

Report on Socio-Economic Differences in Health Indicators in Europe

Health inequalities in Europe and the
situation of disadvantaged groups



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Europe and the situation
of disadvantaged groups**

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 **Foreword**

The issue of social inequality in health had for quite some time been regarded as a problem of the past within the countries of Europe. But since the mid 1980s it had been pointed out in many reports that this was a false conclusion. The enormous differences in health which had still existed between the social groups in the 19th century had been reduced thanks to changing living conditions and a health and social policy favouring the lower social groups. However, even at the end of the 20th and at the beginning of the 21st century differences in the health of persons belonging to different social groups can be observed. These differences are less obvious but they are nevertheless a reason for concern.

It is the task of health reporting to identify problems in health or health care based on the description of the population's health and, as far as possible, describe ways of finding a solution to the problem. Therefore health reporting is required to provide information on the health status of the population also depending on its social status and on this basis point out to approaches for reducing or even eliminating the problem.

In principle, the issue of social inequality in health can be approached from two different points of view. First, related to the overall population stratified by different socio-economic characteristics such as education, occupational status or income. The health status of each social group can be determined or the correlation between social status and health can be quantified across all social groups. This population-related approach corresponds with strategies in health and social policy. A second approach is related to individual population groups living in an especially unfavourable situation or to marginalized groups. To define these groups various categories are used such as „living in poverty“ or „migration“. The social groups built based on these horizontal characteristics are regarded as socially disadvantaged or prone to health risks. At the level where action is taken this approach, due to the in each case specific needs in health care of the individual population groups, corresponds more with target-group specific measures than with strategies pertaining to society as a whole.

”Monitoring and reporting of socio-economic differences in health indicators in the European Union”

The project „Monitoring and reporting of socio-economic differences in health indicators in the European Union“ (sponsored by the European Community represented by the Commission of the European Communities; Agreement/Contract No SOC 98 201376 05F03) was intended to examine the European dimension of this problem. The project was aimed at developing bases for a system with which socio-economic differences in health can be observed (monitoring) and conveyed to health care actors (reporting). In accordance with this aim the project is made up of two parts: in a first part monitoring guidelines including references to the social indicators to be used were developed. With the help of these guidelines the health differences between the different social groups in Europe were determined and the development over one decade was described (Kunst, Bos, Mackenbach 2001). The second part of this project consisted in developing a concept for a health monitoring scheme on socio-economic differences in health and in translating this concept into practice as a pilot scheme.

The health reporting concept developed on „Social inequalities in health“ can be outlined as follows: At first the two approaches of describing social differences, both the horizontal and vertical approach, should be used. The report should not be restricted to a description of the correlation between social disadvantages and a poor health status but also discuss possible causal correlations between the two conceptions. On this basis it should be possible to develop strategies for eliminating socially caused inequalities in health. This report should not be addressed to scientists only but to persons who are actively involved in health policy. These are the major points determining the drafting of this pilot report.

Policy-oriented report about socio-economic inequalities in health in Europe

The introductory part of the pilot report deals with the question as to why socially caused differences in health were under discussion in the last two decades of the 20th century. In this context the relevance of this issue both for the individual countries of Europe but also for Europe as a whole is described.

The second part describes evidences for the correlation between social status and health. Following a short historical excursion, the countries of Europe are

compared with regard to these two characteristics and from this ecological approach first conclusions on the correlation between health and social status are drawn. These are illustrated with the help of data collected under the project part "Monitoring socio-economic inequalities in health indicators". It turns out that in a population stratified by education, income and occupation the lower social groups have a poorer health status. This situation has not improved from the 1980s to the 1990s but deteriorated.

The health status of especially disadvantaged population groups is treated in the third part of the report. Eleven groups are described as an example; they can be distinguished both by their numbers and the nature of their health problems: "Children living in poverty", "old people living in poverty", "single-parent families", "unemployed young people", "long-term unemployment", "migrants", "asylum-seekers, refugees and people with illegal abode", "homeless people", "alcohol addicts", "consumers of hard drugs" and "prisoners".

A further chapter of the report analyses how the correlation between social status and health can be explained. Besides the rather unlikely possibility of an artefact, the report on the one hand discusses the social selection approach (i.e. social decline of persons with poor health) and on the other hand the approach of health impairing lifestyles in lower social groups and/or disadvantaged population groups. Both explanations do not exclude each other but underline the close correlation between social and health-related matters which may exacerbate each other in a "vicious circle".

In the final part of the report strategies are discussed with the help of which socially caused inequalities in health can be reduced. In this context the possibilities health care has to counteract social disadvantages are addressed as well as the necessity to also include other areas of policy above all social policy into the development of strategies for eliminating socio-economic differences in health.

This pilot report was drawn up under the project „Monitoring and reporting of socio-economic differences in health indicators in the European Union“ and forwarded to the European Commission along with the final report. Slightly reviewed, this report is now made accessible to a broader public.

**Part 1**
Introduction**Relevance of inequalities since the last two decades**

For the developed industrialized countries of Europe, the 20th century is characterized by the establishment of comprehensive social protection systems and far-reaching medical progress. For entire population groups this had led to an increase in their life expectancy and to a rise in the scope and quality of medical care to an extent up to then unimaginable. A pronounced reduction in infant and children's mortality as well as the containment of endemic infectious diseases illustrate this development in a special way. Thus it seemed to have been possible to invalidate the historic equation of poverty and death, of social disadvantages and increased morbidity risk and/or inferior health care. In the post-war decades, most west European countries thus attached little attention to the topic of 'socio-economic inequalities in health', their health policy was restricted to the well-directed extension of medical care to reduce inequalities in isolated areas.

At the beginning of the 80s, however, this situation changed: the Research Working Group on Inequalities in Health set up on instruction by the British government submitted the 'Black Report' which documented significant social class-related differences in the mortality of the British population both for men and for women. The same negative correlation could be observed for the frequency of certain chronic diseases and for the demand of medical and in particular preventive health care services - in a country which in the post-war period had set up the National Health Service to secure comprehensive health care. Later studies referred to a deterioration of this situation in the 1980s and early 90s, similar findings were discovered for the Scandinavian welfare states and other European countries.

During the 80s and early 90s, almost all European nations, after phases of continuous prosperity, were confronted with phases of economic depression leading

to a general deterioration of the socio-economic situation. In 1994, the average unemployment rate at EU level reached 11%, more than three times as high as in the 1970s with an increasing share of long-term unemployment. The benefits of the welfare state are questioned, in many cases cuts in social services within the framework of 'modernization policies' are the result and prepare the ground for increasing disparities. A result of the Europe-wide globalization are social differentiation processes among regions, parts of a region and cities on the one hand and segregation processes within these areas on the other hand.

These changes have led to a relative deterioration of the health status of the population of individual countries particularly in east Europe and to an increasing differentiation among individual groups also within prosperous European countries. Worsening economic conditions and restructuring health care systems in eastern European countries have meanwhile led to a gap of 15 years in the average life expectancy between east and west of Europe, and for the first time since World War II the average life expectancy in Europe was thus declining.

Stimulated by these developments, the topic of social inequalities before disease and death was increasingly put back on the health policy agenda in the 1980s. In retrospect, the special significance of the Black Report has to be seen in the fact that here for the first time - commissioned by national authorities - the attempt was made to find the reasons for undeniable inequalities in health and to link these explanations to a series of health policy-related recommendations for the promotion and/or restoration of health: improvement of the material living situation of poor population groups - especially for children and people with handicaps, including a realignment of health and social services. The report can be seen as the forerunner of a broadly based strategy of drawing the attention of health policy makers to research results on inequalities in health now increasingly submitted in many European countries. The existence and the scope of inequalities both of the health status and access to health services could be examined and certified by empirical social research for almost all European countries. This 'mountain of evidence' led to the formulation of a new maxim in the combat against inequalities in health:

"The debate is no longer about whether inequalities in health exist, but what can be done about them."

The European perspective

In some European countries, this new orientation towards actively combating inequalities led to a concentration on smaller manageable problem areas at different levels, instead of developing and pursuing comprehensive programmes. The demand for realizing health-related equality was adopted as a resolution of the WHO Europe:

"By the year 2000, all citizens should have reached health standards allowing them to lead a socially and economically productive life."

The revision of the recently readopted targets for Europe includes the following self-commitment of the EU Member States in target 2 of "The Health 21 Strategy":

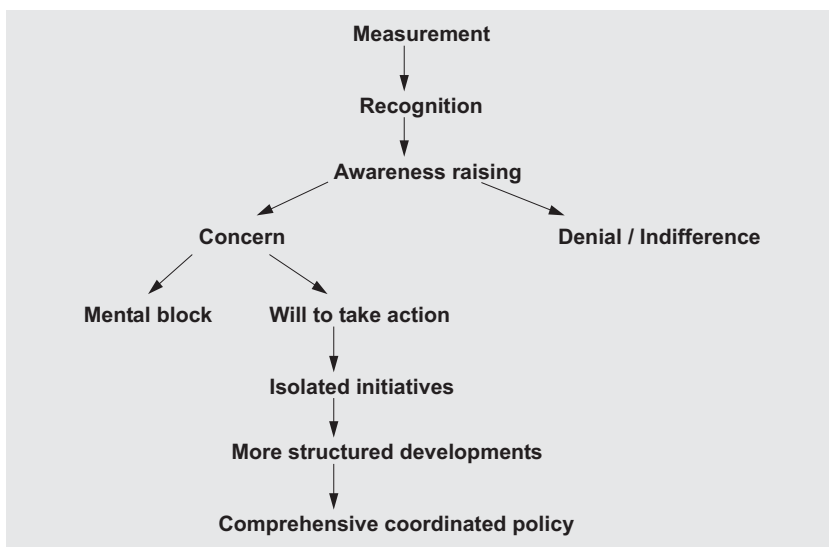
"By the year 2020, the health gap between socio-economic groups within countries should be reduced by at least one quarter in all Member States, by substantially improving the level of health of disadvantaged groups."
(WHO Europe, 1999)

Quite deliberately, target 2 quoted from the WHO Health 21 Strategy is not aimed at realizing **equal health** for all parts of the population, but calls for the realization of equal chances in health for all citizens. Accordingly, the WHO Strategy for Europe is geared to the following core elements:

- lifestyles and health,
- factors influencing health and the environment,
- realignment of the health care system,
- mobilising political, social as well as interdisciplinary and cross-sectional support for bringing about the necessary changes.

The attention the overall issue of 'inequalities in health' as a problem in health policy has received at the national and international level is documented by a variety of extremely heterogeneous activities over the last years. On a scale reflecting possibilities of how to express attention for the issue of health inequalities, the spectrum of presently observed activities on the one hand ranges from countries which up to now have not even established corresponding information systems for monitoring inequalities in health - let alone recognize that inequalities do exist within their territories - to a few countries on the other hand which have developed a coordinated national strategy for coping with the problem. In addition to such primarily isolated activities efforts are however being made to come to a more coordinated approach at the international level (fig. 1-1).

Fig. 1-1



Action spectrum on inequalities in health in European countries

Source: Whitehead, M. 1998

In the field of social science research, this has at first led to a number of cross-country studies to empirically prove the existence of social inequalities before disease and death. In particular two recent activities are of fundamental importance which could provide comprehensive and Europe-wide comparative surveys

on available data sets on inequalities in health (Doorslaer et al. 1997; Mackenbach et al. 1997) and thus impressively document the negative impact of elements of social inequalities on health.

Taking the ball: growing importance of the EU

However, also with regard to awareness in health policy and reactions to the overall complex of social inequalities and health, a clearly increasing European dimension has to be observed. So the realization of equal living conditions and chances to lead a life in health and social security for all citizens is one of the most important elements of the European Unification process.

The Maastricht and Amsterdam Treaties have given the European Community a legally confirmed mandate in the field of public health, stipulating that the Community shall provide a contribution to securing a high level of health protection. Moreover, quite deliberately, the task of health protection was broadly defined, stating that the necessary requirements should to a large extent be included in other areas of EU policy. Article 152 (formerly 129) gives the Community a complementary and subsidiary role in the health sector and concentrates the activities of the Community on the fields of prevention and health promotion whereas direct health care exclusively remains within the competence of the Member States. Following the Maastricht Treaty, the Community has identified a number of priority areas which in addition to combating cancer and certain communicable diseases, health promotion, etc. above all include the improvement of health monitoring. In addition to the achievement of a generally high level of health above all the realization of equity in health is a major objective in European health policy.


Part 2
Health Inequalities - an Overview

The discussion on social inequalities before disease and death is looking back on a long tradition. Evidence of substantial socio-economic differences in mortality has been shown for European regions for the 17th and for the 18th century, when survival rates of children of Europe's ruling families were far ahead e.g. of those of the inhabitants of the City of Vienna (Whitehead 1997). In the post-neonatal period, a mortality rate of 106 per 1,000 was registered for members of the ruling families as opposed to a rate of 331 for the Viennese population. The 19th century faced dramatically increasing populations and two major social problems, growing numbers of people in poverty and a variety of negative consequences of industrialization.

Improved statistical data revealed enormous differences in the life-expectancy between rural and urban districts and between social groups, and provoked political action. Table 2-1 gives a rough impression of such differences in longevity in England, due to lacking age standardization the evidence of this estimate is of course restricted.

Tab. 2-1

District	Gentry and professional	Farmers and tradesmen	Labourers and artisans
Rural			
Rutland	52	41	38
Urban			
Bath	55	37	25
Leeds	44	27	19
Bethnal Green	45	26	16
Manchester	38	20	17
Liverpool	35	22	15

Average age of death in families in selected English districts, by class and area of residence, 1838-41

Source: Whitehead 1997

The 19th and 20th centuries went along with dramatic improvements in some of the health indicators for the population in general. A decline in adult death rates started at the end of the 19th century, followed by a declining infant mortality a few decades afterwards.

During the 20th century, chronic degenerative diseases such as coronary heart disease and cancer took the place of infectious diseases which had been the major killers for hundreds of years. Along with morbidity due to 'external causes' such as accidents, violence and suicide, these degenerative diseases were responsible for the majority of deaths at the end of the last century in Europe. The 'return' of certain infectious diseases during the last decades - namely HIV/AIDS - poses new challenges to public health, although, as yet, these causes have not gained a major impact on the morbidity of the population in general.

So, nowadays the term 'inequalities in health' is associated with other forms of evidence than in the days of industrialization. Differences in the distribution of risks regarding morbidity and mortality no longer mean the threatening of individual population groups by death or malnutrition, but differences in:

- life-expectancy (between and within countries);
- healthy life-expectancy;
- distribution of risk factors;
- health-related behaviour, as well as
- access to health care.

Economic growth has been seen as an instrument for the creation of better living conditions in all European countries. Indeed, rises in GDP per capita during the post-war period were associated with improvements in a whole range of living conditions, and especially in gains in life-expectancy at all ages.

Even for the 'rich' countries of the European Union which are marked by a relatively high level of health of the population in general, the existence of a gradient of diseases has been shown, namely in the Whitehall study where Michael Marmot (1984) studied British civil servants. Between the top and bottom of a population, health standards show a continuous social gradient: members of the lowest social groups run at least twice the risk of serious illness and premature death of those of the top groups.

The next chapter will study manifestations of present inequalities between and within European countries in greater detail.

Inequalities relating to overall causes of death and general health

A first look at social and economic indicators shows persisting differences between the Member States of the European Union. Long time trends in life-expectancy show a positive development but substantial differences between European countries. Not all of them already reach the WHO regional target of a life-expectancy at birth of 75 years (tab. 2-2).

Tab. 2-2

	Life expectancy at birth (years)			
	Males		Females	
	1978	1998	1978	1998
Austria	69	74	76	80
Belgium	69	74	76	81
Denmark	71	73	77	78
Finland	68	73	77	81
France	70	74	78	82
Germany	69	74	76	80
Greece	72	76	76	81
Iceland	73	77	79	81
Ireland	70	74	75	79
Italy	70	75	77	81
Luxembourg	68	73	75	80
Netherlands	72	75	79	81
Norway	72	75	79	81
Portugal	67	72	74	79
Spain	71	75	77	82
Sweden	72	76	78	81
Switzerland	72	75	79	82
United Kingdom	70	75	76	80

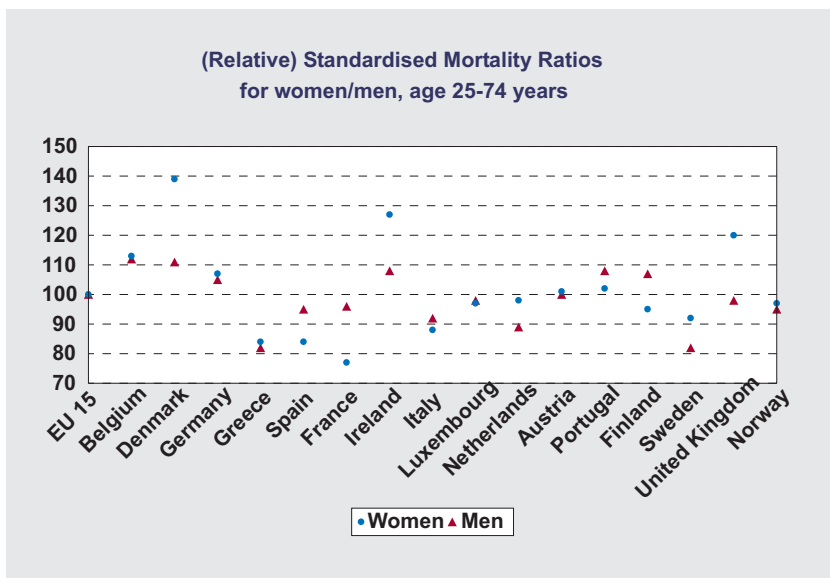
Life expectancy at birth in selected European countries 1978 - 1998

Source: WHO World Health Report 1999

A comparison of mortality ratios, standardised for age and sex structures, shows a similar picture (fig. 2-1):

Besides these differences between countries there is another gap of 5 to 6 years in the life-expectancy of women and men, with the largest differences in France and Finland. Sweden has the largest life-expectancy for both men and women. Rather high rates can also be found for Greece and Italy, for men as well as for women, whereas relatively low levels are to be found among others for Denmark and Finland.

