2. Economic access and alternative health insurance schemes.

The economic access to medical services is primarily determined by the financial strategies adopted to finance the health care system.

Systems primarily based on voluntary private insurance schemes tend to be the most unequal in terms of economic access as large segments of the population can not afford to pay the high premiums necessary to secure a profitable insurance business. Furthermore these insurances usually have a very limited - if any - coverage as regard e.g. long term care for elderly. Consequently these policies - as in the United States - are supplemented with tax financed insurance schemes for less priviliged groups. Still however considerable sections of the population - in the US more than 30 million persons - do not have any health insurance. It should also be observed that the quality of care may also be different depending for persons with private and public insurances.

A special problem with serious consequences from an equity point of view is furthermore that employer paid insurances are linked to current employment. Consequently the effects of unemployment also include loosing the health insurance during a period of excess risks for poor health and early deaths.

In compulsary private insurance schemes the economic access to care is secured but the type and quality of services provided are likely to differ according to type of insurance.

This is not the case in universal publicly financed insurance schemes as long as they can meet the demand of the population and thus are not supplemented with private insurances facilitating shorter waiting lists and additional choices as regards services provided.

5.5.3 Economic access and internal health care markets

Increasing per capita expenditures on health care in combination with organizational structures in need for structural reforms have created a considerable interest for the concept of so called internal markets.

This is equally true in highly market oriented health service systems as found e.g. in the United States and tax financed systems as found in many European countries.

In the former case it is recognized that a free market for health services with an almost unlimited demand for services as new medical technoligies are developed is not affordable even in a very rich country. The controled market is then seen as one approach to cost containment.

In the latter case - the tax financed system - it is assumed that the state no longer can afford provide "free" health services. There has to be a gate keeper. It is also often assumed that an internal market with competition between various providers would create a positive incentive for rationalization and thus more cost-effective services.

Experiences gained indicate that a split between funders and providers and the introdution of specific average prices for various services has increased the efficiency of both private and public systems at least in a short term perspective.

Equally important to observe - but far less discussed - is the fact that patients from disadvantaged groups often need more than an "average cost treatment" because they often have a more complex health problem including not only a specific disease but also misuse of drugs, malnutrition and/or very weak social support systems.

As compared with the average so called "DRG price" they are thus "unprofitable" from the providers point of view.

It is against this background very likely that providers of medical care to avoid a loss try to avoid patients likely to be a loss and intensify their efforts to provide services for patients likely to be profitable.

This problem must be fully recognized in an equity oriented health policy. One approach to eliminate the negative effects of the internal market system in terms of reduced access to good health services among disadvantaged groups could be to make the unprofitable patients the most profitable by adding a risk group payment to the average price calculated for the population as a whole. This would also directly reflect the over all objective of most health care systems of equal access to health care regardless of socio-economic status.

5.5.4 Economic access and direct user charges

Increasing health care costs combined with a political will to freeze or reduce taxes often tend to increase direct user charges in publicly finances health care systems. In addition to strengthen the financial base for services provided it is also often argued that direct user charges reduce the unneccessary demand for medical services.

In an equity oriented health policy there are good reasons to analyze such proposals from two different perspectives.

The first perspective focusing upon who is most likely to overutilize available health services. Most analysis related to this question reveal that people with high education/income are likely to demand more services than less priviliged groups at

equal need. Introducing high user charges on the other hand are less likely to influence the demand of high income groups than the demand of low income groups At the same time it should be observed that the unmet needs for health services - as indicated above - is far greater among economically less priviliged groups.

Against this background it can thus be concluded that high user charges are unlikely to reduce demand among the groups most likely to overutilize existing services and at the same time very likely to increase the unmetdemands among those most in need of services provided.

Consequently it is logical from an equity point of view to try to limit excess demand by other interventions than via usercharges such as stricter rules for referrals and to give priority to various forms of pre-payment schemes.

5.5.5. Geographical access and criteria for resource allocation

Geographical access is concerned with the fair distribution of services between different districts and regions within a country. To improve geographical access efforts have to be made to distribute available resources according to need.

This calls for a resource allocation index not only based on number of inhabitants and the age structure of the population but also of the socio-economic structure of the pupulation to be served.

This type of resource allocation formula taking account of differences in need within different in need within different socio-economic groups form an important equity oriented element of the health care policies in e.g. Sweden, Norway and Finland.

Case study 8. Alloocating resources to improve geographical access to health care in Finland

In the 1960's health authorities in Finland recognised that the distribution of medical personnel in the country was unfair, with inadequate provision in rural areas in Lappland and eastern Finland. The Primary Care Act of 1972 set out a two-pronged strategy to improve access to health care in these regions.

Firstly, new resources were allocated to the developing areas in the northern and eastern parts of the country. The cities, which were already well-provided for, were deliberately left lagging behind in the new primary care arrangements set up in the Act. New posts for doctors and nurses were created in these priority areas, with 70% ofthe costs subsidised by the state.

These posts became attractive because the average monthly salary in the health centres was considerably higher than in the hospital sector.

Secondly, an extensive building project was strated to create high quality working conditions for doctors and nurses in the under-served areas, allowing them to provide health care of a high standard to the local population.

