

# The Right Start to a Healthy Life

Levelling-up the Health Gradient Among Children, Young People and Families in the European Union – What Works?





# **THE RIGHT START TO A HEALTHY LIFE**

Levelling-up the Health Gradient Among  
Children, Young People and Families in the  
European Union – What Works?

Edited by Ingrid Stegeman  
and Caroline Costongs



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## FOREWORDS

“Thank you for reading this book. The fact you have taken the time to consider the information contained within these pages shows that you believe, as we do, that the inequalities faced by children and young people within the 27 member states of the European Union in the twenty-first century are unacceptable.

Parents have always known that their child’s future will be influenced by the conditions the family finds itself in. Their ability to influence and improve these conditions is also dependent on the support of society and its various institutions. From health and social care systems, to schools, employers and civil society, the ability to understand the complex nature of inequalities within a country and the impacts these have on citizens can literally mean the difference between a short and a long life.

This book draws on a wide partnership across Europe, and was funded as part of the GRADIENT project managed by EuroHealthNet. The book’s six chapters will enable you to consider not only the extent of the inequalities faced by our children and young people, but also what governments and organisations are doing to address and reduce these inequalities across Europe.

You will no doubt find this book useful if you work for/with children, young people and their families or create policies and strategies which affect them. It is not aimed at just at academics or researchers it is directly written so that you can use it to help you plan and implement actions to reduce the unacceptable long-term negative impacts inequalities have on children and young people.

Some countries have a phrase: ‘Our children are our future’. I believe our children are our present – it is their children who are the future! Surely they deserve the best possible start to that future. This book can contribute to that future, the authors and contributors to this book have a commitment to making these changes, and by reading this book we believe that you are also committed to change.

Thank you.”

*David L Pattison*  
*President, EuroHealthNet*  
*March 2012.*

“Overall life expectancy for men and women in the EU has risen by four years between 1993 and 2009- from 75.6 to 79.6 years. In 2008, 17% of the EU population was aged 65 and above and this is likely to rise to around 24% by 2030. However, the odds of living longer are not equally distributed in the EU. The reasons for these differences are complex and involve a wide range of factors including income, level of education, living and working conditions, and health behaviour in accessing healthcare.

Tackling health inequalities is high on the agenda of the European Union. I recommend reading “The Right Start to a Healthy Life” as a guide for possible action. This publication aims to identify measures that can be taken to even-out the socio-economic gradient in health amongst children and young people in the EU.

Inequalities experienced in early life in access to education, employment and health care can have a critical bearing on the health status of people throughout their lives. To reduce the health gradient, the greatest impact is likely to be achieved through early life policy interventions and by creating equal opportunities during childhood and adolescence.

EU funding for research in public health aims to provide a sound scientific basis for informed policy decisions on European health systems, and for better health promotion and disease prevention strategies.

This book is the result of a project funded through the EU’s Seventh Framework Programme for Research, under the Health Theme. Not only does it provide knowledge on health inequalities in the EU and in the national context but also provides examples of good policy options and interventions, and helps decision-makers design and evaluate policies and interventions.

I hope that this book will serve as a useful handbook for the development of new and effective policies to address the determinants involved in health inequalities in children and adolescents.”

*Line Matthiessen, MD PhD*

*Head of Unit Infectious Diseases and Public Health*

*Directorate for Health*

*Directorate-General for Research and Innovation, European Commission*

*March 2012*

## EXECUTIVE SUMMARY

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This book begins by introducing Anna, Daniel, Elena and Michael, four of the approximately 20 million children in the EU today. Anna, Daniel, Elena and Michael's physical, mental and social well-being will to a large extent be determined by whether they are brought up in nurturing, stress free environments that expose them to healthy activities and positive social relations. Yet their families' abilities to live in ways that optimise health and well-being are based on factors that are often outside of their direct control and shaped by wider socio-economic and cultural environments that together make up what the health community refer to as the 'social determinants of health', or the conditions in which "we are born, grow, live and work and age".

### THE DETERMINANTS OF HEALTH FOR CHILDREN AND FAMILIES

The factors that can lead to or undermine health are very similar to the factors that lead to social vulnerability. Health, educational achievement and socio-economic status are all closely correlated. Cognitive skills, for example, are partially genetically transmitted and partially the result of nurturing, or environmental stimuli. Yet parents' abilities to stimulate the cognitive development of their children often depend on whether they themselves were well nurtured, and whether they are currently in a situation to do so. The lower the socio-economic status of parents, the more likely they are to suffer from stress due to financial or health problems, and to pass this stress on to their children in the form of conflictive relationships or disengagement. The lower their socio-economic status, the higher the chances that they will live in crowded environments with bad housing conditions and lacking green spaces, and the lower the chances that they will be able to afford good quality child and health care for their children.

### HEALTH INEQUALITIES AND THE HEALTH GRADIENT

The first chapter of this book outlines how in all countries in the EU, children like Anna and Daniel, born into lower socio-economic classes, have more physical and mental health problems and live shorter lives than children in



higher socio-economic classes. The concept of the health gradient is closely related to this, and refers to the *systematic* correlation between the level of health and social status, and to the linear or step-wise decrease in health that comes with decreasing social position. How much worse the health of Anna and Damien is *vis-à-vis* that of their wealthier peers (i.e. how steep the gradient is) depends in large part on the public policy provisions in place in their countries of origin. Nevertheless, it remains the case everywhere: for every step down the socio-economic ladder, children and youth experience higher levels of a wide range of physical and mental health problems. The fact that there is a *systematic* correlation between health status and social status means that health inequalities cannot be explained by genetics, or by the fact that parents of children like Anna and Damien systematically choose to behave in unhealthier ways. All health inequalities are therefore unjust and unfair.

### **IMPACT ON HEALTH LATER IN THE LIFE COURSE**

Chapter 1 discusses how the consequences of growing up in disadvantaged environments become apparent very early on in life, and increase the chances of adverse developmental outcomes, worse health, and negative behavioural and economic outcomes over the life course. For example, it cites evidence that as early as the age of three, children from poor homes are already up to a year behind middle class peers in 'school readiness' and 'level of vocabulary'. By the age of 14, they are almost two years behind. A cohort study in England reveals that the cognitive abilities of children from lower socio-economic groups who had strong average scores at two years of age declined over time. By the time they were ten, the abilities of these children had been overtaken by those of children from higher socio-economic classes that had low average scores at two years, but whose abilities increased over time. Furthermore, if children like Anna and Daniel are exposed to unhealthy diets, they are more likely to develop medical conditions like coronary heart disease as adults. The consequences of economic and social problems in childhood will therefore exert a long-lasting negative impact on their health throughout their lives. Research has revealed that even if Anna or Damien manage to climb up the social ladder, this will not undo the potential damage of earlier structural disadvantage upon their lives. Thus moving from low socio-economic status during childhood to high adult socio-economic status does not necessarily lead to commensurate gains in health in adulthood.

## **THE GRADIENT IN HEALTH AFFECTS ALL CHILDREN**

Socio-economic gradients in health among children and young people are an issue that concern everyone. Only the richest members of society enjoy a right to “the highest attainable standard of health”, as declared in the preamble of the WHO constitution. This means that the majority of children growing up in the EU will fall short of achieving their health potential. As such, gradients in health suggest that the EU is failing to meet its commitments under the UN Convention on the Rights of the Child. They also undermine European values of justice and solidarity, and the collective aim of European societies to improve well-being and to give all children equal opportunities.

## **ECONOMIC AND SOCIETAL CONSEQUENCES**

The book describes how the steep socio-economic gradient in health among children and young people represents a huge loss in human capital to society. This will generate economic costs in terms of productivity losses, and higher levels of health care expenditure. High levels of inequality, exacerbated by marked class divisions can result in social instability and resultant social and economic costs. Children currently represent 20 per cent of the population in the EU; by 2050 they will represent 15 per cent. The inability of large groups of children in the EU to achieve full potential in terms of mental, physical and social well-being signify losses that EU societies cannot afford.

Given this life-course influence, public expenditures linked to mitigating the adverse effects of low socio-economic status at an early age will be much lower than dealing with the consequences of childhood poverty later on in a person’s life. Governments and other relevant actors must therefore be extremely vigilant that the current austerity programmes provoked by the economic crisis do not impact on parents’ and other care-takers capacities to nurture and invest in children. If parental capacities become more unequal, social divisions will become even more deeply entrenched in today and tomorrow’s knowledge societies and contribute to social instability.

The EU2020 Strategy for Smart, Sustainable and Inclusive Growth aims to make Europe a strong and sustainable economy with sound employment opportunities that is competitive, social and green. Ensuring the right opportunities for children and young people, which lead to more equal health outcomes, is crucial to the achievement of these goals. The steepness in levels of socio-economic gradients in health can serve as an important

outcome indicator to reflect how countries are doing with respect to their pledges to achieve the EU2020 Strategy goals.

## **WHAT CAN BE DONE?**

Subsequent chapters of this book focus on what can be done to level-up socio-economic gradients in health among children, young people and their families from a range of perspectives.

## **ACTION NEEDED ACROSS DIFFERENT POLICY SECTORS**

It is clear from the evidence presented in this book that no single policy or strategy can achieve a reduction of health inequalities and contribute to levelling the health gradient. Instead, it requires cross-governmental strategies, or 'whole-of-government' approaches, to develop coherent policies that address unequal distribution of resources in society and improve the underlying conditions that undermine the health of large segments of the population. Whole-of-government efforts are also necessary to develop holistic approaches to improving the life circumstances of children and young people. If schools, for example, take measures to improve equity but this is not paired with measures to improve other conditions in which children live, these will have less effect. Similarly, measures to improve access to quality health care will have only a limited impact on reducing morbidity rates among poorer children and young people if the underlying factors that lead to ill health are not also addressed.

It follows from this that most of the policies and interventions that are effective in contributing to levelling-up socio-economic gradients in health are not health-care related. The health sector, however, has an important role to play in ensuring that available public resources are invested in the delivery of good quality health care in proportion to need. It also has a very significant role to play in increasing awareness about health inequalities and socio-economic gradients in health, and in fostering collaborations with other sectors to optimise population health across the gradient.

### ***Universal social welfare policies***

Since the well-being of children and young people is dependent on those that care for them, the most important measures that can be taken to level-up gradients in health are those that enhance the capacities of parents or other caretakers to nurture them. The greatest impacts will therefore come from universal policies to improve family and community environments in which

they grow up, by empowering parents and caretakers and ensuring that they have adequate financial resources through e.g. minimum incomes for healthy living, unemployment benefits and child benefits, provision of free or low-cost access to health care, education and childcare services.

Chapter 2 outlines how EU member states can be (roughly) categorised into different welfare state models, which reflect their historical and cultural traditions regarding the redistribution of resources across their populations. Data showing health gradients in these countries reveal that some appear to be more successful than others in creating the conditions that lead to more level health gradients. Countries like Slovenia and Sweden, for example, invest in universal family policies which provide income support, high quality early childhood education and stimulate employment for lone mothers. Analyses undertaken as part of the GRADIENT project identified that socio-economic gradients in health in these countries were less steep than those in the Netherlands and the UK, which have somewhat less generous family policies. Chapters 2 and 3 also illustrate how national differences with respect to the design and generosity of policies aimed at children and families are reflected in variations of (amongst others) poverty rates, the number of working mothers and in early school drop-out rates. This indicates that the ways social policies are designed, as well as their generosity, are important to social health and human development.

### **“MAMA WORKING”**

A good example of effective measures that governments can take to level-up the socio-economic gradient in health is to stimulate maternal employment, particularly amongst low-income families. Doing so can improve family earnings, while breaking dependencies on more passive forms of income redistribution, such as unemployment benefits. However, the quality of employment must be good in that it must offer job security and control, while working conditions must enable mothers to combine work and family life in a way that does not generate even more stress for them and for their children. This means that governments must pair policies to stimulate maternal employment with ones that improve the access of low-income families to day-care centres with highly trained staff, and where fees are scaled on the basis of ability to pay. Improving employ-

ment opportunities for low-income mothers has the added benefit of empowering them and improving their negotiating skills within the household, since it has been found that fathers in two earner families dedicate more time to their children, which stimulates the development of the children. In addition, high-quality early childcare centres can also improve children's start to life, and lead to greater equity in educational outcomes. While the resources involved in stimulating maternal employment, particularly amongst lower income groups, and of providing universal access to high-quality childcare might be substantial, these costs are likely to be offset by the contributions of maternal earnings and tax-contributions over a lifetime.

Chapter 3 discusses another group of important measures that governments can take, namely ensuring greater equity through educational systems. Education systems should ensure that children with different educational needs are not segregated into different schools or classrooms, since this can exacerbate inequalities. Education systems should, rather, encourage flexible curricula that enable children to learn at their own pace. It is also important that vulnerable children and young people receive special support, particularly during the more sensitive stages of their lives, such as the transition from primary to secondary school.

### **PREVENTION OF EARLY SCHOOL LEAVING**

Other good examples of interventions that can contribute to leveling socio-economic gradients in health are those that offer holistic approaches to reducing early school leaving amongst young people. Early school leaving is likely to lead to low earnings across the life span, unemployment or bad working conditions, high levels of stress and to physical and mental health problems. All too often schools, health services and municipalities work in silos rather than together in their efforts to support vulnerable young people. Case studies presented in Chapter 3 of this book illustrate how school officials, physicians, municipal authorities and private-sector actors can come together to support students that are at risk of falling into the negative spiral indicated above.

## **IMPROVING SOCIAL CAPITAL THROUGH ACTIONS AT THE COMMUNITY LEVEL**

Chapter 4 investigates how the nature of the communities in which children live can impact on their health. It shows how investing in health assets like community social capital can be an effective approach to tackling health inequalities. Health assets can refer to individual strengths like motivation, or to environmental strengths such as community support and quality of the surroundings. They can pave the way to resilience, which refers to an individual's capacity to adapt to adversity encountered along the life course. Different components of community social capital, such as neighbourhood disorder, social mistrust, neighbourhood cohesion, collective efficacy and neighbourhood potential for community involvement with children influence the impact of socio-economic status on health outcomes in children and adolescents. For parents of young children, a lack of social capital and networks can be a significant source of stress.

GRADIENT found that health gains incurred by increasing social capital are particularly marked for disadvantaged children and young people in communities with low social capital. This evidence supports the notion that investing in community social capital can be an effective approach to levelling the health gradient. Community social capital can be developed through organisations such as sport associations, which foster positive norms and values relating to health and health behaviours, such as physical activity, non-smoking, or drinking; this appears to benefit not only those directly involved in the organisations but also the health of the whole community. Community social capital can also be strengthened by encouraging parents to engage in activities that foster interaction, communication and trust, such as parental involvement in schools. It can additionally be achieved by lowering the (perceived) level of crime in communities with low levels of social capital. Local governments should be conscious of which groups in the community (e.g. mothers, unemployed young people) need support, and invest in the development of community organisations to address the needs of these groups.

The relationship between community social capital and health implies that policy makers should ensure that they do not develop and implement measures that undermine social cohesion. It also suggests that they should develop and refine measurement tools to record the presence or absence of social capital in the community, assess the effects of existing programmes on social capital and integrate information about social relationships into the design and implementation of new programmes.

## THE NEED FOR PROPORTIONATE UNIVERSALISM AND WELL-DESIGNED TARGETED MEASURES

Universal policies are more likely to be effective in reducing socio-economic gradients in health than targeted policies, since they are broad enough in scale to have a population-wide impact. Yet this book also identifies how universal policies can lead to even steeper socio-economic gradients in health if they are not adopted by those who are less well off, and if they benefit wealthier people more than poorer people. Different chapters of this book therefore stress the need for what Michael Marmot has referred to as “proportionate universalism” – that is, ensuring that policies are applied with a scale and intensity that is proportionate to the level of disadvantage.

While targeted policies can play an important role in addressing specific problems of low socio-economic status, they usually do not in themselves address the underlying causes of health inequities. In some cases targeted interventions, such as food banks, can stigmatise the recipients. In addition, interviews with policy makers and user groups of policies and programmes targeted at more deprived groups found that in many cases these are still being designed and implemented without the input of the user groups, which makes them less effective in addressing their needs. The debate regarding universal versus targeted policies is an important one, in light of the global financial crisis. Due to the financial constraints that all EU member states are facing, universal services are being reduced in favour of targeted ones. Cuts in universal services are likely to hit those who are already the worst off. It is therefore important to assess the contribution that these policies can make to levelling-up socio-economic gradients in health, and to continue to develop the evidence base on the cost-benefits of these contributions.

## GRADIENT EVALUATION FRAMEWORK

The Gradient Evaluation Framework was developed as part of the GRADIENT project to provide policy makers and practitioners with a model that they can use to assess whether a policy or measure is “gradient friendly”. It establishes eight key components that are important to underpin the design and evaluation of effective policy actions (proposed or in place) in terms of their potential to level-up social gradients in health. The Framework, introduced in Chapter 5, invites those who use it to consider for instance whether a measure takes a *life-course approach* and whether it will impact on the long-term development of individuals. Policy makers and practitioners should also assess whether a measure simply addresses the symptoms, or also the underlying *social and wider determinants* of problems that affect the well-

being of children and young people, such as ill health, bad parenting practices or bad educational outcomes. They should assess whether the policy or measure is part of a *whole systems approach* to address a problem and its underlying causes, and is coherent with other measures being taken, and whether the measure applies the principle of *proportionate universalism*, whereby resources are employed according to need. The Gradient Evaluation Framework calls for *gradient friendly indicators* to be identified and linked to specific policies and measures, so that their outcomes can be assessed and contribute to the evidence base of what works to address socio-economic gradients in health among children, young people and their families. The Framework also addresses steps linked to the policy cycle and evaluation.

The factors that lead to low capital and cultural resources within families and to social and health inequities compound themselves, and are reinforced across generations. This book demonstrates that the only way to break these cycles and to make a real impact on levelling-up gradients in health is to invest in universal measures to improve the health and well-being of *all* children and young people. The EU is a unique arena of natural experiments' where countries can learn from each other about effective and innovative models of economic, social and human development which optimise the well-being of their populations. Chapter 6 of this book addresses how the EU has played an important role to-date in encouraging its member states to focus on reducing health inequities and levelling socio-economic gradients in health. Nevertheless, opportunities for progress are being missed.

The austerity measures that are being taken in EU member states in response to the economic crisis are likely to lead to even greater social and health inequities, particularly among children and young people. Health and health equity are rarely considered in EU impact assessments. There is much potential through indicators in EU-wide surveys to collect data that can be used to assess the health equity impact of different policies and measures. Such data must be collected on a regular basis, and employed vigorously to ensure that policies and measures being taken within EU member states and at EU institutional level improve rather than undermine well-being across the socio-economic gradient. This book hopes to encourage policy makers and practitioners across the EU to adopt such measures, to ensure that European children and young people get the right start to a healthy life and can live in and contribute to prosperous, cohesive and sustainable European societies.







## **CHAPTER 1**

Health Inequalities Among  
Children, Young People and  
Families in the EU



## CHAPTER 1

### HEALTH INEQUALITIES AMONG CHILDREN, YOUNG PEOPLE AND FAMILIES IN THE EU

Ingrid Stegeman, Giorgio Barbareschi, Caroline Costongs

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**Anna** is 12 years old and lives alone with her mother, who works in a shop. Until recently, Anna's mother relied on welfare payments for income. Her grandparents helped to take care of her until she was three years old, and then she attended a state subsidised early-childhood education programme on a part-time basis before starting school. Because her mother stopped school at an early age, she puts a lot of pressure on Anna to do well in school, which makes her feel stressed, particularly since she is struggling to keep up in some subjects. Nevertheless, Anna says she likes to see her friends at school, and she has some nice teachers, although some of the kids are 'snobbish'. Anna generally goes to an after-school programme until her mother comes home from work, which she dislikes, since most of the other children are younger than she is. She attends a subsidised dance class twice a week, which she really enjoys. She generally eats the meals her mother prepares for her, which include fruits and vegetables 'fairly often'. Sometimes her mother smokes, but never at home. Anna wishes she could see more of her mother, and that her mother had more money to buy her nice things, like new clothes, instead of buying second-hand ones.

**Damien** is ten and lives with his parents and his younger brother. His mother stayed home to take care of him and his brother until they started school, but now works part time again as a nurse while his father works in a transport company, although his working hours were recently reduced. This means they now have less money to do nice things and that his dad is often in a bad mood. Damien says that

he gets on well with his parents, although he doesn't like it when they argue. He generally likes going to school but finds some subjects boring, so he gets told off for not trying enough. He complains about the fact that there are no nice spaces to play football in his neighbourhood, and that he is restricted from going out on his own, because his parents say it is unsafe. His family usually eats together, and his mother tries to make sure that they eat healthy things, but sometime they have fast food. Damien worries about the fact that both of his parents smoke, since he knows that it can give you cancer; his mother is trying to stop, but is finding it difficult.

**Elena** is 14 and has two brothers. She lives in a suburban area outside a mid-sized city. Her parents own a small business. Before starting school, Elena and her brothers attended childcare and preschool on a part-time basis. Her mother and her grandparents took care of them for the rest of the time. Since her parents work a lot and everyone is busy, they seldom eat together in the evenings. Unless Elena's mother has prepared meals in advance (which she usually does) Elena prefers to eat junk food. She is, however, worried about her weight and conscious about eating too much and about getting exercise. Elena likes school and wants to do well, although they sometimes give lots of homework and it can be too demanding. Elena has many friends that live in her neighbourhood; they often visit each other after school and over the weekends. She also goes to gymnastics twice a week after school, and has piano lessons at the weekend. Neither of her parents smoke, but her older brother does sometimes, which she thinks is stupid.

**Michael** is 15 years old and lives in large house in an affluent suburban area with his parents and his twin sister. His father works full time as director of a department in a large insurance company, while his mother co-owns a boutique. When he was little, his mother took care of him and his sister, although they also attended a preschool programme two days a week before starting school. In the evenings, the family always eats together. His parents enjoy a glass of wine with dinner and his father sometimes smokes cigars. His mother encourages

him to eat vegetables and fruits although he doesn't like them. Michael is conscious about health issues since his grandfather, who lives in the same street and whom they see a lot, is chronically ill, which makes him sad and worried. Michael likes school and is involved in a French language group which organises activities over the weekends. He also likes sports, and plays tennis and football after school.

## 1.1 GRADIENTS IN HEALTH AMONG CHILDREN AND YOUNG PEOPLE IN THE EU

Every one of the 97.5 million children growing up in the EU27 (20 per cent of the EU population) (SPC 2008)<sup>1</sup>, such as Anna, Damien, Elena and Michael, profiled at the start of this book, is unique. This uniqueness is determined by their genetic makeup and their specific life circumstances and experiences. At the same time, children, young people and adults across the EU share many of the same needs and values. These commonalities start early: a recent study showed that children across the EU have very similar desires, namely to spend time with their family and friends, and to play outdoors (Nairn 2011).

This chapter will demonstrate and discuss how the conditions in which children and young people are raised shape them and continue to have a strong impact on their adult lives. It will demonstrate why it is of societal interest to ensure that all children and young people get an equally good start to a healthy life. This chapter will further provide an initial overview of what can and is being done to level-up the gradient in health among children and young people in the EU.

Children and young people's well-being is strongly dependent upon the nature and quality of their families and family support systems, and the communities in which they live. These factors are in turn affected by the local, regional and national policy environment, which both shape and are shaped by cultural attitudes towards children and family life. This is reflected in the model on child development (Figure 1) where children are presented in the centre of a series of concentric circles that represent the broad range factors which directly affect their well-being.

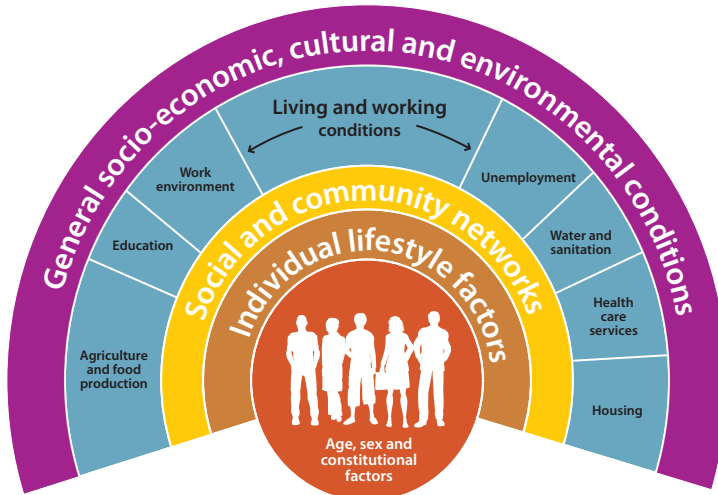
<sup>1</sup> This is based on a definition of children between ages 0-17. A child means each and every human being below the age of 18. Young people above the age of 18 who have not settled into adult life, and who are specifically targeted by public health policies for reasons of risks, behaviour, etc. specific to their young age group, are also included in this definition (see Glossary).

The model in Figure 1 is very similar to Dahlgren and Whitehead’s model of the social determinants of health (Figure 2). This model is based on the widely applied WHO definition of health as “a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity”. The Dahlgren and Whitehead model illustrates how a person’s health is not only determined by the health care they receive, but also by other ‘social determinants’. It reflects how health is influenced by individual lifestyle factors, which are influenced by micro-systems shaping a person’s life, such as the community and living and working conditions that s/he is exposed to, which are in turn shaped by macro-systems, such as the socio-economic and cultural environment. Sir Michael Marmot refers to these as the conditions in which we are “born, grow, live, work and age” (CSDH 2010).

Figure 1. Based on the adapted child rights social ecology model (Nairn 2011)



Figure 2. Dahlgren and Whitehead model on the Social Determinants of Health (1993)



The likeness between the models is not surprising; they show that concepts like health, well-being and development are very similar, and that all are outcomes of the conditions in which children and young people live.

If Anna's mother's income is, for example, below 60 per cent of the median household income in her own country, she will be considered 'poor'<sup>2</sup>. She would then be among the ranks of an estimated 21 million children in the EU (20 per cent of children in the EU) living below the poverty line. One can assume that the lack of resources available to Anna's family affects their ability to provide her with the factors necessary to optimise her development, and that Anna is therefore less likely to be healthy and satisfied than most children in the EU. This is confirmed by research which shows that throughout the EU, young people with a higher socio-economic status, as defined by their parent's income, occupation and educational level<sup>3</sup>, tend to be in better health and more satisfied than their peers from disadvantaged backgrounds (Barnekow 2008; WHO Europe 2009; Lampert 2007).

Links between wealth and health are evident when comparing data on life expectancy across EU member states. This reflects that young people growing up in the relatively poorer parts of Europe will have shorter lives,

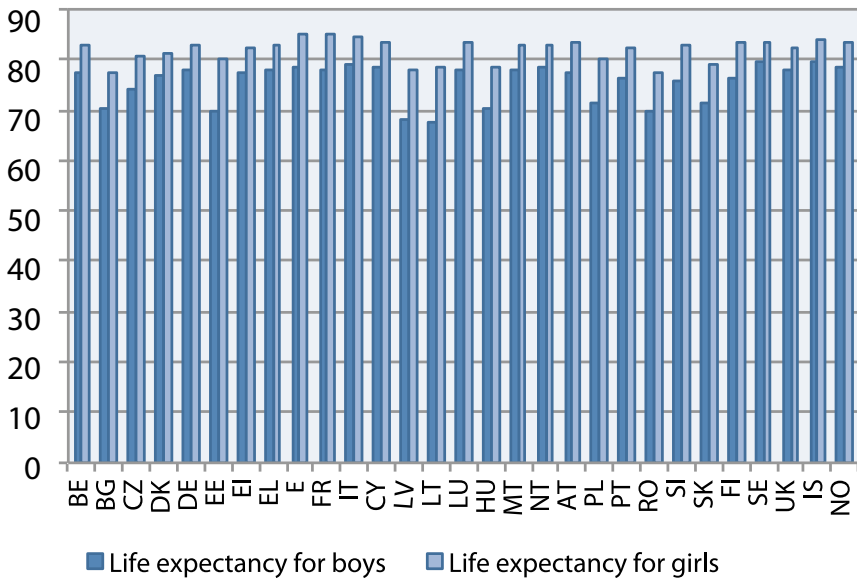
<sup>2</sup> See Glossary for definition of Poverty.

<sup>3</sup> See Glossary for definition of Socio-economic status.



and have poorer health than children and young people living in richer countries. For example, if Michael comes from a northern or southern-European country, while Damien comes from an eastern or central-European country, Michael can expect to live up to 14 years longer than Damien. Michael could also expect to live up to 20 years longer in good health, since he is less likely to suffer from preventable diseases (Eurostat 2007).

Figure 3. Life expectancy at birth by sex for countries in the WHO European regions<sup>4</sup>

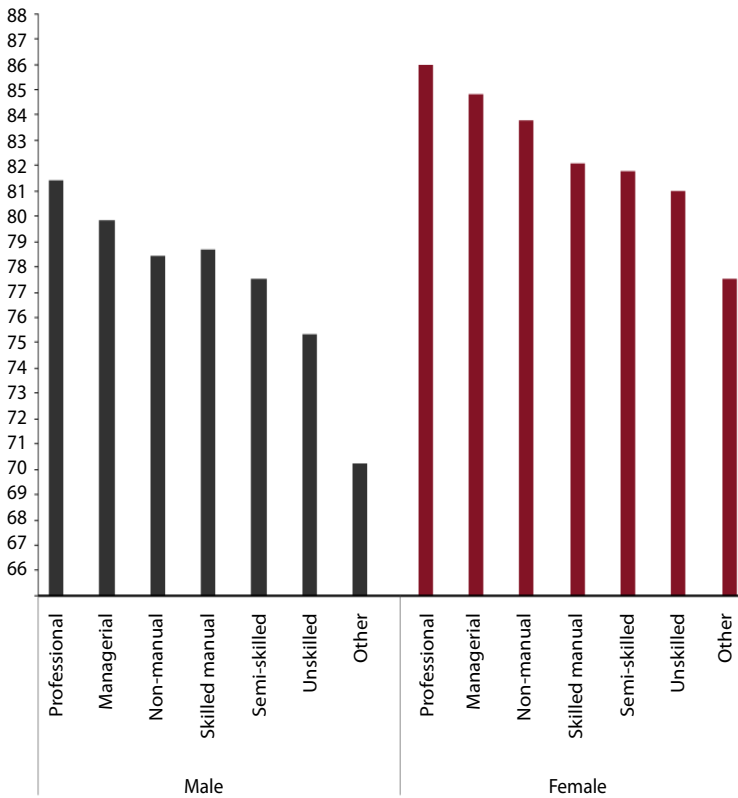


This correlation between wealth and health exists between and within countries. The socio-economic status of children and young people’s families vis-à-vis others in their country is also likely to be of great consequence to their health. This is evident from data which shows that there are substantial differences in health between different socio-economic groups. People with a lower education, income or occupation tend to die at a younger age and to have a higher prevalence of most types of health problems. If Damien and Michael both come from Ireland, for example, and Michael’s family is among the highest social classes within his country, while Damien’s family is among the lowest social classes, Michael would, according to country averages, live to be approximately 82, while Damien would live to be approxi-

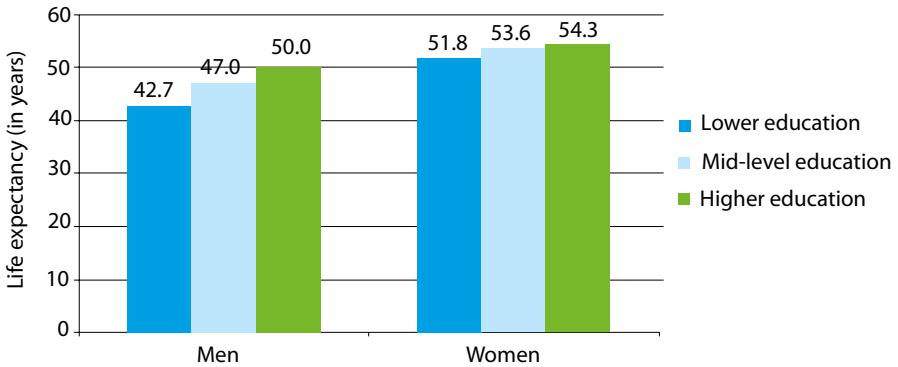
4 EUROSTAT, 2010

mately 75. If Anna and Elena come from the Netherlands, Anna will start having health problems at age 52, while Elena will start having health problems 20 years later (Council of Public Health NL 2011). Such differences in life expectancy and healthy life years between the lowest and the highest socio-economic groups can be found in all EU member states. For life expectancy, these differences range from four to ten years for boys and two to six years for girls (EC 2009). Similar patterns exist for a very wide range of subjective measures of physical and mental health.

Figure 4 . Life expectancy at birth by social class<sup>5</sup>



<sup>5</sup> Central Statistic Office, Ireland 2010.

Figure 5. Life expectancy at 30 relative to education and gender<sup>6</sup>

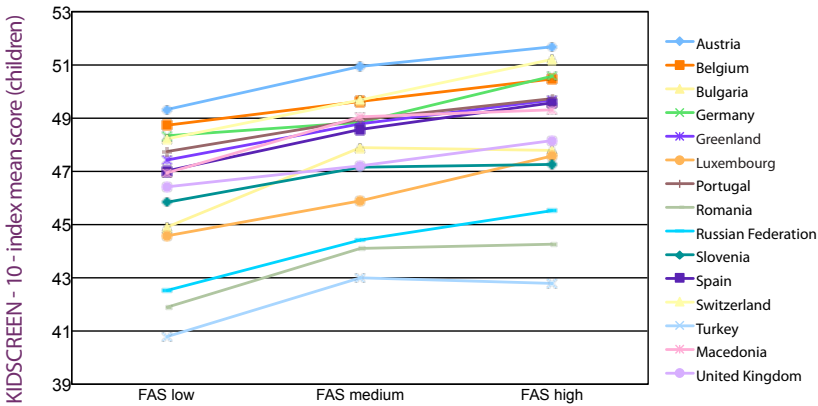
As Figure 4 and 5 illustrate, such differences exist not only between the lowest and highest socio-economic classes, but follow a gradient pattern. This means that a family's health status corresponds to their social status at every step of the socio-economic ladder, so that the members of a middle-class family are generally in better health than those below them on the socio-economic ladder, while those in the highest echelons are the healthiest of all.

There is evidence of this socio-economic gradient in health across a wide range of health-related conditions and indicators. Anna, Damien, Elena and Michaels' risk of dying as babies or as a result of injury, their risk of developing an infectious disease and their likelihood of receiving medical attention when needed, their linguistic and cognitive abilities (Noble *et al.* 2007; Fernald *et al.* 2011), and their socio-emotional development (Spencer 2001) are all related to their families' socio-economic status. The higher their position along this ladder, the more likely they are to be satisfied with their health and life in general and to be resilient to difficulties (due to, for example, greater family involvement, better problem solving skills, and higher levels of physical activity) and to have high self-esteem and good educational achievements. The lower the position on the socio-economic ladder, the more likely they are to report fair or poor 'self-perceived' health, a decline in health between the ages of eleven and 15 years, and to be overweight or to smoke (Keating, Herzman 1999; Currie *et al.* 2008).

Figure 6 reflects the outcomes of correlating the KIDSCREEN index scores with 'family affluence levels' of eleven, 13 and 15 year olds in 15 EU countries (Ministry of Health and Social Policy of Spain 2010). The KIDSCREEN index is a new multi-domain instrument that was developed to reflect different

dimensions of health and well-being. KIDSCREEN scores bring together information in questionnaires that relate to physical and emotional well-being, family and peer relationships, and satisfaction with school performance. While the natures of the gradients differ, there are clear gradients in the overall health and well-being of those questioned and their families' levels of affluence in almost all of the 15 countries analysed.

Figure 6. Socio-economic differences in self-reported health<sup>7</sup>



## 1.2 DEFINITIONS AND IMPLICATIONS

Poorer and/or more disadvantaged people are more likely to have illnesses, injuries and disabilities and live shorter lives than those that are more affluent; these differences are generally referred to as 'health inequalities'. While the term 'inequalities' is an objective measure of health differences, the term 'inequity' is in many cases used to capture the fact that these inequalities are unfair and unjust (Marmot 2010)<sup>8</sup>. They are unfair and unjust because they cannot be attributed to individual behaviour, but are the result of the conditions in which people "are born, grow-up, live, work and age" (CSDH 2008).

The concepts of health inequalities and the gradient in health are closely linked. While health inequalities refer to differences in health (as measured by mortality, morbidity or self-reported health) between social groups, the health gradient refers to the linear or step-wise decrease in health that comes with decreasing social position – or to the systematic correlation between

<sup>7</sup> Erhart *et al.*, 2009

<sup>8</sup> The term "inequality" when used in this text will include connotations of unfairness and injustice, and will be used interchangeably with the term "inequity". For further definitions see the Glossary.

level of health and social status. In western societies, over time, the health gradient as a whole tends to shift upwards because overall health of most groups is improving. Yet the degree and rate of improvement tends to be greater in higher socio-economic groups, meaning that relative differences and therefore the degree of inequalities and inequities (and hence the slope of the health gradient) also tend to increase (Graham 2001).

