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Inequalities in health and wellbeing and their social determinants - some international comparisons and recommended actions

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Overview

- Norway is a country characterised by a high and increasing standard of living for much of the population
- But with some significant and growing social and economic inequalities.
- Despite a long tradition of reducing these inequalities by introducing welfare policies and structural measures, inequalities in health and the social determinants of health persist and are widening for some groups

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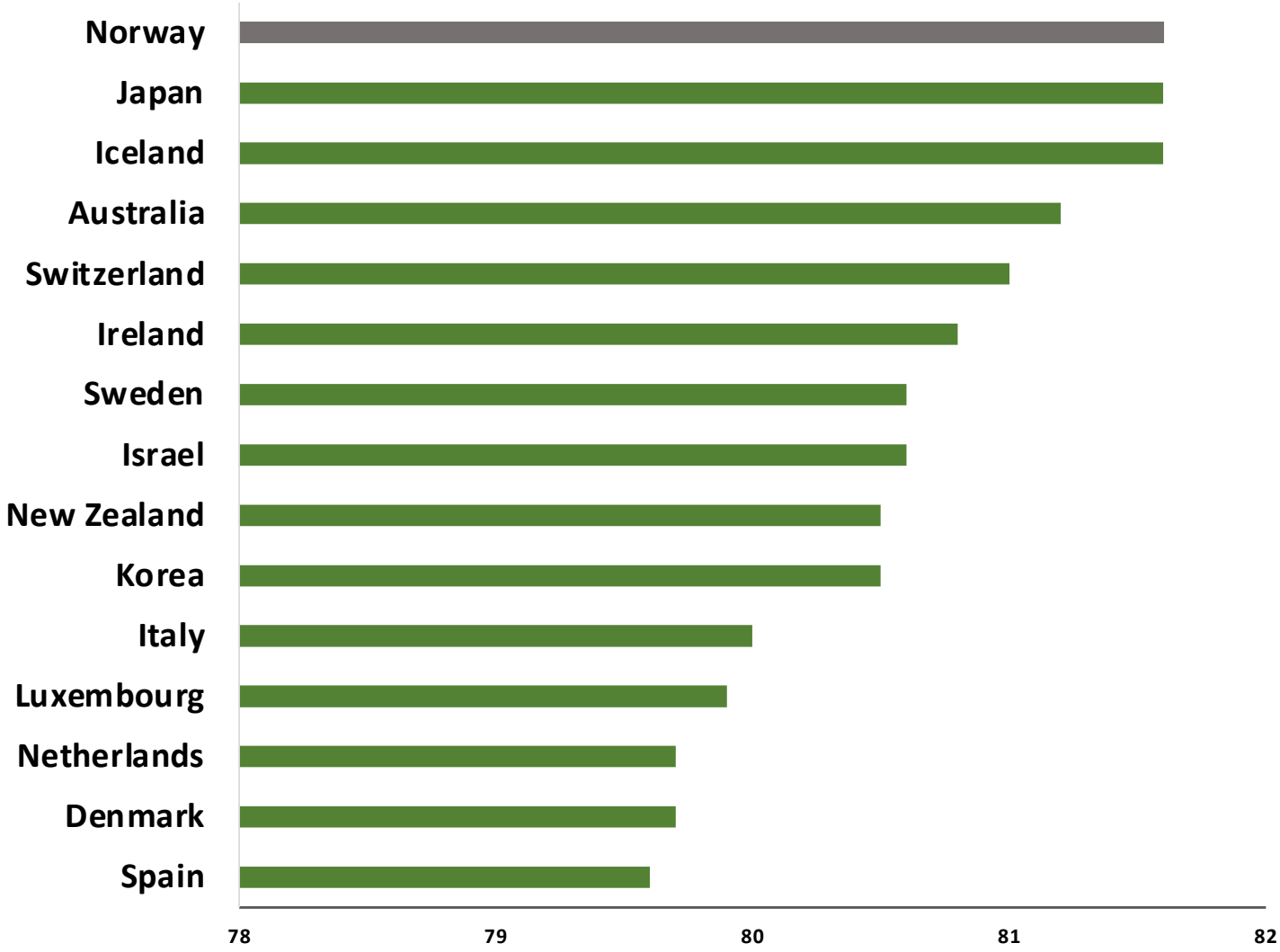
Countries with the highest life expectancy on the OECD database: males, 2020



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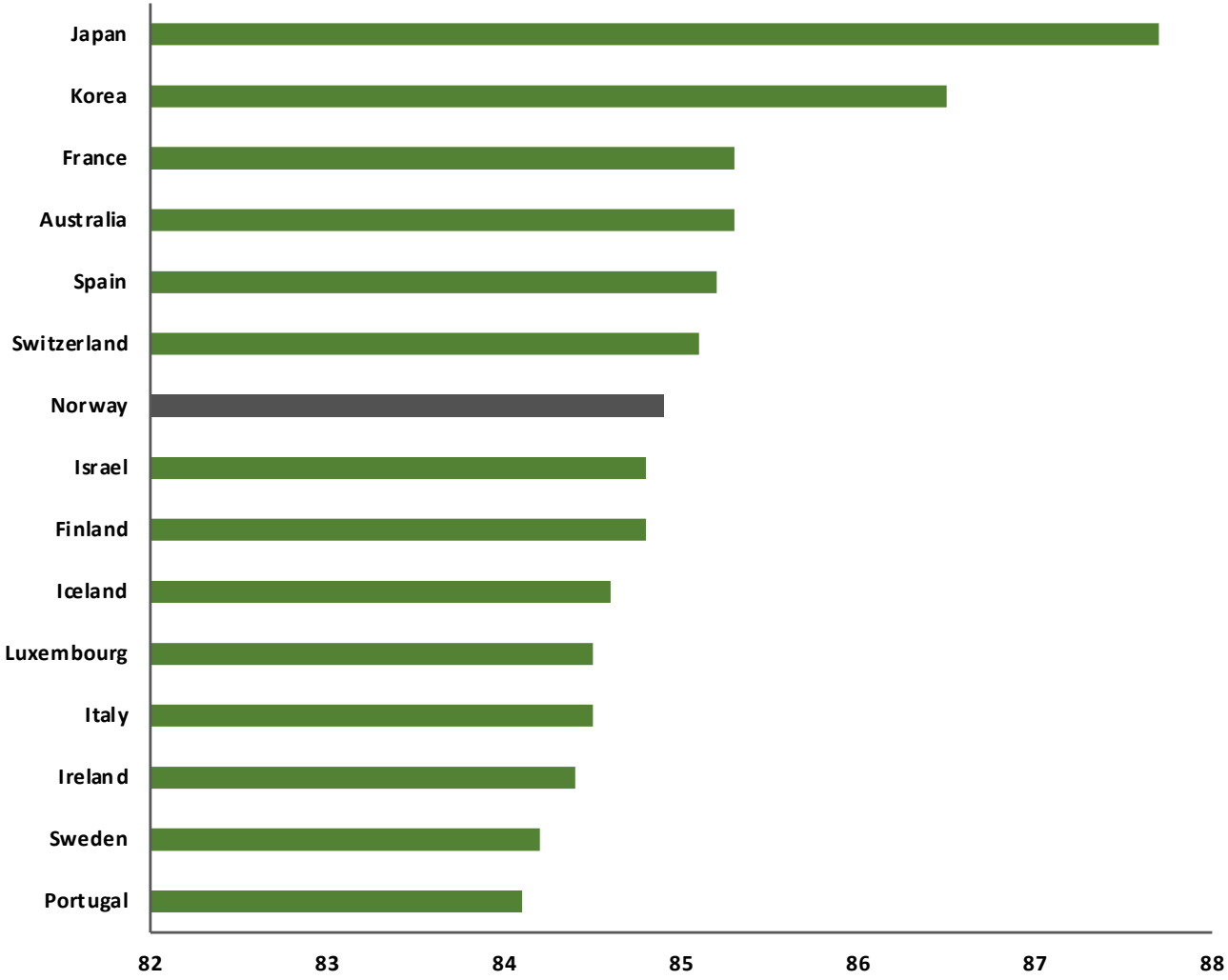
Countries with the highest life expectancy on the OECD database: females, 2020



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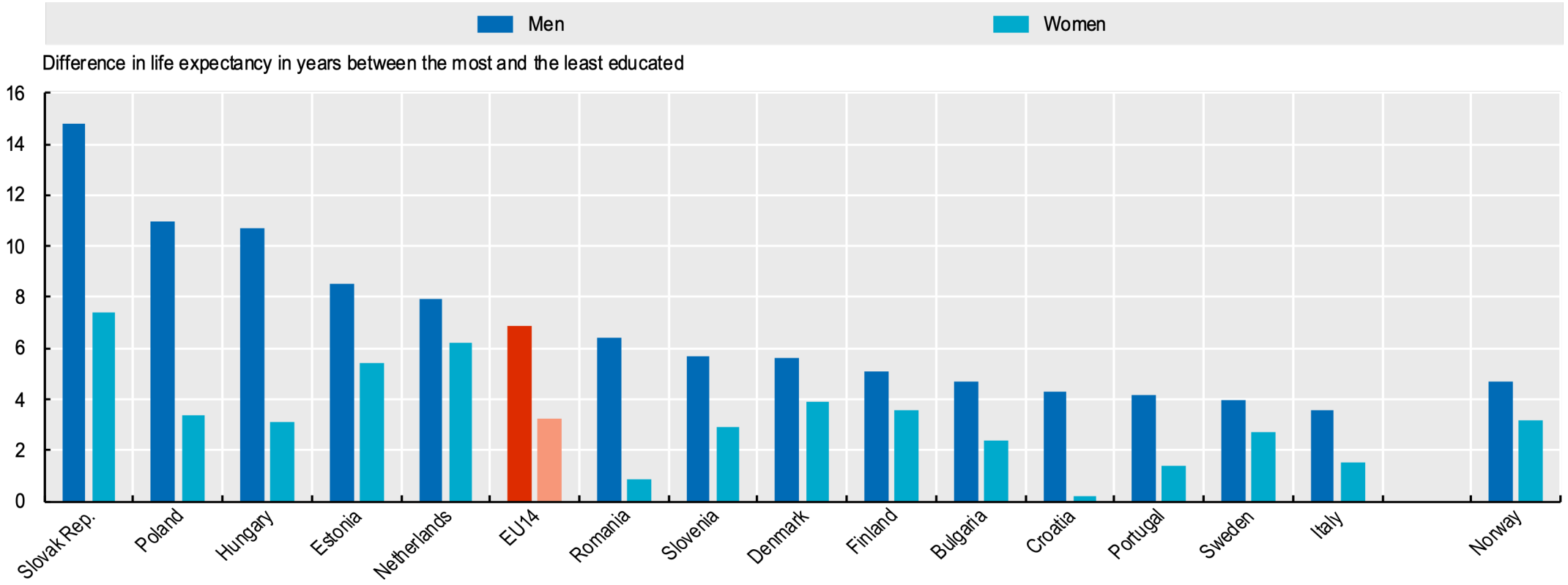
Gap in life expectancy at age 30 between people with the highest and lowest level of education, 2017 (or nearest year)



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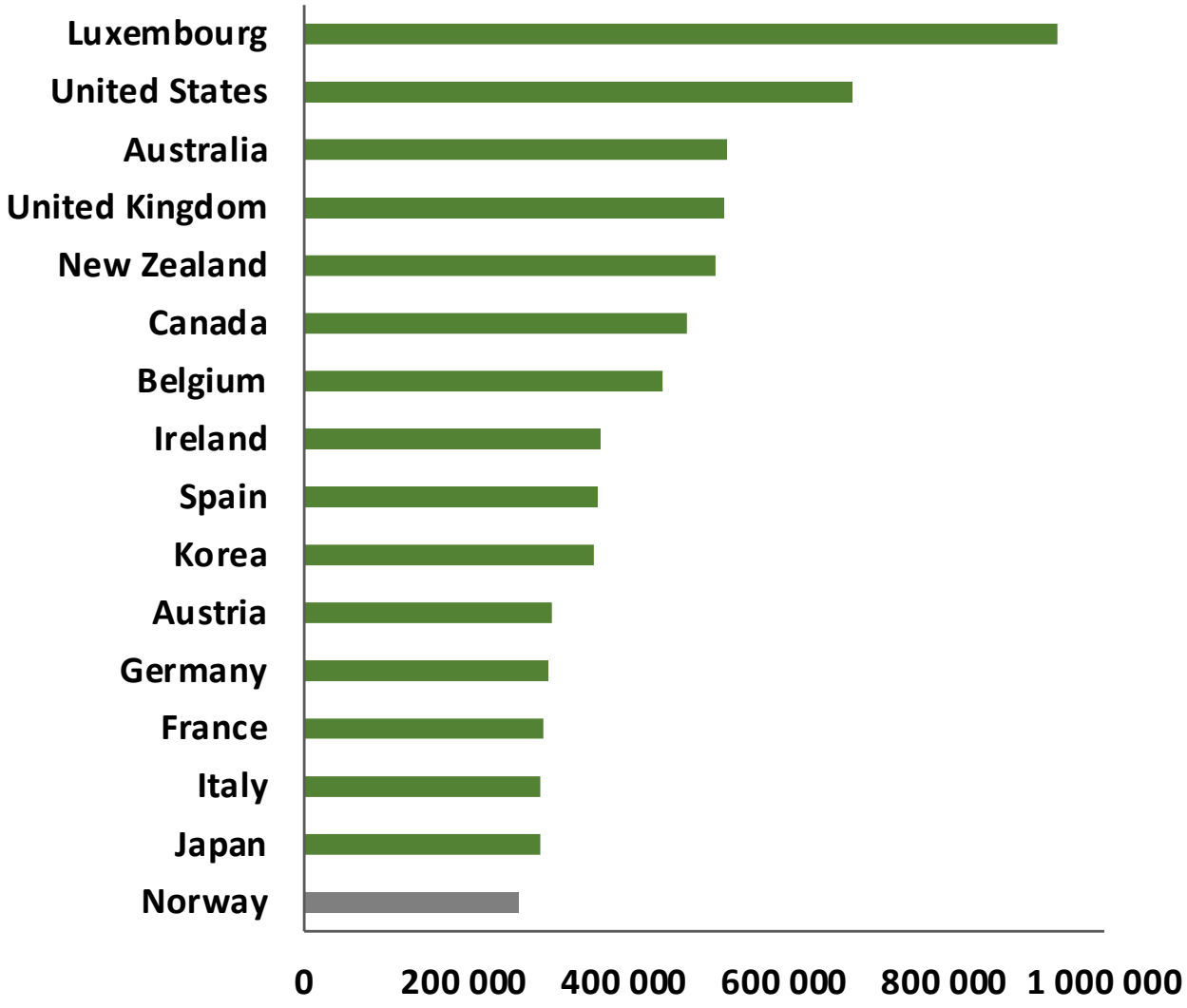
Countries with the highest household net wealth: OECD Better Life Index



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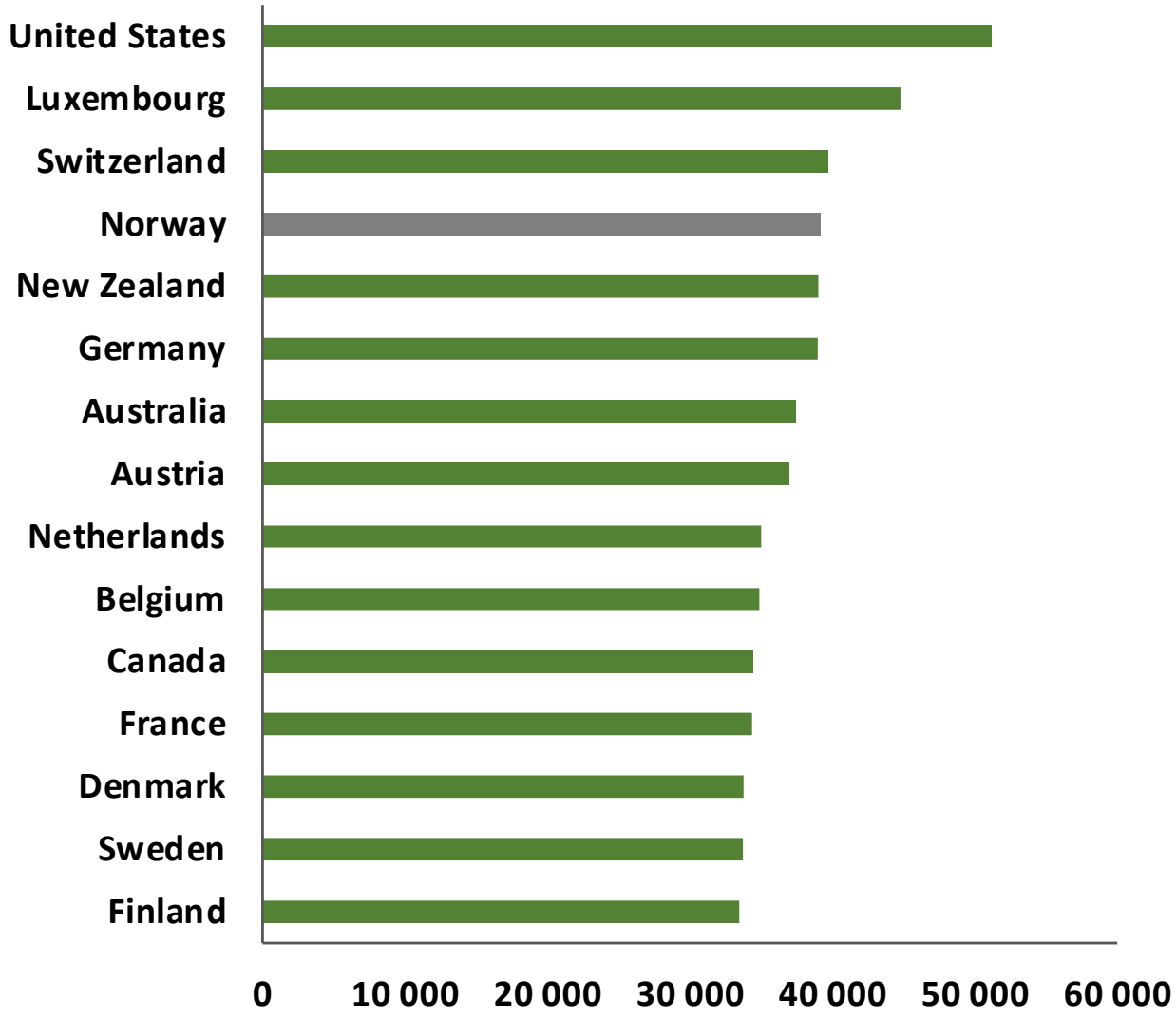
Countries with the highest household net adjusted disposable income: OECD Better Life Index



