Tackling Health Inequalities

ICOHIRP Meeting  May 21st 2015

Professor Sir Michael Marmot
@MichaelMarmot
www.instituteofhealthequity.org
Key principles

- Social justice
- Material, psychosocial, political empowerment
- Creating the conditions for people to have control of their lives

www.who.int/social_determinants
The WHO Commission on Social Determinants of Health (CSDH) – Closing the gap in a generation

- Improve the conditions in which people are born, grow, live, work, and age
- Tackle the Inequitable Distribution of Power, Money, and Resources
- Measure and Understand the Problem, Evaluate Action, Expand the Knowledge Base, Develop the Work Force
Fair Society, Healthy Lives

The Marmot Review

Review of social determinants and the health divide in the WHO European Region: final report

Health inequalities in the EU
Final report of a consortium
Consortium lead: Sir Michael Marmot
Fair Society, Healthy Lives: 6 Policy Recommendations

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
Working for Health Equity: The Role of Health Professionals
1. Workforce Education and Training
2. Working with Individuals and Communities
3. Health Sector as Employers
4. Working in Partnership
5. Workforce as Advocates
1. Workforce Education and Training
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• Every sector is a health sector
  – Health and well being as outcomes

• Empowerment
ELSA (older adults): Age-standardised prevalence of edentulousness with SEP markers

Subjective and Clinical Health

US adults (NHANES III)

Adjusted for: age, sex, ethnicity, insurance (dental/medical), BMI, smoking, diabetes, diet, blood pressure, exercise.

Adult Dental Health Survey 2009

Dentate: different patterns of OHRQoL inequalities:

- Education: more of a **threshold “effect”**
- Income (and IMD): clear **gradient**

Inequalities **mostly among younger adults** - future implications?

### Oral health inequalities by welfare state

<table>
<thead>
<tr>
<th>Welfare State Regime</th>
<th>Managers and professionals</th>
<th>Intermediate</th>
<th>Manual workers</th>
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<tbody>
<tr>
<td>Scandinavian</td>
<td>0.5%</td>
<td>1.0%</td>
<td>3.0%</td>
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<td>Anglo-Saxon</td>
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<td>Bismarckian</td>
<td>0.5%</td>
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<td>Southern</td>
<td>0.5%</td>
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<tr>
<td>Eastern</td>
<td>0.5%</td>
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* $P$ for trend $\leq 0.01$

... Clear gradients everywhere...

Limitations with health education

- Ineffective in reducing inequalities - fails to tackle causes
- Costly - high professional input
- Non sustainable
- Duplication of effort
- Public apathy and resistance
Scottish dental health education intervention

Plaque index = 0

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<thead>
<tr>
<th></th>
<th>Before intervention</th>
<th>1 month after</th>
<th>4 month after</th>
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<tr>
<td>Non-deprived</td>
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<tr>
<td>Deprived</td>
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No bleeding

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Conceptual Framework for Social Determinants of Oral Health Inequalities

Structural Determinants (Political and economic drivers)
- Socio economic & political context
  - Macro economic policies
  - Social & welfare policies
  - Political autonomy
  - Historical/colonal
  - Globalisation

Socioeconomic Position
- Social Class
- Gender
- Ethnicity
- Occupation
- Income

Material & social circumstances
- Living & working conditions
- Food security
- Social capital

Behaviour & biological factors
- Age, genetics
- Inflammatory Processes
- Infections

Psychosocial Factors
- Stress
- Perceived control
- Social support

Health Services
- Quality of care
- Appropriate Access
- Evidenced based preventive orientation

Adapted CSDH Framework (WHO 2008)
Upstream - downstream interventions

Watt, CDOE (2007)

- National &/or local policy initiatives
- Legislation/Regulation
- Fiscal Measures
- Healthy Settings- HPS
- Community Development
- Training other professional groups
- Media Campaigns
- School dental health education
- Chair side dental health education
- Clinical Prevention

‘Upstream’ Healthy Public Policy

‘Downstream’ Health Education & Clinical Prevention
1. Workforce Education and Training
2. Working with Individuals and Communities
3. Health Sector as Employers
4. Working in Partnership
5. Workforce as Advocates
Socio-emotional difficulties at age 3 and 5: Millennium Cohort Study

Age 3

Fully adjusted = for parenting activities and psychosocial markers

Age 5

Fully adjusted = for parenting activities and psychosocial markers

Kelly et al, 2010
Obesity
Inequalities in childhood obesity are increasing in England: Obesity prevalence by deprivation decile 2006/7 to 2012/13

Children in Year 6 (aged 10-11 years)

Child obesity: BMI ≥ 95th centile of the UK90 growth reference

Health inequalities post the Marmot Review – National Child Measurement Programme 2006/7 to 2012/13
Prevalence of overweight and obesity in Eastern Mediterranean Region, by sex

Source: WHO EMRO
Patterns of consumption
Soda Market Sales Forecast By Region

Source: Euromonitor International

Bloomberg Business
1. Workforce Education and Training
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Employment and working conditions have powerful effects on health and health equity

