SOCIAL EXCLUSION & STRUCTURAL HEALTH INEQUALITIES

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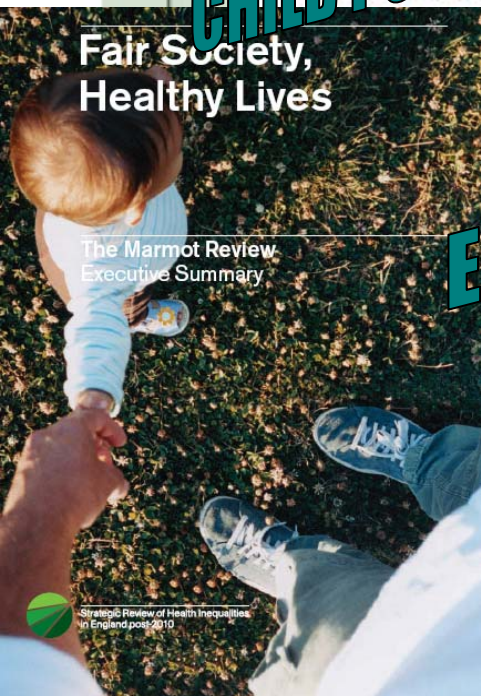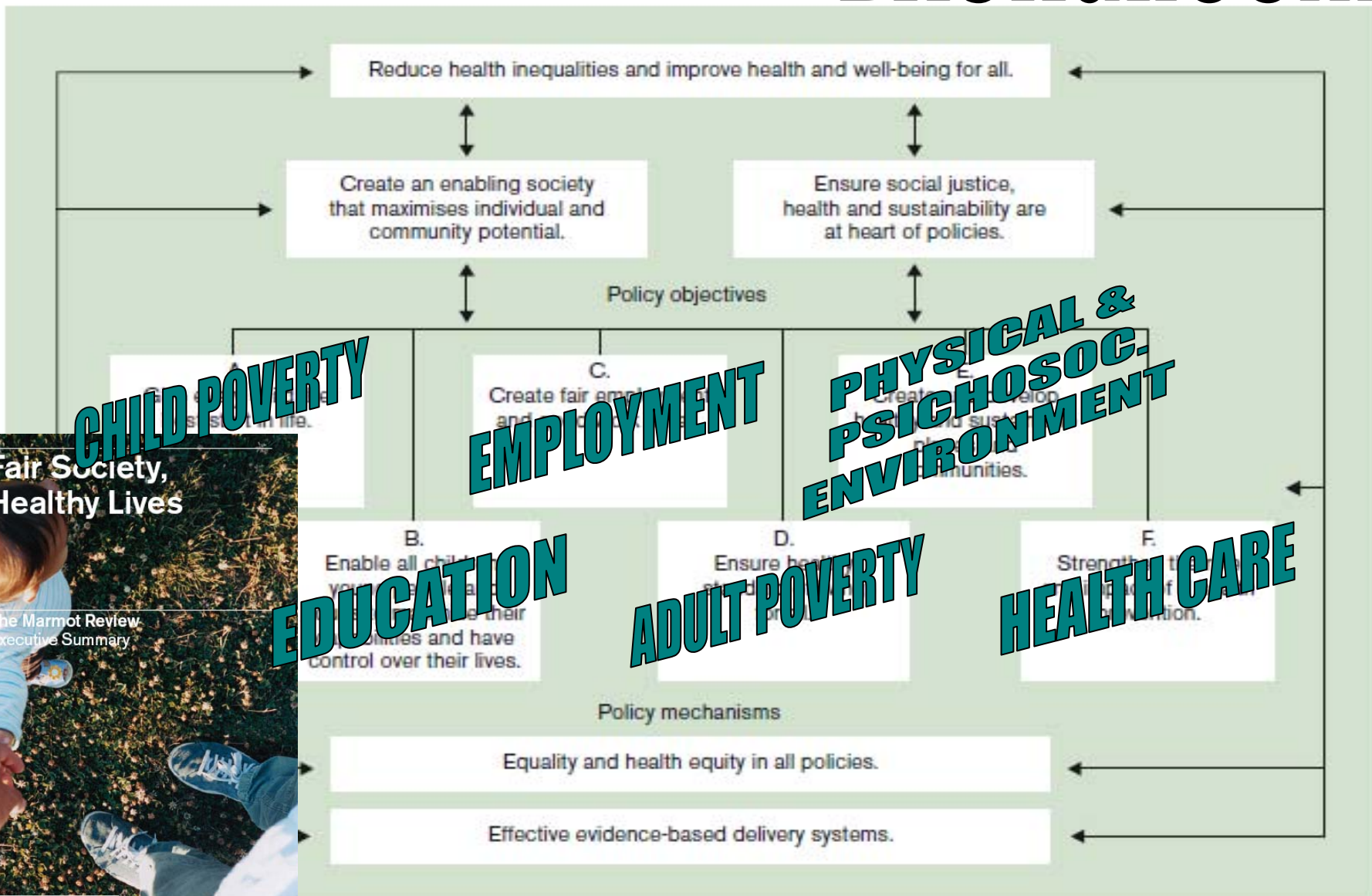**ROSA URBANOS**
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GOALS & CONTENTS