Fig. 2-1



Overall mortality differences in the European Union

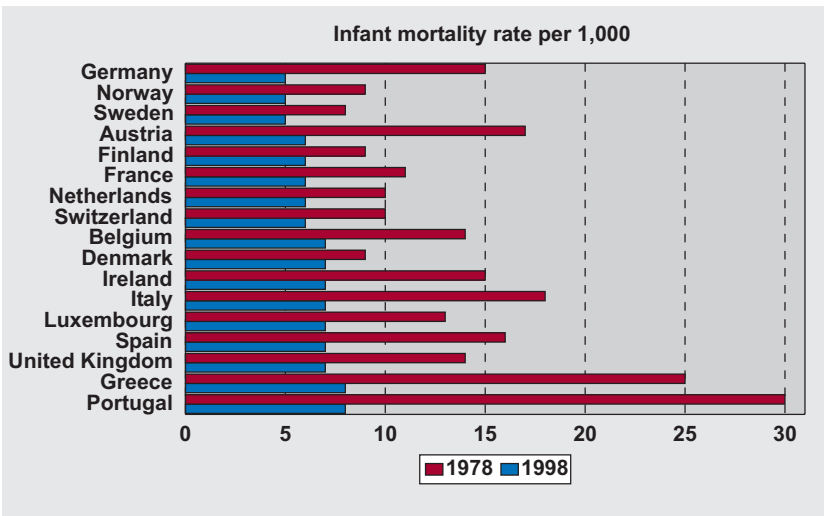
Source: Eurostat 1997

Women in Denmark, Ireland and the United Kingdom face much higher mortality rates than could be expected from the levels for men in these countries. The opposite result is seen for France, Finland, and Spain, with excess mortality for men.

Most of the Mediterranean countries (i.e. Greece, France, and Spain) as well as Sweden at present have SMR-levels below the average rates of the European Union, both for men and women.

Similar differences can be seen comparing the level of infant mortality between selected European countries (fig. 2-2). Obviously, the average rate of infant mortality in Western Europe has considerably decreased during the last 20 years. In addition, the gap between the countries with the lowest and highest rates seems to have narrowed in the same period of time (from 8/30 to 5/9). Especially at the top of the scale, the ranking of the countries has slightly changed: The former leading group of the Scandinavian countries has been substituted by Germany, Norway, and Sweden, while Denmark at present shows a higher rate than Austria, Finland, France, and the Netherlands. Greece and Portugal are still to be found at the end of the scale.

Fig. 2-2



Narrowing the gap in infant mortality in selected European countries

Source: WHO World Health Report 1999

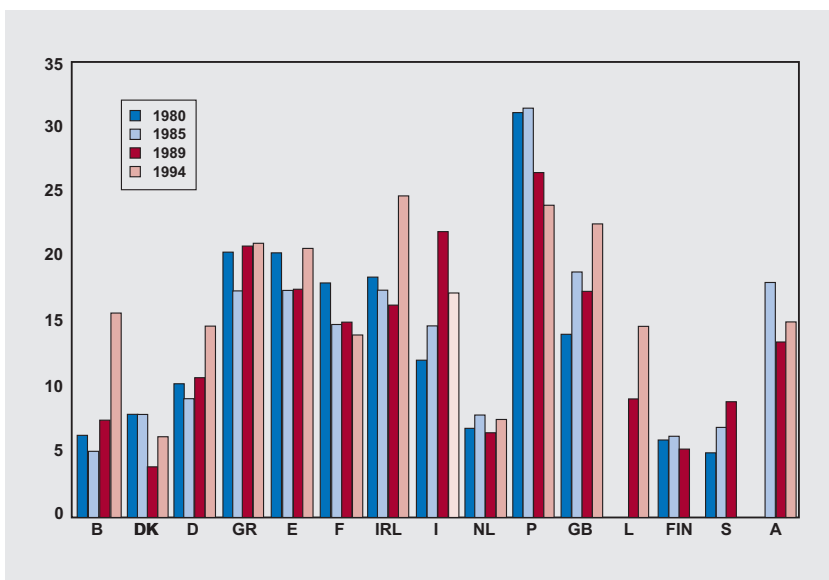
Infant mortality has been regarded as a relatively good crude indicator reflecting the situation of effective health care, and even more as probably the best available

indicator for poverty at the international level. So, these preliminary findings will be discussed when looking at trends in economic differences in Europe.

Poverty and social exclusion in the European Union

Poverty and social exclusion do exist in the Member States of the European Union, even if these countries belong to the most prosperous of the world. Taking into account the criteria for 'poverty' as used by the European Commission (50% or lower of the average monthly national household income, weighted by household size), about 69 million people or 18.5 % of all households were living in such a social situation during the transition period from the 80s to the 90s. Particularly in south European countries poverty rates have been and are still especially high. In Portugal still 24 % of the population live in poverty despite a decrease in the 80s and 90s. With 24.8 % the highest rate is seen in Ireland (see figure 2-3).

Fig. 2-3



Poverty rates in the European Union 1980 - 1994

Source: Huster 2000

On the other hand, Denmark and the Netherlands show poverty rates far under average. Denmark more than halved its rate during the 80s, with a slight re-increase until 1994. Large states such as Germany and France show relatively stable medium rates, following the common trend they increased to about 14 %. The United Kingdom showed a continuously increasing rate and with 22.6 % closed up to the countries of the south. The recent members of the European Union - Austria, Sweden and Finland - have partly moderate rates resp. belong to the segment of the large states.

Poverty and social exclusion are caused by a multitude of factors, and therefore their manifestations may differ. Summing up, special risks of poverty are tied up with unemployment, lack of education and insufficient pension schemes. There is also the fact that certain family constellations - induced by an increasing proportion of lone parent families - do require additional forms of social protection. The distribution of these priority risk factors not only differs between the various Member States but also within these countries, at regional or local level.

Inequalities in health in Europe

Evidence of socio-economic differences in morbidity and mortality in European countries has been proved by various studies, at first in a comparison between countries. Cross-country comparisons may provide evidence for health policy-makers of the relative extent of health inequalities in their own country, may prove the principal reversibility of inequalities by presenting positive trends from other countries, and may provide evidence of the potential impact of welfare state interventions.

Across the countries, a strong connection was found between inequalities in health and inequalities in income. A study on income-related inequalities in self-assessed health in nine industrialized countries revealed remarkable evidence: Generally, inequalities in health favour the higher income groups and are statistically significant for all countries examined. The indices vary across the countries and looking at the general level of health inequalities four clusters of countries emerged (fig. 2-4).

Fig. 2-4

Income-related inequalities in self-assessed health in 9 industrialized countries

<i>Level of health inequalities</i>	<i>Clusters of countries</i>
Relatively high	United Kingdom, United States
Medium	The Netherlands, Spain, Switzerland
Medium to low	Finland, West Germany
Low	East Germany, Sweden

Source: v. Doorslaer et al. 1997

Up to now it has been demonstrated that social inequalities in the course of time and between countries correlate with the health status of the respective population. These findings are the basis for further analyses now based on the individual level.

Detailed examples of inequalities relating to mortality and morbidity

After presenting evidence from ecological studies that socially related inequalities in health do exist, this part and the following one will present some recent results from a study describing socio-economic inequalities in European countries at the individual level. This study was led by the European Working Group on Socio-Economic Inequalities in Health (and supported by the European Commission (EC Contract SOC 98 201376 05F03)).

First of all, some methodological considerations about describing social inequalities in health should be made referring to the measurement of the social situation, of health, and of the sources which can be used for analyses. Up to now a wide range of criteria to demonstrate socio-economic differences in health has been used to describe the social situation of people. There are indicators which allow a ranking of persons according to their level of education, occupational status, or their income (vertical criteria). Other criteria will allow a classification of persons according to factors such as age, sex and nationality which do not allow a ranking (horizontal criteria). Some other criteria refer to the living situation of

individuals for example the size of flats or the housing area. The multitude of possible indicators for the social situation of persons each covering only one or few aspects of the social status leads to the application of combined indicators. These indices summarize for example education, income and occupational status into one index for socio-economic status. Because of interdependences of the basic indicators, the interpretation of these indicators must be regarded as problematic. Measuring the health of individuals (and populations) is equally complicated. There is no "best indicator" to determine health but a number of indicators for health has been developed. A direct measure of health is the subjective statement of persons how healthy they feel. This subjective feeling of people not always reflects their objective health status expressed by their ability for daily living or absence of chronic illnesses. Morbidity determined e.g. by a physician's diagnosis or hospitalisation is therefore another indicator for health. And last but not least mortality reflects the health status of persons and populations. Mortality data can be utilized to determine the age of death of individuals and which causes resp. illnesses are leading to their death. Just to complete this list it should be mentioned that health behaviour and healthy lifestyles can be used to indicate the health status of persons.

The combination of health indicators and social indicators demonstrates their interdependence. At an aggregated level, e.g. the gross national product of countries combined with the life expectancy of their populations will allow conclusions about the interdependence between health and social situation. The validity of conclusions is much higher in studies combining social and health indicators at the individual level. So it is necessary to look at possible sources of data for this kind of analysis. Official registers are the first data sources. Deaths and causes of death are officially registered in most countries so that mortality can be determined; differences between registers exist with regard to the registration of further information on the individual, e.g. his education or occupation. A second approach are health surveys or health related surveys in which persons are interviewed: here it is possible to ask for information about their health status and social situation in parallel. These two sources allow the interpretation of connections between health and social status at the individual level and can be assumed to be representative either by coverage of the total population or by determining the representativity of a sample.

The choice of indicators and methods widely depends on the interests of the individual study and the possibilities of official registers. For the choice of demonstrations of socio-economic inequalities in health the following considerations were made:

1. aim to cover as many European countries as possible
2. using well-accepted indicators for the social status
3. using well-accepted indicators for health.

Education

Education is a basic factor for success in life and begins early in childhood. Good education is a condition for getting good jobs and a good income later on. Besides its significance as a basis for wealth, well educated people are assumed to have more self-esteem, more knowledge about health and how to avoid sickness. According to this knowledge persons with higher levels of education tend to avoid a health damaging behaviour such as smoking and promote their health with for example healthy nutrition habits or regular exercise. It is found that they make better use of medical care and take part in prevention and early detection programmes. It can be assumed that their contact with health care personnel is more communicative and promotes compliance.

This fundamental meaning of education is well known and thus most countries attempt to improve the education of their inhabitants.

In the above-mentioned study on monitoring socio-economic inequalities in health it was possible for four European countries to demonstrate educational differences with regard to mortality including the trend for a ten-year-period. The data analysed stems from longitudinal analyses (follow-up after 10 respectively after 5 years). Education was divided into three levels comparable for the countries included in the study. The lowest level represents elementary or even less education, the "mid" represents secondary education and "high" a third level of education lasting about 17 years. The results can be seen in table 2-3 for men and 2-4 for women.

Tab. 2-3

Country	Level of	Death rate (per 1,000 person years)			Trend* in inequality
		1980-1984	1985-1989	1990-1994	
Finland	high	9.0	7.6	6.9	significant increase
	mid	11.2	10.4	9.8	
	low	14.4	13.8	12.5	
	total	13.0	11.9	10.8	
Norway	high	7.5	7.2	6.1	significant increase
	mid	9.1	9.3	8.2	
	low	10.8	11.6	10.5	
	total	9.5	9.7	8.4	
Denmark+	high	3.5	3.4	2.8	significant increase
	mid	4.9	4.7	4.4	
	low	5.1	5.4	5.3	
	total	4.8	4.8	4.8	
Turin	high	7.9	6.8	6.3	slight increase
	mid	10.5	9.1	8.1	
	low	11.6	10.4	10.0	
	total	10.8	9.5	8.6	

Mortality according to educational level, men 35-74 years (directly standardised mortality rate)

* The trend in inequalities is expressed by rate ratios of extreme groups comparing the 1990 data with 1980 data. "Significant increase" means statistically significant increase in inequality, "slight increase" means increase of no statistical significance.

+ Age group 35-59 years in Denmark

Source: Kunst, Bos, Mackenbach 2001.

Tab. 2-4

Country	Educati	Death rate (per 1,000 person years)			Trend* in inequality
		1980-1984	1985-1989	1990-1994	
Finland	high	4.0	3.8	3.4	significant increase
	mid	4.5	4.5	4.1	
	low	5.7	5.6	5.3	
	total	5.2	5.1	4.6	
Norway	high	3.6	3.5	3.2	significant increase
	mid	4.2	4.1	3.9	
	low	5.2	5.3	5.1	
	total	4.6	4.5	4.2	
Denmark +	high	2.4	2.2	2.2	stability
	mid	2.8	2.8	2.6	
	low	3.3	3.4	3.3	
	total	3.0	3.0	2.8	
Italy	high	4.5	3.8	3.0	slight increase
	mid	4.7	4.2	3.8	
	low	5.4	4.6	4.4	
	total	5.1	4.4	4.0	

Mortality according to educational level, women 25-74 years (directly standardised mortality rate)

* See note above 2.3

+ Age group 35-59 years in Denmark

Source: Kunst, Bos, Mackenbach 2001.

As shown in the tables, there is a strong relation between educational level and mortality: Low-educated persons generally have higher mortality rates. This relation remains stable over the time instead of the secular trend of decreasing mortality. Men are obviously more affected by this relation than women.

Tab. 2-5

Country	Educational	Prevalence rate		Trend* in
		1980s	1990s	
Finland	high	25.9	23.9	stability
	mid	40.2	36.9	
	low	48.8	45.7	
	total	41.7	37.0	
Sweden	high	12.0	13.1	stability
	mid	20.1	19.5	
	low	24.7	26.9	
	total	19.6	19.2	
Norway	high	10.4	11.8	slight decrease
	mid	12.9	14.9	
	low	26.5	22.1	
	total	20.4	16.8	
England	high	14.2	12.8	stability
	mid	21.7	12.8	
	low	32.7	30.3	
	total	26.4	20.7	
Netherlands	high	10.9	10.3	slight decrease
	mid	17.1	16.9	
	low	27.4	25.3	
	total	19.9	18.4	
Germany	high	46.4	45.8	slight increase
	mid	53.8	50.7	
	low	56.6	58.3	
	total	54.3	53.9	
Switzerland	high	9.3	9.4	slight increase
	mid	15.6	12.5	
	low	17.5	21.9	
	total	13.8	13.2	
Austria	high	14.8	16.0	stability
	mid	27.0	26.1	
	low	33.2	35.7	
	total	26.8	26.3	
Italy	high	19.5	21.3	significant increase
	mid	25.3	32.0	
	low	32.5	42.1	
	total	27.9	34.2	
Spain	high	19.6	18.8	slight increase
	mid	22.6	23.1	
	low	30.3	34.7	
	total	27.2	27.2	

Prevalence of 'less than good health' according to educational level: men 25-69 years

* The trend in inequalities is expressed by odds ratios of extreme groups of education comparing the 1990 data with 1980 data. Source: Kunst, Bos, Mackenbach 2001.

Differences between men and women are partly interpretable by educational differences: women are mostly less educated than men and women might perhaps be more conscious about their health and more often make use of medical care and prevention programmes.

Tab. 2-6

Country	Educational	Prevalence rate (per 1,000)		Trend* in
		1980s	1990s	
Finland	high	26.9	20.7	slight increase
	mid	38.3	35.8	
	low	48.0	43.3	
	total	41.5	35.4	
Sweden	high	12.0	13.1	stability
	mid	24.8	22.3	
	low	34.1	31.0	
	total	24.8	21.4	
Norway	high	8.0	10.0	stability
	mid	15.7	17.5	
	low	26.0	24.2	
	total	22.0	19.2	
England	high	17.4	14.2	slight increase
	mid	19.2	17.1	
	low	31.4	30.1	
	total	26.1	22.0	
Netherlands	high	13.2	16.2	slight decrease
	mid	18.5	19.9	
	low	26.6	29.6	
	total	22.2	24.3	
Germany	high	45.5	46.1	stability
	mid	51.5	45.1	
	low	62.1	60.1	
	total	58.2	54.5	
Switzerland	high	14.2	10.7	slight increase
	mid	14.3	15.8	
	low	20.3	23.0	
	total	16.1	17.4	
Austria	high	18.9	19.1	stability
	mid	27.2	24.5	
	low	36.9	35.4	
	total	31.6	28.5	
Italy	high	25.0	31.8	significant increase
	mid	32.2	38.3	
	low	39.0	48.8	
	total	35.4	42.0	
Spain	high	25.4	17.5	slight increase
	mid	26.6	27.0	
	low	39.5	41.5	
	total	36.5	32.4	

Prevalence of 'less than good health' according to educational level: women 25-69 years

"Significant increase" means statistically significant increase in inequality, "slight increase" means increase of no statistical significance, "stability" indicates no remarkable change in inequality, "slight decrease" means decrease of no statistical significance.

Source: Kunst, Bos, Mackenbach 2000.

Education was also related to self-reported health status expressed as "less than good health"; here the data stems from health surveys resp. health-related surveys. Tables 2-5 and 2-6 demonstrate the subjective health according to educational level for men and women respectively.

Despite differences between countries in the prevalence of "less than good health" obviously resulting from cultural differences between the countries, it can be seen that lower-educated persons evaluate their health as less good than higher-educated persons. Self-evaluated health is assumed to reflect among others minor illnesses and complaints. The differences between countries demonstrate the social and cultural influences on this self-evaluation. In spite of these cultural differences it is clearly demonstrated in all countries that both men and women of lower education describe their overall health status as less good than higher educated male and female individuals.

Summarizing the results it can be stated that persons of lower education have poorer health. The relation between low education and poorer health is confirmed:

- for health indicated by mortality as well as for the self-evaluated health status
- for both men and women
- for the 1980s as well as for the 1990s.

