

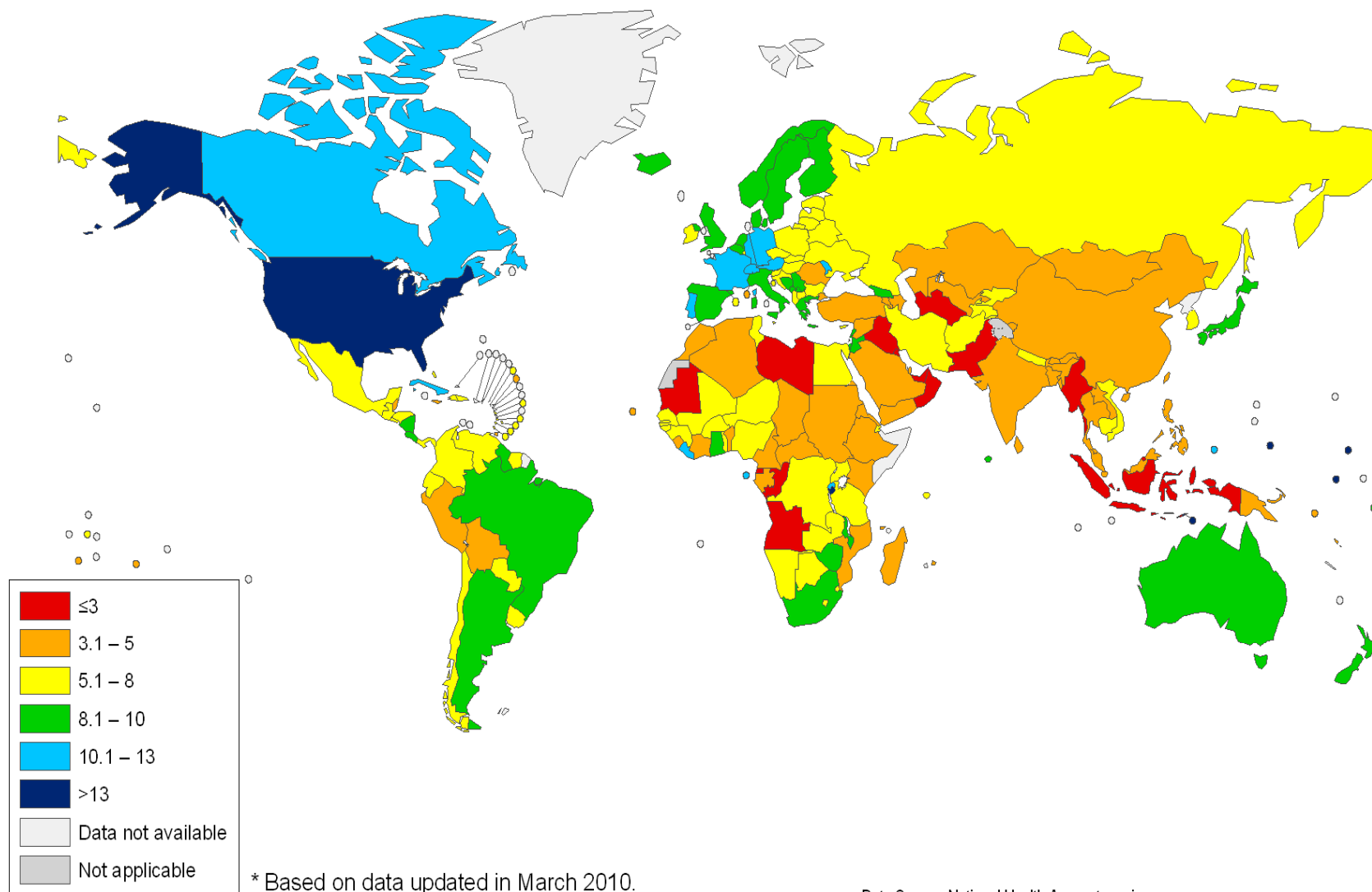


Wealth, Health and Illness

A need for a paradigm change

Gábor KAPÓCS

Health spending around the world, 2007 * (share of gross domestic product, %)



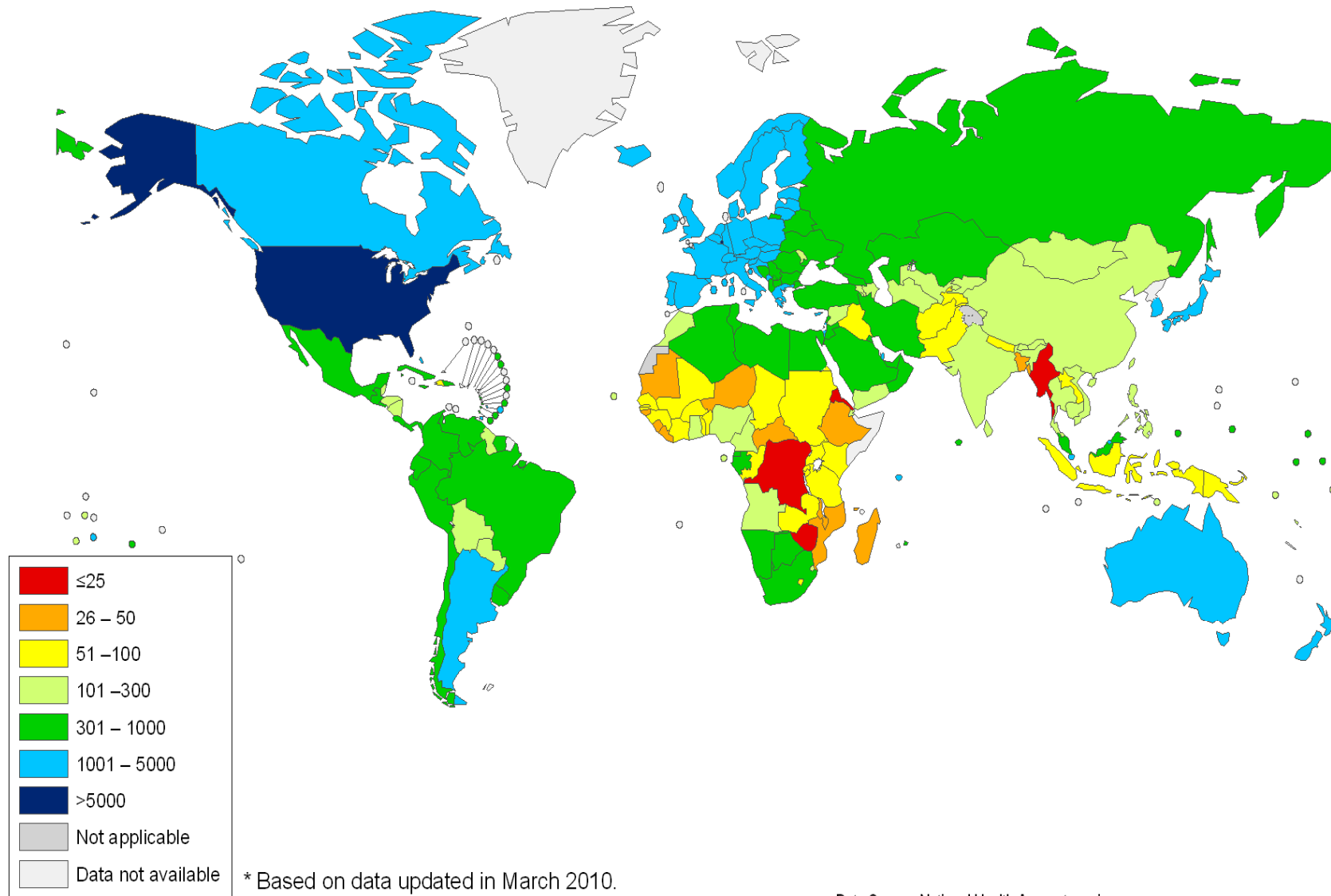
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Data Source: National Health Accounts series,
World Health Organization
Map Production: Public Health Information
and Geographic Information Systems (GIS)
World Health Organization



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Total expenditure on health per capita, 2007 * (in International \$)



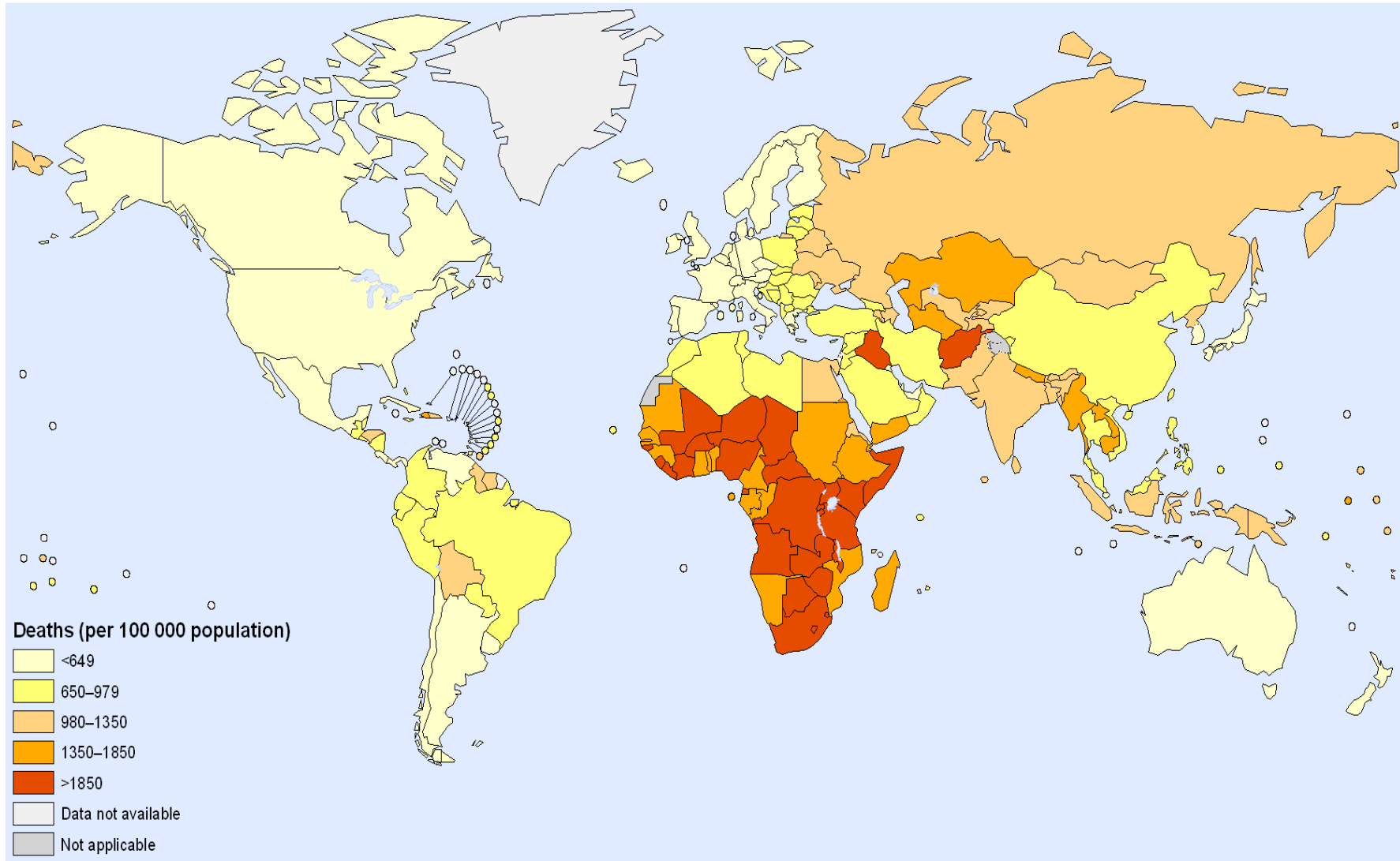
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Data Source: National Health Accounts series,
World Health Organization
Map Production: Public Health Information
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World Health Organization



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Age standardized death rates, 2004



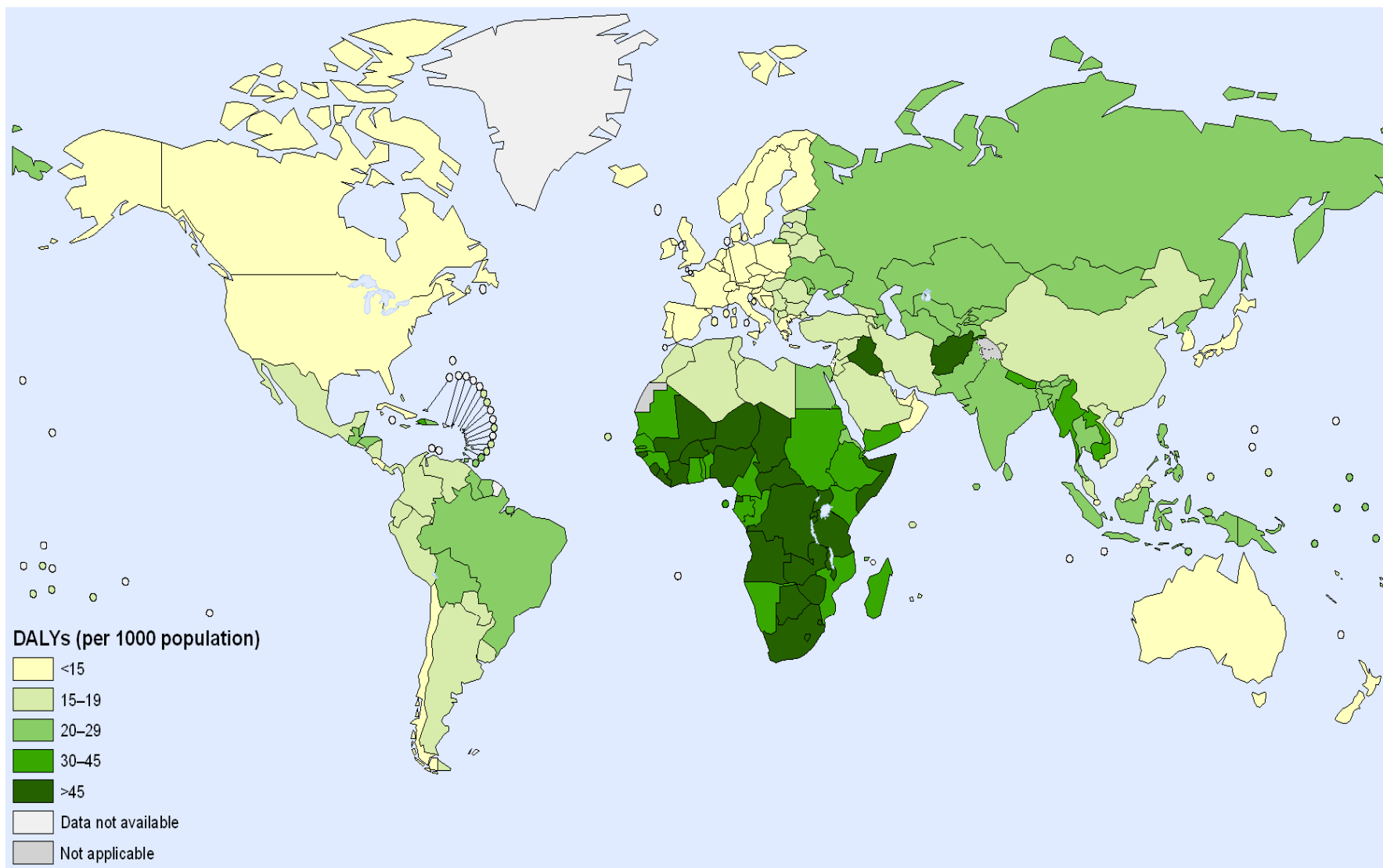
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Age standardized disability-adjusted life year (DALY) rates, 2004



