The next step towards more equity in health in Sweden

– How can we close the gap in a generation?

KOMMISSIONEN FÖR
Jämlik Hälsa

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Olle Lundberg

www.kommissionsjamlikhalsa.se/en

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The next step towards more equity in health

Sweden is a country in which public health, measured by means such as infant mortality or life expectancy, is very good, but in which inequalities in health and life expectancy are substantial. Therefore, more can and needs to be done, to both strengthen individuals' own opportunities to act and generate resources, and to increase the public sector's capacity to provide resources to individuals and families during stages of life or in situations in which their own resources or scope for action are insufficient. More equitable living conditions and opportunities to a good upbringing, a good education, a good job and a reasonable income will also leads to more equitable health.

At the same time, it is probably more difficult to design and implement further measures for more equitable conditions and opportunities in Sweden, as we have already come quite far. Therefore, we do not believe that the path to more equity in health is via one or a few decisive measures, but rather via diligent efforts on many different issues in a broad spectrum of sectors. We stress, among other things, the importance of more equitable conditions in childhood, in the possibilities to aquire knowledge, in work and in economic terms. Thus, health inequalities do not begin with health related behaviours, and cannot be tackled through health and medical care alone. On the other hand, it is important to recognise that the opposite also applies; we cannot achieve more equity in health unless we address health related behaviours and work for more equitable health and medical care.

Issues relating to equality and resource allocation are largely political. There has been clear political consensus in Sweden concerning the importance of striving for good and equitable

health. However, opinions have diverged concerning the means that should be used to achieve more equity in health – is it society that must change or is it individuals that must be supported? We believe, however, that the perception of a contradiction between supporting individuals' own health choices and tackling the more fundamental conditions for health is outdated and must be overcome if we are to move towards more equity in health. A broad spectrum of measures is needed, both in terms of content and direction, as well as a broad spectrum of actors. The health gradient affects all people in society, which is why the entire society must be committed to efforts for more equity in health.

In its final report (SOU 2017:47), the Swedish Commission for Equity in Health makes an overall assessment regarding the steps necessary to ensure that long-term and sustainable efforts for good and equitable health can continue. We discuss the direction that these efforts should take and the measures that may be required to achieve the Government's objective of closing avoidable health gaps within a generation.

An important condition for achieving this objective is that efforts to create the conditions and opportunities for good and equitable health are conducted in a perseverant and long-term way across the whole welfare area. This is why, in our previous report (SOU 2017:4), we proposed a number of measures that we consider necessary to bring about a system for such long-term efforts, in which ongoing strategy work is a central element. The proposals on the direction of the efforts, as well as concrete proposals concerning conditions and scope for action that we present within the framework of each objective area, should therefore be seen as important input to our proposed ongoing strategy work.

We also present more comprehensive proposals here, not least concerning general prerequisites for more equitable health. These include infrastructure, and governance and follow-up issues that cannot be addressed within the framework of the proposed strategy work.

Starting-points

The Commission takes the view that health inequalities consist of systematic disparities in health between social groups, and that these take two partially different forms – in part as a gradient throughout society as a whole, and in part as health problems in groups in particularly vulnerable situations or positions.

Furthermore, health inequalities generally develop as a result of inequality in access to resources – circumstances, conditions and opportunities – among different social groups. In our first report (SOU 2016:55), we identified seven central areas of life in which lack of resources and vulnerabilities are particularly crucial for equitable health. These include 1) early life development, 2) knowledge, skills and education, 3) work, working conditions and working environment, 4) incomes and economic resources, 5) housing and neighbourhood conditions, 6) health factors, and 7) control, influence and participation. Resources in these areas of life are generated in part by individuals themselves, in the education system, in the labour market, in the family and together with others in various civil society groups, and in part via the welfare state's various institutions and activities. This leads to both a strategic focus of proposals on these seven areas of life, and the fact that we should identify proposals that strengthen both individuals' own ability and public institutions' role as a resource for citizens.

Disparities in resources in these areas of life lead to health inequalities through 1) differences in risk exposures, 2) differences in vulnerability and susceptibility, and 3) differences in social and economic consequences of ill health. Inequitable health is also driven by differences in scope for action and socially determined behaviour patterns, which in turn can be negatively impacted by resource shortages. This leads to a need for measures to strengthen both resources and scope for action.

An important aspect of our understanding of how health inequalities arise is that health and its determinants are part of an ongoing interplay. Health has important value in itself and is shaped by the conditions and opportunities in which people live. However, at the same time, health is a decisive factor for maintaining and developing these living conditions. This approach is vital for policy and proposals: it is a matter of identifying how we

can best promote a positive interplay between work, income and health, for example, and counteract a corresponding negative interplay. This interplay between different kinds of living conditions is also in itself an important argument in favour of the need for cross-sectoral efforts.