Occupational classes

Relations between occupational class and health have been widely described. Occupation encompasses a big part of life, covers different psychosocial, physical, and economic aspects and therefore can be linked to health in different ways.

Psychosocial aspects of occupation resp. of being employed are resources for health as well as health risks. Occupation and especially a good profession is a source of self-esteem and guarantees social status. Both are health promoting factors, while their lack may endanger the health of the individual. Physical aspects of employment are mostly described in terms of health risks, e.g. noise at the working place, toxic agents or physical work load.

Besides psychosocial and physical aspects occupation is linked to other indicators of the social situation: education and income. High level education is a

necessary condition for getting good jobs, which provide psychosocial resources for health and lessen health risks. And furthermore, good jobs are well paid and assure a regular income. (Additional information and possible connections and causal links are presented in chapter 4).

To demonstrate the connections between occupational class and income in the above-mentioned study, an analysis was carried out which related mortality data from different European countries to the occupational class. The occupation of persons in the study had to be classified in a way which reflects the socio-economic situation of persons of different occupations in the European countries from which data was available. A classification into three to four classes (using EGP-scheme resp. corresponding nation schemes) allowed this procedure:

- non-manual workers
- self employed
- agricultural (farmers and farm workers)
- manual workers.

This order represents a ranking order with non-manual workers as the favourable occupational class, manual as unfavourable occupational class.

Table 2-7 presents the death rate of men aged 30 to 59 years according to their occupational class for three time periods between 1980 and 1994. (Women were not included in this analysis because the determination of their occupational class is [still] problematic.).

Tab. 2-7

Country	Occupational	Death rate (per 1,000 person years)			Trend* in inequality
		1980-1984	1985-1989	1990-1994	
Finland	non-manual	4.7	4.0	3.6	significant increase
	self-employed	6.1	5.6	4.8	
	agricultural	5.9	5.4	4.7	
	manual	7.4	7.2	6.9	
	total	6.3	5.8	5.3	
Sweden	non-manual	3.4	3.0	2.5	significant increase
	self-employed	3.9	3.9	3.2	
	agricultural	3.7	3.8	3.5	
	manual	5.1	4.7	4.1	
	total	4.2	3.8	3.3	
Norway	non-manual	3.7	3.5	2.8	significant increase
	self-employed	5.0	4.4	3.8	
	agricultural	3.4	3.6	3.5	
	manual	5.2	5.1	4.3	
	total	4.4	4.2	3.5	
Denmark	non-manual	4.3	4.4	3.9	stability
	self-employed	5.3	5.2	4.6	
	agricultural	3.5	3.5	3.5	
	manual	6.2	6.2	5.7	
	total	5.0	5.1	4.6	
England & Wales	non-manual	3.9	3.3	3.0	stability
	Self-employed	4.3	3.7	3.2	
	agricultural	4.2	3.3	3.1	
	manual	5.3	4.7	4.6	
	total	4.7	4.2	3.7	
Ireland	non-manual	4.7		3.2	slight increase
	agricultural	4.3		3.9	
	manual	6.2		5.4	
	total	5.2		3.8	
Turin +	non-manual	4.0	3.7	3.0	slight increase
	self employed	5.1	4.2	3.9	
	manual	5.3	4.7	4.3	
	total	4.8	4.3	3.7	
Spain	non-manual	3.8		2.6	significant increase
	agricultural	3.5		4.3	
	manual	5.4		5.1	
	total	4.5		4.1	

Death rate according to occupational class: men 30-59 years

* The trend in inequalities is expressed by rate ratios of manual vs. non-manual workers comparing the 1990 data with 1980 data.

+ Age group 35-59 years in Sweden, England & Wales and Turin.

Source: Kunst, Bos, Mackenbach 2001.

As can be seen in table 2-7, in each country and each period manual workers have higher mortality rates than members of other occupational classes. Because of several factors it can be assumed that manual jobs represent many of the above-mentioned unfavourable conditions for health. On the contrary, non-manual wor-

kers represent the lowest mortality rates. The other two classes, as far as available for the individual country, come in between and the ranking of these two groups differs between countries. This result may be due to the heterogeneity of these two groups.

Summary

Taken together it can be demonstrated that there is a relation between occupational class and health as indicated by mortality: groups of lower occupational classes have higher mortality rates. This relation is especially true for the comparison of non-manual with manual workers and can be demonstrated for the 1980s as well as for the 1990s.

Income

Money resp. financial resources allow access to the material resources necessary for life in most parts of the world. In European countries, basic supply with the necessities of life is usually guaranteed by the state. So the relation between income and health is derived from the surplus benefits which can be bought: A higher income will improve access to healthy living conditions and health care. Besides this, income is related to other indicators of the social situation such as education and occupation: persons with higher income are mostly better educated and have a good job.

The relation between income and health was determined with the help of data from surveys in which both income and the perceived general health were assessed. Income was measured as "household equivalent" which is the income of one household adjusted by the household size (number of household members). In order to maintain the comparability of the countries in this analysis, the participants were divided into quintiles according to the income distribution in this country. This means that e.g. the group with the lowest income level consists of about 20% of the participants of this special country with the lowest income. Tables 2-8 and 2-9 show the perceived health of the groups classified according to their income level.

Tab. 2-8

		Prevalence rate (per 1,000 respondents)		Trend* in inequality
Country	Educational	1980s	1990s	
Finland	1 (highest)	34.0	26.7	stability
	2	39.7	38.9	
	3	44.6	41.0	
	4	50.7	41.6	
	5 (lowest)	54.5	49.0	
Sweden	1 (highest)	12.0	11.8	slight increase
	2	20.8	18.0	
	3	22.2	17.4	
	4	31.5	30.8	
	5 (lowest)	31.0	30.0	
Netherlands	1 (highest)	11.6	10.8	slight increase
	2	16.9	13.2	
	3	20.4	18.2	
	4	25.3	21.5	
	5 (lowest)	31.8	35.4	
Germany	1 (highest)	46.7	46.9	stability
	2	51.3	53.2	
	3	50.9	55.1	
	4	59.2	55.9	
	5 (lowest)	59.8	62.5	
Switzerland	1 (highest)	10.9	9.4	stability
	2	10.6	12.1	
	3	12.9	16.5	
	4	18.5	19.1	
	5 (lowest)	18.1	14.9	

Prevalence of 'less than good health' according to income level: men 25-69 years

* The trend in inequalities is expressed by odds ratios of extreme groups of income comparing the 1990 data with 1980 data.

Source: Kunst, Bos, Mackenbach 2001.

Tab. 2-9

Country	Educational	Prevalence rate (per 1,000)		Trend* in
		1980s	1990s	
Finland	1 (highest)	32.9	26.9	stability
	2	39.5	34.4	
	3	42.3	37.2	
	4	49.1	43.1	
	5 (lowest)	51.4	42.4	
Sweden	1 (highest)	32.9	26.9	slight increase
	2	19.5	18.8	
	3	24.4	21.1	
	4	34.3	29.9	
	5 (lowest)	31.4	30.0	
Netherlands	1 (highest)	15.2	15.3	slight increase
	2	20.6	20.0	
	3	23.3	24.0	
	4	23.9	28.5	
	5 (lowest)	25.1	36.5	
Germany	1 (highest)	51.1	43.2	stability
	2	53.9	47.6	
	3	58.1	53.6	
	4	58.2	58.9	
	5 (lowest)	66.8	63.2	
Switzerland	1 (highest)	12.6	12.0	stability
	2	11.2	15.1	
	3	16.5	18.6	
	4	17.8	24.7	
	5 (lowest)	21.6	19.6	

Prevalence of 'less than good health' according to income level: women 25-69 years

*The trend in inequalities is expressed by odds ratios of extreme groups of income comparing the 1990 data with 1980 data.

Source: Kunst, Bos, Mackenbach 2001.

As already noticed above, the proportion of persons describing their health as "less than good" varies considerably between the countries in the analysis. The relationship between income and health is a nearly linear one, thus indicating that the lower the income the poorer the self-evaluated health status. This relationship can be found each for men and women and for the 1980s as well as for the 1990s.

In European countries, the health care system is governed by the state and the population has general access to medical care. So the connection between income and health seems to be influenced by other factors such as living conditions or demand for health care. Persons with a low income have fewer chances to develop health-promoting lifestyles. For example health promoting living conditions in a

good residential area in most cases mean higher rents and higher real estate prices. A health-promoting behaviour such as regular sport activities and healthy nutrition also has to be financed. And finally it seems that particularly those groups which due to their living conditions are in special need of health care refrain from using it. This discrepancy has been described particularly in connection with the use of screening schemes or health-promoting measures.

It can finally be demonstrated that there is a nearly linear relation between income and self-perceived health status; this relationship can be found both for men and women and is valid for the 1980s as well as the 1990s. It is assumed that the connection between low income and poor health will be stronger if groups of relative poverty are considered.

Trends in the nineties

This chapter will present examples of recent trends in European countries in the nineties, based on evidence from latest available data.

As seen in tables 2-3 to 2-9 socio-economic inequalities in health exist during the time periods which were covered by the analyses (1980s and 1990s). To prove whether there are trends in inequalities, the secular trends in both the socio-economic and health status of the population have to be regarded. For example if the overall mortality in the chosen age groups decreases between the 1980s and 1990s, shifts in the distribution of mortality by educational and occupational classes can be the result. By calculating different indices such as rate or odds ratios this effect has been taken into account. In addition, these indices contrast the extreme population groups of each social indicator (highest vs. lowest level of education, manual vs. non-manual workers, highest vs. lowest income). They indicate the socio-economic inequality in health and express evidence whether trends are statistically significant and not effected by chance (see last column of tables 2-3 to 2-9).

Education

Inequalities in health which can be related to education increased from the 1980s to the 1990s. Especially for mortality an increase in inequality can be found, however data on mortality related to education could only be provided for four countries. Education related to the prevalence of "less than good health" which can be calculated for ten countries produces a less consistent picture. The tendency is varying between increases in inequality, but also stability and even decrease.

Occupational class

Occupational class could be related to death rate as a health indicator in eight countries for men between 30 and 59 years of age. Occupation-related inequalities increased from the 1980s to the 1990s, in most countries significantly.

Income

The trend of income-related inequalities in health expressed by self-evaluation is less distinct than for occupation-related inequalities. There seems to be an increase in inequality, however only for two of the five countries in the analyses was this trend of a certain relevance.

In summary these findings suggest the following conclusions regarding trends in inequalities in health from the 1980s to the 1990s:

- Socio-economic inequalities in health continued to exist in the 1990s as well as in the 1980s.
- The overall trend is that social inequalities in health are slightly increasing. Especially for education and occupational class with respect to death rates this trend is (statistically) significant. Decreasing inequalities are few and not significant.

The question arises as to which factors can be held responsible for this trend. In general, the health situation of people in Europe is improving (e.g life expectancy is increasing) but it seems that groups of a lower social status tend to profit less from this tendency. Here the question is as to whether a more detailed analysis of these groups will help to understand the mechanisms and trends of socio-econo-

mic differences in health, for example if the observed trend could be provoked by a disproportionate improvement in the health of people with a relatively high social status, an aggravation in the health of persons with a low social status or a combination of both effects. Especially the latter alternative would demonstrate the need for interventions in health policy. The next chapter will describe the health (and health needs) of selected socially disadvantaged groups.

Part 3

Health of Specific Disadvantaged Groups

Introduction: selection of groups

In times of limited financial resources welfare payments must be concentrated on those who are in special need. The efficiency of benefits granted depends on how far the life situation of people in need is taken into consideration. For this purpose, in addition to the economic situation, the social and cultural conditions of existence have to be considered as well. As early as in 1986, the WHO General Assembly recommended all Member States to use the health status of the population and in particular changes in disadvantaged population groups as an indicator for assessing the quality of societal developments. At a WHO meeting on "Health Inequities in Europe" held in Lisbon in 1987, this recommendation was repeated.

Various politically oriented health reports in European countries can be understood as first attempts to implement these recommendations. More recent publications include the Dutch report "Inequalities in Health" and the English "Independent Inquiry into Inequalities in Health". The following text is modelled on the mentioned examples. It includes eleven groups of persons and among them groups with primarily economic and social problems (long-term unemployment, homelessness, migrant status) and further groups whose status results from certain diseases (alcohol-, drug dependence). The selection of these groups cannot be explained in more detail, short references to the relevance of these groups can be found in the first parts of each chapter. Also this selection does not claim to be complete. A person's membership in one of these selected groups does not necessarily mean a socially disadvantaged position as can be shown by the example of unemployment or the migrants' status. Finally, a lack of conceptual clarity also has to be seen in the fact that persons may belong to several groups at the same time. For example someone can be homeless, unemployed and addicted to alcohol. The advantage of focussing on socially disadvantaged population groups

however lies in the concreteness and problem orientation of the presentation, hence in what a politically oriented report should characterize.

Box 3-1

Definitions

Poverty: below 50% of the average net household income, adjusted to household composition

Children: 0-14 years

Youth: 15-24 years

Elderly: 65 years and older

Single parents: someone who lives with at least one child aged under 18 years, may or may not be living with other adults in the household but does not live with a partner

Long-term unemployed: longer than 1 year

Very long-term unemployed: longer than 2 years

Migrants: non-nationals (i. e. citizens of a EU-country, resident in another or citizens of a non-EU-country)

Asylum-seekers: persons applying for refugee status (Geneva Convention)

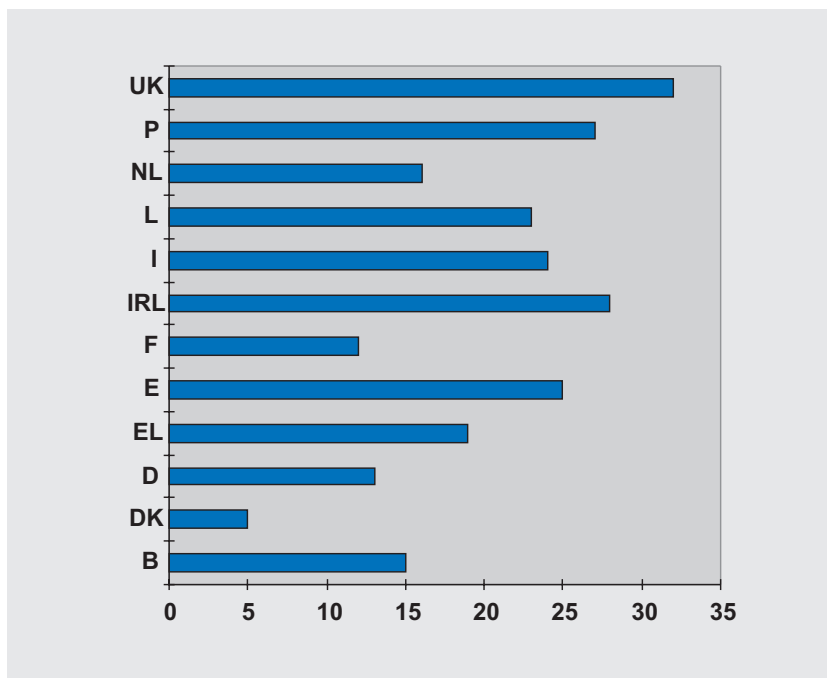
Homeless: people lacking a home of their own / sleeping rough on the streets or in community shelters / being in need of aid, accepted by local authorities

Definitions: selection of groups

Children living in poverty

As is shown by the early prohibition of children's work and the introduction of compulsory school attendance, the development of the welfare state is closely related to concerns about the well-being of children. The fight against poverty has contributed to the reduction of mortality in children and infants. Twenty years ago, the Black Report however pointed out that poverty in children continues to be the most important instrument for reducing inequalities in health among the population. For children poverty not only constitutes an especially unfair violation of equality in health but its elimination is one of the most effective social investments into a healthy society of the future.

Fig. 3-1-1



Children living in poor households (% of all children)

Source: Hackauf/Winzen 1999

Scope, social structure and trends

In the mid 90s, the number of children living in poverty amounted to about 13 - 14 million in Europe. Over the last years an increase has to be recorded which is primarily caused by corresponding increase rates in the bigger European countries. In no other country has the number of children living in poverty seen such a dramatic increase as in the United Kingdom: from 1.2 million in 1979 to 3.9 million in 1995/96. But in Germany and Italy as well pronounced increases are obvious. On the other hand, in some other countries such as Finland, Norway and the Netherlands this problem could be reduced or at least kept at a low level (fig. 3-1-1, 3-1-2).

Fig. 3-1-2

Poverty * of different age groups in Germany 1963-92



* Proportion of persons receiving income support

Source: Hauser 1997

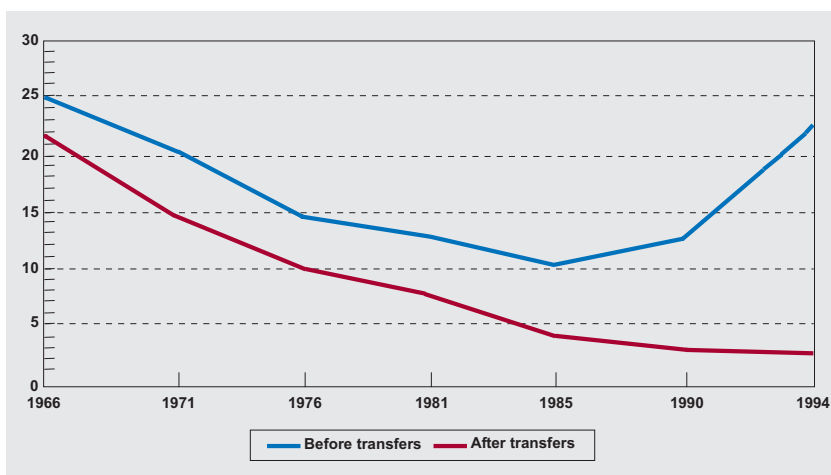
Most of all children in poverty grow up in families with no work-related income. This applies above all to families hit by unemployment and to children of single parents. Sometimes also families with many children (more than 3) live on incomes below the poverty line. There are however no mechanisms which under the mentioned circumstances invariably lead to poverty. This can be demonstrated by some examples from different countries:

- In Finland the proportion of families with children among the poor has diminished and is clearly lower than their proportion in the total population. However, without national benefits the proportion of children living in poverty would not be 2-3 % but about 20% (fig. 3-1-3).
- In Sweden as well children with single parents are by no means more frequently hit by poverty risks than children living with both parents.