- **Background**: Social sciences & public health
- **Data:** Social exclusion & e*structural* HIs, EU
- **EU priorities**: HIs as key to justice and development
- **EU & LA indicators:** social exclusion, SHD & HIs
- **Proposed indicators:** estructural His & social cohesion
- **Conclusions** & further action

Figure 4 The Conceptual framework

BACKGROUND

Fair Society, Healthy Lives

The Marmot Review
Executive Summary

Strategic Review of Health Inequalities in England post-2010

Reduce health inequalities and improve health and well-being for all.

Create an enabling society that maximises individual and community potential.

Ensure social justice, health and sustainability are at heart of policies.

Policy objectives

CHILD POVERTY

EMPLOYMENT

PHYSICAL & PSICHOSOC. ENVIRONMENT

EDUCATION

ADULT POVERTY

HEALTH CARE

Policy mechanisms

Equality and health equity in all policies.

Effective evidence-based delivery systems.

2.1. STRUCTURAL CAUSES OF INEQUALITY: SOCIAL POWER RESOURCES

BACKGROUND

Knowledge-based resources

Collective action resources

Informal, experience-based
Formal, evidence-based

Internal cohesion

Coalition capacity

External support

Financial resources

Institutional resources

Formal political power
Formal organizational power

Ownership
"Sponsorship"

SOCIAL SCIENCES: POWER RESOURCES THEORY
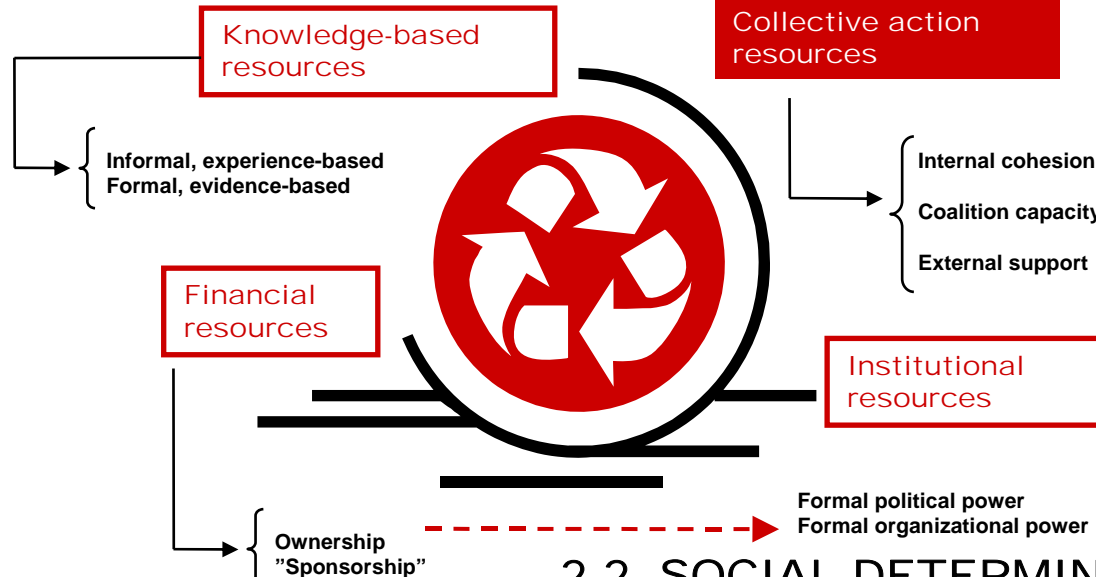
2.2. SOCIAL DETERMINANTS OF HEALTH INEQUALITIES

