Concepts, Principles, and Policy Approaches to Tackling Health Inequity

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1. Introduction

The purpose of this paper is to review and update the concepts, principles, and policy approaches to tackling health inequity. At the outset, it is universally acknowledged that health is a fundamental human right and a basic human need. Health is needed for functioning in every sphere of every individual's life. It is a primary public good because many aspects of human potential such as employment, social relationships, and political participation, are contingent on it (IOM, 2003; CSDH, 2017).

As health is invaluable to communities, society, and state, in general, creating the conditions for people to be healthy should also be a shared social goal. The development of society, rich or poor, can be judged not only by the quality of its population's health, but also how fairly health is distributed across the social spectrum, and the degree of protection provided for the disadvantaged and ill-health population (IOM, 2003; CSDH, 2017).

Countries around the world have made improvement in population health, and yet there remain major health inequalities between and within countries (CSDH, 2017). Social injustices make some population groups more vulnerable to poor health than other groups, leading to health inequity. The gross inequalities in health seen within and between countries present a challenge to the world. As a body of evidences have supported, global efforts to reduce and eliminate health inequalities should address the “causes of the causes” – the fundamental structures of social hierarchy and the socially determined conditions these structures create in which people grow, live, work and age. Efforts to strengthen health equity should be targeted towards those social determinants of health (SDH), which rest beyond the immediate causes of disease (CSDH, 2017).

Consequently, concerted efforts to reduce health inequalities should aim at removing obstacles to health in any sector—for example, in education, housing, or transportation—and achieving a standard of living necessary to protect and promote health. To be effective and sustainable, interventions that aim to redress inequities must go beyond remedying a particular health inequality and empower the group in question through systemic changes, such as law reform or changes in economic or social relationships (WHO, 2017a).

2. Why is Equity in Health Important?

It is hardly arguable that good health is fundamental to a good society. Health is needed for functioning in every aspect of human life. Ethicists point to the special role that health plays in the enjoyment of an active life, a thriving community, and a productive nation. Without a certain level of health, people may not be able to fully participate in many of the goods of life, including family and community life, gainful
employment, and participation in the political process. This view is also grounded in international codes and agreements, from the World Health Organization’s Constitution (WHO, 1946) to the United Nations’ Universal Declaration of Human Rights, which ascribe intrinsic value to health (IOM, 2003).

Equity in health is an important policy goal. There are two underlying reasons for the policy objectives to reduce and eventually eliminate health inequity. First, inequities in health are unfair. Health inequity contradicts the basic human rights principle that everyone has the right to the highest attainable standard of physical and mental health. As Frank Dobson (Health Secretary of the UK, 1997–2000) said in 1998, “Inequality in health is the worst inequality of all. There is no more serious inequality than knowing that you’ll die sooner because you’re badly off”. To be fair everyone deserves a fair chance to lead a healthy life. No one should be denied the resources needed to be healthy—including not only medical care but also health-promoting living and working conditions (Dahlgren and Whitehead, 2007; Abrahams, 2016; WHO, 2017b).

Second, health inequalities are largely avoidable. The causes of health inequality are complex but they do not arise simply by chance. Many differences in health between groups of population are systematically shaped, and the causes of health inequalities are identifiable and largely modifiable. As evidences have shown, the social, economic and environmental conditions in which people live strongly influence health between groups. Health inequalities can largely be explained by the consequences of unequal access to good housing, education, adequate income, and healthy food. These conditions are known as the social determinants of health, and are often the results of public policy (Woodward and Kawachi. 2000; Vichealth, 2017; NHS Highland, 2017; WHO, 2017d).

Consequently, health inequities ought to be reduced and ultimately eliminated. Levelling up the health status of less privileged socioeconomic groups to the level already reached by their more privileged counterparts should therefore be a key dimension of all international, national and local health policies (Dahlgren and Whitehead, 2007).

3. Defining “Health Disparities”, “Health Inequality”, and “Health Equity”

“Health disparities”, “health inequality”, and “health equity” are three concepts that have become increasingly familiar in public health. However, confusion often occurred as these words are often used interchangeably and even mistakenly. Ambiguity in the definitions of these terms could lead to misdirection of resources. For example, if these terms are vaguely defined, socially and economically advantaged groups could capitalize the terms and advocate for resources to address their advantaged social group’s health needs. The definition determines not only which measurements are monitored by national, state, and local governments and international agencies, but also which activities will receive support from resources allocated to address the disparities. Therefore, it is important to understand the difference between these catchphrases (Thomson et al., 2006; Issar and Seth, 2013; Braveman, 2014; BPHC, 2017).
3.1 Health Disparity

In a dictionary the word “disparity” is generally defined as difference, variation, or, inequality, without further specification. However, difference in health and health disparity are not identical. As Braveman (2014) put it, not all health differences are health disparities. The term “health disparity” was coined in the United States around 1990 to denote a specific kind of difference, namely, worse health among socially disadvantaged people and, in particular, members of disadvantaged racial/ethnic groups and economically disadvantaged people within any racial/ethnic group (Issar and Seth, 2013, Braveman, 2014). Particularly, in the United States “health disparities” often refer to “racial or ethnic differences”. For example, the Institute of Medicine (IOM) report on unequal treatment concluded “racial and ethnic disparities in healthcare exist and, because they are associated with worse outcomes in many cases, are unacceptable”.

The term disparity may connote a difference that is inequitable, unjust, or unacceptable (Whitehead, 1992; Krieger, 2005). In order to contrast with “health difference”, Braveman (2014) points to the concept of social justice that sits at the heart of “health disparity” — justice with respect to the treatment of more advantaged vs. less advantaged socioeconomic groups when it comes to health and health care.

Thus, health disparities do not refer generically to all health differences, or even to all health differences warranting focused attention. They are a specific subset of health differences of particular relevance to social justice because they may arise from intentional or unintentional discrimination or marginalization and, in any case, are likely to reinforce social disadvantage and vulnerability.

As Healthy People 2020 defines it, health disparity is “a particular type of health difference that is closely linked with economic, social, or environmental disadvantage. Health disparities adversely affect groups of people who have systematically experienced greater social or economic obstacles to health based on their racial or ethnic group, religion, socioeconomic -status, gender, age, or mental health; cognitive, sensory, or physical disability; sexual orientation or gender identity; geographic location; or other characteristics historically linked to discrimination or exclusion” (Braveman, 2014).

