**Analysis of social determinants of health and health inequities**
**- a multi country event on approaches and policy**
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# Abstracts of key-note lectures

**Prof. Sir. Michael G. MARMOT**

**Action on Social Determinants of Health**

The WHO Commission on Social Determinants of Health (CSDH) was tasked with collecting and synthesizing global evidence on the social determinants of health and their impact on health inequity and to make recommendations for action to address that inequity. The CSDH argued that for reasons of social justice, action to achieve health equity is imperative. Health inequity between and within countries are related to levels of social disadvantage and inequality; they are not inevitable. The CSDH outlined how government policies, governance and social and economic forces shape health, even in more developed countries.

Tackling health inequities requires action across social, political and economic domains. The evidence to support this approach was documented in the CSDH Report. With few exceptions the evidence shows that the lower an individual's socioeconomic position the worse their health. Attempts to reduce health inequity must therefore be predicated on addressing gradients in the wider social and economic determinants, such as levels of education, economic status, work and power relations.

A number of countries and regions are developing whole of government strategies to improve health and reduce health inequities. Reducing health inequalities has been a focus of government policy in the UK for a number of years. Following the report of the CSDH, the Department of Health for England and Wales commissioned the Strategic Review of Health Inequalities Post 2010 (Marmot Review), chaired by Michael Marmot, to report back its findings and advise on strategies in early 2009.

In order to monitor and assess performance improvement in achieving health equity through the social determinants, the Marmot Review has been working to identify a framework for establishing potential targets and indicators of outcome, output and process to underpin the areas of action that have emerged from the Review, underpinned by the CSDH conceptual framework. Based on this conceptual approach, the Marmot Review has examined the types of indicators that might be appropriate for monitoring process, outputs and outcomes in reducing the gradient.

**Prof. Martin BOBAK**

**Social inequalities in Central and Eastern Europe in the period of societal transformation**

The health status of populations of the countries of Central and Eastern Europe and the former Soviet Union underwent major changes after the fall of communism. While mortality started declining in Central Europe, mortality rates in Russia and most other countries of the former Soviet Union rose dramatically and have yet to improve. Fertility, to give another example, declined to lowest-low levels, mainly due to stopping / postponing second births. In terms of socioeconomic changes, some countries, mainly in Central Europe, were able to contain the fall in income and rise in income inequalities but across the former Soviet Union gross domestic product plummeted and income inequalities grew rapidly. This has led to two types of inequality: fist, the widening gap in health between countries, and second, the increasing social gradients in health within countries. The exact pathways are not entirely clear but available evidence confirms the importance of both psychosocial mechanism and health behaviours (e.g. excessive alcohol intake).

**Dr. Andrea MADARASOVA GECKOVA**

**KISH findings on social determinants of health and health related behaviour**

Routine monitoring of health inequity and the social determinants of health as well as evaluation of health equity impact of policy and programs are critical to improving health. Despite decades of effort there is still a gap in research capacity and data availability which are basic conditions to fulfil this task. More than 10 year lasted collaboration between University of Groningen and University of PJ Safarik in Kosice significantly contribute to establishment of research program focused on social determinants of health including sustainable research capacity building, networking and bridging research and policy. KISH findings on social determinants of health and health related behaviour as well as several possible analytical strategies will be presented.

**Prof. Mark EXWORTHY**

**Why policy matters: translating evidence into policy**

Despite increasing volume of evidence about interventions to address the social determinants of health (SDH), there remains little evidence about how to design and implement these policies. SDH presents specific and unusual challenges to policy-makers. This presentation argues that the policy process is a complex activity that is poorly understood, not least by policy-makers and public health practitioners. So, it will introduce key concepts and ideas about policies to address SDH. It will cover: (i) policy learning and drawing lessons, (ii) explanations of the policy process, (iii) understanding equity, and (iv) SDH challenges for health policy including trade-offs. It will then draw conclusions about getting evidence into policy.