Three important points can be drawn:

- The first is the fact that there is a *systematic* correlation between health status and social status, which means that differences in health across socio-economic groups cannot be explained by genetic or behavioural factors. Individuals in lower socio-economic groups do not systematically choose to behave in ways that are damaging to their health. This means that systematic social differences in health outcomes are structurally determined through broader environmental, social, economic, and cultural factors and are not the result of individual choice<sup>9</sup>. This also suggests that *all* health inequalities are unfair and unjust.
- The second point is that the socio-economic gradient in health affects all individuals. It is not simply that the poorest experience less than optimal health; there is a gradient of risk across the whole population (Poulton *et al.* 2002; Chen, Martin, Matthews 2006). The Preamble to the WHO Constitution declares that it is one of the fundamental rights of every human being to enjoy “the highest attainable standard of health”. This is also stated in Article 24 of the UN Convention on the Rights of the Child (UNCRC). Socio-economic gradients in health reveal that in practice those who are better off enjoy this right more than those who are less well off.
- As the gradient cuts across all population groups, action needs to be directed at the whole population and not just at the most disadvantaged groups. Providing assistance to the children and young people in the EU who live under the poverty threshold must be a societal and public policy priority. However, to improve overall health and to level-up the health gradient a strong focus should also be placed on those children and young people in all but the highest socio-economic groups, whose health is also less than optimal.

<sup>9</sup> When individuals who are in good health emigrate, they often experience a decline in their socio-economic status due to (for example) difficulties in finding employment which matches their educational level in their new home country. Their health, in turn, often deteriorates (see Karlsen, Nazroo 2000).

Health inequalities and the socio-economic gradients in health among children are particularly unfair and unjust, since they can have implications over children's life spans. As will be discussed below, the effects of being born into and raised in relative disadvantage can have long-lasting consequences and can lead to intergenerational patterns of deprivation and ill health that are very difficult to break.

### 1.3 AN EQUAL RIGHT TO HEALTH FOR CHILDREN AND YOUNG PEOPLE IN THE EU

*"Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population's health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health"*  
(Marmot 2010).

Evidence in recent years has pointed to a rise in the level of health inequalities in all EU member states (Ebner 2010; OECD 2011); the current economic crisis is likely to exacerbate this trend. While most EU member states are still showing relative improvements in population health, the health status of those who are better off is in many cases improving faster than that of those who are less well off, leading to a widening of the health gap between social economic groups. Studies comparing changes over time have found increases in health inequalities, particularly in eastern-European countries (Leinsalu *et al.* 2009), but also in the Nordic countries (Shkolnikov *et al.* 2011).

Rising levels of inequities and steeper socio-economic gradients in health among children and young people defy the common EU values of justice and solidarity and member states' commitment to protect children and young people's rights. These values and commitments suggest that children and young people such as Anna, Damien, Elena and Michael should not grow up in poverty, that they should have access to good health care, that they should have the same educational opportunities and that governments should promote and monitor their social integration and well-being, regardless of social background (Dahlgren, Whitehead 2007). In other words, all children should be granted the same chances to healthy, fulfilling and comfortable lives, irrespective of the socio-economic position of their families. In fact, however, children's health status and their ability to fulfil their potential remain strongly correlated to their socio-economic status.

## ***Treaty of Lisbon***

### ***Article 2***

The Union is founded on the *values* of respect for human dignity, freedom, democracy, *equality*, the rule of law and *respect for human rights*, including the rights of persons belonging to minorities. These values are common to member states in a society in which pluralism, non-discrimination, tolerance, *justice*, *solidarity* and *equality* between women and men prevail.

### ***Article 3***

The Union's aim is to promote peace, its values and the *well-being* of its people.

### ***Article 9***

In defining and implementing its policies and activities, the Union shall take into account requirements linked to the high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health.

EU institutions and its member states have legally bound themselves, through Article 3 of the Treaty of Lisbon and Article 24 of the EU Charter of Fundamental Rights, to protect children's rights. These rights are stipulated in the UN Convention on the Rights of the Child (UNCRC), which has been signed by almost all governments worldwide, including all EU member states. Taken together, the provisions in the UNCRC oblige governments to act in the best interests of children and young people. The socio-economic gradient in health among children and young people within EU member states demonstrates that EU institutions and member states are falling short in their obligations to do so.

The risk of poverty among children is, in general, higher than among the population as a whole in most member states (Tarki 2010). In the EU, 20 per cent of children live in poverty, versus 17 per cent of the adult population (Eurostat 2010). Further evidence of this failure to meet the rights of children and young people lies in a report from the OECD, which states that the number of children living in poverty increased between 1995 and 2005 in most EU countries. This was confirmed by the UK's above-mentioned National Equality Panel, which reported that 1.7 million or 13 per cent

of all children in the UK lived in severe poverty in 2007-08, compared with eleven per cent in 2004-05. This means that the burden of social inequalities is falling disproportionately on children and young families with children.

Pillas and Suhrcke (2009) indicate that “there is now an increasingly refined understanding of the factors that can promote healthy development and lay the foundations for a good life”. For the EU institutions and its member states not to act upon this knowledge is an affront to the values that they claim to share and to their commitment to protect children’s rights. The European Commission has confirmed this by stating that: “*The size and scale of the differences in health of people living in different parts of the EU represents a challenge to the EU’s commitment to solidarity and equality of opportunity*” (EC 2009). The steepness of socio-economic gradients among children and young people can serve as a revealing outcome indicator of the extent to which societies are fulfilling their pledge to respect the rights of children and young people.

#### **1.4 THE IMPORTANCE OF AN EARLY GOOD START TO A HEALTHY LIFE**

A child’s development is highly susceptible to environmental influences. A crucial reason to address health inequities from a very early stage is that what happens in the early years is likely to have an impact across the course of their lives. Evidence shows that health inequalities result from an accumulation of exposures that can harm health, which start in early life, and are exacerbated across childhood and into adult life. The science of early childhood development shows that virtually every aspect of early human development (physical, cognitive, socio-emotional) is sensitive to external influences in early childhood and has lifelong effects. The foundations for every individual’s physical and mental capacities are laid during this period (Pillas, Suhrcke 2009). The first two years of a child’s life have been identified as particularly important, and underpin numerous later abilities – to manage emotions, to pay attention at school and to have empathy for others (Gerhardt 2010).

Children’s well-being depends primarily on the quality of their family environments. Esping-Andersen (2007) writes that there are four major mechanisms that individually and jointly influence opportunities: family income, family structure (e.g. single or two-parent families), parental dedication and ‘cultural capital’ (the learning milieu within which children grow up).

Children like Anna and Damien, whose parents may not have completed formal education and/or earn comparatively low wages and are at risk of unemployment are often not able to provide their children with the same



material resources or 'cultural capital' as the parents of peers that are better off. These parents might suffer from mental and physical health problems, particularly since the psychological experience of inequality can have a direct effect on health. Michael Marmot came to this conclusion following three decades of research that began with the Whitehall Studies in the 1970s, which showed that even among white-collar employees with steady jobs there was a clear social gradient in health. In *The Status Syndrome* (2005) Marmot explains that this is because those persons who are lower down the social hierarchy have less control over their lives, less autonomy and fewer opportunities for full social participation. These factors are so important to health that a lack of them leads to a deterioration in health. Wilkinson and Pickett in *The Spirit Level* (2009) write that "individual psychology and societal inequality relate to one another like lock and key". Parents of children like Anna and Damien may not have the ability, due to their own physical or mental health status and economic, knowledge, cultural and/or linguistic constraints, to make healthy choices for their children and to engage them in activities that stimulate their development.

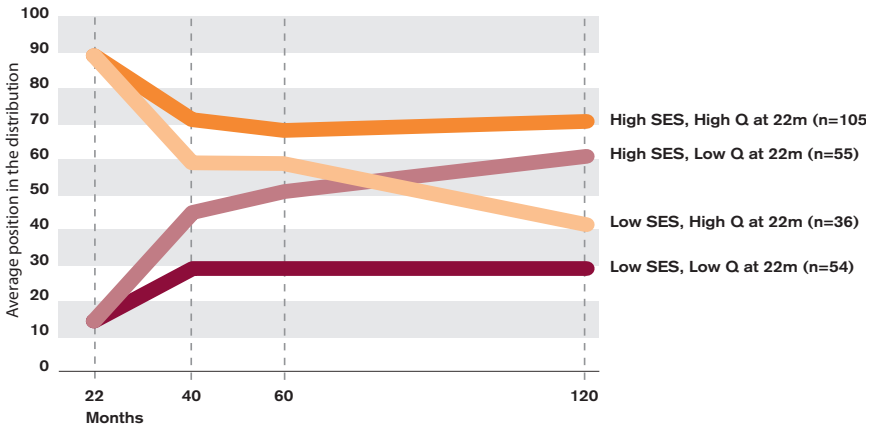
Children's early experiences and how they impact on their health have long-term consequences. Positive exposures in early life can bolster a child and young person's long-term health, and help them build a 'capital reserve' that can be of benefit throughout life, while negative exposures can undermine this. If Anna and Damien grow up in stressful environments due to economic constraints, without strong and positive affective ties to their parents, this could interfere with their normal development and influence their cognitive capacities. This in turn could affect their physical capabilities and their ability to deal with stress in later life. If they are exposed to unhealthy diets as children and are unable to get adequate exercise, this will affect their eating and physical activity habits as adults, and make them more likely to develop medical conditions like coronary heart disease. If, on the other hand, their home environments are stress free and provide conditions that optimise their development, this will benefit them throughout their life course (Power *et al.* 2009). In other words, a poor start to life increases the probability of adverse developmental outcomes and to worse health, behavioural and economic outcomes over the life course (Pillas, Suhrcke 2009). To compound matters, differences in health at an early age are likely to lead to even greater differences at later ages (Poulton *et al.* 2002).

The factors that can undermine well-being in later life manifest themselves very early on. Research shows that children growing up in poverty have poorer brain and cognitive development than children growing up in wealthier environments (Neville 2011). Studies of early-school leavers, who tend to come from lower socio-economic backgrounds, suggest that as early

as preschool education they are likely to have developed patterns of underachievement, problematic behaviour and poor attendance strongly associated with the likelihood of failing to complete school. It has, for example, been found that by the age of three, children of poor homes whose parents have low educational attainment are already up to a year behind their middle-class peers in terms of school readiness and level of vocabulary. This gap continues to grow, and by the age of seven, poor children are already 2.5 terms behind their middle class peers, while by age 14, they are almost two years behind (Hirsch 2007).

Such educational delays are not necessarily linked to the inherent abilities of these children. Figure 6 presents outcomes of research into inequality in early cognitive development of 1,292 British children assessed at 22, 42, 60 and 120 months (Feinstein 2000). Feinstein states that cognitive outcomes at 22 months have been shown to be related to family background. Yet the children of educated or wealthy parents who scored poorly in early cognitive tests had a tendency to catch up, whereas children of worse-off parents who scored poorly were extremely unlikely to catch up. In fact, at 120 months, the children with low cognitive outcomes at 22 months but from wealthier families outperformed children from lower socio-economic groups that had initially displayed strong cognitive outcomes.

Figure 7. Inequality in early cognitive development of children in 1970 British Cohort Study at ages 22 months to 10 years<sup>10</sup>



The drop in the cognitive outcomes of children from low socio-economic groups who initially had a high average position suggests, according to Feinstein, that their potential was “swamped” over time by environmental influences.

Research reveals that it is very difficult to undo such effects of early disadvantage, since they entrench themselves across the life course. This suggests that efforts to improve the health and well-being of all children and young people, particularly those in lower and the lowest socio-economic groups, is the most efficient and effective way to address gradients in health. Most research on social inequalities among adults for example attribute these to low socio-economic status, and assume that the main underlying cause for the link between health and social status relate to financial constraints. According to this conception, the socio-economic gradient in health could be levelled by redistributing wealth to those in lower socio-economic classes in adulthood. However, an emerging body of research shows convincingly that intervening in adulthood is likely to ‘miss the boat’. Specifically, the evidence-base demonstrates that social inequalities in health emerge much earlier in the life course, and that growing up in socio-economically disadvantaged circumstances exerts a long-lasting negative impact upon health. The strongest data comes from prospective-longitudinal studies conducted both in Europe (Power *et al.* 2005) and elsewhere (Poulton *et al.*

10 Adapted from Feinstein (2000). Inequality in early cognitive development of British children in the 1970 Cohort.

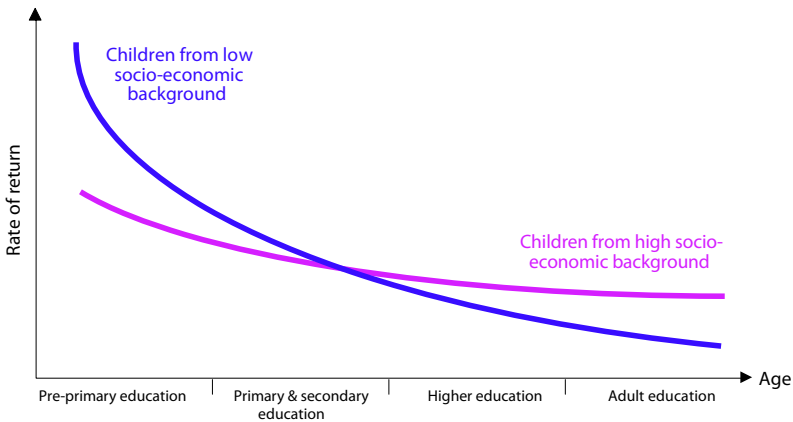
2002; Melchior *et al.* 2007) showing that childhood socio-economic status predicts adult health, even after adjusting for adult socio-economic status. In other words, the ill effects on adult health are not simply the result of continuity between low childhood socio-economic status and low adult socio-economic status.

Perhaps most tellingly, a study that controlled for both selection effects (i.e. the health 'reserve' people began life with), as well as their adult socio-economic status, found that the impact of childhood disadvantage was not undone or mitigated by upward social mobility. Specifically, moving from low socio-economic status during childhood to high adult socio-economic status *did not* lead to commensurate gains in health by adulthood (Poulton *et al.* 2002).

These findings provide a strong rationale for intervening in the early years to achieve the maximum benefit from strategies aimed at levelling the gradient, and thereby promoting gains in population health and well-being.

### **1.5 LEVELLING THE GRADIENT AMONG CHILDREN AND YOUNG PEOPLE MAKES ECONOMIC SENSE**

Investing in levelling the health gradient among children and young people, and thereby reducing health inequalities across the general population, is crucial for the sustainable development of our societies. Feinstein points out that the persistent low cognitive abilities of individuals starting out in families with low socio-economic backgrounds leads to a loss of human capital that have significant macro-economic implications. Esping-Andersen (2007) also argues that growing differences in educational outcomes between the rich and poor in today's knowledge-based economies will only exacerbate existing social inequalities, which could lead to social instability. As Figure 8 illustrates, investments to address inequalities in educational outcomes must begin very early in the life course, since the cost of later remedial measures is likely to increase in proportion to the initial learning defect. Likewise, the effectiveness of later learning and that individual's contribution to society is a function of how strong a start the child received.

Figure 8. Returns to investment at different levels of education<sup>11</sup>

In addition, there is a great deal of focus and concern in EU member states about the ageing of their populations. This will have severe economic repercussions, and place strong burdens on coming generations. In 2005, children aged 0-17 represented 20 per cent of the population in the EU27. By 2050, the share in the total EU population is projected to be around 15 per cent, as a result of the ageing of European societies (SPC 2008). Investing early in children's development, and in reducing avoidable and unnecessary ill health and premature death along the gradient is an important way to address this problem, since it enables people to contribute better and longer to society. Given his lower socio-economic status, for example, Damien is likely to die at a younger age than Michael, and to spend more years prior to his death in poor health, generating high health care costs. Michael, on the other hand, will remain fit and productive. He will retire at a later age and only require more intensive medical attention at the very end of his life. Through the right policies and interventions, however, Damien's health could be improved and his life extended, which would be fairer and reduce the time he would spend accruing high health-care costs.

Applying the right policies and programmes to improve the health of those in relatively lower socio-economic positions generally makes economic sense, since it would increase productivity, result in higher tax revenues, reduce welfare payments and lower treatment costs (Inside Government 2010). This conclusion is supported by an EC study which has estimated the costs of socio-economic inequalities per year due to premature deaths and ill-health cases. When economic costs of health inequalities were consid-

<sup>11</sup> Adapted from Cuhna *et al* 2006.

ered in terms of loss to labour productivity (i.e. as a capital good), the costs seem to be modest in relative terms, although large in absolute terms (€141 billion, or 1.4 per cent of GDP). If health is valued as a 'consumption good' that yields direct satisfaction and utility, the economic impact of socio-economic inequalities were found to be huge: in the order of about €1,000 billion, or 9.5 per cent of GDP<sup>12</sup>. Inequality-related losses to health were calculated to account for 15 per cent of the costs of social security systems, and for 20 per cent of the costs of health care systems in the EU as a whole. The authors of the report stressed that these estimates represented yearly values, which meant that as long as health inequalities persist, these losses will continue to accumulate over the years (Mackenbach *et al.* 2007)<sup>13</sup>.

Reducing social and health inequalities and levelling the health gradient would improve the quality of life of everyone in society. In *The Spirit Level* Wilkinson and Pickett (2009) demonstrate statistical associations which reveal that the higher the level of inequality in a society, the worse the outcomes relating to physical health, mental health, drug abuse, education, imprisonment, obesity, social mobility, trust, community life, violence, teenage pregnancy and child well-being. In addition, the investments required to reduce social inequalities in health among children and young people could be offset by much lower rates of social security spending. UNICEF (2011) and the WHO Early Child Development and Knowledge Network (2007) argue that investment in child health is the most powerful preventive strategy that a country can make, with returns over the life course much greater than the original investment. Work from the US suggests that every \$1 spent on children in a particular programme led to social savings of \$7 through reduced prison rates and higher incomes, and reduced levels of social security spending (Schweinhart, Weikart 1997). A report from the New Economics Foundation (2009) calculated that the United Kingdom spends £161.31 billion a year on social problems such as teenage pregnancy, crime, mental illness, obesity and drug abuse. The report concluded that spending similar amounts on early intervention and prevention programmes would lead to such a reduction in social problems that these costs could be recuperated in ten years' time, while the investment would bring net returns to the UK economy of £486 billion (roughly five times the annual budget of the National Health Service) (Gerhardt 2010).

12 In the conceptual framework developed by Mackenbach, Meerding and Kunst, health is considered both a 'consumption good' and a 'capital good'. As a 'consumption good', health directly contributes to an individual's 'happiness' or 'satisfaction', and as a 'capital good' health is an important component of the value of human beings as means of production' (Mackenbach, Meerding and Kunst. 2007).

13 Specifically, the report concludes that: "Our estimates suggest that the economic impact of socio-economic inequalities in health is likely to be substantial".

## 1.6 WHAT CAN BE DONE?

The reasons for levelling-up the socio-economic gradient in health among children and young people in the EU are compelling. Yet these gradients are complex phenomena caused by factors that compound on each other and that are related to general inequities in society. Levelling-up the health gradient cannot be achieved by the health sector alone, although the health sector must play an important role by raising awareness about the issue and mobilising cross-sectoral action to address it. No single policy or strategy can lead to a reduction of health inequalities and level socio-economic gradients in health. A co-ordinated and multifaceted approach is required, comprising policies and interventions across a range of the most relevant entry points (see Table 1).

### *Effective Strategies*

The main focus of policies that aim to produce better outcomes for children and young people should be on enhancing the quality of their family environments as well as the communities in which children develop (Dyson *et al.* 2010). Effective policies are therefore those that improve the conditions in which children and young people grow up, since, as discussed earlier, children are very sensitive to stressful family environments, which can interfere with their normal development (Evans 2003). This can entail fiscal initiatives designed to ensure a minimum level of living standards. Equal access to early childhood development programmes and educational systems that focussed on ensuring greater equity across socio-economic groups are also crucial to redressing social inequities in power and resources. Another crucial entry point to levelling social gradients in health among children and young people is to ensure access to quality health care, particularly among lower income groups (Poulton 2011). This entails the provision of health-promotion programmes to enhance mental health and help parents improve their parenting skills and cope with stress. *Chapter 3 of this book examines in more detail what kinds of policies and interventions can level-up the socio-economic gradient in health among children, young people and their families.* It is widely recognised that social affiliation is associated with better health and that a lack of social capital, including social support, can contribute to ill health (Berkman, Kawachi 2000.) *Chapter 4 of this book looks specifically at the relationship between social capital and health inequities.*

Table 1.

### Entry points for action

The following sets out important entry points for policy making and action which have been identified by Dahlgren and Whitehead (2007), combined with entry points identified by the Albeda Commission in the Netherlands and insights from the GRADIENT project:

- *Different levels of power and resources:* Groups that are better off typically have more power and opportunities to live a healthy life, and they experience less psychosocial stress relating to financial difficulties and adverse living and working conditions than groups that are less privileged. This calls for processes that address the 'root causes' of social inequalities, and reduce differences in social-economic position (e.g. income, education, occupation).
- *Different levels of exposure to health hazards:* Exposure to almost all risk factors (material, psychosocial, behavioural) is inversely related to social position. It is therefore necessary to address these risk factors (e.g. housing, working and environmental conditions) along the socio-economic gradient and improve access to health care.
- *The same level of exposure leading to differential impacts:* The effects of health hazards (e.g. depression, anxiety and alcoholism) are likely to be much stronger for people in lower-income groups, since they are exposed to several risk factors simultaneously and often lack the social, cultural and economic support systems of higher-income groups. It is therefore necessary to develop policies and actions that are sensitive to differential impacts across the socio-economic gradient and which reduce or eliminate synergistic effects, such as community based health programmes.
- *Different social and economic effects of being sick:* The consequences of being sick (low school results, loss of a job, social isolation and exclusion, high out-of-pocket payments for treatment, etc.) impact lower income groups more strongly than high-income groups. It is therefore necessary to reduce the negative effects of health problems on income, occupational grade and



education by providing financial support proportionate to need to ameliorate income loss and providing effective rehabilitation and retraining activities.

The WHO Commission on the Social Determinants of Health (CSDH) has stressed that to reduce the socio-economic gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage (Marmot 2010). These types of strategies are referred to as “proportional universal strategies”. In this way, it is possible to improve the health of those in poverty, narrow the gap between the rich and the poor and reduce health inequalities between all groups, not just between the extremes of the social scale. Greater intensity of action is likely to be needed for those with greater social and economic disadvantage, so that their health improves at a faster rate than that among the rich.

Another strategy to level-up the socio-economic gradient in health is to build health equity objectives into existing social, economic policies and programmes relating to economic growth, taxes, unemployment, education, housing, social protection, transport and health services. This means assessing how a policy or programme affects the health of different social groups and what can be done to ensure positive health impacts. *The Gradient Evaluation Framework (see Chapter 5) has been developed to help execute this approach.*

It is clear from the examples above that levelling-up the gradient in health requires actions that are far beyond the remit of the health sector and that are taken across the whole of society. To what extent then, are EU member states concerned about health inequalities and socio-economic gradients in health? Are they taking comprehensive or piecemeal actions to address health inequities? It is to these questions that we turn in the section below.

## 1.7 ACTIONS IN EU MEMBER STATES TO ADDRESS HEALTH INEQUALITIES

As indicated above, effective action in levelling-up socio-economic gradients in health among children and young people will require co-ordinated action across all sectors of government, to uphold values such as ‘equity’ and ‘solidarity’. While all EU member states claim to uphold these values, there are no objective definitions of what these terms mean. Each member state must determine how it can achieve economic growth and redistribute the benefits in a way that maximises societal well-being and is consistent with concepts of equality, justice and solidarity. These processes are

different in every EU member state, and are dependent upon cultural and historical developments in those countries. A detailed investigation of how some member states are approaching this is beyond the remit of this book. This section will provide a broad overview of whether and how different EU member states are explicitly addressing the issue of health inequalities and the socio-economic gradient in health. *Chapter 2 will look in more detail at different types of welfare regimes in four EU member states, the kinds of policies that they are implementing in relation to children, young people and their families, and how these are influencing the socio-economic gradient in health.*

While the bad news is that health inequalities within and between states appear to be growing, the good news is that levels of awareness are also growing, and that the issue is currently receiving political attention. The facts of inequality in disease and death have been well known before the beginning of the twentieth century. However, governments didn't acknowledge the problem, as this would mean recognising it as a societal concern and having to take responsibility for it (Nathanson 2010). In the late 1970s and 1980s research from the UK (Black Report), Sweden and Finland drew attention to the phenomenon and it was, for the first time, embraced as a public issue in some European countries. National committees such as the Ginjaar Commission in the Netherlands (1995) and the independent inquiry into health inequalities by Sir Donald Acheson (1998) were set up to explore the problem and to identify strategies to address it (Mackenbach, Bakker 2003). The WHO has also, since the 1980s, played an important role in trying to put health inequalities on the agenda of all its European member states through its 'Health for All' Strategy.

During the 1990s, awareness of health inequalities grew, and some progress was made in policies and interventions to address them. Between 2000 and 2010 more countries undertook efforts to address health inequalities through whole of government approaches and by applying 'health in all policy' approaches. Today, most EU member states have some data to indicate the existence and extent of health inequalities in their countries, and about two-thirds have included intentions to reduce health inequalities in their health-related policy documents. The influential work of the WHO Commission on the Social Determinants of Health (2005-2008) and widespread interest in the outcomes of this work has given even more impetus to this field, and raised knowledge and awareness about how the conditions in which people are born, grow live, work and age affect their health, and about socio-economic gradients in health (CSDH, 2008). *The EU has also been instrumental in encouraging member states to take action on health inequalities, in particular through the EC Communication on Solidarity in health: reducing health inequities in the EU (EC 2009) (see Chapter 6).*

Only a few governments, however, recognise the socio-economic gradient in health as a societal concern that relates to all socio-economic groups, not just the poorest in society. In the UK health inequalities have been high on the political agenda and explicit action has been co-ordinated at the top level of government. In 2001 England established a Cross-Cutting Spending Review to consider how a range of government programmes in education, welfare, criminal justice, environment, transport and local government benefited health and the distribution of these benefits. Its outcomes were incorporated into a cross-government strategy: *Tackling Health Inequalities, a Programme for Action*. The new Conservative coalition government in the UK has since committed to improve population-wide health and reduce health inequalities' through cross-governmental action on the underlying social determinants of health (Secretary of State for Health 2010). It has, however, reduced the funding that is allocated to the National Health Services to contribute to this from 15 to ten per cent (Kings Fund 2011). The new government has also placed a strong emphasis on local-level action and moved responsibility for public health programmes that were previously co-ordinated by the NHS to local governments. This could in theory foster more integrated approaches to addressing the needs of specific areas and population groups. While the national government provides broad policy guidelines, specific actions are determined and implemented at the local level (ID&A 2010).

In Scotland, changes in levels of health inequalities are an indicator of whether the Scottish government is achieving its overall objective of becoming a "Wealthier and Fairer, Smarter, Healthier, Safer & Stronger and Greener" nation. The same is true for Wales, where health inequalities are among the indicators being used to assess whether the government is really achieving its aim of becoming "a more self-confident, prosperous, healthy nation and society". A new national development plan in Slovenia includes a chapter on health equity, indicating that here too action will be initiated at the top levels of government. Explicit, cross-sectoral action is also being taken in the Nordic Countries, although responsibility for this action rests mainly with the health sector. Norway and Finland are currently implementing comprehensive National Strategies that call for partnership and joint working with other sectors (Norwegian Strategy to Reduce Social Inequalities in Health, and Finish National Action Plan to Reduce Health Inequalities (2008-2011)). The Swedish Public Health Policy (2003), which has a strong focus on health inequalities, is based on the recognition that actions that affect health are often the responsibility of all policy areas. However, the more conservative coalition government that came into power in 2006 has placed a stronger emphasis on individual responsibility for health behaviour.

The Ministry of Health in Spain developed a National Strategy for Health Equity built around nine priority areas. These included the development of a plan for childhood and youth health, to promote equal opportunity for all children's development, regardless of their family background. In this area priority would be given to policy actions to increase enrolment and affordability of preschools (for children 0-3 years old) on a universal level and to provide quality preschool education (3-5 years). Strong emphasis was also placed on ensuring favourable working conditions (stability, wages, etc.) to reduce the economic difficulties faced by households, and on providing adequate employment conditions for parents (Commission on the Reduction of Social Inequalities in Health in Spain 2010). More recently however, a new conservative government has changed these priorities.

Some other countries explicitly mention the need to reduce health inequalities within their national health policies, but have few and/or small scale programmes in place to achieve this objective. Other countries indicate that they are addressing health inequalities implicitly through their national social protection policies. Some of the countries that state that they are addressing health inequalities, either explicitly or implicitly, point to initiatives focusing on the health of socially vulnerable groups as evidence of action.

In countries such as the Netherlands, Germany and Spain, regional and local levels have a strong responsibility for developing and implementing health and social policy, on the basis of broad national guidelines. Here, explicit recognition of and the level of action on health inequalities and of collaboration between health and other policy sectors is strongly dependent on the extent to which regional and local authorities prioritise the issue.

Thus there is a great variation between EU countries regarding their strategies to explicitly tackle health inequalities and these strategies can change quickly over time.

### **Data and Monitoring**

Finally, collecting data and monitoring health inequalities is crucial for designing any strategy to levelling-up social gradients in health. This requires information on health status, socio-economic determinants and the risk factors posed by major public health problems, and how these impact differently on socio-economic groups, in different countries and over time (Kilpeläinen *et al.* 2008).

The availability of such data differs widely between EU countries. These differences reflect their historical and political contexts, their information needs, their financial resources and capacity for data analysis and moni-

toring. Most national health information systems have access to and collect data on demography, such as causes of deaths, communicable and non-communicable diseases and vaccinations (Kilpeläinen *et al.* 2008). In some countries health information systems are quite advanced and health indicators stratified by socio-economic status and/or geographical area are available. However, the data on the extent of health inequalities within countries is often weak, since it is not easy to correlate data systems and stratify health outcomes indicators by socio-economic status.

The situation is improving through the development of the European Community Health Indicator (ECHI) system (see Table 2) and implementation of Health Interview Surveys. All EU member states collect data on income and living conditions (EU-SILC Survey)<sup>14</sup> and most implement the EU Health Interview Survey<sup>15</sup>. Information from these surveys should enable all member states to have comparable information on health inequalities (self-assessed health status stratified by income or education) in their countries. However, data collection processes are not standardised across EU member states, raising questions about comparability of the data. At present, only some countries can make comparisons on smoking habits, obesity, self-reported diseases and use of medicines, and some healthcare utilisation data.

The lack of appropriate and timely comparable data in EU member states and across the EU is a key barrier to greater knowledge and effective analysis on health inequalities. The EC is however encouraging and facilitating advancements in this area. Ensuring comparability of data at EU level and making available data stratified by socio-economic status remains a challenge for a sustainable health monitoring system in Europe. However, in the past years the relevance and use of data have increased, while policy priorities and needs have led to constant progress and improvement on the data and monitoring systems for health equity and the social determinants of health.

14 The EU-SILC Survey covers the entire adult population aged 16 and over in the countries surveyed, except those in institutions (prisons, mental health hospitals, etc). The survey contains questions that can be used to examine inequalities in four areas: self-rated general health, chronic illness or conditions, activity limitations (disability) and unmet need for medical or dental examination or treatment. Information is also collected on education and income, allowing population stratification by socio-economic status. The survey is conducted annually. Data are currently available for 15 EU countries for 2004, and 27 EU countries for 2005. Data on earning disparities is available for 2006. Data tables can be found on the Eurostat website: <http://www.epp.eurostat.ec.europa.eu>.

15 Under the EU Health Information Survey (EHIS), Eurostat has developed a number of modules to measure a wide variety of indicators of health status, health care use and socio-economic status in a harmonised way. EU countries are being encouraged to periodically (once every five years) implement these modules in their national surveys. About two-thirds of the 27 EU countries have committed to implement the survey between 2006-2010. THE EHIS hold potential for future analysis of health inequalities by SES.

Table 2.

### **The European Community Health Indicator System**

Collecting data and monitoring health and the social determinants of health in order to compare differences between localities, regions and socio-economic status is crucial to progress on levelling-up the social gradient in health among children and young people.

Eurostat and DG SANCO provide data and indicators on health status indicators and socio-economic conditions across Europe through their European Community Health Indicator (ECHI) system and Heidi data tool<sup>16</sup>. These data, mostly based on Eurostat assessment, are readily available and reasonably comparable. For all indicators where this is considered useful or appropriate, stratification by gender and age is applied. A significant weakness of the system is that not all indicators, and especially those related to health status can be stratified by socio-economic group. It is possible, however, to identify levels of health and socio-economic inequality between EU countries, with some restrictions as available data are not yet fully comparable. It is also possible to identify levels of inequality related to socio-economic determinants of health within countries (and sometimes between regions).

The ECHI system (European Community Health Indicators) includes 88 indicators. Not all of these have been properly collected<sup>17</sup>. The ECHIM Joint Action (Health Programme 2008-2013) aims to consolidate and expand these indicators and to make ECHI a sustainable health monitoring system in Europe.

Among the 88 indicators the most relevant ones from a health gradient perspective are:

- Demographic and socio-economic situation section are those linked to unemployment, population below the poverty line, income inequalities and population stratified by sex, age, educa-

<sup>16</sup> See [http://ec.europa.eu/health/indicators/policy/index\\_en.htm](http://ec.europa.eu/health/indicators/policy/index_en.htm).

<sup>17</sup> Not all the indicators have been implemented. A few of them are under development and still need further refinement before being accessible in the Heidi data tool.

tion or occupation, as well as the crude birth rate and age distribution of mothers at childbirth.

- The health status section in ECHI includes indicators on infant mortality prenatal mortality and low birth weight and also on disease – specific mortality and incidence and prevalence for major diseases (like cancer, diabetes, stroke, asthma, and chronic respiratory diseases).
- The determinants of health section comprise indicators like pregnant women smoking, consumption of fruit and vegetables as well as breastfeeding and physical activity.

### Healthy Life Years

Another very important indicator is the Healthy Life Years (HLY) indicator. Although it is among the core set of the European Structural Indicators (its importance was recognised by the EU Lisbon Strategy (2000-2010)), the HLY indicator is not widely available stratified by socio-economic groups. Similar to other health indicators, calculating HLYs by socio-economic status (SES) requires:

1. Data on health status by socio-economic group (e.g. Belgian health interview survey).
2. Data on mortality rate by socio-economic group (e.g. census).

The most reliable data for group-specific (e.g. SES/gender, etc.) estimations are provided by linked-record studies. There is, as one might imagine, an enormous amount of documentation and literature regarding statistical and methodological issues pertaining to HLY. It is, however, still not widely used across EU Member States.

#### *Example:*

Lower SES groups (measured by level of education) may have the same life expectancy as higher SES, but much shorter HLY expectancies. For example, in Belgium in the 1990s, among males aged 25 the difference in health expectancy between the highest and lowest levels of education can be up to 17 years – substantially more than the difference in life expectancy (5.23 years). Among females this difference is 11.42 years, while the difference in life expectancy is,

at most, 3.22 years (see EHEMU Country Report). These gaps have increased over time, perhaps mirroring changes in the distribution of wealth and a more general rise of inequalities. *Literature demonstrates that the shorter the life expectancy of a population, the longer a person can expect to live in poor health (i.e. the shorter the HLY).* As such, HLY may be a much more promising proxy of both health and the gradient in health than life expectancy.

## 1.8 CONCLUSIONS

This chapter has outlined what the socio-economic gradient in health is, and how it has manifested itself among children young people and families in Europe. It has also provided compelling reasons why governments and society should aim to level-up the health gradient among children and young people in the EU. Doing so is not only in the interests of a large proportion of children and young people in the EU, it is also critical to the prosperity and stability of society as a whole. It is therefore important that EU member states improve and harmonise data collection and monitoring systems of health inequalities. This will enable them to regularly assess the steepness of socio-economic gradients in health within their populations and to measure the impact of different policies on these gradients.



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## **CHAPTER 2**

# Understanding the Political Context





## CHAPTER 2

### UNDERSTANDING THE POLITICAL CONTEXT

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This chapter addresses the national political context in which health(-related) policies are set, and analyses how those political contexts can influence the health gradient as well as develop policies designed to tackle it. It discusses how this context influences the perception of health inequalities, how the set of social policies in different welfare regimes influences the health gradient itself, and how different welfare regimes generally address and affect the health gradient. The concept of welfare regimes, the problem of the gradient as a political issue and the different types of policies (universal and targeted) are discussed.

#### 2.1 NATIONAL-LEVEL POLICIES: WELFARE REGIMES

Social inequalities shape a pattern of a gradient through populations (Graham 2002, 2003). It is not only the poorest who stand out as having worse health than the average. The wealthiest have better health than the second wealthiest, who have better health than the third wealthiest, as described in the introductory chapter. Social inequalities in health are therefore an issue which concerns the whole population. Applying a gradient perspective to study social inequalities in health implies that welfare policies in many areas must be considered when studying the distribution of social inequalities in health.

In Chapter 2 we present findings from a case study comparing policies to reduce social inequalities in health in four European countries, and aim to answer the following questions:

- Do different welfare states matter in reducing social inequalities in health among families with children?