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Countries reporting their income distribution to the OECD : Gini coefficient of income inequality, 2020

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Countries with the lowest labour market insecurity: OECD Better Life Index

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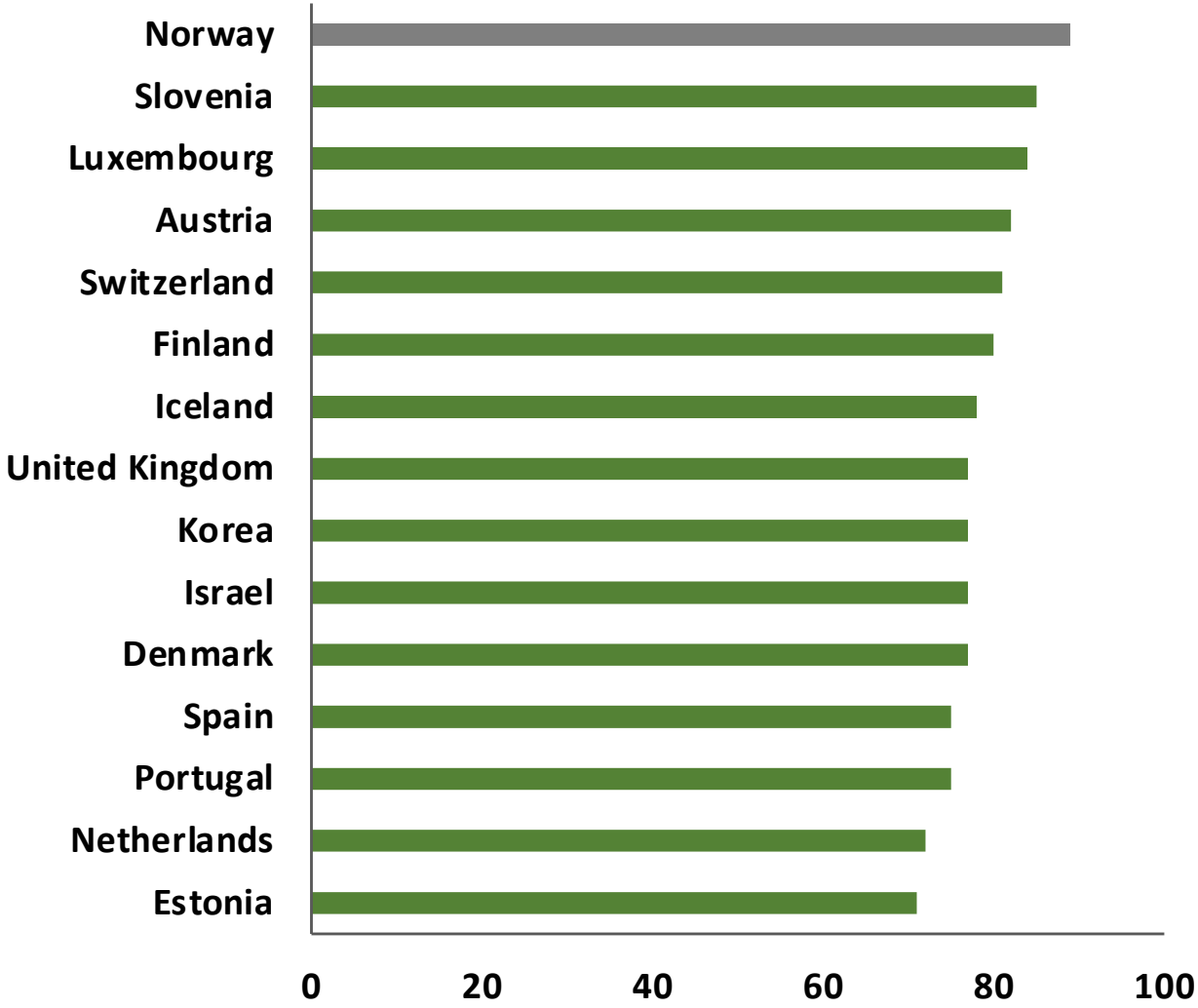
Countries with the highest percent of women feeling safe walking alone at night: OECD Better Life Index



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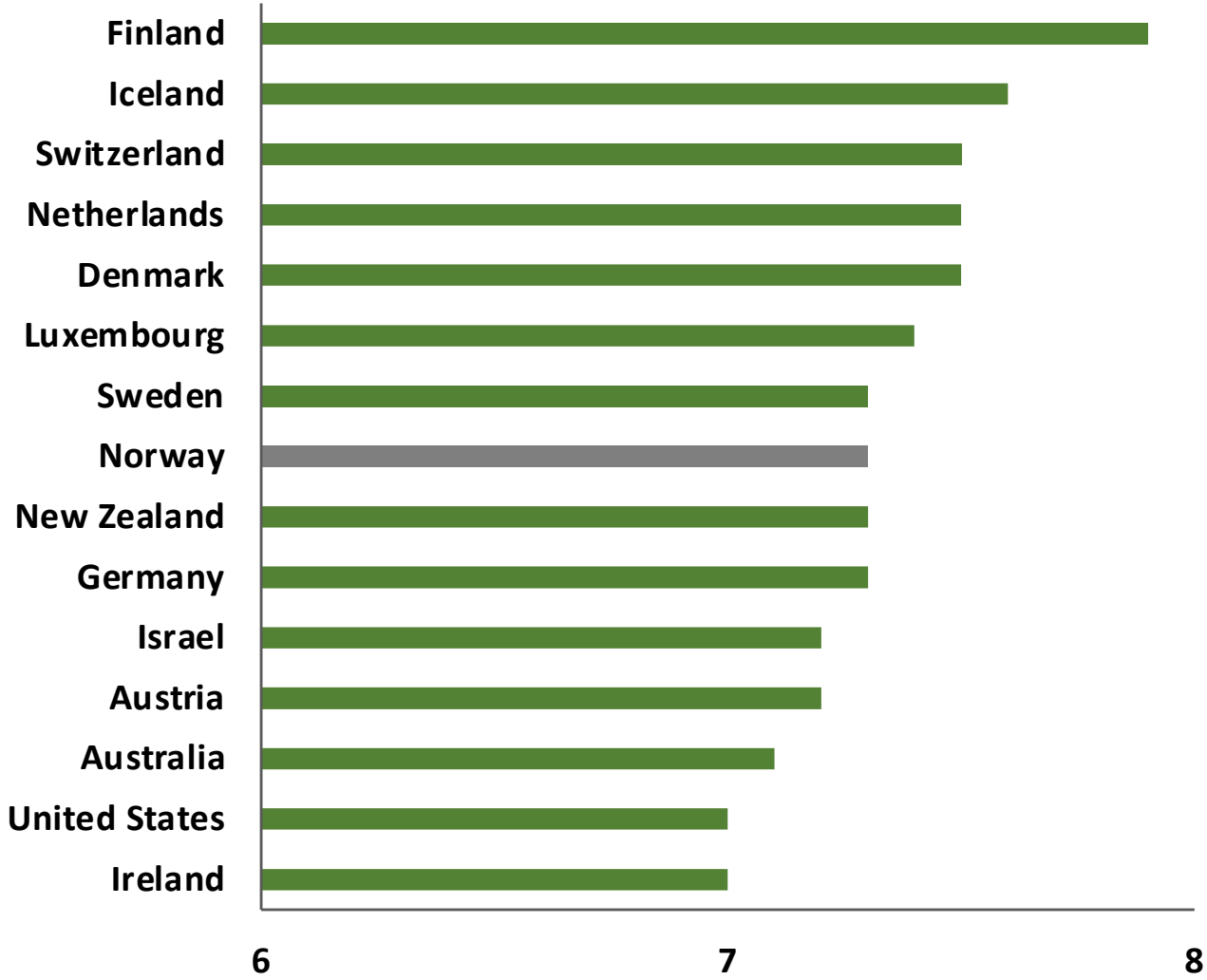
Countries with the highest life satisfaction score: OECD Better Life Index

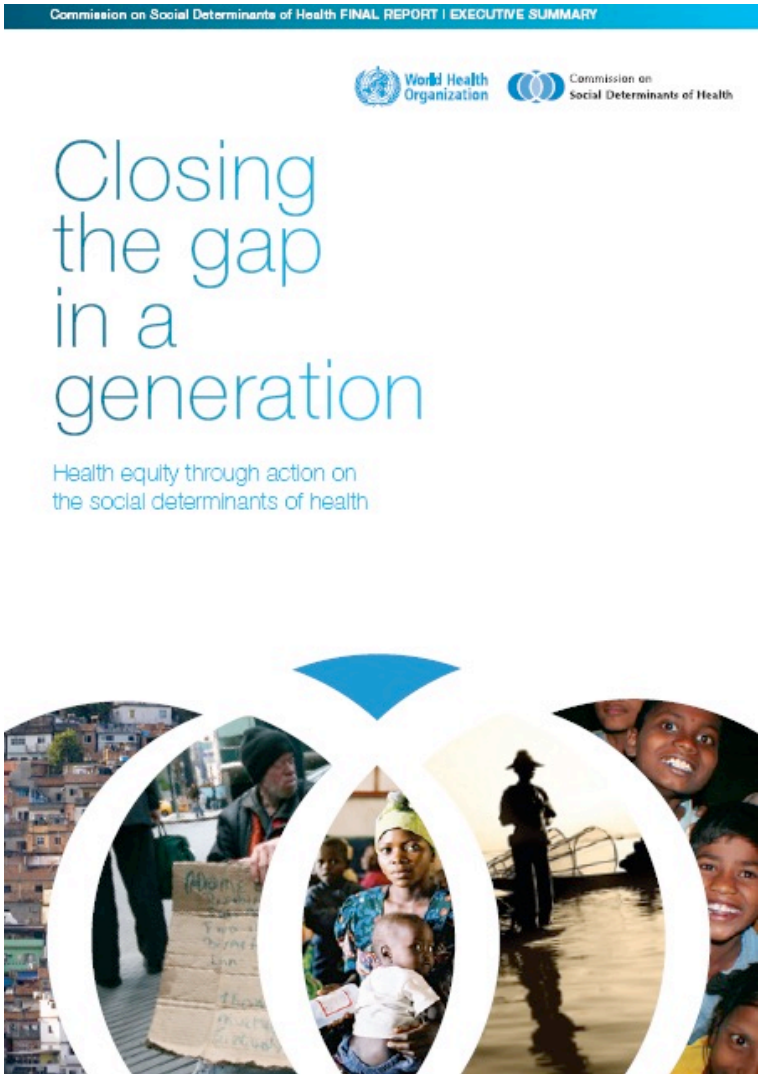



Health is a human right
Do something
Do more
Do better

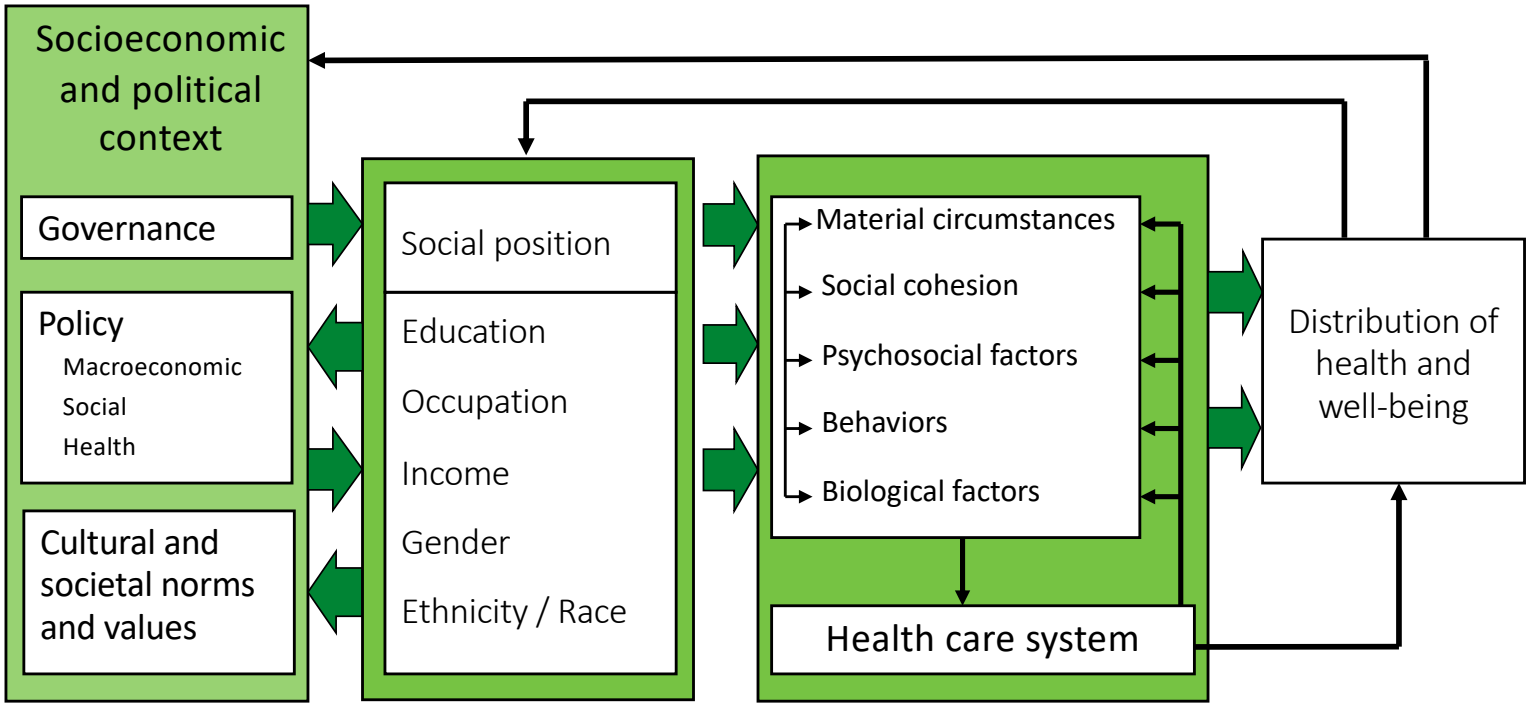
Social determinants of health and wellbeing

- The focus of the report is on inequities in health, that is systematic differences in health between social groups that are avoidable by reasonable means.
- These inequities are a result of the social determinants of health:
- the conditions in which people are born, grow, live, work, and age, and
- the structural drivers of these conditions – the unequal distribution of power, money and resources

- Social justice
- Empowerment – material, psychosocial, political
- Improving the conditions in which people are born, grow, live, work and age
- Shaped by distribution of power, money and resources



