The Swedish Commission for Equity in Health

A summary of the interim report

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KOMMISSIONEN FÖR
Jämlik Hälsa

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Foreword

The Swedish Commission for Equity in Health was set up when the Swedish Government decided on the terms of reference on June 4th 2015. On the same day Professor Olle Lundberg was appointed as Commission Chair, while the other members of the Commission was appointed on August 21st. The members of the Commission are: Maria Albin (Professor of Occupational and Environmental medicine), Åke Bergmark (Professor of Social Work), Laura Hartman (Associate professor of Economics), Margareta Kristenson (Professor of Social Medicine and Public Health Sciences), Ingvar Nilsson (Economist), Per Nilsson (Professor of Pedagogy), Anna Sjögren (Associate professor of Economics), Denny Vågerö (Professor of Medical Sociology), Ing-Marie Wieselgren (Specialist in Psychiatry) and Per-Olof Östergren (Professor of Social Medicine).

The basis for the Commission's work is the Government's long-term goal to end avoidable health inequalities within a generation. The Commission is given two main tasks, namely to produce proposals that can help to reduce the health inequalities in society and work for raised awareness of health inequalities in society and among stakeholders.

As the work of the Commission is part of the Government committees of inquiry system, our work is primarily documented and published in Swedish. However, an interest in how we analyse inequalities in health in Sweden and what we believe are the best ways to tackle those inequalities may be of interest also for a wider audience. This publication, basically an executive summary of our recent interim report *Det handlar om jämlik hälsa* (SOU 2016:55), is a way to provide a brief overview of our work to date.

Stockholm, October 2016

Olle Lundberg
Professor, Commission Chair

Table of Contents

How can the health gaps in Sweden be closed?

The remit

The basis for the Commission's remit is the Government's goal to close the avoidable health gaps within a generation. More specifically, the task assigned to us has two main parts. First, we shall submit proposals that can help to reduce the health inequalities in society. In doing this, our primary focus will be on health inequalities between socioeconomic groups and gender differences in health. Second, our work shall be characterised by an outreach-oriented and inclusive approach in order to collect ideas, gain support for proposals and raise awareness of health inequalities. Thereby our work shall ensure that the proposals presented have good prospects of gaining traction in various decision-making processes and that we can build support among stakeholders in society who can help reduce health inequalities in society.

The Commission is supposed to apply a cross-sectoral social determinants perspective, both in the analyses of drivers for health inequalities and in the work on proposals. This means that we shall conduct our work on the basis of a broad public health and welfare policy perspective and consider factors in several areas that are important for the health of the population, including education, labour market and working life, leisure time, the environment, and health and medical care. The final results of the Commission's work shall be reported by 31 May 2017.

As an important milestone an interim report – *Det handlar om jämlik hälsa* (*It is all about equity in health*) – was published in the Swedish Government Official Reports series (SOU 2016:55) and presented for the Minister for Health Care, Public Health and Sport Gabriel Wikström on 29 August 2016. It provides the starting points for our

work as well as a discussion of a number of key issues and the Commissions position on these. Some general principles for the work with proposals are also formulated. In the following some of these key messages from the report will be summarised.

Concepts and models

We define inequalities in health as "systematic differences in health between societal groups with different social positions", but we also differ between two types of health inequalities, namely 1) the health gradient running through society, and 2) the health situation of groups in marginal and/or vulnerable positions/situations. These groups are often facing multiple social, economic and/or health problems that put them in situations more vulnerable than 'just' being further down on the gradient. Hence, we believe that this distinction is important, not least because different policy solutions are likely to be needed.

We argue that an overarching understanding of how health inequalities are produced and sustained has to be based in the unequal distribution of key resources (see Fritzell and Lundberg 2007; Lundberg et al. 2015). More precisely, we say that inequalities in health arise through inequalities in *circumstances, conditions and environments* (resources) between people in different social positions. Furthermore, we combine elements from different theoretical models in order to formulate a framework of understanding for how fewer resources are translated into poorer health, also in well-developed welfare states as Sweden. In particular we build on the model developed by Marmot and colleagues in the Marmot Review (2010), Finn Diderichsen's model (Diderichsen, Evans and Whitehead 2001) and the capability model developed by Sen and other scholars (see in particular Robeyns 2005).