A.-C. SOCIAL STRUCTURE

D. INSTITUTIONAL AND SOCIOPOLITICAL CONTEXT

INSTITUTIONAL
State institutions

Social, economic and political rights

Policy (economic, social, health, education & culture)

SOCIO/POLITICAL
Government leadership

Political participation

Cooperation & responsiveness

National culture

SOCIAL EPIDEMIOLOGY & PUBLIC HEALTH

A. Economic resources (work, status, income, ownership)

B. Education & knowledge

C. Social status & social support

E. MATERIAL LIFE CONDITIONS

Biological factors and disability
Physical & work **environment**
Housing and recreation

H. HEALTH

Health Inequality

F. PSICHOSOCIAL CONTEXT

Subcultures (attitudes, values, identities)
Information (health, social, political)
Behaviour (health, social, political)

SOCIAL COHESION/ EXCLUSION

G. HEALTH SYSTEM

Effective access and quality of health care, prevention and social protection

DESPOTISM (1946), The British Enciclopedia, at google videos

At-risk-of-poverty rate before and after social transfers, 2006

Reduction in %

After transfers

0%

25%

50%

75%

LV, EL, ES&IT, RO, LT, UK, IE, EE&PT&PL, EU-25, BX-1, HU, EN-15, T&FR, DE, FI, BG, MT, LU, SK, SI, IR, CZ, DK&SE, NO, NL

Before transfers
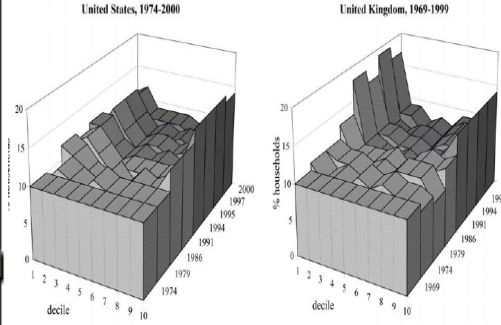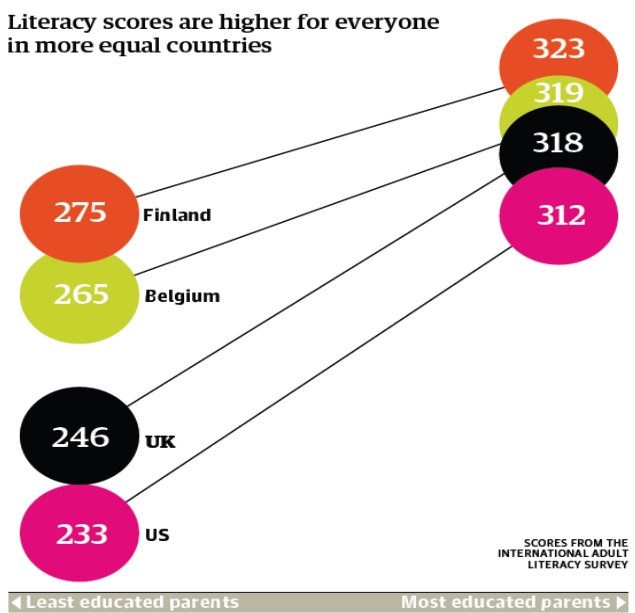
EVIDENCE

United States, 1974-2000

United Kingdom, 1969-1999

Figure 3. Relative distributions, U.S. 1974-2000 and U.K. 1969-1999

How much richer are the richest 20% than the poorest 20%?

Income gaps
How many times richer are the richest fifth than the poorest fifth?