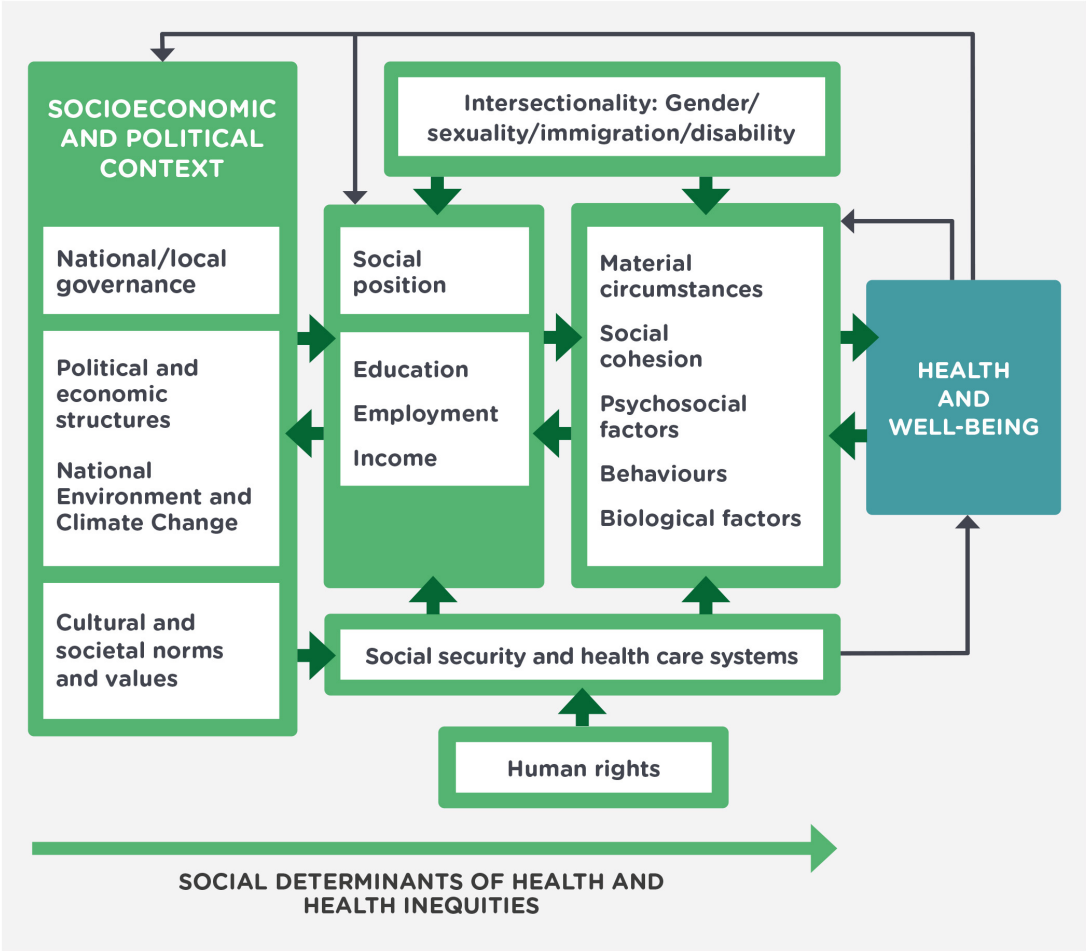
www.who.int/social_determinants/en



Commission on Social Determinants of Health Conceptual Framework

Source: CSDH Final Report, WHO 2008

Figure E.1 Social determinants of health framework for Norway



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MARMOT PRINCIPLES

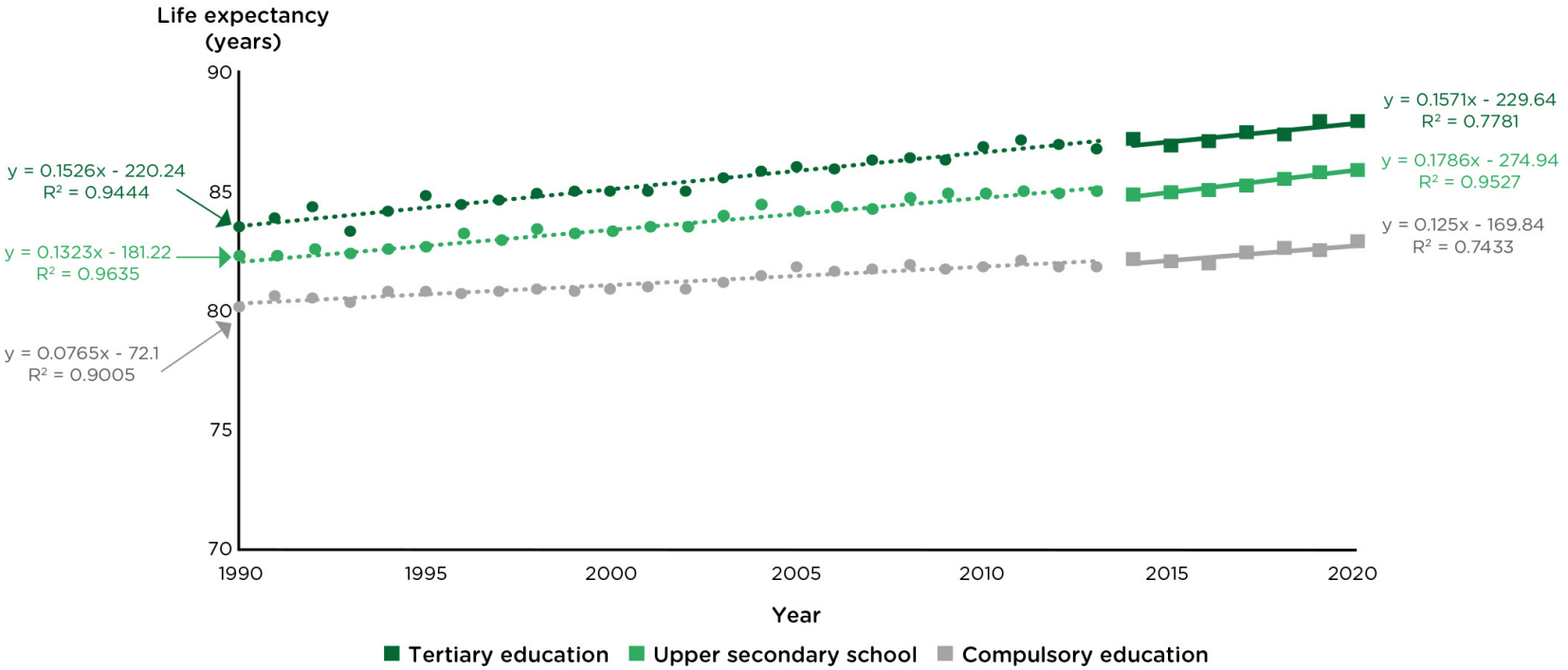
- Give every child the best start in life
- Enable all children, young people and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill health prevention
- Tackle discrimination, racism and their outcomes
- Pursue environmental sustainability and health equity together

Inequalities in health

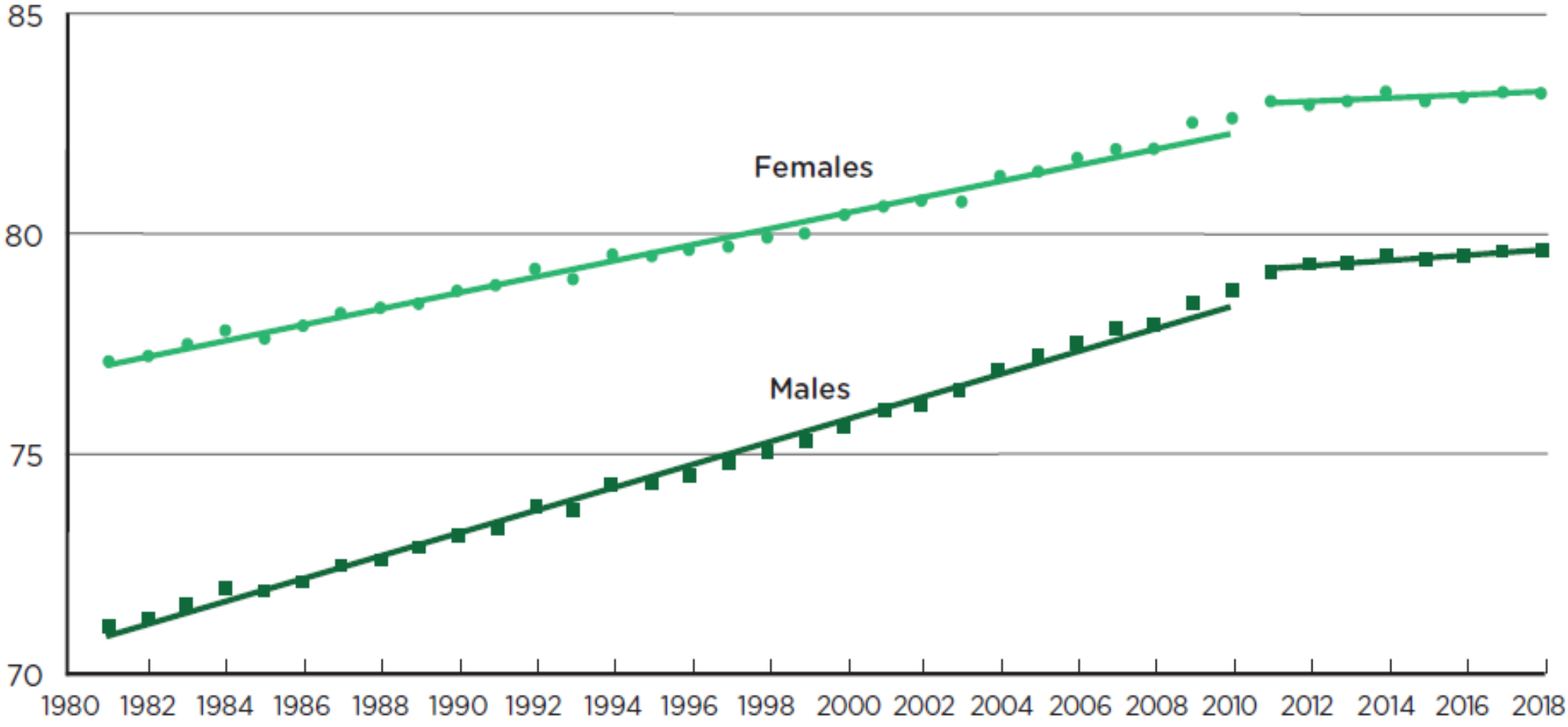
- There are persistent gradients in inequalities in life expectancy and death rates in Norway whether measured by educational level, occupation or income.
- The gaps between the most advantaged and disadvantaged large groups vary only slightly by type of indicator - between 3.5 and 5.5 life years for women and 5.0 to 7.3 years for men.

Persistent inequalities in life expectancy by education– widening for women

Figure E.2 Female life expectancy at age 35 by education, 1990 to 2020

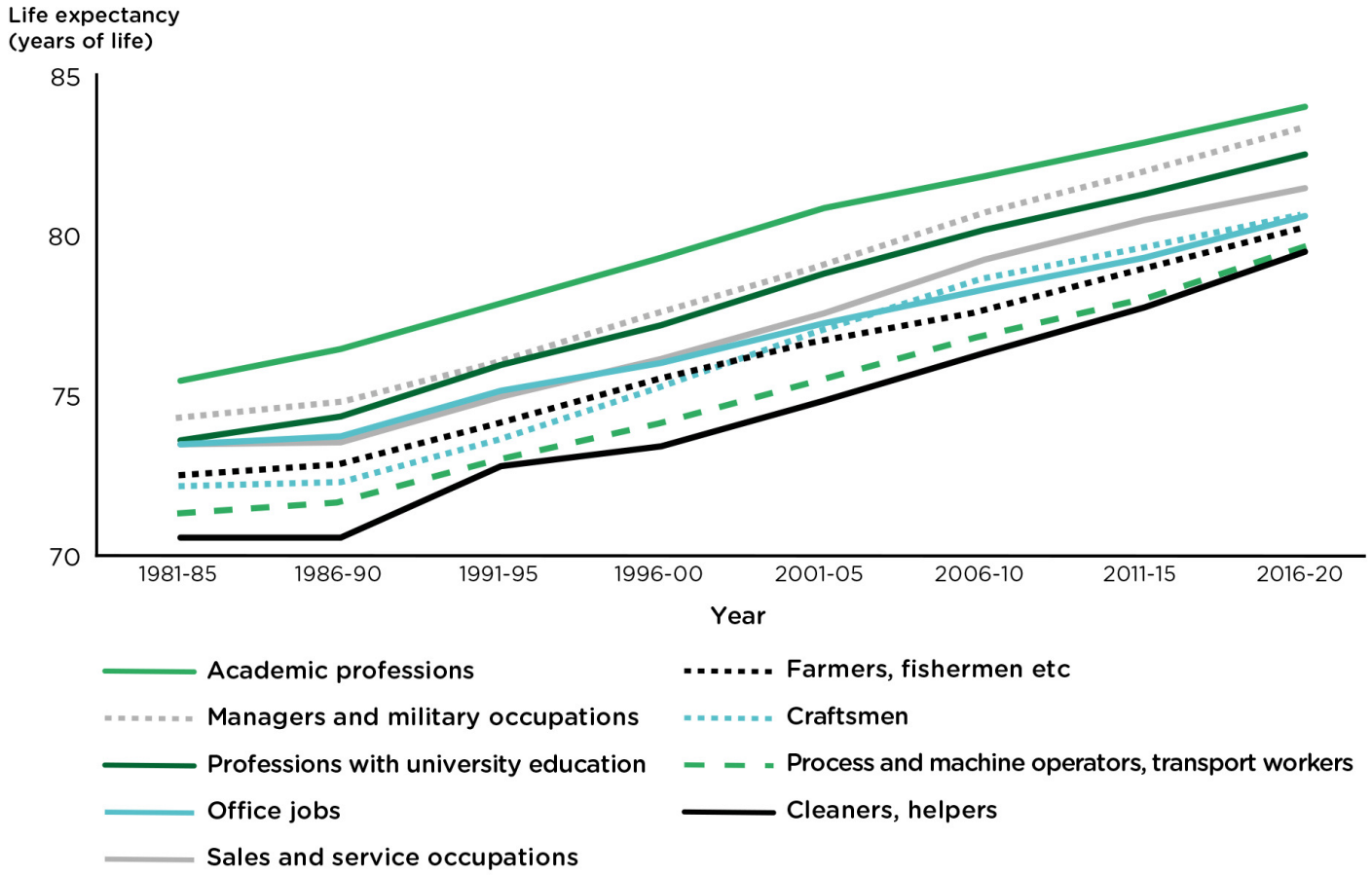


Increases in life expectancy at birth stalling in England



Persistent inequalities in life expectancy by occupation

Figure E.3 Male life expectancy at birth and broad occupational groups and five-year time periods, 1981-2020



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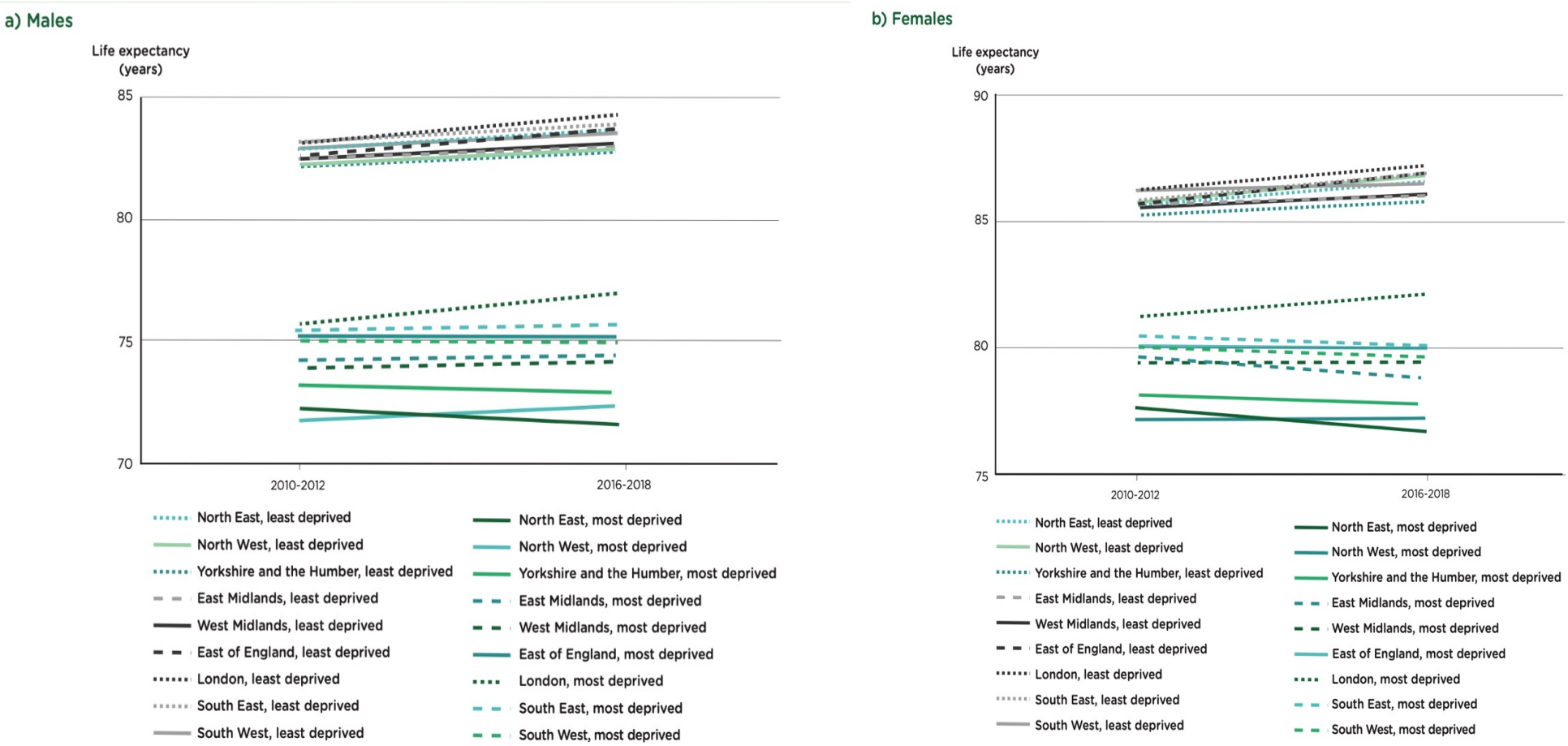
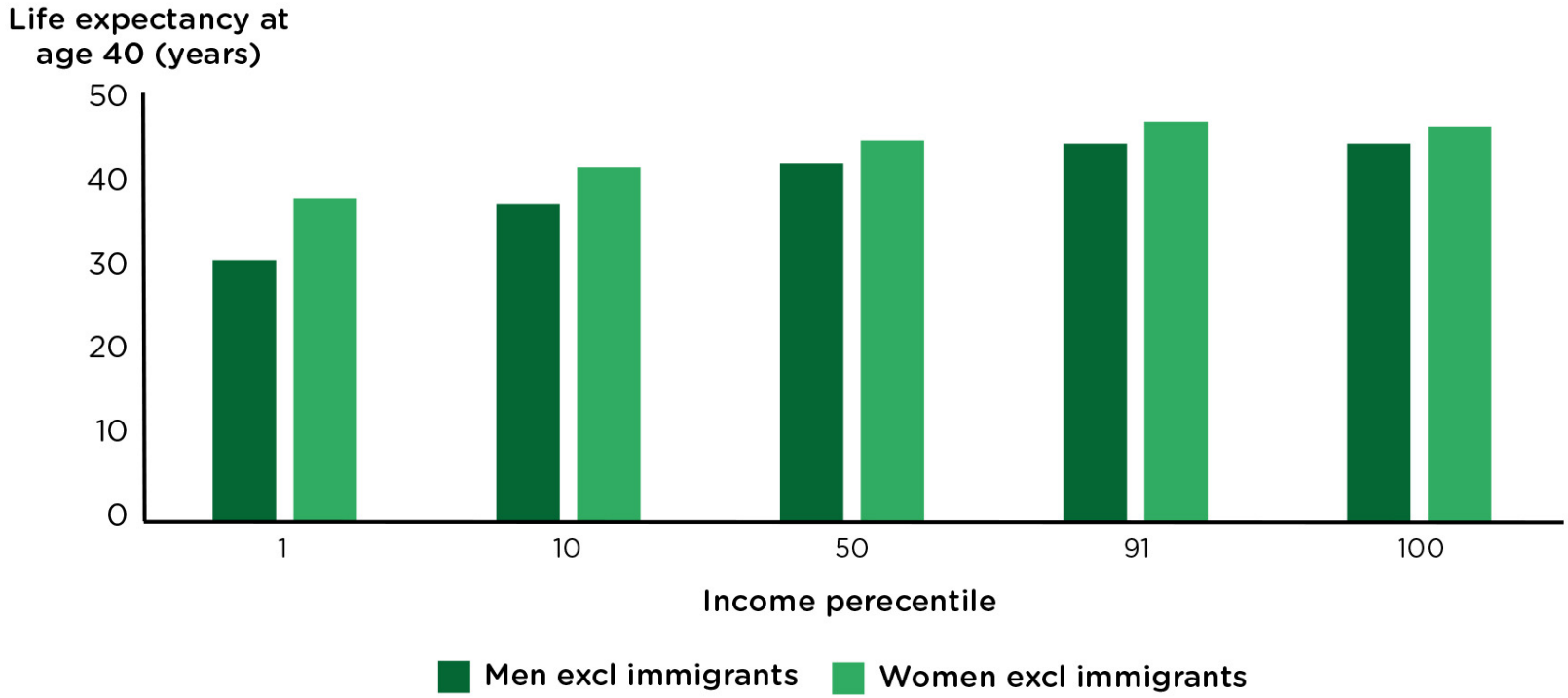
Life expectancy at birth by sex for the least and most deprived deciles in each region, England, 2010–12 and 2016–18