This strategy had the desired effect: by the early 1980's the average working conditions in remote and rural health centres were better than in cities, and these health centres were also better staffed in relation to doctors, nurses and auxiliairies (Koskinen et al 1985)

5.5.6 Cultural access

Cultural access is concerned largely with the relationships between health workers and patients. A prerequisite for high-quality care is that there is a good professional-patient contact. From an equity point of view there is often a barrier to such contact because of differences in educational and cultural background of academically trained professional and unskilled worker. Establishing a good dialogue is therefore most difficult when it is most neede. In addition, increasing numbers of patients in many European countries are migrant or guest workers with limited command of the mother tongue of the new country, yet they are often very disadvantaged and in need of health care. To improve cultural access:

- strategies should develop and strengthen social and cultural communication skills of health workers.

- policy should also include the explicit objective of providing adequate interpretation services (including interpretation of cultural values and habits).

Case study 9. Promoting cultural access to health care in the UK

Several countries recognise that ethnic minorities within the populatin may face cultural as well as economic barriers in attempting to gain access to health care. A number of strategies has been employed to help overcome these barriers.

The Asian Mother and Baby Campaign and extensive evaluation, ran from 1984 to 1986 in England and was centrally funded by the Department of Health, the Save the Children Fund and the Health Education Authority. This was triggered in part by evidence of the poorer health and survival chances of babies born to mothers originating from the Indian sub-continent compared to babies of mothers born in the UK.

A programme of publicity and health promotion was combined with the employement of 96 linkworkers - 4 to 8 in each of the district health authorities participating in the scheme. These were Asian women who were fluent in English and at least one Asian language, employed to help improve communication between service providers and pregnant women.

The evaluation showed that the publicity campaign had very limited succes, and there were also problems with the management of the linkworker scheme, including widespread opposition among other health workers in the participating districts. However, there were also several positive results. Overwhelmingly, the mothers praised the linkworkers for bringing about improvements in the maternity servcies offered to individual women. In addition to improving communication and giving support and advice, improvements associated with the linkworkers included:

the provision of longer dressing gowns;
facilities for private prayers;
more appropriate hospital food;
greater guidance about hospital procedures;
Asian women-only parentcraft classes in more suitable community settings;
training for other health professionals on the needs of ethnic minority patietns.

From the evaluation, the linkworkers greatest contribution appeared to be in reducing the level of stess experienced by Asian mothers during antenatal care and childbirth. There was also some evidence from one health district that the presence of Asian likworkers was related to a critical increase in the mean birtweight of babies born to Pakistani women identified as being "at risk", but this needs confirmation with further studies (Rocheron and Dickenson 1990).

6. Equity aspects of social and community support (Policy level 3)

Weak social support networks have been linked to conditions such as depression, hypertension, heart disease, multiple accidents, complications in pregnancy and suicide. Lack of social support may also damage health indirectly by increasing the use of health-damaging substances such as alcohol and tobacco, as weays of coping with stressful situations.

In contrast, supportive relationships have a strikingly high protective effect for the mental health of people under stress.

However, social networks and support systems are often weaker among disadvantaged groups, especially those who are unemployed or have been forced to move due to lack of jobs at home or housing difficulties. A general assessment of the differences in the social networks in various socio-economic groups is, however, very difficult to make. What is clear is that disadvantaged and vulnerable groups tend to have the least say and lowest participation rates in key decisions affecting their health and wellbeing. There is evidence that community support can help bolster the confidence of disadvantaged groups and help them to have some controle over events in their neighbourhood.

An important dimension of strategies to promote equity in health is therefore to facilitate and promote the possibilities to establish positive social networks in e.g. deprived areas.

Two different but complementary lines of actions for this type of support can then be considered.

The first being to "create" relaxed meeting places outside the home for e.g. drinking a cup of coffee, reading a newspaper, meeting neighbours, playing cards or just watch TV together. Support can then be given to special & local resource persons able and willing to contact persons likely to have very few friends and/or in special need for social support. (e.g. among the elderly population and very young single mothers.)

This type of "active networking" from within can be a positive factor for releasing possiblities and resources of the persons engaged.

Single mothers may then by coming together find new ways to support each other with practical matters and at the same time share common experiences. Elderly lonely people may in the same way find new possibilities to engage in programmes for mutual support and for meeting neighbours.

Thinking in terms of existing and potential social relations is also essential when planning longterm institutional care. This can for example imply that old people with a "foreign" mother tounge - if they so prefer - can be placed together with

persons with the same cultural background and mother toungue when moving to a nursing home.

The second line of action is to encourage and facilitate community development programmes and projects aiming at e.g.

- collective action on the causes of ill-health such as heart diseases and accidents.

- better access for people to health information for example in the form of local community diagnosis presenting basic facts about the distibution and changes as regards both health hazards and diseases within the local population.

- improved self-confidence in particular among young people with very limited family support and unemployed

- greater possibilities to influence health policies including allocation of resources.

Various types of non-governemental agency and local action groups can be of critical importance in facilitating this kind of "health by the people" movement.

Case-study 10: Enhancing social support networks in London

The Newpin Project in London began as a response to local concern at high rates of maternal depression, isolation, poor child health and child abuse in a serverely deprived area. The aim was to encourage the creation of a mutually supportive community of parents with young children. The project consists of a voluntary befriending service at home and a drop-in centre which referred women were encouraged to attend by trained volunteers recruited from the local community. The centre contains an office, kitchen, sitting room for mothers and playroom/creche as well as individual couselling rooms. Women are referred by health or social service staff, or by themselves and friends, usally because of depression, isolation of parenting problems. Women joining the project are carefully matched with another local mother and are also given a list of telephone numbers so they can contact other mothers at night or over weekends. Once a befriender has been assigned, she visits the referred woman for mutual support. Befrienders are also encouraged to bring women to the drop-in centre. At the centre, women can relax, meet and talk to others in the same circumstances and see how others handle their children. They can also take part in individual and group therapy and counselling.