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- What strategies are in place in different countries?
- The role of politics: How do governments made up of different political parties conceptualise the issue of social inequalities in health?

The findings are contextualised by data showing the situation regarding living conditions and health for different types of families in the four countries studied. We also discuss this in relation to one family type which is particularly vulnerable: single mothers.

## 2.2 DO DIFFERENT WELFARE STATES MATTER?

In the Oxford English Dictionary politics is defined as “The activities associated with the governance of a country or area, especially the debate between parties having power”. Policy in a governmental context is defined as a course or principle of action adopted or proposed by government.

Navarro and colleagues have documented the importance of political parties and the policies they implement when in government, such as the level of equality/inequality in a society, the extent of the welfare state, the employment/unemployment rates, and the level of population health in OECD countries in the period 1945-1980 (Navarro, Shi 2001; Navarro *et al.* 2003a; Navarro *et al.* 2003b). The results indicate that political traditions more committed to redistributive policies (both economic and social) and full-employment policies, such as the social-democratic parties, are generally more successful in improving the health of populations.

Governments address the issue of health inequalities differently. The policies and strategies chosen by politicians will have implications for the results achieved. Policies targeting marginalised groups may improve the situation for these groups, but the gradient will not change; policies aimed at the whole population are needed in order to reduce the social gradient in health. Recent studies have suggested that universal policies are successful in reducing the social gradient (Lundberg *et al.* 2008a), and that in order to reduce inequalities in health, proportionate universalism should be applied to implement these universal policies more strongly where the need is greater (Marmot 2010). In *Fair society, healthy lives* (2010), Marmot argues that “actions must be universal, but with a scale and an intensity that is proportionate to the level of disadvantage. We call this proportionate universalism”. This will demand structural measures, and is therefore also a highly political issue.

One of the research questions tackled by GRADIENT is whether different welfare states secure the living conditions for families and children differently.

What are the characteristics of different welfare state types? Is it the case that one type of welfare state is better than another?

Within the literature of welfare states and welfare state typologies these questions have been the basis for overall discussions. Esping-Andersen's *The Three Worlds of Welfare Capitalism* has been ground breaking in the study of how different states redistribute resources, particularly to disadvantaged groups (Esping-Andersen 1990).

The terms 'welfare state' and 'welfare state policies' have different meanings in different political systems. There are international variations in social rights and welfare state stratification, and there are also qualitatively different arrangements between state, market and the family. The welfare state types are therefore not linearly distributed: according to Esping-Andersen they are clustered by different welfare regimes type. Esping-Andersen divides the welfare regimes into three types: liberal, conservative and social democratic, each having particular characteristics.

- In the *liberal welfare regime*, market forces play a dominant role in welfare provision and the state encourages the market to flourish, either passively, by guaranteeing a minimum of regulation, or actively, by subsidising private welfare schemes. Public transfers are means-tested and only modest universal benefits and social insurance plans exist. Examples of this type of welfare regime are the UK, the USA, Canada and Australia.
- In the *conservative welfare regime*, the market does not play a predominant role with regard to protecting the health of the population. The idea of social rights and encompassing social security networks holds a high degree of legitimacy. Its basis is built on conservative grounds, and the upholding of 'traditional' family values. The social security systems are built on the male bread-winner model; they are strongly attached to the labour market, and hence mostly exclude women not employed outside the home. Countries listed as conservative regimes include France, Germany and the Netherlands.
- The *social-democratic regime* is characterised by its emphasis on solidarity and universal principles in the distribution of services. This includes a principle of redistribution of resources among social groups, mainly through a progressive tax system and entitlements for vulnerable groups. This is a system of emancipation, not only from the market, but also from the family. The result is a welfare

regime with direct transfers to children and one which takes direct responsibility for the care of children, providing the conditions for women with families to engage in paid work. Women are encouraged to work and the welfare state is dependent on female participation in the labour market. Scandinavian countries are usually cited as exemplars of the social-democratic welfare regime.

Esping-Andersen's books have raised a lot of debate and have been criticised from several angles. There are a number of studies showing that the health of different population groups is not better in the social-democratic welfare states, as might be expected given the comprehensiveness of this welfare state regime. On the other hand, there seems to be an agreement that the absolute level of health is better in social-democratic welfare states, but that the relative inequalities between socio-economic groups are not smaller than in other countries (Bambra 2007; Bambra, Eikemo 2009).

Even though Esping-Andersen's welfare regime typology has been criticised, there is also a large body of empirical research that supports the main hypothesis that population health is best in the welfare regime with the most redistributive and generous welfare arrangements, and particularly for the target groups included in the GRADIENT project: families with children. For the purpose of this project we choose to use Esping-Andersen's typology of welfare regimes as categories for classification. From our point of departure the classification covers the most important issue, namely how policies aimed at families with children are developed and implemented in different countries.

Lundberg *et al.* (2008 a, b) show that although all rich nations have welfare programmes, there are clear cross-national differences with respect to their design and generosity. These differences are evident in national variations in poverty rates, especially among children and the elderly. The ways in which social policies are designed, as well as their generosity, are important for health. Hence, social and welfare policies are of major importance for how we can tackle the social determinants of health.

Dahl (2009) and colleagues state that it is easier to redistribute money than health, but that the Nordic model definitely has larger success than other countries in redistributing money (Dahl *et al.* 2006). Michael Marmot (2009) states that the social-democratic model reduces pre-redistribution poverty by an astonishing 70 per cent. Countries in the social-democratic model have well-developed welfare arrangements, many with universal coverage. At the core of these arrangements is the political aim of redistribution between social groups. Policies aimed at families with children form an important part of social-democratic regimes.

Lundberg (2009) states that welfare policies aiming to provide children and their families with a decent standard of living and schools of good quality should contribute to child health and well-being. Research shows a clear relationship between family policy generosity and the child poverty rate: countries with more generous family policies tend to have substantially lower child poverty rates. There is also a clear relationship between family policy generosity and infant mortality.

In this chapter we study four European countries, representing different welfare state regimes. England<sup>19</sup> represents the liberal regime, the Netherlands the conservative regime and Sweden the social-democratic regime. As a former communist country, Slovenia was not part of Esping-Andersen's classification, so we found it interesting to include Slovenia in our study. In the discussion of the situation for lone mothers, UK and Sweden are included but not the Netherlands and Slovenia.

### **2.3 SOCIAL INEQUALITIES IN HEALTH IN THE FOUR COUNTRIES: GENERAL SITUATION**

So far this chapter has laid out literature on welfare regimes and their potential effect on population health and the gradient of health. What do we see if we take a closer look at health and the gradient of health in these four countries? Do we see gradients of health across the population in all the four countries? Are health inequalities larger in the UK liberal example or the conservative Netherlands example than in social-democratic Sweden? Does Slovenia show patterns similar to social-democratic Sweden or to central-European neighbouring countries which are postulated as belonging to the conservative regime type? Which country has the best protection for child families at risk? Where is child health the best? The following part of this chapter aims to throw some light on these questions.

Of course there are many elements to consider in discussing this. The four countries have different historical backgrounds and economic situations, and they are at different levels of development. Let us first look at the Human Development Index (HDI)<sup>20</sup> ranking for each of the countries (Table 1).

19 Even though England is the case for the study, some of the documents and statistics include the whole of UK.

20 The HDI is a composite of health status, education status, and living standards in a country.

Table 1. HDI and Gini coefficient scores of the four countries.

	HDI Ranking <sup>1</sup>	Gini <sup>2</sup>
<b>Netherlands</b>	3	25.5
<b>Slovenia</b>	21	23.8
<b>Sweden</b>	10	24.1
<b>UK</b>	28	32.4*

1. UNDP (2011 Human Development Report)
2. Eurostat (2010 statistics), \*UK statistics available only from 2009

Not unexpectedly the Netherlands and Sweden both rank well when it comes to HDI, respectively at positions 3 and 10. It might come as more of a surprise that the UK ranks lowest, at position 28, with Slovenia ranked at 21. The second column in Table 1 shows the Gini<sup>21</sup> coefficient scores for each country. According to the Gini coefficient, Slovenia has the lowest inequality in family income distribution with Sweden and then the Netherlands following close behind. The UK has the highest level of inequality.

If we move on to look at national economy and health expenditure we see that each country has a health expenditure per capita that corresponds to the national economy, and we also see that Slovenia has a markedly lower Gross National Product (GNP) per capita than the three other countries (Table 2). The Netherlands has the highest GNP per capita, and also the highest health expenditure, and Slovenia the lowest. However, a child born in Slovenia has a higher chance of reaching the age of five than a child born in the Netherlands or the UK. In addition, a girl born in Slovenia may expect to live to the age of 82 – as long as a girl born in the UK. Slovenian boys, on the other hand, face a somewhat shorter life span than boys from the three other countries.

21 The Gini coefficient measures the degree of inequality in distribution of family income in a country. The index is a ratio, with lower scores referring to lower inequalities and higher scores referring to higher inequalities.

Table 2. GNP, health expenditure, child mortality and life expectancy in the four countries <sup>22</sup>

	<b>Gross national product per capita in PPP<sup>23</sup></b>	<b>Health expenditure per capita (Int. dollar 2009)</b>	<b>Probability of dying under five (per 1000 live births)</b>	<b>Life expectancy at birth (male/female)</b>
<b>Netherlands</b>	40,620	4,389 (10.8%)	5	78/83
<b>Slovenia</b>	27,160	2,476 (9.1%)	3	76/82
<b>Sweden</b>	37,780	3,690 (9.9%)	3	79/83
<b>UK</b>	36,240	3,399 (9.3%)	5	78/82

GRADIENT aims to highlight policies which protect children at risk and to reduce child-health differences. One of the best-known risk factors for poor health is poverty, and we have already stated that there are varying degrees of income differences in the four countries (Table 1). A commonly used measure of being at risk of poverty is having an income less than 60 per cent of the median income in the country. From Table 3 we can see that the highest child-at-risk-of-poverty rate can be found in the UK, both for two-parent and one-parent families. Slovenia and Sweden cluster together as the countries with the lowest risk of child poverty – despite the poorer national economy of Slovenia (as demonstrated in Table 1). Also, the absolute distance in poverty risk of one-parent families to the overall average is lower in Slovenia and Sweden than in the two other countries.

Table 3. Child at-risk-of-poverty rates, %<sup>24</sup>

	<b>All families</b>	<b>Single-parent families</b>	<b>Distance of one-parent families to average</b>
<b>Netherlands</b>	15	31	16
<b>Slovenia</b>	12	26	14
<b>Sweden</b>	9	20	11
<b>UK</b>	21	38	17
<b>EU-25 average</b>	19	34	15

<sup>22</sup> WHO country statistics 2011 (figures from 2009).

<sup>23</sup> PPP stands for Purchasing Power Parity, a criterion for an appropriate exchange rate between currencies. It is a rate such that a representative basket of goods in country A costs the same as in country B if the currencies are exchanged at that rate. (WHO <http://www.who.int/choice/costs/ppp/en/>).

<sup>24</sup> EC 2008



We can see here that Sweden, not surprisingly, has a high degree of human development, a low degree of family income inequalities, low child at-risk-of-poverty rates, and low child mortality. This is in accordance with expectations from the literature. The Netherlands show a mixed picture, with a higher HDI ranking and health expenditure than Sweden and Slovenia, but nevertheless with poorer scores for income inequality, child mortality and child at risk of poverty. The UK scores poorly not only on inequality and child poverty measures, but also on child mortality. For Slovenia, again, a pattern seems to emerge with a closer similarity to social-democratic Sweden than to conservative Netherlands. Slovenia has the weakest economy, but low levels of inequality and low child at risk of poverty scores, and also low child mortality. Previous research has suggested that population health is better in countries with smaller economic differences (Navarro and Shi 2001, Wilkinson and Pickett 2009). From the numbers presented in Tables 1, 2 and 3 we cannot show any firm evidence of this, but the numbers definitely support the idea.

The following analyses make use of data from the European Social Survey (ESS), which is a biannual EU-funded Europe-wide project collecting high-quality data from representative samples in each country<sup>25</sup>. For the analyses in this chapter a subsample of child families were selected. One parent from each family took part in the survey, the mother or the father. The sample included families with own children, partner' children, foster children and adopted children. Age was restricted to parents aged 55 or less. Unless otherwise stated, the sample included both one and two-parent families. To maximise the sample size cumulative data from years 2002-2008 were used. The sample included approximately 2000 child families per country. The exception is the analysis shown in Figure 1, which for technical reasons is based on data from 2008 with approximately 500 child families per country.

So far we have only looked at general population statistics, and not really assessed whether we can see a gradient through the populations. In Figure 1 we see a visual display of this gradient among child families in the four study countries.

25 See <http://www.europeansocialsurvey.org/>.

Figure 1. Subjective general health of parents

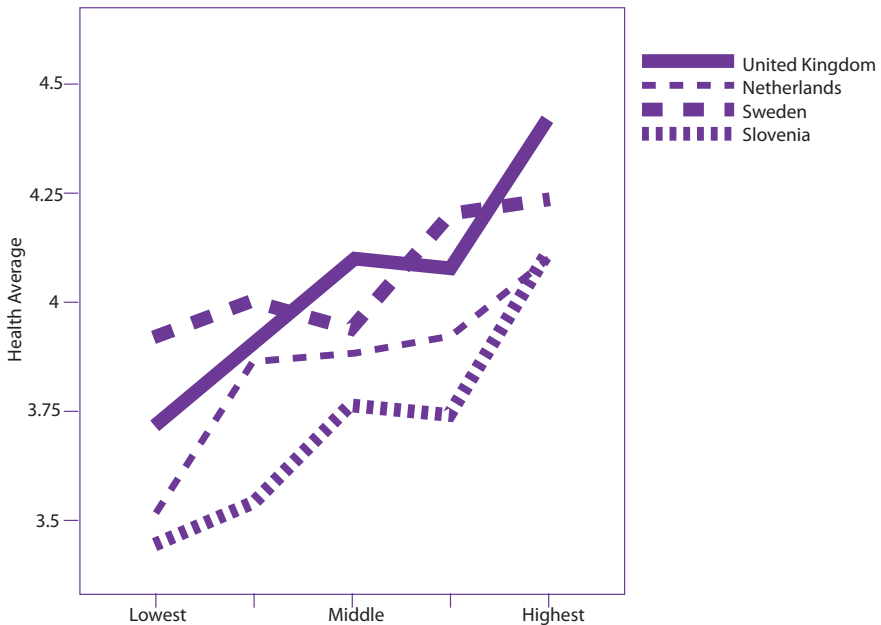


Figure 1 shows how parents in families with children perceive their own health<sup>26</sup>, and this is combined with information about their economic position. The health measure applied is not objective, but is commonly used in survey research, as it corresponds well with objective measures of morbidity. The figure shows how subjective general health is perceived as being better for each of five steps up the income ladder (income quintiles).

There are gradients to be seen in each of the four countries, but the gradient is less steep in Sweden, suggesting that the health differences are smaller between each step. The gradient in the UK seems particularly steep. The single group with the very best self-reported health of all is the richest quintile of the population in the UK. This group reports better health than the richest quintile in Sweden. However, the poorest group in the UK has a lower health score than the poorest group in Sweden. It is worth mentioning that the UK is the country among the four which has the greatest inequalities in family income according to the Gini coefficient. Slovenian parents report somewhat poorer health scores on this question on adult self-reported health. However, objective health statistics are favourable in Slovenia (Table 2).

26 Subjective general health is measured as "How is your health in general? Would you say it is very good, good, fair, bad, or very bad?", with health referring to both physical and mental health.

How is the situation if we look at child families at risk? In studies of families with children and risk factors, one of the most relevant comparisons is between one and two-parent families. For a child, what differences can we see between growing up in a one versus a two-parent family? We can see from Figure 2 that a child growing up in a one-parent family is more likely to have a parent (mother or father) with poorer health than a child in a two-parent family. This goes for all four countries. However, in Slovenia the health of the parent is not likely to be much worse than that of parents in couple families. Next, the figure demonstrates an important aspect of health differences: the fact that health can be better or worse in an absolute sense, or better or worse in a relative sense. From this perspective one can see that health in the absolute sense is best in the UK and Sweden, and somewhat poorer in the Netherlands, with Slovenian parents reporting lower subjective general health. However, the relative difference between the groups is smaller in Slovenia. This might suggest there are factors protecting single-parent families in Slovenia, while this particular analysis cannot suggest what they are.

It is also interesting to note that Slovenian parents score lower on subjective questions about health and about life satisfaction, while they do well on objective health measures (Table 2). This touches upon a debate on the challenges of using subjective health measures. It should be noted that previous literature has stated a tendency in eastern and southern-Europe to 'report on the negative side', while there is a tendency to respond positively in northern-Europe. We do not have relevant data to test whether this is the case in our study. Should it be the case, however, there might be reason to interpret the subjective health and satisfaction scores from Slovenia as being overly negative. The interested reader might explore the topic further in Paulhus (1991) and Berry *et al.* (2002).

If we do a similar analysis with life satisfaction as the outcome instead of health, we find the same pattern of smaller differences between the groups in Slovenia. We also see that parents in the UK report surprisingly low life satisfaction with large differences between one- and two-parent families. This analysis suggests strongly that the absolute standard of living (as reflected by national GDP per capita) does not correspond with perceived quality of life for the population. The group with the lowest life satisfaction of all is single parents in the UK.

Figure 2. Subjective general health in two-parent and one-parent families

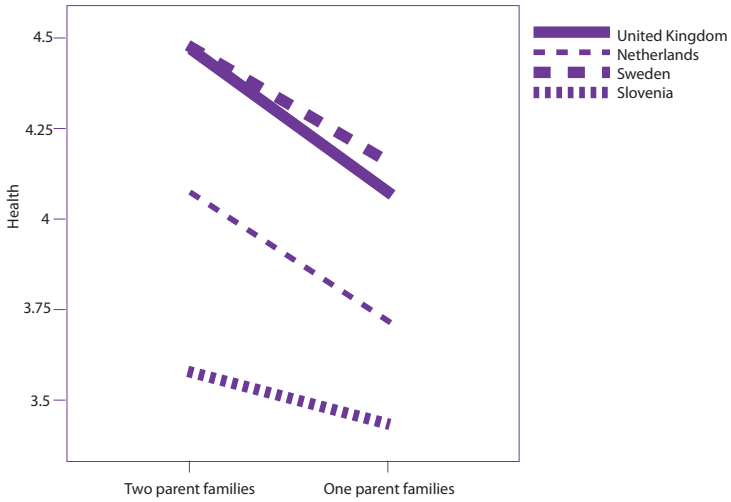
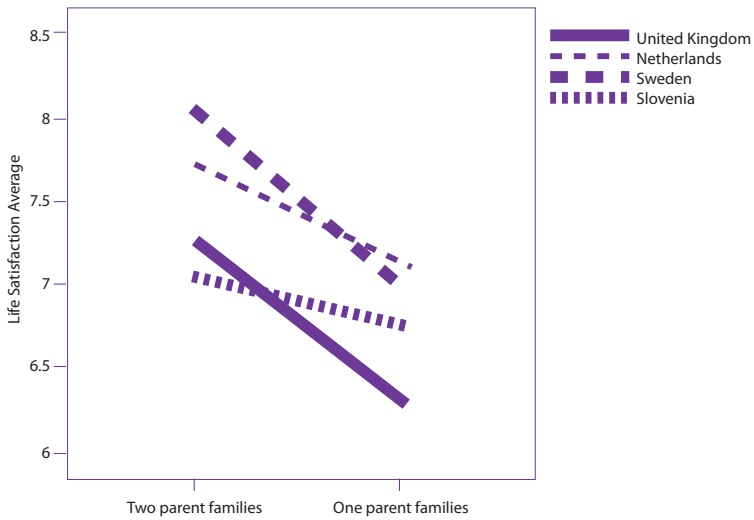
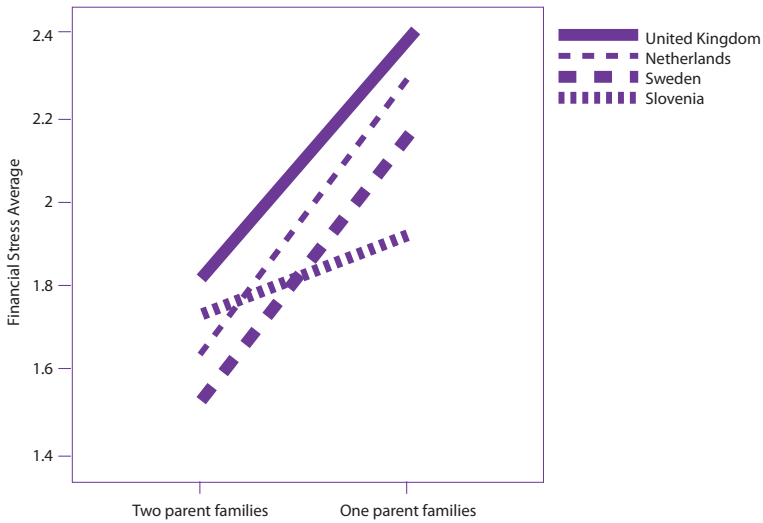


Figure 3. Life satisfaction in two-parent and one-parent families



In quite a few ways Slovenia now begins to show an interesting pattern of smaller differences between the reference group and groups that are generally considered to be at particular risk. The same pattern can be found in other comparisons – see for instance Figure 4 which shows that Slovenians experience smaller differences in financial stress by partnership status.

Figure 4. Financial stress<sup>27</sup> by partnership status



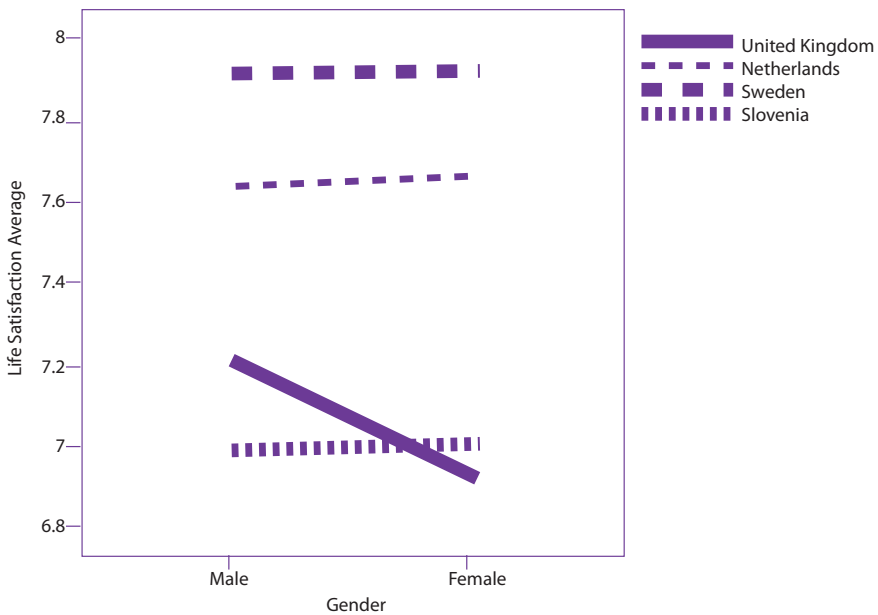
In addition to the remarkable smaller differences between the groups in Slovenia, Figure 4 tells us that single parents in Slovenia experience a lower degree of financial stress than single parents in all the other countries. The highest level of financial stress among parents is experienced in the UK. The difference in financial stress between family types is of the same magnitude in Sweden, the Netherlands, and the UK. A very similar pattern is found if one looks at differences in financial stress between unemployed and employed parents (not shown in figure). Financial situation is known to be a factor which influences both health and life satisfaction (CSDH 2008; Bull 2009). Smaller differences in financial stress might therefore be part of

<sup>27</sup> Financial stress is measured by a variable which asks how easy or difficult it is to manage on the household's income, with response options ranging from 'living comfortably on present income' to 'it is very hard to get by on present income'. For this analysis, scores may be within a range of 1 to 4, with higher numbers referring to higher stress. This variable is a subjective measure of perceived financial position, but it corresponds closely to objective measures of income. It also overcomes the problem of comparing currencies and the differing costs of living in the different countries.

the explanation behind the patterns of smaller subjective health differences that we see in Slovenia.

Another way of assessing inequalities in welfare within a country is to assess differences between the genders. How do the countries fare when it comes to equality in life satisfaction between mothers and fathers? Figure 4 shows a remarkable pattern for the UK, with mothers in families with children reporting a clear lower level of life satisfaction than fathers. The UK is the only country with noticeable differences in life satisfaction between the genders. It is worth noting that this marked difference is not noticeable in the UK population as a whole, only in families with children. Figure 4 also shows us that parents in Sweden and the Netherlands report the highest overall life satisfaction.

Figure 5. Life satisfaction by gender of parents



Also related to gender is the degree to which mothers are in paid employment or at home with responsibilities for housework and childcare. The social-democratic regime with its universal and extensive welfare policies is based on high female labour market participation. Table 4 shows the employment rates for mothers in the ESS samples on which the analyses

for this chapter are based<sup>28</sup>. As we can see, Slovenia and Sweden follow the social-democratic pattern of high female employment among both single and couple mothers, while the Netherlands, in particular, has low rates of mother employment. This is in line with the characteristics of the conservative regime type where care is considered to be a responsibility of the family. More women in the Netherlands and UK report housework and care to be their main activities, not searching for employment, and the weekly number of hours worked among those mothers employed is lower in the Netherlands and UK than in the two other countries.

Table 4. Main activity of mothers<sup>29</sup>

	Couple mothers			Single mothers		
	Paid work <sup>1</sup>	House/care work <sup>2</sup>	Weekly work-hours <sup>3</sup>	Paid work <sup>1</sup>	House/care work <sup>2</sup>	Weekly work-hours <sup>3</sup>
<b>Netherlands</b>	46.8 %	46.3 %	25.21 hrs	49.2 %	26.7 %	29.31 hrs
<b>Slovenia</b>	58.0 %	20.3 %	43.62 hrs	31.6 %	11.5 %	43.30 hrs
<b>Sweden</b>	82.2 %	3.8 %	36.47 hrs	68.0 %	2.2 %	37.20 hrs
<b>UK</b>	62.0 %	28.5 %	30.53 hrs	46.6 %	24.7 %	32.07 hrs

<sup>1</sup> This category includes mothers who are in paid work, or away temporarily, regardless of whether they are employees, self-employed, or working for a family business.

<sup>2</sup> This category includes women who are doing housework or looking after children (or other persons) as a main activity. It excludes mothers who are not in paid work due to on-going education, and those who are actively looking for employment.

<sup>3</sup> The number of average weekly work-hours includes overtime, whether it is paid or unpaid.

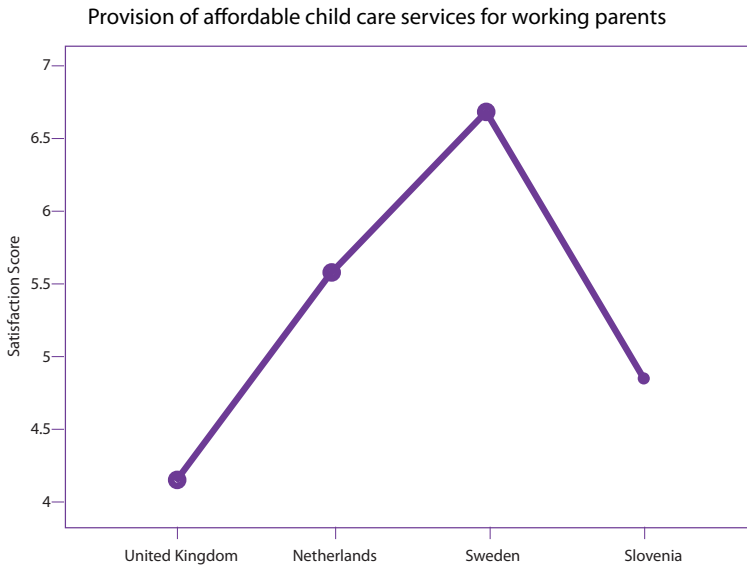
With mothers active in paid employment, availability of quality childcare outside the family at reasonable prices becomes of importance for healthy child development. The price of quality childcare is one of the factors which may introduce differences in opportunities for children from different family backgrounds (Lyonette *et al.* 2007). How satisfied are parents in the four countries with the provision of affordable childcare? In Figure 5 we see that the highest satisfaction with availability of affordable childcare is reported in Sweden, while the UK has the lowest level of parent satisfaction with child care provision. The Netherlands and Slovenia both have middling scores, with somewhat higher satisfaction in the Netherlands. From a welfare regime perspective it is also interesting to see whether parents consider childcare provision to be a responsibility of the government. Analyses show a very

<sup>28</sup> Authors' own calculations from the European Social Survey (ESS), rounds 1 and 2 (conducted in the years 2002-2006). The ESS is a survey representative of all persons aged 15 and above for more than 20 European countries. See <http://www.europeansocialsurvey.org>

<sup>29</sup> ESS Survey cumulative data 2002-2008, authors' analysis

clear pattern of high agreement with this claim in Sweden and Slovenia, and low agreement in the Netherlands and the UK (not shown in any figure).

Figure 6. Satisfaction with provision of affordable childcare services<sup>30</sup>.



Summing up, the UK has high scores for subjective general health, but a steep gradient in the population. Parents in the UK experience the highest level of financial stress, regardless of partnership and employment status. There are also considerable gender differences in life satisfaction in families with children in the UK, while such differences are absent in the three other countries; HDI is surprisingly low, while the Gini coefficient shows large economic inequalities. The UK has the highest child mortality of the four countries. Sweden generally scores well on health outcomes, and on levels of financial stress. The gradient in self-rated general health is the least steep in Sweden. There are differences between the groups by partnership status and employment status in Sweden as well as in the other countries, but no gender differences between mothers and fathers in families when it comes to life satisfaction. The Swedish population welcomes the responsibility of the state to provide for childcare services. The population in the Netherlands scores in the mid-range on most measures. Financial stress is medium, Gini is medium, health scores are medium, HDI however is very high, as

<sup>30</sup> Respondents were asked "What do you think over all of the provision of affordable childcare services for working parents?" Responses options ranged from 0 (extremely bad) to 10 (extremely good).



is GNP per capita. Also in the Netherlands there are differences between groups by partnership status and employment status, but not between genders. Parents in the Netherlands seem to have low expectations toward the government regarding childcare provision.

Slovenia comes out as an interesting case among the four countries. Even if GNP per capita and health expenditure per capita is lowest in this country, the Gini coefficient reveals low economic inequality. This low inequality in the population is confirmed in various analyses on other variables, such as between one and two-parent families, employed and unemployed parents, and between genders in child families. Financial stress is also reported to be surprisingly low, and child at-risk-of-poverty rates are low. Despite low inequality, adult subjective health and life satisfaction scores are lower in Slovenia, while objective health outcomes are good (Table 2). Support for government responsibilities towards childcare provision for working parents is strong. Thus, Slovenia shows a pattern more consistent with the social-democratic regime type.

The analyses presented in this section of the chapter have shown some interesting patterns for the different countries, but also inconsistencies. To some extent the analyses illustrate and reflect expected findings regarding the situation of families with children in different welfare state settings. However, the Slovenian example suggests that not only the level of economic wealth, but also its distribution in the population, has bearings on health, not least on the health of children. In the next part of the chapter we follow up some findings regarding a group of parents which is particularly vulnerable: lone mothers.

## **2.4 LONE MOTHERHOOD, SOCIAL POLICY AND HEALTH**

Lone mothers have poorer mental and physical health than couple mothers, regardless of whether the measure is self-reported health, admission to hospital or mortality. Not all of this increased risk can be explained by health selection, there is also something inherent in being a lone mother that takes its toll on health. These pathways to poor health may differ between welfare states, and studies that compare living conditions and health among lone mothers between settings may yield important insights as to how inequalities in health come about, and what could potentially be done to reduce them (Burström *et al.* 2010).

The policy environment sets the scene for the life chances and life-course trajectories for individuals and social groups. Living conditions and the health of lone mothers have been described as a litmus test of how well a society cares for its most vulnerable citizens (Hobson 1994). Lone mother-

hood is in itself a dynamic phenomenon, shown not least by its increasing prevalence. The perception of, and consequently the policy framework around lone motherhood is formed by societal values, shaped in turn by history, religion, gender roles and female emancipation. Lone motherhood is not static over time, but changes as society develops.

Lone mothers have both earning and caring responsibilities. Lacking the complementary income of a partner, they have to have sufficient income to support themselves and their children. Otherwise, they have no choice but to rely on the state or family for support. Living conditions of lone mothers are therefore very sensitive to how social policies are set up.

A previous study found large differences in the prevalence of lone motherhood, as well as differences in the route into lone motherhood between UK, Italy and Sweden (Burström *et al.* 2010). These differences in routes to lone motherhood may be due to cultural, religious, economic and institutional factors. Here we will report findings from the UK and Sweden, as these are the countries included in the study presented in this chapter. In the UK it is young working class women who are more likely to become lone mothers. In Sweden, lone mothers are more evenly distributed among social classes. The study also indicated that poverty may be more damaging to health of lone mothers in UK than in Sweden, and pointed out the non-employed as a particularly vulnerable group.

Employment patterns and employment opportunities for lone mothers differ between the UK and Sweden. Gainful employment is important as it protects against poverty, and is increasingly important for alleviating poverty risks (Fritzell, Ritakallio 2010). The association between health and employment status plays out differently in different countries (Bambra, Eikemo 2009), and might also differ between social groups. Combining work and family has positive effects for health of women, including lone mothers (Fokkema 2002; Lahelma *et al.* 2002; Artazcoz *et al.* 2004; Zabkiewicz 2010). A previous study showed that being employed greatly reduced the risk of poverty for lone and couple mothers in both the UK and Sweden, but especially so for British lone mothers. The poverty rate was 50 per cent among non-employed lone mothers compared to 19 per cent among those working (Burström *et al.* 2010).

The proportion of lone mothers working is highest in Sweden and lowest in the UK. The lone mothers not participating in the workforce include two groups: one group is not employed and not looking for a paid job; this group includes home makers who choose not to participate in the work force. The second group is the unemployed. Unemployment rates are similar among lone mothers in the two countries. The UK and Sweden are examples of different welfare regimes, as described earlier in the chapter. Care policies

are one of the important factors influencing women's economic independence (Huber *et al.* 2009). Childcare in UK (part of the liberal model) has been described as costly and of variable quality. Lately, the development of an explicit family policy in UK has altered the policy environment for parents and lone parents in particular, and there have been improvements in the health of lone mothers (Burström *et al.* 2010).

The Swedish welfare state (part of the social-democratic model), which is based on high employment rates, parental leave policies and universal availability of affordable good-quality childcare aims to ensure labour market access for lone and couple mothers alike. However, there have been signs of under-employment among lone mothers the last decades. In addition, on-going study of health and financial strain among Swedish lone mothers revealed that combining work and lone parenthood is also difficult in Sweden (Fritzell *et al.* 2011).

As described above, lone mothers have worse self-rated health than couple mothers in both Sweden and the UK. A previous study found that there was a vertical relationship – a social gradient in the percentage ill, with increasing ill health in lower classes in the two countries. But there was also a horizontal relationship – with higher rates of less than good health among lone than couple mothers in all social classes, indicating that there was a health disadvantage in being a lone mother over and above that associated with occupational class (Burström *et al.* 2010). Furthermore, lone mothers without employment are a group of concern since they are particularly exposed to financial hardships and report poorer health in all three countries, and in the case of Sweden, have also experienced a large increase in poor health. From a policy perspective it is important to improve living conditions for lone mothers, as their social and financial participation in society has implications not only for their own health but also impacts on the lives of their children. Improving the possibilities to combine work and lone parenthood and ensuring sufficient financial conditions for lone mothers without employment are within the scope of social policy and is important in tackling the gradient in health.

The case of lone mothers again stresses that in order to reduce the social gradient in health it is necessary to have policies in place that are in line with the principles of "proportionate universalism". In other words, universal labour market and family policies will have a strong influence on the living conditions of single-parent families. In addition, it will be necessary to implement policies that reduce the burdens faced by this group.

In the next section we will present policies aimed at families with children in England, the Netherlands, Slovenia and Sweden. In order to reduce

the social gradient in health, it is important that a country has developed general family policies, like employment policies and public day-care. It is also important to have an explicit aim to reduce social inequalities in health and that policies are designed to reduce these inequities. The importance of maternal employment will be further discussed in Chapter 3.

## 2.5 HEALTH INEQUALITIES: THE POLITICS BEHIND POLICIES

As is illustrated by the single mother case presented earlier in this chapter, social inequalities may be defined as a so-called “wicked” problem. The concept of a “wicked” problem was first introduced by Rittel and Webber (1973). Their point of departure is that searching for scientific bases for confronting problems of social policy is bound to fail, because of the nature of these problems: in a pluralistic society there is nothing like the ‘undisputable public good’; there is no objective definition of equity; policies that respond to social problems cannot be meaningfully true or false; and it makes no sense to talk about ‘optimal solutions’ to social problems unless severe qualifications are imposed first. Even worse, there are no ‘solutions’ in the sense of definitive and objective answers. Rittel and Webber thus confirm the statement by Navarro *et al.* (2003) that reducing social inequalities in health is a highly political issue. It demands a political agenda that regards social inequalities as unfair. It will also demand concrete policies and interventions. Furthermore, by prioritising reduction of social inequalities, other policies may be moved further down the political agenda.