Persistent inequalities in life expectancy by income

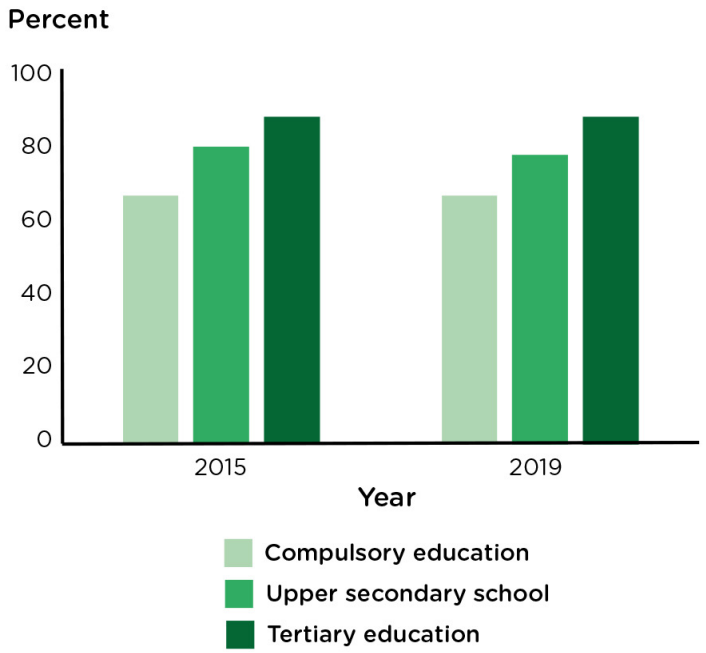
Figure E.4 Life expectancy at age 40 by household income percentile and sex, excluding immigrants, 2011-15



Note: *The primary income measure was "equivalized household income," defined as household income after tax divided by the square root of the number of household members, averaged across the preceding five years.*

Self-reported health and well being are socially graded

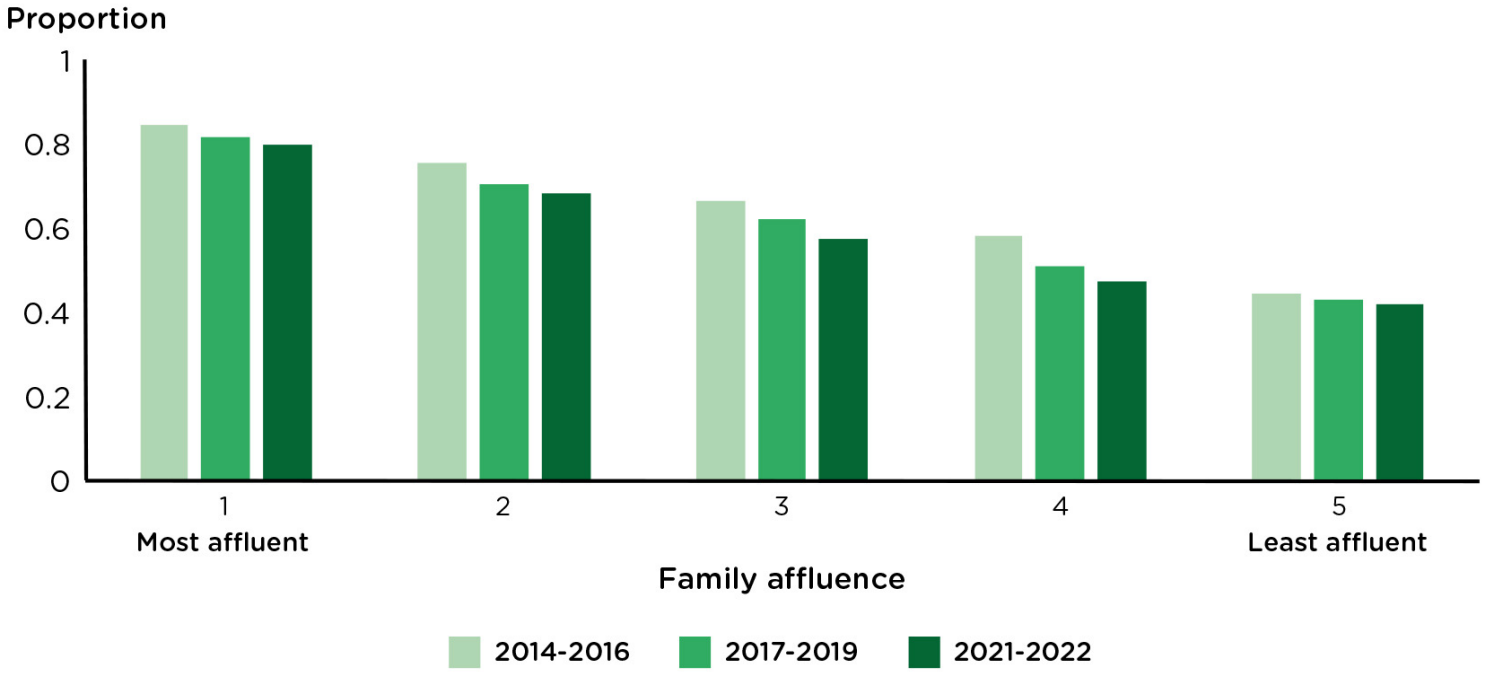
Figure E.5 Age standardised proportion of survey respondents who perceive their health as very good or good, by educational level, Norway, 2015 and 2019



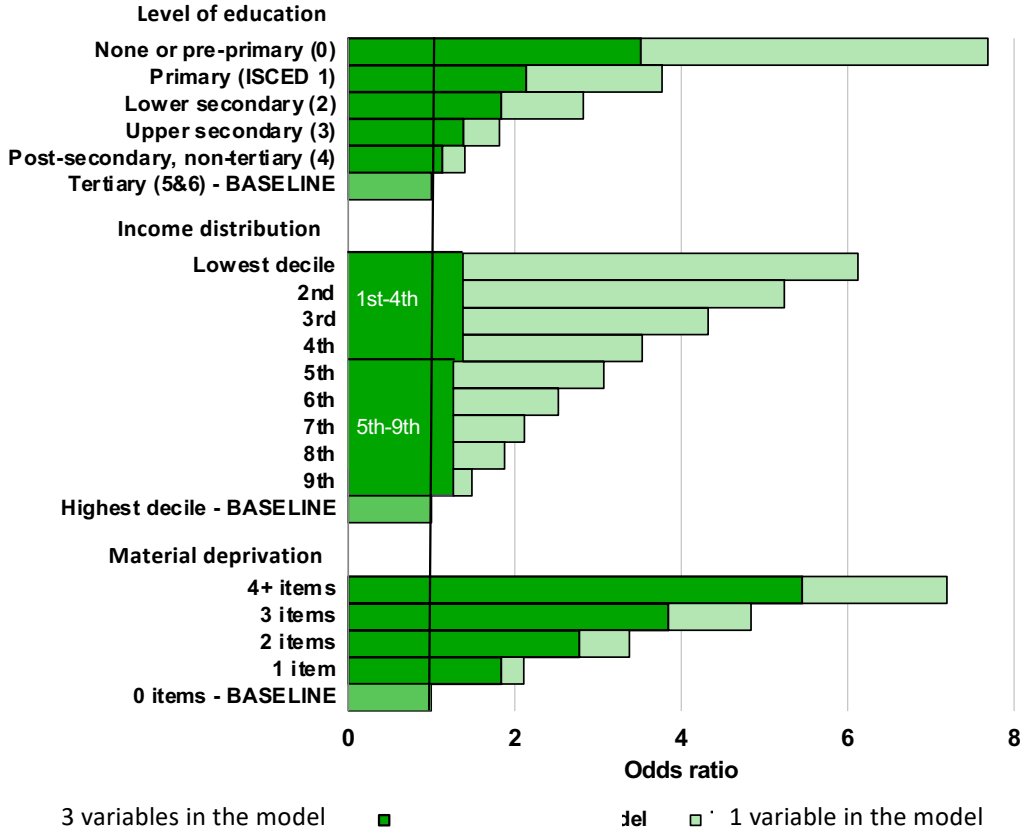
Source: *NIPH Database (7)*

Self-reported health and well being are socially graded

Figure E.6 Boys in lower secondary school who expect to have a good, happy life by family affluence, 2014-16 to 2021-22



Estimated odds of reporting poor or very poor general health by socioeconomic characteristics, 25 EU Member States*, 2010



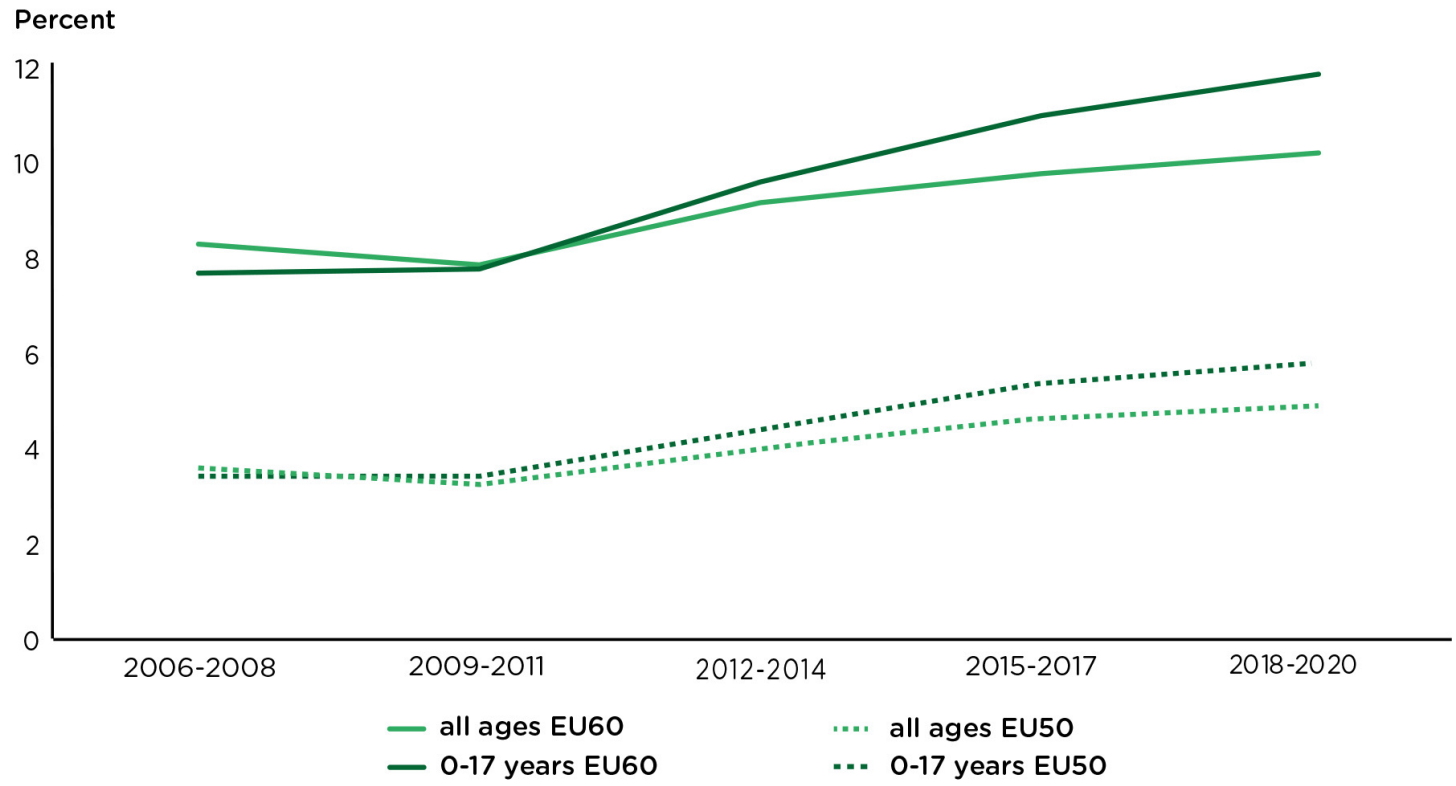
Source: Health inequalities in the EU

Child poverty

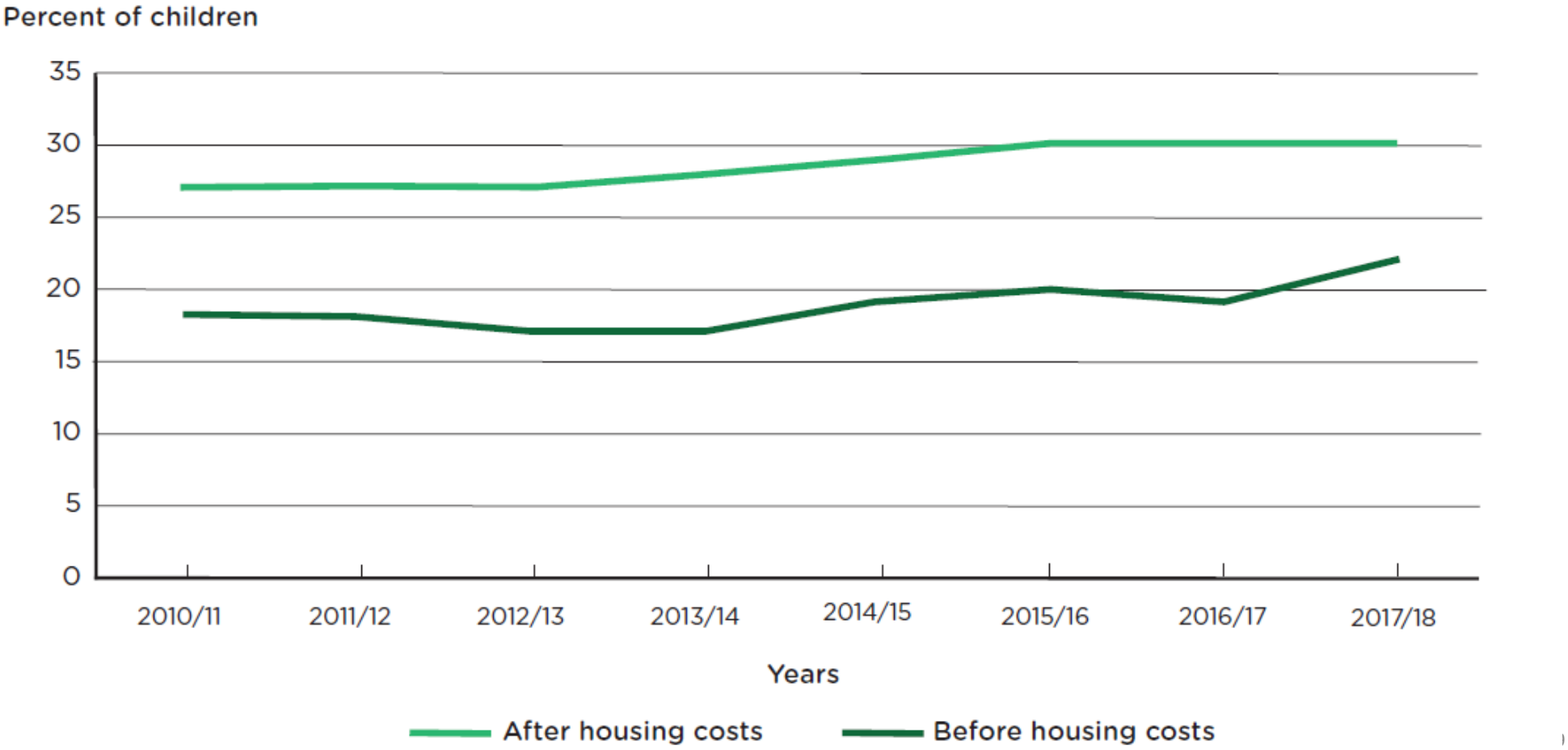
- Child poverty has increased in Norway at a faster rate than that for the population as a whole and universal child allowances have not kept pace with inflation
- In 2020, 11.7 per cent of children in Norway lived in a household with persistently low household income.
- Child poverty in Norway is associated with parental low level of education, weak attachment to the labour market, single-parent households and immigrant background with six out of 10 children in low-income households having an immigrant background in 2020.
- The need to actively 'opt in' for receipt of certain benefits can disadvantage those with lower Norwegian language skills or financial management skills – many of the same households that are likely to be in poverty.
- The rise in child poverty in Norway provides a strong rationale for increasing spending on benefits and services in line with the cost of living.

