Fair Society, Healthy Lives

Michael Marmot

CARDI International Conference, Dublin
2-4 November 2011
- Social justice
- Material, psychosocial, political empowerment
- Creating the conditions for people to have control of their lives

www.who.int/social_determinants
• “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
Conditions in which people are born, grow, live, work and age

Structural drivers of those conditions at global, national and local level

Monitoring, Training, Research

CSDH – three principles of action
CSDH – three Linked Areas for Action

- Structural drivers of those conditions at global, national and local level
- Early child development and education
- Healthy Places
- Fair Employment
- Social Protection
- Universal Health Care
- Monitoring, Training, Research
Health Equity in all Policies

- Early child development and education
- Healthy Places
- Fair Employment
- Social Protection
- Universal Health Care

- Fair Financing
- Good Global Governance
- Market Responsibility
- Gender Equity

Political empowerment
– inclusion and voice
• Fairness at the heart of all policies.

• Health inequalities result from social inequalities – requires action on all the social determinants; the causes of the causes

• Focusing solely on the most disadvantaged will not reduce inequalities sufficiently – action is needed across the social distribution.
Life expectancy and disability-free life expectancy at birth by neighbourhood income deprivation, 1999-2003

Source: Office for National Statistics
English Longitudinal Study of Ageing (ELSA)
• A lot of people at older ages are doing quite well
• More likely to be doing well if you are better off
• ELSA looks at physical and mental health and well being
• Not just material wealth – participation
• Biological markers
Self-assessed health: men

- 50–54: Fair/poor: 20%, Good: 30%, Excellent/very good: 50%
- 55–59: Fair/poor: 20%, Good: 30%, Excellent/very good: 50%
- 60–64: Fair/poor: 20%, Good: 30%, Excellent/very good: 50%
- 65–69: Fair/poor: 20%, Good: 30%, Excellent/very good: 50%
- 70–74: Fair/poor: 20%, Good: 30%, Excellent/very good: 50%
- 75–79: Fair/poor: 20%, Good: 30%, Excellent/very good: 50%
- 80+: Fair/poor: 20%, Good: 30%, Excellent/very good: 50%
• At age 80+, 30% describe their health as very good or excellent

• Another 30% good

• At age 50-54, 20% describe health as fair or poor
• Professional and managerial classes have less illness in their 70s than ‘routine and manual’ classes 15 years earlier
At age 80-84, 
72% of women 
84% of men 
Have no difficulty with walking speed
People in professional and managerial classes reach the same level of disability as those in routine and manual classes about 15 years later.
Wealthier healthier?
Deaths between waves, by wealth

[Graph showing percentage of deaths by wealth quintile for different age groups (50-59, 60-74, 75+) across the poorest to richest quintiles.]
% still without any of 17 diagnosed chronic diseases, by sex & wealth

Covers 4 eye diseases, 7 CVD-related, 6 other physical diseases

Age-standardized, weighted
Obesity and high waist-hip ratio by sex and wealth quintile

Obese: BMI $\geq 30$ kg/m$^2$
High WHR $\geq 0.95$ men
$\geq 0.85$ women
• Fairness at the heart of all policies.

• Health inequalities result from social inequalities – requires action on all the social determinants; the causes of the causes

• Focusing solely on the most disadvantaged will not reduce inequalities sufficiently – action is needed across the social distribution.
Life course stages

Accumulation of positive and negative effects on health and wellbeing

Prenatal | Pre-school | School | Training | Employment | Retirement
---|---|---|---|---|---
Family building
Fair Society: Healthy Lives:
6 Policy Objectives

A. Give every child the best start in life
B. Enable all children, young people and adults to maximise their capabilities and have control over their lives
C. Create fair employment and good work for all
D. Ensure healthy standard of living for all
E. Create and develop healthy and sustainable places and communities
F. Strengthen the role and impact of ill health prevention
Fair Society: Healthy Lives: 6 Policy Objectives

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Percentage shares of equivalised total gross and post-tax income, by quintile groups for all households, 1978 – 2007/8

Note: Gross income comprises original income and direct cash benefits (e.g. pensions, child benefit, housing benefit and income support). Post-tax income comprises gross income after direct and indirect taxes (e.g. VAT).

Source: Office for National Statistics
Distributional impact of welfare measures announced in the Spending Review to be in place by 2014–15

Assumes councils means-test CTB more aggressively

Institute for Fiscal Studies, Oct 21st 2010
Distributional impact of tax and benefit measures to be in place by 2014–15

Income Decile Group

- Poorest: -4.91%
- 2: -4.46%
- 3: -4.31%
- 4: -3.54%
- 5: -3.63%
- 6: -3.28%
- 7: -2.81%
- 8: -2.69%
- 9: -4.55%
- Richest: -5.60%

Total as a % of income

Institute for Fiscal Studies, Oct 21st 2010
The Health Impacts of Cold Homes and Fuel Poverty

Marmot Review Team

Published by Friends of the Earth and Marmot Review Team

Parliamentary Launch 12th May 2011
• Number of fuel poor households in England dramatically increased between 2004 and 2010 from 1.2 million to 4.6 million

• Much of the increase in fuel poverty is due to the increased costs of energy

• Fuel poverty – having to spend 10% or more of a household’s net income to heat their home to an adequate standard of warmth
The risk of fuel poverty according to household income, England 2009

