Health equity through action on the social determinants of health

Michael Marmot
August 13, 2012
Social justice

Material, psychosocial, political empowerment

Creating the conditions for people to have control of their lives

The CSDH – closing the gap in a generation 2005-2008

The Marmot Review – Fair Society Healthy Lives 2009/10
Action on the social determinants of health: what can health professionals do?

Practice
Education
Incentives, monitoring and requirements
PRACTICE

• Creating the conditions for people to take control over their own lives
• Advocacy and influencing policy
• Enable and encourage cross-sector and partnership working
• Information
• Improve signposting, referral and innovative social prescribing
• Commissioning
• Health practitioners as employers and managers
EDUCATION

• Under- and post-graduate course curricula
• Dual accreditation in public health.
• Training placements
• Continuing Professional Development
INCENTIVES, MONITORING AND DIRECTIVES

• Incentives
• Monitoring
• Directives
Putting it into practice
Fair Society: Healthy Lives: 6 Policy Objectives

A. Give every child the best start in life
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives
C. Create fair employment and good work for all
D. Ensure healthy standard of living for all
E. Create and develop healthy and sustainable places and communities
F. Strengthen the role and impact of ill health prevention
Marmot Review: 6 Policy Objectives

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“Disadvantage starts before birth and accumulates throughout life. Action to reduce health inequalities must start before birth and be followed through the life of the child. Only then can the close links between early disadvantage and poor outcomes throughout life be broken.”

Readiness to learn at school entry, by income, Toronto, 2004/05

Socio-emotional difficulties at age 3 and 5: Millennium Cohort Study UK

Age 3

Age 5

Fully adjusted = for parenting activities and psychosocial markers
Kelly et al, 2010
Country ranking: equality in child wellbeing - material, education, and health

<table>
<thead>
<tr>
<th>Score</th>
<th>Country</th>
</tr>
</thead>
<tbody>
<tr>
<td>8</td>
<td>Denmark, Finland, Netherlands, Switzerland</td>
</tr>
<tr>
<td>7</td>
<td>Iceland, Ireland, Norway, Sweden</td>
</tr>
<tr>
<td>6</td>
<td>Austria, Canada, France, Germany, Poland, Portugal</td>
</tr>
<tr>
<td>5</td>
<td>Belgium, Czech Republic, Hungary, Luxembourg, Slovakia, Spain, United Kingdom</td>
</tr>
<tr>
<td>3</td>
<td>Greece, Italy, United States</td>
</tr>
</tbody>
</table>

Source: UNICEF Report Card 9, ranking 24 OECD countries by their performance in each of three dimensions of inequality in child well-being
Proportion of young children attending pre-school in 58 low-income and middle-income countries by income quintile within country

Data are from the UNICEF’s 2005 Multiple Indicator Cluster Survey 3 for children aged 3 and 4 years. Countries in central and eastern Europe, CIS, and Baltic states in study: Albania, Belarus, Bosnia and Herzegovina, Georgia, Kazakhstan, Kyrgyzstan, Macedonia, Serbia, Tajikistan, Ukraine, Uzbekistan

Source: Engle et al, Lancet 2011
Partnership in action: Starting at the beginning - early years care and education

Bromley by Bow Centre

Linden Children’s Centre,
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• Unemployment associated with poor mental and physical health;
• For those in work – employment and working conditions affect physical and psychological health
Mortality* of men aged 16-64 by social class and employment status at the 1981 census

<table>
<thead>
<tr>
<th>Social class</th>
<th>Standardised Mortality Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Employed in 1981: 56</td>
</tr>
<tr>
<td>II</td>
<td>Employed in 1981: 74</td>
</tr>
<tr>
<td>IIIN</td>
<td>Employed in 1981: 82</td>
</tr>
<tr>
<td>IIIM</td>
<td>Employed in 1981: 86</td>
</tr>
<tr>
<td>IV</td>
<td>Employed in 1981: 97</td>
</tr>
<tr>
<td>V</td>
<td>Employed in 1981: 112</td>
</tr>
<tr>
<td>I</td>
<td>Unemployed in 1981: 92</td>
</tr>
<tr>
<td>II</td>
<td>Unemployed in 1981: 102</td>
</tr>
<tr>
<td>IIIN</td>
<td>Unemployed in 1981: 118</td>
</tr>
<tr>
<td>IIIM</td>
<td>Unemployed in 1981: 118</td>
</tr>
<tr>
<td>IV</td>
<td>Unemployed in 1981: 139</td>
</tr>
<tr>
<td>V</td>
<td>Unemployed in 1981: 176</td>
</tr>
</tbody>
</table>