Small-scale evaluation of the Newpin Project indicates major improvements in self esteem and recovery from depression, fewer child behaviour problems, improvements in family relationships, reduction in social isolation, and no sign of child abuse so far

Case-study 11: Resource-mothers in South Carolina, USA

In the so called Pee Dee area known for having the highest pregnancy rate and post-neonatal mortality in the state of California a programme was initiated (1981) to support poor pregnant girls under eighteen. The key persons in this programme were local women who were trained to become "resource mothers". All of these community women had raised children and most of them also had experienced being a teenage mother.

The training of resource-mothers included information about family planning, labor and delivery, infant safety, sanitation and feeding as well as emotional and social aspects of pregnancy. They were also taught conseling, record keeping and how to mobilize community resources.

The tasks of the resource mothers were to meet "their" girls regularity (at least once a month) talk about "life as experienced" and possible actions needed.

Particular attention was given to secure adequate medical contacts. The resource mothers also assited in contacts with welfare agencies, housing agencies, schools and employers.

Evaluations of the programme showed that the control group had 55 percent more low birth babies and four and a half time as many very low birthweight babies. In addition to these direct measurable results it was also evident that the resource-mothers had contributed to the pregnant girls' sense of comfort dignity and belonging.

Source: Schorr, Within our reach.

Case-study 12 The right to health movement" within the workers labour union in Sweden

The Labour Organization (LO) is the national confederation for blue-collar workers in Sweden, covering 2.2 million members including most of the groups in the labour market with higher than average risks of poor health. In 1985 the LO bacame concerned about the inequities in health observed between their members and more fortunate groups in the labour market. The LO saw the great potential of action organised around the workplace to influence not only working conditions but also the living conditions and lifestyles of their members, and thereby help reduce inequities in health.

It wqas argued that workers would be much more interested in taking note of information concerning lifestyles if this was done in combination with improvements in working conditions and working environment. They would also be much more likely to accept information sprining from their own workmates than from some outside authority.

The LO Health Project was set up in 1987 for an initial period of five years, in collaboration with the national Health and Welfare Board, the Organisation of Dounty Copuncils and the Organisation of Local Communities. The ideas was to provide information, advice and training to local union branches to stimulate local health projects, but the form the projects took would be determined by what the members nearly all regional LO-districts had become involved in health promotion for their members, with a varity of schemes underway, all very different from one another.

For example, at one company near Stockholm, they chose to focus on the reduction of heart disease. Seventy percent of the workfaorce participated in health checks, a well-equipped exercise room was set up, a better choice of food was provided in the factory canteen, better provision was made for shift-workers who wanted a meal, working hours were changed, the working environment was improved in the store area, and safety delegates received more apropriate training.

In the centre of Sweden, the Transport Workers Union identified a particular obstacle for long-distance lorry-drivers in obtaining regular healthy meals. The union, therefore, established contact with hotels and restaurants along the main routes and negotiated agreements on a more healthy choice of food, available at convenient times for the drivers.

In a third example, an LO branch in the South West of the country started to make telephone calls to contact members who had been on sick leave for a long time. Study circles were formed, consisting of union members on sick leave and active workers. These groups met once a week and arranged many activities together, combining health education with mutual social support.
In 1991 the health activities of the LO were extended into a major Social Justice programme, funded for a furtherfive years, focusing on promoting equity in many spheres of members lives, including health (Lindberg 1990)

7: Equity aspects of lifestyle policies (policy level 4)

Many aspects of health are influenced by individual lifestyles, such as smoking, abuse of alcohol, poor diet, and lack of exercise. There are considerable differences in lifestyles between different social groups, with disadvantaged groups tending to adopt more health-damaging behaviour in terms of smoking, diet, lack of exercise in leisure time and lower uptake of preventive health care for themselves and their children. The social patterns in relation to alcohol use is not so clear cut but the social-economic and thus health effects of a too high alcohol consumption are usually more severe among disadvantaged groups with weaker networks for social and professional support.

From an equity point of view, it is important to recognise the relationship between personal behaviour and socio-economic factors. For example, economic policies influence the price of essential produce, and may put anything other than the cheapest goods out of reach of people on low income.

Several in-depth studies of why people continue with unhealthy ways of living show how families on low income are limited in their choice of lifestyle by practical constraints of time, space and money. For example, lack of money restricts food choice and sometimes spending on food is cut down to keep the family out of dept or to pay essential costs like the rent. In some adverse circumstances, activities that go against professional advice turn out to be the most rational option for an indivudaul within the limited resources at their disposal. Sometimes actions which seem detrimental to an individual's health are chosen because they maintain the family's health. So, for example, cigarett smoking may be used by some mothers as a way of easing feelings of stress without leaving their children unattended.

* Strategies aimed at improving lifestyle need to be based on an understanding of the restrictions on choice of people in difficult circumstnaces, so that realistic, credible advice and help can be given.

* Lecturing people on the error of their ways and blaming them for their own ill-health should be avoided. Not only does this approach over-simplify the situation, but as a strategi it has been shown to be ineffective in changing bahaviour because it makes people defensive and resistant to change.

* A range of educational approaches needs to be used to ensure that there is successful communicaiton with all sections of the population, not just the most highly educated.