A) GIVE EVERY CHILD THE BEST START IN LIFE

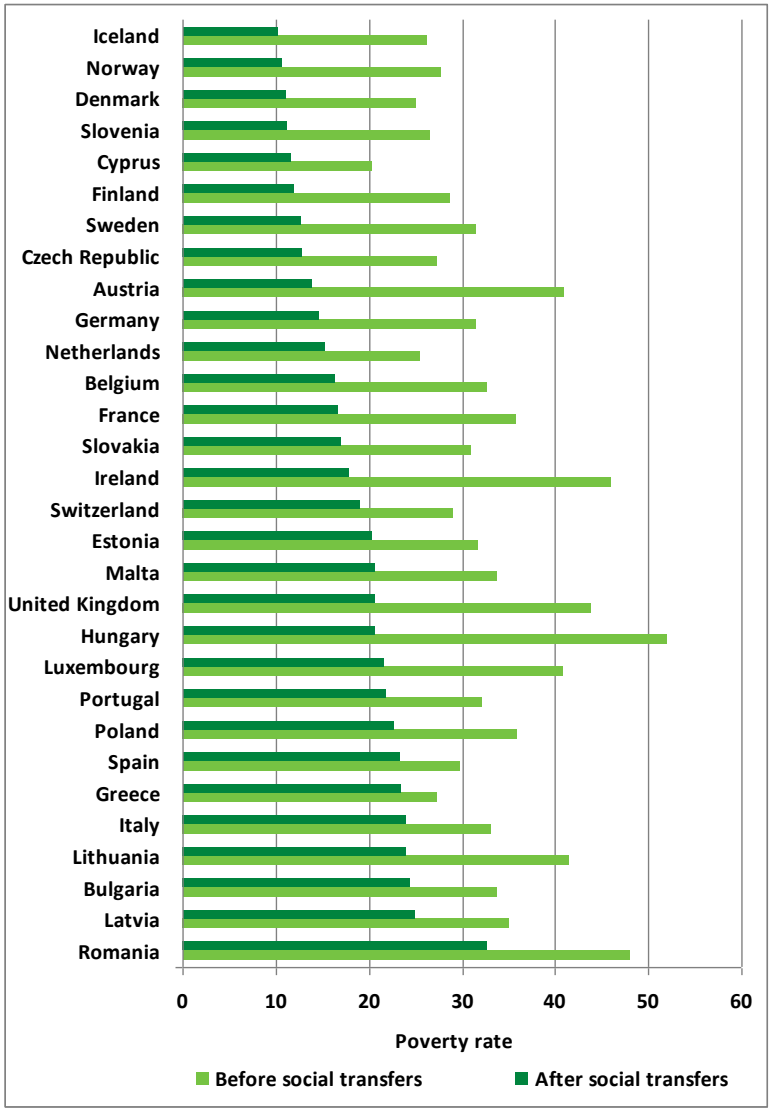
Figure E.7 Percent of households in poverty levels (EU50 and EU60 indicators), all households and those with children aged 0 to 17, Norway, 2006-8 to 2018-2020



Children living in poverty before and after housing costs in England



EU Child poverty rates <60% median before and after social transfers 2009



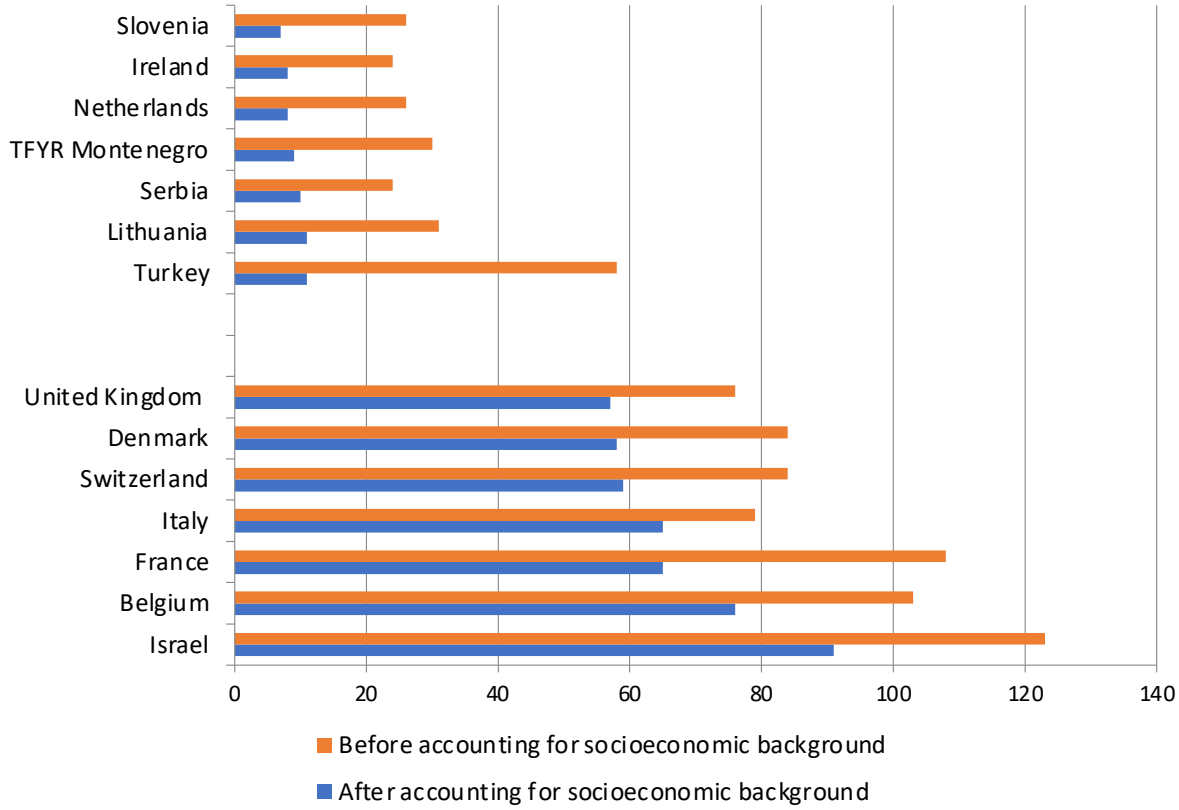
Source: EU SILC

Early years education

- Attending high quality kindergarten has a beneficial impact on children's development, especially for children from families with limited education and low income,
- However, children from families with limited education, low income and parents from minority backgrounds are also less likely to attend kindergarten than other children.

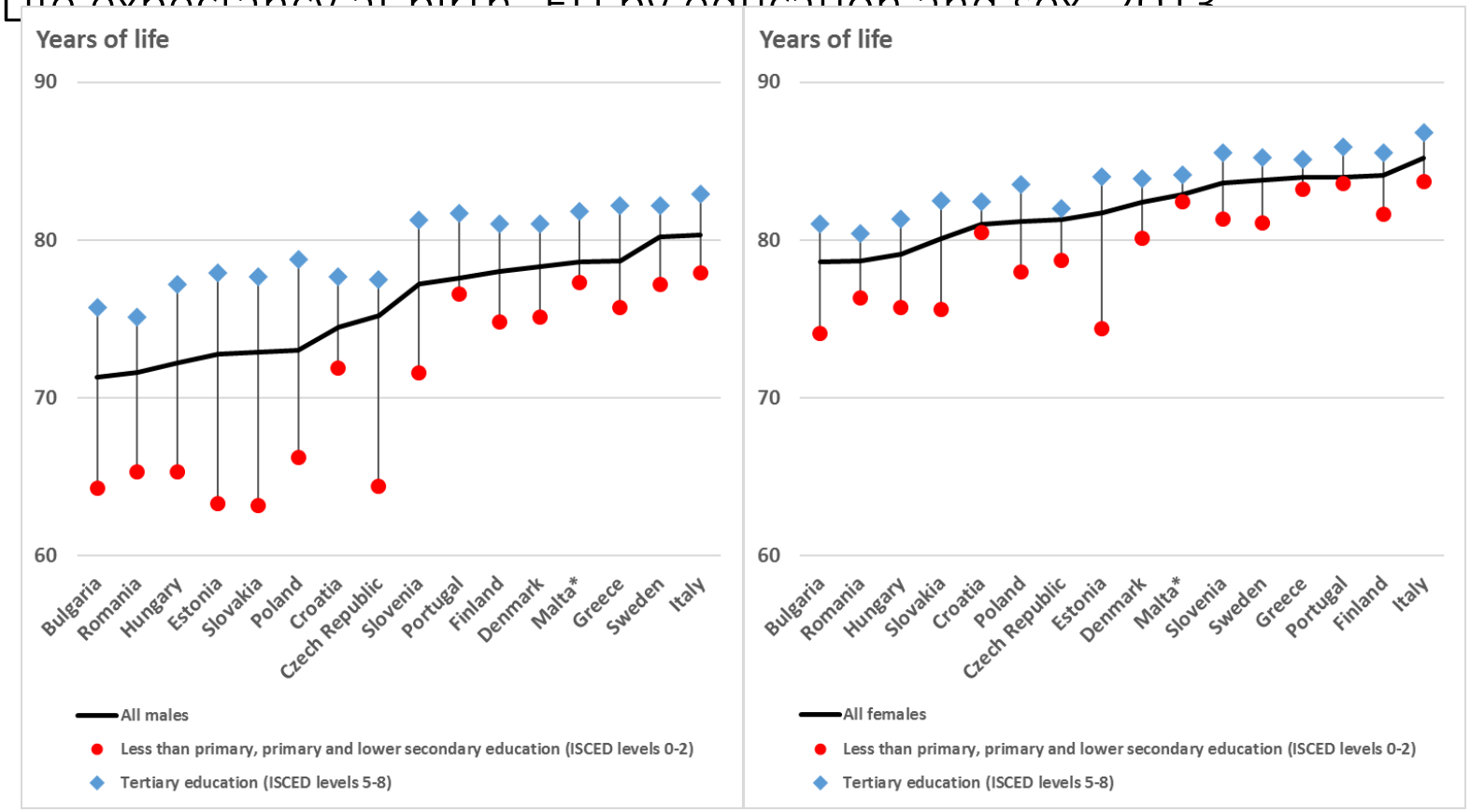
- Learning support for children at age six has not been proportionate to needs, and has contributed to widening social gaps in educational attainment.
- There are steep inequalities in numeracy and reading based on parents' educational level among children in the fifth year of primary school that persist in secondary school.
- Family socioeconomic status is a strong predictor for children's educational attainment and performance at age 15.

Differences in PISA scores in the EU by attending preschool for more than one year before and after accounting for socioeconomic background



OECD PISA 2009 database

Life expectancy at birth - EU by education and sex, 2013



* Figures for Malta 2011

Source: Eurostat

A. GIVE EVERY CHILD THE BEST START IN LIFE

Reduce the perpetuation of inequities from one generation to the next by:

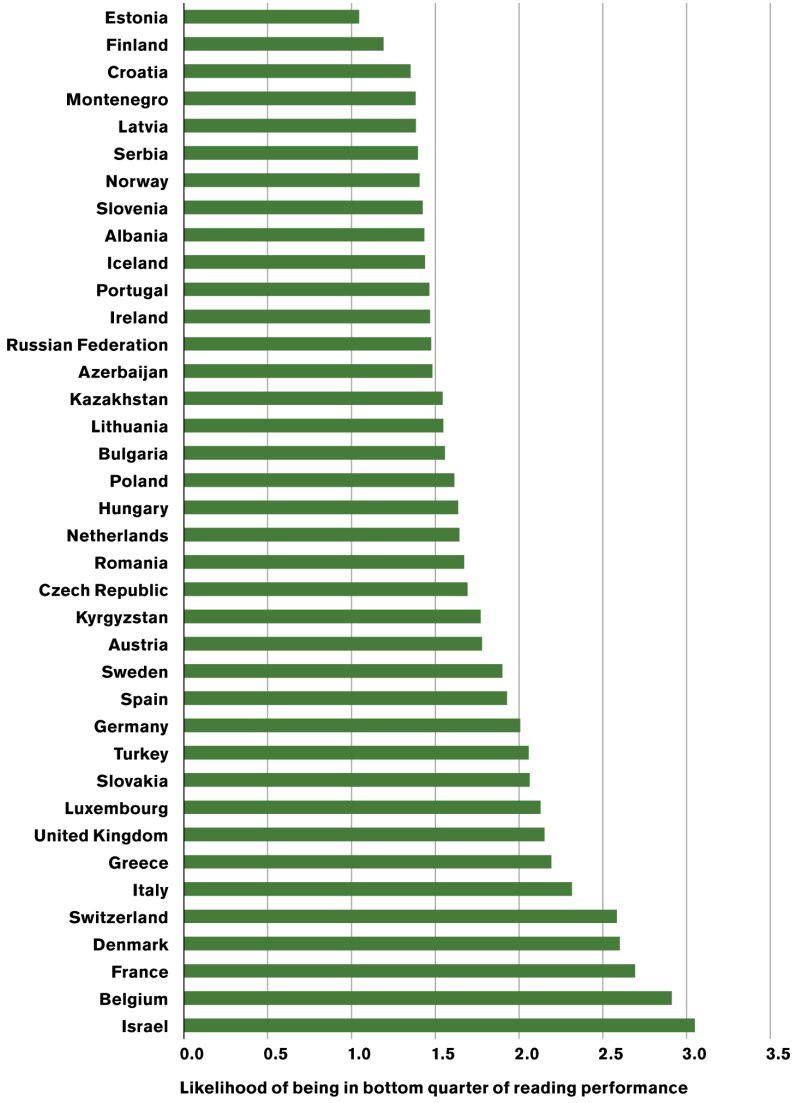
• Ensuring equal access to high quality early childhood education and care that are socially inclusive and culturally sensitive.

• Joining up service support by enhancing coordination, reducing bureaucratic barriers to access and developing coordination mechanisms for families.

• Increasing financial support proportionately to reduce child poverty.

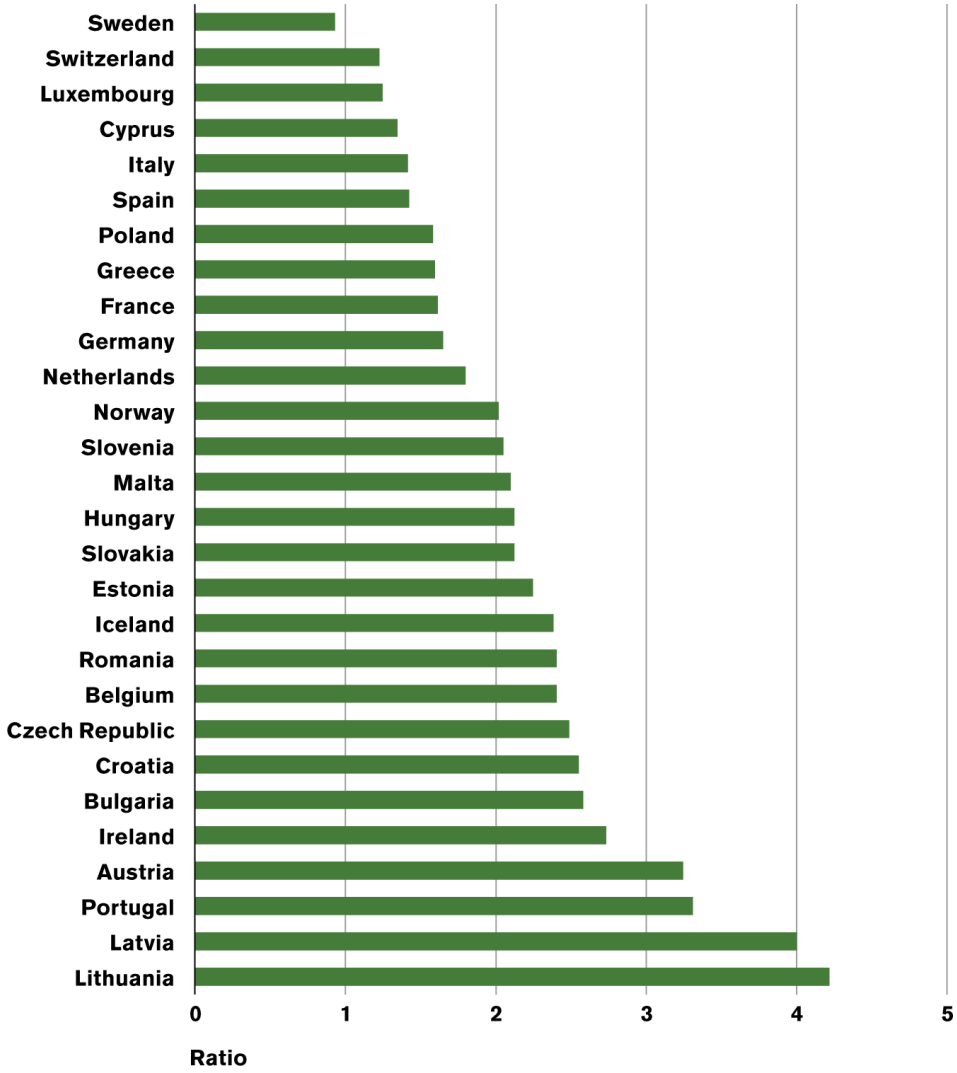
• Ensuring resources are directed proportionately to meet the needs of children of immigrants, undocumented migrants and those in poverty. In particular through increasing access to high-quality maternity services and early years childcare and ensuring that stay-at-home subsidies do not act as a reward for keeping children at home.