In the following part we present findings from a case study that was undertaken as part of GRADIENT. The overall question is whether the different countries have policies in place to reduce the social gradient in health among families with children. The analysis aims to answer the three initial research questions: Do welfare states matter in reducing social inequalities in health? What strategies are in place in different countries? How do governments from different political parties conceptualise the issue of social inequalities in health?

Data is based on analysis of national policy documents and interviews with national policy-makers and experts in the four countries. The analysis was based on policy documents that described government policies (like government White Papers) and action plans or other documents that outlined strategies to follow up the government policies. The policy makers interviewed were experts in family policies and social inequalities.

All the four countries have policies in place for children and families, and these policies are also high on the political agenda in all the countries. The

policies are both general policies concerning education, leisure time activities, etc., and also general welfare policies for families and children. All countries also have public health policies in place, and children are a main target group in all the countries. However, the policies have a different focus and in the proceeding section similarities and differences will be discussed.

Among the four, England and Slovenia have an overall objective to reduce social inequalities in health. The strategies are, however, somewhat different between the two countries. England has a policy mainly aimed at supporting vulnerable groups and geographic areas. One policy-maker expressed it as follows:

*“Child poverty should not exist in a society like Britain, there was a wish to create a fairer England, particularly for children... It was important to raise the profile of health inequalities, and even making it an issue for the NHS. It was also important to set out cross-cutting strategies and to have an infrastructure of support...”.*

Slovenia combines targeted measures with universal support to families and children, like rights to parental leave and subsidised day-care and preschool for all. Slovenia has thus introduced policies that will contribute to reducing the social gradient. The policy is described as follows by a public health policy maker:

*“The overall aim of the public health policy in Slovenia is good health for the whole population and to reduce social inequalities in health. This is mainly done through universal policies, like parental leave, universal health care for children, and education. There is a high standard in the family policies... Universal policies are a tradition in this country. The link of this and social inequalities in health is more recent. Earlier this was implicit, now it is explicit”.*

The overarching aim of Sweden’s national public health policy is to create social conditions that will ensure good health, on equal terms, for the entire population. The Swedish approach is described as follows:

*“The Swedish public health goals capture the structural determinants, through their eleven areas. These are still the most important. Individual efforts are not so effective”.*

However, in recent policy documents this aim is not mentioned or emphasised and it has not been operationalised into concrete strategies for action.

Thus, it seems fair to conclude that Sweden presently does not have a formulated policy with explicit aims to reduce social inequalities in health. Another policy maker points to changes that have occurred over the last few years in Sweden:

*“Social inequalities are not high on political agenda any more. There has been a shift of focus to tobacco, alcohol and drugs. The government has also prioritised children, elderly people and mental health. They say they have chosen some areas to get results. The downside is that other social determinants are not being prioritised”.*

In the Netherlands, reducing social inequalities in health is also not explicitly a part of present policies, but policy makers think they can still include this perspective when developing and implementing policies. This is how a Dutch policy maker describes the situation:

*“There is no rhetoric around social inequalities or health inequalities in policy documents. But still, ‘we do what we do’. This means that even if there is no political agenda on this, it is still an implicit aim when policies are developed”.*

On the local level, focus in the Netherlands has mostly been on deprived areas. This was started by the former government, and it is being followed up by the new government. The aim was to increase security and good living environments in these areas. As a consequence of this programme, health also became an issue.

*“It started with 40 deprived areas. The government is responsible, together with other actors: schools, private actors, etc.”*

In both the Netherlands and Sweden there is mention of supporting disadvantaged groups, but in the documents this is not the dominant focus. There are, however, clear differences between the two countries. In Dutch documents families' responsibility for the health and well-being of children is strongly emphasised. In Sweden a policy to support parents in their role is also strongly emphasised. The main difference between Dutch and Swedish policies seems to be that the Swedish government explicitly states its responsibility in this matter and suggests universal measures to support families in their role as parents.

## 2.6 WELFARE REGIMES

The four countries participating in this study represent different welfare regimes. An important question is therefore if the differences between the countries reflect the welfare regime each belongs to. The conclusion so far is that they do to some extent, but that there are elements that do not fit in.

England belongs to the liberal welfare regime, where the main ideology is that government should be passive and that families basically are a part of the private sphere. This picture does not fit with the English policies over the last 13 years. On the contrary, families have been at the core of policies and interventions aimed at reducing social inequalities in health. On the other hand, the measures were mainly targeted at disadvantaged groups and areas, which would be in line with the ideology of the liberal welfare regime. A policy maker described the situation as follows:

*“It is misleading to label the UK as ‘liberal’. There are great differences between the US and UK. They have very different policies in the public field. The UK welfare state tradition dates back to the 1940s and 1950s post-war welfare state. The Conservative Prime Minister Winston Churchill proclaimed a welfare state that had an all-embracing structure: ‘from cradle to grave’. There is a long tradition of government interventions in the social area, and we are much more European than American”.*

The social-democratic regime is at the other end of the continuum regarding policy interventions in the family sphere, and families are one of the main target groups for policy interventions. Reducing social inequalities in health is at the core of the social-democratic regime, and therefore it may seem like a paradox that Swedish policy does not have this as an explicit aim in current policy documents. On the other hand, the Swedish welfare system exists as a buffer and provides basic protection against poverty, and there is a basic ideology of redistribution via the tax system. This is explained in the following way by a Swedish policy maker:

*“In Sweden the transfers are not so large, but they show a different pattern than in many other countries. Institutions that build the welfare state are the most important, like day-care institutions and student loans for everybody. This creates equality... It doesn't make such a big difference with a conservative/liberal government”.*

As a former socialist country, Slovenia is not part of Esping-Andersen's typology. Slovenia seems to be in the process of building up a comprehensive welfare state, taking on clear characteristics of the social-democratic regime type. Development of family policy is an important means of building up the welfare state, and the principles of redistribution among socio-economic groups are introduced, both in taxation and also in welfare arrangements for families. A former policy maker described the situation in the country after the independence from the former Yugoslavia:

*"After socialism we faced some dilemmas: how to keep equity principles but combine this with a market economy and individualism. We saw a danger of going too far in the liberal direction; competitiveness on the one hand and keeping welfare on the other. At the time there was a recession: we were losing markets in the old Yugoslavia, and starting to re-orientate towards the West. At that time the level of unemployment went up from 1.3 to 13 per cent.*

*Education was used deliberately for the accommodation of this shock: how far could we go in investing in education, also considering the market and growth? The conclusion was that the economy would come out of the recession, so it was a good idea to invest in education. We hoped that having good-quality schools, infrastructure, healthy and good school meals for people in need, textbooks for everyone (to be borrowed for those who couldn't pay), PCs, etc., would help reduce inequality".*

The Netherlands seems to be the country most representative of the welfare regime it belongs to. Families' main responsibility for bringing up children is strongly emphasised in Dutch policy documents. There is no explicit aim to reduce social inequalities in health, but there is recognition that disadvantaged groups may need extra support. One of the policy makers emphasised that the social security system also aims at reaching disadvantaged groups:

*"Reducing social inequalities is part of what we want to do. As long as you don't label it health inequalities, we can still work out policies to reduce social inequalities. The health system for children and families is very good and reaches more or less the whole population".*

Health inequalities really are a so-called "wicked" political issue: there are no clear-cut "correct" solutions to the problem, and it is a highly politicised issue. Based on their traditions, social-democratic parties will support policies to reduce social inequalities, while conservative governments seldom



have this issue high on their political agenda (Navarro, Shi 2001, Navarro *et al.* 2003a, Navarro *et al.* 2003b).

In England the wickedness of the problem has been quite visible. After the Conservative regime of Margaret Thatcher, social inequalities increased dramatically in the UK and hit poor families with children particularly hard. The first Labour government saw the improvement of living conditions for these groups as one of their most important tasks when they came into office in 1997. This is the background for the strong efforts to reduce health inequalities in the UK. The new conservative/liberal government has been arguing against strong government interference in their public health paper (Secretary of State for Health 2010). However, the government has also given explicit support to the Marmot Review and is referring to this in the paper on public health. One of the policy makers commented as follows:

*“The new government is still supporting the wider social agenda. It is important that it is a coalition government, but even within the Conservative party there are different voices.*

*At the moment we are in a state of flux, we don't really know where we are going. The work done by Marmot and others still remains a challenge. Also there is the economic recession which has led to a process of reforming the public sector.*

*It is important how the concept of 'proportionate universalism' is understood. And what is 'social justice and fairness'? These are concepts that can be understood differently”.*

In the Netherlands a conservative government has been in office throughout recent years. The problem of inequalities has held no high priority in this period and the term inequality has not been mentioned in recent political documents. The strategies are mainly interventions to adopt healthy lifestyles. However, in the interviews policy makers emphasised that even if there has been a shift of political rhetoric parallel to the shift of government, this is not reflected in changes of policies, for example youth policy:

*“Youth policy is not so different with the new government. The rhetoric changes, but not the policies so much. The new government emphasises people's responsibility for their own health. The former minister sent out the suggestion for the new youth policy, the new government adopted it”.*

Sweden has also taken a conservative turn, and even if the policies of the government build on the Swedish model of welfare, the focus on the social determi-

nants of health applied by the former social-democratic government has been adjusted and the policies have been more clearly aimed at changing individual lifestyles. The issue of social inequalities is not mentioned in recent policy documents. This change also has implications, according to the policy makers:

*“Social inequalities in health have limited political attention. The rhetoric is about creating equal conditions for health, but not on creating equalities in health. This is a political area, and the knowledge is politicised”.*

As a former socialist country, Slovenia had a good social security net. In many of the other eastern-European countries the security nets have been replaced by market-oriented healthcare solutions based on individual insurance schemes, while social services and job security have been reduced. Slovenia seems to have moved in a different direction than these countries, by aiming to build up a comprehensive welfare state, more similar to the social-democratic welfare regime. There was a social-democratic government in office until September 2011, at which time they had to leave office as a consequence of a vote in parliament. A new election was held in December 2011, and the social-democratic coalition again got a majority.

Policies to reduce social inequalities in health and level-up the social gradient in health vary across the four countries. To some extent the policies reflect the different welfare regimes the country belongs to, but the policies also seem to reflect the current political situation. In the following section we discuss the situation in the four countries in more depth, and also draw some conclusions from the study.

## **2.7 DISCUSSION AND CONCLUSIONS**

As shown in the overview of the different countries, the steepness of the gradient varies between the countries, and there are also differences between the countries regarding living conditions and quality of life in families with children. Slovenia and Sweden show the flattest gradients, while England (UK) shows the steepest. The data confirm that social differences in a country are reflected in the quality of life of its citizens. Slovenia has relatively small differences in health and well-being between social groups. Slovenia is an interesting case, as it is not a part of the typology developed by Esping-Andersen (1990). In terms of GDP Slovenia is the poorest country of the four included in this study. Still, there are smaller social differences in Slovenia than in both the Netherlands and England (UK). Furthermore, the child mortality rate is lower than in the Netherlands and England (UK),

and there are lower poverty rates. There are also smaller differences in social status concerning life satisfaction and lower levels of financial stress.

The statistics show that Slovenian single parents experience less financial stress than those of the Netherlands and England. The study on single mothers also shows that even if single mothers are in a more difficult life situation than couple parents, welfare arrangements like reasonable day-care and transfers at least partly compensate for the difficult life situation for this group.

The document and interview studies show that Slovenia has universal and comprehensive policies in place for families with children, and that family policy is a priority area. There is also an explicit aim to reduce social inequalities in health and the social gradient. The strong emphasis on family policy dates back to the Yugoslavian socialist era, and was also given high priority when Slovenia became an independent country. As such, Slovenia seems to be included in a social-democratic welfare style.

Slovenia and Sweden have developed universal, redistributive policies aimed at children and families, and these policies may contribute to leveling the social gradient. Marmot (2010) states that actions must be universal, but with a scale and an intensity that is proportionate to the level of disadvantage, so-called “proportionate universalism”. Together with Sweden, Slovenia applies the principle of proportionate universalism in policies aimed at families with children. The present study thus confirms Marmot’s statement that proportionate universalism should be the basic principle for distribution, in order to level-up the social gradient in health.

Both Slovenia and Sweden also have generous family policies in place. Research shows that welfare policies aiming to provide children and their families with a decent standard of living and schools of good quality (among other things) contribute to child health and well-being (Lundberg 2009).

In addition to belonging to a particular welfare regime, the current political makeup of governments in the countries also seems to influence how issues of social inequalities are addressed. It seems that social-democratic governments are taking the issue of social inequality much more seriously than conservative governments, independent of the welfare regime the country belongs to. During the Labour government period until 2010, the UK had reducing health inequalities among families with children as its highest priority. Even though the current Conservative/Liberal government publicly supports agenda, policy changes indicate that the issue has a lower priority. Local governments are provided with the main responsibility for the public health policy, but without strong national support. There are also severe cutbacks in service provisions, also for families with children. In the Netherlands and Sweden present conservative governments do not

use the expression “health inequalities” in the description of their policies. Even though welfare policies for children and families are still in place, these are not seen as a part of a policy to reduce social inequities. In this regard Slovenia stands out: at the moment Slovenia is the only country among the four where there is an explicit political aim to reduce the social gradient in health. This is an explicit aim of the social-democratic government.

The results thus support the findings from Navarro and colleagues who indicate that political traditions more committed to redistributive policies, such as the social-democratic parties, are generally more successful in improving the health of the populations and reducing social inequalities in health (Navarro and Shi 2001, Navarro *et al.* 2003a, Navarro *et al.* 2003b).

The main aim of this project was to study how the balance between welfare state regimes and national politics plays out in policies aimed at families with children. It definitely seems that both are important, but that particularly countries with policy structures reflecting the social-democratic welfare state regime are more sustainable to political changes and cutbacks in welfare arrangements, particularly concerning families with children. A vital point seems to be the fact that family policies are a fundamental part of these regimes. Policies such as generous parental leave and affordable good-quality childcare represents support to dual earner families in general, but also provide single parents with a security net that prevents them from falling into poverty. The key message of this chapter is thus that policies aiming to reduce social inequalities and level the social gradient in health are an investment in the future and can contribute to securing the health and well-being of families with children from all socio-economic groups.

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## **CHAPTER 3**

Examples of Policies and Interventions  
to Address the Health Gradient





## CHAPTER 3

### **EXAMPLES OF POLICIES AND INTERVENTIONS TO ADDRESS THE HEALTH GRADIENT**

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The previous chapter investigated different types of welfare regimes and how they impact on inequalities. This chapter will provide examples of more specific policies and interventions that can have an effect on levelling-up the health gradient among children and young people. While the evidence base of what works is thin, enough is known through cross-country comparisons and evaluated initiatives to guide action. The chapter will first look at social protection policies such as those aiming to stimulate maternal employment and provide quality early childcare. Given the strong correlations between levels of education and health, the chapter will also highlight what can be done to improve equity in educational outcomes across social groups, and to stem early school leaving.

The discussions will then turn to health system interventions, focusing primarily on what kinds of promotion and prevention activities can be effective in levelling-up the health gradient among children and young people. Some of the limited evidence that is available about the impacts of population-wide health interventions across the social gradient indicates that they may be least effective for lower socio-economic groups. This means that such interventions could contribute to even steeper socio-economic gradients in health. The chapter will investigate what can be done about this, and how to ensure greater uptake across the whole gradient. The final section will discuss how successful approaches to level-up the gradient in health include a combination of universal and targeted approaches.

### 3.1 EVIDENCE ON MEASURES TO REDUCE THE SOCIO-ECONOMIC GRADIENT IN HEALTH

Despite the fact that much is known about how to address health inequalities, there is very little evidence on what actions are effective in levelling-up health gradients in general and among children and young people in particular (Bambra *et al.* 2010; Schrijvers, Storm 2009; Oliver *et al.* 2008).

However, much was learnt through the Marmot Review in the UK (2010), which is the most comprehensive effort to-date to review evidence regarding policies and interventions to address the socio-economic gradient in health. Their major task was to assemble the evidence and to advise the UK government on the development of a new Health Inequalities Strategy. The evidence relied heavily on the scientific literature, and engaged a wide range of stakeholders to learn from their insights and experience. A specific group Task Force reviewing the evidence on education and early years (Dyson *et al.* 2010) emphasised that measures have to embrace not only those directly targeted at children, but also those which support families, communities and neighbourhoods. In this way, measures to create employment, raise minimum wages, promote community cohesion and educate adults are as much a part of children's policy as policies on assessment in school, or child protection standards in childcare.

The Task Force confirmed that there is very little evidence of what is effective to tackle the socio-economic gradient in health among children and young people. From the available evidence, it seems that improving housing and reducing speed limits are likely to have a strong impact on reducing health inequalities, since the latter will impact on the single most important cause of death amongst children in England. The Task Force stressed, however, that improving children's lives is a matter of developing a co-ordinated approach across a wide range of policy domains. There are no 'quick win' solutions, and the positive outcomes of policies, such as the implementation of early child development programmes, could take a long time to manifest themselves. It concluded that most policy tools that are needed are already there, and future development of policy has to focus on how existing tools are used, rather than developing new ones.

In essence, improving the quality of life and health outcomes for children and young people can only be achieved by enhancing the quality of their environments, particularly their family environment and the communities in which they live. The general conclusions of the Marmot Review on what kinds of policies and measures are needed to address the socio-economic gradient in health therefore apply to initiatives focusing specifically on children and young people as well:

- *Policies to tackle health inequalities must focus on the wider determinants of health:* inequalities in early child development, education, employment and working conditions, housing and neighbourhood conditions, standards of living, and, more generally, the freedom to benefit equally from society.
- *Policies, delivery systems and targets should tackle inequalities along the whole social gradient, rather than focusing on specific segments of it:* the emphasis has been either on downstream actions that affect only a small proportion of individuals, or on approaches that have a socially neutral impact at best.
- *Policies need to be cross cutting at national and local level and cut across organisational boundaries at all levels:* too often action has been limited by organisational boundaries and silos.
- *Policies need to have longer time horizons and adequate funding for those time periods.*
- *Policies need scale and intensity.* Small-scale isolated projects cannot make sufficient impact, however effective they may be at a small scale.

The following sections will discuss examples of actions that can be taken within social policy and social protection systems, health systems and education systems, which contribute to levelling the socio-economic gradient in health among children and young people. These discussions are consistent with the Marmot Review's recommendations on the need for large-scale, long-term and holistic approaches to generating more equity in health and life chances for children and young people across the socio-economic gradient.

### **3.2 SOCIAL PROTECTION POLICIES TO REDUCE SOCIO-ECONOMIC GRADIENTS IN HEALTH AMONG CHILDREN AND YOUNG PEOPLE**

A key strategy to reducing the health gradient among children and young people is the need to improve living standards and conditions for those in relatively lower socio-economic groups. Social policies and social protection systems are central to this, since they redistribute resources and therefore reduce socio-economic differences between different segments of society, as we have seen in Chapter 2. Governments can undertake active labour market interventions to promote employment and increase the earnings and capacities of workers through (re)training initiatives to ensure that at the very least they earn a minimum income for healthy living. They can also provide social assistance through child benefits, income support benefits and/or support to those who are unemployed or who are disabled, as well as the working poor. In addition, governments manage health insurance schemes to ensure that everyone has access to health services. They are also responsible for education systems and determine the scale and quality of the provision of early childcare services. These are all areas where governments can take measures to ensure greater equity among children and young people and their families.

Social protection systems are important in safeguarding a certain standard of living, and preventing people from falling below the poverty line. However, the levels and types of social protection offered by governments in different member states vary. Table 1 provides an overview of indicators of determinants and policies which are relevant to social inequalities in families with children, and which may have a subsequent impact on health inequalities. These figures on child poverty rates, poverty rates amongst single mothers and the numbers of early school leavers across the member states covered in the GRADIENT project illustrate how diverse policies and structures in these countries lead to different social outcomes.

Table 1: Indicators of social determinants of health

INDICATOR	COUNTRY										
	Belgium	Czech Republic	Germany	Iceland	Netherlands	Norway	Slovenia	Spain	Sweden	United Kingdom	
<b>Gini coefficient 2010</b> <sup>a</sup>	26.6	24.9	29.3	25.7	25.5	23.6	23.8	33.9	24.1	33.0	
<b>Female employment rates (15-64 y) 2010</b> <sup>b</sup>	56.5	56.3	66.1	76.2	69.3	73.3	62.6	52.3	70.3	64.6	
<b>GDP per capita in PPS Index (EU27=100)</b> <sup>b</sup>	119	80	118	111	133	181	85	100	123	112	
<b>Early leavers from education and training (at most a lower secondary education)</b> <sup>c</sup>	Male	12.8	5.5	11.5	25.2	13.1	21.8	72*	37.4	11.9	17.0
	Female	9.3	5.2	10.7	17.5	8.6	13.4	32*	24.7	9.5	14.5
<b>Infant mortality (deaths per 1000 live births in 2008)</b> <sup>c</sup>	3.7	2.8	3.5	2.5	3.8	2.7	2.4	3.3	2.5	4.6	
<b>At-risk-of-poverty rates - children 0-17 (60% of median inc)</b> <sup>d</sup>	17	13	15	11	13	10	12	24	13	23	
<b>At risk of poverty (60% of median inc) after social transfers, total population</b> <sup>d</sup>	14.6	9.0	15.6	9.8	10.3	11.2	12.7	20.7	12.9	17.1	
<b>Relative poverty rates - total population (50% of median inc)</b> <sup>e</sup>	8.1	5.8	9.5		6.3	7.1	7.1	14.1	5.60	11.2	
<b>Relative poverty rates - children (50% of median inc)</b> <sup>e</sup>	7.2	10.3	11.9		9.2	5.3	5.5	17.3	4.7	13.0	
<b>% Children living in single mother families</b> <sup>e</sup>	10.3	12.6	16.5 (2004)		9.3	14.7	9.4	7.2	18.0	22.5	
<b>Children poverty rates - single mother families (50% of median inc)</b> <sup>e</sup>	28.1	34.5	53.6		22.8	14.8	22.3	29.7	10.4	29.1	

a Eurostat: <http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=en&pcode=tessi190&plugin=0>

b Eurostat homepage: <http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&plugin=1&language=en&pcode=tec00114>

c Eurostat Yearbook 2011

d [http://epp.eurostat.ec.europa.eu/cache/ITY\\_OFFPUB/KS-SF-10-009/EN/KS-SF-10-009-EN.PDF](http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-10-009/EN/KS-SF-10-009-EN.PDF)

e LIS (2010) key figures inequality and poverty, waves V-VI-VII. Belgium 2000 V; Czech Republic 2004 VI; Germany 2007 VII; Netherlands 2004 VI; Norway 2004 VI; Slovenia 2004 VI; Spain 2004 VI; Sweden 2005 VI; United Kingdom 2004 VI



Table 2 demonstrates the extent to which social transfers other than pensions, namely family benefits, unemployment benefits, social assistance and disability allowances, reduce the at-risk-of-poverty rates for children. We see that in several EU countries, family benefits reduce the risk of poverty of children by 36 per cent or more (up to 49 per cent in Austria), and by 26-32 per cent in the Czech Republic, Germany, Estonia, France and Luxembourg. Social transfers are lowest, and therefore have the least impact on child poverty in the southern-European states, namely Spain, Greece and to a certain extent Portugal and Italy. It should be noted that these figures do not take into account other public spending that can also impact on the situation of children and on their risk of poverty, such as tax credits related to the presence of children in the household, housing benefits, and the availability of free or subsidized early child development programmes and pre-primary schooling.

Table 2: Children at risk of poverty before and after transfers (excluding pensions), and after family benefits (% EU25 2005)<sup>31</sup>

Country	At-risk-of-poverty rate before transfers (excl. pensions)	At-risk-of-poverty rate after family benefits	At-risk-of-poverty rate	Impact of all transfers	Of which impact of family transfers
CY	21	16	13	36%	24%
EL	23	22	21	9%	2%
DK	25	21	10	60%	18%
NL	28	23	16	42%	19%
SI	28	17	12	57%	39%
ES	29	28	25	14%	2%
SK	30	23	19	37%	24%
MT	30	24	22	27%	19%
DE	31	21	15	53%	31%
LV	31	25	22	29%	19%
FI	32	19	11	66%	40%
EE	32	23	22	32%	28%
IT	31	27	24	23%	14%
PT	31	27	24	23%	12%
BE	34	26	19	45%	22%
CZ	34	24	17	49%	30%
LT	35	30	28	21%	13%
FR	34	25	15	57%	26%
LU	36	24	21	42%	32%
SE	35	21	9	73%	39%
AT	37	19	16	57%	49%
PL	39	35	29	25%	10%
IE	40	31	23	43%	23%
UK	42	34	21	49%	18%
HU	45	29	21	53%	36%

31 EU-SILC (2005)

As discussed in Chapter 1, the early years of a person's life are very sensitive, and what happens during these years can have strong implications on the rest of that person's later life. Social systems must therefore place a strong emphasis on family policies that support parents' capacity to care for their children. Income and job security are, for example, a precondition of positive parenting. A recent report from the OECD (2011) notes that social protection systems in OECD countries, including many EU member states, have since the late 1990s and early 2000s become less effective at reducing high levels of market income inequalities, and that inequalities are therefore generally on the rise in these countries.

While secure income is very important for a family's well-being, it should not be the only focus of policies aiming to improve the welfare of children and young people – particularly those in socio-economically vulnerable families. Esping-Andersen (2007) believes that "income support is a necessary but in itself insufficient strategy". He states that "a policy based exclusively on income distribution will probably fail if parental time dedication and cognitive stimulus are not addressed as key mechanism behind social inheritance and unequal outcome". It is therefore important to put in place policies and programmes that improve families' abilities to nurture and stimulate the development of their children. This could be through the provision of targeted programmes to help improve parental mental health and parenting skills, through community centre settings or through home visits.

### **3.3 THE IMPORTANCE OF "MAMA WORKING" AND THE PROVISION OF GOOD QUALITY CHILDCARE**

Esping-Andersen (2007) points to a less direct but more powerful way to improve families' income levels and reduce dependency on redistributive systems, while at the same time enhancing parents' 'cultural capital' –ability to promote the development of their children. This can be achieved through policies that stimulate maternal employment, particularly amongst lower socio-economic groups. He argues that in contemporary European societies, it is mostly well-educated mothers in high socio-economic groups that are in paid employment. Less well-educated mothers tend to stay at home and be housewives. Families with only one wage earner, however, are much more prone to insecurity. As highlighted in the last chapter, lone mothers are in the most precarious situation of all. Therefore, if mothers work, it raises the level of the family income.

A consequence of 'mama working' is that it reduces the time that mothers have available to spend with their children. Mothers with lower levels of education, however, tend to have more children than their better-

educated counterparts, and to spend less quality time with them in activities that stimulate their development. Any active labour market policy to enhance maternal employment must therefore be paired with provision of high quality day-care centres, with subsidised fees that are based on ability to pay. Early intervention programmes that include strong behavioural and cognitive stimulus could help cancel-out the stimulus gap that some children may suffer. Such programmes would therefore be very effective in equalising educational outcomes, especially to the advantage of the most at risk.

This is supported by the EC Communication on Early Childhood Education, which states that universally available high-quality early childhood education and care (ECEC) can close the gap in social development and numeracy and literacy achievement between children from socially advantaged and disadvantaged backgrounds. ECEC can therefore break the cycle of low achievement and disengagement that often leads to school drop-out and to the transmission of poverty from one generation to the next (EC Education Executive Agency 2011). The Communication quotes research from the USA, which shows that the beneficial impact of ECEC on children from poor families is twice as high as for those from a more advantaged background (Barnett 2004). The Communication also states that the benefits of ECEC extend far up the income ladder beyond poverty, and it can help address a number of educational problems in a more lasting and cost-efficient way than later interventions in all groups of people (Barnett 2010).

Esping-Andersen calculates that the costs of providing maternity leave coverage for a year and early childcare is cancelled out by income taxes raised when mothers continue employment. Another strong benefit to children from this scenario is that when women's income levels increase, their negotiating power in the home appears to become stronger, as fathers become more involved in housework and dedicate more time to their children. Esping-Andersen found, using Danish data, that for every €100 addition to the mother's relative wage, the father contributes an additional 24 minutes of childcare – allowing for virtually symmetrical substitution.

Esping-Andersen holds that the probability of child poverty drops by a factor of three or even four when mothers are employed. The effect is potentially strongest in lone-parent families. In Denmark, for example, the lone mother activity rate is about 80 per cent while in the UK it is only 35 per cent. Poverty rates among lone mothers are unsurprisingly much higher in the UK.

Rather than focusing on passive forms of supplementing incomes and providing family benefits, governments should therefore focus on active labour policies to stimulate employment and women's participation in the

workforce, and on providing high-quality childcare with subsidised fees based on ability to pay.

Table 3: Employment, childcare arrangements and public spending<sup>32</sup>

	<b>Slovenia</b>	<b>Sweden</b>	<b>UK</b>	<b>EU27</b>
Women in full and part-time work (%) 2008	64.2	71.8	65.8	59.1
Women working part-time (%) 2008	11.4	41.4	41.8	31.1
Children 0-3 years age in care (%)	35	48	30	35
Children 3 - compulsory school age in care, between 1 and 29 hours a week (%) in 2008***	4 <sup>UD</sup>	18	31	15
Children 3 - compulsory school age in care, 30 hours and more a week (%) in 2008***	27	30	4 <sup>UD</sup>	13
Number of months of maternity/paternity/parental leave with benefits replacing at least 2/3 of salary (2008)***	12	18.5	1.5	28
Compulsory school age ****	6	7	5	
Public spending on pre-primary education (% of GDP)*****	0.5	0.4	0.2	0.44

UD Unreliable Data

\* Eurostat (2008)

\*\* Eurostat (n.d.)

\*\*\* EU-SILC, Formal childcare by age group and duration (% over the population of each age group) (2009)

\*\*\*\* EU-SILC (2010)

\*\*\*\*\* Platenga, Remery 2009; Plantega *et al.* 2004

\*\*\*\*\*OECD (2005)

32 Habbig (2010)

Table 4: Quality of Childcare<sup>33</sup>

	Slovenia	Sweden	UK
Child/staff ratio*	9.6:1	5.1:1	3:1 (0-2 years) 4:1 (4 years) 8:1 (3-7 years)
80% of all childcare staff trained**	Yes	Yes	Yes
50% of all staff with tertiary education with relevant qualification**	Yes	Yes	No

\* Platenga & Remery (2009)

\*\* UNICEF (2008). Data for UK only refer to England.

Table 3 provides information relating to early childcare in three EU countries (UK, Sweden and Slovenia) that participated in GRADIENT. It illustrates that policies encouraging maternal employment in EU member states vary, which influences the numbers of mothers working (Habbig 2010). It is evident that the countries with higher levels of children under the age of three in childcare for more than 30 hours a week, and which spend more on pre-primary education, also have higher rates of female full-time employment. It is however important to ensure that the quality of childcare is of a high standard. In practice, it appears to vary, as reflected by ratios of children per staff member and the number of trained staff (Table 4). In failing to provide quality childcare, to optimise maternal employment and enabling mothers to strike good work-life balances, governments are jeopardising the welfare of children – particularly those in lower socio-economic groups and losing critical opportunities to improve their health, their well-being, and their future life chances.

### 3.4 EXAMPLES OF EDUCATIONAL INTERVENTIONS TO REDUCE GRADIENTS IN HEALTH AMONG CHILDREN AND YOUNG PEOPLE

Another example of policies and interventions that have the potential to level-up the socio-economic gradient in health among children and young people are those that are related to education. As discussed in Chapter 1,

33 Habbig (2010)

there is a strong correlation between educational status and health status. Evidence shows that adults with higher levels of education tend to live longer, enjoy better physical and mental health, and have healthier lifestyles than adults with lower educational status. One explanation for this relationship is that the higher the level of education an individual attains, the higher their level of income. This affects where they stand in the social hierarchy, which in turn establishes the nature of other social, economic and environmental factors affecting their lives and their health. A good education can also empower individuals to make healthier choices. These relationships have led to the assertion that “when educational systems function, they are the best health care delivery systems in the world” (Kropf, O’Toole 2010).

Yet just as socio-economic status is correlated to health status, so too is it correlated to educational outcomes. Despite years - in some countries generations - of initiatives and reforms, it remains the case that social background and educational outcomes are inextricably linked (Dyson *et al.* 2010). It can be argued that education systems in EU member states continue to reproduce or even exacerbate social inequalities.

Equity issues in school systems manifest themselves in the form of (amongst other things) early school leaving, gaps in outcomes between more or less disadvantaged learners, problems relating to access to education, and stresses and strains in schools serving disadvantaged populations. As such, they are a growing concern for school systems, which nevertheless find it very difficult to address them. This is because patterns of inequality in development and in cognitive abilities begin to manifest themselves very early on in children’s lives. By the time children reach formal schooling it is already late to begin redressing the consequences of an unequal start. Traditionally organised education systems rely heavily on the cognitive and cultural resources that learners bring with them from their home backgrounds. The efforts of educational systems to ‘compensate’ for the supposed absence of such resources have tended to be weak, and to have underestimated the barriers which some learners experience in these systems (Dyson 2012).

There are concrete measures that schools can take to avoid exacerbating inequalities in educational and therefore health outcomes. The OECD identified from the Programme for International Student Assessment (PISA) Studies those factors that tend to promote equity (OECD 2008), while UNESCO has long been advocating ‘inclusive’ approaches to education in order to reduce the marginalisation of disadvantaged groups (UNESCO 2009). Both bodies have come to the conclusion that an important measure that governments and schools must take to ensure greater equity is to not treat all students equally: schools in less privileged areas should receive extra resources to

meet their greater needs and children and young people from low-income and poor families should receive extra support. In addition, schools and classrooms should avoid segregating students in the same school year according to their capacities, as this only exacerbates inequalities.

### **Early school leaving: a European perspective**

There are some periods in children and youth's lives that are particularly important. One of these moments is the age of 15-18, during the final years of secondary schooling.

Many 15-18 years old Europeans in the EU lead unhealthy lifestyles. This is particularly the case amongst those who are neither in education nor in work (EC 2010). Not being in education, employment or training between these ages is a major predictor of later unemployment, low income, teenage motherhood, depression and poor physical health (Moving Project 2009). Given the close correlation between education and health, it is important to encourage young people to complete their education and develop healthier lifestyles.

Despite the fact that many efforts are being made to stem early school leaving in the EU, rates are still high. Austria, the Czech Republic, Finland, Lithuania, Poland, Slovakia and Slovenia have already achieved the 2020 targets on EU on early school leaving (ESL), which is ten per cent. This is in contrast to Malta, Portugal and Spain, where rates are higher than 30 per cent. Looking at the relative performance of member states, there are reasons for optimism, although the picture is quite varied across EU countries. All but three (Finland, Spain, Sweden) have reduced their rates of ESL since 2000. Countries like Romania, Malta, Italy, Cyprus and Portugal have achieved significant relative reductions since 2000, although they are still far from the Euro2020 target. Countries like Luxembourg, the Netherlands, Lithuania and Poland which already had low rates of ESL also showed considerable progress. The strong progress of some member states in reducing ESL shows that achieving the benchmark is possible, but that reinforced efforts are needed (EC 2010).

Despite this progress, around six million young people in the EU are currently leaving school with lower secondary education or less (EC 2011). Over 70 per cent of these early school leavers only complete lower secondary education, while 18 per cent only have a primary school education (EC 2010).

The reasons for leaving school are diverse. They can be linked to drug use or other health-related matters. The underlying causes, however, are often related to socio-economic status, as young people from lower socio-economic backgrounds are most likely to be early school leavers (Laflamme *et al.* 2009, Suhrcke, Paz 2011). Their educational disadvantage starts early, and discouraged and disheartened by educational systems, they leave before finishing secondary school. These young people are at serious risk of falling into poverty and of becoming socially excluded, as well as of passing on disadvantage to their children (EC 2011).

In order to make a real impact on equity in educational outcomes and on early school leaving, educational system improvements like those mentioned above must be coupled with strategies to tackle the factors beyond the school that impact on learners' access and achievements. The most effective strategy that governments can take to stem early school leaving is to invest in quality early child development programmes to improve children chances at the earliest possible stage of education. Once formal education begins, schools should collaborate with other actors and sectors to provide vulnerable students with the support that they need in different aspects of their lives which impact on their learning capacities. The case studies presented below are examples of what can be done to help vulnerable young people that are at risk of becoming early school leavers. The Dutch M@ZL project shows how schools can pair up with youth health care physicians to identify and help manage any underlying problems that are manifesting themselves in educational failure. The intervention in Värmdö is a local example of the Swedish national early school leaving policy, and demonstrates how education systems can collaborate with municipal counsellors and private sector actors to provide young people with additional opportunities and the motivation to continue their studies.

### **The Dutch policy and M@ZL project**

In the Netherlands a law exists on school leaving and truancy. According to this Dutch law, all students under the age of 18 are obliged to be in a programme of study with mandatory attendance. If a student has over 16 class hours of absence within any consecu-



tive four-week period of the school year, they are reported to the Truancy Board. Absence due to health problems is seen as excused absence and is not included in this law. Over the last few years the number of health-related school absence in the Netherlands has risen. The reasons for this are not clear. The M@ZL project was developed to tackle health related school absence. It approaches early school leaving from a different point of view. Instead of truancy, the project focusses on the reasons for absence and provides guidance to students who are often absent.