In addition to measures directly focused on the seven central areas of life identified as significant for health, and equitable and health-promoting health and medical care, we believe that measures for more strategic governance, follow-up and evaluation is a way of achieving more equitable health. Ultimately, of course, this is about generating more welfare for citizens, although focus lies on how various changes in how activities function, are governed and followed up can create better quality and accessibility, which in turn can contribute to improved living conditions, opportunities and health for those who need support and initiatives from the various welfare systems.

Challenges and limitations of welfare policy

The need for more equal conditions and opportunities makes welfare policy a central tool in efforts to ensure more equitable health. More equitable health can thus be achieved if people's resources in a number of important areas of life are more equally distributed. These resources are generated primarily by individuals within the family, together with others in civil society associations and in the labour market. Inequity can thereby, in various respects, also be said to begin before birth and in early life through the differences in conditions and opportunities that children are provided with since their parents and others close to them differ regarding access to important resources. Resources are transferred between generations, and various types of inequity are thereby also preserved over several generations – a fact that applies even in relatively equitable countries such as Sweden.

Consequently, the resources that are available to citizens via different welfare institutions are also important, in particular for people who have fewer resources of their own. This means that these institutions play a decisive role in offsetting, to some extent, the differences in conditions and opportunities that arise in

families and that are propagated across generations and the lifecycle. The primary tool available to counteract different forms of inequity among health determinants is therefore the various institutions of the welfare state. Even in cases where we see needs and opportunities to increase people's own ability to create or manage the resources they have access to, efforts are ultimately focused on various types of skills and human capital development.

This means that it will also be important to discuss the scope and opportunities that may be available for decision-makers to implement improvements or reforms in welfare policy. We point to external and internal challenges, as well as difficulties that may significantly affect the welfare state's opportunities to support individuals and families.

The external challenges consist of various circumstances outside the welfare systems, such as growing internationalisation in which resources, goods and capital move between countries and across borders at an increasing rate, as well as an ageing population. These challenges facing society represent two crucial factors for welfare policy costs and access to financing. At the same time, we believe that these processes are neither fated nor that they necessarily lead to a 'race to the bottom' where countries compete to attract business by reducing ambitions for social policies and lowering taxes. On the contrary, new research indicates that higher welfare expenditure can increase a country's competitiveness under certain circumstances. It is not possible to focus unilaterally on tax bases and changes to their mobility in an argument on the significance internationalisation may have on opportunities to fund an ambitious welfare policy. Immigration could offer a well-needed injection of young labour in this context, provided that integration and labour market participation can be improved.

The internal challenges consist of problems linked to the organisation of and content in welfare systems, which can mainly be said to be caused by domestic decisions (and lack of decisions). Here we point to the significance of the content that the welfare systems are to deliver (quality, accessibility and treatment). If welfare systems do not deliver according to citizens' expectations, trust in and support for the welfare systems in particular, but also policy in general runs the risk of being undermined. Both actual

content and the level of trust in the systems are important factors for maintaining a well-functioning welfare state.

Shortcomings in the content of welfare systems may be caused by inadequate resources in relation to a given mandate, but also by how activities are organised and governed. Public sector services in Sweden are ambitious and complex, and are extensively broken down by sector, which is an essential prerequisite for the efficient functioning of the public sector. At the same time, a high level of specialisation may create more boundaries and exacerbating communication problems and efficiency losses. In a corresponding way, allocation of responsibility between different levels of society – national, regional and local – can create friction. There is probably a need, in particular with regard to cross-sectoral challenges, such as social and gender equality and environmental issues, to find new methods for governance, organisation and cooperation.

More equitable conditions and opportunities

Efforts to close avoidable health gaps within a generation must be long-term, systematic and dynamic in relation to a changing society, and must be carried out so as to create co-ownership among relevant actors. A palette of a few very concrete proposals within a few areas by the Commission is not in line with this reasoning.

In its final report the Commission presents its proposals for more equitable conditions and opportunities within the framework of the eight objective areas suggested in our second report (SOU 2017:4). For each of these areas an overall description of the situation is provided, followed by the Commission's considerations concerning the desired direction of policy to create more equitable conditions and opportunities. This assessment is thus more general, and can be regarded as input to the ongoing strategy work that we proposed earlier. Based on this direction, we conclude by presenting a number of proposals addressed to the Government, municipalities, county councils and regions, as well as other actors such as the social partners and civil society. These proposals form a collection of measures that in the Commission's overall

assessment, would contribute to good and more equitable health, but that are not necessarily sufficiently detailed in the sense that it would be possible to implement them immediately.

The overall direction of each target area is summarised below.