Likelihood of a child who did not attend preschool being in the lowest reading quintile at age 15, PISA 2009



Source: OECD 2010

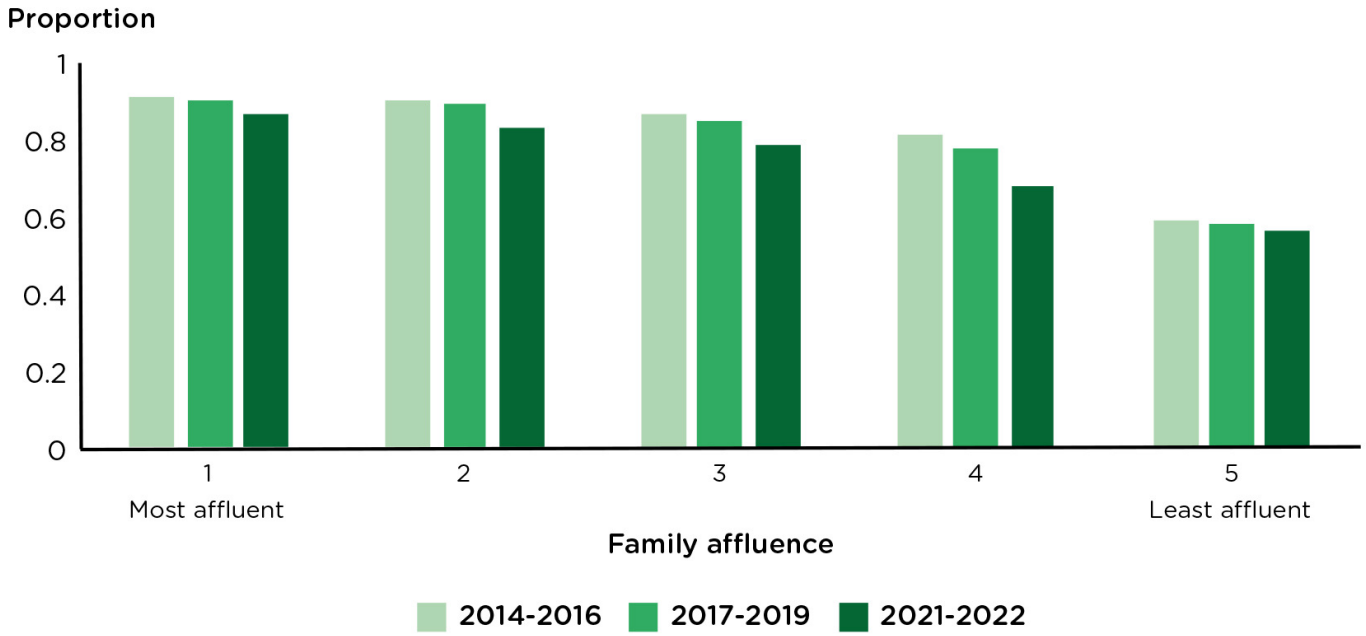
Ratio of poor health among people with primary-level education (level 1) to poor health among those with basic tertiary education (level 5) in selected European Region countries, 2010



Source: EU-SILC 2013

B) ENABLE ALL CHILDREN, YOUNG PEOPLE, AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

Figure E.8 Girls in lower secondary school who indicate that their teachers care about them by family affluence, 2014-16 to 2021-22



Source: Young Data (11)

Wellbeing of young people

- Level of family affluence has a graded impact on the wellbeing of adolescents, as measured by
  - loneliness,
  - coping,
  - making a contribution
  - psychological distress-
  - expectations for future wellbeing
- Social relationships within secondary schools are socially graded by family affluence- e.g. bullying, and interaction between teacher and students.

Entering the labour market

- A large proportion of young Norwegians not in education, employment or training (NEETs) have poorer mental health, and lower levels of education compared with other European NEETs.
- More than half of all NEETs in Norway are young people without an upper-secondary school qualification.

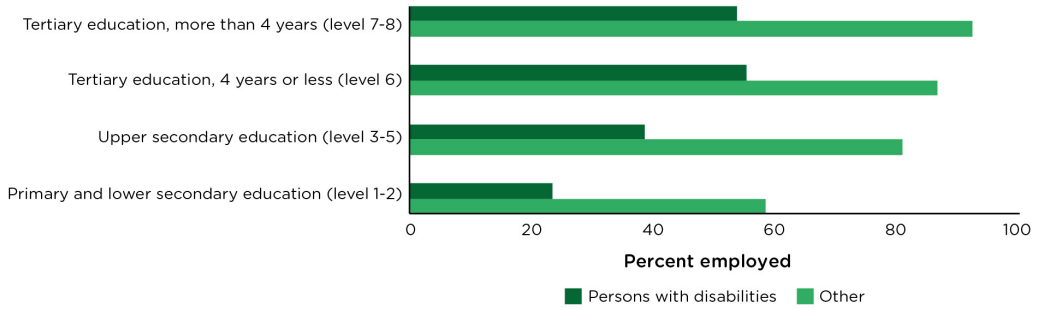
B. ENABLE ALL CHILDREN, YOUNG PEOPLE, AND ADULTS TO MAXIMISE THEIR CAPABILITIES AND HAVE CONTROL OVER THEIR LIVES

Reduce the proportion of young people left behind by the education and training systems or who become socially isolated by:

- Reducing inequalities in educational attainment.
- Ensuring an adequate balance between academic and vocational skills and reducing educational dropout rates.
- Adopting a whole-systems approach to schooling and education and ensuring meaningful learning activities and supportive environments that promote experiences of coping and mattering.
- Promoting the social integration and mental health of adolescents and young people through schools, tertiary education facilities and employers.
- Increasing public investment of, and business involvement in, apprenticeships and ensuring that there is greater inclusivity in all these programmes.
- Increasing proportionate investment in skills development across the life course, focused on addressing the needs of those with skill deficits that lead to labour market exclusion

C CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

Figure E.9 Percent aged 15 to 66 employed by educational level and whether or not with a disability, 2021



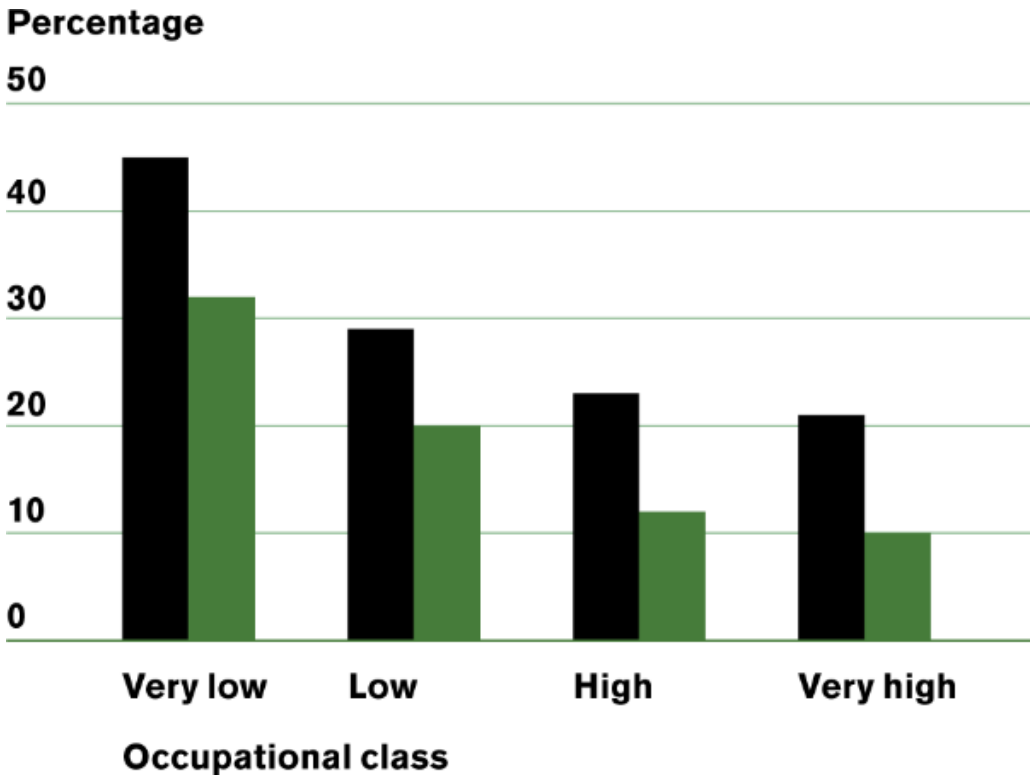
Key contribution of work and employment

- Participation in labour market
- Appropriate income
- Avoidance of adverse hazards
- Positive psychosocial environment

Employment

- Structural changes in the labour market have affected the low-skilled and those without higher education, lowering their employment rates.
- Around 18 percent of those aged 18 to 66 were either out of work or not in education in 2019.
- They are increasingly comprised of people who have either never worked or been out of the labour market for a long period of time
- While it is an explicit aim that social assistance should be short-term, over 40 percent were recipients for minimum six months and those who receive social assistance for prolonged periods tend to have very poor mental and physical health.
- At each educational level, those with a disability have markedly lower employment rates than others.
- .

Psychosocial stress and occupational class in the EU



SHARE 2004/2005

Effort–reward imbalance

Low control

Source: Wahrendorf et al. 2012

C. CREATE FAIR EMPLOYMENT AND GOOD WORK FOR ALL

Strengthen measures to ensure all benefit from access to employment and good-quality work by:

• Promoting the adoption of good management guidelines to reduce musculoskeletal injuries and workrelated stress, in particular.

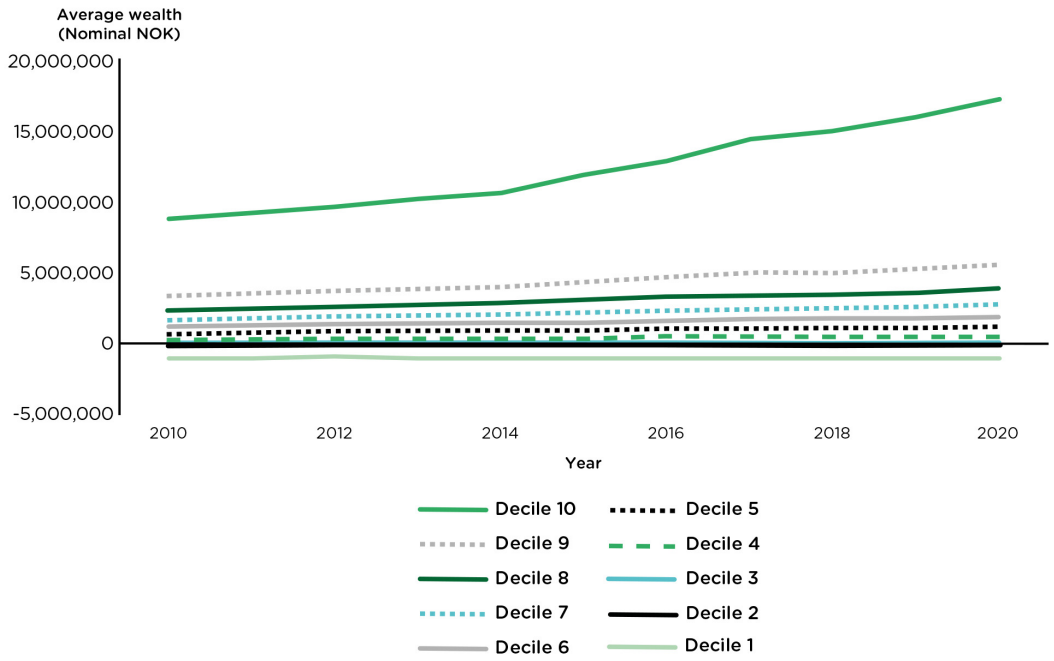
• Improving the quality and evaluation of active labour market programmes.

• Increasing participation in the labour market of people with disabilities and ill health by increasing access to work and adequate support systems.

• Ensuring that the level of minimum wages and working conditions are sufficient to support workers' health and wellbeing across all sectors and social groups, with particular attention to women and immigrants in vulnerable situations

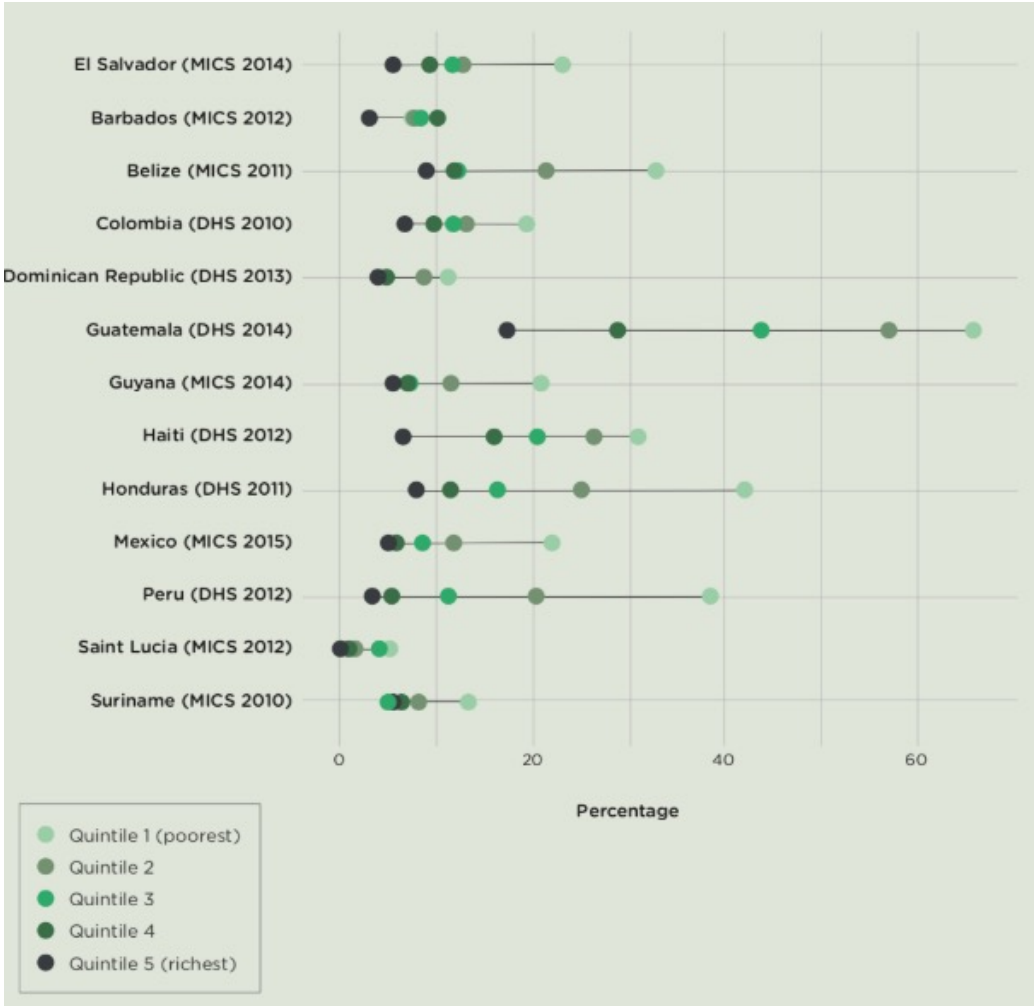
D) ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

Figure E.10 Average net wealth of households, by decile 2010-20



"*RELATIVE DEPRIVATION* IN THE SPACE OF *INCOMES* CAN YIELD *ABSOLUTE* DEPRIVATION IN THE SPACE OF *CAPABILITIES*"

Amartya Sen, Inequality Re-examined, 1992



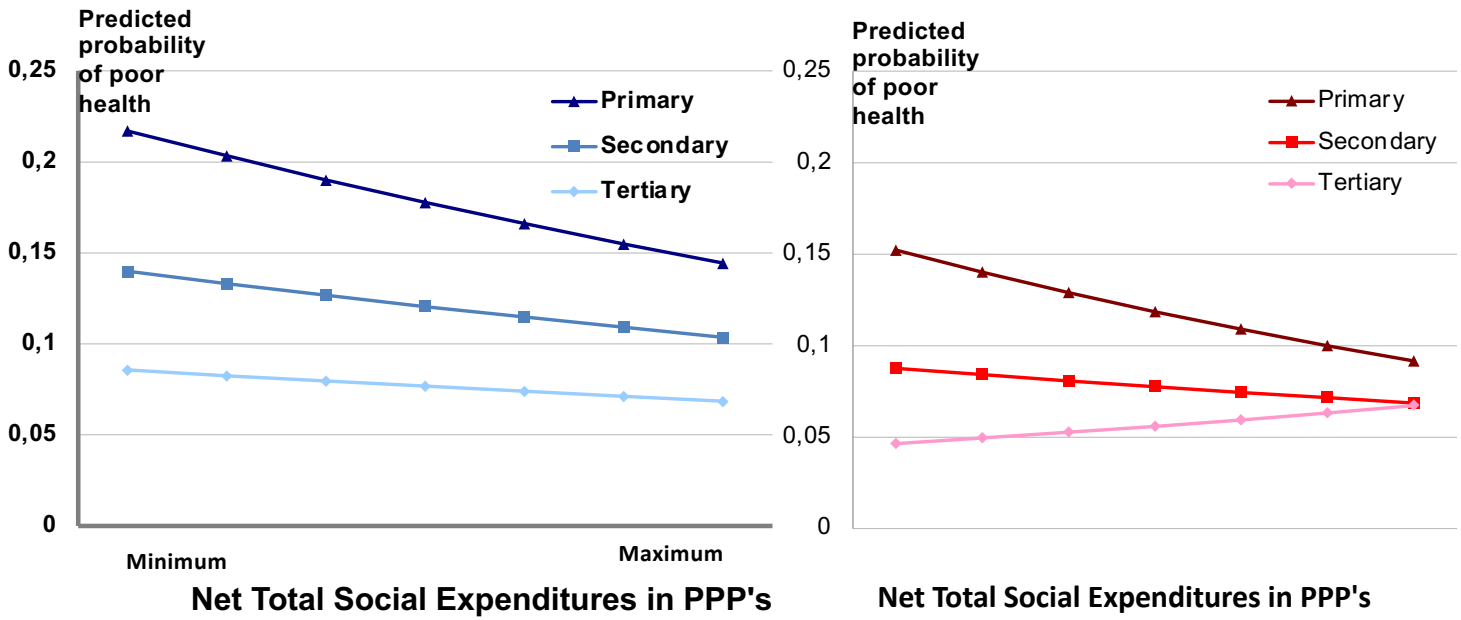
Percentage of children stunted by wealth quintile, countries with comparable data, 2014 or latest available

Source: Health Equity Assessment Toolkit (HEAT): Software for exploring and comparing health inequalities in countries. Built-in database edition. Version 2.1. Geneva; World Health Organisation; 2018.

