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Editorial

From social determinants to reducing health inequalities

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Reducing health inequalities is a central aim of health policy both on the national level and internationally[1–3]. A growing concern on the wide inequalities has been evident for at least thirty years[4–5]. Mortality and the prevalence of most common diseases as well as restrictions in functional capacity tend to be at least twice as high at the lowest end of the socioeconomic hierarchy compared with the highest sections[1,2,6]. In general, inequalities in health seem to be persistent or even increasing.

There are several reasons to stress the importance of health inequalities. First, as social health inequalities are largely due to factors amenable to intervention, they are not inevitable and therefore not ethically acceptable. This ethical argument is often emphasized in political rhetoric, but it does not always have the power to affect decisions on different policy areas. Also other implications of health inequalities have to be underlined.

Poor health in large population groups with lower education and income notably weakens the average health of the whole population. For example, in the whole Finnish population approximately one half of deaths ensuing from respiratory diseases, heart diseases or excessive use of alcohol would be avoided if the whole population could reach the situation prevailing among persons with a tertiary education. Also the number of older persons needing daily care due to functional restrictions would be one half of the present level if functional capacity were as good in all groups as it is in those with higher level education[7]. Success in this would significantly improve work ability in the working aged population and reduce the need for health services and care for elderly.

Furthermore, poor health and many of its determinants contribute to social exclusion which has repercussions on the wellbeing of all members of the society. Thus health inequalities are not only an ethical problem. They seriously compromise the general level of health, sufficiency of fit workforce and public services, and, as a consequence, the economic prospects of the society[8].

The need for action is obvious. The report of the WHO Commission on Social Determinants of Health[2] is undoubtedly a cornerstone for future debates, research and action in this field. It brings forward a comprehensive picture. Of particular importance is the global approach of the report. Hopefully the report and the following discussion both on international and national levels will lead to actions in different ways: drawing the attention to the general backgrounds of health inequalities and also to more direct effective interventions.

Many plans for action can be based on solid evidence concerning the aetiology of health inequalities. Causal chains can be identified from material circumstances and related cultural factors to behaviour, biological markers, disease and death[1,2,6]. Excessive use of alcohol, for example, is responsible for one quarter of the six-year difference in life expectancy at age 20 between men in manual vs. upper non-manual class in Finland[9]. The corresponding contribution of deaths caused by smoking can be estimated to be approximately as large.

These causal chains are shaped during all phases of the life span, starting from prenatal conditions. However, changes in contemporary risk factors have a great potential, and the outcome is not predestined by circumstances in early life[1–3,5,6].

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Thus determined progress in specific evidence based policies like for tobacco and alcohol have a great practical potential.

Health systems intervene in these processes for good and bad. For example, the rapid decline in regional and socioeconomic inequalities in infant and child mortality around the middle of the last century in Finland can partly be attributed to the development of mother and child health clinics which rapidly covered all segments of the population[10]. Unfortunately, there are also opposite examples. Patients with acute myocardial infarction receive the most adequate treatment if they have good income and education, whereas the patients from lower socioeconomic groups quite often fail to receive adequate treatment[11].

There are also important gaps in the knowledge base needed for effective action. Quite a lot is known about the contribution of environmental and behavioural factors to health inequalities but much less about the impact of different efforts to tackle these determinants. More information is needed on how various kinds of interventions and policies influence different loops in the causal chain of inequalities. We should study and evaluate both universal policies and interventions and those targeted to the poorer segments of the population.

Concerning universal policies, work around the "Health in All Policies" concept[12] and "Health Impact Assessment" should be upgraded, also to help reduce health inequalities. This should be emphasized in the implementation of the European health strategy[3]. Of practical importance would also be inclusion of health inequalities dimension in the European health monitoring plans.

Finally, in reducing health inequalities as well as in our modern public health work as a whole, a major issue is the implementation gap. Much is known about the background of health inequalities, both concerning general and specific backgrounds. But much less is known about the process of influencing change. Greater emphasis in research and practice should be on issues how to bridge the gap between our health knowledge and political decision making, or how to help drive social change process for better health for all[13].

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