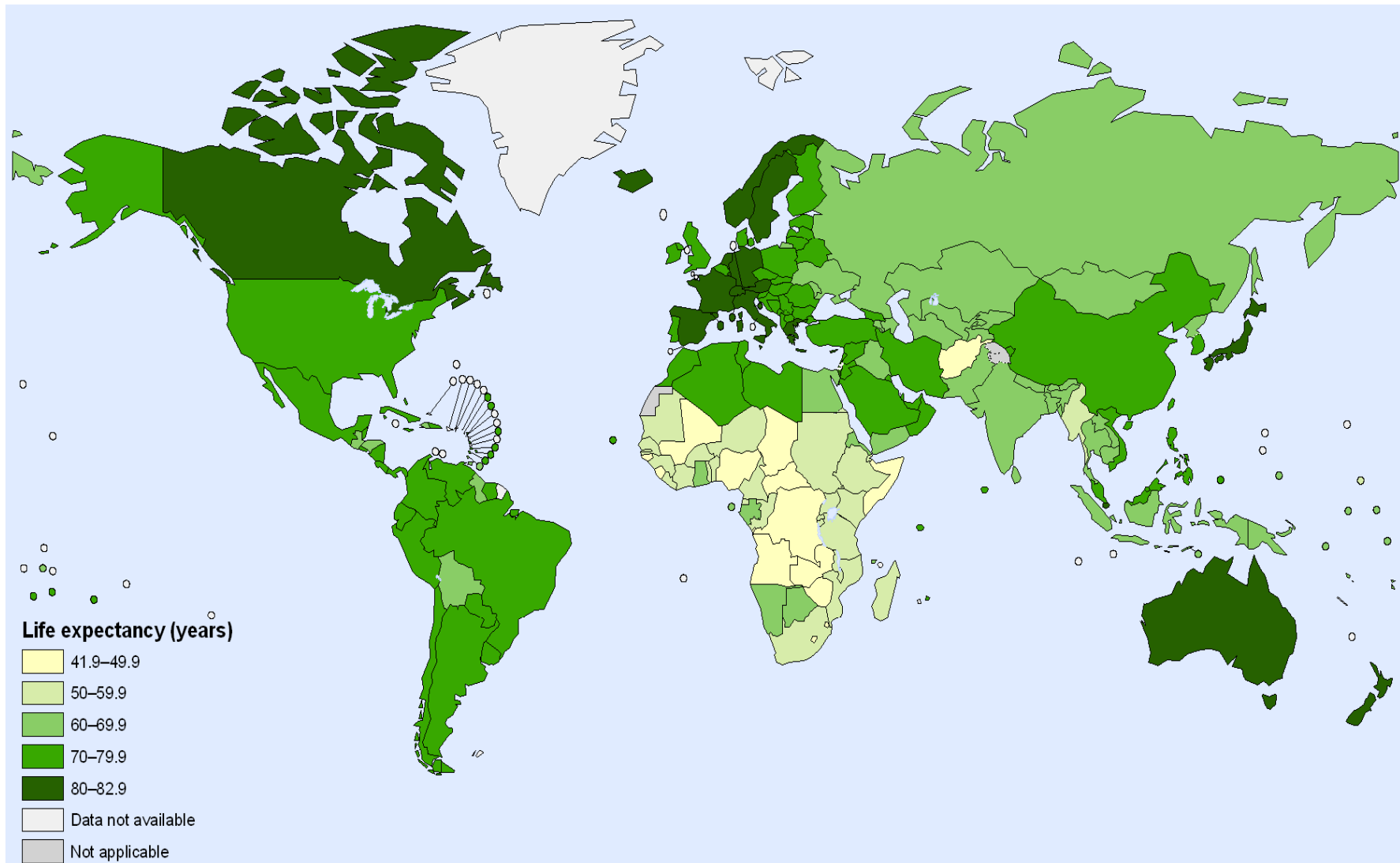
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Data Source: World Health Organization
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Life expectancy at birth, 2008



The boundaries and names shown and the designations used on this map do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

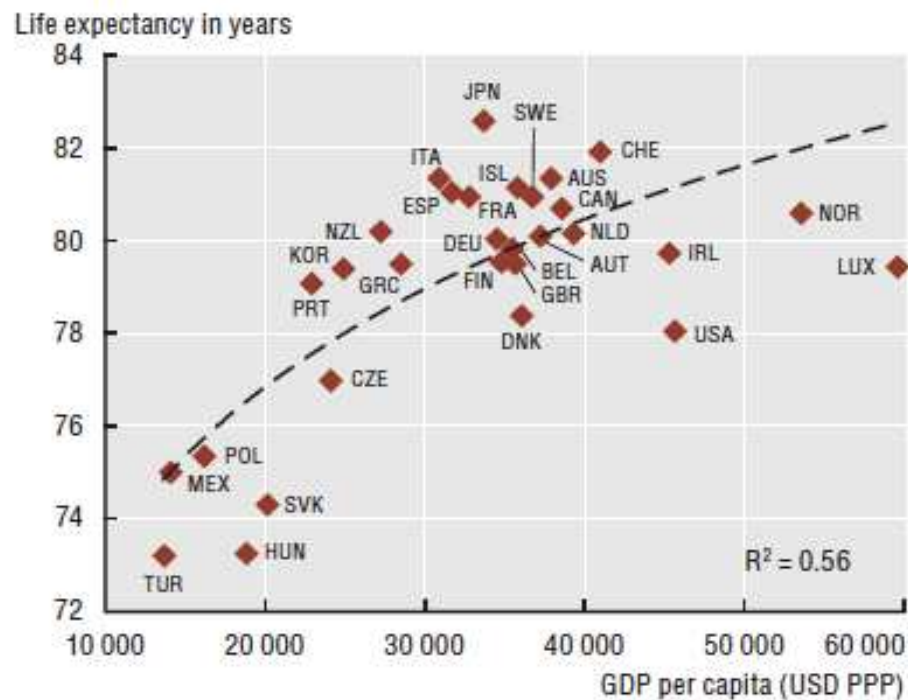
Data Source: World Health Organization
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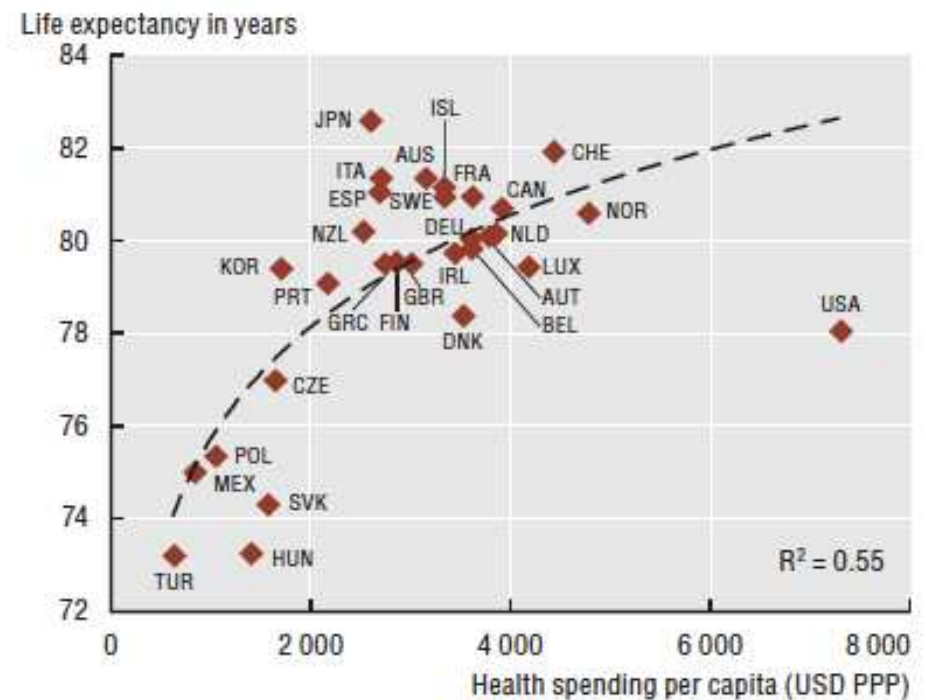
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Life Expectancy at Birth

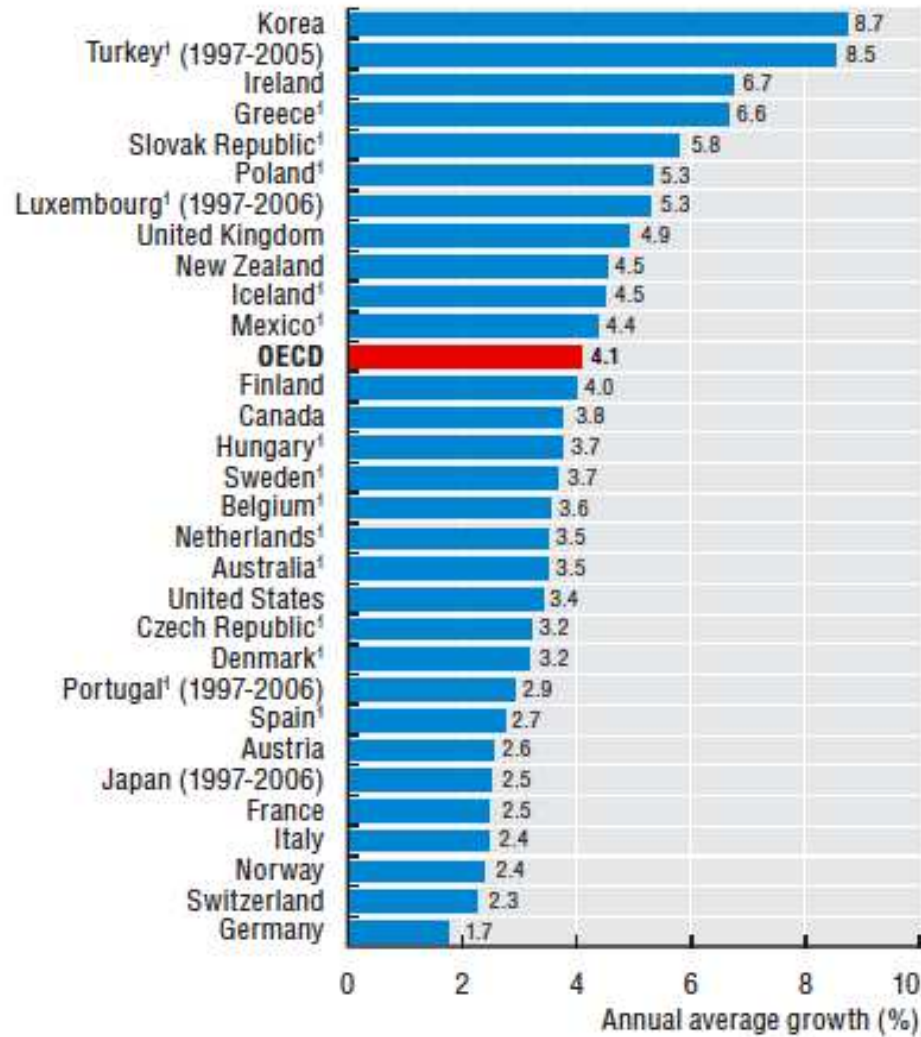
1.1.3 Life expectancy at birth and GDP per capita, 2007 (or latest year available)



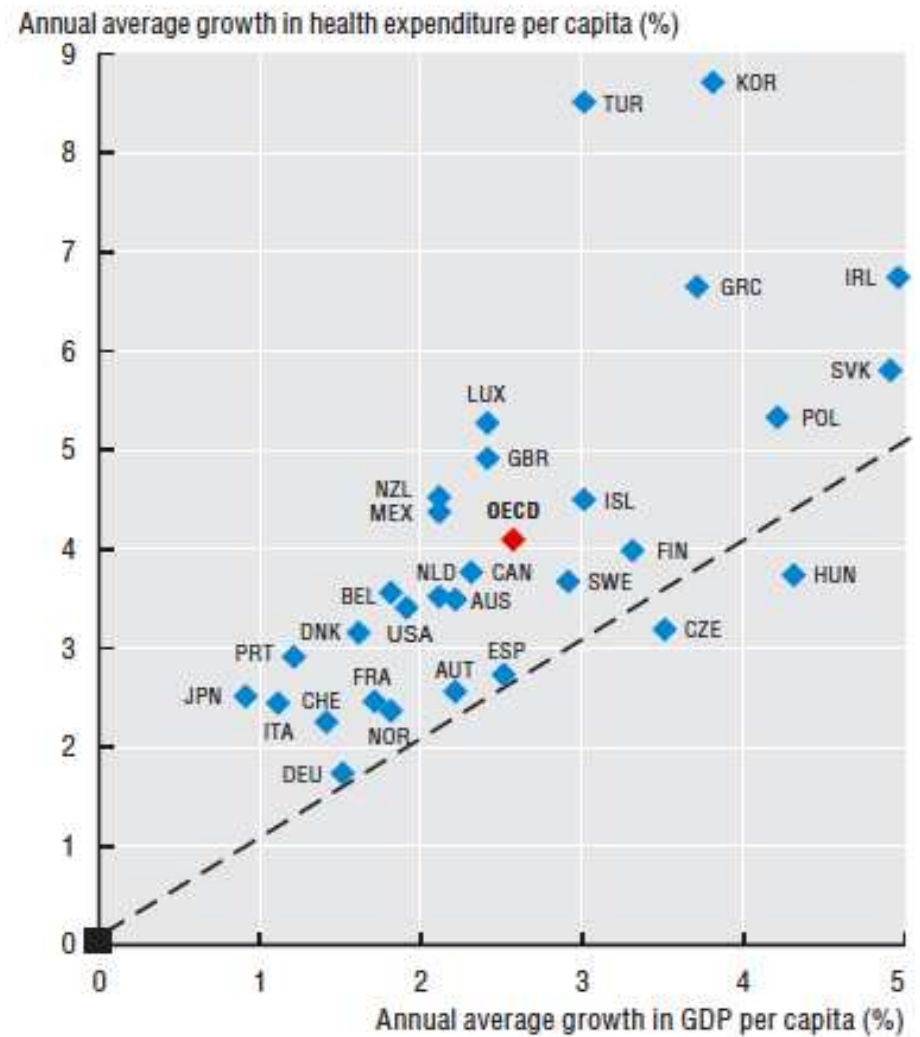
1.1.4 Life expectancy at birth and health spending per capita, 2007 (or latest year available)