Income and wealth

- The proportion who are low paid is greatest in the private sector (nearly 30 percent) and lowest among state employees (around seven percent).
- Income inequality has increased since the 1980s and the gradient in wealth is becoming steeper.
- The wealth of the top 10 percent has increased markedly since 2010 while the wealth of the bottom 50 percent has barely increased

Self reported health by education and social expenditure: 18 EU countries



Source: Dahl & van der Wel 2012, data from EU SILC 2005

D. ENSURE A HEALTHY STANDARD OF LIVING FOR ALL

Ensure a sufficient income for health and wellbeing by:

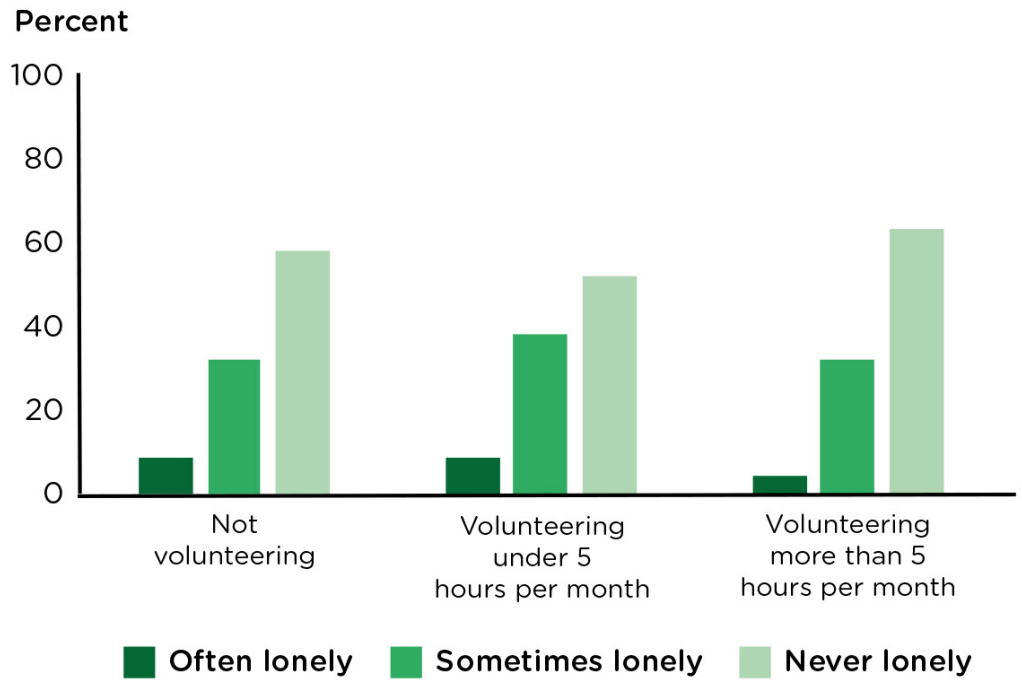
• Ensuring greater equity of income and wealth across the gradient, and that the poorest are not left behind, through a more integrated and proportionate tax and welfare system.

• Providing social security safety nets that are sufficient to guarantee adequate replacement income to people who cannot work, and for those most at risk of losing their jobs and reduce barriers to accessing these.

• Improving digital inclusion by increasing digital literacy and access to devices for those in vulnerable situations.

E CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

Figure E.11 Distribution of the experience of loneliness by time spent volunteering, 2021



Inclusion

- Nine percent of the population have low levels of digital inclusion - the strongest driver is educational level, but other factors include being retired, older, unemployed and living in areas with few inhabitants
- There is a strong culture of volunteering and people engaged in volunteering report substantially lower levels of loneliness and better health and wellbeing. However, the proportion of people volunteering has decreased from 63 percent in 2019 to 55 percent in 2021 and there are socioeconomic inequalities in participation.

Housing

- The number of long-term tenants has increased due to rising costs around the major urban areas.
- However, the main priority of the government is an increase in home ownership, rather than affordable or social housing, risking leaving behind some of the most vulnerable.
- In 2020, 19 percent of children between 0-17 years of age lived in households with cramped living conditions affecting health in the immediate and longer term, rising to 36 percent in Oslo.

Environment

- Key areas in which environmental sustainability, health and equity are overlapping priorities include
  - green spaces,
  - outdoor air pollution,
  - transport,
  - housing and buildings,
  - healthy and sustainable diets,a
  - healthy and sustainable economic model including wellbeing economies.
- The long-term transportation development plan is focused on connecting the population, mainly using private (electric) vehicles as shown in the slide.
- It does not address the inequalities in access between and within municipalities and does not present solutions to connecting the most remote areas of the country sustainably.
- No specific plans are provided on how to achieve the planned goal of increasing cycling's share in urban areas.
- While committed to reducing emissions domestically, Norway's crude oil and gas exports constituted 60 percent of the total value of Norway's exports in 2021

E. CREATE AND DEVELOP HEALTHY AND SUSTAINABLE PLACES AND COMMUNITIES

Ensure healthy and sustainable places by:

• Strengthening community co-creation and delivery of policies and interventions and supporting community participation and volunteering for all.

• Ensuring equitable access to local green spaces and meeting places.

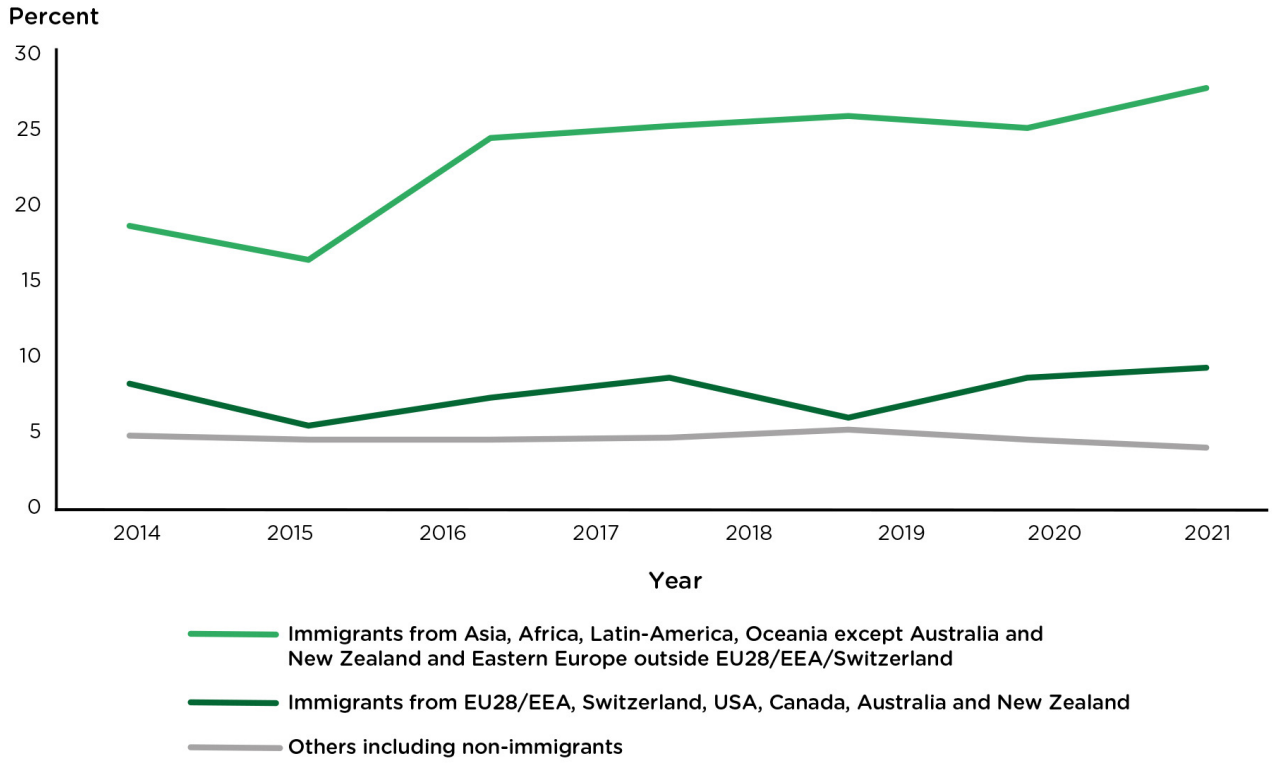
• Extending an affordable public transport system across Norway, reducing reliance on road vehicles and supporting active travel infrastructure.

• Increasing the supply of social housing and improving housing affordability.

• Developing and enforcing a standard for healthy housing quality, including the private rented sector.

F) TACKLING THE SOCIAL EXCLUSION OF MINORITIES AND OTHER LEFT BEHIND GROUPS

Figure E.12 Percent of those aged 16 years and older having difficulty making ends meet by country background, 2014-21



F. TACKLING THE SOCIAL EXCLUSION OF MINORITIES AND OTHER LEFT BEHIND GROUPS

Reduce discrimination and social and economic exclusion of minority groups in vulnerable situations by:

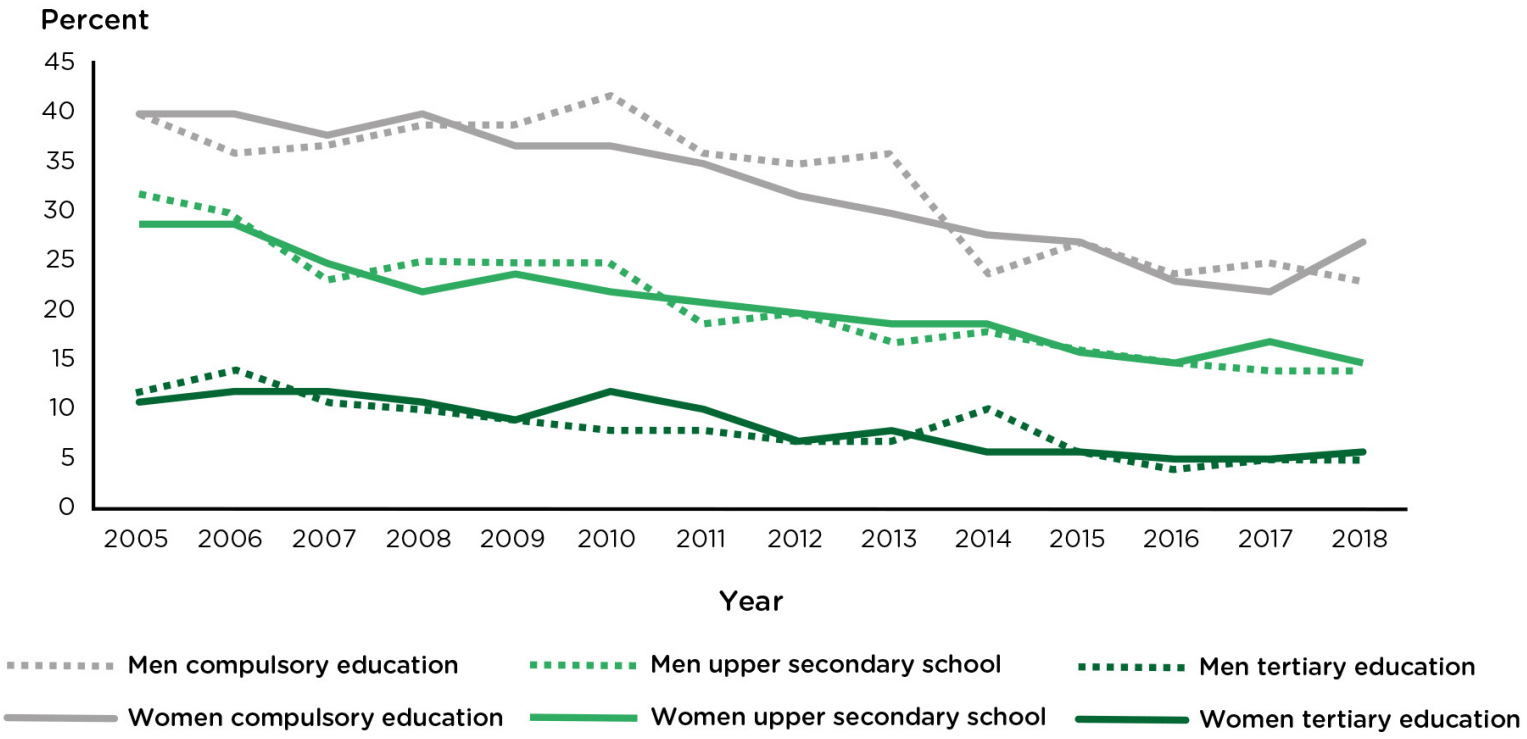
• Taking effective intersectoral action to reinforce the efforts of service providers to ensure equitable access, experiences and outcomes in health, education and employment.

• Ensuring effective engagement of minority groups in the development and delivery of services and interventions and in community development – working with cultural and religious sensitivities while recognising intra-group diversity and avoiding stereotyping.

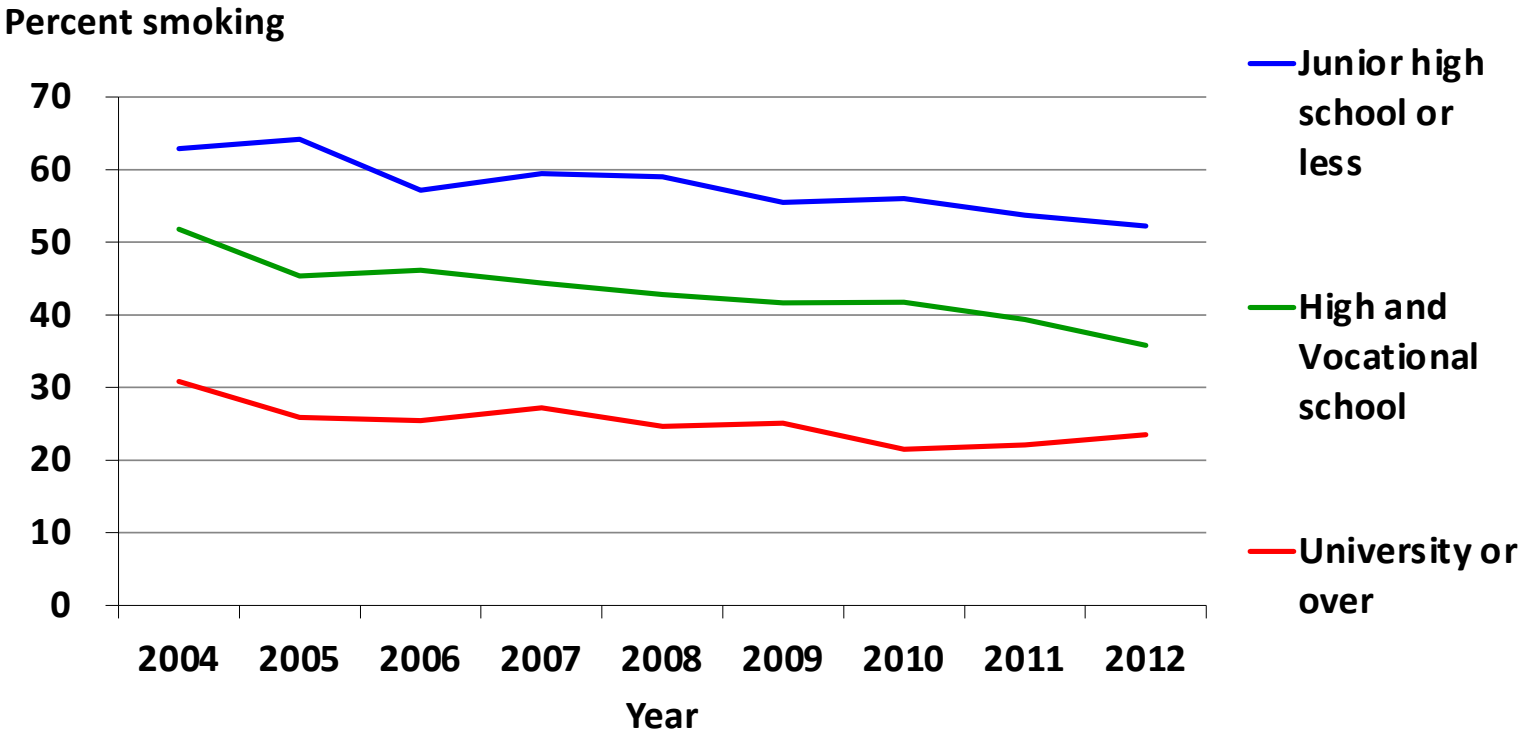
• Ensuring that an asset-based approach is taken in the design and delivery of services to gain critical involvement of and feedback from minority communities including prisoners, the LGBTQI+ community and those with serious mental health problems and substance misuse problems.

G) STRENGTHEN THE ROLE AND IMPACT OF ILL-HEALTH PREVENTION

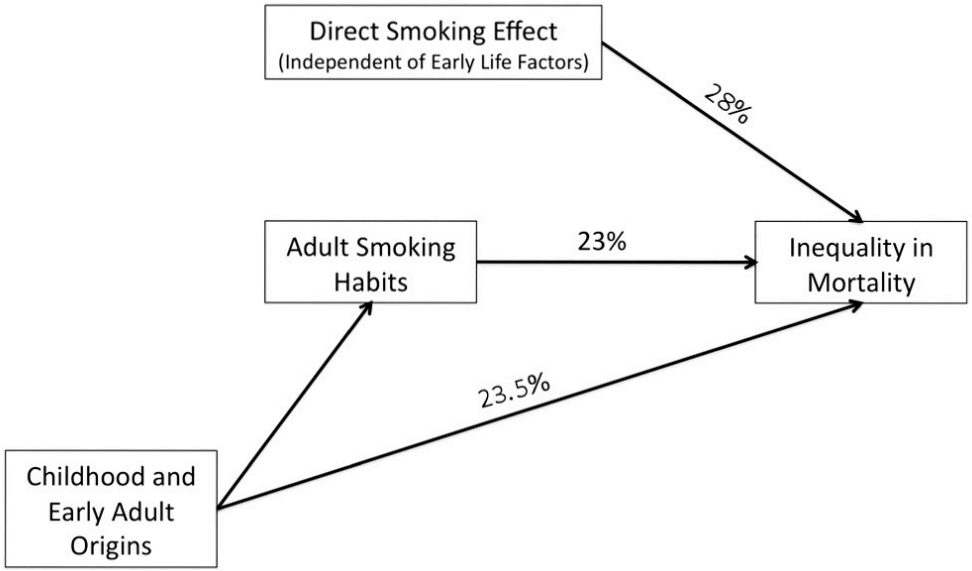
Figure E.13 Percent smoking daily by sex and educational level, Norway, 2005-2018



Percentage of males in Taiwan born before 1955 smoking, by education, 2004-12



Life-course pathway from early life origins to inequality in mortality mediated by smoking, British 1946 birth cohort



Giesinger I, et al. J Epidemiol Community Health 2013

Health behaviours

- The odds that someone with compulsory education smokes is over five times that for someone with tertiary education.
- There are also clear inequalities associated with education level in obesity, consumption of sugary drinks, salted food and fruits, berries, and vegetables , as well as physical activity
- While taxes and subsidies affecting the price of food items have potential to reduce inequalities in healthy eating, interventions directly targeting individuals' dietary behaviour increase inequalities in healthy eating.