In this definition, economic disadvantage refers to lack of material resources and opportunities. Social disadvantage is a broader concept that refers not only to economic disadvantage but also to an individual’s relative position in a social order, in which individuals or groups can be stratified by their economic resources, as well as by race, ethnicity, religion, gender, sexual orientation, and disability. Environmental disadvantage refers to residence in a neighborhood with concentration of poverty and/or the social disadvantages. These characteristics can influence how people are treated in a society and how health is distributed among social groups. For example, low income or lack of wealth, and the consequent inability to purchase goods and services, can hinder the production of health in one group relative to another, resulting in health disparity (Braveman, 2014).

For example, Figure 1 shows under-5 mortality rates for four countries with households classified according to socioeconomic quintile. Child mortality varies
among countries. Within countries, not only is child mortality highest among the poorest households but also there is a social gradient: a “dose-response relationship” where the higher the socioeconomic level of the household the lower the mortality (Marmot, 2005). It illustrates health disparity as the differences in health within country are closely linked with economic disadvantage.

![Figure 1: Under-5 mortality rates per 1000 livebirths by socioeconomic quintile of household. Source: Marmot, 2005](image)

### 3.2 Health Inequity

Health inequity is differences in health that are not only unfair and unjust but also unnecessary and avoidable between groups of people within countries and between countries (Whitehead, 1992; WHO, 2017b; BPHC, 2017). Within the inequity there exist systematic and potentially remediable differences among population groups defined socially, economically, or geographically (Starfield, 2011). Health inequities are rooted in social injustices that make some population groups more vulnerable to poor health than other groups (BPHC, 2017).

Specifically, to contrast with “health difference” or “health inequality”, which are simply differences in the presence of disease, health outcomes, or access to health care between population groups, “health inequities” are differences in health that are not only unnecessary and avoidable but also considered unfair and unjust. The term inequity refers not only to a moral and ethical dimension, but also to the social cause of inequality, which is social injustice. In order to describe a certain situation as inequitable, the cause has to be examined and judged to be unfair in the context of what is going on in the rest of society. It is considered unacceptable to treat people differently according to their gender, race, ethnicity, religion, sexual orientation, social status, or place of residence. Inequalities in health outcomes associated with such personal characteristics are therefore unfair and should be minimized (Whitehead, 1992; Norheim, 2016).
3.3 Health Equity

Equity is widely acknowledged to be an important policy objective in public health. Equity, like efficiency, is a goal that is pursued by policy-makers in all types of health care systems. Health equity has been defined as the fair distribution of health and health determinants, outcomes, and resources within and between segments of the population, regardless of social standing (CSDH, 2017; Klein and Huang, 2017). Health equity also denotes the study and causes of differences in the quality of health and healthcare across different populations (Colorado Department of Public Health and Environment, 2011).

Health equity is different from health equality, as it refers not only to health difference but also to some kind of social justice. The term is a normative ethical construct that embodies an underlying principle to reduce—and, ultimately, eliminate—disparities in health and in its determinants, including social determinants (Whitehead, 1992; Braveman, 2014).

Healthy People 2020 defined health equity as “attainment of the highest level of health for all people”. It implies the norm to value all people equally, and therefore everyone should have a fair opportunity to live a long, healthy life. No one is denied the possibility to be healthy for belonging to a group that has historically been economically/socially disadvantaged. In other words, health should not be compromised or disadvantaged because of an individual or population group’s race, ethnicity, gender, income, sexual orientation, neighborhood, or other social condition. Pursuing health equity means striving for the highest possible standard of health for all people and giving special attention to the needs of those at greatest risk of poor health, based on social conditions (Braveman, 2014; BPHC, 2017).

Health Equity and Health Disparity. “Health equity” and “health disparities” are intertwined constructs. Both constructs have a common principle that social justice sits at their cores. Health disparities and health equity cannot be defined without defining social disadvantage (Braveman, 2014; Arcaya et al., 2015). As Arcaya et al. (2015) writes it, “a health inequity, or health disparity, is a specific type of health inequality that denotes an unjust difference in health”.

However, distinction can be drawn between the two concepts in two aspects. First, as Starfield noted, “health disparities” are systematic, not isolated, or exceptional situations. “Health disparities” are systematically linked with social disadvantage, and may reflect social disadvantage, but a causal link may not be demonstrated. Whether or not a causal link exists, “health disparities” adversely affect groups who are already disadvantaged socially, putting them at further disadvantage with respect to their health. It is important to define “health disparities” without requiring proof of causality, because there are important “health disparities” for which the causes have not been established, but which deserve high priority based on social justice concerns (Braveman et al., 2011).

The term “health equity”, in contrast, refers to social justice in health. It is the distribution of health within population or between populations that is causally linked with the existence of social justice. Thus the causal link is an important feature of “health equity”. In addition, within health equity there is the value underlying
commitment to reduce and ultimately eliminate health disparities (Braveman et al., 2011).

Second, “health equity” refers to a theoretical and unobservable construct that denotes fairness in health distribution to be achieved. As Starfield (2011) writes it “some people use the term ‘unfairness’ to define inequity, but unfairness is not measurable...”. McLachlan and Maynard (1982) once remarked somewhat cynically that “… equity, like beauty, is in the mind of the beholder ...”. In contrast, “health disparities” is observable. It can be viewed as an operationalization of “health equity” construct at the observational (empirical) level. “Health disparities” can be regarded as a system of related measures that facilitates the quantification of health equity. A reduction in health disparities, in absolute and relative terms, is evidence of progressivity in realizing health equity (Braveman et al., 2011; Bravement, 2014).

**Health Equity and Altruism.** Another distinction need to be drawn between “equity” and “altruism”. As a social policy objective, fair distributions of health, health determinants, and resources, within and between segments of the population, can arise from two sources. First, they can arise from considerations of social justice and fairness – that is health equity. Second, the distributional objectives can arise from feelings of altruism or caring (Wagstaff et al., 1989).

Altruism is quite distinct concept from equity and has quite different policy implication. Caring and altruism are matters of preference. In the context of health care, a caring individual might be one who derives utility—i.e. an external benefit — from seeing another person receiving health care. In this case the caring individual prefers that the person in question receives health care and is prepared to sacrifice resources to ensure that the person actually obtains treatment. How much the individual is prepared to sacrifice will depend on how much he cares (which will depend on his income) and on the cost of providing health care (Wagstaff et al., 1989).

Alternatively, a caring individual might be one that derives utility from the act of providing health care for others. How much of his income the individual will be prepared to sacrifice to provide health care for others will depend on the utility he derives from the act of providing medical care (which again will depend on his income) and on the cost of providing health care (Wagstaff et al., 1989).