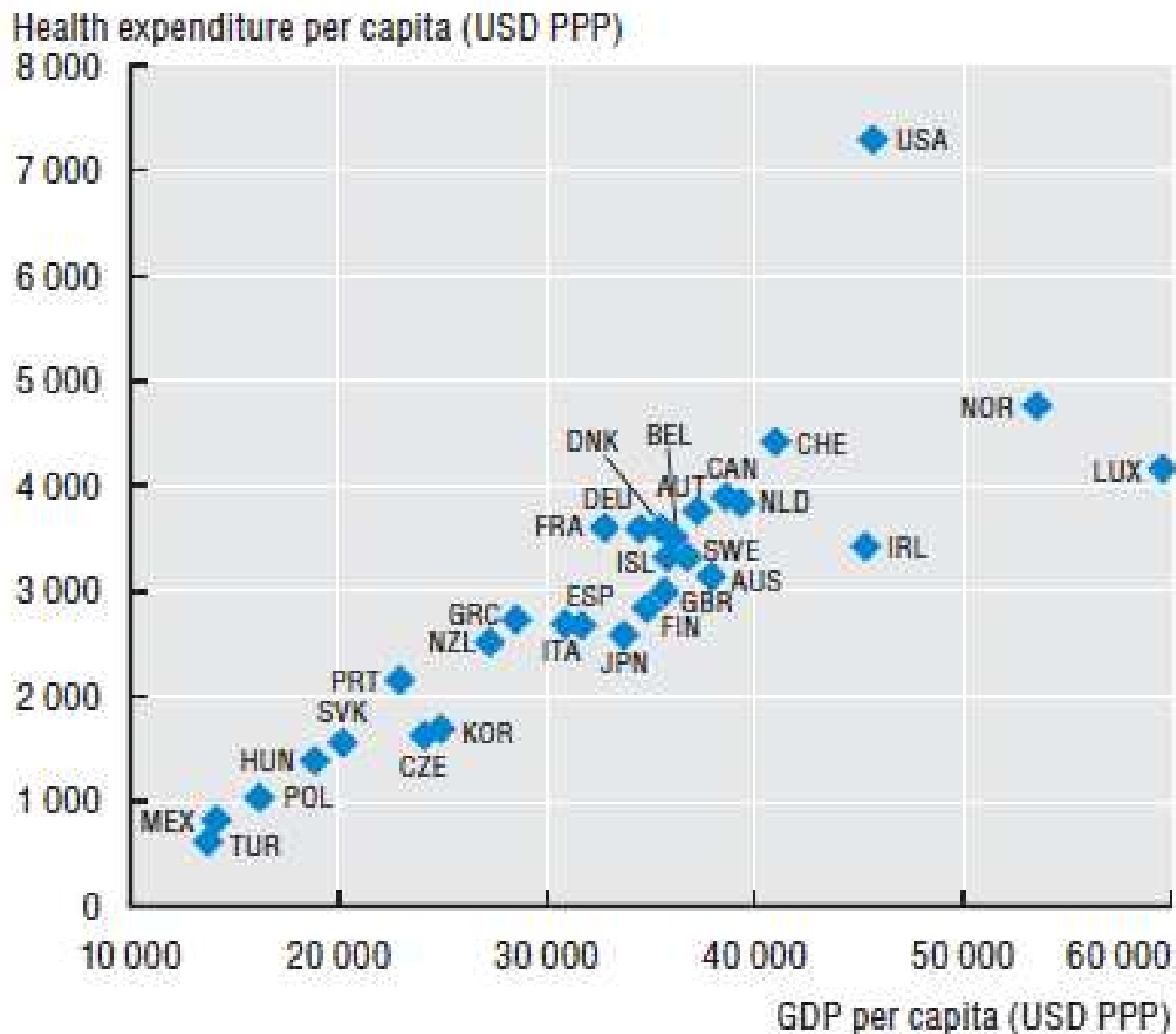
7.1.2 Annual average real growth in per capita health expenditure, 1997-2007



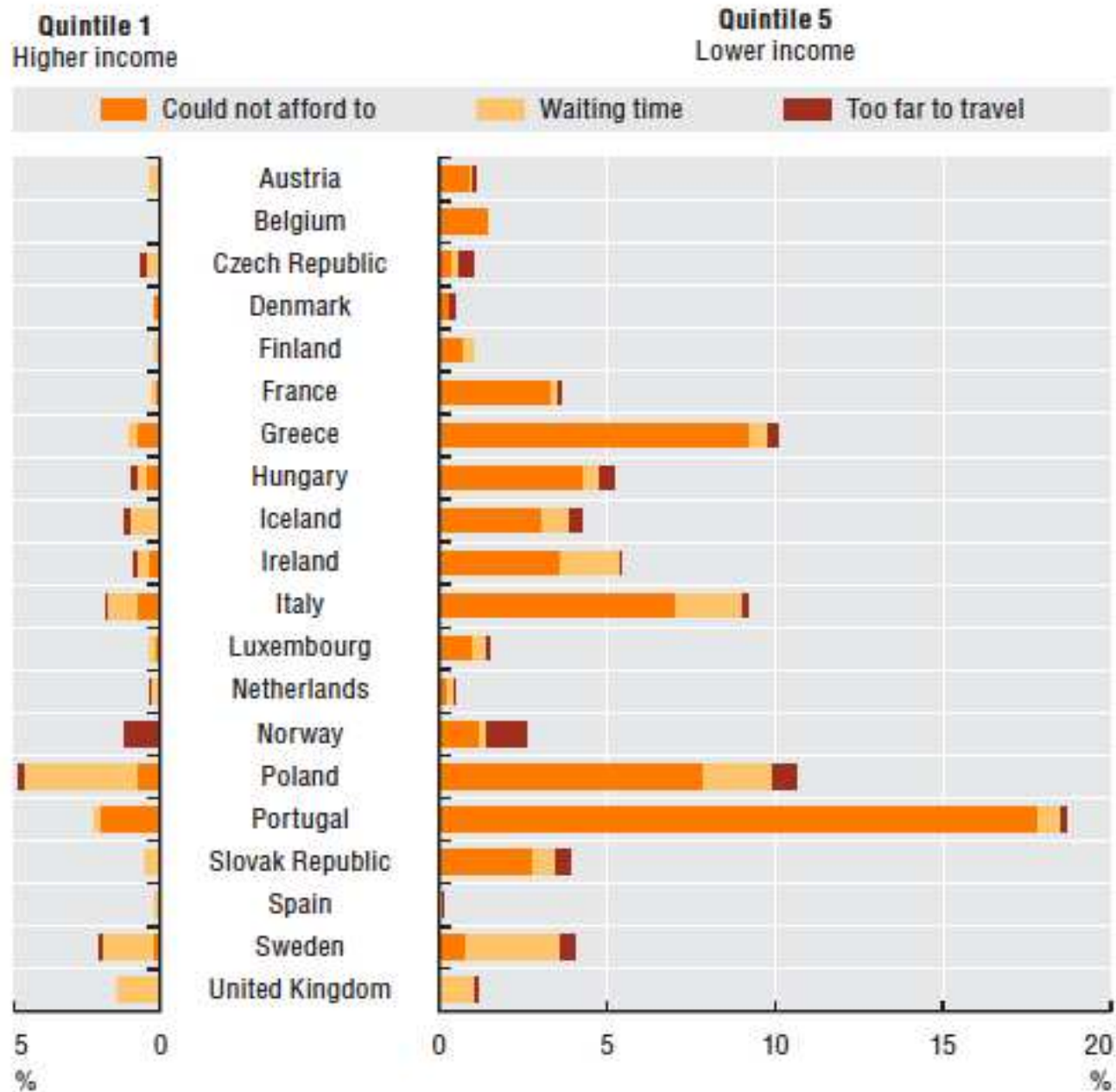
7.1.3 Annual average real growth in per capita health expenditure and GDP, 1997-2007



7.2.4 Total health expenditure per capita and GDP per capita, 2007



6.1.1 Unmet need for a medical examination, selected reasons by income quintile, European countries, 2007



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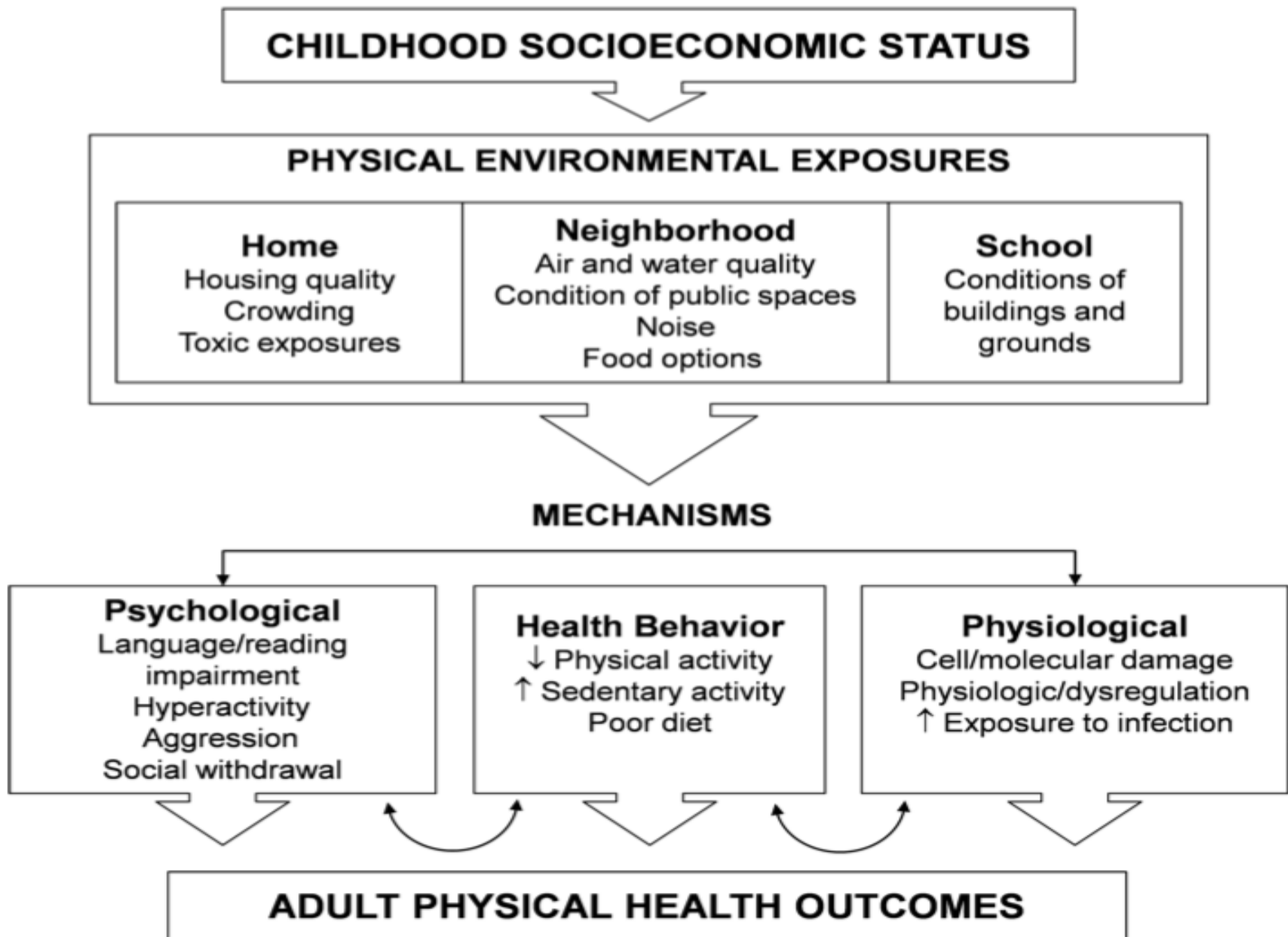
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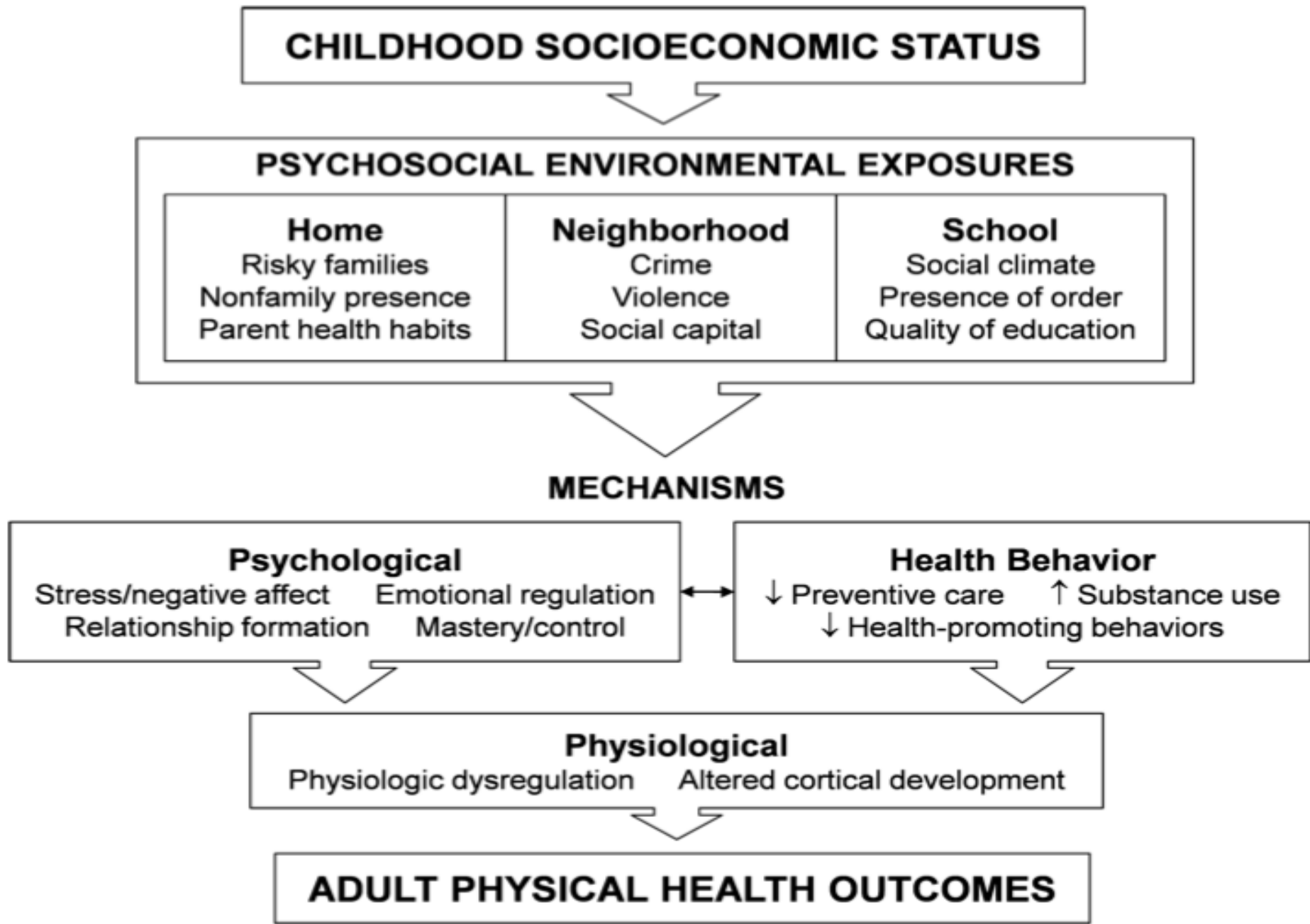


February 2010

**Volume 1186 The Biology of Disadvantage: Socioeconomic Status and Health
Pages 1–275**



Cohen et al.: Childhood socioeconomic status and adult health



Cohen et al. Childhood socioeconomic status and adult health

Conclusions

- **Exposures during childhood are powerful predictors of**
 - **adult cardiovascular morbidity,**
 - **cardiovascular mortality,**
 - **all-cause mortality, and**
 - **mortality due to a range of specific causes.**Ann.

