Can we promote equity when we promote health?

The answer to this question is not self-evident. A large number of empirical studies throughout the world show higher mortality and morbidity rates and increased risk among people with lower education, lower income or a lower classified occupation, compared to people in higher socio-economic groups. In many countries there is now a reasonable picture of what are the inequities in health and we have a much better understanding of why they occur. However, we still seem to be some way from understanding how to tackle inequities. Over the last few years organisations such as the World Bank have joined WHO in stating that these inequities can only be reduced through an intersectoral approach and through the pursuit of economic growth policies that benefit the poor.

Many scientists argue that it is necessary to pursue equity in health by creating equal opportunities to achieve health. This principle—in accordance with the Ottawa Charter—is justified through the framework of maximising individual freedom of choice, and requires that everyone be given the opportunity to be as healthy as possible. As Stronks and Gunning-Shepers (1993) suggest, a distinction can be made between unjust, unavoidable and acceptable health inequalities. The determinants of socio-economic differences which lead to inequalities considered to be unjust must be the target for appropriate policies. That is also the basic proposal of Dahlgren and Whitehead (1992) who have presented an analysis of the policies and strategies to promote equality in health.

The preparatory document of the Fourth International Conference on Health Promotion—New Players for a New Era—concludes: ‘Where inequity and poverty increase, so does disease’ (WHO, 1996). We must recognise that the currently used tools of health promotion and primary prevention can at best only achieve solid results among the middle and upper-middle classes of society. This also means that effective health promotion is likely to contribute to the increase of social inequalities in health. The old health education and prevention dogmas are often useless among the poor, ethnic minorities, the unemployed and immigrants. Sometimes conflicting interests—like equity versus value for money—will make it difficult to develop a health promotion strategy to influence these inequities.

Positive discrimination is also not without risk. Segregation sharpens the focus but at the same time it easily confirms the segregation, and deepens the difference. Unless health promoters are really able to empower as they work, their effect might be controversial. The path of victim-blaming and moralising leads nowhere. In the socially excluded groups the everyday alternatives of middle-class healthy lifestyles are lacking. The media usually do not work and the skills for self-help and self-organisation are generally low.

Ideally, strategies to reduce social inequalities in health should be based on solid research. However, the causal mechanisms from macro-economic and social phenomena to a biological outcome, are rarely studied. We should, for example, learn much more from modern social stratification theories in the social sciences.

In a historical perspective there is, however, evidence of successful public health policies and programmes for reducing social inequities (e.g. infant mortality, communicable disease). There are grounds for modest optimism—even in times of cost containment and restrictions regarding the possibility of reducing social inequities in health, or at least reducing the upward trend.

No country has—in spite of health being one of the most important factors for our well-being—yet developed an explicit and comprehensive healthy public policy with a clear focus on equity. The main strategy should be to integrate an equity dimension in all multisectoral actions for health, including economic and labour-market policies.

As Dahlgren and Whitehead (1992) point out, we should consider the typical clustering of risk
factors and the linkages between living conditions and so-called ‘lifestyle’ factors. The challenge, then, is to break the dynamics of the vicious circle of poor health, rather than focus upon each risk factor separately. Empowerment becomes a critical issue. So does the relationship between health policy and social, education and immigration policies, all of which have great impact on the integration of groups and individuals in society. More attention should be paid to the outreaching of community-based health promotion, not only from the perspective of health but also from the perspective of social participation.

Wilkinson (1996), in his recently published book Unhealthy Societies, the Afflictions of Inequality, concluded that among the developed countries it is not the wealthiest countries which, on average, have the best health, but rather the countries with the smallest income gaps between rich and poor.

The Jakarta Conference will review and evaluate the impact of health promotion on equity and identify innovative strategies to achieve success. We all have to work on this vital issue for the next century.

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REFERENCES