Case-study 12: Developing a health promotion stategy based on equity - Oxford's experience

Oxford Regional Health Authority, responsible for hospital and community health services for a population of 2.5 million in the UK, drew up a regional strategy for health promotion, for the years 1984 to 1994. Originally it was very traditional in approach, focussed on prevention of premature deaths from strokes, CHD and cancer, through general (untargetted) action on smoking, diet, exercise and health checks. A substantial ten-year budget was allocated to carry out the strategy, divided among the eight district health authorities within the region, according to projects submitted for funding. However, following a lifestyle survey which gave a health profile of the region, great variations in health and lifestyle factors were found between men and women, between socio-economic groups and between deprived and affluent areas within each of the districts. It was realised that the original strategy would have widened these differences still further. The strategy was therefore refined from 1987 onwards by:

a) setting differential targets by socio-economic group and by gender, for example, setting a target of 80% for the proportion of non-smokers belonging to social classes I, II, and IIIN in 1994 (from a base line of 75% in 1986) and a target of 70% for social classes IIM, IV, and V (from a base line of 58%)

b) focussing resources on more socially deprived districts, then focussing on deprived areas within these districts. The rationale was that relatively larger sums of money need to be concentrated on smaller geographical areas to be effective,

c) looking at the opportunities for health promotion in each setting - getting away from a focus on disease. This led to a shift towards community outreach and community development methodoligies. believed to be more effective with the groups for which traditional health education had failed.

d) targetting disadvantaged groups - to use resources most efficiently by tackling the problems of those with the worst health and lifestyles.

An extensive monitoring and evaluation programme has been designed, covering the 10-year period of the strategy.

8 The risk group perspective

8.1. Cumulative health hazards in every day life.

The search for determinants of health is usually characterized by a reductionistic approach. A specific riskfactor - be it smoking or stress - is identified and risks assessed.

Equally important is to consider the cumulative effects of a combination of risk factors. The reason for this is the strong tendency that those at greatest risk e.g. at work very often are those at greatest risk also for many other risk factors e.g. poor housing and high risks for unemployment. In addition there are often synergetic effects between different riskfactors increasing the risk more than would be expected if these riskfactors were looked upon as isolated entities.

These cumulative and reinforcing factors are in fact one of the most important aspects to consider when trying to formulate a strategy for reducing social inequities in health.

The dynamics of these cumulative effects can usually be described in terms of positive or negative health effects. The positive effects are then characterized by the fact that healthy living conditions favour healthy life styles.

The prosperous ones are not only less exposed to various environmental health hazards but also more likely to benefit from health education.

The opposite is true for the vicious circle of poor health. Cumulative effects experienced by disadvantaged children in England have in the Black Report been described in the following words: "It is the children from working class background whose nutrition and health are most affected by political decisions made in the name of economy to raise the price of school meals or abandon the service; to curtail the supply of free school milk ... It is these same children who must live in substandard housing. It is these same children who feel the cold wind of unemployment blowing through their parents' lives. It is these same children who will suffer from a mortality rate from accidents five times higher than the children born into class one".

The key issue using the risk group approach is to identify an effective entry point for action.

Considering that disadvantaged groups often experience the triple burden of poor living conditions, weak social networks and unhealthy lifestyles - as described above - the most effective entry point is usually to be found at policy level 1 and 2. (structural changes and improved living and working conditions) Within that context special attention should be given to poor working conditions and inadequate housing facilities "blocking"opportunities to live a healthier life.

Experiences gained from many countries also clearly indicate that the support to disadvantaged groups is more effective if it is comprehensive including both social, economic and health related elements "tailor-made" for each individual/family.

This calls for a coordinating person at the family level such as the resource mothers described above (case-study no 11) or local intersectoral service centres.

8.2 The visious circle of poor health in a life perspective

The cumulative effects of various health hazards and conditions unfavorable to health should also - whenever possible - be focused upon in a dynamic long term perspective.

This type of longitudinal perspective on health often reveals how poor living conditions as a child not only increases the risks for poor health during childhood and adolescence but also is closely related to a higher risk for various diseases and early deaths as an adult.

The vicious circle of poor health often include the following elements:

* Having a mother smoking cigarettes and drinking alcohol during pregnancy increases the risk for being a low birth weight baby.

* Being a low birth weight baby increases the risk of poor health. This risk is further increased in poor living conditions.

* Poor living conditions is often linked to each of attention and stimuli during the first years of life. This is likely to create a low self esteem and increase the risk for accidents.

* The low self esteem is reinforced if the educational system is not equipped to give extra support to pupils from disadvantaged homes.

* Always being compared with the better pupils rather than with achievements made in an individual perspective increases the risk of being a school drop out.

* A young person leaving school too early without strong support from family and/or society is likely to experience unemployment and live on the "borderline" in terms of crime and drug-addiction. Living conditions and lifestyles then experienced are very closely related - indeed - to poor health and early deaths.

Actions to break this type of "visious circle of poor health" are most likely to be effective if initiated during pregnancy and the very first years of life.

Important elements of an equity oriented health policy must therefore be a comprehensive system of MCH-services accessable to

all and effective support systems securing as far as possible a healthy environment for infants and small children. Good quality day-nurseries are of particular importance in socially deprived areas, as well as well equipped certain extent - the social support normally given within a family context.

9 Age, sex, and hereditary factors

The process of ageing is of course one of the main determinants of health. There are no indications however that the biological factor at work within this process contribute to social inequities in health. The differences found in e.g. life expectancy between different socio-economic groups are caused by differences in living conditions and lifestyles.