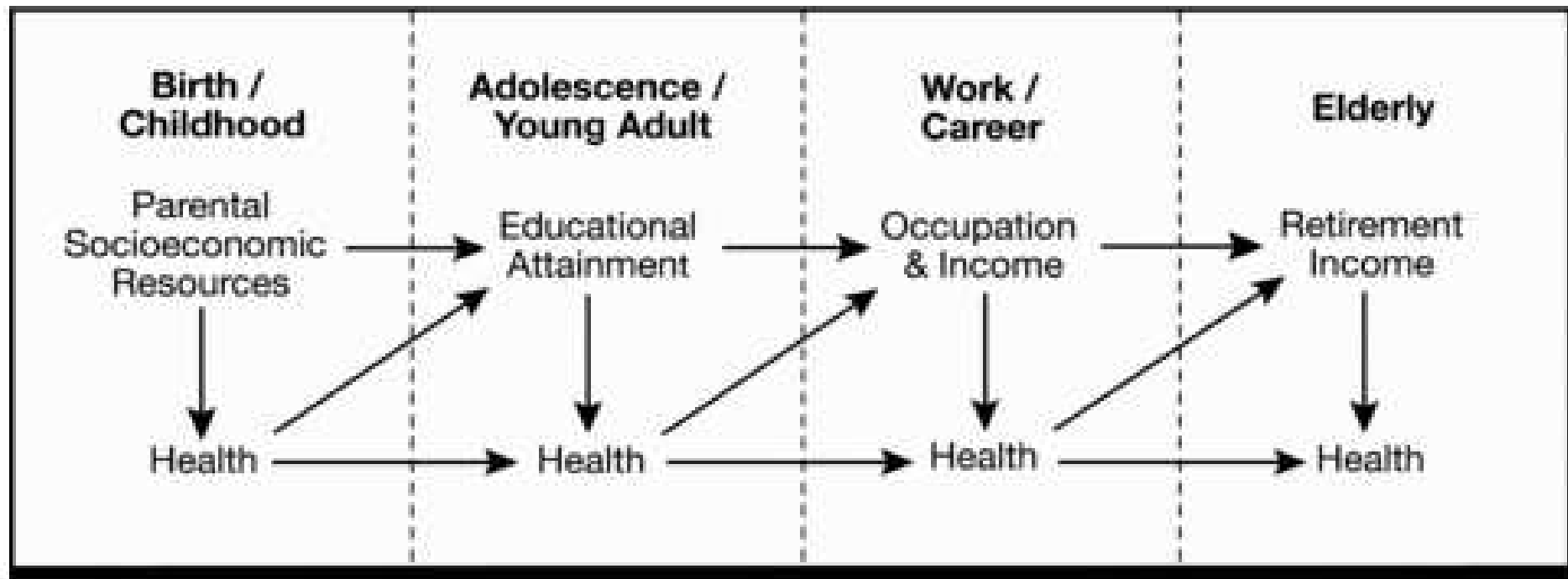


Figure 2. The dynamic relationship between SES and Health.

Health disparities across the lifespan: Meaning, methods, and mechanisms

Nancy E. Adler¹, Judith Stewart²

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Issue



Annals of the New York Academy of Sciences

Volume 1186, The Biology of Disadvantage: Socioeconomic Status and Health **pages 5–23**, February 2010

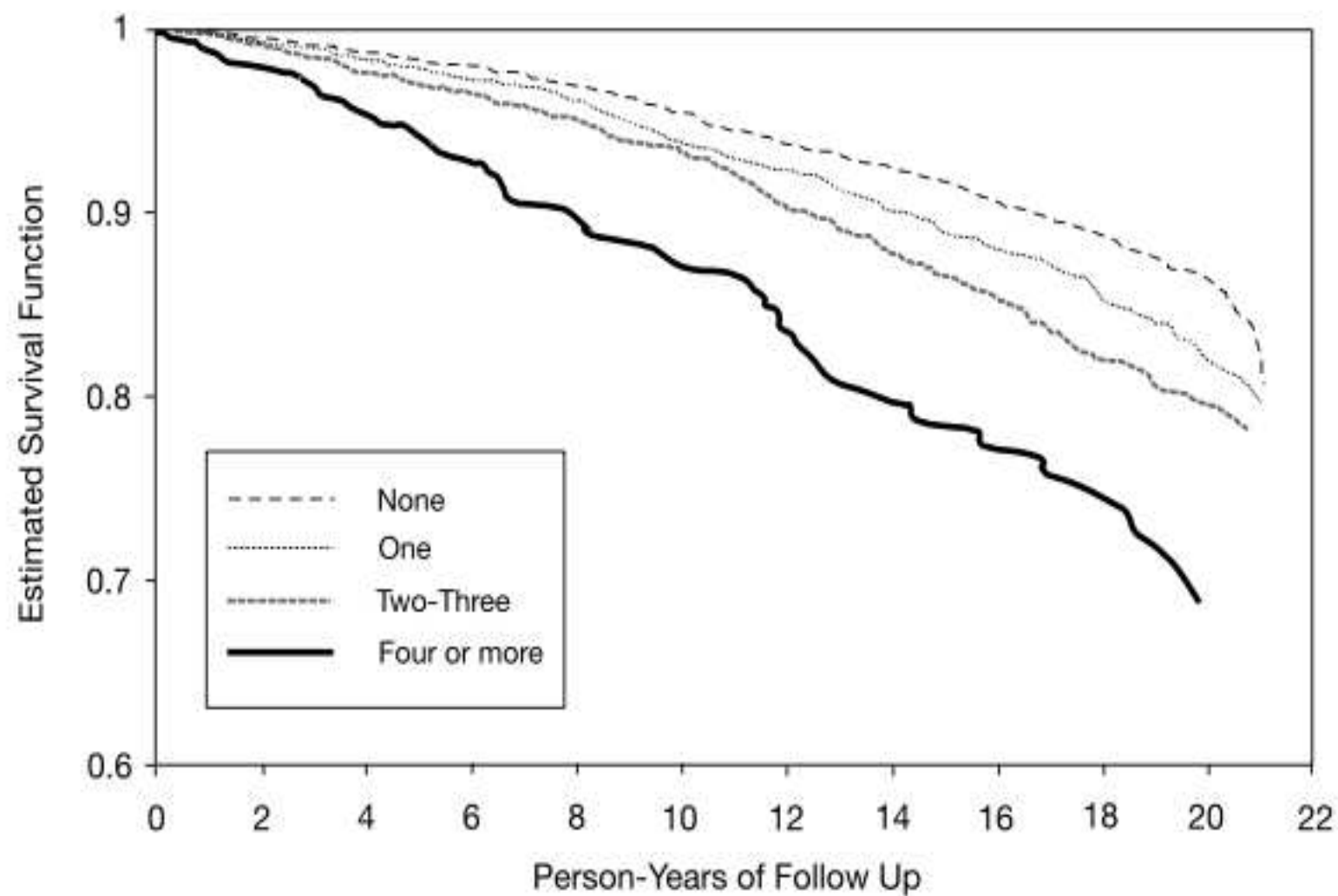


Figure 4. Number of psychosocial risk factors and risk of incident coronary heart disease. Note: Ref. 43. Copyright 2007 by Lippincott Williams & Wilkins. Reprinted with permission.

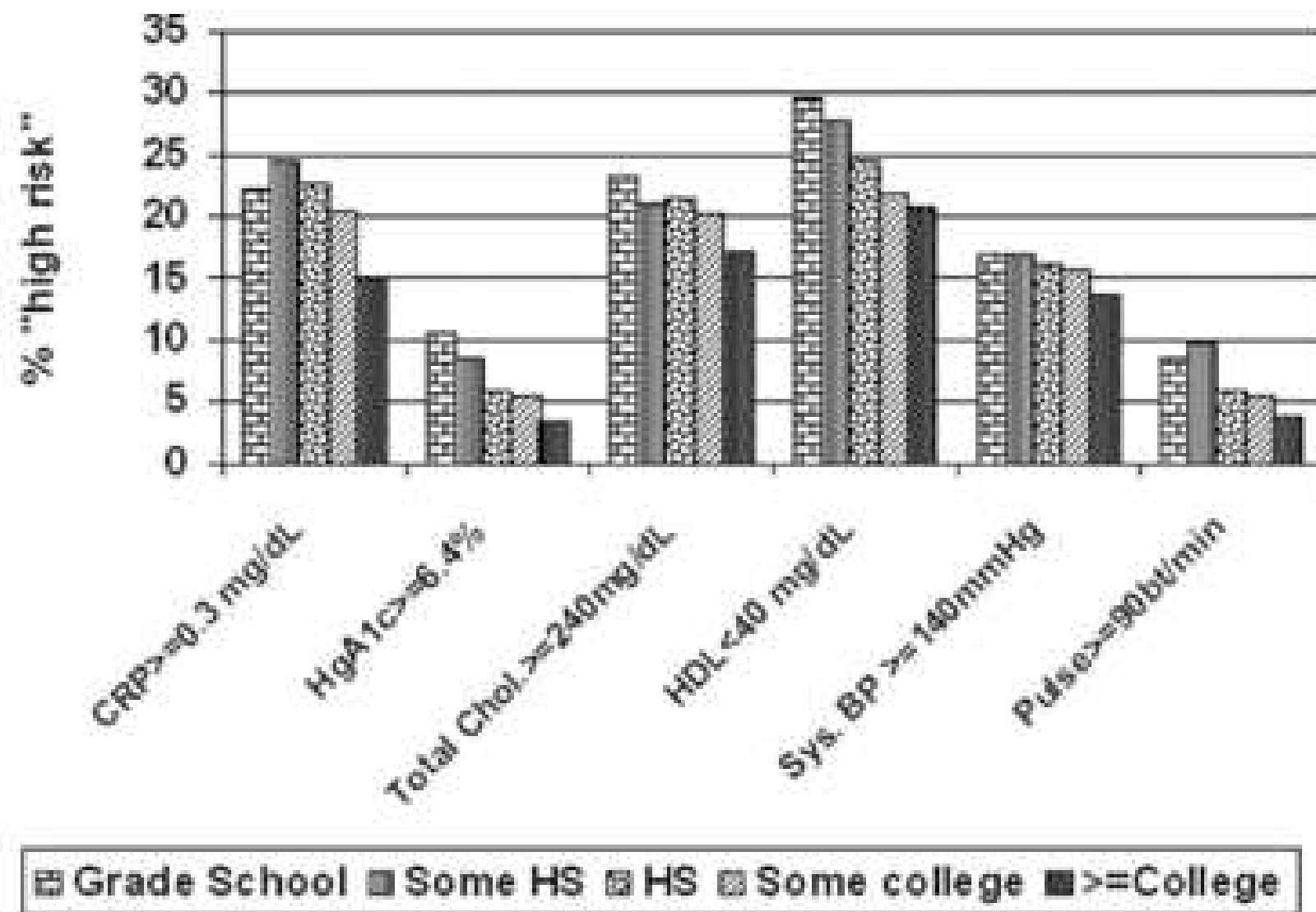


Figure 2. Education gradients in "percent with high risk values" for components of allostatic load.

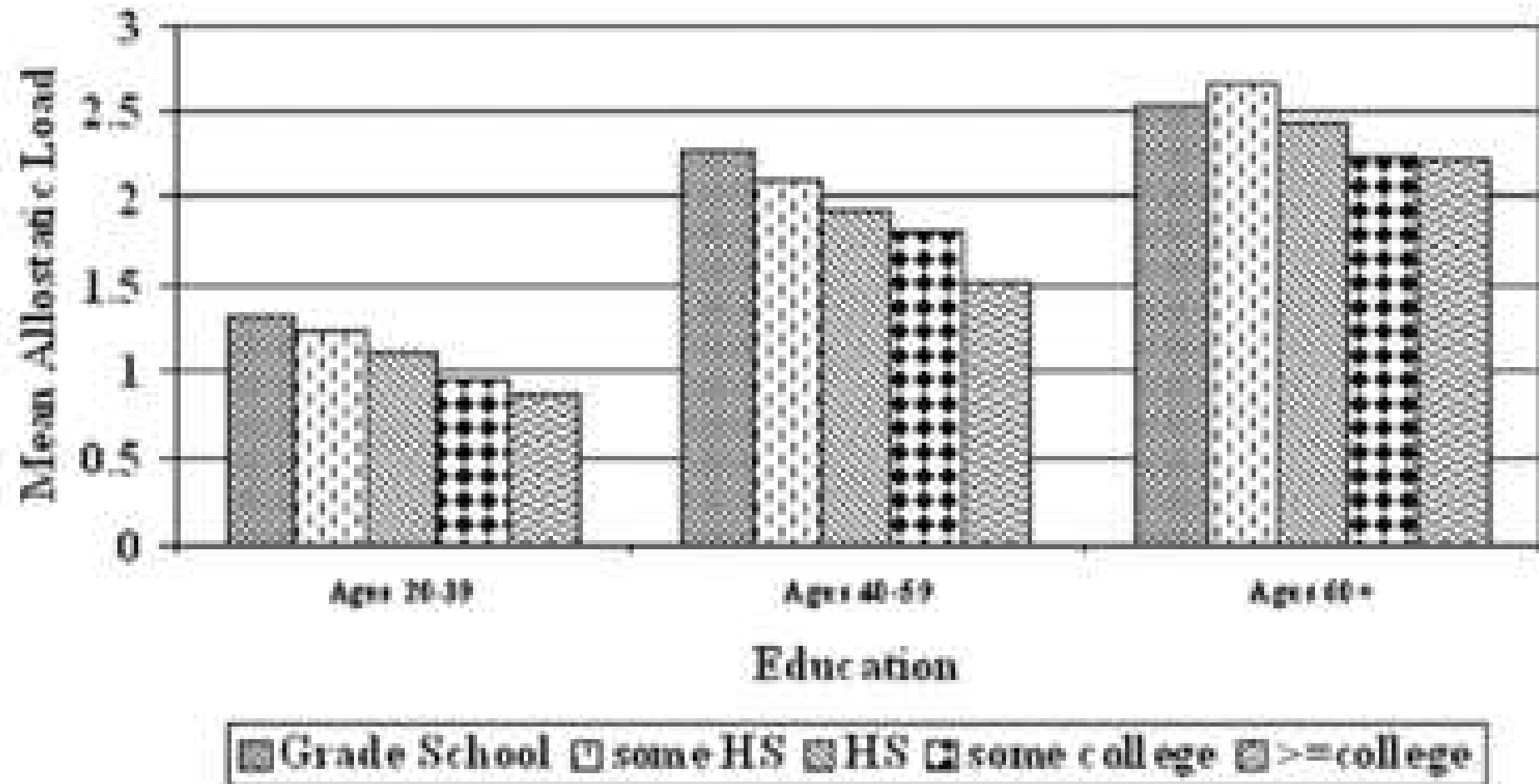


Figure 3. Total allostatic load by education. SES and total allostatic load among adults—NHANES III (1988–1994).