When these are good they can provide:-

• financial security
• paid holiday
• social protection benefits such as sick pay, maternity leave, pensions
• social status
• personal development
• social relations
• self-esteem
• protection from physical and psychosocial hazards

… all of which have protective and positive effects on health

(CSDH Final Report, WHO 2008)
Occupational stress in European countries

Per cent

Occupational class

- Very low
- Low
- High
- Very high

- Effort reward imbalance
- Low control
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Typology of multi sectoral action on NCDs

- **NCD-Sensitive Actions on Social Determinants**
  - e.g. education, employment, social protection, healthy places

- **NCD-Specific Actions on Social Determinants**
  - e.g. alcohol/tobacco taxes

- **Expanding Delivery Platforms**
  - e.g. settings – schools, workplaces

Source: Bell, Lutz, Webb & Small, UNDP 2013
Adverse Childhood Experiences: England

How many adults in England have suffered each ACE?

**CHILD MALTREATMENT**
- Verbal abuse: 18%
- Physical abuse: 15%
- Sexual abuse: 6%

**CHILDHOOD HOUSEHOLD INCLUDED**
- Parental separation: 24%
- Domestic violence: 13%
- Mental illness: 12%
- Alcohol abuse: 10%
- Drug use: 4%
- Incarceration: 4%

For every 100 adults in England 48 have suffered at least one ACE during their childhood and 9 have suffered 4 or more

Bellis et al., 2014
Adverse Childhood Experiences: England

Preventing ACEs in future generations could reduce levels of:

- Early sex (before age 16) by 33%
- Unintended teen pregnancy by 38%
- Smoking (current) by 16%
- Binge drinking (current) by 15%
- Cannabis use (lifetime) by 33%
- Heroin/crack use (lifetime) by 59%
- Violence victimisation (past year) by 51%
- Violence perpetration (past year) by 52%
- Incarceration (lifetime) by 53%
- Poor diet (current; <2 fruit & veg portions daily) by 14%

Bellis et al., 2014
Health and wellbeing Boards one year on – what priorities have been agreed?

Source: The King’s Fund, 2013
## Evidence reviews

Provide information for local authorities and their partners to tackle health inequalities locally.

Commissioned by PHE, written by Institute of Health Equity

Available on the PHE and IHE websites – www.instituteofhealthequity.org

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<th>Health Equity Evidence Reviews</th>
<th>Health Equity Briefings</th>
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<td><strong>Early intervention</strong></td>
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<td>1. Good quality parenting programmes and the home to school transition</td>
<td>1a. Good quality parenting programmes</td>
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<td>1b. Improving the home to school transition.</td>
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<td><strong>Education</strong></td>
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<td>2. Building children and young people’s resilience in schools</td>
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<td>3. Reducing the number of young people not in employment, education or training (NEET)</td>
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<td><strong>Employment</strong></td>
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<td>5. Increasing employment opportunities and improving workplace health</td>
<td>5a. Workplace interventions to improve health and wellbeing</td>
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<td>5b. Working with local employers to promote good quality work</td>
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<td></td>
<td>5c. Increasing employment opportunities and retention for people with a long-term health condition or disability</td>
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<td>5d. Increasing employment opportunities and retention for older people</td>
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<td><strong>Ensuring a healthy living standard for all</strong></td>
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<td>6. Health inequalities and the living wage</td>
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<td><strong>Healthy environment</strong></td>
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<tr>
<td>7. Fuel poverty and cold home-related health problems</td>
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<tr>
<td>8. Improving access to green spaces</td>
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<td><strong>Implementation and impact: Health Equity Briefings</strong></td>
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<tr>
<td>9. Understanding the economics of investments in the social determinants of health</td>
<td>10. Tackling health inequalities through action on the social determinants of health: lessons from experience</td>
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6.7 million of the 13 million people in poverty are in working households, UK 2011/12

Source: Households Below Average Income, DWP; the data is for the UK

(JRF 2013 using DWP data)
Tactics of the sugar industry

• Deny evidence that sugar is harmful – “No good or bad foods”

• Divert focus of attention – fluorides; physical activity

• Bias the debate – put up scientists who offer contrary evidence – create a controversy to get media attention

• Undermine the credibility of opponents

• Aggressive lobbying of national and international organisations eg WHO
Poverty Reduction
Per cent below national poverty line: Colombia

Source: World Bank Indicators
Colombia

• Income share by lowest quintile
  – 2012: 3.3%

• GINI index (World Bank estimate)
  – 2010: 55.5
  – 2011: 54.2
  – 2012: 53.5

(Source: World Bank Indicators)
Health is a human right
Do something
Do more
Do better
UCL Health and Society
Summer School: Social Determinants of Health
29th June – 3rd July 2015

For further information please email: e.skinner@ucl.ac.uk
http://www.ucl.ac.uk/summer-school-social-determinants-health
Twitter: #UCLSDoH