This shows that some countries obviously provide effective protection against poverty risks such as the more difficult conditions of working experienced by sin-

gle-parent families or the financial burden of families with many children. A high level of poverty among children can be interpreted as the result of such lacking protection mechanisms but in some cases this also reveals inadequate efforts in fighting poverty in general.

Fig. 3-1-3



Change of child poverty in Finland before and after income transfers 1966-1994 (%)

Source: Forssén 1998

Health

Over the last decades, the health of children has permanently improved in almost all countries. Most prominent changes for the better can be observed in those countries with a more unfavourable starting position. A pronounced decline in prenatal and infant mortality of about 83.5 and/or 96 % is registered for Portugal. Despite this positive trend social inequalities in the health of children have remained. They are most obviously demonstrated by regional comparisons of the mortality and morbidity of prosperous and deprived areas as is confirmed by analyses in Italy and the United Kingdom (comparison of northern and southern regions)

as well as in Norway (comparison of areas of the city of Oslo). In constituencies inhabited by the population million with the worst health status mortality in children and infants in the United Kingdom exceeds mortality in the population million with best conditions in health by about 26-32%.

Looking at the causes of death and diseases, it can be found that the overall improvement has partially led to a characteristic shifting of health problems. The example of Finland shows that infectious diseases, caries and severe accident injuries are declining whereas the prevalence of asthma, allergies and diabetes is increasing. There is also evidence of a concentration of psychosomatic health problems (insomnia, anorexia, headache, sickness, nausea) in children coming from disadvantaged families - caused by inadequate primary care and psycho-social wellbeing provided by the family. It has been proven that social and particularly material living conditions are of fundamental importance for the family atmosphere.

Finally studies of various countries show a correlation between children's health and detrimental health behaviour of their parents. The social gradients of smoking, use of alcohol and drugs refer to indirect consequences of poverty among adults on the health of children.

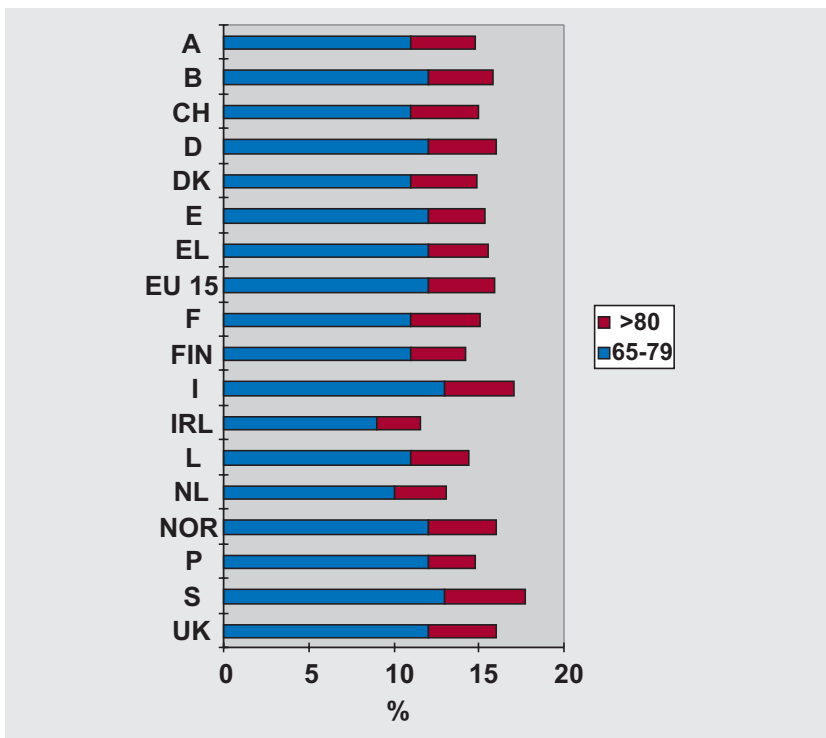
Old people living in poverty

Declining birth rates and an increased life expectancy lead to an increase in the proportion of old people in the population. This development, together with increases in expenditures for the financing of social and health care systems, contribute to the financial burden of the working population. This leads to questions on the distribution between the generations and on the functioning of the welfare systems in the long run. This recent view of the socio-demographic process of the ageing population clearly differs from that of earlier decades when poverty among the elderly still met with greater attention.

Scope, social structure and trends

About 60 million people in Europe are 65 years or older, about 14.5 million of them older than 80 years. The proportion of old people living in poverty considerably varies between the Member States. Whereas in some countries this problem seems to have been almost eliminated others have a prevalence of old age poverty of more than 20%, comparisons are however limited. Also in some countries with a low level of poverty pensioners draw an income which hardly exceeds the poverty line. Pensioners with a low income require additional benefits when higher treatment costs have to be paid (fig. 3-2-1).

Fig. 3-2-1

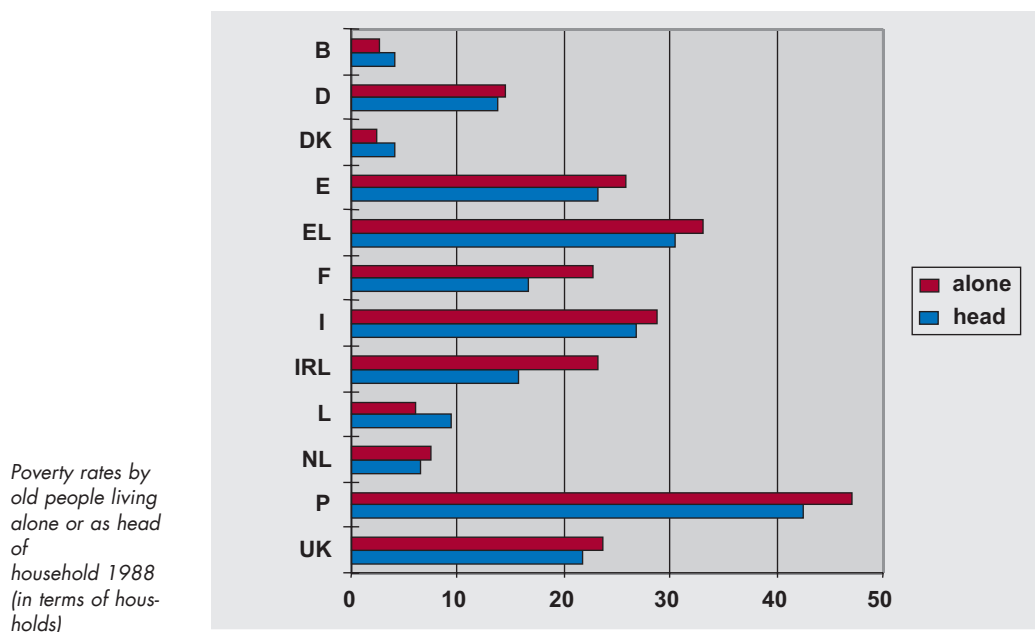


Old people living in Europe 1996

Source: Eurostat 1997

Old-age poverty is still a problem which is relevant to single-living women. In regional respect, various aggregations can be observed. In North European countries, poor single-living elderly people are concentrated in large cities. In southern countries, a different geographical composition of poverty can be seen in general but also among the elderly. In the Centre-North of Italy, the most economically disadvantaged elderly are found within families consisting of single-person households (mainly consisting of women) and/or aged couples, while in the South poor elderly live in larger size households (fig. 3-2-2).

Fig. 3-2-2



Source: EUROSTAT 1996

The differences in the prevalence of poverty among old people are the result of efforts to fight old age poverty. In Finland for example, it has been reduced from 17 to 0 % (1960-1990). In Norway as well, old people have seen the most pronounced improvements of their income of all age groups in the past. Moreover, it has to be taken into consideration that people who retired during the 90s may have

seen a longer period of prosperity - in contrast to previous cohorts of elderly people.

Health

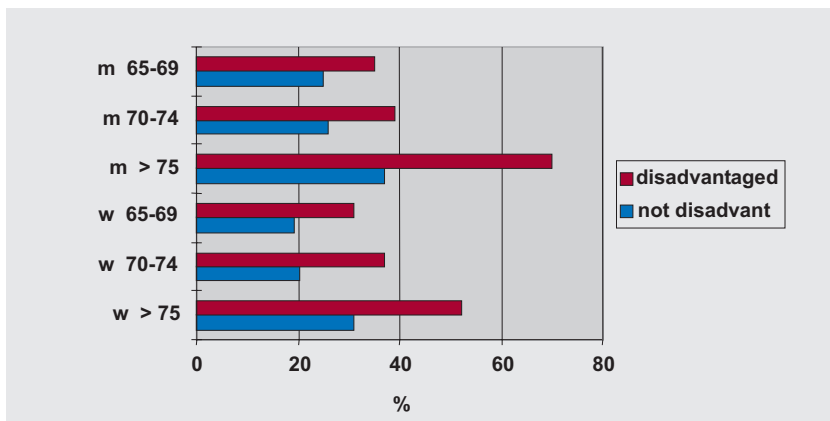
Poverty has a negative impact on health and life expectancy - this statement accompanies poor people from "the cradle to the grave". Whoever in the United Kingdom belongs to the lower social classes, at the age of 65 has a reduced life expectancy of 2-2.6 years (women/men) compared with people of the same age belonging to the upper social classes. As far as comparable analyses are possible in other countries, similar gradients can be more or less observed.

Poverty has a negative impact on diseases and handicaps among old people. The manifestations of handicaps and the loss of independence in everyday life activities are "crucial turning points". The loss of a partner is also of considerable importance. In the United Kingdom, women aged 75-84 years have a 60% lower chance of living together with a partner if they live in the areas of the "worst health million". An analysis carried out in Italy shows the negative consequences which cumulating disadvantages have on elderly people's health and their need for nursing care (fig. 3-2-3).

The following diseases and complaints frequently occur in elderly people belonging to the lower social classes:

- chronic arthritis, bronchitis, gastro-intestinal diseases
- physical disabilities, for example climbing stairs or dressing
- mental diseases
- losing all teeth
- coronary heart diseases and apoplexy
- injuries caused by accidents (falling within one's flat, etc).

Fig. 3-2-3



Inequalities in the prevalence of health needs* among disadvantaged** old people in Italy 1994

* Health need is represented by the occurrence of at least a limitation of autonomy caused by a chronic disease or disability, or by the need for help for daily activities, or by the presence of a coronary heart disease or cancer. ** Being disadvantaged is represented by the occurrence of inadequate income/quality of housing and/or lack of family support (living alone).

Source: Antonelli, Paganetto 1999

In some countries, there is evidence of inadequate medical and nursing care for low income population groups and/or of financial burden due to treatment costs. In the United Kingdom, around 1 million state retirement pensioners do not claim the means-tested benefits they are entitled to. A number of factors may operate, including lack of knowledge of entitlement, a perception of being stigmatised by the receipt of benefits, and physical or other difficulties in the processes of claiming. Fear of cost is thought to deter some poor older people from seeking services and aid, for example dental treatment, which would be free to them. In Germany, over the past years almost 4 million pensioners have been freed from out-of-pocket contributions to their medical treatment because their income is too low. In Ireland, an estimated 11% of the elderly people are without health insurance protection.

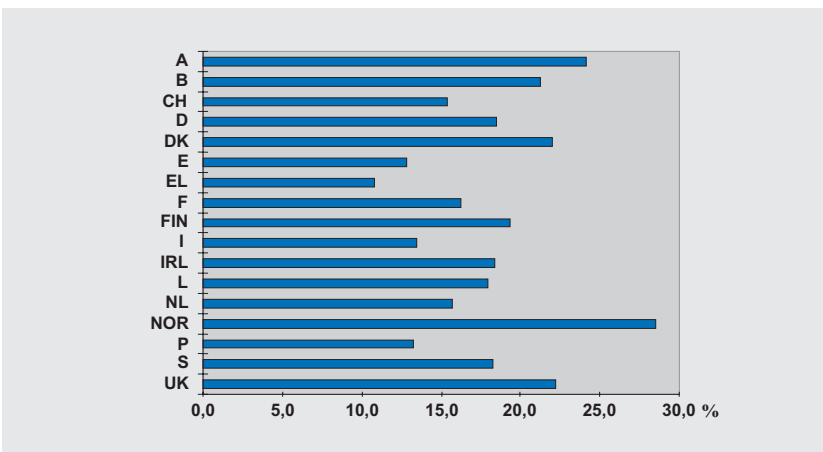
Single-parent families

Single-parent families need support by the welfare state to compensate for disadvantages they have to cope with compared to "normal" families with shared responsibilities for taking care of children and earning a living. Concerns about the well-being of families are again concentrated on children but also on the in most cases young mothers who, under poorer circumstances, make an important contribution to the future of society.

Scope, social structure and trends

11.2 million single-parent households with one or more children were counted in Europe at the beginning of the 90s. With more than 20% single-parent families are especially common in Norway, Austria, Iceland, the United Kingdom, Denmark and Belgium. In southern countries such as Greece, Italy and Portugal their proportion accounts for 11-16% (fig. 3-3-1).

Fig. 3-3-1

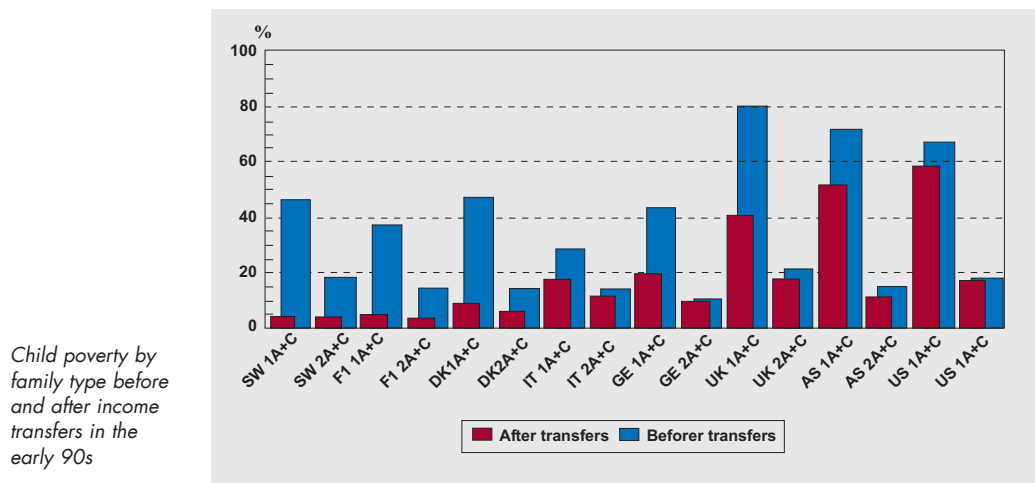


Single-parent families in Europe 1990-91

Source: Eurostat 1996

Looking at the socio-demographic structure of these families, the differences are even more pronounced. An average of 85% of all single-parent families consists of mother and child(ren). In the United Kingdom, 16% of the lone mothers are between 16 and 24 years old whereas in southern countries many older children live in households of their divorced or widowed mothers. The Netherlands registers the highest percentage of lone fathers among single parents (23.7%). Looking only at families with children at pre-school age (under 6 years), female single parents are even more dominant. Only in the Netherlands and in Luxembourg just over 2% of the children under 6 years of age live together with their father (fig. 3-3-2).

Fig. 3-3-2



Abbreviations: SW = Sweden, FI = Finland, DK = Denmark, IT = Italy, GE = Germany, UK = United Kingdom, AS = Austria, US = United States; A = Adult, C = Child(ren)

Source: Forssén 1998

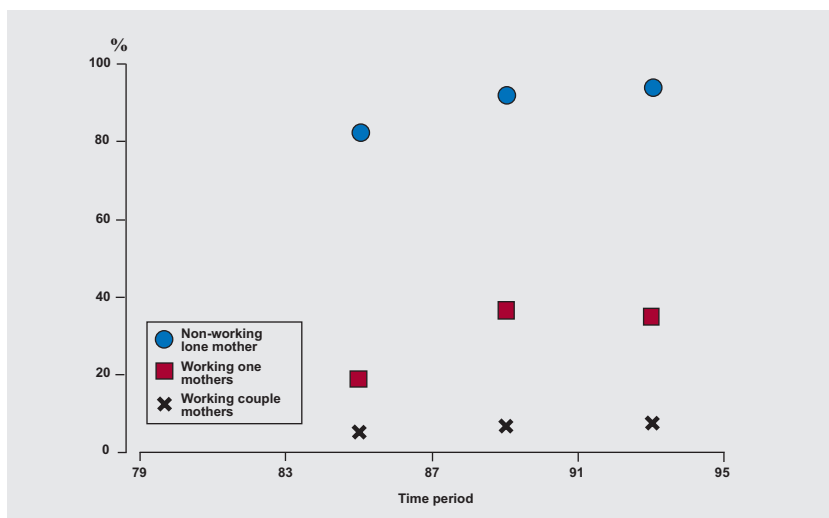
Depending on the country, single-parent families are exposed to a 3-11 fold higher poverty risk. Income transfer systems have a major influence on the proportion of families definitely living in poverty. Social assistance is above all financial in kind but also consists of facilities allowing mothers to work themselves. The

effect is however limited by the strained situation on the labour market in all countries. Even in countries with a well-developed social system single mothers are disadvantaged and increasingly threatened by unemployment. A very negative trend can be registered in the United Kingdom for the last 20 years. The proportion of lone mothers has almost doubled (1979-1983:12%; 1992-95:21%) and the poverty rate has almost increased from 57% (1984-87) to 70% (1992-95). 90% of lone mothers without work live in poverty but even among working mothers 35% of incomes do not exceed the poverty line (fig. 3-3-3).