3.4 Japan, 3.7 Finland, 3.9 Norway, 4.0 Sweden, 4.3 Denmark, 4.6 Belgium, 4.8 Austria, 5.2 Germany, 5.3 Netherlands, 5.6 Spain, 5.6 France, 5.6 Canada, 5.7 Switzerland, 6.1 Ireland, 6.2 Greece, 6.7 Italy, 6.8 Israel, 6.8 New Zealand, 7.0 Australia, 7.2 UK, 8.0 Portugal

Source: Wilkinson & Pickett, The Spirit Level (2009)

www.equalitytrust.org.uk

Fig. 1. Generalized (social) trust - international comparison

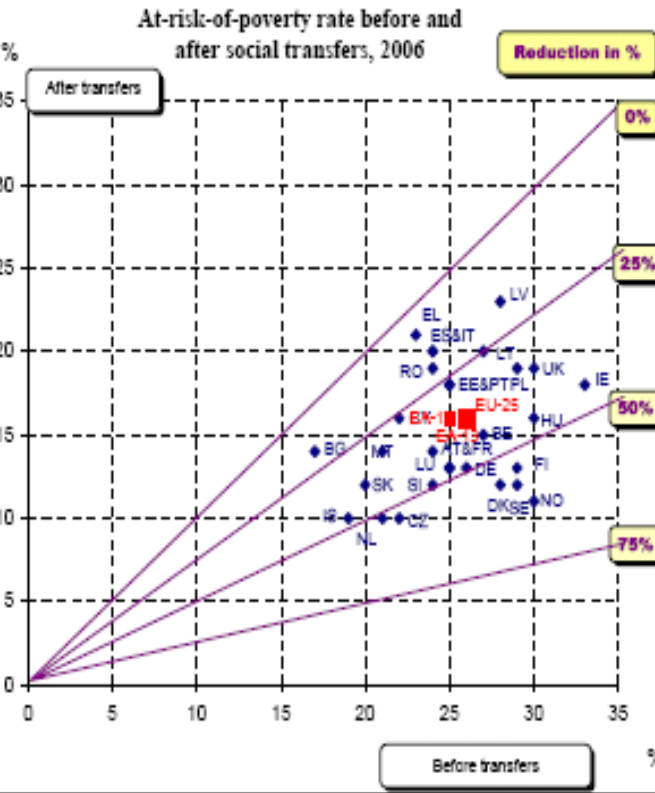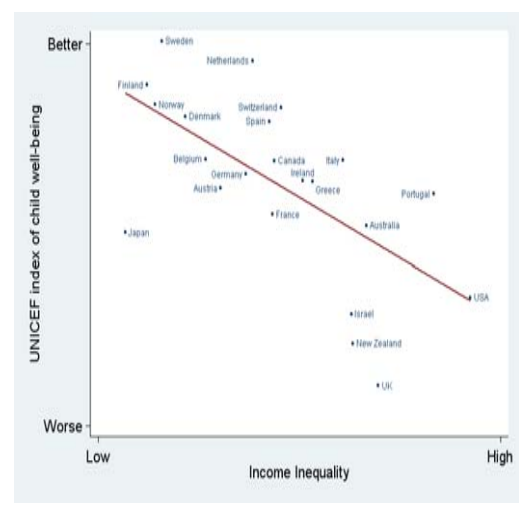Denmark, Sweden, Netherlands, Finland, United Kingdom, Spain, Ireland, Germany, EU15, Estonia, Austria, Luxembourg, EU25, Belgium, Total, Hungary, Slovenia, Portugal, Malta, Italy, France, Bulgaria, Cyprus(south), Greece, Romania, Czech Republic, Slovakia, NMS10, Latvia, Lithuania, Poland

Source: Special Eurobarometer 223

Literacy scores are higher for everyone in more equal countries

323
319
318
312

275 Finland
265 Belgium
246 UK
233 US

SCORES FROM THE INTERNATIONAL ADULT LITERACY SURVEY

◄ Least educated parents — Most educated parents ►

Child Well-being is Better in More Equal Rich Countries

Better — Worse

UNICEF index of child well-being

Sweden, Netherlands, Finland, Norway, Denmark, Switzerland, Spain, Belgium, Canada, Italy, Germany, Ireland, Austria, Greece, Portugal, France, Australia, Japan, Israel, New Zealand, USA, UK

Income Inequality: Low — High

Source: Wilkinson & Pickett, The Spirit Level (2009)

www.equalitytrust.org.uk

Children Experience More Conflict in More Unequal Societies

High — Low

Children's experience of conflict

UK, France, Greece, Israel, USA, Belgium, Austria, Canada, Italy, Spain, Portugal, Ireland, Norway, Denmark, Netherlands, Switzerland, Germany, Sweden, Finland