The M@ZL project has been developed in close partnership with youth health care services, secondary school boards and the municipal education attendance service. Project partners share the same goal of reducing school absence related to medical reasons and preventing early school leaving, thereby optimising children's future chances of fully participating in society. This is done by providing guidance. Students from secondary schools which have implemented M@ZL are checked by a youth health care physician when they miss a substantial number of schooldays due to illness. Whilst each school establishes its own criteria for this, the consultation is compulsory. In cases where a student misses an appointment with the physician, the school attendance officer takes further action.

The guidance consists of a consultation session involving the youth health care physician, the student and his or her parents to identify any underlying problems. If needed, the youth health care physician may refer the student to a medical specialist or a psycho-social support network. In addition, the youth health care physician gives advice to the student, his parents and the school regarding how to improve the students' health and well-being and maximise participation in school activities. Before the implementation of M@ZL, it was difficult for participating schools and youth health care physicians to put a limit to medical school absence and to provide these youth with adequate care and support. The project provides a legal framework in which the health care physician can operate. Currently, 12 schools in the city of Breda (the project pilot area) have implemented M@ZL in their school policy. The project is currently undergoing an evaluation with preliminary results showing that at the individual level, absenteeism amongst students who received guidance through the M@ZL project declined by two-thirds after four months. At the level of the entire school population, including

the core healthy pupils who are hardly ever sick, average rates of absenteeism declined from 8 days before M@ZL to 6.9 days per month with M@ZL; a decrease of 13 per cent (Landelijk Platform Onderwijs en Jeugdzorg 2010).

### **The Swedish policy**

The national policy on early school leaving in Sweden is that the municipality where the person lives must keep track of all individuals who are below the age of 20 and do not have any occupation (such as studying or working), and offer appropriate individual measures. Most early school leavers in Sweden do so in the third year of upper secondary school. Nearly every third young person has incomplete grades from the upper secondary school (they are thus not qualified for higher education). Immigrant background and socio-economic status have a large impact. Nearly half of all students with parents with low educational qualifications and with foreign backgrounds finish their studies with incomplete grades from upper secondary school. Students whose parents have low educational qualifications are also more likely to drop out during the first years, while students with more highly educated parents continue for 3-4 years before they leave upper secondary school with incomplete grades. Men are more likely to be early school leavers than women.

Värmdö is an example of a municipality in Stockholm where the share of students who are not qualified for higher education is high (Skolverket 2008). It is a local example of the Swedish policy on early school leaving. Here, GRADIENT participants interviewed a municipal counsellor and a student about the policy. The municipal counsellor guides students who have left or are in the process of leaving high school. Early school leavers are contacted by the counsellor after they have left school. The counsellor helps students to find a work placement, and the student continues to receive normal study grants. During this process the counsellor puts the student at the centre of the action in order to achieve what is best for him/her. Furthermore, the counsellor presents the negative consequences of early school leaving to the adolescent. They hope to show that “dropping-out” does not imply that you get a lot of free time to spend

with friends. The amount of contact with the student depends on the needs of the individual. The counsellor must also provide support to the employee responsible for mentoring the adolescent during the work placement and it is the duty of the mentor to ensure that early school leavers feel valued during their placement.

Among the main causes of early school leaving reported by the municipal counsellor are problems or no tradition of study at home. Sometimes it seems that students have no realistic goals or simply no goals at all. According to the counsellor, in cases like these, adolescents chase grades without understanding how the knowledge they gain will benefit them later in life, as a result of a lack of knowledge of the labour market. Furthermore, the counsellor believed that there are also early school leavers who are not prepared for the next step at school, having previously found it easy and not feeling challenged. As a result they have never learned to study and lack basic knowledge and study techniques. Additionally, young people may leave school because they lack energy and motivation and because they are not happy at school or with themselves.

Although there is pressure upon adolescents to stay in school, the counsellor believes that it is not advisable to keep adolescents in school in every circumstance. As mentioned, it can be beneficial for adolescents to meet new adults other than school staff and parents. According to the counsellor it may sometimes even be better to advise an adolescent to stop school, to take a break and instead do a placement or find a job. This can allow them to gain insight into the 'real' world, which would help them to get a realistic view on the labour market. This can help to re-motivate the early school leaver.

### **3.5 EXAMPLES OF HEALTH SYSTEM INTERVENTIONS TO REDUCE THE HEALTH GRADIENT AMONG CHILDREN, YOUNG PEOPLE AND FAMILIES**

In addition to the redistributive, employment, early childcare and education policies described above, health policies can also be effective in level-ing-up the health gradient among children and young people. Generally, this means ensuring that all segments of the population benefit from the health services that are available to them. In fact, geographical, financial, legal or socio-cultural barriers impede many people from receiving good health services. The burden of payment for health care is a growing concern amongst socially and economically vulnerable people, and there is clear

evidence that “the availability of good medical care tends to vary inversely with the need for it in the population served” (Dahlgren, Whitehead 2007). Studies show higher crude utilisation rates of primary health care (i.e. utilisation rates without taking into account disease burden) by people from lower socio-economic groups than people from higher socio-economic groups, who tend to visit specialists more frequently. However, when taking into account the higher morbidity of people from the lower social classes, the difference in public health care utilisation between higher and lower social classes seems to melt away, while specialist care still seems to favour the better off (Regidor *et al.* 2008, Droomers, Westert 2004, Veugelers, Yip 2003).

There are a wide range of primary care and public health and health-promotion interventions that could have an effect on improving the health of children and young people in lower socio-economic groups. Mielk, Graham and Bremberg (2002) identified 47 interventions aimed at children, adolescents and families that could tackle inequalities in childhood. Most of the interventions were conducted in the UK, and focussed on accident prevention and on improving the mental health of young people and parents, thereby increasing their capacities to care for their children. Other interventions focussed on dental health, tobacco use, and on nutrition. All interventions were positively evaluated through randomised controlled trials or controlled experiments. Many interventions were delivered by professional staff working in the main settings in which children live (home and school) and highlight the contribution that both settings can play in tackling health inequalities in childhood.

The GRADIENT project aimed, in particular, to identify health-related policies and interventions that could contribute to levelling-up the socio-economic gradient in health among children and young people (Dorgelo *et al.* 2011). Few policies were found in the seven EU member states participating in this strand of GRADIENT work; three specific interventions were identified (years 2000-2010) with documented evidence on whether or not they had an impact on the socio-economic gradient in health. Even for these three interventions the documented evidence was not strong, with the exception of the KOPS intervention (see policies below).

### **Preventative oral care in Germany**

Preventative dental care is provided to all children in kindergarten and school in Germany, and involves oral health, fluoridation and sealing of teeth. Looking at different studies on oral health of the German population, the authors discuss the impact of changes in DMF-T (Decayed- Missed-Filling-Teeth – measurement of dental health) indicators on social status. As a result of the intervention the DMF-T of 12-14 year old children in Germany improved significantly between 1989-2005. Differences in DMF-T between social strata were remarkably reduced, although there was still a gradient in oral health outcomes between socio-economic groups (Frübuß, Schürer 2009).

### **The French Mother and Child Protection Programme**

The policy programme La Protection Maternelle et Infantile comprises of a set of measures that aim to protect pregnant women, mothers and children up to school age (i.e. diagnostic procedures and preparation for birth). The programme also aims to prevent preterm birth and comprises of free access to preventive examinations, provision of information, training of health professionals, lifestyle counselling and financial support. The programme was found to have an impact on the socio-economic gradient in health. The preterm birth rate in France decreased between the early 1970s and the late 1980s. After 1988 the rate increased again due to a shift in the age structure of pregnant women and an increase in the number of twin pregnancies. While the social gradient in the frequency distribution of preterm births in the population decreased, women facing financial difficulties still received fewer medical examinations during pregnancy. As a result, they also continued to face a higher risk of preterm births compared to all pregnant women; this had negative consequences for their pregnancies (Schneider 2003).

### **Kiel Obesity Prevention Study (KOPS)**

KOPS is an eight-year cohort study. From 1996-2002 children were recruited as part of health examinations by school physicians in different parts of Kiel, in north-western Germany. The intervention was conducted in three schools each year. Data obtained in these intervention schools were compared with data obtained in three socio-demographically matched reference schools. Families with overweight and obese children and/or obese parents were offered a face-to-face counselling and support programme within the family environment, as well as a structured sports programme.

The goals of the intervention were to reduce gains in weight and fat mass in children and to improve knowledge on nutrition and daily physical activity levels among children and their families. In order to achieve this, KOPS applied two different approaches. Health messages on the consumption of fruit and vegetables, reducing intake of high fat foods, keeping active at least one hour per day and decreasing TV viewing to less than one hour a day were delivered to primary school children during their first year. The children were also provided with an eight-hour course of nutrition education including 'active breaks'. In addition, families identified by a school physician as having overweight and obese children and/or obese parents were offered a counselling and support programme consisting of three to five home visits by a nutritionists.

Long-term evaluation of the school-based intervention was available over four and eight years, while the family-based intervention was evaluated over one year. The results revealed that the school-based intervention improved the weight status of children of high socio-economic status and of normal weight mothers over the long-term. Even with this individualised and family based approach, the project was not effective among children in low income families since it did not lead to a reduction in obesity among these groups (Plachta-Danielzik et al. 2008).

These examples all relate to universal interventions which aimed to improve the health and health behaviours of the general population, and reflect the difficulties in doing so in a way that effectively levels-up the socio-economic gradient in health. The first intervention - related to a universal policy to improve dental care - appears to have done so, since it was of even greater

benefit to poorer segments of the population who may not otherwise have been able to afford dental care. The second intervention might have contributed to levelling the gradient in premature births, although this appears to also be based on higher levels of premature births among the wealthier sectors of the population, due to the higher average age of the mother. This means that levelling was partially based on a 'levelling down' rather than a 'levelling-up' of the gradient, which is undesirable. The third intervention - related to a universal policy - improved the health of children in higher socio-economic groups, but was ineffective in families and children in lower socio-economic groups, and thereby contributed to an even steeper gradient in health. The latter intervention was therefore unable to address the proportionally greater needs of more vulnerable populations.

Similar tendencies in reduced uptake among lower socio-economic groups are apparent in some EU member states with respect to immunisation. Immunisation can protect individuals from diseases that might have long-term consequences (Law 2009; WHO 2010). Sweden and Slovenia have vaccination rates for three key vaccines (diphtheria, tetanus and pertussis) of 98 and 96 per cent respectively. The percentages of children vaccinated against common diseases like influenza and measles in the UK is, however, about 5-10 per cent lower than in the other two countries (WHO 2008). Inequalities in vaccination rates have also been identified within the UK. Disadvantaged children from single-parent families are immunised less frequently than children of families with a high socio-economic status (Law 2009). However, the social gradient in immunisation in the UK has flattened in the past decade. This is not related to improved vaccination rates among children from disadvantaged families, but rather to a growing reluctance among well-educated families to have their children vaccinated, which is again an example of levelling down. This shows that special efforts are needed to encourage uptake of measures that can prevent ill health that are sensitive to the needs of all socio-economic groups.

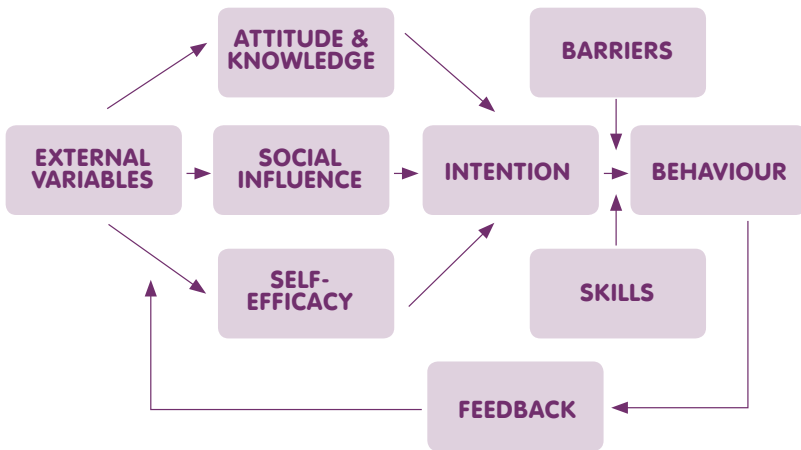
### **3.5.1. REASONS FOR DIFFERENTIAL IMPACT OF PUBLIC HEALTH AND HEALTH-PROMOTION INTERVENTIONS**

Why do interventions that aim to improve the health of more deprived groups fail to level the gradient in health, and sometimes lead to even steeper health gradients? There are strong social gradients in cigarette use, unhealthy diets and lack of exercise, which would suggest that interventions targeted at improving health-related behaviours among lower socio-economic groups could play an important role in levelling the gradient in health. Yet it is often those in higher socio-economic groups who respond

better to population-based public health and health-promotion initiatives, which appear to be less effective in improving the health of those in lower socio-economic groups.

Health professionals have for a long time been studying how best to influence the health related behaviours of individuals, as demonstrated by the model below:

Figure 1: AttitudeSocial influence-Efficacy (ASE) Mode<sup>34</sup>



The model shows how external variables (such as socio-economic circumstances, environmental conditions and social capital) shape attitudes and knowledge regarding health, exert influence and affect self-efficacy (belief that one is capable of performing in a certain manner to attain certain goals). This influences intention, which is in turn affected by external barriers and skills, and one's ability to implement the intended behaviour.



**Main outcomes of interviews with 258 ‘hard-to-reach’ individuals in the North West Region in the UK regarding their attitudes towards health and awareness of health related issues**

The North West Region in the UK has very high levels of social deprivation. In some areas, 50 per cent of the population is said to be deprived. ‘Hard-to-reach’ individuals were for the purposes of the study defined as those who did not routinely use health care systems, were economically deprived and had existing health risk factors. Of those questioned 187 were smokers, while 67 were clinically obese. The majority of those questioned thought that it was their responsibility to look after their health, and that they would not feel embarrassed to discuss conditions such as weight loss, alcohol use and smoking with their general practitioners. Nevertheless, only 16 per cent had visited a general practitioner in the past year, and those that had mainly did so for an illness certification for benefit claims or for an ill child.

Across almost all areas investigated, respondents thought that they were significantly healthier than they actually were. Of those questioned, 26 per cent were clinically obese (with a BMI of over 30) yet only seven per cent recognised that they were overweight. Approximately one-fifth of those questioned realised that they should eat more healthily in order to live to the age that they aspired to. Of those questioned, 84 per cent said that they did not really worry about their health at the moment, although over half said that they would be likely to worry about their health in the future.

The people questioned made observations relating to their health based on the people and lifestyles of those around them. For example, 56 per cent of smokers believed their health was about the same as others in their local area.

The report reflecting the interview outcomes identified some effective approaches to address this lack of uptake of public health and health-promotion interventions. Essentially, it recommended developing interventions around an understanding of the specific user groups in question and their motivations. This would entail refining the content and delivery of messages about healthy lifestyles and preventive services. It also suggests using information channels that users themselves identify as being effective, such as

television and local newspapers. This also means reshaping services to better meet the needs of the target group regarding place, time and style and ensuring that the public sector workforce is fully aware of the attitudes and preferences of harder to reach population groups and is sufficiently skilled in responding to them. (Adelphi Research 2010)

As demonstrated above, it is possible to change health behaviour, though efforts can be constrained by the social and environmental factors linked to socio-economic status. Behaviour should not therefore simply be viewed simply as a lifestyle choice. As set out earlier, the underlying causes of social deprivation and the social determinants of health must be addressed in efforts to improve health-related behaviours; this calls for comprehensive strategies.

### **3.5.2 VIEWS OF POLICY MAKERS AND POLICY USERS ON ENHANCING UPTAKE OF INTERVENTIONS**

GRADIENT participants (from Spain, the Czech Republic, Sweden and the Netherlands) interviewed policy makers as well as those affected by the policies to gain more information about how to improve the uptake and impact of policies and interventions that aim to improve health across the social gradient, and particularly among those most in need (Dorgelo *et al.* 2011). Those interviewed were involved in the projects identified in Table 5.

Table 5: Policy Selection

Policy name	Country	Aim	Implementation level			Age group					Policy effect on HI	
			National	Regional	Local	0-6 yrs	6/7-12 yrs	13-18 yrs	19-25 yrs	(Indirect target group)*	In theory	Aims for ▼ HI**
<b>Centre for Youth and Family</b>	NL	To have one place where family and youth could go with questions about education and raising children. And to collaborate between all different institutes who work with families and adolescents.	+		+	+	+	+	+	+	+	
<b>M@zi-project</b>	NL	A preventive approach to reduce drop-out rates in secondary prevocational education.		+					+		+	+
<b>Kaleidoscope</b>	NL	To enhance the development skills and chances in education (pre-school).			+	+					+	+
<b>National Youth Policy</b>	SE	To enhance the living conditions of Swedish youth.	+						+	+		+
<b>Stockholm County Public Health Policy</b>	SE	To reduce inequity in health in Stockholm County.		+	+	+	+	+	+			+
<b>A healthy school start</b>	SE	To develop a programme for parental support for healthy eating and physical activity within a school setting, effective especially among groups with low socio economic status				+	+				+	+
<b>DELTA</b>	ES	To reduce the incidence and prevalence of obesity among children and adolescent.		+				+	+			+
<b>National Programme of Health of the Czech Republic (3 interventions)</b>	CZ	To evaluate the structure and quality of Roma families and children in Ceske Budejovice, and improvement of their nutrition.	+			+	+	+			+	+

Policy makers identified numerous reasons why people in lower socio-economic groups are less likely to respond to public health and health-promotion (related) interventions. Barriers such as costs and travel distances were raised, as well as the issue of language, traditional lifestyles and eating patterns, which affected uptake amongst migrant groups and the fear of official organisations (see also Dorgelo *et al.* 2011).

Policy makers also commented on the difficulty of making user groups enthusiastic about an intervention, since they were in some cases indifferent to its objectives. User groups did not always see the need for a policy or an intervention, and therefore lacked the motivation to participate. Some of the policy makers interviewed therefore stressed the need to take into account the opinions and interests of different user groups, and of involving people from various socio-economic groups in the development and implementation of policies and interventions concerning them.

They also pointed out that information about interventions is in many cases not well communicated across all socio-economic groups. In the case of the Dutch school-based Kaleidoscope project, the parents questioned did not even realise that their children were involved in the project. Without parental involvement, however, it is very difficult to assess the benefits of specific interventions, since they are most likely to be able to identify its effects upon their children. In this respect it is also important to identify which elements of the policies or interventions would encourage specific user groups to participate, and which could act as potential barriers to uptake. Insight into the beliefs and motivations of different user groups should therefore be incorporated into the communication with them regarding a particular policy or intervention. In addition, policy makers emphasised that in order to improve uptake, it is important to develop interventions that address different facets of individuals' lives, thereby taking an integrated approach. Single, piecemeal interventions are unlikely to work.

These findings are not new. Public health and health promotion, as well as social care specialists and practitioners, have long stressed the need to consult with user groups and to involve them in development and implementation of initiatives. They have also stressed the need for a holistic, integrated approach that involves co-operation with other policy sectors. The outcomes of the interviews with policy makers and policy users, however, demonstrate that there is still insufficient attention to these factors, since they are not being implemented in practice in a consistent manner. The views, interests and needs of user groups are still lacking during the development, implementation and evaluation of interventions.

The GRADIENT project (Dorgelo *et al.* 2011) suggests going over some key questions (see checklist) when developing a policy or intervention to enhance the uptake of policies and interventions across the social gradient.

### **GRADIENT checklist to ensure policies address needs across the social gradient in health**

- ✓ What is important to user groups across the social gradient with respect to this policy? What motivation do they have to get involved and what are their attitudes towards the policy? Are particular skills needed to respond to the policy?
- ✓ Are there any possible external influencing factors, such as culture, social environment, or health of the family? Have physical abilities, mental health and financial and cultural considerations been taken into account that can influence all user groups' ability to respond to the policy?
- ✓ Are all user groups properly informed about the policy? Are practical factors addressed to motivate or facilitate uptake? (e.g., a financial incentive, advice after office hours, language, geographical issues)
- ✓ Do all user groups have a broad and realistic perspective regarding the benefits and limitations of the policy?
- ✓ Do all user groups have enough time and personal support to adapt to the policy?
- ✓ Is there a monitoring system that keeps track of how user groups across the social gradient respond to the policy?

### **3.6 CONCLUSION: THE NEED FOR HOLISTIC, UNIVERSAL AND TARGETED APPROACHES**

This chapter has provided a number of examples of policies and interventions that can contribute to levelling-up socio-economic gradients in health among children, young people and their families. Many of the examples provided, such as those relating to policies to improve maternal employment, early childhood education and care programmes, and the prevention of early school leaving, involve holistic approaches. Such holistic approaches, which address the underlying factors or the social determi-

nants of health and vulnerability are essential to making progress in levelling-up health gradients. In reality, despite awareness of the need for more integrated approaches, many governments at national, regional and local level are stimulating models of service provision that actually undermine their ability to offer effective and integrated support.

This chapter has also made reference to targeted initiatives such as health-promotion activities specifically designed to meet the needs of socially vulnerable groups. Many of these programmes are still designed from the 'top-down', and without the involvement of user groups, so they are likely to be ineffective, of insufficient scope, and potentially unsustainable. While targeted programmes have an important role to play in improving living conditions and the health of relatively disadvantaged children and young people, they must engage and take into account the specific needs of different user groups across the social gradient if they are to be effectual.

Universal policies that stimulate maternal employment, provide equal access to good quality early childcare programmes, as well as education and health care, are essential to levelling-up socio-economic gradients in health among children and young people. Such universal policies can serve to redistribute societal resources and address the underlying causes of health inequalities and help to ensure that all children, irrespective of origin, come to enjoy similar (high) standards. Nevertheless, this chapter has illustrated how universal policies can actually lead to steeper health gradients if they benefit the wealthier more than the poorer segments of society. This is because the effects of multiple disadvantage may inhibit the ability of disadvantaged families to benefit from the opportunities provided. Levelling-up the health gradient among children and young people in the EU therefore requires carefully designed universal policies that address greater proportional need with greater intensity or link fees to ability to pay. These universal policies must, where necessary, be paired with well-designed targeted interventions, developed with the involvement of user groups to ensure that those children, young people and families most in need receive additional resources and assistance.

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## **CHAPTER 4**

# Working with the Community to Improve Child Health Equity





## CHAPTER 4

### **WORKING WITH THE COMMUNITY TO IMPROVE CHILD HEALTH EQUITY**

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Earlier chapters in this book have focussed on measures to improve conditions in the environments that most directly influence children and young people, such as the households in which they are raised and the quality of the childcare and educational facilities they attend. This chapter will focus on the role of the community, and more specifically on the role of community social capital, and how this affects the health of children and young people. The literature on how to tackle health inequalities and level-up the health gradient among children and young people is largely dominated by the “deficit model” and the search for “risk factors”, and how these can be dealt with. Another approach, however, which is receiving growing attention, is to focus on “health assets” which can serve as “protective” factors for health. An assets approach builds on the strengths of individuals and communities.

This chapter focusses on the contribution of community social capital as an example of an assets approach to enhance health and flatten the health gradient. We discuss the results of new European empirical research on the protective effects of social capital on the health of young children and on the question of how community social capital can be developed and enhanced in order to reduce the health gradient among children. Although we define community social capital as a feature of the community, it depends on the actions of people. Organisations and networks are formed, organised, attract members and are maintained by people. The new research presented here was undertaken in Flanders and Iceland as part of the GRADIENT project, and reveal that investing in community organisations like sport clubs can enhance community social capital. Community social capital in the form of

trust and reciprocal interactions between community members may be an important way to level-up the gradient in young people's health.

#### **4.1 POSITIVE ASSETS TO REDUCE HEALTH INEQUALITIES**

Health assets are commonly defined as protective health factors that focus on maintaining health capacities (Salimnen 2009). Health assets can refer to individual strengths and qualities (motives, relational capacities, volition) as well environmental or community qualities (support, norms, physical characteristics) that can contribute to health (Rotegård *et al.* 2010). Health assets promote successful development, foster competence, improve peoples ability to make healthy decisions, and improve ability to solve problems and seek help when needed. In other words, health assets are factors that facilitate positive health behaviours and optimise health and wellness outcomes (Rotegård *et al.* 2010).

According to Fergus and Zimmerman (2005) health assets are complex constructs that pave the way to resilience through psychological, biological and environmental contextual processes. This means that health assets are the building blocks of resilience. Resilience refers to an individual's capability to adapt to adversities along the life course. One is not born with resilience; it is something that is obtained over time, depending on the physical and social environment one is in (Constantine *et al.* 1999). It is important to invest in health assets not only in terms of enabling individuals to adopt healthy behaviours (Rotegård *et al.* 2010) but also in terms of reducing health inequalities, and in the long run levelling-up the gradient in health. Health assets and resilience, in particular, are of particular importance for children growing up facing adversities such as poverty, social exclusion and unstable family relations.

The value of investing in health assets for reducing health inequalities is further seen with caring relationships and social involvement. Children who experience caring relationships (parents, grandparents, etc.) - in contrast to children without - are likely to experience healthy development, engage in activities, foster responsibility, have dreams and aspirations, feel meaningful by participation in society and have a greater sense of well-being. Encouraging healthy relationships as well as motivating children to engage in the community (i.e. increasing or building social capital) are therefore crucial aspects to consider when tackling health inequalities.

## 4.2 SOCIAL CAPITAL

The scientific literature on social capital and health has exploded over the last few decades. A search for “social capital and health” on the most popular public scientific database dealing with health issues, Pubmed, resulted in over 42,000 articles dealing with this topic (September 2011). Yet if you wound the clock back to circa 1996 then you would be hard-pressed to find an article in the public health literature that even mentioned this concept (Kawachi *et al.* 2008). Within this short time span, social capital has captured the public health debate and become one of the “essentially contested concepts” in the social sciences, like “class”, “race”, and “gender” (Szreter, Woolcock 2004).

Getting a grip on social capital is complex. So far, there is no single definition of social capital that everyone agrees upon; nor is there a standardised approach to measure it. This intriguing concept is basically about people and the interactions between them. Social capital is built on a solid structure of social networks, and is only the front end of complex underlying social processes. A social network is defined as “the web of social relationships that surround an individual”(Berkman, Glass 2000). People are embedded in all kinds of social configurations, like peer groups, family structures, love affairs, colleague groups, neighbourhoods, organisations, clubs, and so on. As all aspects of human life are inextricably bound within the context of social relations, every conceivable epidemiological exposure is related to social factors (Kaufman, Cooper 1999). Is social capital actually more than the connectedness between people? Yes, a lot more: social capital refers to the *functional* aspects<sup>35</sup> of social relations which have a relation with health.

### ***Two social capital schools***

Despite the lack of consensus concerning its definition, two distinct conceptualisations of social capital can be distinguished (Kawachi 2006).

- First, the “*social cohesion*” school conceptualises social capital as the resources - for example, trust, norms, exercise of sanctions, and mutual assistance - available to members of social groups (for example a work place, a school, or a community). Imagine an uncooperative, mistrusting parent that resides in a community where others are trusting and helpful toward each other. In this situation, the uncooperative parent

35 Analogous to the related concept of social support.



and his or her children may benefit from the voluntary actions from his or her neighbours – for instance by refusing to participate in the community citizen guard for playgrounds, but nonetheless benefiting from the security provided by the voluntary labour of his neighbours. Making the connection with individual health, will this isolated family, living in a lively and socially cohesive community, obtain health benefits from the community where they live, bearing in mind their individual lack of social relations? The social cohesion school emphasises are so-called “contextual” influences exerted on the individuals who live within certain contexts.

- Second, the “*network school*” conceptualises social capital as the resources - for example, instrumental support, information channels, social credentials - that are embedded within an individual’s social networks (Lin 1999). In contrast to the social cohesion school, the network approach conceptualises social capital as an individual attribute as well as a property of the collective (Kawachi *et al.* 2008). Individual social capital is sometimes conceptualised as *valued resources* that individuals can access through their social networks. These resources may be available in several domains of life (work, family, clubs) and may take the form of material goods (e.g. money), instrumental goods (e.g. information), emotional goods (e.g. affection and support), symbolic resources (e.g. prestige and influence), and so on. Another approach within the network school focusses on the *structural properties* of the group. For example, the density of a network can have a large impact on the success of certain health promoting initiatives. The diffusion of information will occur faster in denser networks. Another example is the impact of social control: social sanctioning may be particularly effective when members of the network all know one another. Some excellent introductions on these topics can be found elsewhere (Lin 1999, 2001; Luke, Harris 2007).

Both the social cohesion school and the network school have produced valuable insights for the social capital literature. One of the most important discussion points in the literature is the question of whether social capital should be considered an individual or a group attribute, referring to the level on which social capital has an influence in general (Portes 2000), and more specifically on health outcomes (Islam *et al.* 2006; Kawachi *et al.* 2004; Morrens 2008; Poortinga 2006; Subramanian, Lochner, Kawachi 2003). Are the beneficial health effects of social capital a product of the individual level or of the contextual level (i.e. are they the result of social relations between

people or of the social structure of a community)? For now, there are no consistent theoretical and empirical arguments to ascribe social capital exclusively to one or the other. To quote Lin (Lin 1999), social relations with embedded resources can be expected to be beneficial (and occasionally harmful) to both the collective and the individuals in the collective. Therefore, following Kawachi *et al.* (2004), our provisional point of view is that it is both.

### ***Bonding & bridging social capital***

Apart from the social cohesion school of social capital or the network school, there exists a broad consensus about the importance of distinguishing between bonding and bridging social capital (Kawachi 2006; Szreter, Woolcock 2004). Bonding social capital is defined as “trusting and co-operative relations between members of a network who see themselves as being similar, in terms of their shared social identity”. Bridging social capital, by contrast, refers to “relations of respect and mutuality between people who know that they are not alike in some socio-demographic (or social identity) sense (differing by age, ethnic group, class, etc.)”.

### ***Criticism***

Although different authors report social capital's beneficial influence, others also identify possible negative effects of social capital (Ferlander 2007; Field 2003; Portes 1998). Portes (1998) emphasises the so-called dark sides of social capital. He identified four negative consequences of social capital: exclusion of outsiders, excessive claims on group members, restrictions on individual freedoms, and downward levelling norms. Another often heard criticism of the social capital literature has pointed out the fairly widespread practice of using proxy (indirect) indicators to measure area-level social capital (Paldam 2000). Compromising secondary data, researchers have resorted to a diverse set of indirect indicators ranging from voting behaviour, volunteering, crime rates, perceptions of corruption, and even newspaper readership. Some of these indicators may affect social capital or be consequences of social capital, but they should not be confused with the concept of social capital itself (Kawachi 2006).

A second criticism levelled at social capital, is that building social cohesion has been sold by some as a “cheap” way to solve the problems of poverty and health inequalities (Pearce, Davey Smith 2003). Sceptics see it as a way for politicians and policy makers to justify retrenchment of the state's responsibilities to provide for the welfare of its citizens. Ultimately,

it would be far cheaper to let the poor help each other than for the state to invest in the development and implementation of anti-poverty or public health intervention programmes.

This brings us to a final major criticism of social capital, which is the lack of clarity about the policies and interventions needed to build it. In this respect, Kawachi *et al.* (2008) made some useful comments in their authoritative 2008 book: *Social Capital and Health*. We will attend to this matter in the final part of this chapter (4.4 Setting up interventions on Social Capital).

#### 4.2.1 CONNECTING SOCIAL CAPITAL TO HEALTH

There is growing recognition that ever more sophisticated medical interventions and media campaigns have had a disappointing impact on some of society's most persistent social ills (e.g. smoking and depression) (Szreter, Woolcock 2004). Together with these failures of public policy, the rise of social epidemiology persuaded public health researchers to focus more on the social determinants of health (Berkman, Glass 2000). As all aspects of human life are inextricably bound within the context of social relations, every conceivable epidemiological exposure is related to social factors (Kaufman, Cooper 1999).

The idea that social conditions influence health is not new. The French sociologist Emile Durkheim is the precursor of the community approach to social capital. In his classic study, *Le Suicide* (1897), he concluded that suicide has a social cause, rather than a psychological basis (Durkheim 1951). He argued that social ties provide people with a sense of meaning and purpose, whereas social isolation fosters meaninglessness and despair. He therefore considered low social cohesion to be an important predictor of suicide. Health is a social product with strong societal roots (Wilkinson 1996). Mechanisms that produce health and illness cannot only be explained by individual characteristics, but have to be investigated within the broader social context.

The last twenty years have witnessed an explosion of interest in neighbourhood or area effects on health (Diez Roux 1998, 2001; Macintyre *et al.* 2002; Pickett, Pearl 2001). Yet, the relationship between neighbourhoods and health remains under-explored and calls for more careful analysis (Ellen *et al.* 2001). Particularly children's and young people's health behaviours are shaped not only by personal decisions of individuals but also by the routine organisation of everyday settings (Mechanic 1990).

### **Psychosocial and material pathways to health**

Social capital has entered the field of public health and epidemiology principally through the work of Robert Putnam and Richard Wilkinson. Although Putnam's 1993 book, *Making Democracy Work*, did not itself address public health issues, it grounded the social capital theory in innovative empirical research. He performed a comparative study of regional governments in Italy, and argued that the success or failure of a democracy is determined by the social capital between citizens. It was Wilkinson who was the first to introduce Putnam's conceptualisation of social capital to the public health field in his seminal 1996 book *Unhealthy Societies. The Afflictions of Inequality*. The argument is that high levels of income inequality are associated with low levels of social support and cohesion and therefore have a negative effect on the health of the rich and poor alike (Kawachi, Kennedy 1998; Wilkinson 1997, 1996). Wilkinson argued that among the most affluent societies a transition towards more uneven income distributions (e.g. US and UK) is characterised by individuals with increased anxiety and declining social support institutions, and by rising levels of violence between citizens. These findings were supported by the work of Marmot *et al.*, *Health inequalities among British civil servants: the Whitehall II study* (1991), which identified a psychosocial mechanism in the relationship between socio-economic inequality and health.

Critics like Lynch and Muntaner claim that the "psychosocial" interpretation denies the material causes of the effect of income inequality (Lynch *et al.* 2000; Muntaner, Lynch 1998). Wilkinson (2000) counters this statement with the argument that the social capital path is not a way to minimise the importance of material causes, but rather a vehicle to understand how income distribution affects health in a particular way. Furthermore, Wilkinson suggests that an important part of the social gradient in human health is attributable to the direct effects of social status, rather than to other influences on health such as poor-quality housing. Others have also identified the erosion of social cohesion and social capital as an additional mechanism underlying the relation between income inequality and health (Kawachi, Berkman 2000; Kawachi *et al.* 1997). Kawachi *et al.* (2002) highlight that social capital has sometimes been erroneously identified as a purely psychosocial variable (Lynch *et al.* 2000). However, it should be clear that the resources made available through social relationships can sometimes take the form of tangible factors (such as loans, voluntary labour, access to information), in addition to psychosocial factors (such as trust, norms and reciprocity).

#### 4.2.2 THE PROTECTIVE ROLE OF COMMUNITY SOCIAL CAPITAL FOR CHILDREN AND YOUNG PEOPLE'S HEALTH

Communities are important for physical and mental health and well-being (Marmot *et al.* 2010). Our lives are affected by the neighbourhoods which we live in and the social structures that operate within these neighbourhoods. Researchers and policy makers are becoming increasingly aware of the importance of the concept of social capital as a major issue for public health (Baum 1999; Lynch *et al.* 2000; Wilkinson 2000). Social capital can be a potential resource of resilience and a buffer against particular risk factors of poor health. Especially for parents with young children, a lack of networks is an important source of stress (Wilkinson, Pickett 2009).

Most of the studies on the role of social capital have involved adult populations (Hawe, Schiell 2000; Hemingway, Marmot 1999; Waterson *et al.* 2004). Less is known about this concept and its impact on the health and health behaviour of children and young people (Leonard 2005; Morrow 1999, 2002; Scales 1999). Evidence suggests that social capital may impact children's well-being as early as the preschool years (Runyan *et al.* 1998). Specific evidence on community social capital and children's and adolescents' health remains limited. A number of studies have found beneficial effects of community-level social capital on health (e.g. Folland 2007; Subramanian *et al.* 2001; Ziersch *et al.* 2005). Only a few studies found positive effects of community social capital in adolescent populations (Boyce *et al.* 2008; Drukker *et al.* 2003). Morgan and Haglund (2009) found that adolescents with low neighbourhood participation were almost twice as likely to report 'less than good health'. A number of studies demonstrate that various non-psychotic psychiatric disorders are associated with the quality of social networks and the social cohesion in a neighbourhood, and this effect operates across the life cycle of children, adolescents and adults (Ellen *et al.* 2001).