It is also a well known fact that gender is an important factor in terms of health the normal pattern being that women live longer than men.

Neither age nor sex are influenced by health policy - they are given

Genetic factors finally can - with a few exceptions - also be considered as given. There is no evidence that genetic differences explain the health divide.

This does not imply that genetic factors can not be of critical importance in terms of general health policies. On the contrary new findings as regards the genetic code for various diseases open up a completely new arena for health policy as groups at particular risk for certain diseases can be identified at birth. An early identification of these genetic groups at risk calls for specific actions to reduce the excess risk by trying to avoid additional exposure and/or unhealthy lifestyles which are likely to "trigger off" latent genetic risks for certain diseases.

It is outside the scope of this paper to discuss possible scenarious - and their ethical implications - as related to our expanding knowledge about the genetic codes of various health proglems.

Within the context of this paper it must however be recognized that genetic and soci-economic risk groups must be clearly seperated from each other.

10 BUILDING A STRATEGY

10.1 Selecting a starting point

Turning to building strategies for promoting equity in health, one point needs to be stressed right from the outset. There is not and cannot be a blueprint on how to promote equity in health that would be applicable to every country. Each country in Europe has its own specific pattern of inequities in health, and also very different policy-making structures. The political and economic climate, and public opinion also, change from time to time, so that initiatives suitable for one country at a particular point in time may be unacceptable in other countries.

Detailed strategies, therefore have to be worked out specifically for each country, building on the opportunities available at the time. However, there are some common pointers which are valuable when formulating these specific policies.

There are several possible starting points in formulating plans to tackle inequities in health.

One way is to start with a specific disease for which significant differences in health between socio-economic groups have been observed. An attempt is then made to specify the main determinants of "risk factors" for that particular disease and to work through those to reduce the differences in observed disease reates. For example, noticable inequities in infant mortality became the starting point for action in Sweden in the 1930's when rates varied from 14 per 1000 to 49 per 1000 depending on the socio-economic situation of the family. Strategies focussed on improving hygiene and nutritional standards, improved education and housing, and the provision of free maternal and child health care. Infant mortality was brought down to below 7 per 1000 and differences between various socio-economic groups became small, though not eliminated entirely (Dahlgren and Diderichsen 1986).

Another way is to start with one of the factors blocking opportunities for people to achieve their full health potential, and the resulting strategies may influence more than one disease. Factors known to have an adverse effect on health and to which the most vulnerable groups suffer greater exposure include:

* poverty, particularly in relation to children and elderly people,

* inadequate living conditions (both physical and social),

* sub-standard working conditions (both physical and social)

* unemployment,

* restricted access to a nutritious diet,

* undue pressure to consume hazardous substances, such as tobacco,

* inadequate access to essential social and health care services,

* lack of social and community support,

* dangerously polluted environment

Equally important but less common is to include into this approach access to working and living conditions directly promoting good health (an interesting and stimulating work-environment, good neighborhood facilities for meeting friends and engage in various activities etc.) The social and occupational distribution of these "health-promoting" environments is also of critical importance for understanding existing social inequities in health and thus for initiating strategies to combat these inequities.

In addition to the "risk"-and "health promotion"-factors mentioned above it is also important to try to identify factors that - at a given exposure - protect or reduces the risks for poor health and early deaths. Positive social relations and social support when experiencing very stressful situations due to e.g. poverty, divorce or unemployment are examples of such "health protection" factors.

The case studies presented above record several initiatives taking one of these factors as a starting point.

A third approach springs from the evidence that there is an accumulation of these factors in the same social groups. For example, those with the worst working conditons are often those at greater risk of inadequate housing, more frequent bouts of unemployment, unsatisfactory nutrition, and the risks reinforce one another. In such cases, it would seem inefficient to have ten separate strategies, each dealing with a separate factor.

This approach, therefore, <u>looks for a strategic entry point or setting in which several factors can be addressed at the same time in specific high risk groups</u>. For example, the workplace has often been identified as an important entry point to influence physical and social working conditions, to control harmful substances, and to enable a change to a healthier lifestyle.

In several countries children have been selected as a priority group with great potential to influence several risk factors at a crucial formative stage in development.

This risk group approach should whenever possible be developed as an integrated part of - or supportive programme linked to general welfare policies. Experiences gained from this approach also indicate that successful programmes should offer a broad spectrum of services focused and coordinated from a family perspective. It is also essential to have a holistic view of the problems experienced which for example means that the situation of a disadvantaged child must be seen in the context of the family and the family in the context of general living conditions. This may sound self evident but in terms of specific actions and policies there is still too often a tendency to focus on the problem of the child and forget that the most efficient entry point to tackle this problem may be support to a drug abusing mother or unemployed father.

Finally there is ever increasing evidence (Schorr) that an active participation during the implementation by those supposedly benefitting is not only crucial but usually absolutely necessary for a sustainable development from a family health point of view.

10-2 **USING A STRATEGY MATRIX**

When deciding where to start it can be helpful to build up a strategy matrix.

For example, if the second "risk factor approach" is being considered, a matrix can be drawn out with risk factors and factors promoting and protecting health down one side, and the 4 policy levels outlined earlier across the top, as in Table 1.