Income Inequality: Low — High
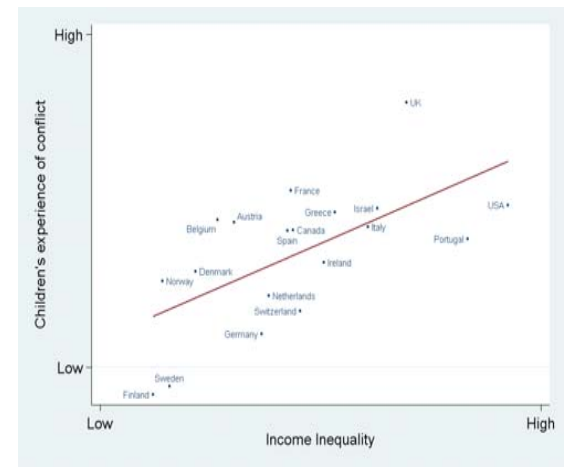
11, 13 & 15 yr olds fighting, bullying, and finding peers not kind & helpful

Wilkinson & Pickett, The Spirit Level (2009)

www.equalitytrust.org.uk

Figure 1 Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999–2003

Age

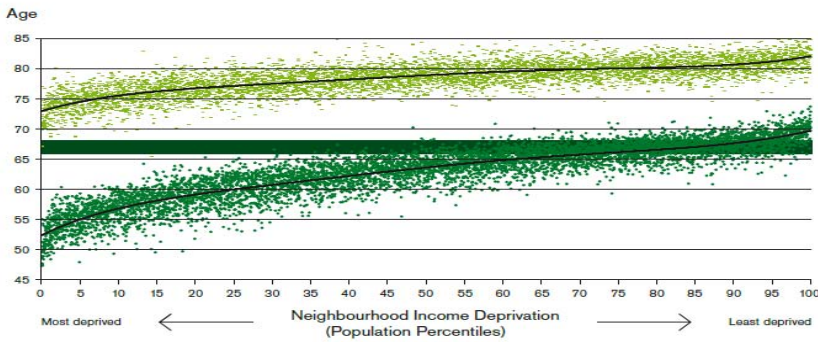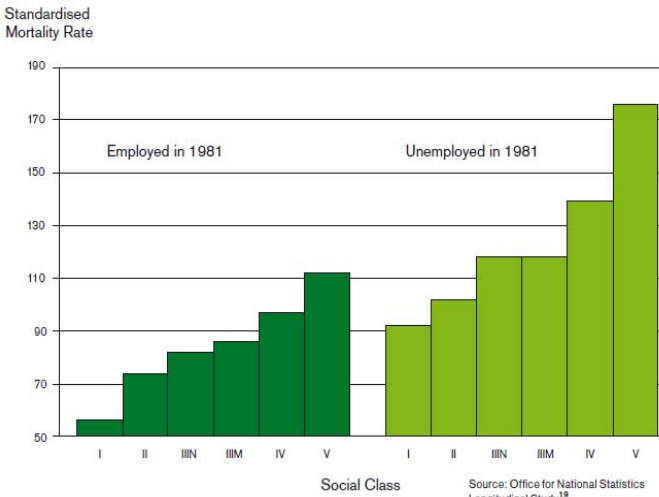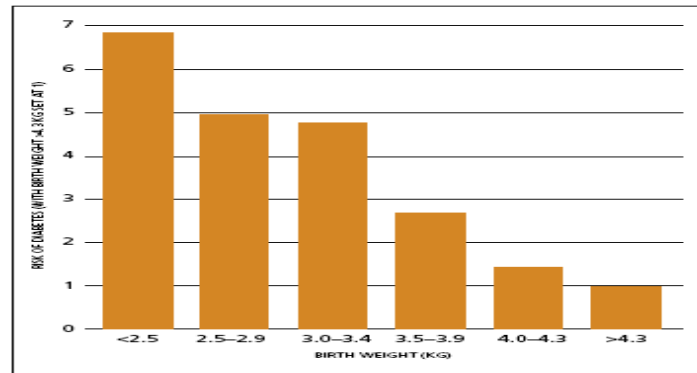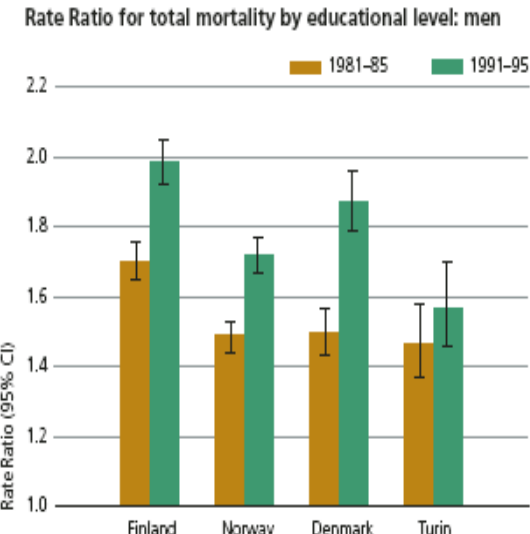Most deprived ← Neighbourhood Income Deprivation (Population Percentiles) → Least deprived