**Types of Health Equity.** Health equity falls into two major categories: (1) horizontal, or (2) vertical. Horizontal equity refers to the equal treatment of individuals or groups in the same circumstances. Horizontal equity exists when people with the same needs have access to the same resources. It is often the case that what might be considered equity (such as equal use across population subgroups) is, in fact, inequity. For example, in population surveys, similar use of services across population groups signifies inequity, because different population subgroups have different needs, some more than others. There comes up the second category of equity - vertical equity. Vertical equity refers to the principle that individuals who are unequal should be treated differently according to their level of need. Vertical equity exists when people with greater needs are provided with greater resources (Starfield, 2011).
Mooney and Le Grand have identified several meanings of “equality” in the definitions of “equity” in the context of health care provision. Four of the meanings are as follows: (1) Equality of expenditure per capita; (2) Equal distribution according to need; (3) Equality of access; and (4) Equality of health (Culyer and Wagstaff, 2009). The “equality of expenditure per capita” definition has underlied the regional budget allocation formulae used in some countries, and yet is open to criticism as it makes no place for “need” (Dwyer et al., 2004).

The “distribution according to need” definition is found in several policy documents and is frequently encountered in the academic literature, but is severely hampered by the lack of agreement as to the meaning of “need”. The “equality of access” definition is more common in policy documents than any other definition. However, there is as much confusion about the meaning of the term “access” as there is about “need”. Many writers in the health care field use the terms “access” and “utilization” synonymously, while others have argued that policy-makers do draw a distinction between “access” and “utilization”. Evidently, equality of access will not necessarily result in all individuals consuming the same amount of care, even when their diagnoses and prognoses are the same, because their preferences may differ (Dwyer et al., 2004).

The “equality of health” underlies the Black Report of 1980 in the UK (Black et al., 1980; Culyer and Wagstaff, 2009). The UK government-commissioned Black Report of 1980, which reviewed available evidence regarding health inequalities, provided a landmark analysis of social class differences in the health of the population in England and Wales. It remains a seminal document in health inequalities research, not only in the UK but also internationally (Smith et al., 2016). However, equality of health outcomes is not generally seen as a realistic goal, given the impact of factors as diverse as individual genetics and climate on the longevity and wellbeing of human beings (Dwyer et al., 2004).

3.4 Health Inequality

The term health inequality generically refers to differences or variations in the health of individuals or groups. Any measurable aspect of health that varies across individuals or according to socially relevant groupings can be called a health inequality (Kawachi et al., 2002; Arcaya et al., 2015). Health inequality can also refer to differences in the distribution of health determinants. As WHO states it, “Health inequalities can be defined as differences in health status or in the distribution of health determinants between different population groups”.

Health Inequality and Health Inequity. Distinction need to made between “health inequality” and “health inequity”. Not all “health inequalities” are unjust or inequitable. For “health inequality” to be called “health inequity”, it must be causally linked with social injustice. If an uneven distribution of health between population groups are attributable to biological variations (e.g., age, sex, genetic) rather than to social injustice, it can be called “health inequality”, not “health inequity”. Health inequality can also result from health-damaging behaviour if freely chosen, such as smoking and participation in certain sports (Whitehead, 1992; Braveman, 2014; WHO, 2017c).
For example, male infants are generally born at a heavier birth weight than female infants. This is a “health inequality”, not “health inequity”, because the difference in birthweight is rooted in genetics, a biological factor. This difference is at large unavoidable. For another example, women, in general, live longer than men. This is a “health inequality”, not a “health inequity” (WHO, 2017c; CSDH, 2017).

**Health Inequality and Health Disparity.** To draw a stark distinction between “health inequality” and “health disparity”, it holds that not all “health inequalities” show linkage with social disadvantages. For “health inequality” to be called “health disparity”, it must be closely linked with economic, social, or environmental disadvantage. The “health inequality” can be said “health disparity” if it reflects differences in social and environmental conditions and thus adversely affects socially disadvantaged groups (Thomson et al., 2006).

For example, a massive body of empirical evidences have shown that there is more genetic variation within races than between races and that race is more of a social construct than a biological construct. More than 100 studies have linked experiences of racism to negative health outcomes. In this instance, the variations in health between races represent a “health disparity” issue, rather than just a “health inequality” issue (Egede, 2006; BPHC, 2017).

4. Measuring Health Disparities

Measuring health disparity is important, as monitoring national trends in disparities in different diseases could provide measures to evaluate the impact of intervention programs designed to reduce health disparities. There are a number of statistical measurements that have been used to quantify various forms of health disparity. As epidemiological method has shown, when two or more populations of individuals are compared, measures of disease frequency such as risk ratio or rate ratio can be calculated to measure a particular disparity in relative term. In absolute term, two or more groups groups can also be compared by calculating risk difference or rate difference (i.e. the absolute difference in risk or rate, respectively) (Issar and Seth, 2013; Moonesinghe and Beckles, 2015; Arcaya et al., 2015).

Both relative and absolute differences can be used, but it is worth noting that these two measures of disparities are different in scale, magnitude, interpretation, and implication. For example, temporal changes in the magnitudes of these measures can occur in opposite directions (Moonesinghe and Beckles, 2015).

Socioeconomic status may be measured based on level of education, occupational characteristics, income and expenditures, accumulated wealth, health insurance, and/or residence in geographic areas or physical environments with particular social or economic conditions. More complex statistical measurements such as population attributable risk can be used to quantify the magnitude of socioeconomic inequalities of health (Issar and Seth, 2013; Arcaya et al., 2015).

Economic inequality in particular can be measured using the Gini coefficient. Braveman explains this measure as one that reflects the overall difference between the observed distribution of economic resources (such as income) in a given
society and a theoretical situation in which everyone has exactly the same economic resources. Some researchers have examined how income inequalities in certain geographic areas (using the Gini coefficient or similar measures) are associated with aggregate levels of health experienced by people residing in those areas (Issar and Seth, 2013).

![Figure 2 Gini coefficient and life expectancy by country in 2012, Source: Inequality, 2017](image)

For example, economists and health experts have known for years that people who live in poorer societies live shorter lives. But research also points to an additional factor in explaining survival: a society’s level of inequality. As Figure 2 shows, people live shorter in nations with higher levels of inequality, as measured here by the Gini coefficient, a standard global benchmark (Inequality, 2017).

![Figure 3 Income inequality (Top 90%; Bottom 10% Ratio) and infant mortality by country in 2012. Source: Inequality, 2017](image)
Likewise, as Figure 3 shows, in 2012, nations with the smallest income gaps between households at the 90th and 10th percentiles had significantly fewer infant deaths than other nations. A household at the 90th percentile has more income than 90 percent of households.