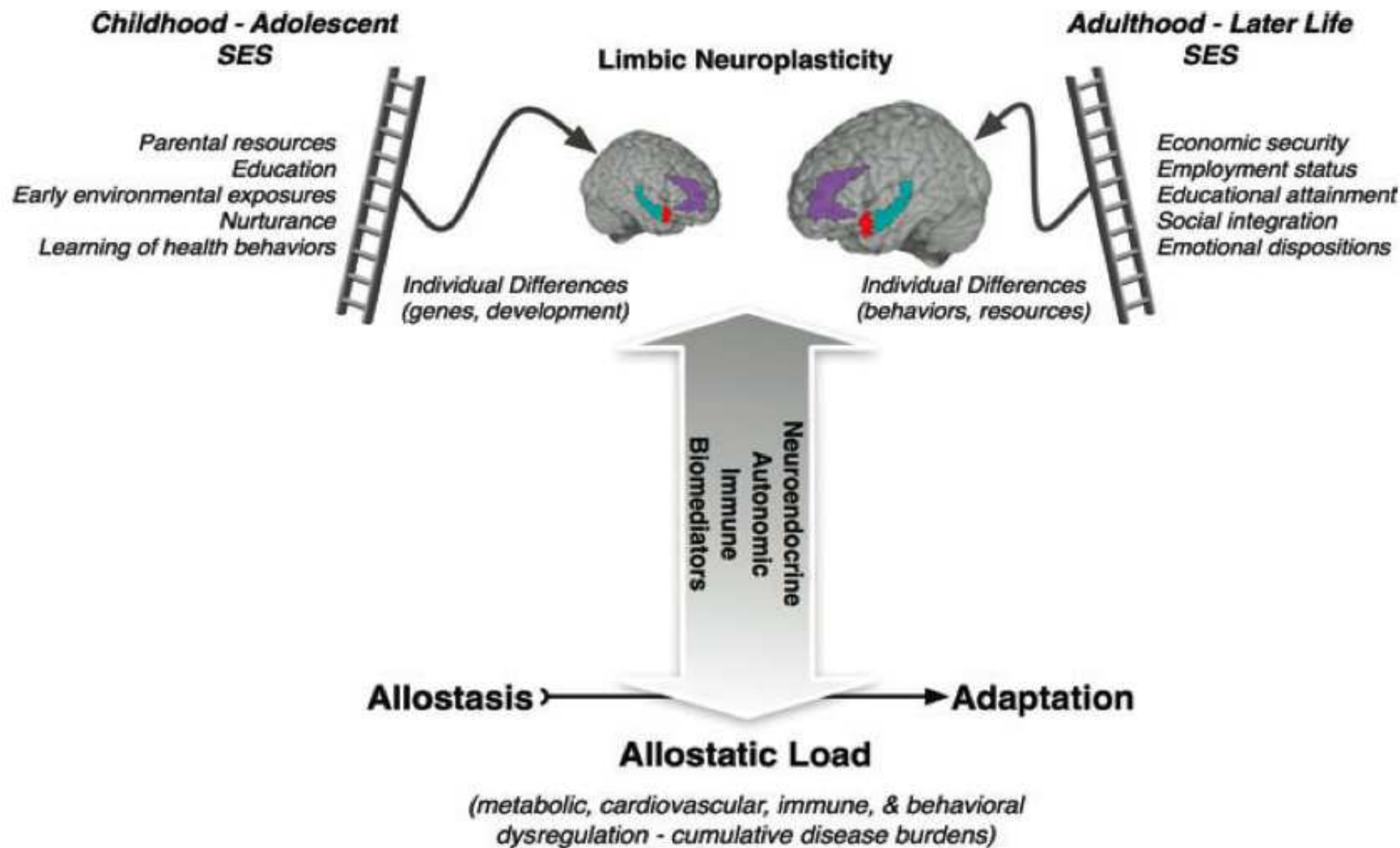


Figure 2. Neurobiological pathways of SES and allostatic load. A heuristic schematic illustrating the potential neurobiological pathways by which psychosocial factors related to SES may impact allostatic control systems underpinning allostatic load and disease risk. In childhood and adolescence, psychosocial factors related to SES and reviewed elsewhere in this volume (e.g., parental resources and education) are likely to interact with genetic and dispositional individual differences to affect the neuroplasticity of limbic brain areas that regulate allostatic control systems. These

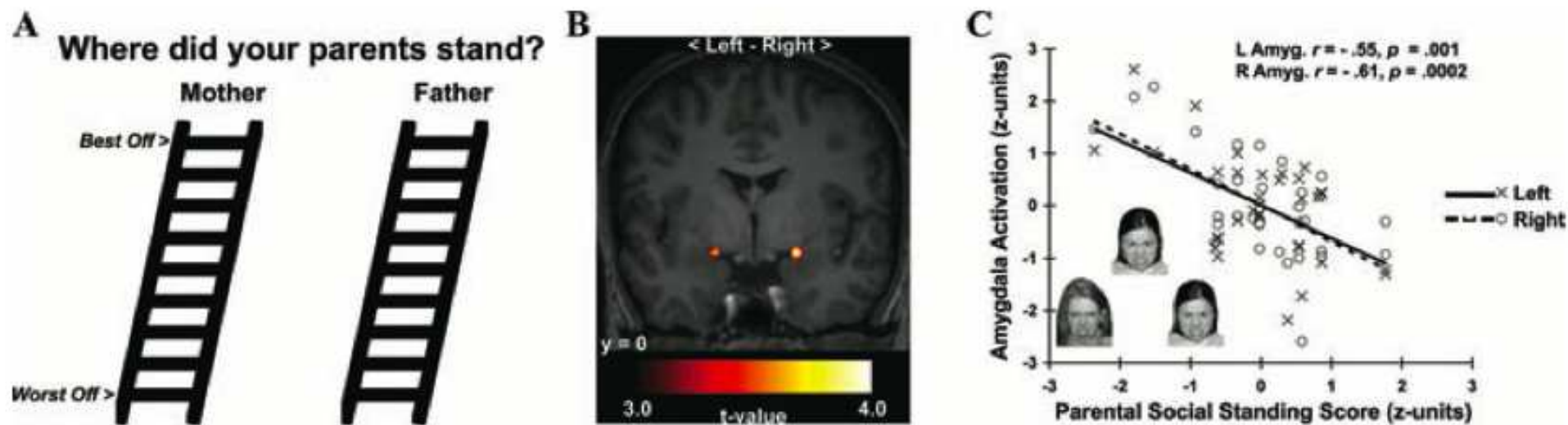


Figure 3. Lower perceived parental social standing predicted greater amygdala reactivity to angry faces in a functional neuroimaging study of young adults. (A) Social ladders used to assess perceived parental social standing. (B) Statistical parametric maps projected onto an anatomical template. The maps profile amygdala areas where lower perceived parental social standing predicted greater reactivity to angry faces. (C) Plots depicting standardized perceived parental social standing scores (x -axis) and mean-centered, standardized reactivity values derived from left (L, *open circles, dashed line*) and right (R, *closed circles, solid line*) amygdala areas in B. Inset in C illustrates exemplar trial of angry faces used to elicit amygdala reactivity. From Gianaros *et al.* (2008), reprinted with permission.

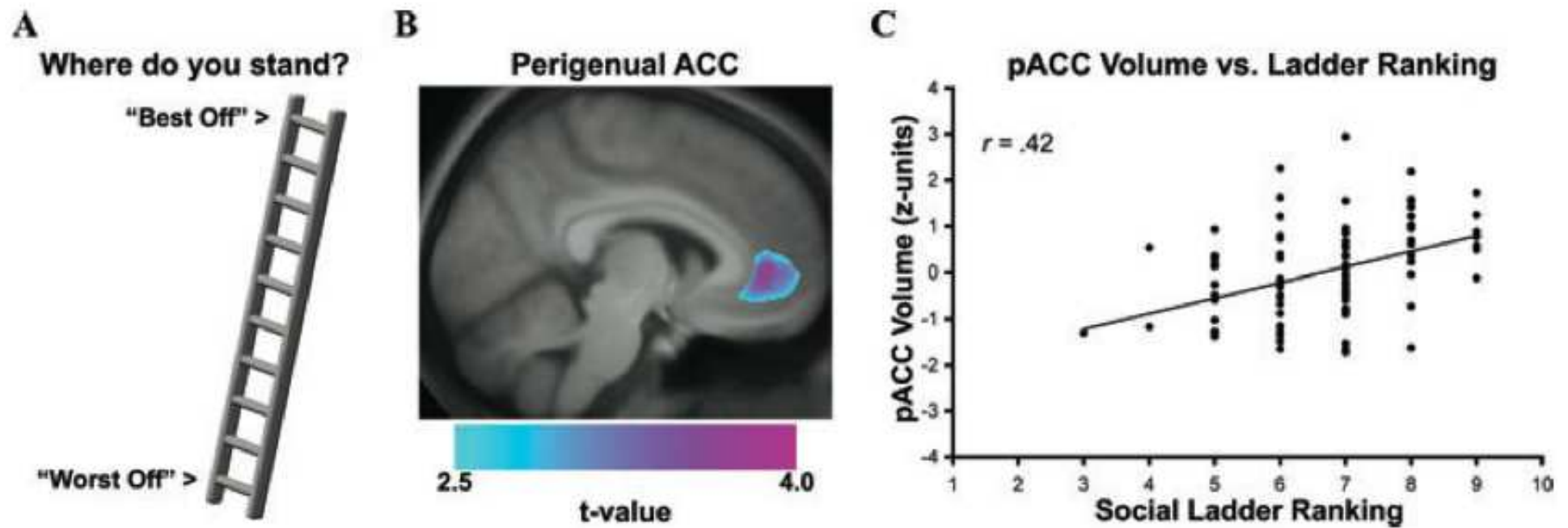
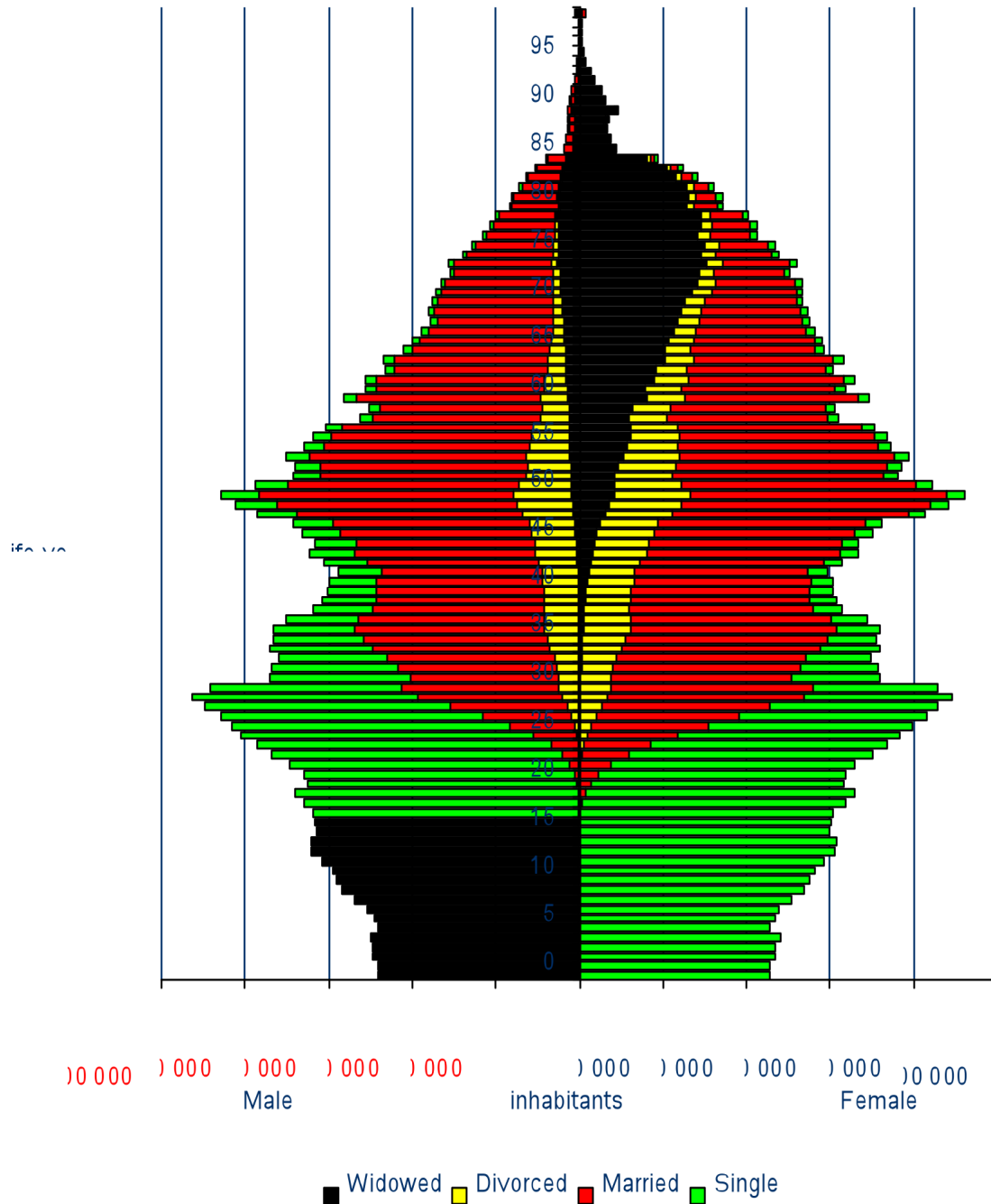


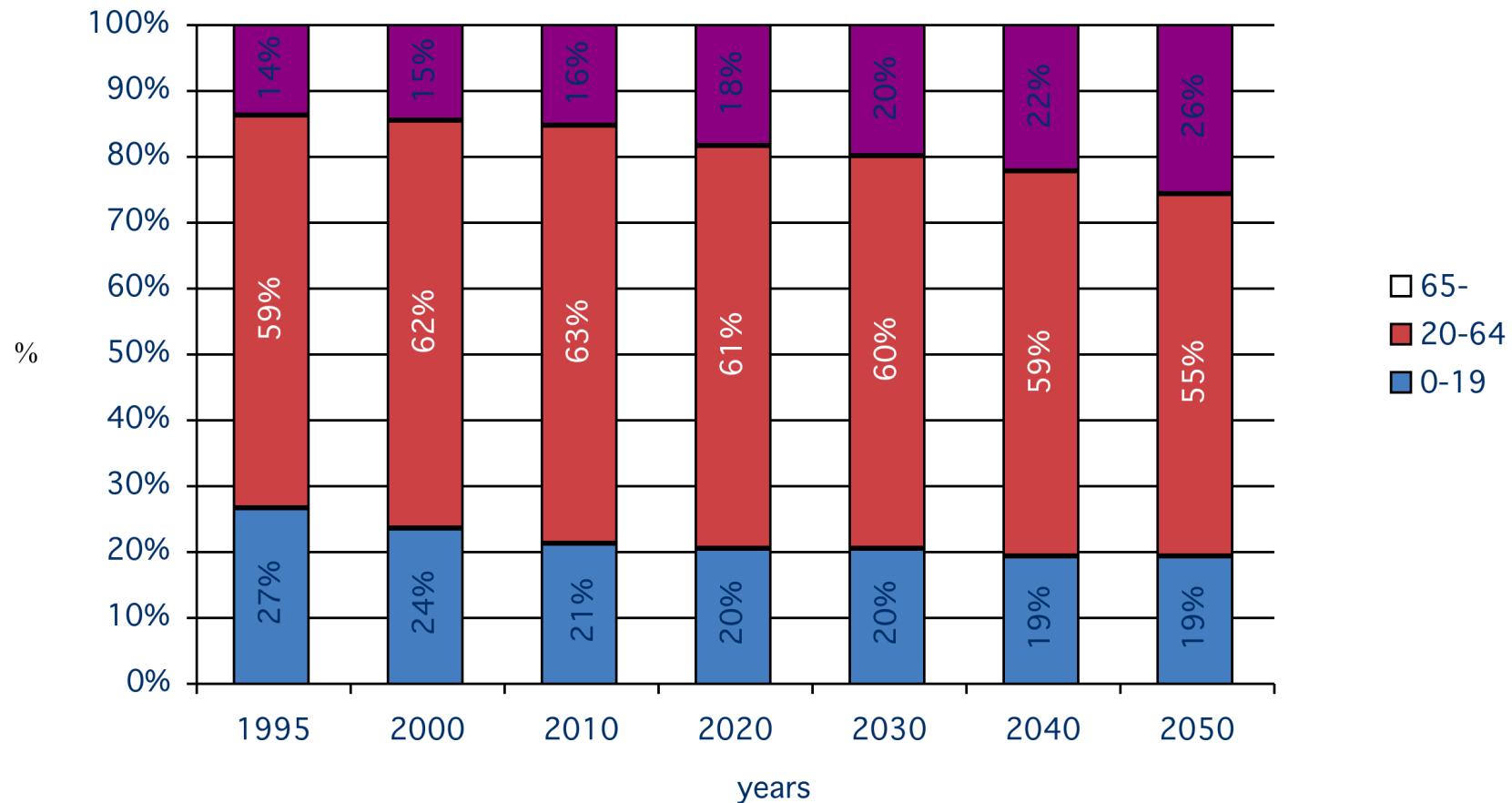
Figure 4. Lower subjective social status, as reflected by a lower self-reported ranking on a “social ladder”, was associated with reduced gray matter volume in the perigenual area of the anterior cingulate cortex (pACC). (A) Illustration of 10-point social ladder scale used to assess subjective social status. (B) Overlaid on an anatomical template is a statistical parametric map of color-scaled t -values, which illustrate the pACC area where lower subjective social status was associated with reduced gray matter volume across individuals. (C) Plotted along the y -axis is the standardized (z-score) gray matter volume values for pACC area profiled in B. Plotted along the x -axis are social ladder rankings from the scale illustrated in A (1 = “Worst Off,” 10 = “Best Off”). * $P < 0.001$. From Gianaros *et al.* (2007), reprinted with permission.