Inequity through different opportunities in *conditions in early life* means that children have different prospects to develop. The foundation for children's physical, psychological and cognitive abilities are laid in their first years of life. To achieve good and equitable health, focus should therefore lie on creating, supporting and strengthening a good start in life by providing all children with the basic prerequisites to develop their abilities based on their own conditions. Important conditions to achieve this include equitable maternal and child health care, equitable, high-quality preschool, and methods and means that focus on the best interest of the child.

People acquire *skills and knowledge* through various types of learning at different stages in life and are strongly linked to people's opportunities to enjoy good health. Strategies for fostering good and equitable health should therefore include an opportunity for everyone to develop their skills and knowledge, and acquire an education. In this context, school is the arena that reaches all children and young people and is thus central to this objective. Equitable health is achieved with the help of a good learning environment in school and an equitable educational system. Special measures are also required to counter academic failure at an early stage among pupils who do not achieve the knowledge goals or have other difficulties.

People's employment and financial security have a major impact on good and equitable health. With regard to *work, working conditions and working environment*, the aim is to strengthen people's own opportunities for employment and thereby their opportunities to act and generate resources. The key factor is to increase the employment rate and reduce unemployment, not least among groups with a vulnerable position in the labour market. For those already in the labour market, it is a matter of making it easier to change jobs if necessary and strengthening the working environment policy to make working life sustainable for all groups and across the entire labour market.

Although *incomes and economic resources* are mainly strengthened through people's own employment opportunities,

everyone runs the risk of being ill or unemployed at some point in their life, and thus losing income from work. To prevent a progression towards a basic security system in social insurance schemes, it is vital to safeguard the loss of income principle, which acts cohesively between different groups in these systems and thereby contributes to more equitable health. Health problems appear to be particularly palpable in financially vulnerable groups or groups on the verge of financial vulnerability. Inadequate financial resources affect opportunities to acquire things available to others and lead to a lower standard of living in terms of housing, food and other necessities. Improving resources for groups with narrow financial margins helps achieve more equitable health.

Access to good *housing and good neighbourhood conditions* contributes to security, trust and good and equitable health. An important prerequisite is that everyone has access to an adequate and affordable home. Residential areas in which the negative impact of housing segregation can be combated, and security, trust and equitable health can be promoted are also socially sustainable. All forms of living environments should have good air quality, access to green areas and equitable access to good preschools and school environments.

Health inequalities are also affected by people's scope for action and opportunities to lead *healthy lives*. To reduce health disparities, people's opportunities to establish and maintain good health habits should be strengthened. Strategies to achieve this should focus on limiting access to products that are hazardous to health while increasing access to health-promoting products, environments and activities. Health-promotion and preventive efforts concerning good health habits within the framework of welfare institutions, such as in schools and health and medical care, are also important tools for achieving good and equitable health.

Control over one's own life, trust in others, *influence* and *participation* in society are important factors influencing health trends among individuals and groups. To achieve more equitable health, measures should be taken to promote all individuals' opportunities for control, influence, and participation in society and in their daily lives. A number of proposals in other objective areas have bearing on people's opportunities to exercise control, but there is particular focus here on various measures to promote

equitable democratic participation and participation in civil society, strengthen human rights efforts, combat discrimination and other degrading treatment, promote freedom from threats and violence and promote sexual and reproductive health and rights.

Despite good intentions regarding care on equal terms, there are unwarranted differences in health care services and outcomes between different social groups for most diagnoses. *Equitable health and medical care that promotes good health* should base its preventive and health promotion efforts on people's needs and opportunities. Efforts to achieve equitable health, and health and medical care that promotes good health should be characterised by systematic focus on equality and target better accessibility to meet different needs. Meetings with health care staff should promote health and create conditions for equitable measures and outcomes. Reinforcement of preventive work in health and medical care is needed to achieve good and equitable health. In addition, county councils should, to a greater extent, lead, direct and organise their activities with the aim of providing conditions for equitable health care. Finally, dental care should also be considered part of health and medical care.

More strategic governance and follow-up

A number of general issues related to governance and follow-up are all linked to the need to create conditions for health-promoting, preventive and long-term efforts that we believe would contribute to good and equitable health. We discuss four such issues, namely 1) the importance of focusing on citizens' needs and interests, 2) the importance of a sector-wide approach that deals with different perspectives and includes efficient collaboration and distribution of responsibilities, 3) financing and a working method that focuses on prevention, a long-term approach and methodological development, and 4) knowledge-based efforts including better follow-up, evaluation, research and dialogue.

We believe that all public sector activities that are relevant for good and equitable health should have *citizens' needs* and interests in focus, incorporating an equal and equitable perspective. To achieve this, more focus must be placed on concrete outcomes for

citizens as pupils, patients and users, not least with regard to equity of measures and equality in outcomes. In addition, citizens should be regarded as co-creators in designing public services.