**Dr. Iveta RAJNICOVA NAGYOVA**

**Data sources: Health equity surveillance system (URHIS)**

Social justice affects the way people live, their chance of illness, and their risk of premature death. Health inequalities arise because of the circumstances in which people grow, live, work, and age; and these are, in turn, shaped by political, social, and economic forces. Due to a complexity of the problem a holistic view of social determinants of health should be adopted when trying to reduce the health gap. Key leaders in tacking the problem of health equities agree that evidence-based policy-making on the social determinants of health offers the best hope for closing the health gap. Action on the social determinants of health will be more effective if basic data systems are in place and there are mechanisms to ensure that the data are understood and applied to develop more effective interventions. In Europe several initiatives exist that deal with health indicators such as ECHI, ISARE, EURO-URHIS, ENHIS, ISG, SDS, EUROTHINE, but some of them concentrate on specific populations (urban, rural), whereas others revealed that collected health indicators are not comparable across countries. The WHO Commission on Social Determinants of Health aspires to adopt a stewardship role in supporting the creation of a comprehensive health equity surveillance system. This system should include vital registration and routine monitoring of health inequity and the social determinants of health and it has to be structured so that it is possible to follow time-trends on social determinants of health separately for men and women and for different social strata. Moreover, in order to ensure knowledge accumulation and to prevent unnecessary duplication of effort there is a need for international collaboration. A creation of a 'clearing house' for evidence on interventions on the social determinants of health could help improving mechanisms for global knowledge accumulation and sharing.

**Assoc. prof. Bettina F. PIKO**

**Explanation framework of health inequality**

Throughout the world, a continuous attention has been paid to the relationship between social inequalities and health. Despite the dramatic increase in life expectancy, life prospects are significantly lower among persons with lower levels of education, income, and occupational prestige. There are a number of factors mediating between SES and health, among others, financial, psychosocial, or lifestyle. However, the relationship between SES and health is not consistent across the lifecycle. Social inequalities in health are highest among middle-aged persons, while there is a certain level of "equalization" in adolescence and elderly age. This relative "SES equality" might be explained by a dominance of biological explanations, as compared to social impacts. During adolescence, morbidity and mortality are relatively rare which might contribute to a relatively low level of social inequalities in health. In elderly age, biological selection is also a main issue due to highest levels of morbidity and mortality.

**Prof. Sijmen A. REIJNEVELD**

**Ethnic differences in health and health behaviour**

Differences in health, lifestyles and use of health care between groups of varying ethnic origin can have important implications for preventive and curative care. For a proper targeting of this care, information is needed on the health status of separate ethnic groups and on the mechanisms which lead to a poorer health status for them, if any. Such a poorer health status may firstly be due to an adverse social and economic position of immigrant and ethnic minority groups. Other explanations are poor living conditions, including discrimination, cultural factors like a different perception of health, and biological factors, especially a poorer health status at the moment of migration and racial differences. Especially racial differences are often chosen as an explanation for ethnic health differences without a proper accounting for socioeconomic and cultural differences.

In this lecture, first the concept of ethnicity as well as it measurement will be discussed. A next topic will be the mechanisms that lead to ethnic differences in health, among which socioeconomic differences. Finally, I will provide some examples of studies on ethnic differences from western and central Europe, including the analysis of contributing factors.[189 words]

**Dr. Marc SUHRCKE**

**Economic analysis of the Social Determinants of Health**

There is growing interest in the use of economic arguments for investing in health, an approach that was eprhaps most prominently promoted by the 2001 report of the Commission on Macroeconomics and Health. The subsequent Commission on Social Determinants of Health (CSDH) has recently made a strong case for the importance of economic and social factors for health and health equity. The CSDH explicitly took a social justice perspective and has preferred to leave aside major economic consideration around its recommended interventions. This raises the question what, if any, is the economic argument for investing in the social determinants of health? In this lecture we start to approach this question by clarifying what the economic argument should consist of from a conceptual level. What are the relevant "costs" and "benefits" of social determinants interventions? We then apply the conceptual discussion to specific policy areas, most notably early child development. We review existing evidence and highlight the scarcity of the existing economic evidence base on the "value for money" of SDH interventions. We also touch upon the issue of inequalities and how distributional consequences may be taken into account in economic evaluations - another area that offers much scope for further research