- Life expectancy
- DFLE

EVIDENCE

Social status affect brain chemistry and behaviour in monkeys

- Living in social groups increased "happy" brain chemicals in dominant monkeys but produced no change in subordinate monkeys.
- These neurobiological changes had an important behavioural influence
- When given access to cocaine, dominant monkeys took less than subordinates

Source: Morgan, D et al. Nature Neuroscience 2002; 5(2), 169-174.

Source: Wilkinson and Pickett 2009, The Spirit Level

Fig. 2. Risk of diabetes in men aged 64 years by birth weight
Adjusted for body mass index

Statistics[8]

RISK OF DIABETES (WITH BIRTH WEIGHT >4.3KG/SET AT 1)
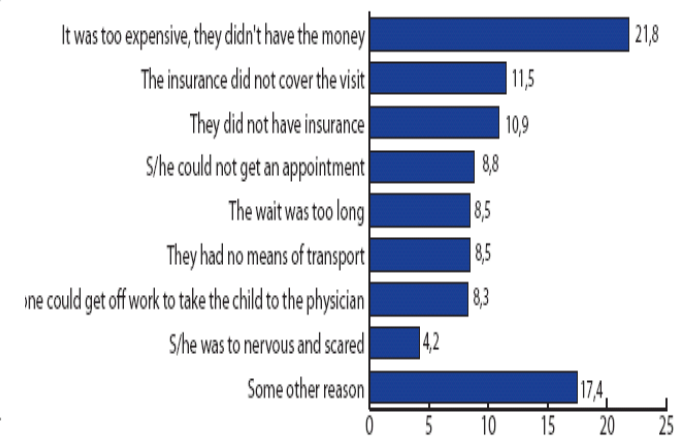
BIRTH WEIGHT (KG)

Rate Ratio for total mortality by educational level: men

- 1981–85
- 1991–95

Rate Ratio (95% CI)

Finland, Norway, Denmark, Turin

Source: Mackenbach 2006

Graph 3.3. Percentage of the Roma population that failed to receive needed medical assistance due to lack of assistance

- It was too expensive, they didn't have the money — 21,8
- The insurance did not cover the visit — 11,5
- They did not have insurance — 10,9
- S/he could not get an appointment — 8,8
- The wait was too long — 8,5
- They had no means of transport — 8,5
- ...one could get off work to take the child to the physician — 8,3
- S/he was to nervous and scared — 4,2
- Some other reason — 17,4

Source: EDIS S.A., European Survey on Health and the Roma Community 2009

Standardised Mortality Rate

Employed in 1981   Unemployed in 1981

I II IIIN IIIM IV V   I II IIIN IIIM IV V

Social Class

Source: Office for National Statistics Longitudinal Study[19]

EU AGREEMENTS

KEY AGREEMENTS

➢ **Health is a key right &** *source of wealth*

➢ **Health inequalities (HI) are a key priority in the EU agenda**

➢ **Structural inequality** (unequal power resources) **is the main social determinant of HIs**

➢ **Structural HIs are avoidable** by concerted policy and social action

➢ **Health and social protection systems must be proactive to reach the most needy**; be culturally sensitive; promote mutual respect; and make services accessible to all

PENDING ISSUES

➢ **Less emphasis on interactions between SES and migration**, disability, gender, old age, the social environment, and **on ethnic & local communities**.