* adjusted for age and salary

Unemployment and Mortality

1% rise in unemployment associated with:
- 0.8% ↑Suicide
- 0.8% ↑Homicide
- 1.4% ↓Traffic death

No effect on all-cause mortality

Source: Stuckler et al 2009 *Lancet*
Population attributable Risk (PAR) for all combined*

46%  95% CI 37%-53%
adjusted for other predictors

34%  95% CI 24%-43%

ERI= Effort reward imbalance

*calculated from odds ratios adjusted for age, sex, employment grade
Youth unemployment rates, EU-27 and EA-17, seasonally adjusted, Jan 2000 - Sept 2011

Source: EUROSTAT
Changes in adult unemployment and in age-standardised suicide rates (age 0–64 years) in old (pre-2004) and new European Union Member States

(Stuckler et al Lancet 2011)
Social Protection

Each 100 USD per capita greater social spending reduced the effect on suicides by: 0.38%, active labour market programmes 0.23%, family support 0.07%, healthcare 0.09%, unemployment benefits

Spending > 190 USD no effect of unemployment on suicide

Source: Stuckler et al 2009 *Lancet*
Relation between social welfare spending and all cause mortality in 18 EU countries, 2000

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Context matters

- Deprivation
- Social inequality
Percentage shares of equivalised total gross and post-tax income, by quintile groups for all households, 1978 – 2007/8

Note: Gross income comprises original income and direct cash benefits (e.g. pensions, child benefit, housing benefit and income support). Post-tax income comprises gross income after direct and indirect taxes (e.g. VAT).
Real earnings growth (%) for men and women working full time by decile, 1980 - 2005

OECD 2008
International comparisons of income mobility

Higher score = lower intergenerational mobility

Trends in income share among top income decile, US: 1913-2007
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Figure 2a: Life Expectancy at Birth, by Income\textsuperscript{1}, Males, Toronto, 2001, 2003 & 2004 Combined\textsuperscript{2}

Figure 2b: Life Expectancy at Birth, by Income\textsuperscript{1}, Females, Toronto, 2001, 2003 & 2004 Combined\textsuperscript{2}

Health of Indigenous Peoples

- Indigenous groups have worse health and lower life expectancy than general population

- Canada: in 2001 life expectancy for First Nations males was 70.4 years and 75.5 years for females compared to 76.5 and 82.1 years for the non-Aboriginal male and female population (INAC 2003)

- Life expectancy at birth for Indigenous men (67.2 years) - 11.5 years less than for non-Indigenous men in Australia (latest estimates)
Closing the gap in New Zealand

Life expectancy at birth for male and female populations. Graphs show increasing life expectancy over time for both Maori and non-Maori populations.

Tobias et al, 2009
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Action on the wider determinants - to tackle health inequalities

• “Every sector a health sector”

• Local authorities, Health and Social Services, Voluntary Sector have a key role to play at local level

• Empower individuals and communities – create the conditions for people to take responsibility
SMRs by cause, all ages: Glasgow relative to Liverpool & Manchester

All ages, both sexes: cause-specific standardised mortality ratios 2003-07, Glasgow relative to Liverpool & Manchester, standardised by age, sex and deprivation decile

Calculated from various sources

Health improvement in difficult times

- A major element of the excess risk of premature death seen in Scotland is psychosocially determined.

- Study evidence of low sense of control, self efficacy and self esteem in population in these areas.

Source: H. Burns, CMO Scotland.
Global Movement
• “This ends the debate decisively. Health care is an important determinant of health. Lifestyles are important determinants of health. But it is factors in the social environment that determine access to health services and influence lifestyle choices in the first place.”

Dr Margaret Chan, the Director General of WHO, at the launch of the CSDH Final Report in Geneva 28th August 2008
World Conference on Social Determinants of Health: Rio de Janeiro 18-21 Oct 2012
Rio Political Declaration on Social Determinants of Health

Rio de Janeiro, Brazil, 21 October 2011

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.

2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global action.
“The main problem of the Rio Declaration is that it failed to explicitly tell us how the unfair distribution of power, resources and wealth will be addressed, especially by Member States.”
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www.who.int/social_determinants
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