Another common measure of socio-economic disparity within a population is the index of dissimilarity (ID). It has been proposed by some authors to measure the overall magnitude of disparities across diverse kinds of groups (such as those separated by race/ethnicity or socioeconomic status). The ID can be used to show neighborhood segregation. It measures the evenness with which two groups are distributed across the component geographic areas that make up a larger area. The ID for a given health indicator sums the differences between rates in each subgroup and the overall population rate, expressing the total as a percentage of the overall population rate (Wagstaff et al., 1991; Issar and Seth, 2013; University of Michigan, 2017).

5. **Theories of Health Inequalities**

Different theories have been proposed to explain the factors and the pathways through which these factors affect health inequalities. These theories point to artefact, biological, behavioral, cultural, psycho-social factors, materialist/structuralist, political-economy accounts, and life-course approach (Macintyre et al., 1993; McCartney et al., 2013; Arcaya et al., 2015; Smith et al., 2016).

Theories that explain causes of health inequalities, the consequential mechanisms, as well as supporting evidences, are important, so as to be able to identify appropriate actions to reduce them. Unless the underlying mechanisms that determine health inequalities are fully understood, it will be hard for policy-makers to create well-targeted public policy strategies.

5.1 **Artefact Theory**

The artefact view proposes that the association between markers of social status and health outcomes is a statistical artefact relating to the way in which social status has been classified over time. However, the theory is gravely undermined by the ubiquitous demonstration of inequalities in health outcomes, even where different statistical measures of social status are used (including income, area deprivation, education, social class and occupational group). In light of this, it is very difficult to sustain a theory that such outcomes are unrelated to social status. Consequently, this theory can confidently be discarded (McCartney et al., 2013).

5.2 **Biomedical Theory**

This theory explains that health inequalities stem from the differences in biological health risk factors that are patterned across social groups or contexts or varied across individuals in a population. Biomedical explanation can suffer the weakness when it focuses on the downstream effects of social context without acknowledging why levels of biological risk factors vary across populations (Arcaya et al., 2015; Smith et al., 2016).
5.3 Behavioral Theory

Behavioral theories of health inequalities suggest that differences in the prevalence of behaviors such as smoking, alcohol consumption, illicit drug-taking, diet, physical activity, and sexual behaviors, between groups, or differences in the dominant cultures between groups, are responsible for the prevalence of health inequalities (Townsend et al., 1992; McCartney et al., 2013; Arcaya et al., 2015; Smith et al., 2016).

These theories also assert that the link between social class and health is wholly or partially a result of class differences in health-related behaviors. The whole behavioral explanation, which focuses only on behaviors, has some problem in that it fails to explain how and why individuals in particular social groups adopt unhealthy behaviors (McCartney et al., 2013).

In the partial behavioral explanation, lifestyle behaviors contribute to health inequality patterns, but it is an insufficient explanation, since the lifestyle behaviors are significantly affected by the socioeconomic contexts in which people live. The behavioral choices are heavily structured by one's material conditions of life, and these behavioral risk factors account for a relatively small proportion of variation in the incidence and death from various diseases. As such, difference in health-related behaviors serve as a contributory factor to the social gradient of health, but not the entire explanation (Townsend, 1992; McCartney et al., 2013; Arcaya et al., 2015; Smith et al., 2016). Alternatively, for health behaviors to be the cause of health inequalities, socio-economic factors would have to be an effect modifier in the relationship as shown in Figure 4 (McCartney et al., 2013).

5.4 Culturally-Orientated Theory

Culturally-orientated theories suggest that differences in the dominant cultures between groups are responsible for the prevalence of health inequalities. They are closely related to behavioral theory. The culture determines or frames behavioral choices, including decisions affecting health, i.e., engaging in higher risk lifestyles that may include drinking, smoking, or an unhealthy diet. The culturally orientated theories have been expressed over time, including: Durkheim’s theory of “anomie”, Oscar Lewis’ “culture of poverty”, and more recently Charles Murray’s “underclass” or “dependency culture” theory (Sundmacher et al., 2011; McCartney et al., 2013).

The latter two theories contend that certain poor populations tend to develop aberrant cultural patterns which have destructive and negative implications for social and health outcomes. The term "culture of poverty" was introduced by Oscar Lewis in...
his seminal 1959 book “Five Families: Mexican Case Studies in the Culture of Poverty”. The “culture of poverty” theory states that living in conditions of pervasive poverty will lead to the development of a culture or subculture adapted to those conditions. This culture is characterized by pervasive feelings of helplessness, dependency, marginality, and powerlessness. According to Lewis, individuals living within a “culture of poverty” have little or no sense of history and therefore lacking the knowledge to alleviate their own conditions through collective action, instead focusing solely on their own troubles (McCartney et al., 2013; Encyclopedia, 2017).

For Lewis, a “culture of poverty” tended to be self-perpetuating – even when the broader structural environment which gave rise to it changed, allowing for better outcomes. The imposition of poverty on a population was the structural cause of the development of a “culture of poverty”, which then becomes autonomous, as behaviors and attitudes (including health behaviors) developed within a culture of poverty get passed down to subsequent generations through socialization processes (McCartney et al., 2013; Encyclopedia, 2017).

The sociological concept of “underclass” refers to a group of people who due to lack of employment, skills, income, wealth or property, appear to stand outside ordinary society. These people are at the bottom of a society having become victims of poverty trap. This class is largely composed of the young unemployed, long-unemployed, chronically-sick, disabled, old, or single-parent (usually the mother) families. It also includes those who are systematically excluded from participation in legitimate economic activities, such as cultural, ethnic, or religious minorities or illegal immigrants. A perception of a lack of self-efficacy is one of these shared problems. (Wilson, 2006; McCartney et al., 2013; Sociologytwynham, 2017).

“Dependency culture” refers to a system of social welfare that encourages people to stay on benefits rather than work. American Sociologist Charles Murray viewed “excessive” state welfare payments as creating a “dependency culture”. For Murray, social welfare (social security as it was once known) started out as a safety-net for people when hit with hard-time, but has become hijacked by a group of people with no intention of working (McCartney et al., 2013; Sociologytwynham, 2017).

The implication of both theories is that behaviors reflect cultural patterns which become inter-generational, entrenched, and rather resistant to remediation (McCartney et al., 2013).

5.5 Materialist

The materialist/structuralist explanation emphasizes the material conditions under which people live. These conditions include availability of resources to access the amenities of life, working conditions, and quality of available food and housing among others. Material wealth increases access to various goods and services, such as health care, transport, an adequate diet, good-quality education and housing, and opportunities for social participation, all of which are recognized as promoting health. (Clarkwest, 2008; Arcaya et al., 2015; Smith et al., 2016).