Community social capital is believed to influence health via different pathways. Fundamentally, high social capital is characterised by supportive, respectful relationships between community members resulting in a civil society (Waterson 2004). These kinds of qualitative relationships influence health by enhancing emotional well-being and by reducing the stress generated by day-to-day life events. Social capital is also an 'external coping resource' that provides social support, information or resources (Kim *et al.* 2006). A high level of social capital in a community is associated with higher levels of support, respect and recognition amongst inhabitants (Kawachi 2000) (Kawachi, Berkman 2000). Feelings of hopelessness and isolation have been shown to weaken health (Aneshensel 1992; House *et al.* 1988). Information networks specific to health are undoubtedly to some degree neighbour-

hood based. Residents will influence each other's health behaviours through direct modelling and through giving feedback on health behaviours of the community residents (transmitting norms about accepted behaviour). Also the use of health care can be influenced through communicating health-facilitating information and providing social support for seeing a doctor or care giver (Ellen *et al.* 2001). For example, smoking may be more socially acceptable in some neighbourhoods than in others, and neighbours can stimulate a young mother to see the doctor for the long-lasting cough of a child. The influence can also be more indirect: neighbours can also stimulate parents to invest in the education of their children as good education is a protective factor for health.

Wilkinson and Pickett (2009) demonstrated that the quality of social relations deteriorates in less equal societies. Putnam (1995) made clear in his writings that inequality and poor social relations in a community are mutually reinforcing. In the United States, levels of social capital and inequality moved in tandem through most of the twentieth century; the higher the levels of inequality, the lower the levels of social capital.

***Community Social Capital: it has an effect on health, but does it also reduce health inequalities?***

Research indicates that investing in community level health assets like social capital can be an effective approach to tackling health inequalities (Morgan, Ziglio 2007). Several studies document the direct effects of social capital on health (Harpham *et al.* 2006; Meltzer *et al.* 2007; Runyan *et al.* 1998) e.g. more childhood asthma has been found in neighbourhoods with low social capital (Gupta *et al.* 2009) and the indirect effects of social capital on the health of children by buffering the negative effects of low SES (Nobles, Frankenberg 2009; van der Linden *et al.* 2003). A Dutch study (van der Linden *et al.* 2003) showed that the negative effect of socio-economic deprivation on mental health service use was stronger in neighbourhoods with low community social capital. However most of these studies have been conducted outside Europe using many different definitions of social capital, many different child-health outcomes and many different analysis strategies. GRADIENT contributes to the knowledge on the possible effects of social capital on *the social gradient in child health* through a systematic review and new empirical research on these issues. This new research is summarised in the following sections.

### **4.3. DOES SOCIAL CAPITAL PROTECT THE HEALTH OF YOUNG PEOPLE IN DIFFERENT SOCIO-ECONOMIC GROUPS?**

The following section describes the findings of two case studies in the Flemish region of Belgium (De Clercq *et al.* 2012) and Iceland. Through this research we wanted to identify health assets that reduce social inequality in children's health. We therefore focussed on the potential role of community social capital as a protective factor for disadvantaged young people's health. More precisely, we hypothesise that community social capital would flatten the gradient in health and thereby reduce health inequalities among children and adolescents. Below, we first found evidence in the literature and then discuss the outcomes of two case studies.

#### **4.3.1 EVIDENCE FROM THE LITERATURE ON IMPACTS ON THE HEALTH GRADIENT**

Within GRADIENT a review was undertaken to explore community social capital as a protective factor for the health of children and adolescents. No intervention studies were reported. This came as no surprise, given the relatively short period that the effects of social capital have been studied: conducting and evaluating intervention studies can take several years.

Nine studies met the inclusion criteria for this review. They made use of a diversity of health-related outcomes and indicators for community social capital, but importantly the quality of the studies was good to very good. Most of the studies focussed on young children and their parents. Five studies found an effect of community social capital on the relation between socio-economic factors and health-related outcomes in children and adolescents. Due to the diverse set of indicators used to measure both social capital and health, it is challenging to draw firm conclusions. However, the results suggest that certain components of community social capital - for example neighbourhood disorder, social mistrust, neighbourhood cohesion, collective efficacy and neighbourhood potential for community involvement with children - influence the impact of socio-economic status on health outcomes in children and adolescents. The effects are better documented for younger children. Of the five studies which focus on young children, four show positive effects, while only one of the four studies on social capital in older children and adolescents show protective effects of community social capital. This could indicate that community social capital has a larger impact on the health of smaller children.

## **Conclusion**

Overall, the results of this review suggest that community social capital may alter the influence of socio-economic characteristics on the health of children and adolescents. However, they also illustrate that the beneficial impact of social capital cannot be simplified. Based on the included studies, it remains unclear what mechanisms explain this link. It could be possible that only certain characteristics of community social capital may be of significance. What conditions in particular are the most amenable by social capital is still uncertain. Also, one should bear in mind that not all components of social capital are included in this study, and the included studies did not use the concept of social capital in the same way. Most of the studies in the review were not set up to test the effect of community social capital on the health gradient but made use of existing data sets. Almost all of the studies were conducted outside Europe and it is unclear if the results of studies in other parts of the world can be translated to the European context.

### **4.3.2 TWO CASE STUDIES: FLANDERS (BELGIUM) AND ICELAND**

As the review made clear, there is limited evidence of the effect of community social capital on health inequalities in children. A greater number of European studies are needed in order to provide more substantive evidence for the European context. In Flanders (Belgium) and Iceland data sets could be identified that could be used to get more insight into the relationship between individual socio-economic position, health and community social capital.

#### **STUDY 1: Flanders**

Flanders is a federated entity in the northern region of Belgium. The number of people living in Flanders is about 6.2 million. With a surface area of 13.682 km<sup>2</sup> it is one of the smallest (though wealthiest) regions of Europe.

To investigate the protective effect of community social capital, data from the 2005/6 Flemish Health Behaviour among School-aged Children survey (HBSC) were used, which is part of the Health Behaviour in School-Aged Children: WHO Collaborative Cross-National Study (HBSC) (Currie *et al.* 2009). These are self-reported data collected from school children from the fifth year of primary school to the fourth year of secondary school. The survey was administrated through a standardised protocol (Roberts *et al.* 2007). The total sample consists of 9773 children living in 601 different communities. Children between 9-18 years were included in the study. To



provide more objective evidence of community effects, this study also used data from the Social Cohesion Indicators Flanders database (SCIF) 2007-2011. These data are gathered at the community level (postal code) from several databases from the Federal Police, Social Security, the National Institute for Statistics, the Federal Government Department of Statistics and the Roman Catholic Church.

### How was it measured?

*Health* was measured using a ten-item index of children's and adolescents' perceived health status and well-being (Erhart et al. 2009; Ravens-Sieberer et al. 2010). It consisted of ten items with five-point answer-categories: "Thinking about last week... have you felt fit and well? Have you felt full of energy? Have you felt sad? Have you felt lonely? Have you had enough time for yourself? Have you been able to do the things that you want to do in your free time? Have your parent(s) treated you fairly? Have you had fun with your friends? Have you got on well at school? Have you been able to pay attention?" (0 = never, 1 = seldom, 2 = quite often, 3 = very often, 4 = always).

The present study includes family affluence as an indicator for individual *socio-economic status* (Currie et al, 1997). The family affluence scale is a composite indicator of self-reported socio-economic status comprising four items that address family assets or conditions that indicate wealth: "Does your family own a car, van or truck? (0 = no; 1 = yes one; 2 = yes two or more); Do you have your own bedroom for yourself? (0 = no; 1 = yes); During the past 12 months, how many times did you travel away on holiday with your family? (0 = not at all, 1 = once, 2 = twice, 3 = more than twice); How many computers does your family own?" (0 = none, 1 = one, 2 = two, 3 = more than two). Responses are summed on a 1 to 10 scale with higher scores indicating greater affluence.

*Individual social capital* is measured by the participation in clubs: "Are you involved in any of these kinds of clubs or organisations?" Response categories: sports club, voluntary service, political organisation, cultural organisation, cultural association, church or religious group, youth club, other club (0 = no, 1 = yes).

*Community social capital* is measured using a five-item scale (Currie *et al.* 2001): “People say ‘hello’ and often stop to talk to each other in the street; it is safe for younger children to play outside during the day; you can trust people around here; there are good places to spend your free time; I could ask for help or a favour from neighbours” (1 = strongly disagree, 2 = disagree, 3 = neither agree nor disagree, 4 = agree, 5 = strongly agree).

### **Research questions**

Is social capital at the community level (trusting people in the neighbourhood, saying “hello” and talking to each other, belief that “the community is a good place to spend free time” and “help is provided among neighbourhood members”) an independent determinant of adolescents’ health after taking account of individual characteristics (e.g. characteristics such as gender, age, socio-economic status, and individual social capital - defined as being a member of one or more organisations)? And more specifically, can community social capital level-up the gradient in health?

### **Results**

The study found that young people’s individual social capital was related to their health. A gradient in the relationship between children’s and adolescents’ socio-economic position and health was also found: children with higher socio-economic positions had better health. Individual social capital was positively related to health, which means that individuals were healthier when they had more individual social capital. The same was true for community-level social capital. Also community social capital and traditional social cohesion (religious participation, absence of property crimes and share of associations) of a community were positively related to children’s and adolescents’ health. So, higher levels of community social capital and traditional social cohesion led to better health for the individuals living in these communities. The level of social capital within one’s community has a stronger influence on people’s health than individual social capital. Although community social capital is positively related to health, it does not explain away the relationship between family affluence and health. But, interestingly we find that the social gradient in health is flattened in communities with a high level of community social capital and consequently

differences in health across different socio-economic groups narrow in high social capital communities.

A further examination of the data revealed that differences in health and well-being across different socio-economic groups substantially narrowed in communities where a certain (average) level of community social capital was present. However, one unit of increase in community social capital did not produce a constant increase in perceived health and well-being in all children. In communities with higher levels of social capital there was no added value of levelling-up the gradient. In terms of policy relevance this means that particularly in communities with low social capital, health gains can be obtained by enhancing the community social capital.

### ***STUDY 2: Iceland***

Iceland is a country in the North Atlantic Ocean with a population of about 320.000 people and a total surface of 103.000 km<sup>2</sup>. Two-thirds of the population lives in or around Reykjavik, the capital city.

The research in Iceland was based on a national population survey that consisted of a sample that covered almost every young person in Iceland in 2007, in two age cohorts (15 and 16 years old). Most children in Iceland go to schools in their neighbourhood of residence. This is an important practical advantage because (i) it enables researchers to derive neighbourhood-level characteristics through school surveys, and (ii) neighbourhood-level characteristics can be linked to individual characteristics.

### ***Research questions***

The study explored the relationship between structural characteristics of school communities and adolescent smoking. School and community are closely linked in Iceland: all adolescents from the same community go to the same school. As a first step, researchers investigated whether low levels of parental SES and residential mobility increased adolescent smoking. Secondly, they tested whether this relationship was influenced by individual and/or community social capital. Three components of social capital were applied: intergenerational closure (e.g. parental social ties to their neighbours and contacts between parents of adolescents), parental participation in the school and youth community, and participation in sports by adolescents.

## Results

Adolescents who live in neighbourhoods that have a high proportion of single parents and a high level of residential mobility are more likely to smoke on a daily basis than adolescents in other neighbourhoods, regardless of their own individual social situation.

The results further indicate that children from poor households are more likely than other children to smoke. However, this association is not the same in all neighbourhoods. Children who live in neighbourhoods with high levels of social capital are affected less by poverty than children who live in neighbourhoods with low levels of social capital. In other words, the correlation between poverty and smoking is lower in communities with high level of social capital than in communities with low level of social capital.

The mechanism underlying the observed protective contribution of social capital is not addressed empirically in the paper. There are no measures of norms in the data set. However, it is well known that most, if not all, sport-clubs in Iceland share strong anti-smoking norms. Norms are of central importance to Coleman's formulation of social capital theory (1988). Social ties, another key component of social capital theory, may facilitate spreading anti-smoking norms in the community but communities with high levels of social capital may also have less tolerance of youth smoking. In such communities parents may have better access to social support, the community may provide more social control, and healthy behaviour in general may be valued highly.

### 4.3.3 WHAT DO WE LEARN FROM THE EVIDENCE?

- i. Different components of community social capital - for example social trust, neighbourhood cohesion, collective efficacy and neighbourhood potential for community involvement with children - may operate as health assets.
- ii. Increased community social capital can reduce the adverse effect of inequality on teenage smoking behaviour, and the perceived health and well-being of adolescents.
  - For the Flemish region, the social gradient in perceived health and well-being is flattened in communities with a high level of community social capital. Community social capital components like trust, reciprocity, and mutual assistance seem to generate health benefits for children and young people.

- For Iceland, the relationship between parental socio-economic status and adolescent smoking is partly mediated through components of individual social capital (parental social ties, parental participation in the youth community and participation in team sports). Therefore, the research suggests that social capital operates mainly as an individual factor. But participation in team sports in the community has an effect over and above individual sport participation: the anti-smoking social norm in clubs seems to spread to all adolescents in the community.
- iii. Strengthening social capital can be achieved by increasing the density of parental social networks, and by encouraging parental activities that foster interaction, communication and trust. These activities can be implemented through parent-school organisation, via parental involvement in sport clubs or through active participation in other leisure activities of their children.
- iv. Strengthening parents' and young persons' social networks is not sufficient to strengthen social capital. The norms in the social network in question are crucial for the creation of social capital beneficial to children and adolescents. In the case of Icelandic sport clubs, anti-smoking norms prevail and are therefore beneficial to sport participating children and adolescents as well as the non-sport participating peers in the neighbourhoods.
- v. This research suggests that the association between socio-economic status and children's health outcomes should preferably be analysed with reference to the social capital in children and young people's communities.
- vi. More specific recommendations:
  - Local decision makers should stimulate local organisations to adhere to positive norms and values towards health and health behaviours, e.g. no smoking and moderate drinking norms, stimulating physical activity.
  - Engagement in these organisations should be fostered for positive effects on the health and health behaviour of young people, especially in communities with low social capital.
  - Lowering the (perceived) level of crime in the community, which is an indicator of community social capital.

The recommendations stemming from this research complement and clarify recommendations formulated in influential documents on the social gradient in health. The Marmot Review (2010) considers the improvement of community capital and the reduction of social isolation across the social gradient as a priority objective for health. We also refer to Dahlgren and Whitehead's discussion paper (2006) on European strategies for tackling social inequalities in health in which social and community inclusion policies are considered as a group of policies which have an effect on health inequalities.

Several EU documents not related to health also refer to the fact that all sectors of society should engage in a new conversation on how we create societies where different groups live in harmony with each other. They provide a vision for inter-community relations – a vision which, it is suggested, is based on creating shared societies for all, which make demands on all sections of society, but at the same time are based on mutual respect for all. Especially in times where economic crisis and social change go hand in hand, the need to build cohesive communities and societies is more important than ever (Andor *et al.* 2001).

It is also increasingly recognised that the nature of disadvantage affecting people in situations of poverty and social exclusion is influenced by the areas in which they live. The link between individual circumstances and local situations runs both ways. A concentration of disadvantaged people in certain neighbourhoods results in increased pressure on public services, reduced economic activity and private investment, the emergence of 'pockets of deprivation', stigmatisation and discrimination and an erosion of social capital. The concentration of disadvantage also appears to be a persistent phenomenon which can spread from one generation to the next. Therefore, social policies need to tackle the territorial aspects of disadvantage if they are to succeed in helping people in the places where they live and to encompass the regeneration of deprived areas as well as supporting the people concerned.

This approach is also promoted through the common principles on active inclusion, which emphasise the importance of local and regional circumstances and the need to ensure access to quality services. Area-based social policy was one of the main themes of the 2009 European Round Table on Poverty and Social Exclusion, organised by the Swedish Presidency, which called for increased efforts to combine 'people-based' and 'place-based' approaches in the social Open Method of Co-ordination (OMC), as well as in Cohesion Policy.

## 4.4 SETTING UP INTERVENTIONS TO BUILD COMMUNITY SOCIAL CAPITAL

### *Importance of the context*

There is no specific method that can be used to build community social capital. In building social capital it is important to respect the cultural, historical and socio-economic context and existing institutional arrangements when designing interventions. Before we can start developing an intervention tool to enhance community social capital, we must use the existing situation within a certain community as a departing point. This would be the product of a prior history of political, constitutional, and ideological work to construct the conditions for such a shared sense of fairness to be perceived by those choosing to participate in the network in question (Szreter, Woolcock 2004). For instance, bridging social capital can only occur spontaneously in a civil society that already shares common characteristics, so that these trusting networks can form. Where there are circumstances - for example high economic and social inequality - in which all individuals do not perceive themselves as enjoying a rough equivalence, it is entirely unrealistic to expect spontaneous bridging social capital to form between "haves and have-nots".

### *What can be done?*

The previous point does not mean that public policy cannot stimulate or hinder the building of social capital. Public policy can even destroy or erode existing community social capital. Implicitly, many governments already have policies in place that support community social capital, for example subsidising voluntary organisations, regulations for having community places or playgrounds in new housing developments, etc. However, for the moment there is limited understanding about how different policies interact in building or eroding social capital and how the health effects of these policies can be measured. Social capital is not a means to an end but rather a supportive process to enhance the health and well-being of all citizens including children and young people. Canada (PRI Project 2003) and Australia (Healy 2007) have therefore drawn up the following policy recommendations: developing and refining measurement tools to register the presence or absence of community social capital; identifying the effects of social capital in existing programmes; and integrating information about social relationships into the design and the implementation of new programmes. These recommendations can be used on the national, the regional and the local level.

According to the Social Capital Building Toolkit developed by Sander and Lowney (Sander, Lowney 2005), our best chances of building community social capital is by making a series of “smart bets” – for example using established principles of community organisation to encourage the formation of neighbourhood-based associations. A local hiker club can be a starting point for an intervention which aims to establish a cohesive community. Keeping in mind the seminal work of Granovetter (Granovetter 1973), we must also be conscious about the *type* of social capital we wish to establish.

Whereas weak ties are more effective at disseminating information, strong ties are more effective for collective action (Chwe 1999). The type of networks one wishes to build is intrinsically related to the forms of social capital on the output side. For example, consider the situation of unemployed young people. Theory would suggest that it’s not effective to invest in bonding social capital among unemployed young people, but especially in bridging social capital between unemployed young people and employed adults by for example providing them with access to role models and mentoring (Sander, Lowney 2005). A network of people within the work field is crucial in order to find a job, whereas the network outside the work field is important as a support system for their general health and well-being. Kawachi *et al.* (2008) also emphasise the need to pay attention to the distribution of costs and benefits. For example, a gender-sensitive analysis of social capital may suggest that the mobilisation and provision of support to others in the community tends to fall disproportionately on the shoulders of women. Since women in many communities play a relatively large role in the provision of support compared to their male counterparts, it is necessary to take this into account in the development of a specific public health policy. Otherwise, a health-promotion strategy that supports only the men from the community at the expense of the women would only lead to a zero-sum outcome.

### ***Importance of the local level***

The local level seems to be particularly important in influencing access to and development of social capital (OECD 2011). There are many varied ways how local governments can support communities to build social capital. There is a role for local government to provide support to communities wanting to take more control of their future. There are excellent tools and resources available that have been developed and trialled through community development and community building initiatives that assist communities to identify and build on their strengths. Local governments can enable



local communities to access information and support in relation to specific initiatives. Local government can facilitate the development of networks of service providers and funding agencies that can be linked with community committees to support the achievement of community priorities.

### ***Feasibility***

Some are, however, sceptical about the interest of politicians in the development of social capital. Even when there is increased awareness of social determinants of health and the potential role of social capital in reducing the social gradient in health, supporting structures will be needed to enable, reinforce and push for change (Green, Kreuter 2005).

In this context there is a role for non-governmental organisations. Apart from the fact that many non-governmental organisations are already building pathways to participate in community life, they can also play an important role in advocacy initiatives to stimulate politicians to take action to enhance social capital.

### ***Enhancing knowledge***

Given the fact that the evidence base for the beneficial effects of community social capital on reducing the social gradient in the health of children is still small, governments should continue to advance knowledge on the effects of social capital on policy outcomes by pursuing research in this area through evaluations, broad surveys and social experiments.

In order to gain insight in the possible value of social capital as a way to tackle the health gradient in Europe, research is needed that focusses on European, 'population-wide' samples. When collecting data on minority groups, research should focus on more relevant minority groups in the European context, such as other EU nationals, (descendants of) north African immigrant workers, nationals from former European colonies or Roma people.

Taking into account feasibility issues of measuring the effects of social capital on health, the effects of community social capital should be measured indirectly. We recommend including social capital measures in health surveys and monitoring and registering social capital in communities (development of social capital or social cohesion indexes in all countries). Combining results from health surveys (with respondents clustered into communities) with social capital indices of the communities can give important insights into the effects of changes in social capital on the health of community residents. Policies and interventions that aim to build social

capital in communities should also be better evaluated on their effects on people from different socio-economic groups. More research and evaluation is needed. The next chapter will provide a framework for how this can be done.

#### **4.5 CONCLUSION**

Building on existing evidence, and adding to this our new results, we claim that there is enough evidence to recommend community-building initiatives that increase cohesion, co-operation, and interpersonal trust among children and adolescents and especially in communities with low social capital for levelling-up the social gradient in the health of children.

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## **CHAPTER 5**

Evaluating Policies: Applying  
The Gradient Equity Lens



## CHAPTER 5

### EVALUATING POLICIES: APPLYING THE GRADIENT EQUITY LENS

John Kenneth Davies and Nigel Sherriff<sup>36</sup>

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#### 5.1 EVALUATING THE EFFECTIVENESS OF POLICIES: AN UNDERESTIMATED PROBLEM

This book has so far presented and discussed various universal and targeted policies and strategies across different policy sectors that can have an impact on the social gradient in health among children and young people. However, the evidence base defining which policies and interventions are most effective in reducing health inequalities is extremely weak. This applies in particular to those policies and interventions that aim to level-up the gradient in health inequalities (Bambra *et al.* 2008; House of Commons Select Committee 2009). Too often, as we have seen in Chapter 3, policies are not evaluated on their distributional impacts, and thereby risk increasing health inequalities. It is important, therefore, that policies and interventions that seek to influence the social gradient in health are more adequately evaluated. This is by no means an easy or straightforward task. There are a number of challenges which need to be faced. No single study can demonstrate which policies are the most effective, and there is therefore a need to invest in evaluation to build up an aggregated body of evidence over time. This chapter will discuss the difficulties around policy evaluation and present a framework to facilitate progress.

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### **Policy design and evaluation**

Evaluation should be integral to systematic programme planning and therefore needs to be carried out at all levels of policy planning, development and implementation. Interpretivist approaches to evaluation, which highlight and facilitate evaluation as an interactive learning process, are particularly helpful in understanding what happens between an intervention's inputs and outcomes. In terms of the latter, there is a need to differentiate short-term impact from longer-term health outcomes. It is therefore important to have a good theoretical understanding of the policy and related interventions being evaluated. Typical public health evaluations focus on the micro-level, with effects focusing on the health of the individual. This is in contrast to macro-level evaluations, where broader impact is linked to societal factors such as community empowerment and social capital. At this macro level there are complex causal pathways with multiple proximal and distal pathways of effects, often stretching beyond the health sector and over long periods of time. As a result, appropriate outcome measures need to be identified. This has resulted in the evidence base on effective action to tackle a range of health inequalities being biased towards downstream interventions. Where evaluative evidence does exist, it tends to be based on downstream initiatives that focus on specific determinants (e.g. smoking cessation among low-income groups or increasing breastfeeding continuance), rather than on more upstream initiatives (e.g. taxation policies) which influence the wider social determinants of health (Marmot 2010).

### **Complex nature of interventions**

Policies that seek to influence the social gradient in health are often perceived as complex and multi-faceted (Petticrew 2011). The complexity of interventions is mainly due to:

*"... multi-component interventions, diverse study populations, multiple outcomes measured, mixed study designs utilized and the effect of context on intervention design, implementation and effectiveness"*  
(Jackson, Waters 2005).

Complex policy interventions therefore require the use of a mixed-methods approach in their development and evaluation (Craig *et al.* 2008). Adopting such mixed-methods involves use of both qualitative and quantitative methods:

*“Mixed-methods approaches allow us to learn about context, process, impact, and outcome, providing evidence on what works, why it works, and in which settings it works best. The need to be able to replicate and increase the scale of an intervention, coupled with advocacy and input into the policy process, are all now important outcomes from an evaluation” (Coombes, Thorogood 2010).*

When designing appropriate policy actions to tackle the health gradient, we need to explore the dynamic relationship between evidence, context and intervention (Kitson *et al.* 1998). Senior policy makers and senior researchers working on health inequalities agree that policy relevance is important when considering a “mixed economy of evidence” (Petticrew *et al.* 2004; Whitehead *et al.* 2004). This means that a conceptual framework is needed to develop and evaluate policy and interventions linked to the intersectoral nature of health inequalities. Such an evaluation framework includes consideration of both macro and micro-level policies and their implementation at regional, member state and European levels.

## **5.2 THE GRADIENT EVALUATION FRAMEWORK (GEF)**

### ***Review of evaluation frameworks***

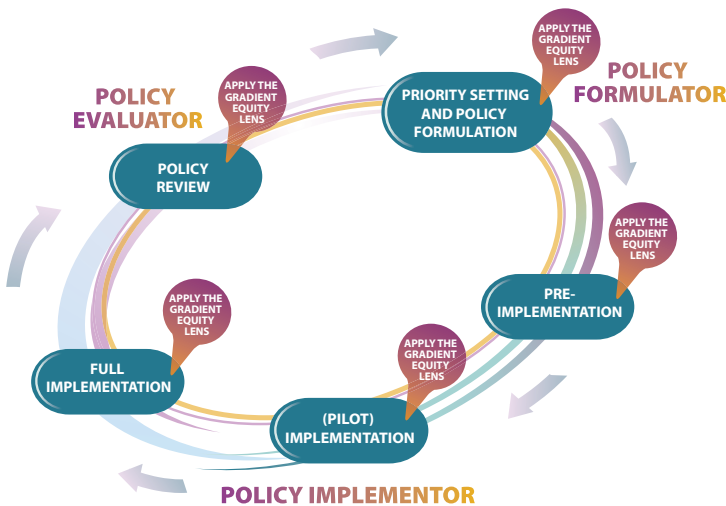
In light of the considerations raised above, a review was carried out to better understand the strengths and weaknesses of using evaluation frameworks to explore policies and interventions that level-up the gradient (Davies, Sherriff 2011a). Results from this review of 34 evaluation frameworks from various countries found no suitable evaluation framework that could be used to evaluate whether policies and/or interventions targeting children and families reduced the health gradient (Davies, Sherriff 2011a). Therefore a custom-made Gradient Evaluation Framework (GEF) has been developed which takes the form of a European action-oriented, self-assessment policy tool (Davies, Sherriff 2011b). This flexible assessment tool includes a set of principles, procedures and mechanisms, which provide an integrated structure for evaluation at each stage of the policy cycle. It is designed specifically to assist policy-makers when developing and evaluating their policy actions in terms of their “gradient friendliness” in other words, their potential to level-up the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families.

## Development of GEF

This operational framework has been progressed in the GRADIENT project through a formal consensus-building process at European level. This process initially used a Nominal Group Technique (NGT) involving external experts from a wide range of European member states. Consensus was achieved initially when the experts highlighted the importance of including relevant evaluation methods and efficacy indicators at each stage of the policy cycle. GEF is built around the key stages of the well-established policy cycle (Figure 1). Although the policy cycle has been challenged by some as being unresponsive, simplistic, and unrealistic, it is nevertheless also generally accepted as being a useful heuristic and iterative device for understanding the life cycle of a policy, especially when evaluating complex policy actions.

GEF sets the planning, implementation and evaluation of policies and their related actions firmly within this cyclical policy development framework. This enables users to identify the relevant entry points and levels of action to influence the underlying structural determinants of health inequalities. Users can thereby decide on the entry point into the policy cycle depending on the context of their particular policy intervention. GEF establishes five core elements to the policy cycle, these being: priority setting and policy formulation; pre-implementation; pilot-implementation; full-implementation; and policy review (see Figure 1).

Figure 1. The Policy Cycle



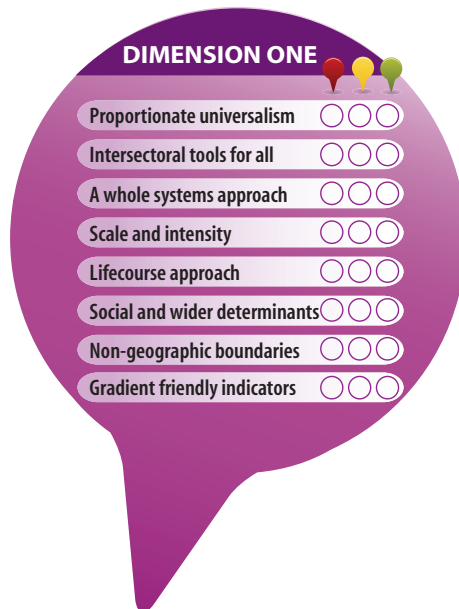
## The Gradient Equity Lens

With the above in mind, GEF offers a *Gradient Equity Lens* (GEL) which operates in practice through a series of self-assessment tasks. GEL can therefore be applied iteratively and flexibly to facilitate appropriate evaluation of policy actions at *each* stage of the policy cycle. This GEL comprises two key inter-related dimensions which together provide a 'gradient perspective' on evaluating policies and their related actions.

The Gradient Equity Lens (GEL) lies at the heart of GEF and consists of the two dimensions.

**Dimension One** (see Figure 2) guides the user through *eight key areas* which form a relative quick 'check-list' of key components deemed important to underpin the design and evaluation of effective policy actions (proposed or in place) in terms of their potential to be 'gradient-friendly' i.e. to level-up the gradient in health inequalities by addressing the social determinants of health which affect the health of children, young people, and their families. A summative traffic-light system (at the end of each key component) is used to provide an overall rating of the policy action. This rating can help in restructuring policy and devising effective actions.

Figure 2. The Gradient Equity Lens: Dimension One





These eight key areas of Dimension One are as follows:

- **Proportionate Universalism** - This term was developed by the Marmot Review team and is based on the principle whereby "...the scale and intensity of provision of universal services is proportionate to the level of disadvantage" (Marmot 2010). The gradient approach to policy action therefore consists of broad universal measures combined with targeted (and proportionate) strategies for high-risk/disadvantaged groups (e.g. low-income families).
- **Intersectoral Tools for All** - Effective policy actions to level-up the gradient in health inequalities requires tools which are able to assist intersectoral collaboration and planning. The factors that influence health inequalities extend far beyond the responsibilities of the health sector (CSDH 2005). It is therefore necessary to raise awareness among those involved in policy and decision making from *all* sectors about the need to level-up the gradient. Intersectoral tools are important policy instruments to achieve this. Therefore political commitment to action is needed from all sectors of government (Marmot 2010).
- **Whole System Approach** - A whole social systems approach is required to tackle the gradient in health inequalities (Davies, Sherriff 2011). Adopting a whole systems approach is concerned with looking at the 'big picture' of issues across a range of different interests within complex organisational environments (Department of Health 2000). A system cannot be viewed in isolation from its environment and context as it is built around the three concepts of its structure, the process it supports, and outcomes of its use.
- **Scale and Intensity** - Policy actions to level-up the gradient in health and tackle its social determinants among children, young people and their families need to be piloted carefully and pre-tested whenever possible. All actions should be evaluated adequately with at least ten per cent of a programme budget being allocated for this purpose. Sufficient investment in terms of funding and person power needs to be allocated to ensure appropriate impact. Targets often have short time frames, resulting in a "focus by governments on 'quick-wins' and individual-level (clinical and/or behavioural) interventions, with the emphasis on these approaches intensifying as the target date draws closer" (Marmot 2010). This approach tends to give priority to health sector interven-

tions aimed at disadvantaged population groups rather than seeking to tackle underlying determinants. Concern should also be given to capacity building and staff development to ensure adequate numbers of trained people with the necessary skills to bring about any potential change in the gradient.

- **Life-Course Approach** - In addressing the gradient, a life-course perspective is important as biological and social determinants influence an individual's health development from conception through to death. Efforts to tackle the gradient in health should therefore pay special attention to children and young people, as actions at these early stages in the life course offer the greatest potential for levelling-up the gradient and producing long-term positive health outcomes (Chen *et al.* 2007; Marmot 2010). Already at the prenatal stage of development the adverse outcomes of pregnancy can be prevented or reduced by specialised antenatal care and home visiting, particularly with women at risk across the social gradient. Such actions should focus on risk reduction – for example facilitating smoking cessation during pregnancy, reducing alcohol consumption, encouraging take-up of a healthy diet, etc. Following birth, mothers should be encouraged to breastfeed. As we have seen in Chapter 3, fathers should also be involved, and appropriate parenting skills support should be provided. At the preschool stage, paid parental leave during the first 12 months should be an entitlement; this should focus on child development milestones, especially in children under two years of age. Transition to school is an important time and support from skilled workers needs to be allocated particularly to those children across the social gradient having greater social and emotional needs. During the transition to workplace training and employment, open access to lifelong learning opportunities need to be made available to all 16-25 year olds across the social gradient (Power, Kuh 2006; Oliver *et al.* 2008).
- **Social and Wider Determinants of Health Inequalities** - There is clear evidence that the conditions into which some people are born, grow, live and work are responsible for health inequalities, which create an inequalities gradient across society (Crombie *et al.* 2005). In the early years health patterns are set in terms of health and disadvantage for the individual's future life course (Chen, *et al.* 2007). This has a cumulative effect in terms of social systemic patterning of inequality and disadvantage (Poulton *et al.* 2002).

- **Non-geographic Boundaries** - There are regional variations in how the social gradient relates to mortality (Marmot 2010). These regional variations expand as one travels further down the social gradient. Efforts to meet national targets may therefore mask inequalities that exist both at local/regional level and within deprived areas, as well as neglecting pockets of deprivation that exist in more affluent areas. So although targeting the worst off is important, this needs to be complemented by stressing universal aspects of policies in order to level-up the gradient. It is most important that: "...an integrated approach at national and local level is adopted if synergy is to be achieved to secure the maximum impact" (Marmot 2010).
- **Gradient-Friendly Indicators** - Exposure to almost all risk factors (material, psychosocial and behavioural) is inversely related to social position – that is, the lower the social position the greater the exposure to different health hazards. Analysing health indicators and the determinants of health for the general population is not sufficient for identifying and analysing health inequalities across the social gradient. Health outcome indicators need to be stratified by at least two socio-economic stratifiers (education, income/wealth, occupational class), ethnic group, and place of residence. In a similar way, where applicable, indicators related to determinants of health need to include a socio-economic stratifier, as the most important determinants of health may differ from different socio-economic groups. The socio-economic measure can include the level of education, occupation or housing tenure as stratifiers (the indicator being obtained from national census-linked mortality data sources) (Mackenbach *et al.* 2007). Indicators related to structural drivers of health inequalities, such as employment, income distribution, education, and poverty rates, should be included in the analysis.

**Dimension Two** (Figure 3) guides the user through six steps linked to particular exemplar activities relevant for the evaluation (and design) of policy actions proposed or in place, again in terms of their potential to be 'gradient-friendly'. Drawing on aspects of Dimension One (as appropriate), Dimension Two is a detailed and in-depth series of self-assessment tasks outlining specific cyclical, iterative, and cross-cutting evaluation activities. Although it is presented as a series of incremental steps, this is purely for demonstration and clarity purposes. Experience shows that the different stages can overlap with each other and may not necessarily proceed in a linear or cyclical fashion; this depends on the stage of development and policy context under analysis.

Figure 3. The Gradient Equity Lens: Dimension Two



Dimension Two of the GEL provides a more in-depth series of self-assessment tasks. These have been developed and adapted from a wide range of existing evaluation frameworks, which all tend to follow a logical step process, and is in particular based broadly (*inter alia*) on the “*Framework for Program Evaluation in Public Health*” (CDC 1999) and the “*Program Evaluation Tool Kit*” (PHAC 2004).

Dimension Two follows six steps which are necessary when carrying out a comprehensive evaluation of policies and actions to assess their potential to be “gradient-friendly”. The steps are:

1. **Describing the Policy and its Related Actions** - Illustrates the policy action’s core components; establishes its ability to make changes; specifies its stage of development or implementation; and describes how the policy fits into the larger socio, cultural, and political environment. Such descriptions set the frame of reference for all subsequent decisions in the remainder of the evaluation activities.
2. **Engaging Stakeholders** - Stakeholders may be categorised as those who are: involved in implementing a policy (e.g. funding agencies, managers,

delivery partners, administrators, project staff, etc.); targeted or affected by the implementation of a policy (e.g. young people and their families, clients, neighbourhood groups, advocacy groups, community residents, etc.); primary users of the policy evaluation (e.g. those included in the previous two categories but who are in a position to decide and/or act upon the findings of the evaluation of the policy intervention).