Table 1 Strategy Matrix
Policy Levels

Factors blocking Influencing individual Health opportunities lifestyles and attitudes	Structural change	Healthy public &business policy	Strengthening &social support	Education for health and
1.Riskfactors				
Poverty				
inadequate housing & living conditions				
substandard working conditions				
restricted access to a nutritious diet				
unemployement				
inadequate accessto essential health and social services				
pressure to consume harmful substances, like tobacco				
2. Factors promoting health				
Interesting and stimulating work				
Exercise				
Medical primary preventons such as immunizations				
3. Factors protecting health				
Social relations and social support				

Then the boxes related to the one or more factors under consideration could be filled in. Take, for example, the line related to inadequate access to essential health care services. At policy level 1,consideration might be given to the financial strategies for the health care system, (private health insurances, tax financed services etc.) At policy level 2, a system of resource allocation within the health care system might be put forward to ensure a more equitable spread of resources between and within different regions and districts. At level 3, the formation of "patient participation" groups might be encouraged for users of the services to join together and gain confidence in expressing their ideas on e.g. access and quality problems in their areas. At level 4, education programmes might be envisaged to increase knowledge of availability and use of health care facilities in low take-up areas.

The same process could be repeated for any of the other factors. For example, in tackling poverty, ways of redistributing income through the tax system would come at level 1. Increases in welfare benefits through the social security sector, or the provision of free school meals through the education sector, would be classed under level 2. The encouragement of credit unions in deprived areas would be seen as a level 3 strategy, while the provision of individual debpt counselling services would be seen as a level 4 initiative.

The matrix is only meant to illustrate the options available and the potential of a comprehensive health policy - but no one is expected to initiate actions in every box!

With that proviso, constructing such a matrix can serve a number of functions. For example, it reinforces the idea that a strategy to influence one factor can operate at any of four different policy levels. It helps people working at one level to see their contribution in the context of the overall policy goal and in doing so helps them set realistic targets for their own work.

In addition, it can help identify likely entry points for effective concerted action where, for example, a structural change in tax policy would influence several factors at once.

It can also highlight neglected areas. For example, the matrix sometimes shows up a pre-occupation with individualistic solutions at level 4 at the expense of structural or community support options at levels 1 and 3. Some national and even international policies exhibit this tendency, with most of the proposed strategies clustering at level 4 and nothing much

happening elsewhere. The same isolationistic tendency is often found in health promotion programmes initiated and implemented by medical professionals. A matrix analysis of this nature can help bring about a recognition of the short-comings of the proposed policies.

Above all, the matrix serves a purpose if it reminds people that there is something they can do about inequities in health at whatever level of organization they operate. An analogy can be made here with recent developments in environmental policy. The environmental problems faced by the planet are of great magnitude, and will require a global solution in the end. However, the sheer size of the problem has not stopped people from taking up the challenge of protecting the environment by the methods they have at their disposal, ranging from international agreements on carbon monoxide emissions negotiated by national governments to individual families recycling their old newspapers. The message is the same for the task of promoting equity in health: action can be taken now in any size of organization, public or private, as long as it is recognised that the initiative is only part of the broader concerted effort required.

10.3 RECOGNISING OBSTACLES

There are very real obstacles standing in the way of action to reduce inequities in health and health care. These need to be acknowledged fully if ways of overcoming them are to be devised.

* Information systems are often not geard up to identify social groups at potential risk in the population and to monitor their health status over time, and this is a serious restriction. It may only be possible in some countries to look at the differences in health between different geographical districts or provinces and other aspects are neglected.

* An added obstacle in some countries is the general attitude to privacy and confidentiality, in which linkages between health and social data are actively discouraged. In such circumstances, there has to be a trade-off between enabling the recording and monitoring of inequities on the one hand and protecting the right to privacy on the other hand. It should, however, be possible to safeguare both principles by regulating the use and exchange of data.

* Generally, there is a lack of debate on priorities in society. There is a feeling in some countries that people may be accepting injustices now that would have been disapproved off ten years ago. At the same time, there is a reawakening of

interest in inequities in other quarters, which shows some promise.

* There is a lack of debate at most levels of organisation about the administrative structure and resources needed to introduce equity considerations into health policy. The management of health services in general is a major area of concern in most countries, so why should the subject of equity gain so little attention as a legitimate management concern?

* The short political cycle between elections in some democracies means that short-term initiatives, yielding results over 2-3 years, are preferred to those requiring long-term commitment. Yet tackling inequities in health will require effort over several years and needs continued political support.

* If not designed carefully, some policies to reduce inequities may stigmatize groups of people or certain neighbourhoods. People do not like to be labelled as "disadvantaged" and may reject an initiative that labels them in that way.

* All proposals to promote equity will have financial consequences, and some will involve reallocation of resources which will make some people feel they have lost out. Nevertheless, the problem of inequity is so important, and the consequences of not doing something about it potentially so serious, that the long-term price tag must be at least as high priority as other long term committments as regard e.g. military expenditures and infrastructural investment.

10.4 Securing financial resources

Health promotion and disease prevention policies are often discussed in a financial vacuum while the financial issues related to most other welfare programmes such as health services are given highest priority.

This lack of a financial dimension is even more typical for intersectoral actions for health aiming at reducing social inequities in health. Health problems initially being everyones concern quickly become no-ones responsibility when resources are to be allocated for specific actions.

Investments in health must therefore be budgeted just as any other investment and within the ordinary budget process for the responsible agency/sector authority.

The following cost implications can then be considered

1. Direct costs for the policies/programmes initiated

2. Indirect costs for not carrying out a proposed policy/programme e.g. in terms of increased costs for healthcare/health insurances.