Population by sex, age and marital status in Hungary, 1 January 2005



Source of data: Hungarian
Central Statistical Office

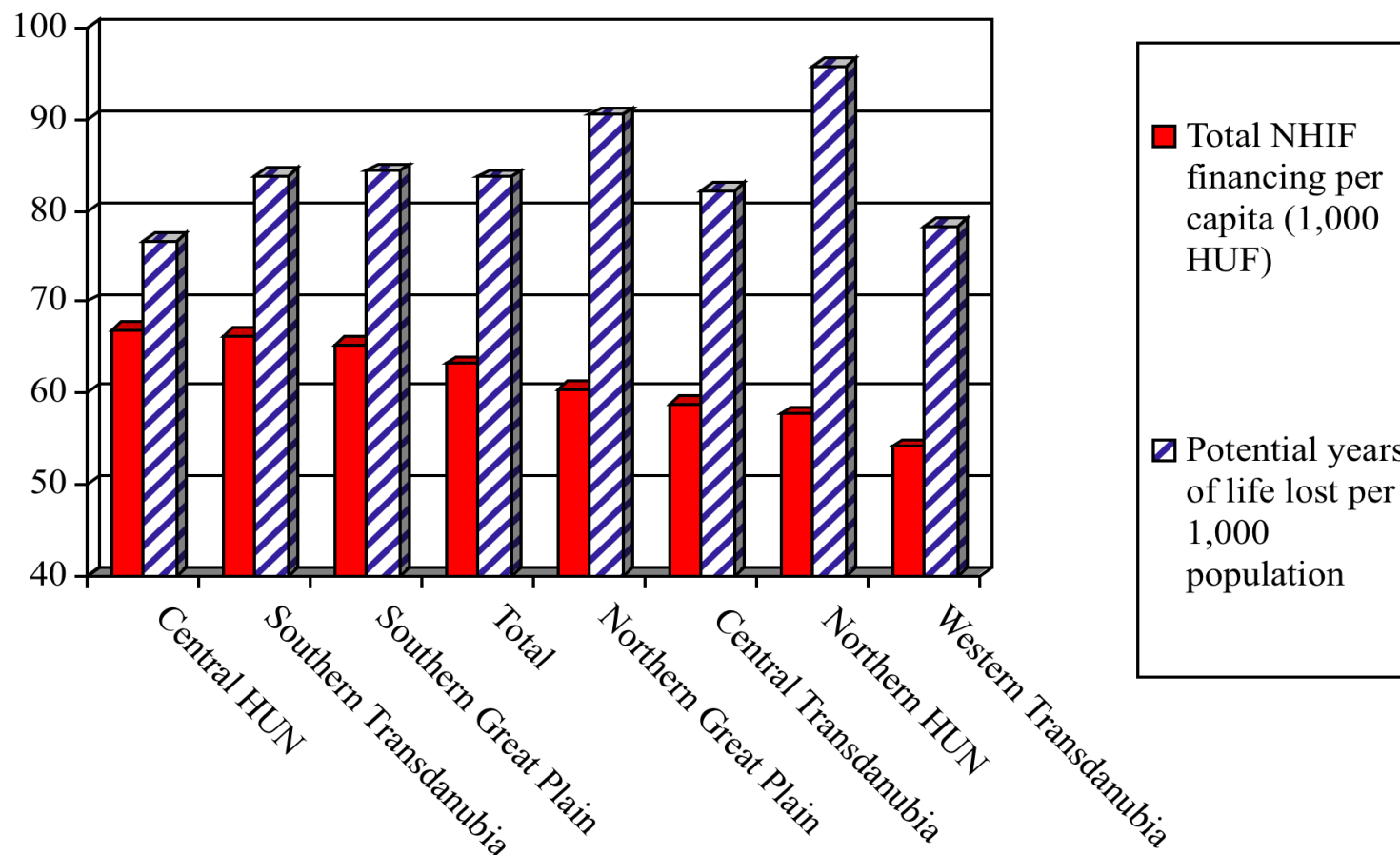
Projection of population by age group in Hungary *1995-2050



Source of data: Population policy-studies: Habcsek László -Tóth Pál Péter:

The role of international migration in the preservation of population number in Hungary, 1999-2050.

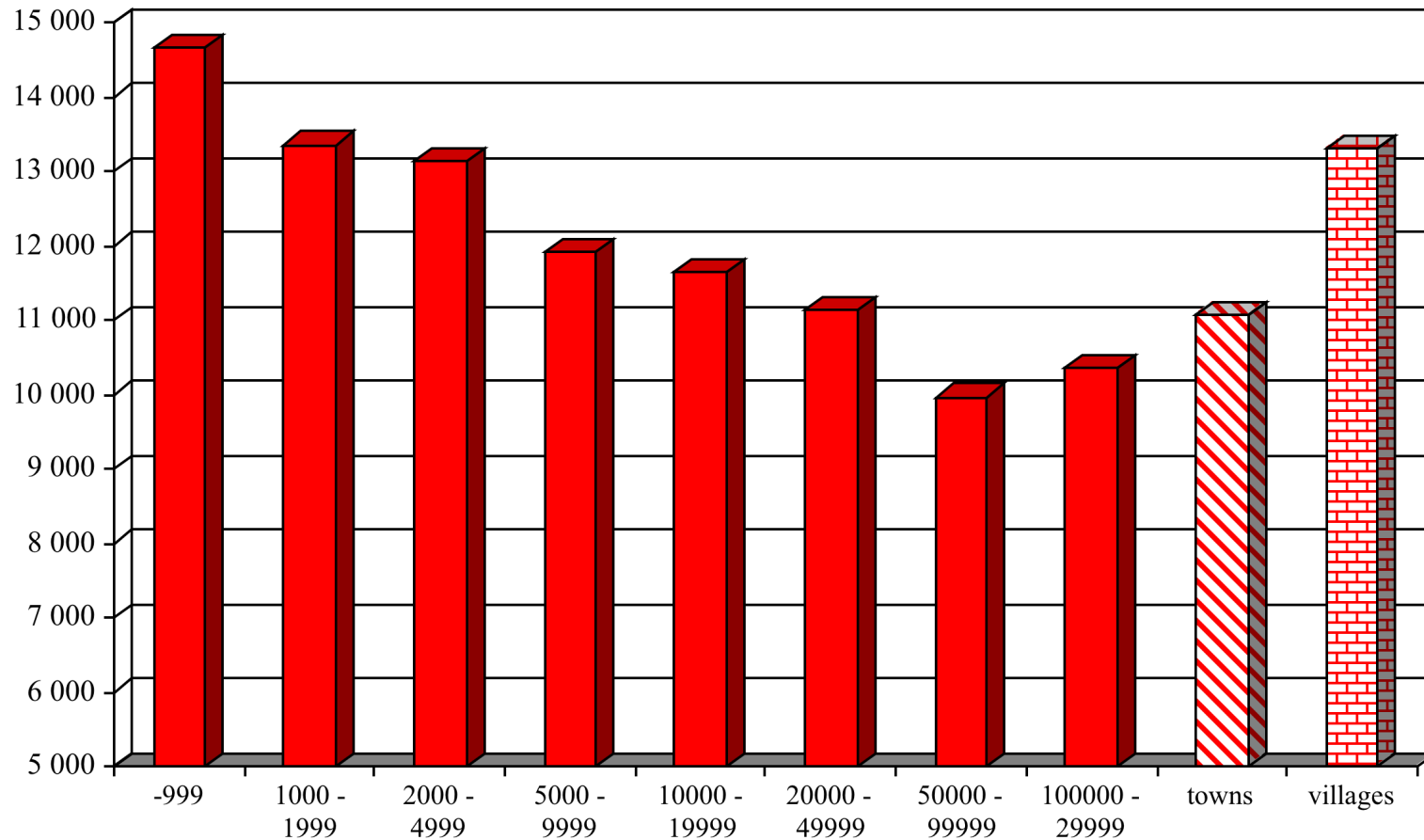
REGIONAL DISPARITIES



Costs of inpatient care distributed according to patients' domicile

Source: NHIF, CSP Demographic Yearbook

Great differences in lost life years in relation to the size of place of residence

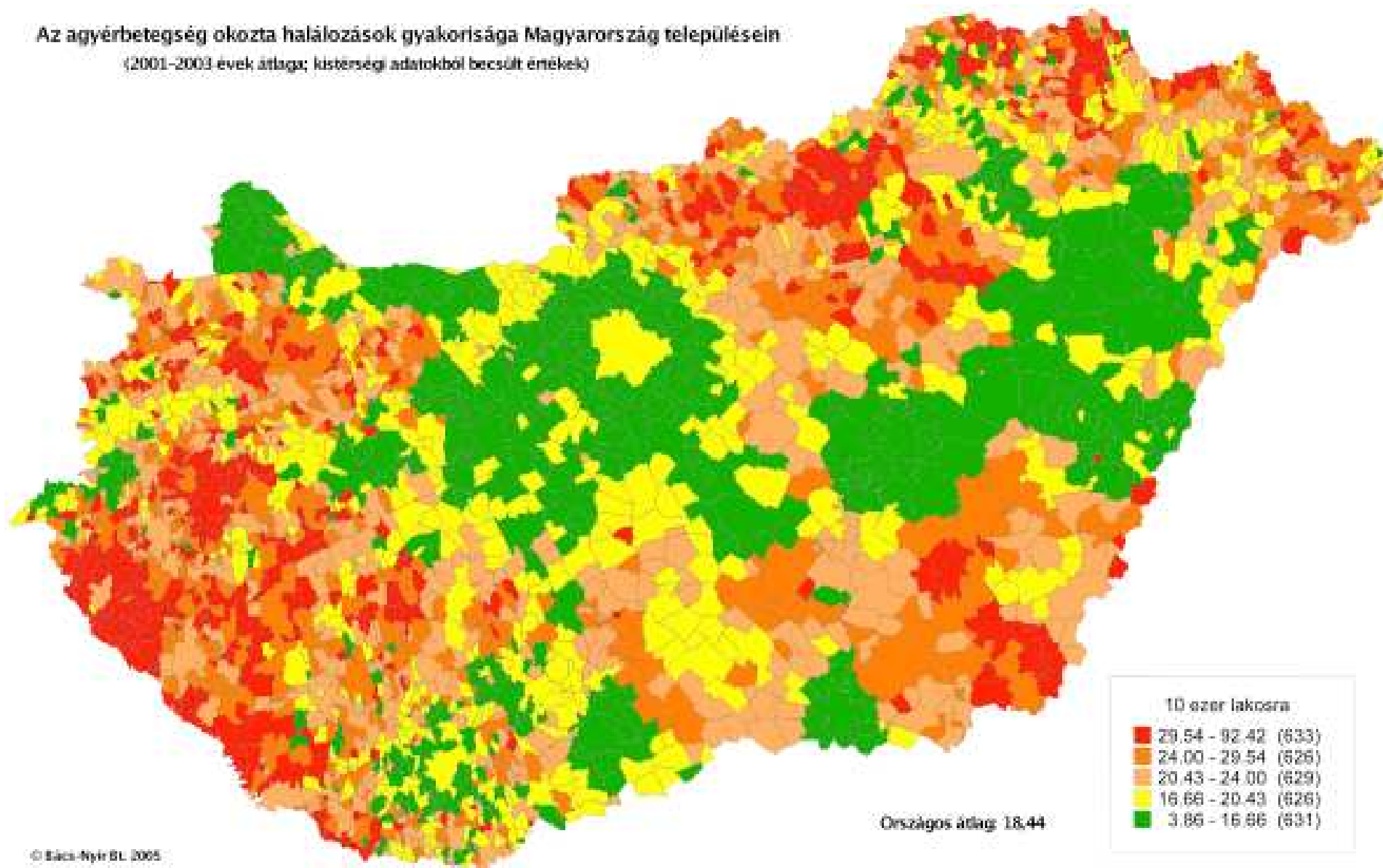


Based on raw mortality

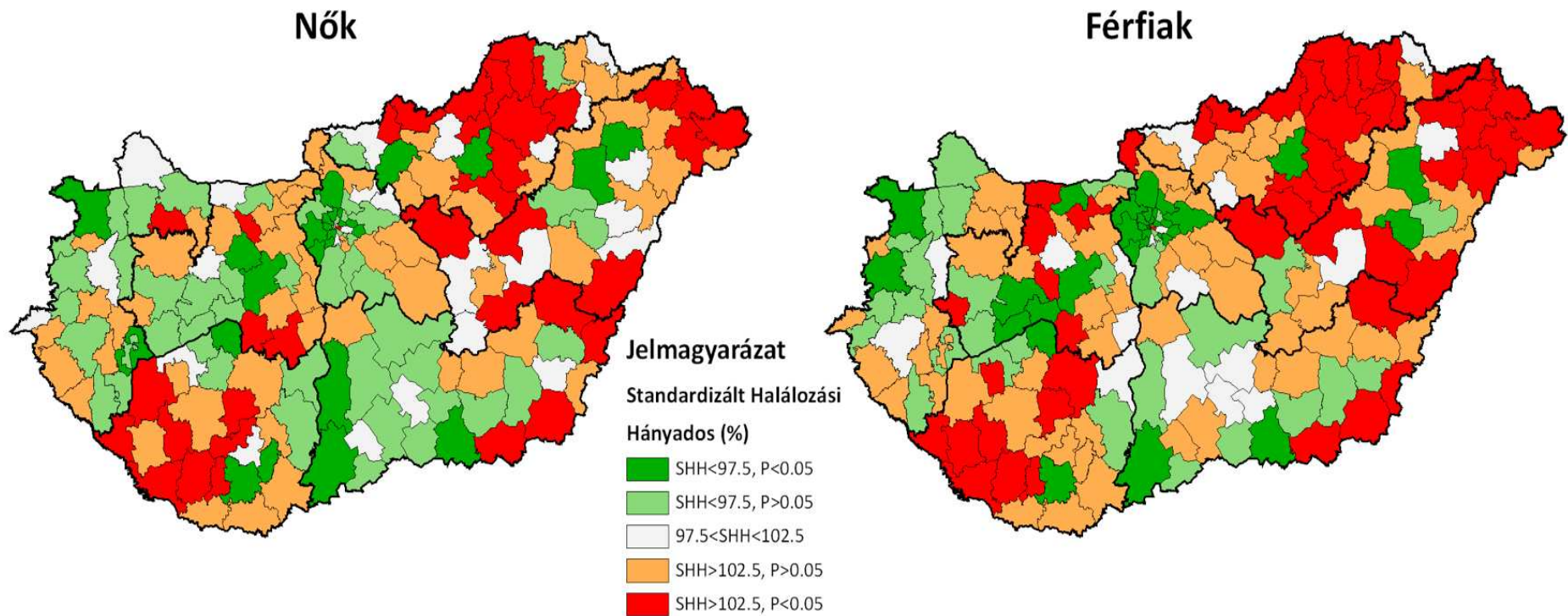
Source: CSO Demographic Yearbook, CD Attachment

