Choosing health for all: lessons from Europe.

All European countries have substantial socio-economic inequalities in health. People from a lower occupational class tend to die younger and experience more ill health within their shorter lives, and life expectancy usually shortens with each step down the social ladder. However, the size of socio-economic health inequalities varies considerably by European country with much of the differences explained in terms of variations in welfare state provision.

A recent study by my colleagues and me of income related inequalities in limiting long-term illness found the least generous welfare states of England and Ireland exhibited the largest health inequalities. Men in the lowest income groups were over two and a half times more likely to have a limiting long terms illness than those in the highest income groups; a larger health inequality than those in the formerly Communist Eastern European countries or less affluent Southern European countries. These inequalities were also a lot larger than those in the more generous Scandinavian or Continental welfare states.

It is perhaps surprising that health inequalities are the largest in England, considering the current government has made tackling health inequalities a priority. However, the persistence of class inequalities in health in the UK is because government interventions have focused on changing the lifestyles of the poorest, even though volumes of research since the 1980 Black Report have shown reducing health inequalities requires actions in many policy fields. But to date there has been only limited attention to the social determinants of health - poor housing, unemployment, stressful work environments, low incomes.

European comparisons suggest these “causes of the causes” are all potentially improved by government action and a strengthening of the welfare state. However, over the last thirty years successive UK governments have pursued a policy of shrinking the welfare state, marginalising the public sector, reducing the value of social security benefits and individualising risk. They have passively sat back or even actively encouraged an increase in income inequality.

The higher health inequalities in England are therefore effectively a political choice, for we have successively not chosen health, but instead have opted for social and economic policies which only serve to increase social inequalities and consequently decrease health equity. Experiences from the rest of Europe, particularly from the Scandinavian countries, have long suggested that another approach is possible, one which will reduce, if not eliminate, health inequalities. We can choose health for all.

If you wish to work with PoHG on this or any other public health issues please contact Debbie at contact@pohg.org.uk

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