**Assoc. Prof. Jitse P. VAN DIJK**

**Translating research into policy: how to cope with systematic difficulties?**

Universities or other research institutes produce epidemiological data on health-risk behaviour such as smoking or negligent driving, or produce forecasts on the likely future burden of various diseases or disabilities. Not every issue which public health experts consider to be a problem is also found to be a problem by the wider public. People need to be convinced that something should be done to change the particular situation before it is recognized as an issue on the wider agenda (Kingdon 1984, 119). In relation to the issue of change, Bachrach and Baratz (1962), who were interested in discovering why there was such an enormous degree of poverty in a society as prosperous as the USA, developed an analytical model which helped them to understand this situation (Bachrach and Baratz 1970, 54). They depicted the policymaking process as a kind of pipeline or tube containing four valves or barriers. All the valves in the model are operated by groups of people who are in favour of preserving the status quo and thus want to keep the valves closed, while other groups in favour of change want the valves to be opened and try to use their influence to achieve this. Kingdon (1984) also points out the necessity of stable coalitions. Coalitions are often not stable over time.

An issue will enter the policy agenda more readily if it originates within government rather than coming from outside (Cobb et al. 1976). In practice this means that public health experts should develop good relationships with the Ministry of Health as a vital element in achieving any intended change. Furthermore, there are two aspects of any issue that should be taken into consideration. The more complicated the manner in which an issue is formulated, the lower the chance that it will reach the agenda (Cobb & Elder 1983). This means that for scientists the most subtle scientific distinctions are not always the most useful tools when it comes to changing society. Secondly, the more an issue is perceived to be likely to change the distribution of values in society, the more difficult its life will be as a policy issue (Lowi 1963). Consequently, an issue should be presented as simply and as rigorously as possible in order to increase the chance of it being accepted.

Those who have more realistic expectations of policy are aware of the fact that after producing the data much still has to be done to influence the public health agenda, such as marketing the data and forming coalitions with partners who have the same aim. Only such an approach will lead to a translation of our very important epidemiological data into public health policy.

**Prof. Niko SPEYBROECK**

**Measuring and understanding SE inequality in health**

Over the past decades, health conditions have improved in different parts of the world, but inequities in health conditions still exist among countries and within countries. Policies aiming at reducing inequities need to be based on a sound assessment of the nature, magnitude and determinants of the problem.

This lecture provides a selection of available health indicators, how to use these with care, and how to investigate the determinants of inequities. This will indicate how information could help shape appropriate policy responses to reduce health inequities. Indeed, the decomposition results that will be illustrated in this course allow policy makers to move from tackling average health problems (the "level approach") to tackling inequities of health (the "gap approach).

The following sections will be dealt with:

(i) A selection of indicators which are available for measuring inequities of health;

(ii) The usefulness and dangers of such indicators in measuring and comparing health inequity patterns in health outcomes across and within countries;

(iii) An introduction to an advanced approach to analyzing the determinants of inequities of health, which may be used to persuade policy makers;

(iv) Data needs for conducting health inequities research;

**Prof. Sijmen A. REIJNEVELD**

**Area based analyses in health and deprivation**

***Socioeconomic (SE) differentials in health*** among human populations have been recognized Since long, both at the individual and at the area level. At the individual level, SE differentials have been reported with regard to mortality and morbidity in various countries. At the area level, differences between areas of varying SE deprivation have been found in ecological studies on mortality at the level of urban areas, and of larger, urban and rural regions, as well as in ecological studies on poor health and on lifestyles.

Two explanations have been proposed for the higher prevalence of poor health and lifestyles in deprived areas. Firstly, individual SE health differences may explain this because of the at average lower socioeconomic status (SES) of residents of deprived areas. Secondly, the social and physical context of these areas may have a detrimental effect on the health and lifestyles of their residents, in addition to individual SES. Practically, such a contextual effect provides reasons for community-based interventions, like improving the availability of healthy food or reducing the number of tobacco selling-points, in deprived areas instead of measures which (only) aim at individuals and their behaviour.

In ***data analyses***, the adverse health effects of area deprivation, over and above the effect due to individual SES, can only be assessed properly if the hierarchical nature of the effects is accounted for. Characteristics of areas and communities have a potential impact on all residents, whereas the individual characteristics of residents which were included only affect those individuals. This implies that the individual responses cluster by area, i.e. their variability due to area characteristics may be smaller than their variability due to individual characteristics.

In ***this lecture***, the background of socioeconomic differences in health and health behaviour by area will be discussed, as well as the best analytic approaches to study them.