Material wealth also enables people to limit their exposures to known risk factors for disease such as physical hazards at work or adverse environmental exposures. Conversely, poverty exposes people to health hazards. Disadvantaged people are
more likely to live in areas where they are exposed to harm such as air-pollution and damp housing (Arcaya et al., 2015; Smith et al., 2016). Figure 5 depicts linkages between poor health and poverty (Dahlgren and Whitehead, 2007).

![Diagram: Linkages between poor health and poverty.](source)

Figure 5 Linkages between poor health and poverty.
Source: Adapted from Dahlgren and Whitehead, 2007

Poor health and diseases cause increased expenditure on medical care, reduced productivity and income. These conditions in turn result in debts, poverty, malnutrition, and sale of assets needed for livelihood. This pathway reverts to the previous state of poor health and diseases forming a sequence of reciprocal cause and effect between poor health and poverty.

While most experts in public health agree that materialist explanations play a role in explaining health inequalities, many find a simple materialist model to be insufficient. For example, the full impact of living standards, however, can only be understood over the course of the life term. It follows that accounting for the life-course perspective is important in analyzing the health impact of material resources. (Healthknowledge, 2017; Judge and Paterson, 2017).

### 5.6 Neo-materialist

The neo-materialist explanation extends the materialist analysis by examining the mechanism through which the living conditions come about. It asserts that economic inequality affects population health by means of investment in health-enhancing infrastructure. Lynch et al. (2000) argued that the effect of income inequality on health reflects both a lack of resources held by individuals, and systematic under-investments across a wide range of community infrastructures. “Infrastructure” refers to any number of factors ranging from provision of clean water and sewer systems to access to high quality medical care to pollution abatement laws.
According to Lynch et al. (2000), understanding the patterns of strategic public and private investment in what they call “neomaterial living conditions” is likely to provide the most complete interpretation of the mechanisms between income inequality and health. Figure 6 depicts a neo-material interpretation of income inequality and health (Judge and Paterson, 2001 adapted from the model presented by Lynch et al., 2000).

Background historical, cultural, political, and economic factors, both create income inequality and, through the lack of resources held by individuals and inadequate investment, negatively impact upon the community infrastructure. The figure shows that both pathways are detrimental to social cohesion and trust.

The figure also suggests that there is no necessary observable association between income inequality and health at the aggregate level. The association between geographic variations in health and income inequality may depend upon the nature and distribution of the community infrastructure, characterized by “neomaterial living conditions”. Nevertheless, the extent of income inequality will always be directly associated with health inequalities at the individual level through its role in determining individual income and, in turn, the ability to buy health-related goods and services. This is consistent with the association established between income and health at the individual level discussed in the materialist section earlier.

In summary, the neo-materialist view directs attention to both the effects of living conditions – the social determinants of health – on individuals’ health, as well as the societal factors that determine the quality of the distribution of these social determinants of health. How a society decides to distribute resources among citizens is important. This distribution of resources can vary widely from country to country,
5.7 Psycho-Social Theory

This approach de-emphasizes the importance of material pathways. Psychosocial explanations see neurohormonal pathways as connecting the psychosocial and biological changes. Social inequality may affect how people feel which in turn can affect body chemistry. For example, stressful social circumstances produce emotional responses which bring about biological changes that increase risk of heart disease. Psycho-social risk factors include social support, control and autonomy at work, the balance between home and work, and the balance between efforts and rewards.

There has been a plethora of research exploring associations between psycho-social factors and health. Evidence shows that people who have good relationships with family and friends, and who participate in the community, have longer life expectancies than those who are relatively isolated (Healthknowledge, 2017).

Marmot and Wilkinson (2001) produced evidence that supports the view that economic and social circumstances affect health through the physiological effects of their emotional and social meanings, not just through the direct effects of material circumstances. They do not accept that material conditions adequately explain health inequalities. Both interpretations are of equal validity: Recognizing that the socio-economic structure has powerful psychosocial as well as material effects means that it is important to identify and tackle the structural issues.

There are two mechanisms by which the psychosocial factors may affect health. At the individual level, the perception and experience of one’s status in unequal societies lead to stress and poor health. Psychosocial health impacts stem from feelings of social exclusion, discrimination, stress, low social support, and other psychological reactions to social experiences. Feelings of shame, worthlessness, and envy can lead to harmful effects upon neuro-endocrine, autonomic and metabolic, and immune systems (Wilkinson, 1996, 1997; Lynch et al., 2000).

The psychosocial comparison explanation considers whether people compare themselves to others and how these comparisons affect health and wellbeing. This approach holds that the social determinants of health play their role through citizens’ interpretations of their standings in the social hierarchy. It emphasizes the role of subjective measures of wealth and considers psychosocial pathway link between income and health. It implies that, beyond a certain basic level of wealth, health is more closely linked to how egalitarian a society is (Arcaya et al., 2015; Smith et al., 2016; WHO, 2017d).

The psychosocial comparison explanation includes the “income inequalities hypothesis”, or the “relative income hypothesis”, which posits that an individual’s health depends not only on his own income (absolute income) or wealth and but also what others in a population earn (relative income). It emphasizes the role of subjective measures of wealth and considers psychosocial pathway link between income and health. It implies that, beyond a certain basic level of wealth, health is more closely linked to how egalitarian a society is (Arcaya et al., 2015; Smith et al., 2016; WHO, 2017d).
As such, addressing material factors alone may not be sufficient to reduce health inequalities.

For example, living in a non-egalitarian society can lead to an individual’s long-term feelings of subordination or inferiority that in turn can stimulate stress responses with consequences in poorer physical and mental health. Comparisons to those of a higher social class can also lead to attempts to alleviate such feelings by overspending, taking on additional employment that threaten health, and adopting health-threatening coping behaviors such as overeating and using alcohol and tobacco (Bartley 2003; Arcaya et al., 2015).

At the communal level, widening and strengthening of hierarchy weakens social cohesion, which is a determinant of health. The social comparison approach directs attention to the psychosocial effects of public policies that weaken the social determinants of health.

### 5.8 Political Economy Theory

The political economy theory of health inequalities draws on materialist and psychosocial explanations, but highlight that these social determinants of health are themselves shaped by macro-level structural determinants, including politics, the economy, the state, the organization of work, and the labor market (Bambra 2011; Ottersen et al., 2014).