Health

It is above all young mothers with infants whose health suffers when they have to live without a partner and moreover under circumstances of poverty and lacking social support. The impact is to a lesser extent seen in serious diseases but perceived poor health and typical psychological problems (anxiety, uneasiness, depression symptoms) (tab. 3-3-4).

Fig. 3-3-3



Poverty rate among lone and couple mothers in the United Kingdom by their economic status; mid-points in time periods

Source: Shouls et al. 1999

In some countries differences in terms of health-relevant behaviour, particularly nutrition and smoking, can be observed. The correlation between poverty and stress is obvious. These ways of behaviour have a detrimental effect when smoking leads to relevant restrictions of the already limited family budget. In the United Kingdom, 55% of the lone mothers on income support smoke an average of 5 packets of cigarettes per week. Studies of the costs of meeting basic needs, which explicitly exclude spending on tobacco, indicate that income support levels are insufficient to secure a basic but adequate standard of living, especially if there are children in the households.

Tab. 3-3-4

Health problem	Prevalence		
	Single mothers	Married mothers	Other women
Perceived general health 'poor' (%)	33	14	19
Two or more chronic conditions (%)	37	22	29
Average number of physical complaints (#)	1.44	1.66	-
Average number of psychosomatic complaints (#)	4	2	2
Depressive syndrome (%)	26	10	-
Score on loneliness scale (#)	4.8	2.4	3.2
Score on self appraisal scale (#)	5.3	6.6	-

Overview of results from Dutch studies on the health of single mothers

Source: König et al. 1992

Unemployed young people

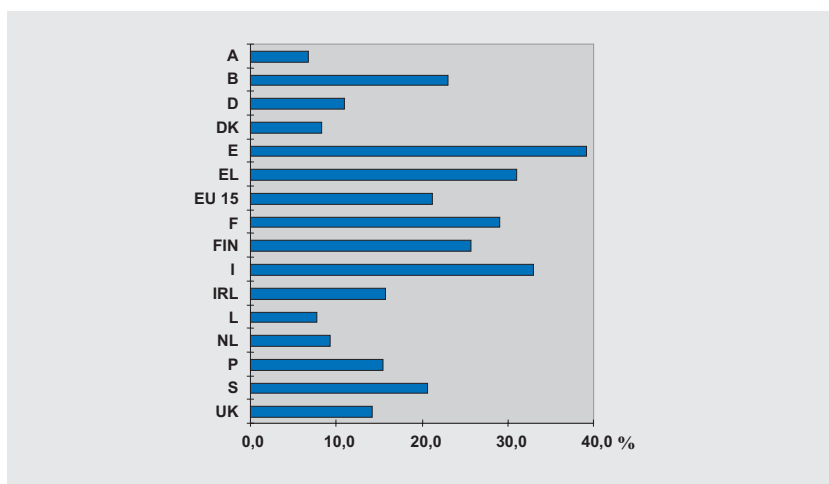
Unemployment among young people is a high priority socio-political problem because it hampers integration into the world of adults which is linked to working

and income including individual autonomy and social prestige. Instead, particularly in the case of prolonged unemployment there is the threat of sustained uncertainty both with regard to one's own person (self-confidence) and society including its institutions. Riots among young people, vandalism and xenophobia can be the spectacular results of this social exclusion process.

Scope, social structure and trends

Young people are still particularly hit by unemployment. With about 4.7 million unemployed under 25 years of age, for 1997 the rate is twice as high as the general unemployment level (21.7%). With 30% or more, youth unemployment in Greece, Spain, France and Italy reached an extreme dimension. A comparably low level of 10% or less is registered for Denmark, Luxembourg, the Netherlands and Austria. The differences are however not to be interpreted without considering the country-specific education and training systems. Special state-run programmes in many countries have contributed to reducing unemployment rates. In Denmark for example about one third of all unemployed young people is employed with the help of public employment schemes (fig. 3-4-1).

Fig.3-4-1



Young unemployed aged under 25 in Europe 1997

Source: Eurostat 1999

Increased efforts by the state were triggered off by the steep increase in youth unemployment which was observed during the 90s in many countries. By 1997, however, only few countries had succeeded in bringing about a clear reduction. Both Ireland and Finland registered declines by about 10%, in Denmark, Spain, the Netherlands and the United Kingdom these were less pronounced.

Special attention should be paid to the structure of youth unemployment including

- concentration in the regions
- unemployment among people aged 20-24 years
- long-term unemployment (more than 1 year)

with a close relation to be seen among the mentioned elements.

Tab. 3-4-2

Area	Men	Women	Total
North-west	17.0	28.0	22.0
North-east	9.7	18.9	14.0
Centre	26.3	40.9	33.0
South	50.6	64.9	56.3
Italy	29.0	39.3	33.5

*Unemployed aged
15-24 in Italy by
gender and geo-
graphical area*

Source: Antonelli, Paganetto 1999

Regions with a high level of unemployment offer young people few chances of overcoming this situation within a limited period of time. Under this aspect a serious dimension seems to have been reached by the figures registered for Italy which reveal an unemployment rate of 50% among young people in the southern regions (tab. 3-4-2). This is contrasted for example by the situation in Finland. Among young people unemployment is usually a temporary phase in life, and nowadays short periods of unemployment are more or less regarded as normal. The average duration of these periods is less than a year, and all job seekers are covered by the social security system. These are the main reasons why unemploy-

ment rarely has negative consequences when young people are concerned. Still that does not mean that there is no risk of marginalization involved. Especially if the unemployment period lasts longer than a year, the risks of poverty and social exclusion increase.

Health

The health of unemployed young people does not differ very much from that of other young people of the same age with a job or undergoing education and training. As far as differences can be observed it seems reasonable to speak of selection effects. In the same way as a strong (negative) correlation exists between educational level and unemployment, chances on the job and training market decline for young people with health problems.

Nonetheless unemployment is not without any impact. It is above all psychological stress if its end is not foreseeable. Unsuccessful efforts of getting a job for example returning into unemployment after having completed a public employment programme exacerbate the situation. Against this background nervous and depressive symptoms occur much more frequently. Compared with elderly unemployed these problems are however less severe. This can possibly be explained by the fact that young people bear less responsibility for other persons - a burden undoubtedly weighing more heavily on unemployed heads of a household.

No clear picture can be drawn with regard to the problem of behaviour detrimental to health. Whereas some studies support the assumption of a pronounced risk behaviour (smoking, alcohol, drug abuse), others arrive at less conclusive results and try to explain this with the limited financial means for financing such consumption.

Long-term unemployment

During the 90s, most European countries saw long periods of mass unemployment which led to an increasing number of long-term unemployed who are permanent-

ly out of work. In addition to unemployed young people these persons are another group whose social situation has to be characterized as especially precarious. As the period of unemployment extends, the risk of poverty and social exclusion increases. According to the statistics long-term unemployment is defined as being out of work for one year or longer. Many unemployed are however out of work for a considerably longer period of time.

Scope, social structure and trends

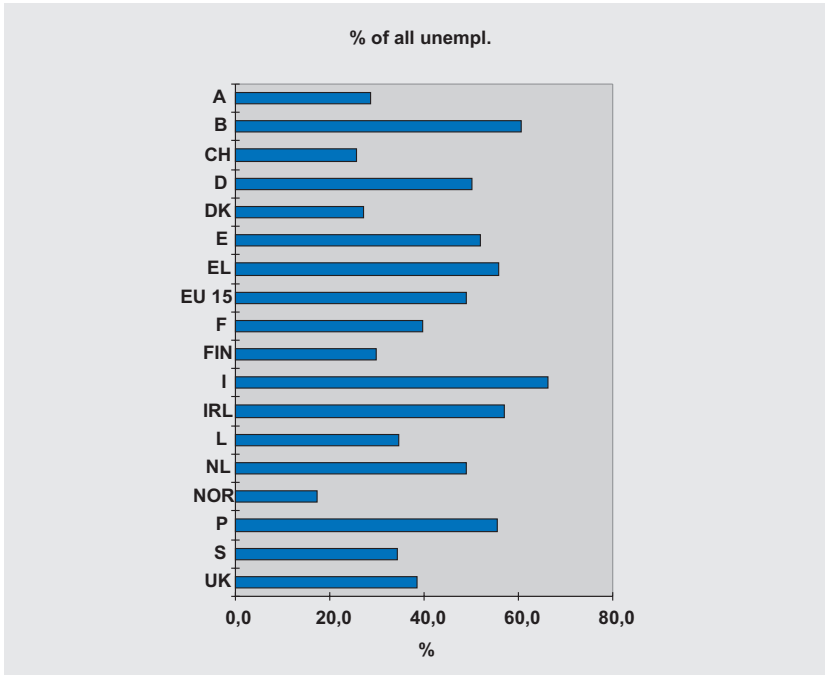
In 1997, 49% of all 17.9 million unemployed Europeans had been out of work for more than one year. In some countries, for example in Italy, Belgium, Ireland, Spain and Portugal this proportion rose to 66%. A considerable proportion of the long-term unemployed - for the year 1992 about 20% - had been out of work for more than two years. Countries with a high unemployment level also have considerably higher rates of so-called "very long-term unemployed" (fig. 3-5-1, 3-5-2).

The risk of being unemployed for a year or even longer increases with age. From the age of 50 the chances of finding a job clearly decline. For this reason various countries have made special efforts to support employment. They have contributed to the fact that for example in countries such as Denmark, Finland, Ireland, the Netherlands and the United Kingdom long-term unemployment could be reduced by 5 - 7 %. In Norway, a reduction of 22% was achieved.

Health

Long-term unemployed are a highly selected group in which health factors play an important role as determinants of the work capacity. In Denmark, the proportion of long-term unemployed who had been ill for more than 6 months in 1987-1994 rose from 28% to 47%. In a study carried out among 50-58-year-old unemployed in Finland, two thirds of the interviewed reported a handicap or long-term disease. One third considered themselves non-employable as a consequence of health-related problems.

Fig. 3-5-1

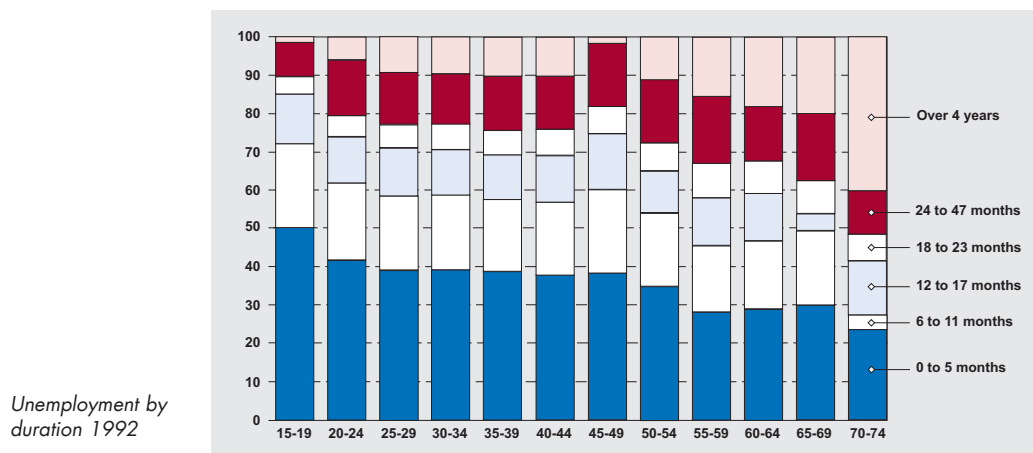


Long-term unemployment in Europe 1997

Source: EUROSTAT - Statistical Yearbook

Moreover, long-term unemployment itself has detrimental health effects which, with increasing duration, are becoming more and more important. This can be attributed to economic, social and psychological consequences, to the partly dramatic reduction of income, loss of social contacts (social exclusion) and the increasing hopelessness of this situation. The psychological consequences vary between symptoms of depression and anxiety to self-harm and suicide. A long-term study carried out in England and Wales arrives at the conclusion of nearly double mortality for unemployed. Mortality caused by injuries and poisoning (including suicide) was especially high in young men (tab. 3-5-3).

Fig. 3-5-2



Source: EUROSTAT 1996

Tab. 3-5-3

Mortality of men aged 25-64 by change in economic activity between the 1971 and 1981 censuses in the United Kingdom

Economic activity:		Number in 1981	Mortality 1981 – 92	
1971 Census	1981 Census		Deaths	SMR
Employed	employed	90,831	4,660	83*
Employed	unemployed	7,007	512	127*
Unemployed	employed	2,172	124	127*
Unemployed	unemployed	1,094	100	194*
Total		101,104	5,396	

*95 per cent confidence interval for SMR excludes 100

Source: Bethune 1997

Similar results are revealed in a five-year-follow-up study in Norway, which compared long-term unemployed with people who meanwhile could find a new job. Whereas 23% of the long-term unemployed showed symptoms of harmful drink-

king, this figure reached only 12% among the re-employed, with regard to suicidal ideas/intentions rates varied between 22% and 6%.

Migrants

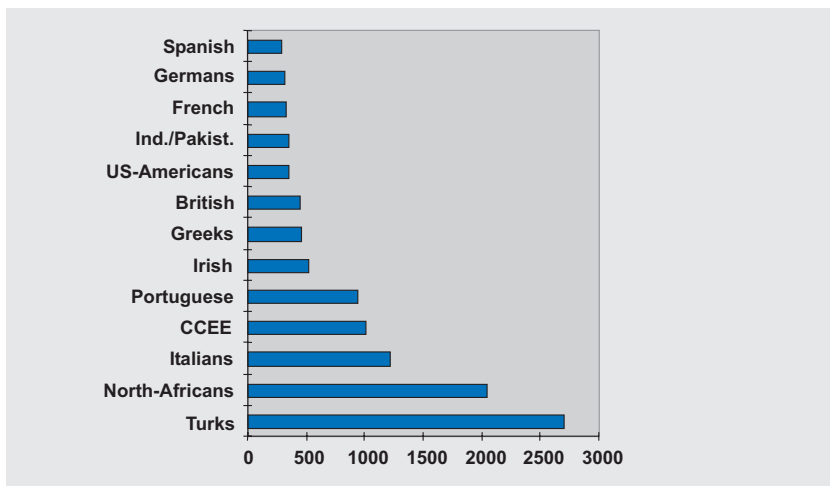
In most European countries, migration has led to the fact that sizable groups of various nationalities have been living for 10 years or longer outside their country of origin. Meanwhile a second generation is growing up, socio-culturally situated between their parent's country of origin and the country in which they were born. Compared to citizens, the conditions of life are unsatisfactory for most migrants. Less than ever before do most European countries, apart from few exceptions, seem to be prepared to regard themselves as immigration countries.

Scope, social structure and trends

Almost 20 million of the European population are migrants (non-nationals). Most of them come from Mediterranean countries, from former colonies and - since the opening of the borders of the former socialist countries - from the countries of Central and Eastern Europe (CCEE). The biggest group are the Turks (2.7 million) followed by North-Africans (2 million) and Italians (1.2 million). Migrants from middle-east Europe follow on fourth position (fig. 3-6-1).

The socio-economic status of most migrants is low. Their work in industry and (more and more) in the services sector is characterized by low qualifications and payment on the one hand and unfavourable working conditions on the other: working time schedules such as shift-work as well as physical and mental stress. Their living conditions can be characterized by poor housing with overcrowding and unfavourable location (traffic noise, emission from industrial plants). Finally, they are more and more confronted with a changing social atmosphere (e.g. racial and discriminatory aspects) which leads to a feeling of permanent threat to their safety and health.

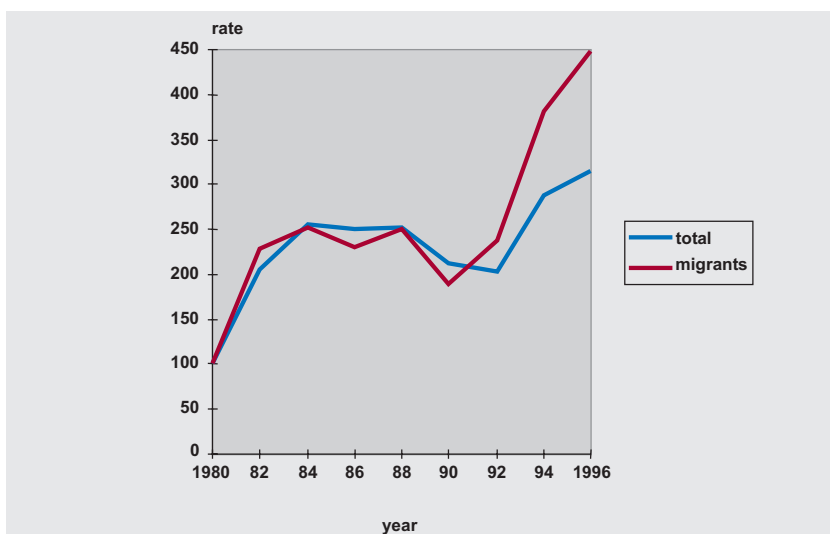
Fig. 3-6-1



Migrants (non-nationals) in Europe, January 1996

Source: Eurostat 1997

Fig. 3-6-2



Unemployment trends in Germany 1980-96 (1980 = 100)

Source: Statistisches Bundesamt 1998

This precarious situation is aggravated by mass unemployment which is disproportionately high among migrants. With about 20% in Germany, the rate is twice as high as the total average. In their efforts of trying to find professional training and jobs young migrants are more disadvantaged than other young people (fig. 3-6-2.)

Health

The first wave of labour migrants was characterised by a status of good health, as they were mostly young and had undergone thorough medical examination. This healthy migrant effect has largely been worn off over the years. Today there is quite a lot of evidence showing a bad health status as a result of the low socio-economic status and additional socio-cultural problems.

Migration, the decision to leave one's home country and to settle in another country with a foreign language and possibly a very different culture is an enormous challenge to the migrant. Unfulfilled expectations regarding the migrants' status in the country of residence and the ensuing lack of prospects especially with regard to the originally intended founding of their own existence in their home countries can lead to severe states of depression. An up to now hardly recognized sub-population are older migrants (60 years and older) who have however increased to about half a million in Germany over the last years. The services provided by the German social institutions seem to ignore the specific needs of these senior migrants.