In addition, we draw on research on how people's scopes of action are not simply a function of their resources and preferences, but determined in part also by social and psychological processes (Abel and Frohlich 2012; Freese and Lutfey 2011). In particular, we stress that resources, and not least the lack of resources (or scarcity) will affect people's actions and choices. This follows from human capital theory (see e.g. Currie 2009), but is highlighted by recent research on how shortage of resources *per se* affect the scope of action and abilities to make decisions (see Shah et al. 2012; Mani et al. 2013).

Taken together, these bodies of research points to how differences in the resources available to people (including the resource of having a good health), are connected in self-reinforcing processes, also in affluent welfare societies. On basis of this we also identify three main mechanisms behind health inequalities, namely:

1. Differences in risk exposures,
2. Differences in vulnerability (interacting exposures, multiple diseases), and
3. Differences in the scope for action (socially patterned action types, scarcity induced action patterns).

As mentioned, we stress that health is one of the key resources in life, and that health and other key resources (such as knowledge, work, income etc.) are linked as mutual determinants. This means that we stress the *dynamic interrelationship between health and the main social determinants*. Health is therefore both a key input and output, which is important not least in terms of how different sectors can be motivated to join forces. This also leads us to the conclusion that identifying how to break vicious circles is central for policy development.

Based on the current scientific knowledge and earlier commissions work we point out seven areas of life where inequalities in conditions and opportunities (resources) are essential for promoting health equity. These are:

1. Early life development
2. Knowledge, skills and education
3. Work, working conditions and work environment
4. Incomes and economic resources
5. Housing and neighbourhood conditions
6. Health behaviours
7. Control, influence and participation

We also discuss a number of arguments for why health inequalities are important to address. From an individual perspective we argue that all people have an interest in and need for a good health. In addition, there are laws and international agreements regarding human rights, there are

arguments derived from justice theory (not least Sen's capability approach), and moral arguments.

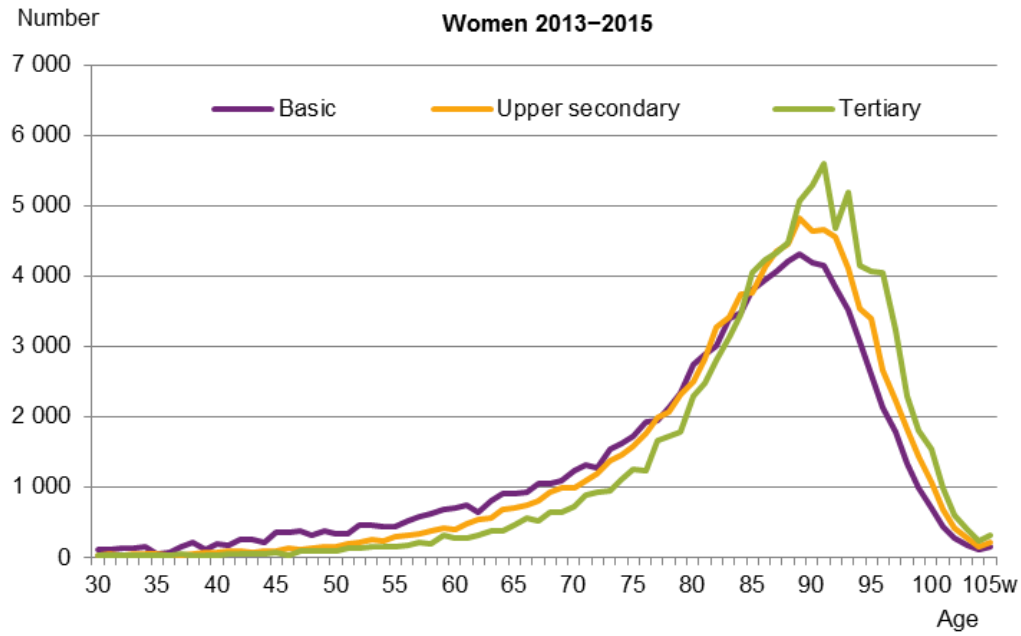
But there are also strong arguments for why equity in health is a collective good of importance for the whole of society. Human capital theory provides strong support for early investments in children (see e.g. Heckman 2006; Currie 2009), but arguments can also be made for prevention as a way to make better use of society's resources, and for health equity as an integrated part of the work for sustainable development.