The distributions of social determinants are shaped by public policies that reflect the influence of prevailing political ideologies of those governing a jurisdiction. Politics, and the balance of power between key political actors/groups, determine whether, for example, states provide collective interventions to reduce inequalities (as would be expected in a strong welfare state) and whether policy interventions are individually, environmentally, or socially focused (Mikkonen and Raphael, 2010).

For example, the existence of public policies and services can shape the extent to which key goods and services, such as schools, transport, and welfare, are dependent on wealth. Likewise, Sewell (2016) argued that many racial disparities in health are rooted in political economic processes that undergird racial residential segregation at the mesolevel—specifically, the neighborhood.

### 5.9 Life Course Perspective

The life-course perspective considers the importance of timing and the whole life course, rather than just particular points within it, in the explanation of health inequalities. Taking a life course perspective involves considering the various risks that individuals are exposed to across their life courses, from fetal development through to old age. This is particularly important for chronic diseases, many of which are known to have long latency periods (Arcaya et al., 2015; Smith et al., 2016).

A lifecourse approach has its origins in the discipline of epidemiology. Life-course epidemiology is the study of long-term biological, behavioural and psycho-social processes that link adult health and disease risk to physical or social exposures acting during gestation, childhood, adolescence, earlier in adult life, or across generations (Kuh and Ben-Shlomo, 1997).
A life-course approach recognizes the unusually high number of critical or sensitive periods during childhood and adolescence. A critical period occurs when there are rapid and usually irreversible changes towards greater complexity taking place. Influences in these periods can have long-lasting, permanent effects. A sensitive period is also a period of rapid change, but one in which there is some scope to modify, or even reverse, the changes at a later time (Kuh and Ben-Shlomo, 1997; Law, 2009).

A life-course approach illuminates the role of childhood disadvantage in determining adult health and inequalities in adult health. Graham and Power (2004) describe two main pathways through which childhood disadvantage results in poor adult health. First, childhood circumstances may influence adult circumstances which in turn affect adult health. For example, poor educational attainment is associated with increased risk of unemployment, and joblessness is associated with poor adult health.

Second, the circumstances that children experience as they grow up influence their childhood health and development (in the widest sense to include mental, social and emotional health as well as physical health and health behaviours). Good childhood health tends to lead to good adult health and vice versa. For example, a mother living in disadvantaged circumstances has a high risk of giving birth to a low birth weight child, and low birth weight is associated with a range of adverse health outcomes in childhood as well as adult life (Graham and Power, 2004; Law, 2009).

Applying a life course perspective to the consideration of the other explanations entails that factors from each category may serve as main exposures, mediators, or moderators, which create a useful but complex causal model in thinking about how health inequalities arise (Arcaya et al., 2015).

6. Models of Health Inequalities

There are a myriad of models that have been constructed to explain the multiple causes or factors that determine health and health inequalities. Some of them are revisited as follows.

6.1 Dahlgren-Whitehead Model

Göran Dahlgren and Margaret Whitehead in 1991 developed the “rainbow model” of health determinants (Figure 7). It maps the relationship between the individual, their environment and health. This framework can help researchers to construct a range of hypotheses about the determinants of health, to explore the relative influence of these determinants on different health outcomes, and the interactions between the various determinants. It can be used to discuss existing approaches to the study of inequalities (Dahlgren and Whitehead, 1991; ESRC. 2017).

At the heart of the Whitehead-Dahlgren model are the biological factors, including age, sex, and hereditary factors. These factors represent biological variations over which the individual has no control.

Surrounding these biological determinants are direct and indirect health influences located in different layers. The first layer, also known as the micro level or
“downstream” level, describes individual behavioral factors, some of which may be labelled “lifestyle”. These factors include smoking, alcohol consumption, eating patterns, and propensity to exercise, which are to some degree controllable. Some of these are theorized to have direct effects on health outcome, while others are seen to operate indirectly. By far the most numerous of the epidemiological studies have directed at understanding the role of risk factors such as these in health inequalities. This body of work is widely referred to as “risk factor epidemiology”.

The second layer, also known as the meso level, describes health influences due to individuals interaction with their peers and immediate community. These factors at the community level include social and community networks and social capital. There are some potential pathways by which neighborhoods share characteristics that might influence their health (Macintyre et al., 1993; Graham, 2009):

1. Physical features of the environment shared by all residents in a locality (for example, air and water quality)
2. Availability of healthy environments at home, work and play (for example, decent housing, secure and non-hazardous employment, safe play areas for children)
3. Services provided to support people in their daily lives (for example, education, transport, street cleaning and lighting, and policing)
4. The socio-cultural features of a locality (for example, its political, economic, ethnic and religious history, the degree of community integration)
5. The reputation of an area (for example, how the area is perceived by residents, service or amenity planners, and investors)

The third layer, also known as the exo level, describes health influences due to individuals living and working conditions, food supply, access to essential goods and services, including health care services. The fourth layer, also known as the macro level or “upstream” level, describes mediators of population health, including the wider economic, cultural and environmental influences prevalent in the overall society (Dahlgren and Whitehead, 1991).
This model for describing health determinants emphasizes interactions. Individual lifestyles are embedded in social norms and networks, and in living and working conditions, which in turn are related to the wider socioeconomic and cultural environment. As such, health (or the lack thereof) is associated with a complex, and not entirely understood, interplay among innate individual factors (e.g., a person’s sex, age, and genes), personal behavior, and a vast array of powerful environmental conditions (Dahlgren and Whitehead, 1991; 1997).

Because health is influenced by these complex interactions and because many threats to health (e.g., drug-resistant microbes or environmental contaminants) confront entire populations, protecting and assuring the population’s health requires an organized communal undertakings.

6.2 The Commission on the Reduction of Health Inequalities Model

The Commission on the Reduction of Health Inequalities in Spain (2010) constructed a conceptual framework of the determinants of social inequalities in health, based on the models proposed by Orielle Solar and Alec Irwin for the WHO Commission on Social Determinants of Health and by Vicenç Navarro. This framework comprises structural determinants of health inequalities and intermediary determinants (Figure 8).

The structural determinants of health are made up by two components: (1) Socioeconomic and political context; and (2) Social structure. The socioeconomic and political context refers to the political traditions, policy choices, and social-economic actors, that significantly affect social structure and distribution of money, power, and resources within the social structure, at global, national, and local levels.
The social structure refers to the various dimensions of inequality in society pertinent to social class, gender, age, ethnicity, race, and territory. These dimensions define the differential opportunities for good health due to inequalities in power and access to resources within the social structure as manifested in discrimination and unfair class, gender, or race relationships.