G. STRENGTHEN THE ROLE AND IMPACT OF ILL-HEALTH PREVENTION

Improve health prevention measures by:

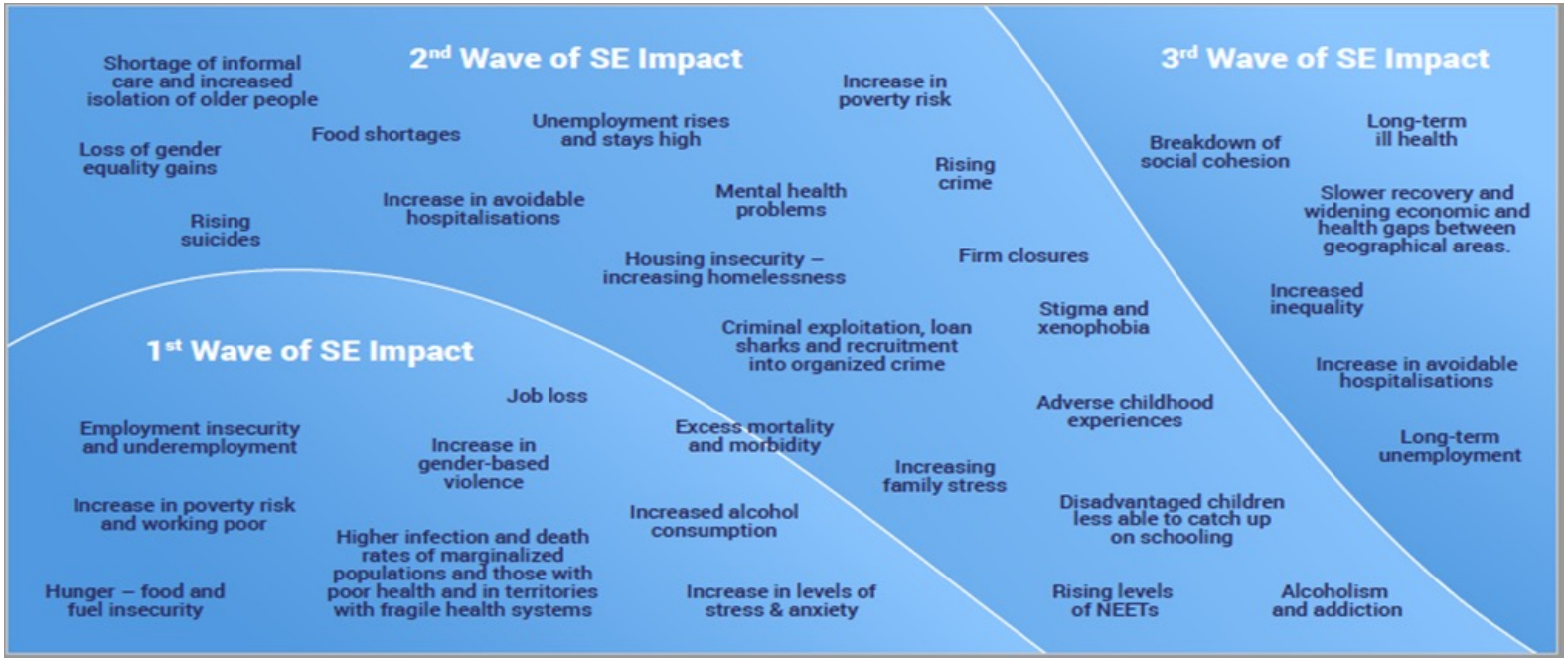
• Increasing resources for preventative health measures as a percentage of the total health budget in Norway to achieve greater intensity of action in reducing inequalities in determinants, public health measures such as vaccination, and behavioural outcomes.

• Basing health behaviour interventions on principles of proportionate universalism to reduce inequities in these behaviours.

• Using tax and regulatory measures

THE IMPACT OF THE COVID-19 PANDEMIC AND THE COST OF LIVING CRISIS

Phases of Socio-economic Impact from COVID-19

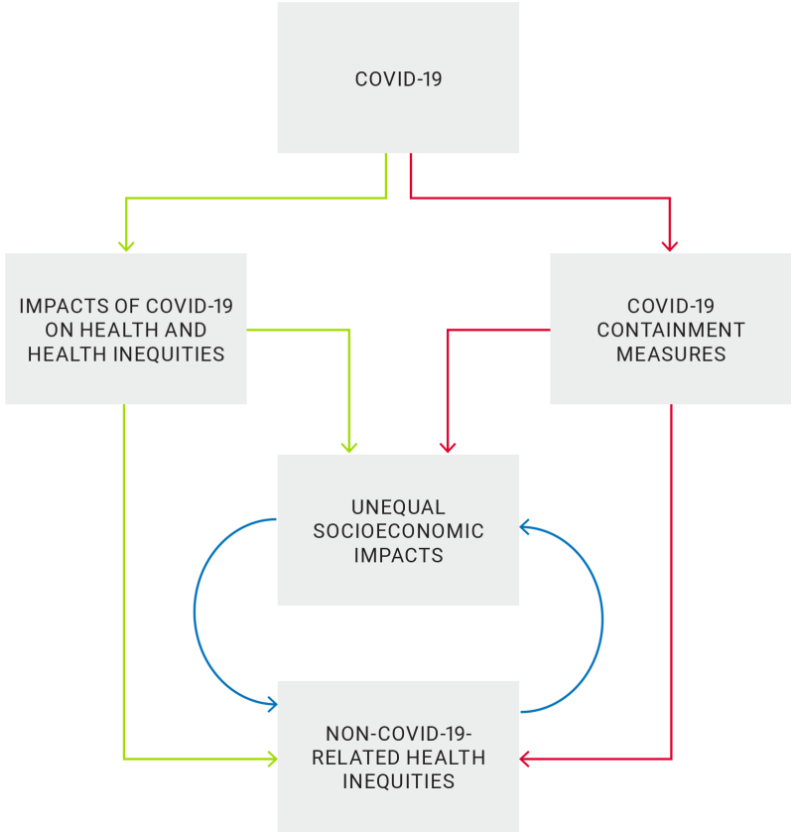


Source: WHO (2020) Strengthening and adjusting public health measures throughout the COVID-19 transition phases

World Health Organization
REGIONAL OFFICE FOR Europe

INSTITUTE of HEALTH EQUITY
REDUCING HEALTH INEQUITIES THROUGH ACTION ON THE SOCIAL DETERMINANTS OF HEALTH

Three mechanisms for COVID-19 socioeconomic impacts and their inequities



Source: WHO (2020) Health inequity and the effects of COVID-19

Impacts of COVID-19

- The COVID-19 pandemic exposed and amplified inequalities in health and socioeconomic conditions.
- Vaccination rates were lower among immigrants
- The immigrant population, especially those of African and Asian origin, and lower socioeconomic groups were overrepresented among those infected and among those who became seriously ill.
- Control measures had a major impact on children and young people, especially those in more vulnerable situations
- Unemployment increased more steeply for those with low levels of education, young people and immigrants born outside the EU
- Strict travel restrictions and closed borders affected the Sami disproportionately

Impacts of the cost of living crisis

- The cost of living crisis is deepening health and social and economic inequalities
- Between January and June 2022, the financial situation of around35 percent of Norwegians is reported to have worsened, with. around 25 percent in a vulnerable financial position in June 2022
- The most affected groups are households with younger members, families with children and households with incomes slightly above average or lower.

THE IMPACT OF THE COVID-19 PANDEMIC AND THE COST OF LIVING CRISIS

Reduce the inequitable social, economic and health impacts of the pandemic and the cost of living crisis by:

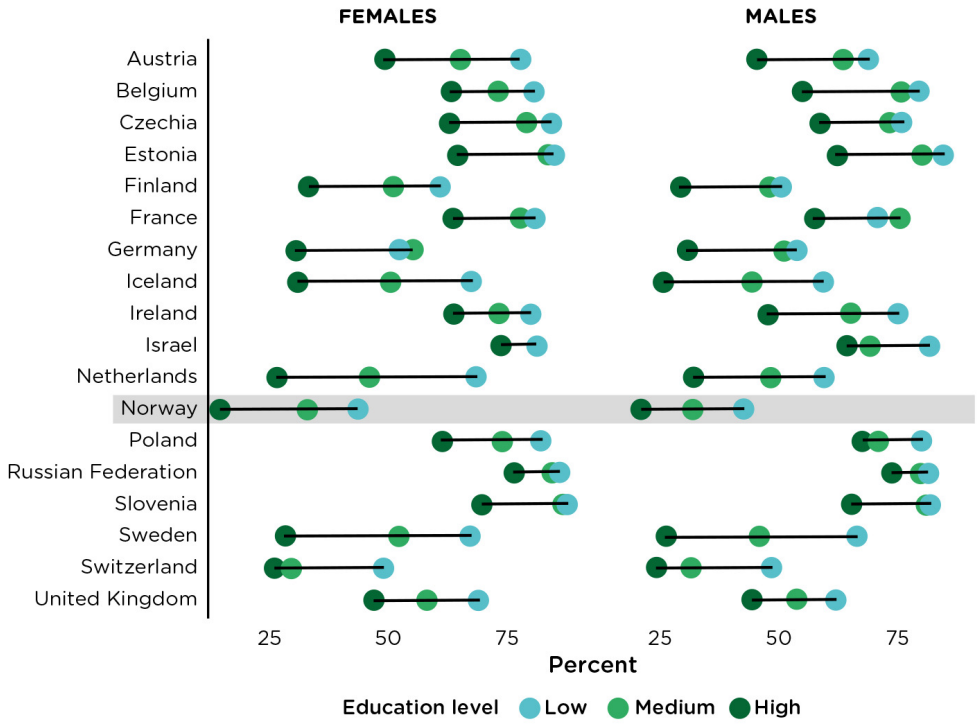
- Ensuring that the inequitable social and economic impacts from COVID-19 containment measures are considered in planning and implementing Government policies.
- Undertaking timely and regular assessments of the impacts of the cost of living crisis on social and economic position and on health.
- Providing the additional resources, programmes and interventions needed to address inequalities in health, wellbeing and their social determinants as the cost of living crisis impacts further.

Whole of society action required

- Action on the social determinants requires an effective health equity system comprising the whole of society
- the voluntary sector
- communities,
- health care
- business and the economic sector,
- public services
- national and local government.

THE HEALTH EQUITY SYSTEM IN NORWAY

Figure E.14 Percent reporting an inability to influence politics by level of education, 2016



THE HEALTH EQUITY SYSTEM IN NORWAY

A national strategy and subsequent policy on health equity should be developed to take action on the social determinants of health and prioritise health equity and wellbeing by:

- Ensuring that the following key principles for action on the social determinants of health are adopted in the strategy:

> Developing the wellbeing economy approach.

> Public sector innovation.

> Democratic participation in national and local policy decisions.

> Strong partnerships between national and local governments and between sectors and organisations.

> Health equity impact assessments.

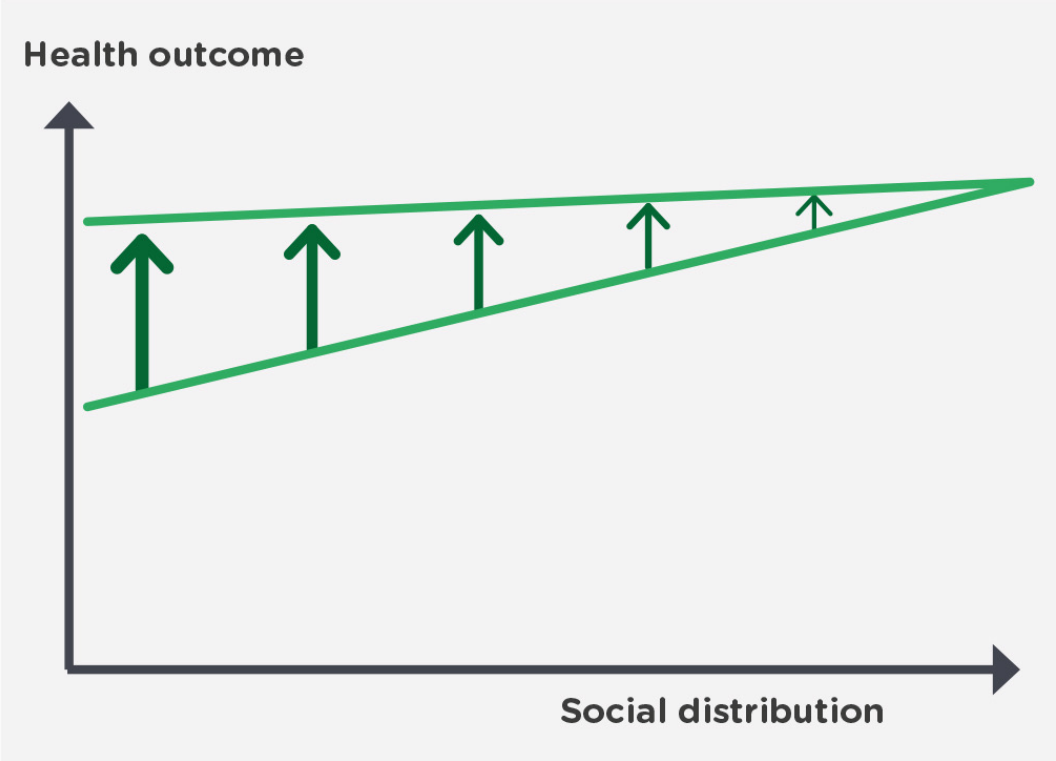
> Proportionate universalism.

> Strengthened accountability and effective monitoring for health equity.

- Developing a health equity system which comprises national and local governments, the voluntary and community sector, healthcare organisations, business and the economic sector, public services.

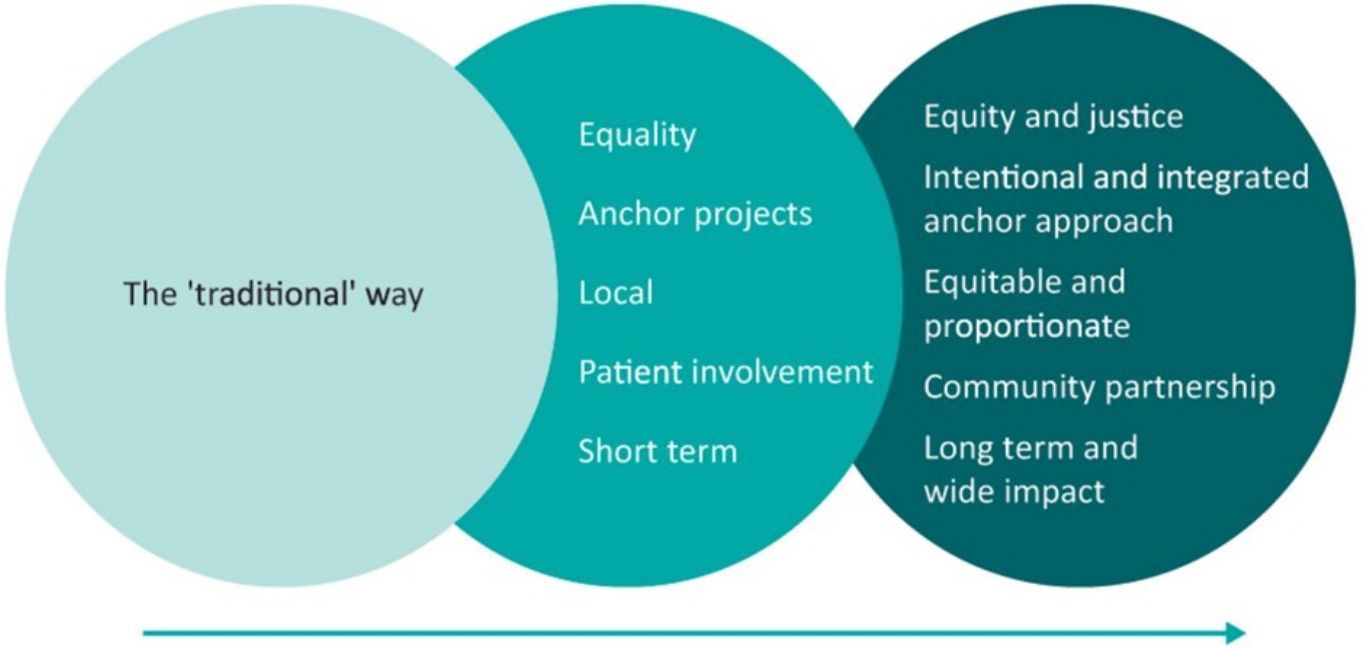
THE HEALTH EQUITY SYSTEM IN NORWAY

Figure E.15 Proportionate universalism – levelling up the social gradient in health



THE HEALTH EQUITY SYSTEM IN NORWAY

E.16 Five principles for moving anchor institution work towards equity

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Recommendations of the Commission on the Social Determinants of Health

- Improve the conditions of daily life – the circumstances in which people are born, grow, live, work and age

- Tackle the inequitable distribution of power, money and resources – the structural drivers

- Measure and understand the problem - expand the knowledge base

UN sustainable development goals:

http://www.globalgoals.org/

- “This unequal distribution of health-damaging experiences is not in any sense a ‘natural’ phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad politics.”

Closing the Gap in a Generation,

CSDH Final Report, 2008