Great differences in the frequency of cerebrovascular mortality

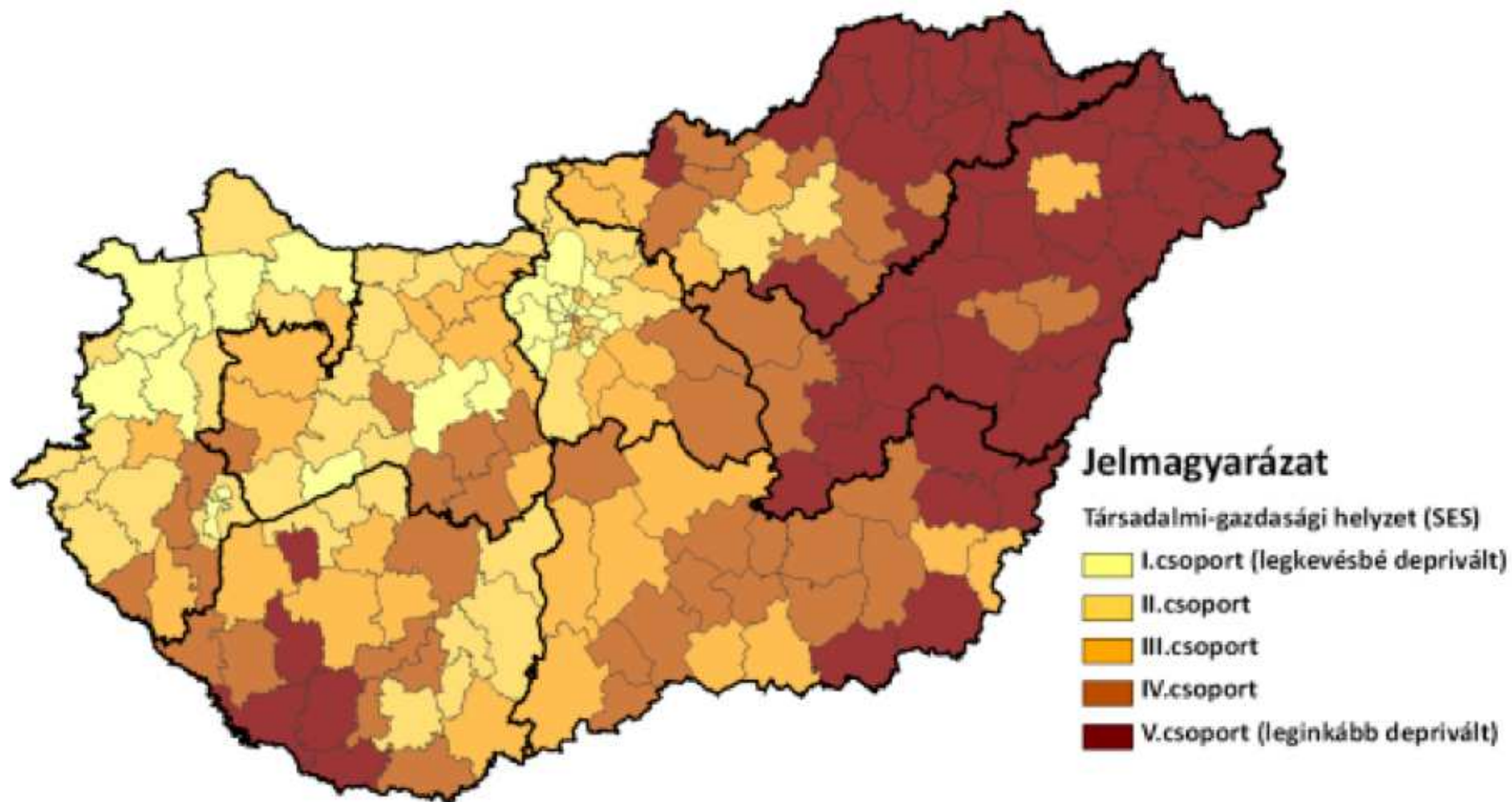
Az agyérbetegség okozta halálozások gyakorisága Magyarországi településein
(2001-2003 évek átlaga; kistérségi adatokból becsült értékek)



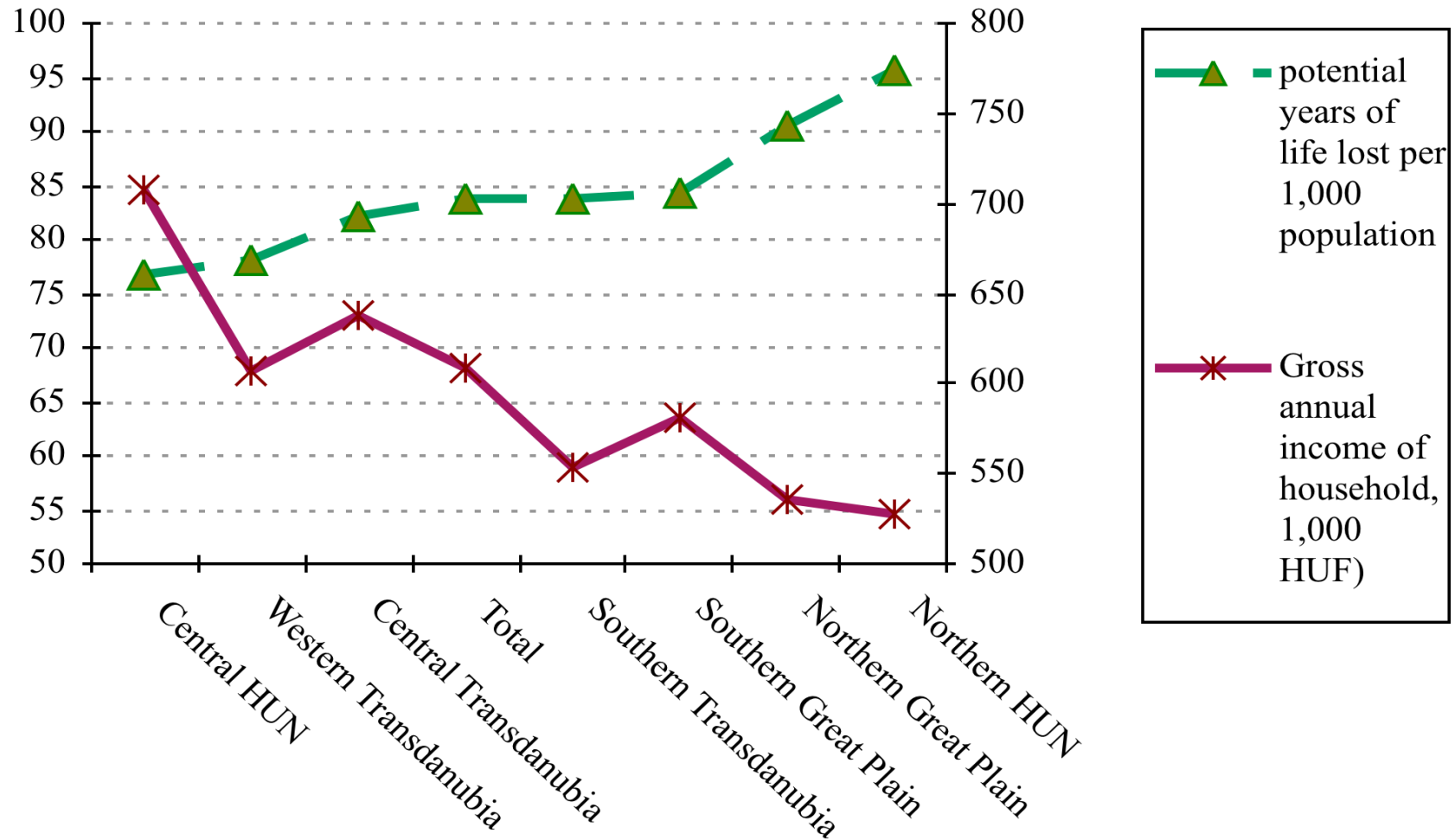
Large differences in avoidable health rates of small regions in Hungary 2006-2008



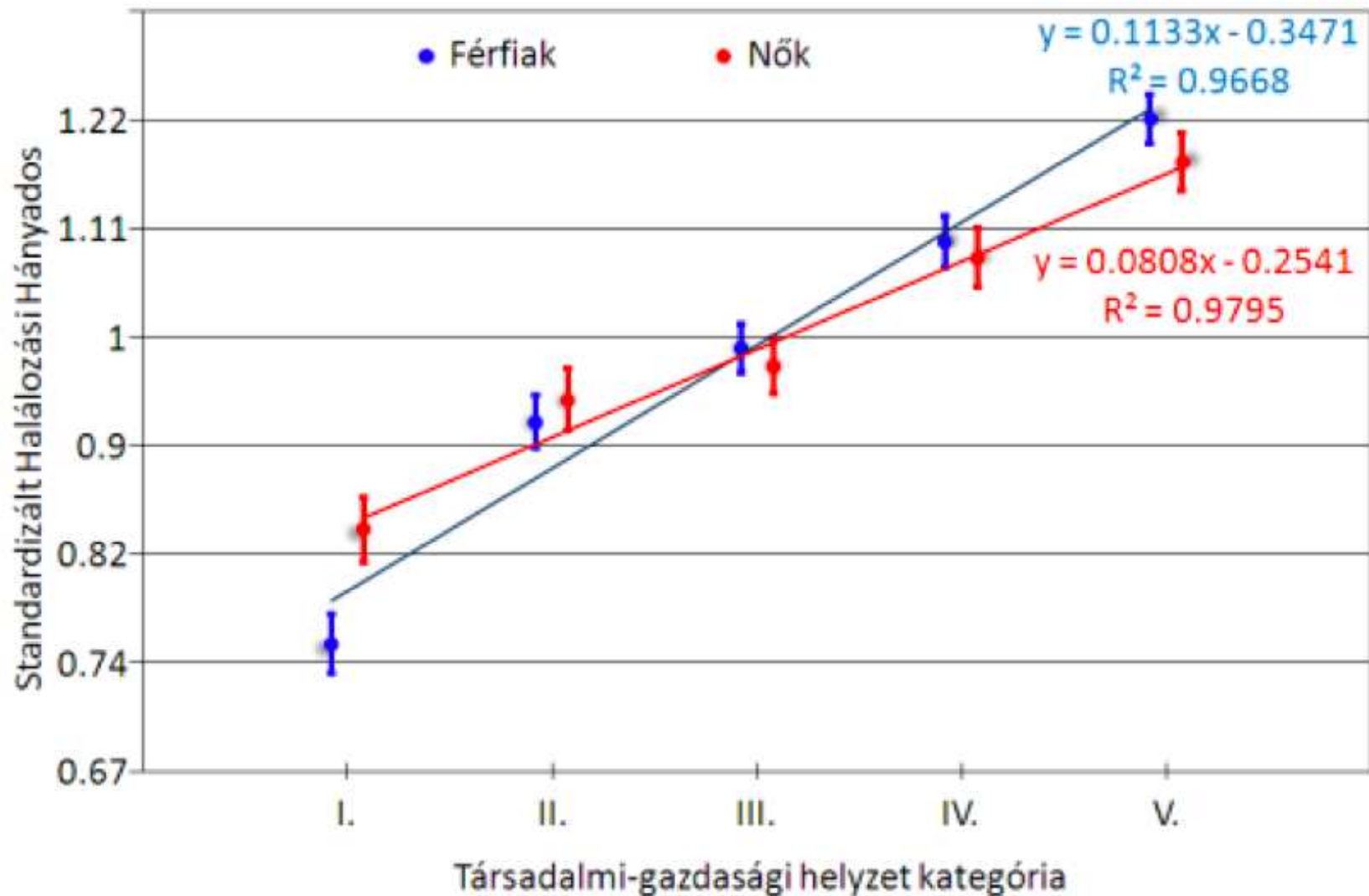
Socioeconomic status 2006-2008



Relationship between years of life lost and household income



Socioeconomical status and avoidable health rates 2006-2008



- **Social inequalities and health: ecological study of mortality in Budapest, 1980-3 and 1990-3**
- P Józán and D P Forster *BMJ* 1999;318;914-915
- <http://bmj.com/cgi/content/full/318/7188/914>



World Health
Organization



Commission on
Social Determinants of Health

Closing the gap in a generation

Health equity through action on
the social determinants of health



Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death. We watch in wonder as life expectancy and good health continue to increase in parts of the world and in alarm as they fail to improve in others. A girl born today can expect to live for more than 80 years if she is born in some countries – but less than 45 years if she is born in others. Within countries there are dramatic differences in health that are closely linked with degrees of social disadvantage. Differences of this magnitude, within and between countries, simply should never happen.

These inequities in health, avoidable health inequalities, arise because of the circumstances in which people grow, live, work, and age, and the systems put in place to deal with illness. The conditions in which people live and die are, in turn, shaped by political, social, and economic forces.

Social and economic policies have a determining impact on whether a child can grow and develop to its full potential and live a flourishing life, or whether its life will be blighted. Increasingly the nature of the health problems rich and poor countries have to solve are converging. The development of a society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.

In the spirit of social justice, the Commission on Social Determinants of Health was set up by the World Health Organization (WHO) in 2005 to marshal the evidence on what can be done to promote health equity, and to foster a global movement to achieve it.

As the Commission has done its work, several countries and agencies have become partners seeking to frame policies and programmes, across the whole of society, that influence the social determinants of health and improve health equity. These countries and partners are in the forefront of a global movement.

The Commission calls on the WHO and all governments to lead global action on the social determinants of health with the aim of achieving health equity. It is essential that governments, civil society, WHO, and other global organizations now come together in taking action to improve the lives of the world's citizens. Achieving health equity within a generation is achievable, it is the right thing to do, and now is the right time to do it.

A new global agenda for health equity

Our children have dramatically different life chances depending on where they were born. In Japan or Sweden they can expect to live more than 80 years; in Brazil, 72 years; India, 63 years; and in one of several African countries, fewer than 50 years. And within countries, the differences in life chances are dramatic and are seen worldwide. The poorest of the poor have high levels of illness and premature mortality. But poor health is not confined to those worst off. In countries at all levels of income, health and illness follow a social gradient: the lower the socioeconomic position, the worse the health.

It does not have to be this way and it is not right that it should be like this. Where systematic differences in health are judged to be avoidable by reasonable action they are, quite simply, unfair. It is this that we label health inequity. Putting right these inequities – the huge and remediable differences in health between and within countries – is a matter of social justice. Reducing health inequities is, for the Commission on Social Determinants of Health (hereafter, the Commission), an ethical imperative. Social injustice is killing people on a grand scale.

The Commission's overarching recommendations

1 Improve Daily Living Conditions

Improve the well-being of girls and women and the circumstances in which their children are born, put major emphasis on early child development and education for girls and boys, improve living and working conditions and create social protection policy supportive of all, and create conditions for a flourishing older life. Policies to achieve these goals will involve civil society, governments, and global institutions.

2 Tackle the Inequitable Distribution of Power, Money, and Resources

In order to address health inequities, and inequitable conditions of daily living, it is necessary to address inequities – such as those between men and women – in the way society is organized. This requires a strong public sector that is committed, capable, and adequately financed. To achieve that requires more than strengthened government – it requires strengthened governance: legitimacy, space, and support for civil society, for an accountable private sector, and for people across society to agree public interests and reinvest in the value of collective action. In a globalized world, the need for governance dedicated to equity applies equally from the community level to global institutions.

3 Measure and Understand the Problem and Assess the Impact of Action

Acknowledging that there is a problem, and ensuring that health inequity is measured – within countries and globally – is a vital platform for action. National governments and international organizations, supported by WHO, should set up national and global health equity surveillance systems for routine monitoring of health inequity and the social determinants of health and should evaluate the health equity impact of policy and action. Creating the organizational space and capacity to act effectively on health inequity requires investment in training of policy-makers and health practitioners and public understanding of social determinants of health. It also requires a stronger focus on social determinants in public health research.



Fair Society, Healthy Lives

The Marmot Review



Strategic Review of Health Inequalities
in England, post-2010

Introduction

Reducing health inequalities is a matter of fairness and social justice

Inequalities are a matter of life and death, of health and sickness, of well-being and misery. The fact that in England today people in different social circumstances experience avoidable differences in health, well-being and length of life is, quite simply, unfair. Creating a fairer society is fundamental to improving the health of the whole population and ensuring a fairer distribution of good health.

Inequalities in health arise because of inequalities in society – in the conditions in which people are born, grow, live, work, and age. So close is the link between particular social and economic features of society and the distribution of health among the population, that the magnitude of health inequalities is a good marker of progress towards creating a fairer society. Taking action to reduce inequalities in health does not require a separate health agenda, but action across the whole of society.