3- Zero costs for implementing certain policies e.g. changes in the school curriculum. The zero-cost statement indicate that a financial analysis has been carried out which showed that no additional funds are needed.

4. Financial savings as a result of implementing certain equity oriented health policies e.g. reductions of tax financed subsidies on less healthydairy products.

The simple point to be made here is that no health policy should be presented without a budget indicating financial resources needed and released.

Given the financial constraints experienced within the public sector it is also important to consider new possibilities to strengthen the financial base for an equity oriented health policy.

One option can then be to create a special Health Fund for matching ordinary public sector or buisness budgets.

The "Swedish work life fund" - described above (case-study No 3) - is one example of a special effort to secure the financial resources for improved working and thus also health conditions.

The temporary tax on business used for establishing this fund was an integrated part of the overall financial policy as related to variations in trade market conditions. Linking overall financial and work/health policies thus created a unique resource base for combatting social inequities in health.

Another interesting option is to use part of the tax revenues from sales of unehalthy products such as tobacco and alcohol for creating a special Health Fund. This approach has been used in Australia when establishing the Victoria Health Promotion Foundation with an annual budget of £ 15 million per year. The Foundation suport;

. research for health promotion (including analysis of social inequities in health)

. sports and cultural events (as a sponsor marketing health promotion issues)

. Health oriented community development programmes at

. Information and Education health promotion

. Systems Development for Health Promotion

The Swedish Work Life Fund and the Victorian Health Promotion Foundations illustrate new possibilities for promoting investments in health. Similar initiatives specifically aiming at reducing social inequities in health should of course be stimulated and promoted when developing financial strategies for implementing an equity oriented health policy.

10.5 Organizational structures

Management and organisation of e.g. public health services constitute a major issue in many countries. How to develop efficient organizational structures for implementing an equity oriented health policy is still almost a non-issue.

This very often blocks the public health process. Epidemiological surveys and in depth analyses of various health problems are only losely- if at all - related to those agencies and driving force able to initiate specific actions.

It must also be observed that most countries still lack specific policy functions for health development both at national and local levels.

The need for this type of functions when dealing with intersectoral policies and actions for economic development should be as obvious as the need for having a Ministry of Finance in charge of intersectoral economic and financial issues and Ministry of Environment for overall policy develolpment and intersectoral actions as regards environmental issues.

The specific organizational set up for developing and implementing an equity oriented health policy can only be discussed within a country specific context.

Within a swedish context the government has for example created an advisory group for health development with representatives from the most important sectors from a health policy point of view. The chair person of this advisory group is the undersecretary of state (deputy minister) at the Ministry of Health and Social Affairs. The main task of this group is explicitly stated to be to promote intersectoral and equity

oriented strategies for health development.

Various forms of intersectoral functions for health development are also found at the local - municipality - level in Sweden. It is interesting to note that these local boards or coordinating bodies for health development often include not only representatives from various public sectors but also persons from the world of private business and non-governmental voluntary organizations.

The key issue at present in many European countries is not - however - to find out which is the most efficient organizational structure for health development but to realize that an organizational structure is necessary for implementing an equity oriented health policy.

11 Health development; Democracy and political will

Descriptions of various types of equity oriented intersectoral actions for health may give an impression of being an advanced form of "health engineering" performed by different professional groups.

In order to avoid this type of instrumental view it may be useful to recall that the real key issue isnot what technically can be done in order to reduce various risk factors but what we as individuals and society want to do. (provided it is technically feasible)

An equity oriented healthy public policy must therefore primarily be a tool for increasing the possibilities to live a healthy life.

The first level of interventions to achieve this - as seen from the individuals point of view - is often the individaul/family level. What can I do together with my family to prevent diseases and promote health. These actions are closely related to policy level 4 as described above.

The next level to be considered is likely to be what can be done "if we join hands" e.g. in local action groups or together with e.g. voluntary organizations such as sport clubs, womens organizations, labour unions etc. These actions often fall within policy level 3.

The third line of action from an individuals point of view is of course to try to influence decisions taken at policy level 1 and 2 within the democratic process.

The importance of facilitating the democratic process also in

the field of health development is often stressed both by politicians and professionals. A prerequisite for making a positive choice is - however - that alternative objectives and options are presented. This is very seldom the case in real life.

At an overall policy level all seem to agree that it is important to increase the possibilities to prevent diseases and promote health as well as to reduce social inequities in health.

In order to make the healthy choice a real choice within the democratic process it is thus important to go one step further and focus uon the main determinants of poor health among disadvantaged groups.

Real health policy issues - from an equity point of view are then who is to "vote" for:

*a reduction of existing inequities in incomes and other material resources

*making it possible for the less priviliged to move away from unhealthy slums and polluted industrial areas

*support disarmament and reallocate a major part of former military expenditures to human development

*stricter legislation for reducing the risk for work related diseases

*additional funds for vocational training of long term unemployed

*a healthy price-structure for agricultural products

*social renewal programmes for deprived urban housing areas

*a healthy school policy including special efforts to support children from underpriviliged families.

*access to health services according to need

If presented in these terms by parties wanting to pursue an equity oriented health policy the likelyhood for real choices for the citizens will be greatly improved.

Differences in political resources between various socio-economic groups may - even when alternatives are clearly presented - be of decisive importance for the content of the political will as expressed e.g. in the political process.

The usual pattern is that the interest to discuss political issues is far greater among professional groups than unskilled workers. It is also a wellknown fact that the proportion using the right to vote in general elections is highest among professional groups.