For example, differences in health between men and women are not only biological, but are also gender inequalities due to the social differences that exist between sexes involving differences in education opportunity, employment condition, burden of housework, etc. The uneven distribution of roles and power between men and women leads to different uses of time with an impact on health. The greater burden of domestic work and care prevent women from investing the same time as men in paid work and leisure activities, including physical activity.

Similarly, age (beyond its biological implications), race, ethnicity, and place of origin are other individual characteristics that, depending on the historical context of a country, gain social relevance and can determine health inequalities linked to discrimination and segregation processes.

The social structure determines inequalities in intermediary factors which, in turn, determine health inequalities. The intermediary determinants of health inequalities are made up by the material resources available for the individuals and communities, as shaped by the social structure. These material resources include: (1) Employment and working conditions (job situation, job insecurity, physical and ergonomic risks, working organization and its psychosocial environment); (2) Burden of housework and caring; (3) Income and financial situations (income level, economic and property status); (4) Housing and material assets (ownership and quality of housing and its equipment); and (5) Residential environment (physical characteristics of the residence area and neighborhood).

The material resources, which are shaped by the socioeconomic and political context and the social structure, are often referred to as social determinants of health (SDH). The social determinants of health is defined as the conditions in which people are born, grow, live, work and age (WHO, 2017d, CSDH, 2017). The SDH are responsible for health inequities with some mechanisms as follows. First, the environment in which people live and work determine their individual experiences or response such as the income they earn, the house they live in, the food they eat, the services they access etc, which influence the capacity to create health. Thus, the differences in health and wellbeing are manifestations, or symptoms, of the social inequalities experienced throughout the life course (Beeston, 2014; Braveman, 2014; CSDH, 2017).

Second, the social environment in which people live and work determine the extent of social inequality, the nature of social relationship, and psychosocial process, existing within a society. Social inequality may affect how people feel which in turn can affect body chemistry. Psychosocial risk factors, including the lack of social support, stressful situations (negative life events), etc. influence health.

Third, the socioeconomic contexts in which people live and work influence health behaviors and lifestyle which people adopt, particularly those behaviors which adversely
affect health (smoking, poor diet, lack of physical activity, excessive alcohol consumption and irresponsible sexual behavior).

Fourth, some of the material resources as well as physical environment interact with human biology over time to influence distribution of health across groups (e.g. age, sex). Fifth, the material resources also include the health system available for the communities. Although health services themselves scantily contribute to generating health inequalities, less access and lower quality of health services may result in worse health outcomes.

7. Tackling Health Inequities

Policies to reduce health inequalities are a priority to many countries and respond to goal number 2 of the World Health Organization (WHO) Health Strategy for the 21st Century: “By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all Member States, by substantially improving the level of health of disadvantaged groups” (WHO, 1999; WHO, 2005).

Health inequities have their roots in the socio-political decisions and the resulting unequal distribution of power, money and resources. The socio-political decisions drive the distribution of wider environmental influences that create or undermine health through the availability or not of good jobs, housing, transport, education, shops, services, green space etc.

As such, these social determinants of health and health inequalities need to be addressed at various levels. High-level macro social and economic policy changes that reduce overall inequality are fundamental. Economic/social disadvantage can be ameliorated by social policies, such as minimum wage laws, progressive taxation, and statutes barring discrimination in housing or employment based on race, gender, disability, or sexual orientation (Danaher, 2011; Braveman, 2014; BPHC, 2017; Health Scotland, 2017; WHO, 2017d).

At the same time, community level policy, programs, and investment to ameliorate the impact of health and related inequalities, to adapt national strategy to local conditions, to more effectively coordinate local services, and to leverage and integrate local community-based initiatives are also crucial (Danaher, 2011).

7.1 Three Ways of Addressing Inequalities

The objective of reducing inequalities can be pursued by focusing on three ways: (1) Remediying the health of the most disadvantaged; (2) Narrowing the health gap; and (3) Reducing the health gradient (Graham, 2004).

1. Remediying the Most Disadvantaged

One common way to address health inequalities is to direct policies at the most disadvantaged groups in an attempt to raise their health status. The powerful moral argument behind this approach is that health is a basic need which no one should be unnecessarily denied (Graham, 2004).
The policy advantage of this approach is that defining health inequalities as health disadvantages aligns public health policy with other elements of the government’s welfare program. It allows connection between public health and social exclusion agenda, steering both towards interventions targeted at groups vulnerable to social disadvantage.

However, defining health inequalities as health disadvantages poses some problems. It turns socioeconomic inequality from a structure which impacts on all to a condition to which only those at the bottom are exposed. Firstly, tackling health inequality is not a population-wide strategy. Instead, it is one confined to sub-groups which make up a relatively small proportion of the population. it is therefore possible for the targeted policies to have negative effects on the health of other groups, either in absolute or in relative terms.

Secondly, tackling health inequality does not extend to bringing levels of health in the poorest groups closer to the national average. In a society where overall rates of health are improving, absolute improvements in their health may be insufficient to narrow the gap between the worse and better off (Graham, 2004).

2. Narrowing the Health Gaps

The health gap is a measure of health inequality widely used in research to compare the health of those at the extreme ends of the socioeconomic hierarchy. The health gap is typically expressed as the ratio of one group to the other, for example, the odds of poor health in the lower group relative to that in the higher. Through its incorporation into health policy, the range has increasingly served, not simply to measure health inequality, but to define it. This measure of health inequality is an important driver for policy. It draws attention to the fact that population averages mask wide differences in health between social groups (Graham, 2004).

The moral case for addressing health gaps is enshrined in the constitution of the WHO. Its guiding principle, that “the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being”, was reiterated in the 1998 World Health Declaration (World Health Assembly, 1998).

However, while the goal is more ambitious, the underlying model of health inequalities is the same. The burden of ill health resulting from social inequality is again seen to fall on the poor alone. Like a health-disadvantages approach, a health-gaps perspective conflates inequality with disadvantage, and health inequality with the health deficits of being poor.

A health-gaps understanding of health inequalities limits the reach of public health policy in a number of important ways. Firstly, it directs effort at minorities rather than the majority. Much less attention has been given to how the privileges enjoyed at the top of the socioeconomic hierarchy facilitate rates of health improvement which have consistently outstripped those of other socioeconomic groups.

Secondly, in focusing attention on the worst off, it can obscure what is happening to intermediate groups. The health-gaps approach can underestimate the pervasive effect which socioeconomic inequality has on health, not only at the bottom but also across the socioeconomic hierarchy.
Thirdly, the focus on health-gaps can also be challenged on moral grounds. It raises ethical question if it is acceptable “to give absolute priority to improving the health of the worst-off class if those who are next to the worst-off are also doing very badly” (Marchand et al., 1998).