Figure 1.2 Guiding principles for sustainable development

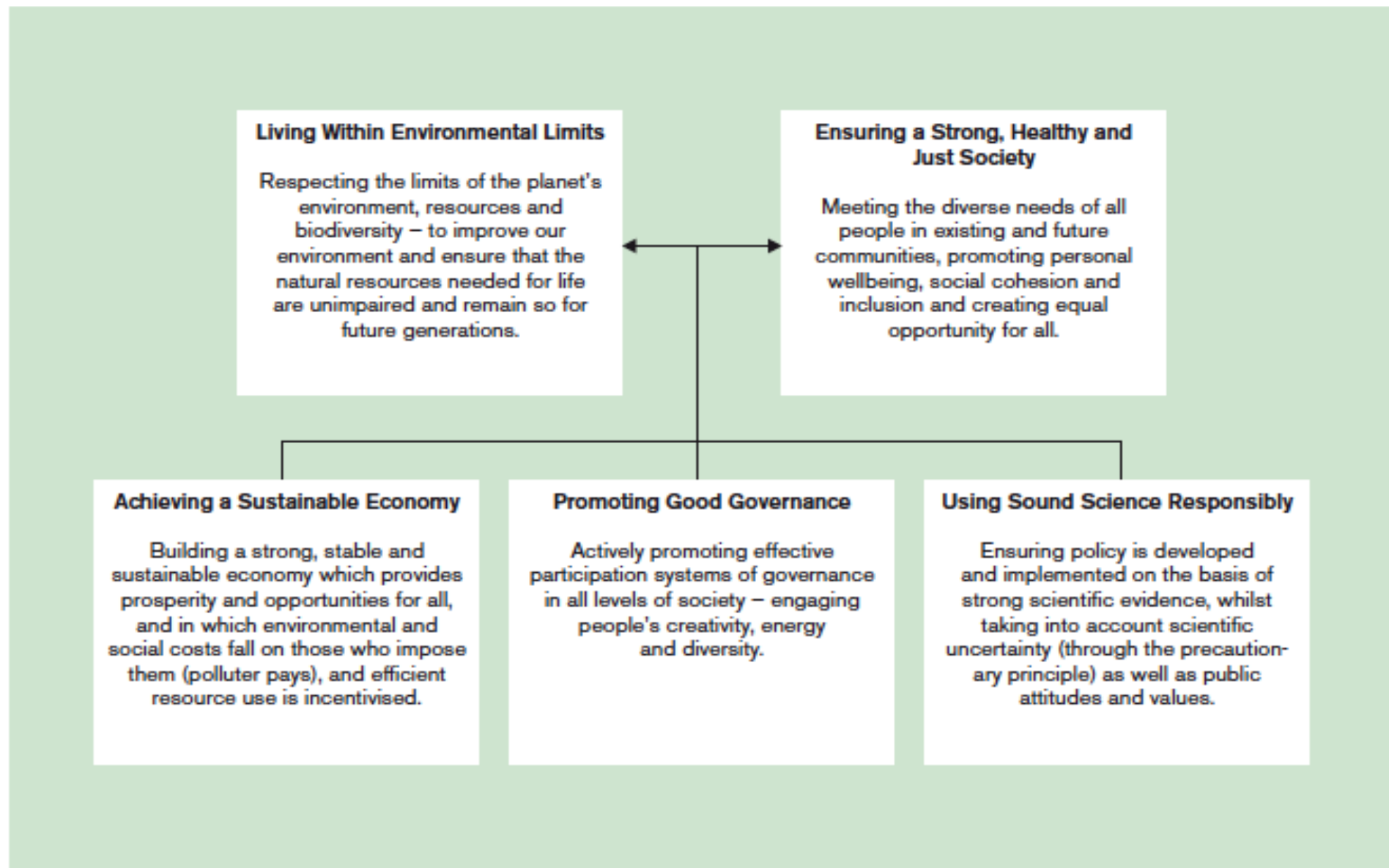


Figure 4 The Conceptual framework

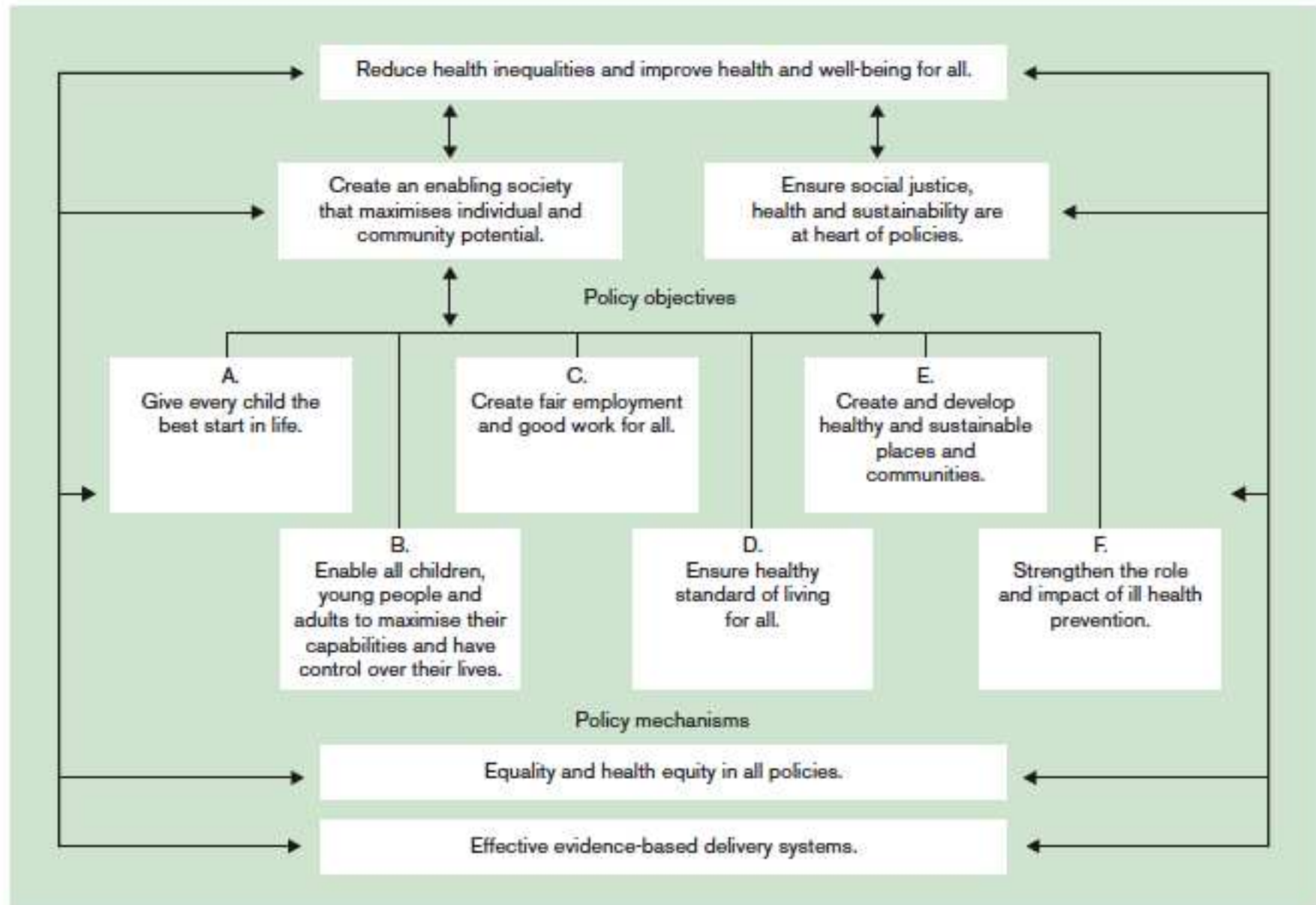
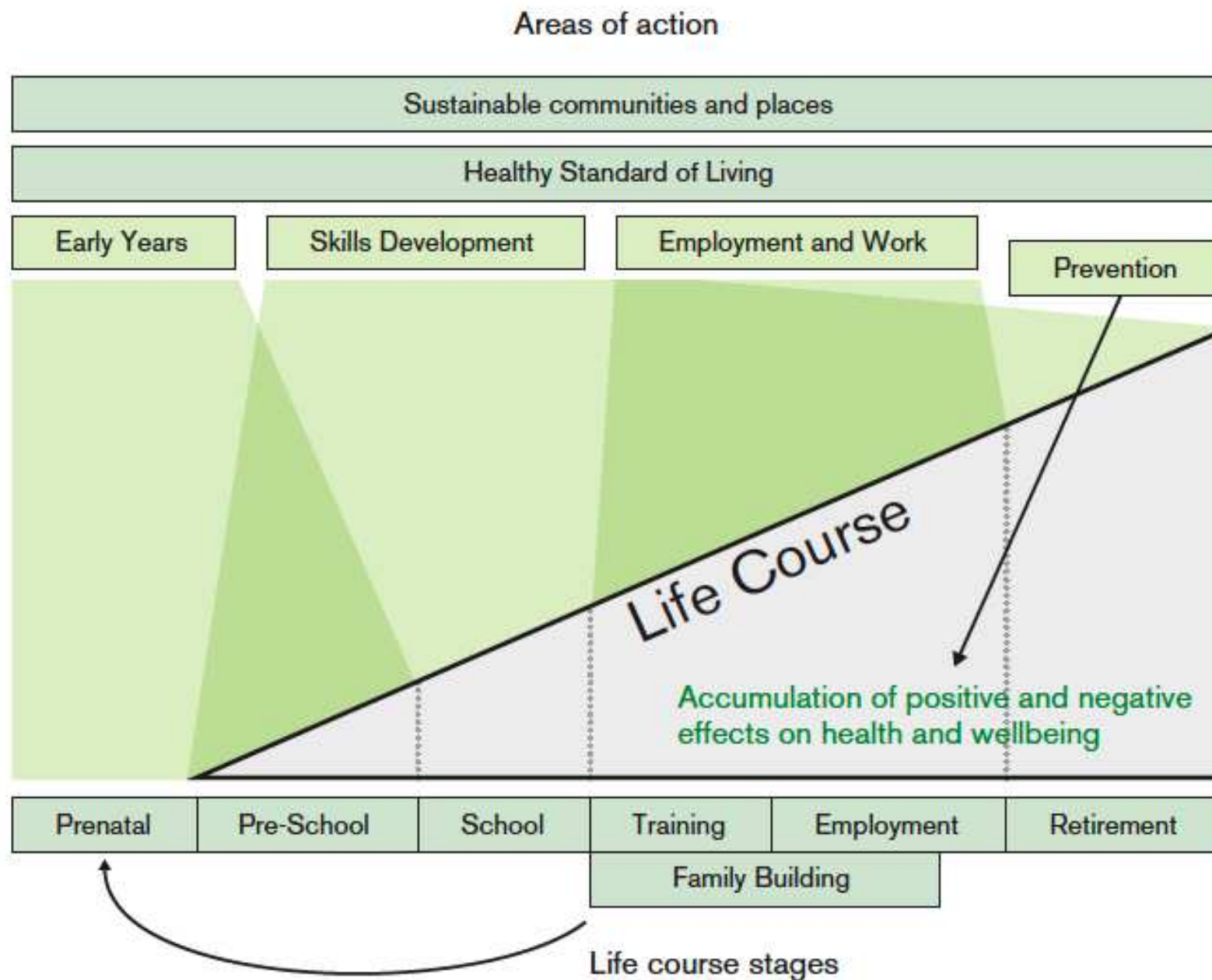


Figure 5 Action across the life course



Executive summary

1. **Reducing health inequalities is a matter of fairness and social justice.** In England, the many people who are currently dying prematurely each year as a result of health inequalities would otherwise have enjoyed, in total, between 1.3 and 2.5 million extra years of life.¹
2. **There is a social gradient in health** – the lower a person's social position, the worse his or her health. Action should focus on reducing the gradient in health.
3. **Health inequalities result from social inequalities.** Action on health inequalities requires action across all the social determinants of health.

4. Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, **actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage.** We call this **proportionate universalism.**
5. Action taken to reduce health inequalities will benefit society in many ways. **It will have economic benefits in reducing losses from illness associated with health inequalities.** These currently account for productivity losses, reduced tax revenue, higher welfare payments and increased treatment costs.
6. **Economic growth is not the most important measure of our country's success.** The fair distribution of health, well-being and sustainability are important social goals. Tackling social inequalities in health and tackling climate change must go together.

Action on six policy objectives:

7. Reducing health inequalities will require action on **six policy objectives**:
 - Give every child the best start in life
 - Enable all children young people and adults to maximise their capabilities and have control over their lives
 - Create fair employment and good work for all
 - Ensure healthy standard of living for all
 - Create and develop healthy and sustainable places and communities
 - Strengthen the role and impact of ill health prevention



8. Delivering these policy objectives will **require action by central and local government, the NHS, the third and private sectors and community groups**. National policies will not work without effective local delivery systems focused on health equity in all policies.
9. Effective local delivery **requires effective participatory decision making at local level**. This can only happen by empowering individuals and local communities.

Policy Objective A

Give every child the best start in life

Priority objectives

- 1 Reduce inequalities in the early development of physical and emotional health, and cognitive, linguistic, and social skills.
- 2 Ensure high quality maternity services, parenting programmes, childcare and early years education to meet need across the social gradient.
- 3 Build the resilience and well-being of young children across the social gradient.

Policy recommendations

- 1 Increase the proportion of overall expenditure allocated to the early years and ensure expenditure on early years development is focused progressively across the social gradient.
- 2 Support families to achieve progressive improvements in early child development, including:
 - Giving priority to pre- and post-natal interventions that reduce adverse outcomes of pregnancy and infancy
 - Providing paid parental leave in the first year of life with a minimum income for healthy living
 - Providing routine support to families through parenting programmes, children's centres and key workers, delivered to meet social need via outreach to families
 - Developing programmes for the transition to school.
- 3 Provide good quality early years education and childcare proportionately across the gradient. This provision should be:
 - Combined with outreach to increase the take-up by children from disadvantaged families
 - Provided on the basis of evaluated models and to meet quality standards.

If you are a single parent you don't get to go out that much, you don't really see anybody.

Quote from participant in qualitative work undertaken for the Review, which explored barriers to healthy lives among specific groups living in Hackney (London), Birmingham and Manchester. See Annex 1 and www.ed.ac.uk/glug/macroreview. The remaining quotes in this summary also come from this work.

Inequalities in early child development

Giving every child the best start in life is crucial in reducing health inequalities across the life course. The foundations for virtually every aspect of human development – physical, intellectual and emotional – are laid in early childhood. What happens during these early years (starting in the womb) has lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to educational achievement and economic status.¹⁸ To have an impact on health inequalities we need to address the social gradient in children's access to positive early experiences. Later interventions, although important, are considerably less effective where good early foundations are lacking.¹⁹

As Figure 6 shows, children who have low cognitive scores at 22 months of age but who grow up in families of high socioeconomic position improve their relative scores as they approach the age of 10. The relative position of children with high scores at 22 months, but who grow up in families of low socioeconomic position, worsens as they approach age 10.

What can be done to reduce inequalities in early child development?

There has been a strong government commitment to the early years, enacted through a wide range of policy initiatives, including Sure Start and the Healthy Child Programme. It is vital that this is sustained over the long term. Even greater priority must be given to ensuring expenditure early in the developmental life cycle (that is, on children below the age of 5) and that more is invested in interventions that have been proved to be effective.

We are therefore calling for a 'second revolution in the early years', to increase the proportion of overall expenditure allocated there. This expenditure should be focused proportionately across the social gradient to ensure effective support to parents (starting in pregnancy and continuing through the transition of the child into primary school), including quality early education and childcare.

Priority objectives

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- 3 Provide good quality early years education and childcare proportionately across the gradient. This provision should be:
 - Combined with outreach to increase the take-up by children from disadvantaged families
 - Provided on the basis of evaluated models and to meet quality standards.

We do have got the information.

We have now sound scientific evidences.

And every of us does have a responsibility to change

- views
- behaviors
- cultures
- actions



Rise up with me against
the organisation of misery
Pablo Neruda



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Thank you
for your attention!