Inequalities in Sweden

In the interim report we present data on the size of inequalities in health in Sweden, primarily for educational groups (as an indicator of socioeconomic position) and gender but also for other groups like national minorities.

We make a special point of looking at not only life expectancies but also mean age at death and the dispersion (standard deviations) around these means (based on the life table standard populations of 100 000). Presenting the age-at-death distributions graphically (Figure 1 and 2) is a good starting point for a deeper understanding of the nature of educational inequalities in longevity.

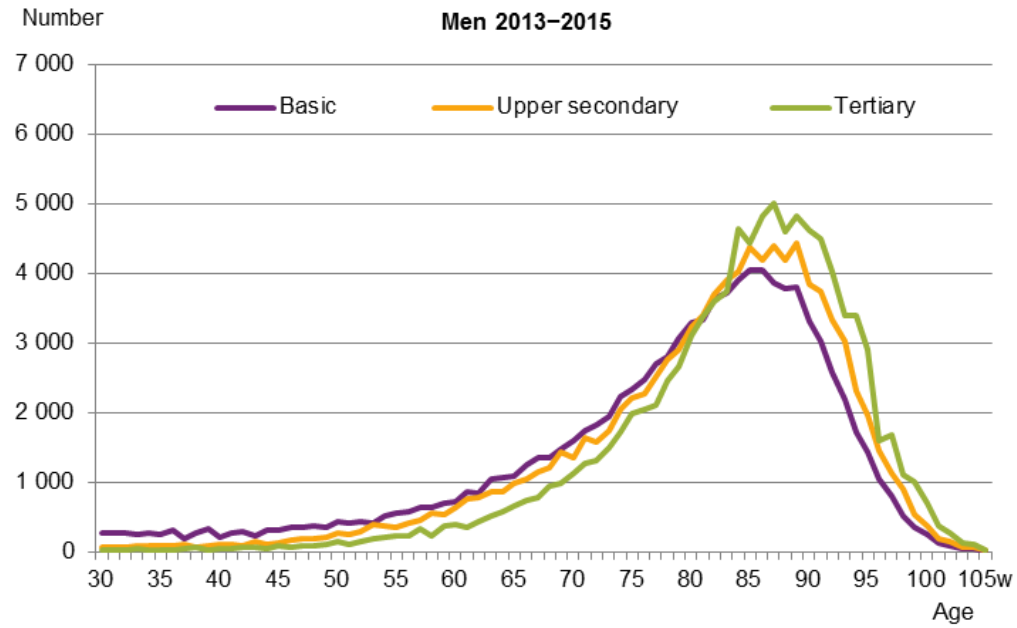
Figure1 Age at death and dispersion (SD) by education, women 2013–2015



Note: Figure 2.5 in the Swedish report. Figures are based on the life table standard populations of 100 000 persons.

First, we note that educational groups share a basic similarity in terms of the general shape of the age-at-death distribution as well as in the age where most deaths occur (around 90). Second, however, it is also clear that mortality is constantly higher in lower educational groups between the ages of 30 and 75–80. In particular this is true for those with basic education. This, in turn, means that the inequality between groups to a large extent is driven by the differences in the variation in age-at-death within groups.

Figure 2 Age at death and dispersion (SD) by education, men 2013–2015



Note: Figure 2.6 in the Swedish report. Figures are based on the life table standard populations of 100 000 persons.

This becomes clear when we look at the differences between educational groups in both mean age at death and standard deviations around this mean (Table 1). In other words, reducing internal variation (i.e. the standard deviation) among the low educated is one important way to reduce inequalities between educational groups.