In an unpublished expertise Geiger (1998) describes the health status of migrants by including various European countries. According to this report migrants suffer more often from reactive psychiatric diseases indicating that the migrant is only coping inadequately with the demands of his specific situation in life. It also helps to explain the findings that migrants more often suffer from psychosomatic disorders and diseases such as gastro-intestinal ulcers. In addition, there are cultural differences in the perception and description of symptoms. There are signs that migrants are more likely to tend to somatisation leading as a result

to long diagnostic processes and delaying the start of adequate therapy (see also MFJFG 2000).

A further characteristic feature of the range of diseases hitting migrants is the higher number of work accidents among migrants. (Geiger, without year, see also MFJFG 2000). Causes can be seen in the fact that migrants more often hold dangerous workplaces, but also cultural characteristics or language problems in understanding working protection measures serve to explain this phenomenon.

Asylum-seekers, refugees and people with illegal abode

At the beginning of the 90s, the number of asylum-seekers temporarily increased considerably in Europe, exceeding by far the volume of labour immigrants and family members. Their number has been reduced again by applying stricter immigration regulations, border controls, a restrictive practice of admitting asylum and forced deportation of persons whose refugee status was denied. In some cases financial, social and medical support was cut down to put more pressure on these people to return to their country of origin. These measures, among other things, have led to an increase of people with illegal abode. Some countries have reacted to this by legalization initiatives for illegals who have been living in these countries for many years.

Fig. 3-7-1

Asylum-seekers in Europe 1987-96



Source: EUROSTAT - Statistical Yearbook

Scope, social structure and trends

The total number of asylum-seekers, refugees and people living illegally in Europe cannot be given due to numerous problems - starting with the different methods of registration and ending with uncertainties of estimating the number of people staying illegally. The number is moreover subject to severe variations. This can be put down both to the development of acute conflicts in the countries of origin - as is shown by the example of refugee streams from former Yugoslavia - and to the asylum practice in the host countries. Despite these uncertainties the group can be described as a relevant proportion of the population of non-nationals in Europe. In Germany for instance, every fifth migrant (22%) belongs to this group - the number of illegals not included (fig. 3-7-1).

Notice should however also be taken of this group not only because of its quantitative dimension but also because of its situation of life which, under social and health aspects, is extremely difficult. Disadvantages and social exclusion are facts which members of this group experience in everyday life with far-reaching, sometimes dramatic consequences. Important factors are:

- **Poverty:** There is hardly a chance for asylum-seekers to find a paid job, for most of them this is explicitly prohibited. In Germany for about one third of all refugees social benefits are 20% below the general level. Illegal employees are without any protection and often exploited by their employers. One extreme example is illegal prostitution.
- **Poor housing:** Asylum seekers are mostly accommodated in refugee camps, often overcrowded allowing no privacy.
- **Social environment:** Restricted mobility, separation from the residential areas of local citizens and a social atmosphere characterized by open animosity are severe obstacles to leading an almost normal life.

Only very few asylum-seekers with higher education and high social status, preferably persons who succeeded in escaping the anonymity of a mass destiny, can expect better conditions in the country of asylum.

Health

In most European countries, medical care for asylum-seekers is concentrated on examinations at the moment of their arrival. Here the discovery of infectious diseases (Tbc, hepatitis, aids, sexually transmitted diseases) which could be a risk to the local population is most important. A screening carried out in Germany (Bremen) in 1993/94 with more than 1,000 asylum-seekers shows in 8% of all cases one of the above-mentioned diseases. Most diagnoses were:

- diseases of the respiratory tract 22%
- skin diseases 19%
- dental problems 12%
- gastro-intestinal diseases 10%
- chronic pain and neuralgic disorders 10%
- psychosomatic diseases 9%

Tab. 3-7-2

Health problems of the four largest groups of Swedish refugee camps 1992/93

Country	Number in the sample	No health problems	Psychological problems	Ache	Chronic disease	Other problems
Bosnia	343	73	13	3	5	8
Iraq	261	80	3	2	6	13
Africa	243	68	10	3	7	12
Asia (not Iraq)	196	75	13	2	1	11

Source: Ginsburg 1995

A special health problem in refugees are the consequences of torture and other forms of violence (post-traumatic stress disorders). Their prevalence is however often over-estimated. Studies in the Netherlands have shown figures of 6-11%, and for Sweden 20-30% are reported (depending on the country of origin; tab. 3-7-2). The sufferings of the victims are however serious. In a study of Dutch refugees primarily from Iran and Turkey, 76% had been tortured in their country of origin, 22% had experienced other forms of organized violence. 78% of them had physical complaints (most of them with no apparent organic reason), 90% had mental complaints (sleeping disorders, anxiety, depression, nightmares etc).

Homeless people

Homelessness is an extreme form of poverty, expressing the inability of realizing a basic requirement of healthy life: a place where to find security and protection. Searching for the reasons of this inability, a fatal interdependence of poverty, social exclusion and stigmatization on the one hand as well as addictions, mental disorders and other diseases on the other hand can be noticed. The different systems providing social support for homeless people such as for example the English acknowledge the case of unintentional homelessness. This leads to the question of how efficient benefits are in order to put an end to this situation of destitution as soon as possible.

Scope, social structure and trends

The number of homeless people can only be given for few countries based on estimates. Different definitions make comparisons more difficult without however concealing how contrastive the situation is in European countries (fig. 3-8-1).

Tab. 3-8-1:

<i>Tab. 3-8-1: Homeless people in selected countries 1997</i>		
Germany (total)		580.000
	multi-pers. househd.	400.000
	children/adol.	180.000
	singles	180.000
NL		30-40.000
FIN		10.000
S		8.000
UK (total)*		165.690
	unintentionally*	103.340
	unofficially*	62.350
NOR		6.000
*households		

Homeless people in selected countries 1997

Source: Country reports on disadvantaged groups 1999 (see Annex)

In Scandinavia and in the Netherlands homelessness is almost completely a problem of individuals and not of families. For instance homelessness of families with children in Finland is generally of short duration and not a problem of single mothers. In the United Kingdom and in Germany, on the other hand families constitute the majority of homeless people. In Britain it is difficult to be accepted as officially homeless without the presence (or imminent arrival) of children. So the officially homeless population contains a large number of mothers and dependent children (57% of households). Further 10% had a pregnant household member (at the time of registration).

In all countries, homeless single persons are in 70 to 80% of all cases middle-aged men, 40-50-year-old men are partly regarded as "old" due to health problems. All countries, however, register an increasing proportion of women and young people. In Lisbon alone, 500 adolescents live on the streets, in Helsinki just 30 persons - all age groups taken together.

In some countries, a decline in homelessness could be seen over the last decade. These include Finland where this figure was reduced by about one third and the United Kingdom where the number of homeless people growing until the beginning of the 90s and between 1992 and 1997 could be reduced by about 25%. Other trends could be observed in Germany, the Netherlands or Portugal.

Health

The health status of homeless people most probably counts among the worst of all disadvantaged groups. This applies above all to single homeless persons who, as described above, constitute the majority in some countries and in others can be seen as a core group. Their health situation is characterized by a high prevalence of multi morbidity, above all by addictions (alcohol, drugs), mental disorders and physical diseases. The prevalence of alcohol and drug addiction varies considerably - depending on the country, structure and examined group and registration method (screening, survey). In the Netherlands, figures of 20 - 30% are given for alcohol dependence and 15 - 25% for drug dependence. In Sweden, two thirds of all homeless persons have a substance abuse problem. In Finland, practically all of them have severe problems with alcohol. Traditionally, homelessness is related to alcohol addiction, but the number of drug addicts is increasing.

Among hostel users and/or rough sleepers in the United Kingdom, mental disorders such as for instance experience of psychological distress, self-reported depression and anxiety are three to ten times higher than for the general population. There is also an elevated prevalence of major mental disorders, most notably schizophrenia and, among young homeless people, a high rate of attempted suicide. Physical diseases include bronchitis, tuberculosis, arthritis, skin diseases and infections. Finally the risk of accidental injuries, especially as a result of violence by others is by several times higher than normal, particularly for homeless women and those sleeping on the streets (tab. 3-8-2).

Tab. 3-8-2

	Sample size	Phys. illness	Phys. & mental	Mental illness	Alc. depend.	Drug depend.	GP registr.
		%	%	%	%	%	%
Hostels	530	36	6	6	16	11	92
PSLA	268	33	2	3	3	7	95
Nightshelters	187	26	9	12	44	29	71
Sleeping	181	39	14	7	50	24	58

Morbidity of a sample of homeless people in the United Kingdom 1996

Source: Gill et al. 1996

A result of all health problems is the high mortality rate among the homeless. Despite limited reliability, isolated studies in Great Britain can give some facts. According to these studies, the average age of death among rough sleepers is about 42 years, the mortality rate in 16 - 64-year-old men is 25 times higher than in the total population.

With regard to medical and social care there still seem to be serious deficits and discriminating practices in some countries, starting with admission barriers resulting from the general organization of health care systems (gate keeper function of general practitioners, specialization of health care providers) and ending with problems related to the status of an "unwanted group". Many diseases lead to consultations with a doctor only at a far-advanced stage, treatments remain without success because instructions by the doctor are not followed or therapies broken off early.

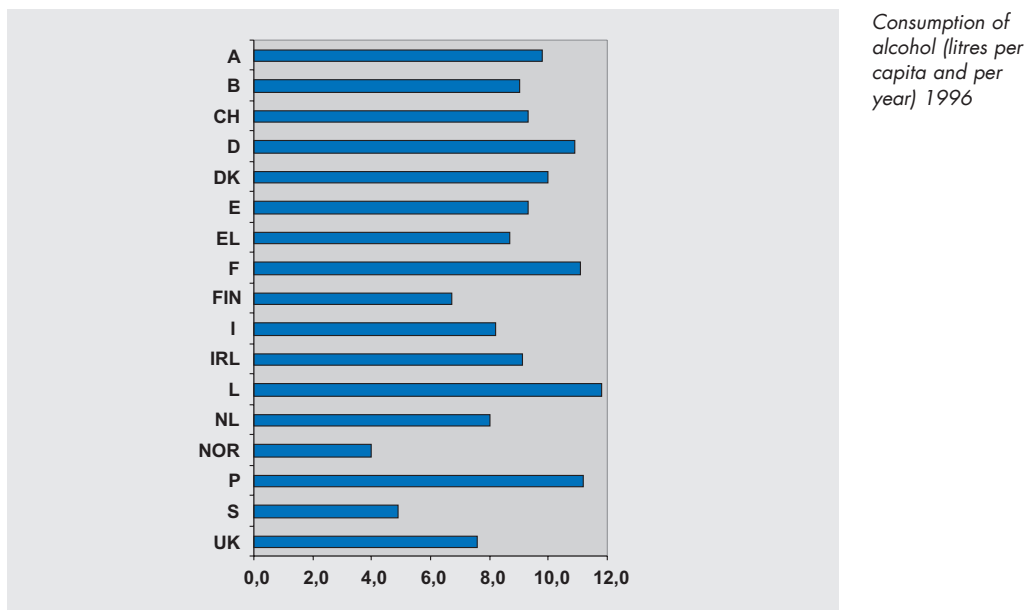
Alcohol addicts

Apart from some restrictions intended to ensure the protection of young people and safety on the roads and at work, the consumption of alcohol is completely legal. The prevalence of everyday drinking takes the first place, leaving all other drugs far behind. Due to its relaxing and, when consumed in higher doses, dulling effect alcohol is an ideal vehicle for driving away individual problems. At the same time "problem drinking" itself often has negative social consequences such as losing one's job or the destruction of family and social relationships. Thus alcohol dependence is a suitable indicator for identifying disadvantaged population groups - irrespective of the question as to which causal relations exist between social status and dependence.

Scope, social structure and trends

An impression of the extent which the alcohol problem takes in Europe is given by the average annual per capita consumption of pure alcohol in the population. With 10 - 11 litres per year Portugal, France, Germany and Denmark take first places. Probably as a result of their restrictive alcohol policy, most Scandinavian countries (Finland, Norway and Sweden) are still found at the lower bottom of the scale. Since by tradition much home-made liquor is consumed in these countries, the documented figures are however a considerable underestimation of the actual situation. For Finland, the documented and concealed consumption taken together results in a total volume of an estimated 8.8 litres (1997) which means an underestimation of about 30% by official figures. Due to the considerable amount of cross-border traffic the figure mentioned for Luxembourg seems to be exaggerated (fig. 3-9-1).

Fig. 3-9-1



Source: Simon et al. 1999

The prevalence of harmful drinking (heavy drinking, problem drinking) is in most countries given with 9 - 12%. However, these figures only serve as a rough orientation since the surveys contain considerable uncertainties and use various definitions. The high share of male alcohol addicts (about 70 - 80% of all addicts) can be regarded as reliable.

The influence of the socio-economic status on problem drinking is illustrated by results from the United Kingdom. Here, both for men and for women under the age of 30, the prevalence for the poorest is twice as high as the prevalence among the most affluent groups, 17% vs. 8% for men and 6% vs. 3% for women. In older adults, a similar pattern exists for men. In older women there is no socio-economic gradient in problem drinking, but compared with affluent women poorer women are more likely to report being drunk.

Concurrent indications of an increased consumption of alcohol among unemployed are mentioned in reports on the situation in Germany (particularly East

Germany), Portugal, Sweden and the United Kingdom. In some cases other disadvantaged groups such as for example the already described homeless or old people in institutions are mentioned.

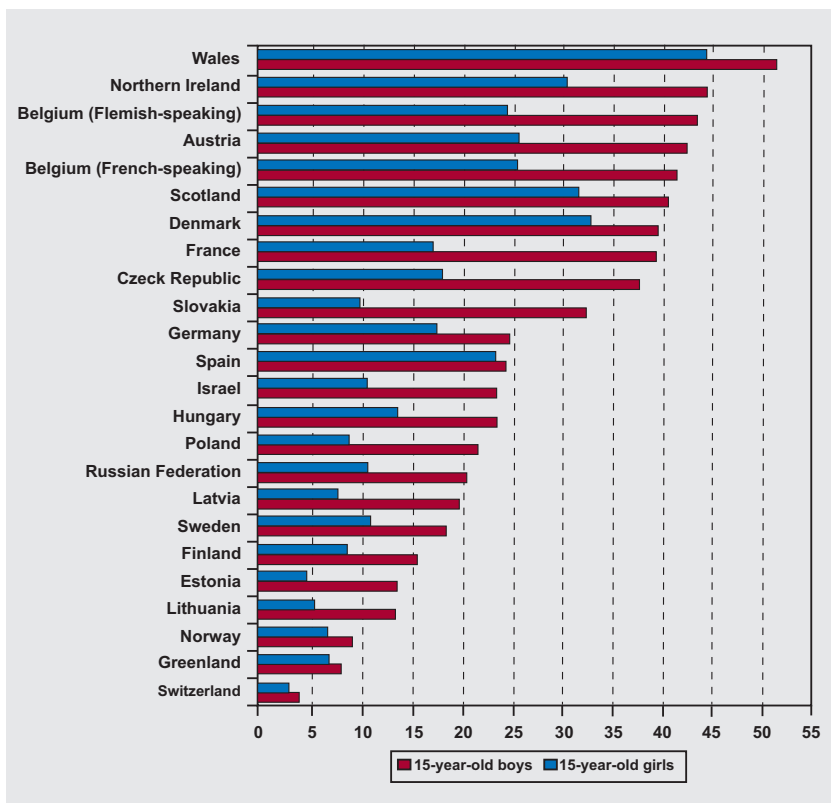
Health

Socio-economic differences in drinking patterns are likely to have corresponding alcohol-related health inequalities (fig. 3-9-2). The degree to which health-damaging drinking patterns in young people persist into later life is unclear. Deprivation may contribute to the probability of continuing to drink in a hazardous fashion and may also inhibit opportunities for positive changes in behaviour. Heavy drinking in people in higher socio-economic groups may be less harmful than in lower socio-economic groups because they are protected from harmful effects by better diet, housing, health care and other factors.

In several countries, for instance in Germany, Portugal or Switzerland, a high proportion of unemployed persons is observed among alcohol addicts undergoing inpatient treatment (Germany about 35%). This figure growing in parallel with the increase in mass unemployment - figures for Switzerland show an increase (1990-1997) from 13-27.2% in men and 11.9-19.8% in women - show that in addition to their health alcohol addicts are increasingly at risk of losing their social existence.

Death from diseases caused by alcohol shows a clear gradient with the socio-economic position, with an almost fourfold higher rate in unskilled working men than in professional groups. In addition, alcohol is a contributory factor to death from accidents, which also shows a pronounced socio-economic gradient.

Fig. 3-9-2



Percentage of 15-year-old boys and girls drinking alcohol at least once a week in selected European countries 1993/94

Source: WHO 1996

Consumers of hard drugs

In public the consumption of hard drugs is regarded as a special threat to public health. For the consumers, among other things, this may lead to an existence almost outside society with numerous, particularly health-related disadvantages. Controversies about how to combat illegal drugs and about alternative ways of tre-

ating drug addiction cannot be described in this context. Instead, it should primarily be pointed out to the fact that several hundreds of thousands of drug addicts in Europe represent a relevant group of disadvantaged human beings.

Scope, social structure and trends

Opiates (in most cases heroin) are the preferred drugs among heavy users in western European countries. In some countries (e.g. Spain), cocaine is more widely used than opiates but the vast majority of those attending treatment services are again primarily addicted to opiates. In proportion to the population size, opiate use appears to be heavier in Portugal and Switzerland than in France or Italy, which in turn have higher rates than Austria, Finland, Ireland and Norway. However, such comparisons must remain tentative as the accuracy of figures for different countries is influenced by the way in which the estimates are carried out (tab. 3-10-1, fig. 3-10-2).