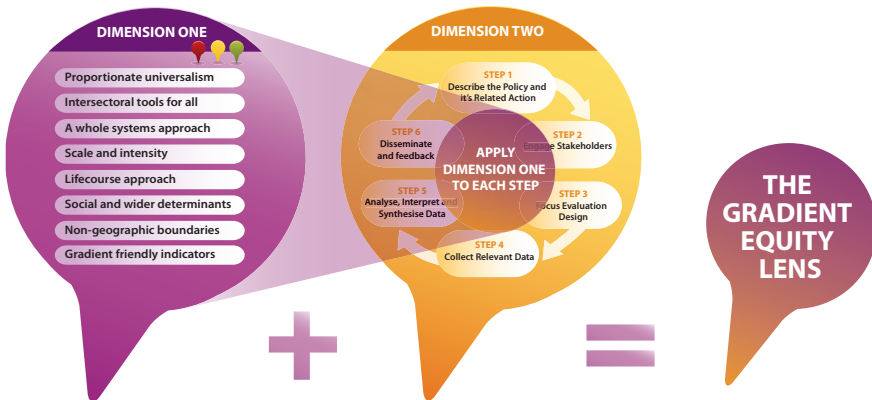
3. **Focusing Evaluation Design** - Includes six main steps: decide on an appropriate design; decide on evaluation methods; understanding and measuring process; understanding and measuring outputs; understanding and measuring outcomes; dissemination and feedback.
4. **Collecting Relevant Data** - Choices of 'gradient' indicators need to be set with a view to enabling sensitivity and measurement of structural drivers of inequalities (relating to policy objectives) such as income equity, poverty and inclusion in the work force. It is also important that indicators for a policy action are differentiated by process, output and outcome (immediate, intermediate, and long-term). Indicative examples of gradient-friendly indicators are provided.
5. **Analysing, Interpreting and Synthesising Data** - Analysis, interpretation, and synthesis of data is often a simultaneous and iterative process. The analytical and interpretive process is an important one, as it allows the identification of outputs, processes, and outcomes (i.e. immediate, intermediate, and sometimes long term). Moreover, data analysis and interpretation can be used to lead to informed judgements and the development of subsequent recommendations for action or consideration regarding the policy intervention in question.
6. **Dissemination and Feedback** - Lessons learned in the course of an evaluation do not automatically translate into informed decision-making and appropriate action. Focus and effort is therefore needed to ensure that findings are used and disseminated appropriately to relevant stakeholders across the social gradient, as well as being fed back into the on-going development and review of the policy action.

### 5.3 GEF IN USE

GEF links Dimensions One and Two to apply the GEL and is designed to be user-friendly (Figure 4). Each step includes an initial explanatory section followed by a series of questions for the user to consider, together with some

explanatory activities. Each step concludes with a Gradient Equity Lens Overview Sheet to enable the user to record general comments together with more specific action points arising from their self-assessment. GEF can be used on any policy, action, programme, intervention or project that either affects or is intended to affect the health and equity of a given population. It is designed primarily to guide policy-makers and/or key decision-makers by reducing their possibility of error, having developed, or when developing, policies and related actions to level-up the gradient in health inequalities. GEF can be used retrospectively in terms of reviewing existing initiatives, and prospectively when designing new ones.

Figure 4. The Gradient Equity Lens



It may be more appropriate to work sequentially through all the GEF questions when, for example, an intervention is being developed from scratch. At other times, some questions or parts may be more relevant than others and users may wish to dip-in-and-out of GEF as and when required. GEF can be used either for rapid assessment (using Dimension One only) or in a more in-depth way (using both Dimensions One and Two). This decision is made by the user and their particular contextual requirements.

The process of using GEF to evaluate and/or design a policy action is as important as the outcome itself, because the process provides an important opportunity to involve stakeholders from across the social gradient in meaningful ways. Moreover, in working through GEF, the issues raised aim to sensitise users regarding the need for action to reduce social inequalities in the determinants of health, and in order to make progress towards level-

ling-up the gradient in health inequalities among children, young people, and their families.

## **5.4 INDICATORS FOR MONITORING THE HEALTH GRADIENT AMONG CHILDREN AND YOUNG PEOPLE IN THE EU**

### ***Measuring inequalities in health***

Any evaluation of a policy action or intervention should strive to collect data or evidence that will convey a comprehensive picture – one that is deemed credible by its stakeholders (CDC 1999). This is important, given that having credible evidence strengthens the conclusions and recommendations that can be drawn from the evaluation and increase the likelihood that actions on such recommendations will ensue. However, the measurement and monitoring of inequalities in health over time and across countries is not a straightforward process, since the choice of the measure or indicator will influence the results. Moreover, no consensus has been reached on the best and most meaningful measures, and not all indicators one may wish to use are actually available. Resolution of these issues is beyond the scope of the current chapter.

As policy action objectives (including targets and thus by proxy outcomes) need to be able to capture the fact that social inequity in health forms a gradient across society, objectives and milestones must not be based purely on health indicators, but also on the social determinants of health as focusing on the former tends to stimulate narrow downstream actions on health care services. Choices of 'gradient-friendly' indicators thus need to be set with a view to enabling sensitivity and measurement of structural drivers of inequalities (relating to the objectives of policy actions) such as income equity, poverty, inclusion in the work force, and so on. As noted earlier, it is also important that indicators for a policy action are differentiated by process, output and outcome (immediate, intermediate, and long-term); although when considering short-term objectives it is often difficult to differentiate between process and outcomes indicators.

The indicators chosen must be relevant to the policy and its implementation mechanisms as well as to the stakeholders involved. Here are some examples of upstream, mid-stream and down-stream policies with examples of process, output and outcome indicators that could be used in evaluation (Marmot 2010; Norwegian Public Health Policy Report 2009).

<p><b>UNIVERSAL (UPSTREAM; SOCIAL REFORM) INDICATORS</b></p> <p><b>Policy objective:</b> provide good quality early years education and childcare proportionately across the gradient</p>	
<p><b>Process indicators</b></p>	<ul style="list-style-type: none"> <li>• Numbers of children accessing quality early education and childcare by socio-economic group</li> <li>• Numbers of well-qualified staff into the workforce by geographical area</li> <li>• Number of early years settings with staff with graduate backgrounds by geographical area</li> </ul>
<p><b>Output indicators</b></p>	<ul style="list-style-type: none"> <li>• Programmes and interventions developed for under 3s to incorporate greater level of structure play, involvement and participation of families in school's educational programmes</li> </ul>
<p><b>Outcome indicators</b></p>	<ul style="list-style-type: none"> <li>• Readiness for school at 5 years (e.g. physical, emotional, behavioural, cognitive)</li> </ul>
<p><b>SELECTIVE (UPSTREAM; SOCIAL REFORM) INDICATORS</b></p> <p><b>Policy objective:</b> review and implement systems of taxation benefits, pensions, and tax credits to provide a minimum income for healthy living standards for children and families</p>	
<p><b>Process indicators</b></p>	<ul style="list-style-type: none"> <li>• Number of regressive taxes. Employment benefits, tax system aligned to meet minimum income for healthy living</li> </ul>
<p><b>Output indicators</b></p>	<ul style="list-style-type: none"> <li>• Income ratios reduced</li> <li>• Reduction in numbers of those living below minimum income for healthy living</li> </ul>
<p><b>Outcome indicators</b></p>	<ul style="list-style-type: none"> <li>• Reduction in adverse health outcomes attributable to living on low incomes</li> </ul>
<p><b>UNIVERSAL (MIDSTREAM; RISK REDUCTION) INDICATORS</b></p> <p><b>Policy objective:</b> improving energy efficiency housing for children and families across the social gradient</p>	
<p><b>Process indicators</b></p>	<ul style="list-style-type: none"> <li>• Fuel prices and affordability based on level of income</li> <li>• Percentage of people with poorly insulated homes</li> <li>• Percentage of population using energy alternatives by geographical area</li> </ul>
<p><b>Output indicators</b></p>	<ul style="list-style-type: none"> <li>• Reduced energy usage per household in different socio-economic groups</li> <li>• Affordability of fuel/housing energy for families with lowest income</li> </ul>
<p><b>Outcome indicators</b></p>	<ul style="list-style-type: none"> <li>• Reduction in adverse (ill-) health outcomes attributable to living in fuel poverty</li> </ul>



<p><b>SELECTIVE (MIDSTREAM; RISK REDUCTION) INDICATORS</b></p> <p><b>Policy objective:</b> improving programmes to address the causes of obesity in children and adolescents across the social gradient</p>	
<p><b>Process indicators</b></p>	<ul style="list-style-type: none"> <li>Percentage of pupils who consume fruit and vegetables daily by SES</li> <li>Percentage of adolescents who are obese/overweight by parental SES</li> <li>Physical activity among young people by parental SES</li> </ul>
<p><b>Output indicators</b></p>	<ul style="list-style-type: none"> <li>Reduction in obesogenic environment and behaviours leading to obesity</li> </ul>
<p><b>Outcome indicators</b></p>	<ul style="list-style-type: none"> <li>Reduction in levels of obesity and diseases associated with obesity in children and adolescents across the social gradient</li> </ul>
<p><b>UNIVERSAL (DOWNSTREAM; RISK REDUCTION) INDICATORS</b></p> <p><b>Policy objective:</b> prioritise investment in ill-health prevention and health promotion among children and families across the social gradient</p>	
<p><b>Process indicators</b></p>	<ul style="list-style-type: none"> <li>Number of information, education campaigns targeting different socio-economic groups</li> <li>Number of people targeted/reached by socio-economic group</li> <li>Level of knowledge and skills on healthy living acquired by socio-economic group</li> </ul>
<p><b>Output indicators</b></p>	<ul style="list-style-type: none"> <li>Improvement in indicators related to healthy living behaviours across the social gradient</li> <li>Increased number of people actively involved in specific disease-prevention and health-promotion programmes by socio-economic groups</li> </ul>
<p><b>Outcome indicators</b></p>	<ul style="list-style-type: none"> <li>Improved disease specific outcomes (incidence, prevalence, mortality)</li> </ul>
<p><b>SELECTIVE (DOWNSTREAM; RISK REDUCTION) INDICATORS</b></p> <p><b>Policy objective:</b> Reduce social inequalities in smoking and alcohol use among children, young people, and families across the social gradient</p>	
<p><b>Process indicators</b></p>	<ul style="list-style-type: none"> <li>Scale, number, and intensity of evidence-based prevention programmes</li> <li>Number of people included in the programme by socio-economic group</li> </ul>
<p><b>Output indicators</b></p>	<ul style="list-style-type: none"> <li>Reduced prevalence of smoking in children, young people, and families across the social gradient</li> <li>Reduced exposure to tobacco smoke for young people and families across the social gradient</li> </ul>
<p><b>Outcome indicators</b></p>	<ul style="list-style-type: none"> <li>Improved disease specific outcomes e.g. linked with tobacco and alcohol (incidence, prevalence, mortality)</li> </ul>

In order to fully understand and appreciate use of the above indicators in practice they should be set within the context of GEF (Davies, Sherriff 2011b). Users of GEF should bear in mind that to use the framework in its entirety requires information, data, and research that may not always be readily available. When gathering further data is not possible, for example due to lack of data collection mechanisms or appropriate gradient-friendly indicators, steps should be taken to notify relevant decision-makers about the need for such data.

## 5.5 GEF IN PRACTICE

As a key part of its developmental process GEF has been pre-tested, by relating it to relevant policies in a number of European member states, and reviewed by a wider group of European experts. With the help of GRADIENT partners and other colleagues, GEF has been pre-tested using a best practice template in the Pomurje Region of Slovenia, in the Flemish Region of Belgium, in Prague in the Czech Republic and nationally in Germany. Respondents were asked firstly to read through and familiarise themselves with the full version of GEF with regard to its scope, purpose and background. They were then provided with GEF in Action – a shortened version of GEF which formed the focus of the pre-test. This version of GEF highlighted Dimension One in particular, which reflects GEF's unique approach to evaluating policies and actions that seek to level-up the gradient in social inequalities in health among children, young people and families. They were then asked to refer back to the full version of GEF if they required more information on any aspect.

Respondents were asked to apply GEF in Action to a specific and relevant policy or intervention/s that either affected or was intending to affect the health and equity of a given population. It was stressed that it was intended to reduce the possibility of error when used retrospectively in terms of reviewing existing initiatives, and also prospectively when designing new ones. They were provided with a series of questions which formed the basis of the best practice template.

The Gradient Equity Lens Overview Sheet was included to help users gain a snapshot of the overall position of their policy action in terms of its 'gradient friendliness' i.e. its likely potential to impact on levelling-up the gradient in health and its social determinants among children, young people and their families. Users were required to simply check red, amber, or green as applicable, noting any major action points or comments as required.







German colleagues from the Federal Centre for Health Education (BZgA) applied the test version of GEF to the work of the National Centre on Early Prevention (NZFH). The ten pilot projects they selected consisted of direct

support to parents and their children, which constituted a downstream measure, together with monitoring and evaluation to help improve the competencies of young people welfare and health workers, which was a midstream/upstream measure. BZgA colleagues clearly understood the eight criteria of GEF Dimension One and its underlying concepts. They found some challenges though in operationalising the tool and answering some of its questions.

In Prague colleagues from the Czech National Institute for Public Health applied GEF Dimension One to policies to increase health literacy among pregnant women. Most of the policy actions were seen as mid-stream targeted lifestyle measures relating to healthy nutrition, non-smoking and improved housing conditions. The basic criteria of GEF Dimension One were clear and overall their operationalisation was straightforward, but there were issues that needed further clarification. For example, GEF was seen to be a tool only for the highest level of policy development as inter-sectoral collaboration was needed. There was also the need to produce clearer guidance on the main social determinants of health. GEF Dimension One was applied to a consultation report on the formulation of a policy to prevent suicide in the Flemish region of northern Belgium. Three groups of policy actions were analysed – universal, selective and targeted measures. Among the universal strategies, three focussed on the social environment – enhancing social inclusion, stimulating help-seeking behaviour, reducing stigma, and making the environment more suicide safe. It was stressed that although suicide is not a health issue for young children, it is necessary to start prevention at an early age.

Figure 5: Pre-test example: a health promotion strategy and action plan for tackling health inequalities in the Pomurje region of Slovenia

 This **Gradient Equity Lens overview sheet** is to help you gain a snapshot of the overall position of your policy action in terms of its 'gradient friendliness' i.e. its likely potential to impact on levelling-up the gradient in health and its social determinants among children, young people and their families. Simply tick **red**, **amber**, or **green** as applicable, noting any major action points or comments as required.

<b>Gradient Equity Lens: Dimension One</b> 	 <b>Comments</b>	 <b>Action Points (including by when and by whom)</b>
<b>Proportionate universalism</b> 	The strategy is planned for long-term implementation; and has been adopted into the regional development programme 2007-2013. The policy is a proportionate in a sense in that vulnerable groups are covered with specific objectives; and in a sense universal: priority health problems such as lifestyle are covered in specific objectives targeting adults in local communities.	Implementation - The coordinator and main carrier of activities is the Institute of Public Health Murska Sobota (IPHMS).
<b>Intersectoral tools for all</b> 	Available data on examples of good practices have been used in preparation and implementation of strategic documents on regional level from Australia, Europe, Canada and the USA; using available evidence and experience. During the last 6 years a step-by-step approach to building a partnership network including stakeholders from different sectors has been adopted.	On-going partnership working with stakeholders from different sectors. Action by IPHMS.
<b>A whole systems approach</b> 	Structure: the strategic document is sensitive to the socio-environmental context, respecting the existing political and welfare system. Reducing health inequities of children and young people is one of the specific objectives; health equity is indirectly involved in other sector policies, what has been connected with objectives of the document There are two programmes and many serials of meaningfully connected activities, which have been implemented each year, some longer than 6 years. All programmes, project and activities are adjusted to the culture, target group and available resources and based on available evidence and empirical experience. The actions have been planned for particular vulnerable target groups, including the most vulnerable ones and for general population. Success is evaluated on a yearly basis for process and structure targets and after 5-10 years on achieved outcomes.	On-going partnership working with stakeholders from different sectors. Action by IPHMS.

<b>Gradient Equity Lens: Dimension One</b> 	 <b>Comments</b>	 <b>Action Points (including by when and by whom)</b>
<b>Scale and intensity</b> <input type="radio"/> <input checked="" type="radio"/> <input type="radio"/>	Resources for evaluation have not been specified. Human resources have not been explicitly specified for evaluation nor for developing and implementing activities. There are planned financial resources for capacity building on yearly basis aimed at public health in general.	There are human and financial resources, which could be aimed at evaluation, but there are no acceptable opportunities for education in evaluation of health promotion/public health within the country. Action by IPHMS is required to lobby for financing of appropriately scaled evaluation activities.
<b>Life-course approach</b> <input type="radio"/> <input checked="" type="radio"/> <input type="radio"/>	The policy is based on life-course approach, particularly targeting pregnant women, pre-school and school children, young people and adults.	Continuation of activities developed by IPHMS, performed with cooperation with local schools, kindergartens, NGO's etc.
<b>Social and wider determinants of health inequalities</b> <input checked="" type="radio"/> <input type="radio"/> <input type="radio"/>	The strategy targets some of social and wider determinants by means of health promotion at regional level.	N/A
<b>Non-geographic boundaries</b> <input type="radio"/> <input checked="" type="radio"/> <input type="radio"/>	Originally the strategy was developed for the Pomurje region of Slovenia, but the process of implementing a bottom-up approach has been spread to the rest of Slovenia. So now each Slovenian region has its own dedicated strategy. However, all document has some common goals and some which are regionally specific.	N/A
<b>Gradient friendly indicators</b> <input checked="" type="radio"/> <input type="radio"/> <input type="radio"/>	No gradient friendly indicators are available. Because of insufficient data on socio-economic stratification and health problems, mainly process and output indicators have been chosen in order to measure the realisation of activities.	Development of appropriate 'gradient sensitive' indicators by IPHMS.  Identification of stratifiers  Identification of (existing) suitable data sets.

Copies of the reviewed version of GEF were sent to a number of European experts to provide constructive feedback and suggestions to facilitate its improvement, to identify any missing parts or weaknesses (technical and presentational) and to gather their overall opinions on GEF and its potential value. Responses were received from experts from Austria, the Czech Republic, Denmark, Finland, Germany, Greece, Italy, the Netherlands, Slovenia and Wales. The following provides a summary of reviewers' comments on the individual sections of GEF and on GEF overall.

### Background

- Comprehensive, clearly presented, providing a solid base
- Some repetition with other sections
- Complex, academic, too much jargon
- Traffic lights good – but needed to clarify their use in practice
- Need to convince people to use GEF, and to highlight outcome benefits

### User Guide

- Concise and understandable
- Undersells GEF – need to highlight the benefits of using it
- Add ‘why you should use GEF’ section
- Gradient Equity Lens is good
- Clarify user – realistic target group

### GEF in Action

- Good research document – but ease of use in practice?
- Link better to case study – how GEF modules completed in practice
- Guidance notes helpful, practical questions, good layout, some repetition
- Awareness of national/regional policy contexts being different in same country

### Case Study Example

- Good case study example – frank and accessible, but narrow in scope
- Need to focus on children and young people
- Useful to show how modules in Section Three could be used in practice
- Use different case studies e.g. western/eastern; regional/national; developing/advanced, narrow/wider policy focus, etc.

### Resources

- Useful, valuable
- Add information to follow-up references in text
- Add guidance on resources needed to apply GEF in practice
- Keep language simple (so as to increase its potential for translation)
- Expand the Glossary

### Overall Views

- Presentational issues – avoid repetition, justify use of GEF
- Improve first three components of Dimension One
- GEF components (4-8) are excellent guiding tools
- If rating bad what to do next to improve?
- In some countries inequalities are not visible: lack of data and information is limited

The findings from the pre-tests and the external review were discussed during a GRADIENT workshop of European experts held in Helsinki in November 2011 and integrated in the final GEF tool. See [www.health-gradient.eu](http://www.health-gradient.eu).

## 5.6 CONCLUSIONS AND RECOMMENDATIONS

Reducing health inequalities is regarded as one of the most important public health challenges facing the EU and its member states (EC 2009). Yet there is a surprising lack of knowledge about which policy actions are effective in reducing these health inequalities, the distributional impacts of (universal) policies and in particular, the actions required to level-up the gradient. This is largely because of the lack of a sound evidence base, which is exacerbated by lack of consensus on meaningful and available measures and indicators.

The development of GEF as a European action-oriented policy tool, linked directly to the policy cycle, is the first attempt to tackle this problem by seeking to inform and guide public health experts to reduce health inequalities and the gradient in health among children, young people and their families. The potential value of GEF has been endorsed through a consensus-building, pre-testing and review process involving a range of European experts from numerous member states. The tool is intended to guide those involved in the policy process (e.g. technical experts working in modern public health) by reducing their possibility of error having developed, or when developing, policies and related actions to increase the potential of levelling-up the gradient in health inequalities.

The process of using GEF to evaluate and/or design a policy action is as important as the outcome. Its underlying principles, theoretical foundations, procedures and mechanisms offer great potential to help clarify which policy actions have more chance of levelling the gradient. Its focus on realist evaluation approaches have proved to be worthy of further investment. GEF is a step in the right direction but only a first step. Further investment is needed to take GEF to the second stage.

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## **CHAPTER 6**

What is the EU Doing to Address the Health Gradient of Children, Young People and Families?



## CHAPTER 6

### **WHAT IS THE EU DOING TO ADDRESS THE HEALTH GRADIENT OF CHILDREN, YOUNG PEOPLE AND FAMILIES?**

Ingrid Stegeman, Cristina Chiotan, Caroline Costongs

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Supranational organisations such as the European Union (EU) and World Health Organisation (WHO) have played an important role in raising awareness about health inequalities through cross-country comparisons that have highlighted national differences and put the issue on the agenda of many EU member states. This chapter will focus on the EU's role in addressing socio-economic gradients in health among children, young people and families, how EU-level initiatives can affect the situation in its member states, and whether the EU is itself mainstreaming (health) equity in relevant policy making processes. The chapter will illustrate how the EU is encouraging explicit action on health inequalities, and, perhaps more significantly, encouraging member states to undertake action on the underlying determinants.

The aim of the EU is to promote peace and, through the creation of an economic union, to generate greater prosperity in order to improve well-being in individual member states. As a supranational body, the EU only has the powers that its member states have granted it. These powers tend to lie in the economic realm, since the principle of subsidiarity applies for health and social issues, which means that the primary responsibility for health and social policy issues lies at member state level. Nevertheless, the EU does have responsibility for ensuring that “a high level of health protection shall be ensured in the definition and implementation of all Union activities”. Since 2009, the Lisbon Treaty has also contained a ‘social clause’, which states that “in defining and implementing its policies and activities, the Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health” (Equity Channel 2010a). Actions taken at EU level therefore have a strong potential to contribute to levelling socio-economic gradients in health among children and young people.

While the EU has little power over how EU member states organise their health and social services, there has been growing awareness that economic integration affects conditions in EU member states that are related to social and health policy, and that stronger EU action is required in these areas. The European Commission's Directorate General for Health and Consumer Protection (DG SANCO) was established in 1999, in large part as a consequence of the so-called 'mad cow disease' and dioxin crisis, which revealed clearly how the creation of a single market have health-related repercussions for member states.

While the EU's aim of improving well-being is both economic and social, there has also been recognition that the social dimension of Europe has progressed less rapidly than the economic one, and that there should be a greater emphasis on this area. In addition, EU member states face many common challenges posed by the economy, demographic changes and increasing costs of social protection, and recognise that they can look to one another for responses and possibly identify common solutions.

## **6.1 EU-LEVEL POLICIES THAT EXPLICITLY ADDRESS HEALTH INEQUALITIES**

Since early 2000, the issue of health inequalities has received growing attention at the EU policy level. Attention was in part stimulated by the accession process, since population health outcomes were generally worse in the new member states than in the old member states. At the same time, the need for a 'social determinants' approach to improving health, and for action on health inequalities within countries was high on the WHO agenda, as well as that of some EU member state governments, who supported its inclusion in the EU agenda. In 2000, Portugal first emphasised these topics during its EU Council Presidency. Over the years, the United Kingdom, Finland and Spain have followed suit during their respective six months as head of the European Council. They organised Presidency Conferences that drew attention to health equity and to the need to act across policy sectors to assure a high level of health promotion (Ministry of Health, Spain, 2010). This led to a series of Council Conclusions on: the common values and principles of EU Health Systems, which confirms that equity is one of these key principles (June 2000 and June 2006); the need for continued efforts to tackle health inequalities (June 2005); the mainstreaming of Health in All Policies (HiAP) (November 2006); and the need to close the gap in health and in life expectancy between and within member states (2008).

The Spanish Presidency Council Conclusions on Solidarity in Health (June 2010) were particularly comprehensive regarding the issue of health equity, and contained specific provisions on what needs to be done by different actors to address these, with specific references to children and young people in the EU. The most recent Council Conclusions under the Polish Presidency (December 2011) focussed on children. Three sets of Council Conclusions were adopted on: prevention, early diagnosis and treatment of chronic respiratory diseases in children; early detection and treatment of communication disorders in children, including the use of e-Health tools and innovative solutions; closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours (European Council 2011).

While these Council Conclusions carry no legislative significance, they reflect a focus on health inequalities and establish common conceptualisations and consensus among member states regarding the importance of addressing an issue, thereby legitimising further EU action in this area.

### **Council Conclusions on Equity and HIAP: Solidarity in Health**

3019<sup>th</sup> Employment, Social Policy, Health and Consumer Affairs Council Meeting, 8 June, 2010.

- Explicitly recognises and 'expresses its concern' that the development of children and young people is influenced by the social and economic circumstances of their parents and community – both having a profound effect on the social gradient in health in adulthood. It also notes that conditions during the first years of life, from the prenatal stage to adolescence, are crucial to reaching adult life in good health.
- **Considers** that it is appropriate to gradually incorporate the equity in health approach into all relevant Union policies, taking into account the social determinants of health and to gradually advance the development of new methodologies and tools for information exchange in order to make this possible.
- **Invites the European Commission to:** develop, together with Member States, a proposal for major elements to be considered when designing... education, health and social services... as an inspiration for reducing health inequalities within and among localities, regions and countries.

- Invites the European Commission and Member States to: Implement policies to ensure a good start in life for all children, including actions to support pregnant women and parents.

This consensus on EU action for health equity is also reflected in funding for numerous initiatives on this topic through EU Public Health Programmes and the EU FP7 Research Programme (e.g. Eurothine, 2004-2007, Closing the Gap, 2004-2007; DETERMINE, 2007-2010, I2SARE, 2007-2010; GRADIENT, 2009-2012, Equity Action, a EC-MS Joint Action on Health Inequalities 2011-2013, DRIVERS, 2012-2015) and since 2009 also through the EU social programme PROGRESS. These projects have and will focus on amongst other things monitoring EU-wide health statistics, sharing good practices among member states, identifying solutions and providing forums for public dialogue and information exchange.

The first broad EU Health Strategy, which was adopted in 2007, also stresses the need to tackle health inequalities (although it failed to do so explicitly in its section on Health in All Policies). The Strategy is currently being implemented through the EC Health Programme *Together for Health* (2008-2013). The EC Communication *Solidarity in Health, Reducing Health Inequalities in the EU* (2009) outlines a series of concrete actions that the EC and member states should take to reduce health inequalities. The Communication indicates, among other things, that the EC and member states should improve co-ordination of policies between different levels of government and across sectors. It reiterates that the EC will complement member state action by facilitating exchange of information and knowledge, promoting the dissemination and uptake of good practices, providing funding for professional training to address health inequalities, and monitoring the impact of policies at all levels on people's health.

In addition, traditional 'vertical' public health initiatives are also being implemented at EU level, for example on alcohol, tobacco, nutrition and physical activity, mental health and environmental health that can improve the health of disadvantaged children and young people. These initiatives encourage member states to monitor, exchange and provide information, set targets and develop effective interventions in their countries around these issues. It is important that these public health initiatives and those on health inequalities in particular continue to be high on EC funding programme agendas.

## 6.2 EU2020 AND HEALTH INEQUALITIES

The need to address health inequalities is implicitly a part of the EU's overall 2020 Strategy for *Smart, Sustainable and Inclusive Growth* (2011-2020) (EC 2011). This Strategy is the EU's overriding policy 'roadmap', and is a powerful instrument which affects the determinants of health inequalities. It sets out the EU's long-term plan to become a strong and sustainable economy with strong employment opportunities, and to be highly competitive, social and green. All major policies in the EU should be aligned to this strategy, which includes five headline targets that have to be translated into national targets and plans. It also includes seven 'flagship initiatives' to stimulate progress under each priority theme. Health equity can be linked to three of the five headline targets and to three of the seven flagship initiatives.

### **EU2020 Strategy Headline Targets** (relating to health equity):

- 75 per cent of the population aged 20-64 should be employed;
- The share of early school leavers should be under ten per cent and at least 40 per cent of the younger generation should have a tertiary degree;
- 20 million less people should be at risk of poverty

### **EU2020 “flagship initiatives”** to support the achievement of the headline targets (relating to health equity):

- “Youth on the move” to enhance the performance of education systems and to facilitate the entry of young people to the labour market;
- “An agenda for new skills and jobs” to modernise labour markets and empower people by developing their skills throughout the life cycle, with a view to increasing labour market participation and better match labour supply and demand, including through labour mobility;



- The “European platform against poverty” to ensure social and territorial cohesion so that the benefits of growth and jobs are widely shared and people experiencing poverty and social exclusion are enabled to live in dignity and to take an active part in society.

The strategy recognises that achieving inclusive growth in the EU will require modernising and strengthening employment, education and training policies and social protection systems, as well as increasing labour market participation and reducing structural unemployment. It will also require improving access to childcare facilities and implementing ‘flexicurity’ principles to enable people to acquire new skills to adapt to new conditions. The strategy makes an explicit reference to health inequalities by noting that “a major effort will be needed to combat poverty and social exclusion and reduce health inequalities to ensure that everybody can benefit from growth” (EC 2011).

The EU2020 headline targets and the supporting flagship initiatives represent key entry points for EU member states to reduce health inequalities. Achievement of these targets can potentially improve health, since they relate to important social determinants of health and can lead to a better distribution of population health since (for example) those most likely to drop out of school and be unemployed come from lower socio-economic groups (Stevens *et al.* 2006). At the same time, health is a prerequisite to the achievement of these goals, since maximising people’s physical and mental well-being improves their quality of life and thereby their productivity and employability, as stressed in the upcoming EC *Health for Growth* Programme (2014-2020).

### **Implementation of EU2020**

EU member states are requested to implement the EU2020 Strategy by applying a series of ten integrated guidelines for the economic and employment policies that were developed by the EC, setting out the reforms that EU member states should undertake to help achieve the headline targets. Member states establish their own targets on the basis of the guidelines, and develop ‘National Reform Programmes’ (NRPs) explaining in detail the actions they will take to achieve them, with a particular emphasis on how to achieve measures to remove the bottlenecks that constrain sustainable

growth at national level. Guideline 10, which is about “promoting social inclusion and combating poverty, supporting income security for vulnerable groups, social economy, social innovation and gender equality” and which refers to the poverty headline target, is most relevant to health equity (Council decision 21 October 2010).

A related key mechanism to help member states meet their targets on social protection (health and long-term care and pensions) and in the area of poverty and social inclusion is the Open Method of Coordination (OMC). The EC requests member states to, on a voluntary basis, submit additional annual reports outlining their progress and objectives relating to social protection and inclusion. To assess progress on ‘health and long-term care’ for example, member states are asked to provide data on, amongst other primary indicators, *life expectancy by socio-economic status*, *healthy life years by socio-economic status* and *infant mortality by socio-economic status*. These specific indicators are ‘under preparation’ and most countries have not provided the requested data on them.

While actions linked to the EU2020 Strategy can represent important entry points to reduce health inequalities, member states do not have a legal obligation to implement the measures outlined in their National Reform Programmes that relate to social protection and employment. While the EU OMC processes encourage them to do so, and provide platforms for support and exchange to help them implement reforms that are in the societal best interest, the EU institutions cannot apply sanctions if member states engage only superficially in the process. In addition, the current economic crisis will hinder concrete progress on achieving the headline targets, as austerity measures are likely to lead to a widening of social and health inequalities. The risk exists that member states will focus primarily on meeting quantitative employment targets, rather than on ensuring that these targets are achieved through the creation of quality jobs, as discussed in Chapter 3.

The EU is, however, proposing large budgets for initiatives that can support member state activities in this area and encourage them to take action. In order to achieve the EU2020 headline targets of improving education levels and increasing the employment rate to 75 per cent by 2020, the EU is proposing, under its post-2013 budget, to allocate €15.2 billion in the area of education and training (EC 2011). A simplification of current structures into one main programme (encompassing youth, sport, lifelong learning, and higher education policies) is also foreseen in order to avoid fragmentation, overlapping and/or proliferation of projects that lack the mass necessary to make a lasting impact (EC 2011).

Another important tool that different actors in the EU can apply to reduce health inequities is PROGRESS (EC Programme for *Employment and*

*Social Solidarity*, 2007-2013). This is a financial instrument supporting the objectives of the EU in the areas of employment, social inclusion and social protection, working conditions, anti-discrimination and gender equality. PROGRESS aims to contribute to the achievement of the EU2020 Strategy and will, together with the European *Employment Services* and the *European Microfinance facility* (EURES) amalgamate into the *Programme for Social Change and Innovation* (PSCI 2014-2020). The PSCI will support policy co-ordination, exchange of best practices and innovative policies and capacity building with the aim of helping to scale-up the most successful measures with support from the European Social Fund.

### 6.3 OTHER EU-LEVEL POLICIES RELATED TO THE HEALTH OF CHILDREN, YOUNG PEOPLE AND FAMILIES

There are a wide range of other policies that are being implemented at the EU level that do not specifically address health equity, but which nevertheless influence the socio-economic gradient in health among children and young people.

- In 2006, the EC communication "*Towards an EU strategy on the Rights of the Child*" proposed to establish a comprehensive EU strategy to effectively promote and safeguard the rights of the child in the EU's internal and external policies, and to support member states' efforts in this field. The 2011 **EU Agenda for the Rights of the Child** presents general principles that should ensure that EU action respects the provisions of the United Nations Convention on the Rights of the Child (UNCRC) and of the EU Charter on Fundamental Rights. It focusses on a number of concrete actions in areas where the EU can bring real added value, such as child-friendly justice, protecting children in vulnerable situations and fighting violence against children both inside and outside the European Union. In November 2011, the EC appointed a new "Child Rights Coordinator" to mainstream children's rights in all relevant EU policies. However, many children's rights organisations working in the EU feel that the EU Agenda for the Rights of the Child, expected to develop the EU strategy, appears to be a compilation of on-going actions rather than a coherent vision of how children's rights will be implemented across EU policies. They nonetheless also feel that the Agenda sets out important actions that can contribute to the health and well-being of all children in the EU. (CRAG 2011, Global Movement for Children 2011) The EU has also launched the "Youth in Action" programme (2007-2013), which encourages young people, especially those from disadvantaged backgrounds, to participate in public life and to promote their interests.

- In 2012 the European Commission is planning to release its recommendation to member states on how to address **child poverty**. While EC recommendations are without legal force, they have the political weight to encourage action in EU member states. The recommendation is expected to outline effective tools to monitor and assess child poverty, and to present essential measures that member states can take to reduce child poverty. In order to encourage member states to act upon the recommendation, the EC will continue to promote the exchange of best practice on effective policies to combat child poverty and promote child well-being.
- The EC has also taken actions to encourage member states to develop and improve the quality of **Early Childhood Education and Care Programmes** (ECEC). In recent years member states have indicated that they wish to co-operate more closely at EU level on issues relating to increasing the quality of ECEC.

### Child care and pre-school in the EU

In 2002, at the Barcelona Summit, the European Council established that EU member states should provide at least 90 per cent of children between three and compulsory school age full-day places in formal childcare arrangements. Places should be provided to at least 33 per cent of children under three. Progress on the targets was uneven. For 0-3 year olds for example, five countries exceeded the 33 per cent target, and five others were approaching it, but the majority were falling behind, with eight achieving only ten per cent or less (EC 2011).

In 2009, the European Council adopted a strategic framework for co-operation in education and training until 2020, which included among the priorities for the period 2009-2011 'to promote generalised equitable access and reinforce the quality of the provision and teacher support in pre-primary education'. They set new European benchmarks on early childhood education by 2020 which don't cover 0-3 year olds but call for 95 per cent of children between the age of four and starting compulsory primary education to participate in early childhood education (European Council 2009).

The EC also issued a Communication on *Early Childhood Education and Care - Providing all our children with the best start for the world of tomorrow* (2011) which recognised that early childhood education can lay the foundations for later educational success, especially for those from disadvantaged backgrounds. The Communication calls on member states to effectively use early education and care programmes to promote equity, and to design efficient models to finance this. It also encourages member states to apply Structural Funds to invest in these areas.

- Finally, **equity between women and men** is one of the European Union's founding values, and goes back to 1957 when the principle of equal pay for equal work became part of the Treaty of Rome. Several EU policies and programmes therefore aim to ensure equal pay policies, and to ensure that women's competences receive the same valuation as men's. While gender inequalities still exist, the EU has made progress in this area over the last years, thanks to equal treatment legislation, gender mainstreaming and specific measures for the advancement for women. The *Strategy for equality between women and men* represents the European Commission's work programme on gender equality for 2010-2015.

Many of the measures that are being taken by the EU in relation to and affecting children, young people and families, such as those mentioned above, tend to be non-binding, and seek to stimulate member states to take action themselves. It is up to member states to determine whether certain population groups should be additionally targeted according to need and how to achieve this.