3. Reducing the Health Gradient

Further along the continuum, health inequalities are not only about health differences between poorer and better-off groups. Health inequalities follow a social gradient. They are related to an individual’s position in society at every level. Data from around the world show that socially constructed gradients exist in every country and can be described by differences in social economic position, such as education (Figure), and place of residence (Figure). Reducing the health gradient means looking not only at the gaps that exist between those at the top and at the bottom of the scale or at the situation of those most disadvantaged, but also at how health is distributed across all population group (Graham, 2004).

Data from around the world show that socially constructed health gradients exist in every country and can be described, for example by differences in education (Figure 9), or place of residence (Figure 10).

The moral case for tackling socioeconomic gradients lies in the moral equality of people with respect to health. As the WHO constitution states, and the Health For All charter reasserts, the highest attainable standards of health should be within reach of all “without distinction for race, religion, political belief, economic or social condition” (Graham, 2004).

A focus on socioeconomic differentials rather than on social disadvantages widens the frame of health inequality policy in three major ways. Firstly, it searches for the causes of health inequality, not in the disadvantaged circumstances and health-
damaging behaviours of the poorest groups, but in the systematic differences in life chances, living standards and lifestyles associated with people’s unequal positions in the socioeconomic hierarchy.

Secondly, tackling health inequalities becomes a population-wide goal. Like the goal of improving health, it includes everyone. Framed in inclusive terms, a health-gradient approach directs attention to the composition of the population: to the distribution of socioeconomic advantage and disadvantage.

Thirdly, reducing health gradients provides a comprehensive policy goal: one that subsumes remedying disadvantages and narrowing health gaps within the broader goal of equalizing health chances across socioeconomic groups.

7.2 Principles in Tackling Health Equities

1. Addressing Social Determinants of Health

Efforts to reduce health inequalities need to address social determinants of health and to be extended to tackle social inequalities. Achieving health equity requires creating fair opportunities for health and eliminating gaps in health outcomes between different social groups. It requires solutions outside of the health care system, involving changes in environmental regulation, education, housing, employment, income, and transport policies, so as to improve the opportunities for health in communities (Danaher, 2011; Braveman, 2014; BPHC, 2017; Health Scotland, 2017; WHO, 2017d).

Health-improving structural changes to the environment, legislation, fiscal policies, income support, accessibility of public services and intensive support for disadvantaged population groups are all likely to be effective in reducing health inequalities. In contrast, information-based campaigns, written materials, information campaigns reliant on people opting-in and messages designed for the whole population are least likely to reduce health inequalities (Danaher, 2011; Braveman, 2014; BPHC, 2017; Health Scotland, 2017).
The social determinants of health are complex, dynamic and inter-dependent. This means that the impact of any single government, policy lever, or program in isolation is necessarily limited. A key driver for multiple sectors to work together is the recognition that solving complex health and social problems is beyond the capacity of any one sector and beyond the realm of the health sector alone (CSDH, 2008; Danaher, 2011; WHO, 2017d).

2. Policy Development and Implementation

The ability to get policies and decisions implemented effectively has become a key principle in the delivery of the government’s reform program in health. The complexity and breadth of the health inequalities agenda, at both national and local levels, are certain. Therefore, implementing policy and delivering improved health poses a significant challenge. If progressive policies are to succeed, there needs to be a shift from hierarchical and command-and-control modes of operating to more lateral network models. An optimal balance between the top-down approach and bottom-up translation is required (Hunter and Killoran, 2004).

This is not solely a management process – politics and power are fundamental. Unequal distribution of power across the population is one of the fundamental causes of health. Social inequalities, driven by the distribution of power, income and wealth, shape health inequalities within populations. Therefore, power imbalances and powerlessness must be addressed if the needs of the most deprived communities are to be given due attention (Dahlgren and Whitehead, 2007; Hunter and Killoran, 2004).

Evidence-based policy is desirable to ensure public policies and interventions optimize benefits and minimize negative outcomes, and use scarce resources effectively. There are gaps in the evidence, and further research is necessary, but there is an equal challenge in implementing what has been proven to work. In some cases research exists, but is not exploited. There may be a case for shifting the balance in “research and development” in favor of development, to provide a greater understanding of the process of change. This may mean a more prominent role for action research (Hunter and Killoran, 2004).

3. Promoting active citizenship

Interventions which enhance participation in the democratic process and promote genuine empowerment of the whole population are likely to make important contributions to reduced inequalities. At a community or local level, inter-sectoral collaboration can involve a wide range of district and municipal government agencies, social service providers, foundations, business, community-based organizations, and other stakeholders coming together (Dahlgren and Whitehead, 2007).

The focus of collaboration can range from improving service coordination, through community development and advocacy, to comprehensive community initiatives to address the structural foundations of health and other inequalities.
4. Developing Multi-Sectoral Policies and Actions

Developing multi-sectoral policies and actions are critical to the success of policies to tackling health inequalities. Addressing systemic health inequalities and their underlying social determinants are complex and challenging social and policy problems. One increasingly important direction that addresses the dynamic and inter-dependent nature of the social determinants of health has been through collaboration across different policy and program sectors (Dahlgren and Whitehead, 2007; Danaher, 2011; WHO, 2017ad).

Health in All Policies (HiAP) is recommended to tackle health inequities. It is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies, and avoids harmful health impacts, in order to improve population health and health equity (WHO, 2013b).

This inter-sectoral collaboration can operate at the policy level - where different departments and agencies within a government or different levels of government coordinate or share responsibility for policy development and implementation.

8. Conclusion

Pervasive and systemic health inequities are a serious problem within and between countries around the world. There is consistent and inequitable gradient of health in which people with lower income, education, or other resources have lower life expectancy, higher rates of chronic disease and poorer overall health. The basis for these health inequities lies in wider structures of social and economic inequality and in access to adequate housing, nutrition, safe environments, and overall social determinants of health.

Addressing systemic health inequalities and their underlying social determinants are complex and challenging social and policy problems. The complexity of the causes of inequalities in health means that multifaceted and therefore multisectoral action is required to tackle the problem. Interventions must tackle the macroenvironmental factors (income and education) and the physical and social environment, as well as adverse health behaviors and access to health care.

Making the broad changes needed to improve health inequities requires collaboration and partnerships across sectors. It requires engagement of unusual players such as public health professionals, businesses, planners, economists, academics, and faith-based leaders, in addition to public health professionals and traditional social service-related fields. A challenge all countries face is the shortage of evidence on effective interventions to reduce inequalities in health.

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