During the first half of the past decade, the number of heavy opiate users seemed to be stabilizing or declining in several countries. In the Netherlands, it is observed that there is no evidence of any increase in recent years. In Spain, there is indirect evidence that the number of problem opiate users may be levelling out or falling. In France, the rate of increase in heroin use is thought to be slowing down and the dependent population is ageing. In other countries there are some indications of an increase (Denmark, Portugal, United Kingdom, Germany, Austria). In particular an increase in the use of heroin for smoking (brown heroin) was noted in Denmark in 1990-1994.

Tab. 3-10-1

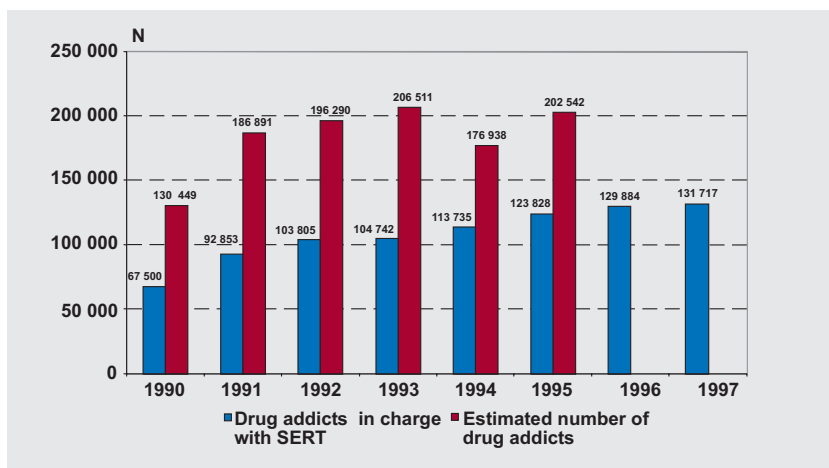
DK	3821*
D	168-210.000
E	38.000*
F	160.000
IRL	1.700*
I	200.000
L	2.000-2.100
NL	28.000
A	10-15.000
P	50.000
FIN	4-10.000
S	14-20.000
UK	75-150.000
NOR	10.000
CH	30.000

* drug users

Hard drug consumption in Europe, estimated figures early- to mid 90s

Source: WHO 1996; Country reports on disadvantaged groups 1999 (see Annex)

Fig. 3-10-2



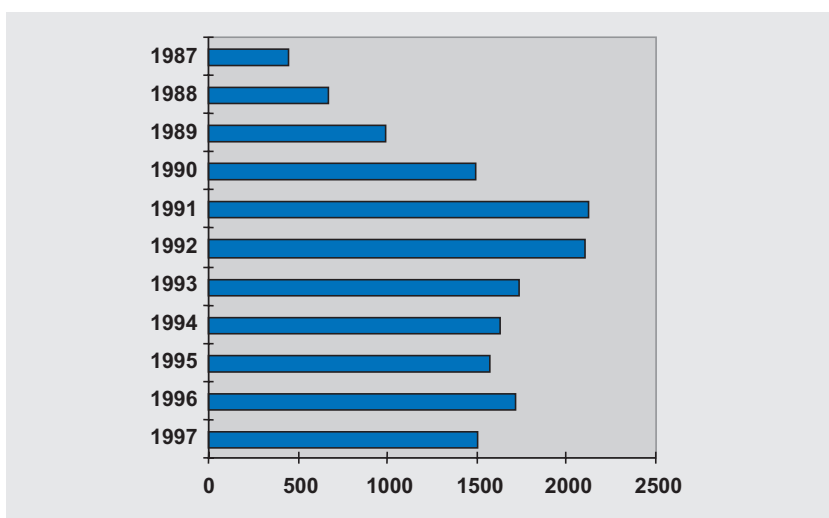
Estimated number of drug addicts in Italy

Source: Country Report Italy 1999 (see Annex)

Living conditions of drug abusers are almost poor. A relevant proportion of them finances the daily consumption illegally (prostitution, drug dealing, other crimes).

A rough estimation of the socio-economic status for example of German drug addicts can be given by the mortality statistics. For only 40% of all deaths information is given on the vocational training (fig. 3-10-3). Far more than 50% were unskilled or skilled manual workers, about one third had no skills. Regarding their last employment, the proportion of those who had been out of work before death increased to more than 65% over the years. For years the statistics have constantly shown that lower classes are over-represented by death from drug addiction.

Fig. 3-10-3



Mortality of drug users in Germany 1987-97

Source: Simon et al. 1999

Health

Drug addicts have a 10-30 fold higher mortality rate than the population in the corresponding age groups. In a Swedish study the observed mortality rate of hard drug consumers without treatment was even 63 times higher over a period of 5-8 years. Drug overdoses represent the major cause of death among injecting drug users. The main health risks include:

- infectious diseases (HIV/Aids, hepatitis)
- mental disorders
- somatic consequences of heroin consumption (unhealthy diet, sleeping disorders, abscesses).

Depressive disorders and anxieties are more frequent. Several countries report a high proportion of drug addicts with at least one suicide attempt before undergoing treatment.

Prisoners

Scope, social structure and trends

The number of prisoners in European countries varies between about 60 per 100,000 inhabitants in Finland up to about 140 in Portugal. Over the last years, there has been a trend towards more imprisonments, leading in some South European countries to an overcrowding of prisons (Portugal 157%).

More than 90% of the prisoners are men (Germany: 96%). In Germany, the proportion of persons under 30 years of age amounts to 43%. The social background of the prisoners is illustrated by a study in Sweden. Lower social class membership is more common among prisoners than among the general population. Also more prisoners have grown up with only one parent (about 50% compared to 16% in the general population). Other problems are frictions within the family, lack of support and help with school work and financial difficulties when growing up. Prisoners have a lower level of education, only 1/3 reported wages to be their main source of income during the last 12 months in freedom. The number of unemployed was 37% compared to 12% in the general population (long-term unemployment: 32 vs. 4%). 42% of the prisoners state that they have had difficulties meeting running expenses (food, rent, bills, etc) during their last 12 months in freedom (21% in the population). During the last month before being sentenced to prison, 15% of the prisoners were homeless.

Health

The most serious health problems of prisoners in almost all prisons in Europe include:

- substance abuse (alcohol, drugs, tobacco)
- communicable diseases (HIV/Aids)
- mental disorders

International committees assume that about one third up to 50% of the 300,000 prisoners in Europe (East European countries included) have made experiences with a hazardous consumption of drugs. Taking the average fluctuation into account, the figure amounts to about 600,000 persons who come into contact with the penal system as drug consumers (tab. 3-11-1).

Tab. 3-11-1

	Prisoners			Population
	Male prisoners n=362	Female prisoners n=49	All prisoners n=387	n=4,683
Troubles from long-term illness ¹⁾	51	65	52	32
Severe troubles from long-term illness ¹⁾	35	47	37	11
Psychological troubles ²⁾	10	10	10	2
Ache ³⁾	37	55	38	21
Psychological problems ²⁾	47	57	49	8

Self-reported health among a sample of prisoners in Sweden

1) Long-term illness, difficulties after an accident, a handicap or regularly taking medicine.

2) Fatigue, insomnia, nervous problems, depression, psychological illness, overstrain.

3) Ache in shoulders, backache, hip pains, sciatica, ache/pains in hands, elbows, legs or knees.

Source: Nilsson and Tham 1999

The health impacts are characterized by pollution of the injected substances, unhygienic injection conditions, self-organized withdrawals and overdosages; the

latter above all immediately after discharge from prison. Drug consumers are to be found at the lower level of the prison hierarchy.

Mental disorders are closely connected to addiction problems. In Finland, the most common mental problems are alcoholism (43%) and personality disorders (about 20%). It has been found that more than half of the prisoners have used psychiatric outpatient services, and every fifth has been hospitalized. Less than half consider themselves mentally healthy or rather healthy.

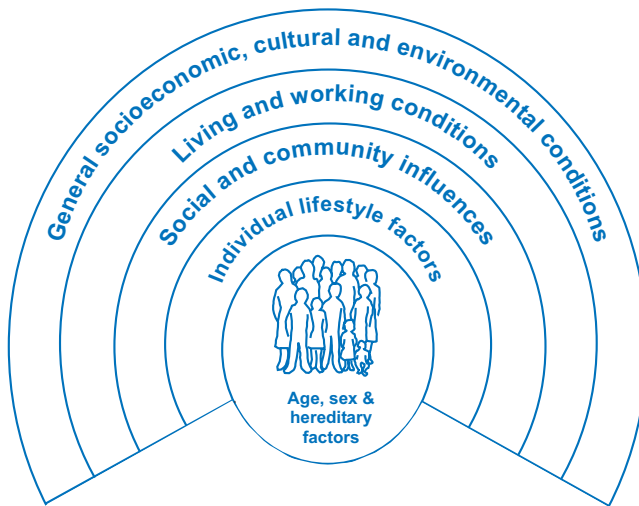
A poor mental condition is also reported from Swiss prisons. Stress and strain are most severe during the first months of imprisonment, often leading to depression and suicide attempts. Of the 213 deaths registered between 1984 and 1985 overdoses accounted for 33%, suicide for 27% and various other diseases for 20%. Mortality in prisons is eight times higher than in the population, in prisons for people awaiting trial it is even higher.

Part 4

Evidence of Causes of Socio-Economic Differences in Health

The persistence of socio-economic differences in morbidity and mortality has been shown by a multitude of studies for today's Europe, both between and within countries. For the development of (health-) policy programmes however, it is indispensable to also understand the processes responsible for the generation and maintenance of inequalities in health. Looking for such explanations it has to be stated that social inequalities before death and illness are principally based on a multilayered structure of causes. Therefore the discussion will start by recalling the principle determinants affecting health.

Fig. 4-1



'The main determinants of health'

Source: Ddrever, Whitehead 1997

The determinants of health

The status of human health / illness is basically affected by a variety of factors, ranging from age, sex and (invariable) biological susceptibilities over health-related lifestyles, living and working conditions to general socio-economic, cultural or environmental conditions, the latter also including e.g. access and response to health care (see Fig. 4-1).

According to this model, the various factors at first sight appear to be disordered and equally ranking with regard to their potential impact on the health status. Studies on the causes of inequalities in health however led to a ranking of these quantities.

Basic approaches to explain social differences in health

To classify the evidence of causes for socio-economic differences in health it proved to be useful to go back again to the Black Report.

As set out earlier it is thanks to the 1982 Black Report that the state of empirical research on manifestations and structure of 'social inequalities in health' in the United Kingdom at that time had been summarized. Additionally, the Black working group took on the attempt to find explanations for these irrefutable empirical findings. In conclusion four basic potential explanations of what health inequalities might be could be presented:

- an artefact due to measurement errors
- the result of processes of social selection
- the product of cultural / behavioural differences, or
- caused by material / structural circumstances of the individual.

Contrasted with more recent findings it is worthwhile to discuss these approaches in greater detail:

Artefact explanations

This approach suggests that size and importance of health differences may be overestimated due to unreliable methods. Naturally, there have been and still tend to be problems with the operationalization of data. For instance, the use of social classes, particularly over long time periods, may cause systematic biases as classes develop in size and structure. Nevertheless, numerous other measures used for the description of the socio-economic status did demonstrate similar patterns of inequality. No measuring tool may ever be perfect - but the size and consistency of evidence do suggest that artefact explanations can largely be discounted.

Processes of social selection

According to theories of social selection, social inequalities in health occur as a result of negative social mobility: poor health would bring people down the occupational scale so that they tend to concentrate in the lower social classes. Individuals with poor health would find it more difficult to obtain employment or would have to move to less demanding jobs, whereas healthy people would tend to be promoted. This would mean that it is more likely that health determines the social position than social conditions affect the health status. As height can be seen as an indicator for health, a classical example might be the observation that taller women in Aberdeen/UK tended to move up the occupational classes at marriage more often than smaller women did, resulting in better infant mortality rates and birthweights of their babies. However, although some evidence of social selection has been shown for younger ages, recent studies suggest that it accounts for only a small proportion of the mortality differences between social classes.

Cultural / behavioural differences

Explanations referring to behaviour suggest that inequalities in health arise because members of lower social groups would tend to a more dangerous and health-damaging behaviour than people in higher groups, and may in addition have less interest in the protection of their health for the future. A prominent example may be cigarette-smoking with highest rates among the most disadvantaged groups.

However, various studies controlling for example behavioural factors like smoking, drinking and exercise have proved a significant social gradient in mortality rates.

In addition, noticing differences in behaviour, it should be stressed that

" these behaviours plainly are embedded in the social structure. When questions are asked not merely how people behave but why they behave as they do, 'lifestyles' provide no release from the need to confront that structure." (Morris 1990, p.492)

It has been argued, e.g. that women may choose smoking as a coping strategy to enable them to look after their families under adverse social conditions and despite the potential negative consequences of smoking.

In this way there is a clear relation between the two approaches relating to cultural / behavioural differences and material / structural conditions. It seems to be more likely that these factors interact rather than that they are clearly distinct.

Material and structural conditions

Whereas the influence of social conditions on health-related behaviour may be regarded as an indirect impact, a variety of direct effects of material and structural conditions on the individual health status has been observed.

With reference to 'material' factors there is a classic triangle of main causes, proved by a variety of international studies:

- school and professional education
- occupational status, position and prestige
- income and property.

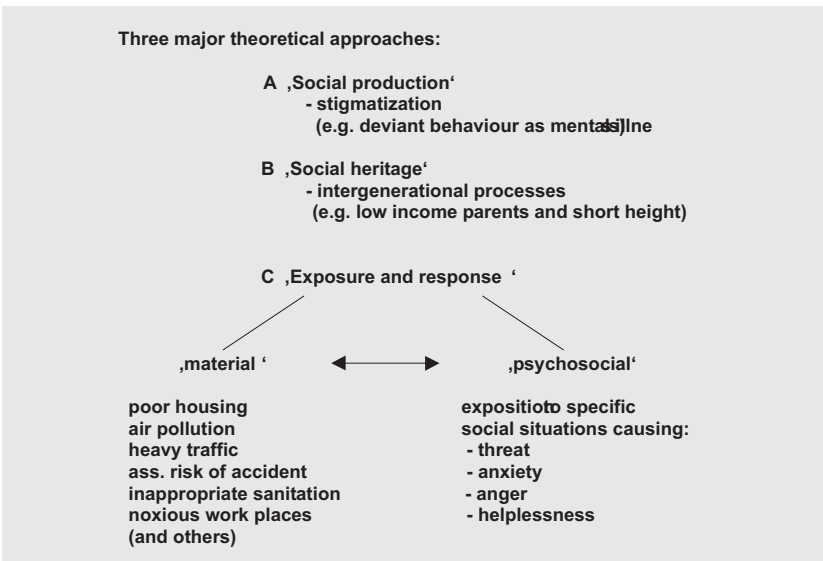
Of course there are interdependencies between these factors: e.g. as a rule a higher level of education will represent a precondition for obtaining a higher income. There is also evidence for the importance of additional variables such as age, sex, family size, place of residence, ethnicity, etc. This has led to a general classification according to 'vertical' distinctive features (education, occupation, income; based on hierarchical gradings), and 'horizontal' features (variables like age, sex,

etc.). This distinction reflects the view that classical influencing factors like education, profession and income may lose weight in contrast to other factors. Recent studies however do refer to the importance of 'vertical' factors again.

The social causation of health and illness

Studies on the main determinants of health and basic explanations of inequalities in health have led to three major theoretical approaches of explaining the social causation of health and illness (see fig. 4-2).

Fig. 4-2



The social causation of health and illness

Source: Adapted from Siegrist 2000

However, especially those explanations related to 'exposure and response' are of practical importance, while 'material' and 'psychosocial' influences tend to be understood as interdependent.

On the basis of these preliminary considerations it is possible to present a

more concrete list of main causes of differences in health, relating to potential areas of (health) policy interventions.

The main causes of differences in health

The following overview separately presents material and psychosocial causes of inequalities. However, as stated above this differentiation should not be regarded as exclusive.

In this respect, exposure to the various forms of stress, its perception by the individual and the coping with it can be regarded as the 'interface' between material and psychosocial factors.

'Material' factors

Poverty / social exclusion

Processes of social exclusion and the extent of relative deprivation in society have a major impact on health and premature death. Living in poverty causes a negative impact on health not only due to material deprivation but also due to social and psychological problems arising from this situation. Poverty may occur in absolute and relative terms. As already mentioned in Part 2 of this report, in some countries as much as one quarter of the total population lives in relative poverty. It has been shown that an individual's health status is generally better in societies with a more equal distribution of incomes (relative income hypothesis). Members of special vulnerable groups such as migrants, ethnic minorities, guest workers or refugees are more likely at risk of social exclusion.

Social gradient

The social gradient in health reflects material disadvantages and effects of security, anxiety and lack of social integration. Disadvantages have many forms and tend to concentrate among the same people, their effects are cumulative.

People further down the social ladder usually run at least twice the risk of serious illness and premature death of those near the top. Between top and bottom,

health standards show a continuous social gradient. Disadvantage have many forms:

- having few family assets
- having a poorer education during adolescence
- becoming stuck in a dead-end job, or
- having insecure employment
- living in poor housing, and
- trying to bring up a family under difficult circumstances

Work / unemployment

Evidence shows that stress at work plays an important role in contributing to the big differences in health, sickness absence and premature death that are related to social status. Several workplace studies in Europe show that health suffers when people have little opportunity to use their skills and low authority over decisions.

Unemployment puts health at risk, and the risk is higher in regions where unemployment is widespread. Evidence from a number of countries shows that, even after allowing for other factors, unemployed people and their families suffer a substantially increased risk of premature death. European countries have been particularly hit by changes in the economies and labour markets of industrialized countries, causing increased feelings of job insecurity. From the early 70s, the unemployment rate in the EU has risen from less than 3% to about 11% in the mid-nineties. Persisting unemployment has been acknowledged by the European Commission as "the major economic - and social problem confronting the Union", reflecting both economic inefficiency and human distress. Often the economic burden of unemployment weighs heavily on other related areas of social policy, leading to attempts to reduce social welfare and employment protection, to lower wages and greater poverty, and increased exposure to health hazards.