Table 1 Age at death by education (30+), mean and standard deviation (SD), women and men 2000–2015

Period	Women			Men		
Measure	Basic	Intermediate	Tertiary	Basic	Intermediate	Tertiary
2000–2002						
Mean age at death	81,1	83,2	85,2	76,9	79,0	81,5
SD (30+)	13,0	11,6	10,5	13,1	12,0	10,8
2006–2008						
Mean age at death	81,3	83,9	85,8	77,8	80,1	82,5
SD (30+)	13,5	11,4	10,5	13,3	12,0	10,7
2013–2015						
Mean age at death	81,4	84,4	86,8	78,1	81,1	83,9
SD (30)	13,7	11,5	10,3	14,1	12,0	10,5

Note: Table 2.1 in the Swedish report.

Towards a policy for good and equal health

Based on the theoretical discussion and empirical evidence referred above, a number of general requirements that our coming proposals will need to fulfil can be formulated. These are:

1. Proposals should include both targeted and universal measures in order to address different types of inequalities in health,
2. Proposals should address both inequalities in resources and in the scope of action between people in different social strata,
3. Proposals should be aimed at strengthening both individual's own abilities and the welfare systems abilities to provide collective resources,
4. Proposals should be designed to prevent or break vicious circles or negative chains of events (between health, education, employment, income),
5. There should be focus on reducing internal variation (early onset) among lower socioeconomic groups as one important route to reduce inequalities between social groups.

In more substantial terms, the Commission identifies two important types of action to achieve more equal health. The first type involves action *directly* on social determinants, more specifically to achieve more equal conditions and opportunities for people in different social positions. The second type is more *indirect* and involves improving governance and follow-up, in particular more strategic governance, follow-up and evaluation, both within the existing Swedish public health policy framework and more generally.

Based in the resource approach, we also recognise that resources are produced both by people themselves (in the family, in the market and in voluntary organisations), but also by welfare state institutions. Such institutions and programmes provide collective resources (Lundberg et al. 2015) in the forms of social investments (pre-schools, schools, training programmes etc.), social insurances and care (child care, care of the disabled and old, health care).

In fact, existing welfare state institutions and programmes map very well on the seven areas of life identified as essential for health equity. This, in turn, led us to two conclusions.

First, we need to take the existing institutions as an important starting point for proposals. Secondly, however, we must also acknowledge that existing institutions are not always providing the resources that they are supposed to deliver.

On basis of this, and the positions we have taken on how inequality is generated, we suggest that our coming proposals may have three different aims. First, they may be aimed at strengthening people's own abilities to act and generate resources. This can include proposals that will lead to more equal chances in early life or proposals that make healthy choices easier in lower social strata.

Second, proposals may be aimed at providing more of collective resources (welfare services or programmes) that works well in terms of living conditions and chances between different social groups. This can involve increases in particular transfer systems, or increased enrolment in pre-school.

Third, our proposals may aim to achieve better quality and availability for citizens and users where welfare services are not in fact the compensating force they are (often) supposed to be. This can involve different organisation of services as well as more strategic governance and follow-up systems.

This leads on to the second type of proposals, directed more toward governance. Here we will be looking specifically at the Swedish public health policy framework, which was implemented in 2003 (Hogstedt et al 2004). This framework introduced a cross-sectorial governance structure, but several of the steering mechanisms included have, for several reasons, lost traction since the implementation. We will review this framework with the intention to reinstall the cross-sectorial components more clearly, and suggest ways in which the public health policy framework can operate and be monitored in relation to the goal to close the avoidable health gap in one generation.

Finally, we will also address a number of more general issues related to governance, such as 1-year budget processes and how they relate to more long-term ambitions for social investments and prevention.

Concluding remarks

The work of the Commission builds on a long Swedish tradition of research and reforms aimed at improving health and welfare as well as reducing inequalities. Recent local and regional work carried out under the general heading of social sustainability also falls within this tradition. It is also highly inspired by the global, international and national reviews led by Michael Marmot, but also by Espen Dahl and Finn Diderichsen. However, while intellectually dependent on these earlier efforts, we need to identify and point out ways to improve and reform the Swedish systems for health and welfare in a way that foster more equity in health. While it is unlikely that we can find out completely new and grand solutions, we hope to point to a number of important changes that need to be made.

In attempting to do that, it is important to remember that social inequality is a feature of society that needs constant attention. Addressing inequalities is therefore an ongoing process rather than an end that can be achieved.

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