➢ **Little discussion** yet in the EU on key issues of governance such as **who should lead** concerted action against HIs; the **priority of different SHD indicators**, or the coordination of the health and social protection systems

➢**Leading role** in heath inequality research and policy **of the United Kingdom, the Netherlands and the Nordic countries**, which can help fill the gaps still not covered at the EU level.
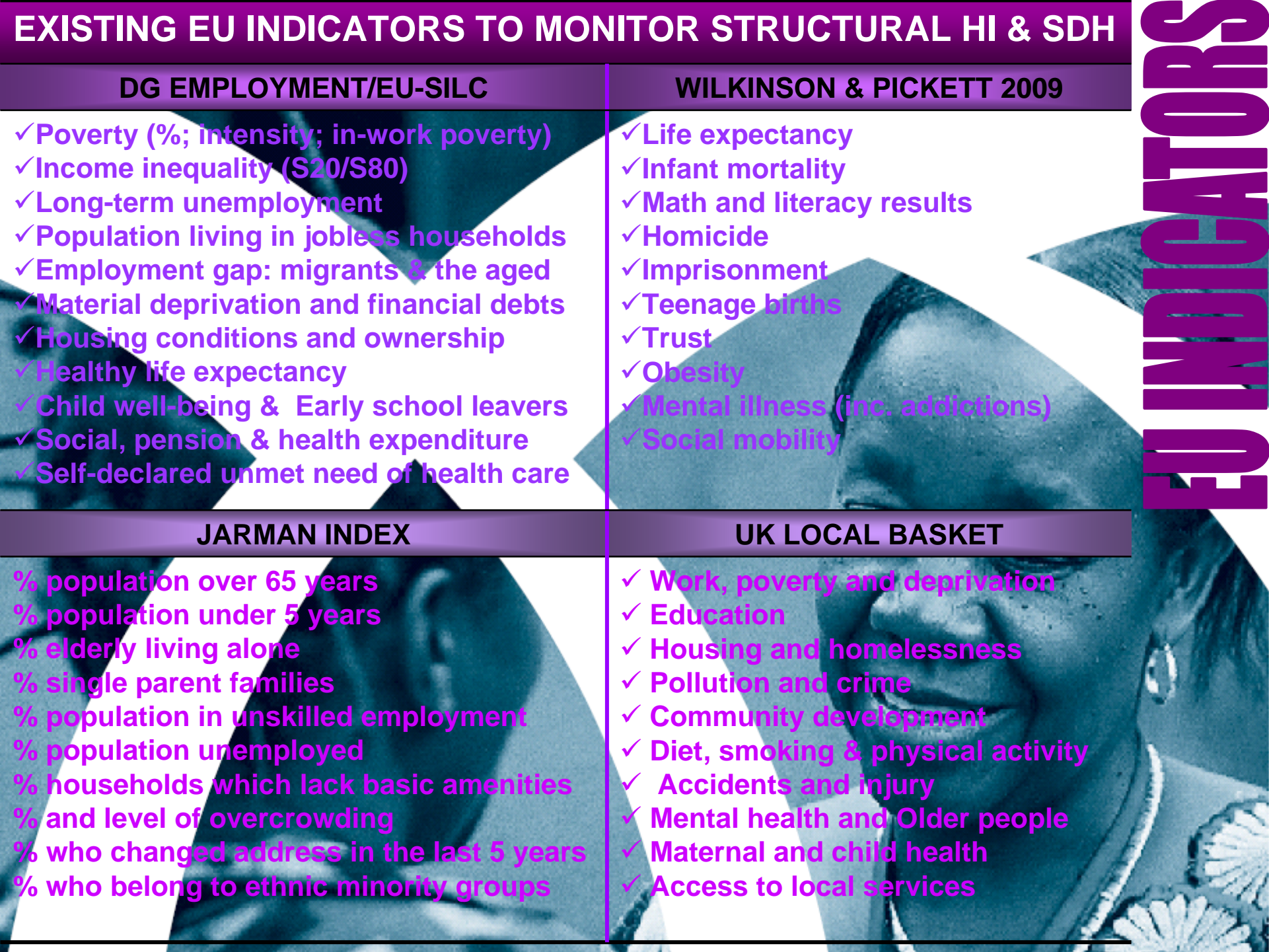
EXISTING EU INDICATORS TO MONITOR STRUCTURAL HI & SDH