The long-term efforts for good and equitable health that we consider necessary are often based on a *cross-sectoral* working method. For this to be effective, collaboration and coordination are required between different areas at national level as well as between national, regional and local levels. Coordination is needed, in particular, with other cross-sectoral procedures and perspectives (e.g. the 2030 Agenda) to ensure that various target conflicts and competing perspectives are not passed on to government agencies and to the regional and local government levels.

We see a great need for *financing models* and working methods that incorporate a *social investment perspective* and that promote an efficient use of public resources, including a clear focus on prevention and a long-term approach. More concretely, we call attention to the fact that the resource allocation models used for the distribution of public funds at central government, regional and municipal level should apply a socio-economic perspective to a greater degree. Furthermore, financial collaboration should be developed for more efficient use of resources, in particular for people who need a variety of support measures. We also point to the fact that it should be possible to use public procurement as a means of promoting good and equitable health, for example by introducing 'social provisions clauses'.

To strengthen conditions for *knowledge-based efforts* for good and equitable health, knowledge should be improved about how political decisions and various activities affect health and its determinants in different social groups. This, in turn, requires better knowledge of the mechanisms and procedures that contribute to health inequalities, and follow-up and evaluation of measures that have an impact on good and equitable health. Enhanced dialogue between different scientific fields is needed for this, especially between research, practice and policy in different sectors of society. Although this requires certain initiatives in research policy, we see a need to more directly stimulate dialogue, research and development on how health inequalities arise and can be prevented. Not least, it requires a more developed and coherent infrastructure for knowledge-building and evidence supply

throughout the entire welfare area, particularly with regard to the impact of activities on equitable health.

More concretely, we point here to the need to better be able to assess whether reforms and changes carried out in the welfare area have the intended effect. This requires broader insight and understanding of the need for such evaluations, better opportunities to design, plan and organise reform implementation in a way that creates opportunities for evaluation, and strengthened and simplified possibilities to use existing register data for evaluation and follow-up. Furthermore, national registers need to be created in cases where these do not exist.

We also propose that a Council for Good and Equitable Health be established with the task of promoting research, evaluation and closer dialogue between research, policy and the health professions. The Council should act as an independent adviser to the Government in matters concerning good and equitable health, by having an ongoing dialogue with relevant government ministries, commissioning and presenting research reports on equitable health, and initiating and supporting evaluations of various measures and reforms in relation to set objectives in public health policy.

Conclusions

With our final report we conclude the Commission's inquiry, but efforts to create better conditions in society for good and equitable health must continue. An important overall conclusion of our work is that achieving more equitable conditions – and thereby also more equal conditions and circumstances for people in different social strata and groups – requires persistent, patient and unrelenting efforts. Since the processes that generate inequity are self-reinforcing, in which people who have a little more will also have greater opportunities to gain a little more, ongoing efforts are necessary merely to keep inequity in society constant. If gaps are to be reduced, further efforts are needed.

Equitable health is ultimately a matter of welfare and living conditions, of the systematic disparities between people's childhood conditions, their opportunities for education, their living and working environments, and their incomes. All these

types of conditions differ between social groups. If more people are able to leave the school system with an education, if more people are able to earn a living through work, if more people are able to have a good working environment, then more people will be able to be healthy longer. Life and health are linked on both the individuals and society level. This is why it is in everyone's interest to help ensure that all citizens have reasonable conditions and opportunities. It is easier for knowledgeable, competent and healthy people to find work and earn a living, which in turn has a positive effect on health. On the other hand, poor health affects both academic performance and the capacity to work.

With regard to many of these more fundamental health determinants, such as knowledge and skills, or work and working conditions, focusing more on equity and more equal conditions is important *in its own right*. Problems such as poor school results and drop-outs in the education system, as well as problems of unemployment and skills shortages in the labour market are often driven by various types of inequity in conditions and opportunities that have not been handled successfully. Health inequalities can therefore not be tackled solely through initiatives for better health behaviours or through health and medical care. However, without addressing health behaviours and more equitable health and medical care it will not be possible to achieve equitable health.

How society is to develop and whether health inequalities are to be prioritised are, of course, ultimately political issues. There is fundamental political consensus on the importance of good and equitable health. However, there are differences regarding which means should be emphasised, and probably mostly the extent to which individuals' own health choices should be supported, or whether more fundamental conditions for health should be prioritised. Our view is that this distinction is outdated and must be overcome if we are to move towards more equitable health.

In many respects, public health in Sweden is good, but our inquiry also shows that more must be done to achieve more equitable health. Individuals' own opportunities to act and generate resources must be strengthened, as must the public sector's capacity to provide resources during stages of life or in situations in which individuals' own resources or scope for action are insufficient. At the same time as we in Sweden can be proud of

how far we have come along the path towards equitable health, there is now every reason to take the next step.

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