There also numerous **binding legislative initiatives** coming from the EU level that impact on children and young people in EU member states. Such measures tend to take the form of decisions or of directives, which first need to be transposed into national law. Many relate to the common market (tobacco advertising and labelling, food labelling, toy safety, drug prevention) or to issues related to the labour market, such as maternity or parental leave. The *EU Pregnant Workers Directive* (Directive 92/85/EEC) sets minimum provisions for maternity leave of 14 weeks at the level of sick pay. Parental leave (which enables parents to take time out of employment after maternity leave or later on), is also regulated at EU level. The revised *EU Parental Leave Directive* will give parents an individual right to four months of parental leave each, of which at least one month needs to be strictly non-transferable between parents (Directive 2010/18/EU).

Other binding legislative initiatives relate to the environment; the new Directive on *ambient air quality and cleaner air for Europe* for example, establishes new air quality objectives for fine particles including exposure reduction targets. This will have a direct effect on children's health, particularly those from families with a low socio-economic status, who are more heavily exposed to pollution and noise caused by urban traffic (UBA 2009).

### **Common Agricultural Policy and Structural Funds**

Two other important areas of EU policy that are not immediately associated with children and young people or families, but which nevertheless affect them, namely the Common Agricultural Policy (CAP) and Structural Funds, will be briefly addressed here, since they are the largest EU 'spending posts'.

The CAP, which receives over 40 per cent of total EU funding, was initially developed to ensure safe, adequate food at reasonable prices and also for sustainable production. The CAP has however led to high fruit and vegetable prices, to high saturated fat and protein content, and to relatively cheap meat and dairy products. Although diet is influenced by many different factors such as cultural origin, food choices are also largely determined by price, access and availability, most notably among people from lower socio-economic groups (WHO 2006). The CAP therefore influences what children and young people in the EU eat. While successive attempts to reform the CAP have mitigated some adverse impacts, they have largely overlooked public health concerns. Some efforts have been made by the EC to find synergies between agriculture policy and stimulating healthier food choice, which has resulted in programmes such as the School Milk Scheme and the School Fruit Scheme, designed to increase the access of vulnerable groups and children to different foods. In general, however, impact assessments of measures related to the agricultural policy should include a stronger health and equity dimension, to assess how they affect health and well-being across the social gradient (Equity Channel 2010b).

The EU Structural Fund policy also indirectly affects the lives of families, children and young people in the EU. About 36 per cent of the total EU budget is spent on structural development programmes to ensure greater equity between EU regions. Most of these funds have been spent on developing infrastructures within poorer EU member states to facilitate economic development. During the programming period 2007-2013, health was, for the first time, included in the list of priorities and a small percentage of the funds (estimated at €5 billion) was made available for health-care related projects, such as the construction and renovation of health-care facilities (Equity Channel 2011). In theory however, Structural Fund money could also

be allocated to “community development” projects to improve the health of children and young people in specific areas by building community social capital (see Chapter 4). However, it is difficult for health organisations and institutions at local level that are not specialised in accessing these funds to do so. This situation will change post-2013, as health will no longer be a thematic priority, but included in priorities focusing on “promoting employment and supporting labour mobility” and “promoting social inclusion and combating poverty”. It will therefore require creativity to apply Structural Funds to address the social determinants of health and the social gradient.

In addition, it will be a challenge to ensure that Structural Funds spent on non-health sector investments, such as large infrastructure projects, actually promote population health and health equity, by making pre and post-project evaluations that assess these issues a funding requirement. Initial efforts to mainstream health priorities into non-health sector investments, so as to impact on the broader determinants of health, are just beginning. In 2010, for example, DG SANCO issued a tender to identify and collect information about how health considerations were taken into account in the design and development of non-health Structural Fund investments in the period 2007-2013, and to develop tools to support in a practical manner the better integration of health considerations in Structural Fund planning and implementation<sup>37</sup>. In addition, a Joint Action between the EC and a number of EU member states on health inequalities (2011-2014) is, among other things, looking at how the Structural Funds can be applied in EU regions to improve health equity<sup>38</sup>.

#### **6.4 THE NEED FOR BETTER DATA AND HEALTH EQUITY IMPACT ASSESSMENTS OF ALL EU POLICIES**

As already indicated in Chapter 1, the EC has made valuable contributions to identifying common indicators that can be applied by all member states to collect information on population health status and on the social determinants of health. Many EU member states are, however, not collecting this data on a regular basis, and it remains very difficult to harmonise data collection processes to obtain comparable information from across EU member states. Compounding these difficulties is the problem of correlating the data on health and the social determinants with socio-economic stratifiers, so as to obtain a good picture of health inequalities and socio-economic gradients in health across countries (Chiotan, Costongs 2010). Improving

37 See <http://www.healthgain.eu>.

38 Further information on this is available on <http://www.health-inequalities.eu>.

this situation is critical to making progress in reducing health inequities and levelling-up the socio-economic gradient in health among children and young people in the EU.

Differences in data collection and use amongst countries have for example led to inconsistent research outcomes on whether or not health inequalities are lower in social democratic welfare regimes than in others, as suggested in Chapter 2. Some studies have for example found that southern and western European countries reported smaller inequalities in mortality and other health measures than Scandinavian Countries (Eikemo *et al.* 2008a; 2008b; Espelt *et al.* 2008; Mackenbach *et al.* 2008). These results seem to point to the fact that while the Scandinavian countries have, through a universal approach, substantially improved population health, relative health inequalities still remain fairly steep (Lundberg 2008; Beckfield, Krieger 2009 ; Brennenstuhl *et al.* 2011; Muntaner *et al.* 2011). Such inconsistencies in research outcomes have been attributed to differences in indicators and the use of relative measures of health inequalities, which makes it difficult to compare across countries (Bambra 2011). The EC could play a valuable role in helping to improve understanding of, and developing common methodological approaches to facilitate sound comparisons.

Better data will also make it easier to assess the impact of EU policies on health inequalities, in order to reduce them where possible; the need for this was stressed by the EC Communication on Health Inequalities (2009). While the instruments for such assessments are in place, the political will to gather the necessary data and to conduct them is not, and stronger efforts are required to make better use of these instruments at the EU level.



## EC Impact Assessment

The Secretariat General (SG) is one of the Directorates-General (DGs) and specialised services that make up the European Commission. Its role is to ensure the overall coherence of the Commission's work, by establishing broad objectives and setting out yearly work plans. The Secretariat General places great emphasis on integrated policy making and on impact assessments of new policy initiatives. These impact assessments should take into consideration three main policy dimensions: economic, environmental and social impacts, the latter of which includes considerations relating to health and equity.

As a general rule, all major policy initiatives and legislative proposals on the yearly work plans are required to undergo formal impact assessment. The EC document Impact Assessment Guidelines (EC 2005) provides more information on how EC officials that are developing policies can supply information about likely impacts on the three main policy dimensions indicated above. The document notes that identifying impacts on different groups in society is a crucial part of impact assessment, since options that would be beneficial to society as a whole may fail to be implemented if too little account is taken of how the positive and negative impacts are spread across society. Among the many potential social impacts that those developing new policy proposals are asked to consider are whether the policy will lead directly or indirectly to greater (in) equality, whether it affects the health and safety of individuals, and whether it would have specific effects on particular groups.

Despite the fact that assessments should be made of how new EU policy initiatives impact on health and on different social groups, a scan by Euro-HealthNet of some recent impact assessments suggested that it is seldom prioritised and carried out, due to the wide range of other impacts for consideration. This was confirmed by the mid-term evaluation of the Health Strategy, which analysed the extent to which health impacts are considered in EC Impact Assessments (IAs). In principle, IAs were expected to be one of the key tools for implementing the Health in All Policies (HiAP) approach at Commission level. The evaluation results suggested, however, that the EU Health Strategy has not led to increased consideration of health IAs. The analysis shows that the percentage of Commission IAs that included an assessment of health impacts peaked in 2007/08, but declined again since then (EC 2011). Another

review of EU impact assessments came to the conclusion that EU-level impact assessments seem to be under-exploited by the health sector (Stahl 2009).

Initiatives like the Gradient Evaluation Framework (Chapter 5) are therefore important tools that can facilitate the process of determining the “health gradient” friendliness of policies and initiatives, also at the EU level.

## 6.5 CONCLUSIONS

The final chapter of this book has reflected that there has been a growing awareness about the issue of health inequalities at EU level, which has been reflected in policy making processes. Subsequent Council Presidencies for example produced conclusions relating to health inequalities, and the EU issued a Communication on health inequalities in 2009, encouraging and outlining specific measures for action at EU and at EU member state level. While health and health equity as explicit concerns are not in the overall framework of the overriding EU2020 Strategy, it nevertheless provides important entry points for action on key underlying determinants of health inequalities such as education, poverty and unemployment.

This chapter has mentioned a range of measures that are being taken in the EU that can have a significant impact on the health and well-being of children, such as those relating to the rights of the child, to parental leave schemes, to early child education and care, as well as those relating to the environment, the Common Agricultural Policy and Structural Funds. The upcoming recommendation on child poverty can serve as an important incentive for member state action on this topic.

While all of these measures can have an important impact on levelling-up socio-economic gradients in health among children and young people in the EU, the true effects are unknown. This is because there is still little consideration for health and health equity within EU Impact Assessments or as a part of policy evaluation. While the EU has identified common EU indicators, EU surveys should be strengthened to collect data on these indicators and they should be conducted more systematically within member states. This would generate the necessary data to design strategies, to monitor health equity and to evaluate the impact of policies and strategies across different socio-economic groups.

While the EU's influence on measures that can affect social gradients in health among children and young people should not be overestimated, since EU competencies in the areas of health and social protection are limited, they should not be underestimated either. EU member states face common social and economic problems, to which they must find common solutions. The EU can play a valuable role in identifying the most effective approaches and stimulating action among Member States to achieve the collective aim of improving well-being.

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**CONCLUSIONS AND  
RECOMMENDATIONS**



## CONCLUSIONS AND RECOMMENDATIONS

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Health inequalities and socio-economic gradients in health are receiving growing attention in many EU member states and at the EU level. Nevertheless, social inequalities, which underlie health inequalities, continue to grow in most EU member states. EU member states generally recognise the need to take action on health inequalities, but too often regard this as improving the health of the poorest segments of society. As such, they are not taking action across the entire socio-economic gradient, so that everyone can enjoy their right to “the highest attainable standard of health”.

Since levelling-up the socio-economic gradient in health among children and young people has been suggested as the best strategy for addressing health inequities in general, this book has investigated how this can be achieved. Chapter 1 provided a general overview of the social gradient in health among children, young people and their parents in the EU. Chapter 2 and 3 looked at the impact of different welfare state regimes on good health outcomes across the social gradient, and in addition looked at the kinds of policies and interventions that are effective in levelling-up health gradients. Chapter 4 investigated the role of community social capital as a “health asset”, and its effect on mediating the impact of socio-economic status on health inequalities among children and young people – a previously understudied topic. The GRADIENT Evaluation Framework introduced in Chapter 5 can help to boost the evidence based on levelling-up social gradients in health. It can be applied to facilitate and stimulate more evaluations of policies and interventions on their distributional impacts and effects on health. Finally, Chapter 6 presented what is being done at the EU level to ensure that *all* children and young people in the EU get the right start to a healthy life.

This final chapter summarises the findings and provides recommendations for the EU, national, regional and local level.



## EARLY INVESTMENT IS LONG-TERM GAIN

1. Socio-economic gradients in health demonstrate the fact that health inequalities concern everyone in society, not simply those who are worst off but all those whose health is less optimal than it should be. The systematic nature of the socio-economic gradient in health also shows that health inequalities are unfair and unjust. This is particularly the case when it comes to children and young people, who are likely to bear the adverse effects of growing up in lower socio-economic classes throughout the course of their lives.

As such, governments, the private sector and other social actors should promote equity in health and education as a top-level policy goal, particularly among children and young people, and develop coherent approaches across policy sectors which reinforce one-another to achieve this goal. Governments should recognise that **investments in addressing the systematic underlying causes of ill health among children and young people will generate social and economic returns**. Austerity measures that reduce the ability of parents to care for children and which cut rather than invest in, for example, quality early child education and care programmes, will backfire by leading to even greater costs and social instability in the long run.

## PROPORTIONATE UNIVERSAL POLICIES ARE MOST EFFECTIVE

2. The most effective approach to improving the well-being of children and young people is to ensure their family or caretakers' ability to nurture them. This is best achieved through universal policies that redistribute societal resources. Universal policies do not entail policies applied uniformly. To ensure that universal measures effectively level-up the socio-economic gradient, governments should first assess and address the specific pathways that lead to bad health in different socio-economic groups and across their life courses. The effects of multiple disadvantage may, for example, inhibit the ability of disadvantaged families, children and young people to benefit equally from certain universal measures. **Universal policies should therefore be designed to address proportionally greater need with greater intensity and/or link service fees or taxes to ability to pay**. In addition and where necessary, universal measures should be complemented by targeted measures, such as well-designed programmes to prevent early school leaving, to ensure that children and young people and families in most need get the support they require.

## “MAMA WORKING”

3. Governments should take into account the characteristics of their welfare regimes and recognise that the socio-economic structures and cultures that existed when they were first established, such as families supported by a single male wage earner, may no longer reflect current social realities. They should consider adapting their approaches accordingly, by developing new ones and prioritising measures like **activating labour markets and expanding the provision of quality early child education and care programmes so that they are accessible and affordable to all, to ensure that mothers, particularly those in low income groups, can work.** Evidence shows that stimulating maternal employment not only improves family incomes, it also leads to greater paternal involvement in family activities and benefits children.

In many countries, lone mothers and their children are exceptionally vulnerable to poverty, social exclusion and poor mental and physical health; that this is not the case in all countries demonstrates that effective measures can be taken to avoid this. Governments should therefore pay particular attention to the situation of lone mothers and support them through the provision of income support, high quality education and care services, and access to good quality and flexible employment, which enable them to combine work with lone parenthood.

## COMMUNITY SOCIAL CAPITAL BENEFITS HEALTH

4. Community level “health assets” like community social capital and initiatives that increase cohesion, co-operation and interpersonal trust, can play an important role in levelling-up the social gradient in the health of children and young people. Evidence from GRADIENT shows that health gains incurred by increasing social capital are particularly marked for disadvantaged (or vulnerable) children and young people in communities with low social capital.

Governments should therefore increase **the capacity of local authorities to develop policies and interventions that strengthen community social capital, especially in disadvantaged areas with high levels of health inequalities and/or low levels of social capital.** This entails the formation of local organisations, particularly those that foster positive norms and values relating to health and health behaviours, such as physical activity, drinking or non-smoking. The evidence

suggests that this benefits not only those directly involved in the organisations, but also the health of the whole community. Providing subsidised membership fees to local sport clubs in disadvantaged areas with low levels of social capital is a concrete measure that local authorities can take to build community social capital and improve health. Other examples are measures that foster interaction among parents, such as parent-school associations, attractive playgrounds or measures that lower the (perceived) level of crime in communities with low levels of social capital. Local authorities should be conscious of which groups in the community (mothers, unemployed young people, etc.) need support and invest in the development of community organisations to address the needs of these groups.

In light of the evidence of the positive association between community social capital and health among children and young people, governments should also invest in measuring levels of social capital in communities. Combining the results of health surveys which include social capital measures with social cohesion indexes in communities can generate important insights into the effects of changes in community social capital on the health of community residences. **This entails developing and refining measurement tools to record the level of community social capital**, identifying the effects of existing programmes on social capital and integrating information about social relationships into the design and implementation of new programmes. Such measures would make it possible to gain a better understanding of how different policies interact in building and eroding social capital, and on how different policies affect health. The need to build rather than erode cohesive communities and societies is particularly important in times of economic crises and social change.

## EVALUATE THE DISTRIBUTIONAL IMPACT OF POLICY MEASURES

5. Governments must get better at assessing the **prospective and post-facto impacts of policies and measures on health across different socio-economic groups**. It is essential to identify what works, to ensure that all children and young people can get the right start to a healthy life. To date, the evidence base on effective action to tackle health inequalities is biased towards smaller interventions that address the symptoms, since this is easier to do, rather than the underlying causes of health inequities as set out in this book. Governments must make greater efforts to improve and implement approaches to monitor the effects of universal policies on the health of people across the whole social

gradient. **The Gradient Evaluation Framework can be applied as a tool to facilitate this.** Given the current economic situation, which is driving many governments in EU member states to make indiscriminate cuts to public services, it is crucial to assess the distributional impact of these policies and to ensure that the cuts do not hit those who are already the hardest off.

EU institutions, together with health experts, must ensure that the relevant EU authorities take health impacts across the socio-economic gradient into account in Impact Assessments, by providing them with pertinent evidence.

## INVOLVEMENT OF CHILDREN AND YOUNG PEOPLE

6. Governments, policy makers and practitioners must ensure the **participation of children, young people and families across the socio-economic gradient in the design and implementation of policies and interventions**, to ensure that these address their expressed needs and effectively reach them. Public health and health promotion specialists have long stressed the need to consult with user groups, including children and young people, and to involve them in the development and implementation of initiatives. This is also obligatory under governments' commitments to the Rights of the Child. However, the views, interests and needs of all user groups are often still lacking in design, implementation and evaluation processes. Governments, policy makers and practitioners must also communicate their policies in clear and understandable ways, to facilitate the participation and uptake of all user groups across the social gradient.

## INCLUSION OF HEALTH GRADIENT INDICATORS IN EU2020

7. Governments should regard the **magnitude of health inequalities and the steepness of health gradients in their countries as an overall indicator of 'fairness' in their society**, and as an indicator of whether they are achieving their targets under the EU2020 Strategy. This means that national, regional and local governments should measure health inequalities and socio-economic gradients in health on a regular basis. This in turn requires the **use of common indicators across EU member states and the regular collection of relevant data to monitor health inequalities.**



## GLOSSARY

Giorgio Barbareschi, Aagje Ieven

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### CHILD

A child means each and every human being below the age of 18 years. Young people above the age of 18 who have not settled into adult life, and who are specifically targeted by public policies are also included in this definition. Specifically, we will use the following terms to describe different age categories:

- Early Childhood (0-5 years), which includes the following sub-categories:
  - Newborns (0-12 weeks)
  - Infants (0-12 months)
  - Toddlers (1-3 years)
  - Preschool (3-5 or 6 years)
- Middle childhood (6-12 years)
- Adolescents (12-18 years)
- Young people (15-24 years)

The United Nations defines young people as persons between the ages 15-24. The United Nations Educational, Scientific and Cultural Organisation recognises young people as a heterogeneous group in constant evolution, and that the experience of 'being young' varies enormously across regions and within countries (UNICEF 1989; UNESCO 2006).

### COMMUNITY

A specific group of people, often living in a defined geographical area who share common culture, beliefs, values and norms, and are arranged in a social structure according to relationships that the community has developed over a period of time. They exhibit some awareness of their identity as a group, and share common needs and a commitment to meeting them (WHO 1998).

**COMMUNITY SOCIAL CAPITAL:** *See social capital.*

## **CYCLE OF POVERTY**

An apparently endless continuation of poverty. The cycle is characterised by a set of factors or events by which poverty, once started, is likely to affect an individual and be passed through generations, unless there is outside intervention. Once a person has become poor, this tends to lead to other disadvantages, which may in turn result in further poverty (Hutchinson Online Encyclopedia).

## **DETERMINANTS OF HEALTH**

The determinants of health are factors which influence health status and determine health differentials or health inequalities. They are many and varied and include natural, biological factors, such as age, gender and ethnicity; behaviour and lifestyles, such as smoking, alcohol consumption, diet and physical exercise; the physical and social environment, including housing quality, the workplace and the wider urban and rural environment; and access to health care. All of these are closely interlinked, and differentials in their distribution lead to health inequalities (Labonté 1993; Lalonde 1974).

## **DIFFERENTIAL IMPACT ON HEALTH**

When a factor (e.g. psychosocial, environmental) produces differences in health between different socio-economic groups, it means that those factors have a differential impact across the social gradient (Scott, Horne, Thurston 2000).

## **DISADVANTAGED FAMILIES AND VULNERABLE CHILDREN**

In 1984 the European Union defined the “poor” as : “those whose resources (material, cultural, and social) are so limited as to exclude them from the minimum acceptable way of life in the member states in which they live”. “Child poverty” is measured on the basis of the EU agreed definition of “at risk of poverty”, i.e.: a) the poverty risk threshold is set at 60 per cent of the national median equivalised household income; b) the household income that is considered is the total household income (including earnings of all household members, social transfers received by individual household members or the household as a whole, capital income, etc.); c) household income equivalised on the basis of the OECD modified equivalence scale in order to take account of the differing needs of households of different size and composition (so as to better reflect households’ living standards);

and d) national at-risk-of-poverty rates are analysed jointly with the level of the related national poverty thresholds expressed in Purchasing Power Standards (SPC 2008).

Families receiving less than the 60 per cent of the national median income are considered economically and socially disadvantaged and at high risk of falling into the poverty cycle. Children from disadvantaged and poor families, often with unemployed parents, lacking adequate nutrition, clothing, and housing, and with scarce cultural and educational resources, are particularly likely to develop, among others, health problems. The Family Affluence Scale developed in the context of the Health Behaviour in School-Aged Children (HBSC), was used in GRADIENT as a measure of family socio-economic status (Currie *et al.* 2008; SPC 2008; UNICEF 2007;). Also see Poverty.

## **EFFECTIVENESS**

The ability of an action, programme, intervention, project, and/or policy to do what it was intended to do: produce a desired result or effect in such a way that it can be measured (from the European Observatory on Health Systems and Policies Glossary 2009). Within the context of this project, the desired effects of public (health) policies is defined as its ability to level-up the health gradient.

## **EQUITY IN HEALTH**

Equity is the absence of unfair, avoidable differences in health among and between groups of people, whether these groups are defined socially, economically, geographically or demographically. Health equity/equity in health means that everyone has a fair opportunity to attain their full health potential, and no one should be disadvantaged from achieving their potential (WHO 2009a).

## **EVALUATION**

An assessment of the extent to which public health/health promotion actions achieve a valued or desired outcome. However, in many cases it is difficult to trace the pathway which links particular action to health outcomes (e.g. because of the technical difficulties of isolating cause and effect in complex, 'real-life' situations). Indeed, "...good evaluation does not necessarily provide definitive answers – instead they reduce uncertainty about the consequences of a choice". Evaluations inform a body of evidence that over time helps to frame the issues and sharpen the focus on how we



think about the net benefits for health, quality of life and other ingredients of happiness. Evaluation is thus inherently political and context specific (Leviton, Khan, Dawkins 2010).

## **EVIDENCE**

Knowledge gathered from a variety of sources, including qualitative and quantitative research, programme evaluations, client values and preferences, and professional experience (Scott, Gall 2006).

## **EVIDENCE-BASED POLICY**

An approach that helps people make informed decisions about policies, programmes and projects by putting the best available evidence from research at the heart of policy development and implementation. This approach stands in direct contrast to opinion-based policy, which relies heavily on either the selective use of evidence (e.g. on single studies irrespective of quality) or on the untested views of individuals or groups, often inspired by ideological standpoints, prejudices, or speculative conjecture (Davies 2004).

## **FAMILY**

Official definitions of families used in census in different populations have changed in the last decades (Reiska 2011). For example the definition of the family proposed by the UN in 1974 was replaced by a reference to “cohabitating partners” (UNECE 1998:191). Moen and Schorr (1987) suggested that rather than using a universal definition of family, it would be better to define the family according to the particular issue involved. They proposed that when dealing with issues of child support the use of a definition including household with children is most appropriate. Thus for the purposes of this book we considered children living with their family, regardless of the modality of cohabitation with their parents.

**GRADIENT:** *See Socio-economic gradient in health.*

## **GRADIENT EVALUATION FRAMEWORK**

The Gradient Evaluation Framework (GEF) is an action-oriented policy tool to guide policy makers when designing and evaluating their policies and related actions to reduce health inequalities. Linked directly to the policy

cycle, it is designed specifically to assist policy-makers working at the member state level to evaluate the likely impact of their policies and related actions on levelling-up the gradient in health and its social determinants among children, young people and their families. It seeks to guide policy-makers by reducing chances of error when developing policies and related actions to level-up the gradient in health inequalities (Davies, Sherriff 2012).

## **HEALTH**

Health is a state of complete physical, mental and social well-being, and not merely the absence of disease or infirmity. Health is a resource for everyday life, not the object of living and is a positive concept emphasising social and personal resources as well as physical capacities (WHO 1986).

## **HEALTH BEHAVIOUR**

Any activity undertaken by an individual, regardless of actual or perceived health status, which promotes, protects or maintains her/his health status, whether or not such behaviour is objectively effective towards that end (WHO 1998).

**HEALTH DETERMINANTS:** *See Determinants of health.*

**HEALTH EQUITY:** *See Equity in health.*

**HEALTH GRADIENT:** *See Socio-economic gradient in health.*

## **HEALTH IN ALL POLICIES**

The interdependence of public policy requires a specific approach to make policy intervention fully effective. "Governments can coordinate policy-making by developing strategic plans that set out common goals, integrated responses and increased accountability across government departments. This requires a partnership with civil society and the private sector" (WHO 2010). Health is recognised as a fundamental resource, which is necessary to meeting policy challenges. For these reasons the health sector needs to engage systematically across government and with other sectors to address the health and well-being dimensions of their activities. The health in all policies strategy implies that "the health sector can support other arms of government by actively assisting their policy development and goal attainment" (WHO 2010).

## **HEALTH INDICATOR**

A health indicator is a characteristic of an individual, population, or environment which is subject to direct or indirect measurement and can be used to describe one or more aspects of the health of an individual or population (quality, quantity and time) (WHO 1998).

## **HEALTH INEQUALITIES**

Health inequalities are measurable differences in health and health outcomes between different population groups – according to socio-economic status, geographical area, age, disability, gender ethnic or other characteristics. Differences in health status are largely attributable to a differential distribution of health determinants between different population groups. However some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case health inequalities are unavoidable. In the second, the uneven distribution is avoidable, unjust and unfair, and actions must be taken to reduce or eliminate the resulting health inequalities. In GRADIENT we use the term inequalities and we take it as synonymous with inequity (Whitehead 1990; WHO Glossary).

## **HEALTH PROMOTION**

The comprehensive social and political process of enabling people to increase control over and improve their health through actions aimed at strengthening individual awareness and skills, changing individual behaviour and changing social, organisational, political, and economic conditions that support good health practices (WHO 1998; Sihto et.al 2006).

## **HEALTHY PUBLIC POLICY**

Characterised by explicit concern for health and equity in all areas of policy, and by accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing (WHO 1998; European Observatory on Health Systems and Policies 2007).

## **INDICATOR**

An indicator is a measurable unit that provides a clue to a matter of larger significance, or makes perceptible a trend or phenomenon that is not immediately detectable. An indicator's defining characteristics are that it quantifies and simplifies information in a manner that promotes the understanding of societal problems, to both decision-makers and the public. Above all, an indicator must be practically and realistically measurable, given the many constraints faced by those implementing and monitoring policies and projects (Joint Research Centre, European Commission).

## **INTERSECTORAL COLLABORATION**

The factors that influence health inequalities extend far beyond the responsibilities of the health sector. Intersectoral collaboration is a recognised relationship between part or parts of different sectors of society which take joint action on an issue to achieve health outcomes or intermediate health outcomes in a way which is more effective, efficient or sustainable than might be achieved by the health sector acting alone (WHO 1998).

## **LEVELLING-UP THE SOCIO-ECONOMIC GRADIENT IN HEALTH**

Levelling-up the social gradient in health was introduced by Whitehead and Dahlgren to highlight the concept that "the only way to narrow the health gap in an equitable way is to bring up the level of health of the groups of people who are worse off to that of the groups who are better off" (2006). Levelling-down is not an option, although it might unintentionally be a consequence of the application of a wrong policy.

## **LIFE COURSE APPROACH**

The life course approach, also known as the life course perspective or life course theory, refers to an approach developed for analysing people's lives within structural, social and cultural contexts. A life course is defined as "a sequence of socially defined events and roles that the individual enacts over time". In particular, the approach focusses on the connection between individuals and the historical and socio-economic context in which these individuals lived. As the life course perspective looks at the full lifespan, from pre-birth to death, and health is influenced even before birth, pregnant women are also included in the research (Mortimer, Shanahan 2003).

## **LIFESTYLE**

Lifestyle is a way of living based on identifiable patterns of behaviour which are determined by the interplay between an individual's personal characteristics, social interactions, and socio-economic and environmental living conditions (WHO 1998).

## **POLICY MAKER**

A person with formal power to influence or determine policies and practices at European, international, national, regional, or local level. We use 'policy-maker' as a generic term to refer to both policy formulators and decision makers (e.g. Ministers of Health) and their policy evaluators or senior technical advisors (e.g. civil servants, external experts, etc.).

## **POVERTY**

Since the evaluation of thresholds of poverty differ per country, criteria of poverty is arbitrary, and it is open to discussion whether living conditions of those living under the poverty line in one country are similar to those living under the poverty line in another country. This suggests that further indicators of economic strain, such as being able to manage unexpected expenses, taking one week of annual holidays away from home, being able to adequately heat a home and to provide nutritious foods on a regular basis should be used in surveys, in order to get a more accurate picture of child poverty in the EU (OECD 2006; SPC 2008). Also see Disadvantaged families and vulnerable children.

## **PROTECTIVE FACTORS**

Protective factors are conditions in families and communities that, when present, increase the health and well-being of children and families. These attributes serve as buffers against the adverse impact that stressors exert on health, helping children and parents to find resources, support, and develop coping strategies (Pearlin 1989).

## **PROPORTIONATE UNIVERSALISM**

The term "progressive (or proportionate) universalism" is based on the principle whereby 'the scale and intensity of provision of universal services is proportionate to the level of disadvantage'. Socio-economic advantage is

linked to better health across all social economic groups, not just a dichotomy between the richest and poorest. Therefore targeted approaches do not provide a complete solution. Policy actions must be universal but with a different scale of intensity to reduce the steepness of the social gradient in health (Marmot 2010).

## **PUBLIC HEALTH**

The science and art of monitoring and promoting health, preventing disease, and prolonging life through the organised efforts of society (WHO 1998).

## **QUALITY OF LIFE**

Quality of life is defined as individual's perception of their position in life in the context of the culture and value system where they live, and in relation to their goals, expectations, standards and concerns. It is a broad-ranging concept, encompassing a person's physical health, psychological state, level of independence, social relationships, personal beliefs and relationship to salient features of the environment (WHO 1998).

## **RISK FACTOR**

Social, economic or biological status, behaviours or environments which are associated with (or cause) increased susceptibility of a specific disease, ill health, or injury (WHO 1998).

**SES:** See Socio-economic status and Socio-economic group.

## **SOCIAL CAPITAL**

There are two main schools of thought regarding the definition of social capital. *The first school* focusses on social cohesion and it is influenced by the seminal work of Robert Putnam, who conceived Social Capital as a *community-level* resource and defined it as features of social organisation such as networks, norms and social trust that facilitate co-ordination and co-operation for mutual benefit.

*The second school* focusses on the social network and is influenced by the work of Pierre Bourdieu who defined social capital as "the aggregate of the actual or potential resources which are linked to possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition".

Community Social Capital. Within GRADIENT social capital is conceptualised in line with the social cohesion school, as a collective characteristic of places arising from people's shared experiences. It can be defined as the quantity and quality of social relationships, such as formal and informal social connections, as well as norms of reciprocity and trust that exist in a place or a community (Kawachi, Berkman 2000; Bourdieu 1986; Putnam 1993).

## **SOCIAL COHESION**

Communities that have high levels of social capital, strong levels of collective efficacy, and low levels of social disorganisation, and are described as 'socially cohesive'. Although no single definition exists, it is important to note that social capital and social cohesion are *not* the same thing. For example, a criminal organisation like the mafia may provide social capital to its members without contributing to the level of social cohesion in a community (Kawachi, Kennedy, Wilkinson 1999).

**SOCIAL INEQUALITIES IN HEALTH:** *See Health inequalities.*

## **SOCIAL NETWORK**

A social network is defined as "the web of social relationships that surround an individual". People are embedded in all kinds of social configurations, like peer groups, family structures, love affairs, colleague groups, neighbourhoods, organisations, clubs, and so on. Social networks could be considered the "structural" element of social capital (Berkman, Glass 2000).

## **SOCIAL SUPPORT**

Social support refers to the assistance available to individuals and groups from within communities that provide a buffer against adverse life events and living conditions, and provide a positive resource for enhancing the quality of life (WHO 1998).

## **SOCIAL DETERMINANTS OF HEALTH**

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are influenced by policy choices (WHO 2009b).

## **SOCIO-ECONOMIC GRADIENT IN HEALTH**

Refers to the linear or step-wise decrease in health that comes with decreasing social position (Marmot 2004). It represents the association between socio-economic position and health across the whole population. In whatever way health is measured, there tends to be a gradient on which the most socially and economically advantaged group have better health and well-being, and lower rates of illness and death than disadvantaged groups. In western societies, the shape of the gradient tends to be relatively smooth, with mortality and morbidity increasing, and self-reported health and well-being decreasing steadily as social disadvantage increases. Over time, the gradient as a whole tends to shift upwards because overall the health of most groups is improving. However, the degree and rate of improvement tend to be greater in more advantaged social groupings, meaning that relative differences, and therefore the degree of inequities and inequalities, also tend to increase (Marmot 2004).

## **SOCIO-ECONOMIC GROUP**

A grouping of people with similar values, interests, income, education, and occupations (Mosby 2009). See also Socio-economic status.

## **SOCIO-ECONOMIC STATUS (SES)**

Socio-economic status (SES) describes an individual or family's relative position in society. This relative position is defined operationally by indicators such as educational attainment, occupation, income and house or car ownership. These variables are therefore considered a good indication of the likelihood that they will be exposed to health damaging factors or possess particular health enhancing resources.

Differences in socio-economic status reflect differences in:

- Economic resources (income, house holding)
- Psychosocial resources (self-efficacy, social capital)
- Cultural resources (cultural capital, educational differentiation)
- Demographic resources (migration, ethnic groups)
- Geographic resources (district variations, urban and rural areas) (Lynch, Kaplan 2000).



## TARGETED POLICY APPROACH

The targeted policy approach identifies a target population segment and monitors the outcomes being attained as the policy develops. This strategy is extensively used, and may well be aligned with other social programmes. However, it has limitations, since its beneficiaries are a subgroup accounting for only a small percentage of the population and its specific problems. In other words, it may not help reduce inequity because it neither integrates action on other structural or intermediary factors, and nor is it targeted at other social groups (Marmot 2004).

## UNIVERSAL POLICY APPROACH

Universal approaches, which produce overall health improvement, involve comprehensive efforts intended to impact on the health of the entire population, including groups of different socio-economic status. Some examples are actions against violence and traffic accidents, the improvement of work conditions and workplace environment (smoking), or the fight to improve environmental conditions. In the long run, universal interventions tend to be both easier to implement and more cost effective than targeted programmes (Marmot 2004).

## WELFARE STATE REGIMES

Gøsta Esping-Andersen distinguished three distinct types of welfare regimes which differed in arrangements between the state, market and family in providing income and services, the way the welfare state influences the system of stratification and affects the social citizenship rights including the decommodification of labour. The three types of regimes are:

- *Liberal regime*: represented by the 'Anglo-Saxon' countries, which favour minimal public intervention under the assumption that the majority of citizens can obtain adequate welfare from the market. The role of government is to nurture rather than replace market transactions and this explains why these countries favour subsidising private welfare via tax deductions.
- *Social-democratic*: represented by the Nordic countries and characterised by its emphasis on universal inclusion and its comprehensive definition of social entitlements. It is also one that has been vocally committed to equalise living conditions across the citizenry. For this

reason, policy has deliberately sought to marginalise the role of private welfare markets and of targeted social assistance. The model is also internationally unique in its emphasis on 'de-familialising' welfare responsibilities, especially with regard to care for children and the elderly.

- *Conservative-corporatist*: represented by the majority of continental European countries - Austria, Belgium, France, Germany, Italy, the Netherlands, and Spain. These welfare states all have conservative origins. The foundations were built around social insurance, often along narrowly defined occupational distinctions. This implies that entitlements depend primarily on life-long employment which has, historically, helped strengthen the male-breadwinner logic of social protection. With the partial exception of Belgium and France, this regime is strongly familialistic, assuming that primary welfare responsibilities lie with family members. Policies that help reconcile motherhood and careers are relatively undeveloped. These welfare states are transfer-heavy and 'service lean' (Esping-Andersen, Myles 2009).

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## The Right Start to a Healthy Life

Levelling-up the Health Gradient Among Children, Young People and Families in the European Union – What Works?

In all EU countries there is a systematic correlation between the level of health and social status - a step-wise decrease in health that comes with decreasing social position. These social gradients in health are harmful and unjust, particularly when it comes to children and young people, since adversity in the early years negatively impacts health throughout the life-course.

This book aims to identify what measures can be taken to level socio-economic gradients in health. It looks at:

- Political and welfare-state factors
- How universal policies on social protection, education and health systems can contribute to reducing gradients in health
- Why community social capital matters
- The importance of monitoring the distributional effects of all policies
- The Gradient Evaluation Framework
- The role of the EU in tackling social gradients in health

The book provides final recommendations for policy makers and practitioners so as to ensure that all children and young people in the EU get the right start to a healthy life.



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