DG EMPLOYMENT/EU-SILC

- ✓ Poverty (%; intensity; in-work poverty)
- ✓ Income inequality (S20/S80)
- ✓ Long-term unemployment
- ✓ Population living in jobless households
- ✓ Employment gap: migrants & the aged
- ✓ Material deprivation and financial debts
- ✓ Housing conditions and ownership
- ✓ Healthy life expectancy
- ✓ Child well-being & Early school leavers
- ✓ Social, pension & health expenditure
- ✓ Self-declared unmet need of health care

WILKINSON & PICKETT 2009

- ✓ Life expectancy
- ✓ Infant mortality
- ✓ Math and literacy results
- ✓ Homicide
- ✓ Imprisonment
- ✓ Teenage births
- ✓ Trust
- ✓ Obesity
- ✓ Mental illness (inc. addictions)
- ✓ Social mobility

JARMAN INDEX

- % population over 65 years
- % population under 5 years
- % elderly living alone
- % single parent families
- % population in unskilled employment
- % population unemployed
- % households which lack basic amenities
- % and level of overcrowding
- % who changed address in the last 5 years
- % who belong to ethnic minority groups

UK LOCAL BASKET

- ✓ Work, poverty and deprivation
- ✓ Education
- ✓ Housing and homelessness
- ✓ Pollution and crime
- ✓ Community development
- ✓ Diet, smoking & physical activity
- ✓ Accidents and injury
- ✓ Mental health and Older people
- ✓ Maternal and child health
- ✓ Access to local services

EU INDICATORS

EU INDICATORS

PROPOSED INDICATORS TO MONITOR ESTRUCTURAL HIs

INDIVIDUAL DATA

A. Risk & intensity of poverty, family SES and social mobility, % who owns a house & car

B. Results in maths and literacy or years of educ.

C. % lives alone or feels socially discriminated

D. % feels institutionally discriminated, % long-term unemployed, % politically active

E. % poor housing or low access to healthy food

F. % stress, little social or recreation activities

G. % unmet health needs, % without a GP

H. % disability & mental ill-health (inc. addictions)

LOCAL & COUNTRY DATA

A. Income inequality (S80/S20) within and across local areas, % areas with >20% pop. poor

B. % Illiterate or doesn't know the language well

C. Trust, % lone young mothers, elderly & migrants

D. Legislation, plans & funds to fight discrimination and structural HI, demonstrations

E. Pollution, work accidents, green areas, water

F. Violence, imprisonments, homeless

G. % areas understaffed in health & education

H. Inequality in life expectancy and infant mortality

MOVING FORWARD

POLICY RECOMMENDATIONS

✓ *The persistent nature of HIs points to its deep structural roots (Mackenbach 2006)*

✓ It also points to *gaps in social protection and health coverage,* and to *access barriers* for vulnerable minorities.

✓ *Social groups affected by overlapping structural inequalities (sick, poor, female & aged refugees, ethnic minorities, migrants, homeless, lone mothers, children and the under-/unemployed) should be specially protected*

✓ *Universal + positive discrimination policies + progressive public financing are needed* to make rights to welfare effective for all

✓ Positive discrimination does require **targeted policies on top of universal ones** (Marmot 2009)

KNOWLEDGE GAPS

✓ *We know a lot on the structural roots of HI*, but *little on resources and needs of specially vulnerable groups;* and *even less on policies* to tackle them

✓ **Existing indicators cover SES well** but **less so** ethnic/migrant and sick/ disabled status or **social exclusion**

✓ **Three urgent information needs are:**

(1) Expanded sample of health surveys to **20000 minimum, to allow for desegregation by minority groups and local areas;**

(2) Inclusion of SDH (inc. family SES and ethnic status) **, as well as discrimination and violence.**

(3) Generation of new databases recording availability of public resources (schools & cultural centers, clean air & green spaces, healthy food and housing, and health and social services) **in poor and excluded areas.**