These inequities in political power within the democratic process are likely to have an adverse effect in terms of power to combat social inequities in health.

There is thus a particular need from an equity point of view to inform and facilitate those at particular risk with political options to improve their possibilities to vote for a healthy life. The proposal mentioned above that health education must include also information as regards necessary changes as regards living and working conditions is such an effort to increase the efficiancy and coverage of the democratic system.

This may seem obvious. The history of health promotion and disease prevention is however full of examples where the health policies introduced were perceived as "big brother" telling how to live. Equally evident is that many regulations introduced to reduce risks are primarily discussed in terms of limiting the freedom of the citiziens.

An authoritarian and technocratic approach to health development is doomed to fail in a society with an increasing proportion of well educated and concerned citiziens who want to increase their possibilies to choose life they want.

The very base for health development must thus be the will of the people as expressed in individual choices, collective actions and within the democratic process.

12 CHECKLISTS FOR ACTION

CHECKLIST 1 Individuals and local action groups
How to start making things happen

For those who want to do something about inequities in health - at whatever level - this checklist gives some hints on how to go about organising and stimulating action, based on the experience of initiatives from various European countries.

1. Analyse your own position and sphere of influence - whether it is local, regional or national - using the suggested matrix as a framework and noting key people with influence on policy.

2. Draw together all available local (and national) information on inequities and present it to key policy-makers to raise awareness and develop debate.

3. Collect and use local data to help get a neighbourhood or locality together and interested in discussing the problem. Quantitative data from national level can be reinforced by qualitative information from more local sources. For example, case studies and quotes from local people often bring a point on equity to life and increase understanding.

4. Don't wait for more evidence to be collected if you know what the problem is and have a possible solution in mind.

5. Pay attention to the media and use the political process to mobilize action and lobby for change.

6. With professionals, stress that it is part of their professional responsibility to report back on situations concerning inequities to the community, the population and policy-makers.

7. Consider setting up long-term interventions at a low level, that are well embedded in existing structures. These may prove more durable than a large programme that may be short-lived if it relies on political support from one party or on the enthusiasm of a particular person

Checklist 2 Policy makers and politicians - immediate opportunities.

Many policy-makers and politicians are under pressure to adopt short-term initiatives where at least some progress can be demonstrated within 2-3 years. The checklist below gives some ideas for policies that could be put into motion relatively quickly and could increase the opportunities available for reducing inequities over a short time-span.

- promoting fluoridation of water supplies in countries where large differences in dental health are observed between children in different social circumstances or from different geographical areas.

- initiating immunization schemes to improve uptake and coverage in populations where childhood diseases and immunization uptake rates show gaps between different social and ethnic groups.

- extending the provision and accessibility of family planning services to larger sectors of the population, in countries working to reduce inequities in maternal and infant health.

- encouraging the identification of areas of low up-take of preventive care and initiating schemes and "outreach" services to promote uptake in those areas, for example, mobile cervical cytology units, domicilary family planning provision, antenatal consultant clinics held in local community centres rather than in distant hospitals.

- commissioning analyses of the effects on equity of any new proposales for changes to the health care financing system or other health service re-organisations.

- promoting "link-worker" or "patient advocate" schemes to help ethnic minorities and others in disadvantaged positions to gain access and make full use of existing services.

- linking into existing quality assurance systems in health services, so that the system not only looks at <u>average</u> provision but also at the <u>distribution</u> of services within the population and includes indicators of equity as aspects of quality of service to be monitored

- improving physical access to public amenities for disabled people.

- identifying parts of cities with high air polution and inintiating clean air regulations to improve the situation.

- identifying the most unhealthy occupations and providing funds to improve those workplaces.

Checklist 3 **Policy makers and politicians - long-term opportunities**

This checklist includes more ambitious challenges. Each item on the list indicates a policy that would facilitate the reduction of inequities in the long-term. Some may take 5 - 10 years to set up and come to fruition, depending on the current starting pont, and therefore need continuing comittment.

- improving the health information system to take socio-economic variables into accout,

- including health information in existing socio-economic statistics at national and international level;

- developing ways of using the health status of disadvantaged groups and how it changes over time as an indicator of social progress and quality of life;

- formulating specific targets for health and health care expressed in terms of improved health status for certain groups, for example, disadvantaged groups already defined as a priority;

- including explicit equity targets in any general health stategy formulated forthe nation or region;

- setting equity targets in an operational plan of action, outlining organisational structures, human and financial resources required.

- developing effective ways of involving vulnerable groups fully in the definition and development of strategies to tackle inequities;

- setting up an office or unit with responsibility for monitoring inequities in health that would report back regularly to policy-makers and politicians;

- analysing the effects on equity in health of national and international strategies;

- analysing the effects on equity of public and buisness policies at national and international level;

- allocating health care resources according to need, with special attention to secureing economic, geographical and cultural access for all;

- giving high priority in national research strategies to multi-disciplinary research on the socio-economic and environmental influences on health;

- developing a country specific health strategy to analyse how action on equity could be facilitated.

- initiating demonstration projects at district level to investigate the potential of combining healthy public policy and community action to reduce locally identified inequities in health;

This is a long list and we would be very surprised if any country could say that all these suggestions had been taken on board. But reading down this list, and looking at the case-studies presented above may give further inspiration on what is possible within a country or distinct specific context. The main point is that these are actions that can be taken now to start to make improvements for the future.

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