Bad housing conditions

Bad housing is likely to damage health, expressed both by higher mortality and

morbidity rates due to poor housing or homelessness. The impact of bad housing arises from three dimensions:

- quantity

rising numbers of households (increasing populations, migrations, growing number of single-person households) may lead to a shortage of adequate and affordable housing.

- quality

the quality of housing continuously improved during the last century; however, low-income households suffer disproportionately from housing under conditions unfit for human habitation

- location

the quality of life of residents may be more affected by the environs than by the condition of the house itself.

Access to and utilization of health care

Social deprivation often correlates with unequal access to health care. Even if the impact of health care systems on the improvement of the overall health of a population has been doubted in the past, it has become obvious that the safeguarding of equal access to health care for special groups at risk results in better chances to maintain their health.

On the other hand, psychosocial impediments - e.g. due to ethnicity - may constitute a threshold preventing the regular utilization of health care services such as screening, monitoring or vaccination. Insufficient screening or vaccination results in higher rates of mortality and morbidity, e.g. of cancer or communicable diseases.

Road transport

"The issue of transport has been growing in importance as food outlets and medical services become centralized. The time and money spent on travelling becomes a factor to be considered in health service use." (Whitehead 1992, p.333).

Lower socio-economic groups, women, ethnic minorities, children and older people disproportionately suffer from travel inconveniences.

Third major health impacts of transport:

- accidents

E.g. for Britain a clear social gradient could be shown for death from road traffic accidents which is highest in childhood (over four times higher for children in the lowest class as opposed to the highest class), but persists at a lower level into adult life.

- air pollution

There is an abundance of scientific evidence as to the effects of key emissions from road transport. While there is a potential hazard for the population in general, a variety of pollutants pose particular risks to special vulnerable groups like pregnant women, elderly people, people suffering from respiratory and coronary diseases, and children. It should be mentioned that these mainly represent the same groups which have least access to cars.

- noise pollution

'Psychosocial' factors

Stress

As pointed out before, 'stress' is marking the interface between material and psychosocial, external and internal factors. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life have powerful effects on health. Such psychosocial risks accumulate during life and increase the chances of poor mental health and premature death. The lower people are in the social hierarchy of industrialized countries, the more common health problems become.

Health-related behaviour

Smoking habits

Social deprivation is associated with high rates of smoking and very low rates of quitting smoking. Smoking is a major drain on poor people's incomes and a leading cause of ill health and premature death.

Addiction

Drug use is both a response to social breakdown and an important factor in worsening the resulting inequalities in health. Alcohol dependence, illicit drug use and cigarette smoking are all closely associated with markers of social and economic disadvantage.

Nutrition

Social and economic conditions result in a social gradient in diet quality that contributes to health inequalities. Access to good, affordable food makes more difference to what people eat than health education.

Physical activity

Social deprivation tends to be associated with low frequency of exercise. Regular exercise can be seen as an important factor for preventing illness. On the other hand, a lack of exercise has been proven as a major risk factor, e.g. for coronary heart diseases.

Early life

Important foundations of adult health are laid in prenatal life and early childhood. Slow growth and a lack of emotional support during this period raise the life-time risk of poor physical health and reduce physical, cognitive and emotional functioning in adulthood.

Social support

Social support and good social relations make an important contribution to health. Access to emotional and practical social support varies depending on the social and economic status. Poverty can contribute to social exclusion and isolation. Societies with high levels of income inequality tend to have less social cohesion, more violent crime and higher death rates.

Part 5

Reducing Inequalities: Strategies for Socio-Economic Differences in Health

Avoidable inequalities

Before formulating strategies of how to tackle inequalities in health, an analysis of options for action and some considerations on the desirability of such changes seem to be appropriate. In international discussions, for several years the term of so-called ‚avoidable inequalities‘ has been used, referring to a necessary differentiation of perceptible phenomena of inequalities in health according to:

- unjust
- unavoidable and
- acceptable inequalities

Thus avoidable inequalities are just those included in the category ‚unjust‘. They principally respond to regulations, they are not wanted by the individual, and up to now they have not been assessed or recognized as manageable inequalities.

Determinants of inequalities regarded as unjust by broad sections of society have to become the subject of political interventions - such as securing adequate physical and social conditions of life or providing the individual with options to avoid unhealthy lifestyles (through education, knowledge, etc). Correspondingly, the English literature used the term of ‚health inequities‘ to describe avoidable/unjustified inequalities, in contrast to the more general term of ‚health inequalities‘ for all sorts of differences. The term of ‚avoidability‘ can moreover be discussed against the background of differentiating between behavioural patterns/preventive measures concerning living conditions.

In a nutshell, for future European reports it is therefore proposed to use the term of *avoidable* inequalities.

The above-made considerations lead to two decisive questions which should be looked at in greater detail:

- *which of the documented types of social inequalities should be regarded as 'avoidable' and thus as the potential subject of (health) policy interventions,*
- *which are promising attempts to combat these avoidable inequalities?*

The question of how to avoid (or compensate for) types of socially caused inequalities at the European level is discussed in the following with the help of selected types/causes of social inequalities. The description concentrates on the described comparison of types/causes.

From the multitude and complexity of the underlying causes of socio-economic inequalities in health described in part 4, it can be seen that programmes aimed at the reduction of these described inequalities can in principle be applied to different intervention levels which in addition to the more restricted area of a - more compensatory - health policy also affect the job market, social and environmental policies (see box 5-1):

Box 5-1

- Reduction of poverty / social exclusion
- Reduction of the social gradient
- Reduction of long-term unemployment
- Reduction of psycho-social stress factors
- Fostering health and development early in life
- Health prevention at work
- Support of (primary / secondary) social networks
- Fostering healthy conditions for nutrition
- Implementation of healthier transport systems

Key areas for tackling inequalities in health

In principle, integrative strategies going beyond politics seem to be a promising approach. In the following, first attempts of classifying strategies and measures already implemented or proposed in literature will be developed.

Interventions for reducing inequalities in health described in international literature can at first be classified as follows:

Structurally effective measures

This category contains interventions leading to direct structural changes (e.g. reduction of financial access barriers to the health system or introduction of school breakfast for all pupils).

Measures in the field of health care

These include interventions within the existing health system with the intention of reaching persons which up to now have not or inadequately participated in effective screening programmes.

Interventions in the field of 'health education'

Interventions serving primarily information purposes have proved effective, particularly for persons with a higher socio-economic status. In addition, there are examples of programmes offering additional personal support and/or advice for example by a health service which reaches out to people. Such health promotion measures have frequently been offered together with structural interventions in the field of migrants' health.

Model initiatives in different countries and at the international level

The following will describe model initiatives to tackle socio-economic differences in health in Europe, both at national and international level, as there can be no

doubt that the reduction of inequalities represents a trans-European issue.

Exemplary initiatives in European countries

The authors of the Black Report already tried to evaluate the potential impact of possible interventions. All in all they favoured a 'programme across departments of higher benefits and better distribution of income, as well as action on housing and services'. The primordial significance of measures for securing a minimal standard of life is also underlined in the updated version of the Acheson Report in that it recommends policies 'to reduce income inequalities and improve the living standards of households in receipt of social security benefits' (see Department of Health 1998 p. 36) to reduce, 'poverty in women of childbearing age, expectant mothers, young children and older people'. The report calls for integrated actions in the problem areas of unemployment, ethnicity, elderly people and disability, as well as generally for families with children, to bring about increases in levels of benefit and real living standards. Moreover, it also recommends to develop strategies to be adopted by the individual. Empowerment strategies for example are aimed at increasing the individual's grade of "control of destiny", the lack of which is regarded as a major cause of the social gradient: Life contains a series of critical transitions. People who have been disadvantaged in the past are at the greatest risk in each transition. This means that welfare policies need to provide not only safety nets but also springboards to offset earlier disadvantages: "Good health involves reducing levels of educational failure, the amount of job insecurity and the scale of income differences in society, we need to ensure that fewer people fall and that they fall less far, policies for education, employment and housing affect health standards."

Evaluating various intervention options, the authors of the Independent Inquiry into Inequalities in Health come to a clear conclusion in favour of income-related measures: "We consider that without a shift of resources to the less well off, both in and out of work, little will be accomplished in terms of a reduction of health inequalities by interventions addressing particular 'downstream' influences."

These considerations are confirmed by an analysis carried out on a series of measures and strategies implemented all over Europe to determine their real impact on inequalities in health (see tab. 5-1).

Tab. 5-1

Type of intervention	Effective	Inconclusive	Ineffective	Total
Structural measures (mainly health care finance)	11	4	1	16
Traditional health care (prevention and screening services)	5	3	3	11
Health education:				
• providing information	6	6	4	16
• providing information and personal support	32	12	5	49
• health promotion and structural measures	2	1	-	3
Remainder	2	1	-	3
Total	58	27	13	98

Tackling inequalities in health: type and effectiveness of evaluated interventions reported in health literature

Source: Gepkens / Gunning-Schepers 1996

One of the more general findings of these reviews has been that generally these measures were more effective than expected.

Recent years have also shown an increasing awareness of (health-) policy decision makers at the international level. EU and WHO as supra-national institutions turned out to be major potential actors.

Closing the gap: strategies of the EU

Recognizing that changes in societal morbidity and mortality to be registered in the whole of Europe call for a corresponding updating and improvement of the existing health monitoring and health reporting systems, the European Community in October 1995 adopted an "Action Programme of the Community for Health Monitoring" (Health Monitoring Programme). Covering an overall period of 5 years, EU funds for corresponding projects were for the first time allocated in 1997. This action programme is based on the awareness that knowledge

about the health problems of EU citizens requires an improved monitoring of their health status and its determinants as well as surveillance and evaluation of corresponding measures. For this reason, the Health Monitoring Programme is aimed at three main objectives:

- joint measuring of health and its determinants as well as comparisons with third countries;
- facilitating the planning, observation, implementation and evaluation of Community programmes and measures;
- providing high-quality, comparable indicators and sufficient health-related information for all Member States in order to support their Health Monitoring Systems and to make a contribution to health policy planning at the national level.

As a result of this programme, a Community-based Health Monitoring System shall be established, comprising

- a set of Health Monitoring indicators;
- a network for collecting and disseminating this data;
- an institution for analysing the indicators.

A first manifestation of these efforts was the presentation of an overview of the health status within the European Community in 1995, a report which in future shall be issued every five years, supplemented by annual reports on isolated issues such as for instance women's health. Important data sets are moreover held by WHO - EUROSTAT; the Statistical Office of the EU primarily bases its publications on these data sets.

With regard to measures for reducing inequalities in health, various actors have already appeared at the European level. In addition to the European Community, these include above all the WHO but also the OECD.

In this context the significance should be pointed out which was attached to this issue by its inclusion into the WHO's list of European health targets. As early as in 1977, WHO Europe adopted a resolution calling for the realization of equity in health:

"By the year 2000, all citizens shall have reached a health status allowing them to lead a socially and economically productive life."

In 1984, this request was included into the list of the 38 European health targets and in the targets for Europe which have recently been adopted. Following their updating and revision, the EU Member States formulate the following self-commitment in target 2 of 'The Health 21 Strategy':

"By the year 2020, the health gap between socio-economic groups within countries should be reduced by at least one quarter in all Member States, by substantially improving the level of health of disadvantaged groups." (WHO Europe, 1999)

Quite deliberately, target 2 quoted from the WHO Health 21 Strategy is not aimed at realizing equal health for all parts of the population but calls for the realization of equal opportunities in health for all citizens. Accordingly, the strategy of WHO Europe is aimed at the following core elements.:

- lifestyles and health;
- factors influencing health and the environment;
- realignment of the health care system;
- mobilizing political, societal as well as interdisciplinary and cross-sectoral support for bringing about the necessary change.

The WHO Copenhagen Declaration 'Opportunities for the future' adopted in December 1994 continues to emphasize considerable inequalities in health between countries and population groups in almost all countries. It stresses values such as solidarity, equal opportunities and human rights; the securing of access for all to optimal and payable health services even with scarce resources. An examination of the results of the HFA 2000 strategy in 1997 led to continuously negative results for target 2:

Equal opportunities in the whole of Europe continue to be a serious problem, so for example "the countries of the Region differ almost 15 years with regard to their highest and lowest life expectancy".

WHO Europe: starting points and strategies

From this disillusioning synopsis the WHO derives the necessity of bringing the social determinants of disease and health even more to the attention of decision makers in health policy and of public health actors. Despite available scientifically proved evidence the significance of this topic is primarily discussed in scientific research. Therefore WHO Europe has decided to launch a campaign intended to summarize in a clear and comprehensible way the present evidence in a specific publication series and to stress implications for the different areas of policy. In this way a broadly based debate and corresponding activities are to be initiated. A first step into this direction was the booklet *Social Determinants of health: The Solid Facts*. This activity coincides with the following Europe-(world-)wide activities (see box: 5-2).

Box. 5-2

1977	WHO passes call for equity in health
1984	Publication of 'Black Report' in England
1984	Integration in HFA 2000 / Health 21 strategies of WHO
1994	Copenhagen Declaration of WHO emphasizes solidarity and equal opportunities
1998	Athens Declaration of the Healthy Cities Project adopts 'equal opportunities' as a key principle
1998	Council of Europe recommends special health programmes for the poor
1997 – 2003	Health Monitoring Programme of the EU

Tackling inequalities in Europe - exemplary actions

In this context, the Copenhagen Declaration of the United Nations (The Copenhagen Declaration and Programme of Action) which was adopted at a World Summit in March 1995 is of importance. In the face of irrefutable inequalities in both the southern and northern countries, the social threats were compared to the threats of nuclear weapons. Modelled on the attempts of the EU during the 80s, the UNO is now looking for possibilities to pick out processes of social exclusion as a central issue even for the 'rich' nations.

In the field of Europe-wide coordinated activities of local self-administrations the Athens Declaration of Healthy Cities as part of the WHO Healthy Cities Programme (23 June 1998) should be mentioned in connection with the launching

of phase III of the Healthy Cities Project. Within the framework of the adoption of key principles governing future actions for improving the health of the population 'equal opportunities' are mentioned in the first place, i.e. the political commitment to

- reduce health gaps between and within the cities
- improve access to health for all
- considerably improve the health of population groups at risk.

In January 1998, the OECD adopted the recommendation 'Fighting social exclusion and strengthening social cohesion in Europe' (Recommendation 1355). It contains various recommendations for the Committee of Ministers to encourage the Member States to embark upon political activities. In the health sector:

- to provide free medical care for the poor with the aim of preventing serious illness
- to fight pathological diseases prevalent among the poor through special medical care programmes.

Moreover, the Committee of Ministers launched a campaign on 'Global interdependence and solidarity: Europe against poverty and exclusion.'

The need for integrated strategies

In this context, based on the described complexity of reasons and against the background of the exemplarily described options for action, the possible status of interventions in health policy should be discussed. At first sight the most promising option is of course the simple recommendation of " ... throwing money at the problem". In view of dwindling resources political strategies should however be developed by putting maximum emphasis on target-orientation and by including various actors.

Integrating policy layers and actors

A discussion of general conditions leading to promising political strategies should therefore start by recollecting once again the already quoted four potential layers of influences / policy (see fig. 4-1 in Part 4 of this text):

1. individual lifestyle factors
2. social and community influences
3. living and working conditions
4. general socio-economic, cultural and environmental conditions.

Principally it can be said that the more strategic policy approaches stand out by the fact that they have spanned several of these layers, i.e. reaching from individual lifestyles to basic conditions, and involving actors at individual, local and (inter)national level.

The 'Our Healthier Nation' strategy for example which was published by the British Government in 1998 focuses on two key aims: prolongation of disability-free life expectancy and reduction of inequalities in health.

Tab. 5-2

	Government and National Players can	Local Players and Communities can:	People can:
Social and Economic	Continue to make smoking cost more through taxation	Provide incentives to employees to cycle or walk to work	Take chances for education, training etc.
Environmental	Encourage employers to have smoke-free workplaces	Provide safe cycling and walking routes	Protect others from second-hand smoke
Lifestyle	Develop Healthy Living Centres	Develop healthy schools and healthy workplaces	Stop smoking or cut down
Services	Encourage health professionals to give advice	Improve access to a variety of affordable food in deprived areas	Learn resuscitation skills

A National Contract to fight heart disease and stroke in the United Kingdom

Source: Selected examples from 'Our healthier Nation'; adapted from Crown 1998

To achieve these aims, the Government intends to establish a 'national contract' involving the national government, local communities and individuals, and describing the potential roles of each of these players. Tab. 5-2 gives an example of

an integrated strategy suggested in the UK within the 'Our Healthier Nation' programme and aiming at the involvement of players from several policy levels.

Practical recommendations - the art of tackling inequalities

Besides these considerations about promising combinations of policy areas and levels, practical experiences with tackling inequalities in health in European countries also result in a series of more practical recommendations, referring to the focus and design of potential strategies.

Looking at the number of positive and negative results or criticism, it turned out that as a basic requirement future political programmes should be:

- prioritized;
- justifying the choice of their objectives;
- concrete (naming policies, interventions and actors as a "recipe for action");
- costed;
- include evaluation and monitoring.

The evaluation of interventions and the conceptual planning of further health policy programmes should be closely linked to each other to ensure as much efficiency and effectiveness as possible when it comes to influencing the complex reasons of social inequalities before illness and death. For this purpose a series of available experiences can also be referred back to.

Summing up

So a realistic résumé consists in the demand for an integrative approach aimed at combating the causes of inequalities:

- The health care sector alone, however, is not in a position to cope with this task (see also Health Report by the European Commission 1996). Health policy measures intended to combat inequalities in health only seem reasonable and effective if they are integrated into a number of socio-political interventions (social security, labour market policy, educational policy, housing policy, immigration policy, etc).

- On the other hand, the required integrative approach does not allow to derive a strategy which would take the load off the shoulders of the decision makers in health policy in the stricter sense of the term. Positive and promising approaches of corresponding initiatives are in many ways available in the European Region.



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