Percent of households in fuel poverty

<table>
<thead>
<tr>
<th>Household income quintiles</th>
<th>Percent of households in fuel poverty</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest fifth</td>
<td>35</td>
</tr>
<tr>
<td>2nd</td>
<td>20</td>
</tr>
<tr>
<td>Middle fifth</td>
<td>8</td>
</tr>
<tr>
<td>4th</td>
<td>2</td>
</tr>
<tr>
<td>Richest fifth</td>
<td>1</td>
</tr>
</tbody>
</table>

Note: Percent in fuel poverty relates to households in fuel poverty after deducting housing costs

Source: English House Conditions Survey, Department of Communities and Local Government
Improving Cold Homes – a 21\textsuperscript{st} century challenge
Direct health impacts - Mortality

- Relationship between excess winter deaths and low indoor temperature and low energy efficiency

- Excess winter deaths are almost three times higher in the coldest quarter of housing than in the warmest quarter

- 40% excess winter deaths attributable to cardio-vascular diseases

- 33% excess winter deaths attributable to respiratory diseases
Direct health impacts - Morbidity

• Children living in cold homes more than twice as likely to suffer from respiratory problems than children living in warm homes

• More than 1 in 4 adolescents living in cold housing are at risk of multiple mental health problems, compared to 1 in 20 adolescents in warm housing

• Cardio-vascular and respiratory diseases

• Mental health

• Colds and flu, exacerbates existing conditions such as arthritis and rheumatisms
Indirect health and social impacts

• Cold housing negatively affects:
  – children’s educational attainment, emotional well-being and resilience
  – family dietary opportunities and choices
  – dexterity; and increases the risk of accidents and injuries in the home

• Investing in the energy efficiency of housing can help stimulate the labour market and economy, as well as creating opportunities for skilling up the construction workforce
We can do better – international comparisons
Countries with more energy efficient housing have lower excess winter deaths

<table>
<thead>
<tr>
<th>Country</th>
<th>Coefficient of seasonal variation in mortality</th>
<th>Cavity wall insulation (% houses)</th>
<th>Roof insulation (% houses)</th>
<th>Floor insulation (% houses)</th>
<th>Double glazing (% houses)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Finland</td>
<td>0.10</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Germany</td>
<td>0.11</td>
<td>24</td>
<td>42</td>
<td>15</td>
<td>88</td>
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<tr>
<td>Netherlands</td>
<td>0.11</td>
<td>47</td>
<td>53</td>
<td>27</td>
<td>78</td>
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<tr>
<td>Sweden</td>
<td>0.12</td>
<td>100</td>
<td>100</td>
<td>100</td>
<td>100</td>
</tr>
<tr>
<td>Norway</td>
<td>0.12</td>
<td>85</td>
<td>77</td>
<td>88</td>
<td>98</td>
</tr>
<tr>
<td>Denmark</td>
<td>0.12</td>
<td>65</td>
<td>76</td>
<td>63</td>
<td>91</td>
</tr>
<tr>
<td>Belgium</td>
<td>0.13</td>
<td>42</td>
<td>43</td>
<td>12</td>
<td>62</td>
</tr>
<tr>
<td>France</td>
<td>0.13</td>
<td>68</td>
<td>71</td>
<td>24</td>
<td>52</td>
</tr>
<tr>
<td>Austria</td>
<td>0.14</td>
<td>26</td>
<td>37</td>
<td>11</td>
<td>53</td>
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<tr>
<td>Greece</td>
<td>0.18</td>
<td>12</td>
<td>16</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>UK</td>
<td>0.18</td>
<td>25</td>
<td>90</td>
<td>4</td>
<td>61</td>
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<tr>
<td>Ireland</td>
<td>0.21</td>
<td>42</td>
<td>72</td>
<td>22</td>
<td>33</td>
</tr>
<tr>
<td>Portugal</td>
<td>0.28</td>
<td>6</td>
<td>6</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

(Healy 2003)
Percentage of population by social grade who visit a green space infrequently in a year, 2009

Source: Department for Environment, Food and Rural Affairs, Energy Savings Trust
Greener living environments: lower health inequalities, England

Deaths from circulatory disease

Ageing, income, and spending
Income distribution: respondents aged SPA+

2002/03

Mean income = £ 244
Median income = £ 188
Gini coefficient = .355

2008/09

Mean income = £ 305
Median income = £ 228
Gini coefficient = .381

Mean income higher in 2008/09 than in 2002/03
Income distribution: respondents aged SPA+

2002/03

Mean income = £ 244
Median income = £ 188
Gini coefficient = .355

2008/09

Mean income = £ 305
Median income = £ 228
Gini coefficient = .381

Income distribution more unequal in 2008/09 than in 2002/03
Spending on basics as % of income falls steeply with income

<table>
<thead>
<tr>
<th></th>
<th>2008/9</th>
<th>Percentage point change in spending as % of income 2004/5-2008/9</th>
</tr>
</thead>
<tbody>
<tr>
<td>Poorest</td>
<td>48.3</td>
<td>12.5</td>
</tr>
<tr>
<td>2nd</td>
<td>34.4</td>
<td>2.2</td>
</tr>
<tr>
<td>3rd</td>
<td>27.6</td>
<td>-1.5</td>
</tr>
<tr>
<td>4th</td>
<td>22.6</td>
<td>-4.1</td>
</tr>
<tr>
<td>Richest</td>
<td>16.4</td>
<td>-7.1</td>
</tr>
<tr>
<td>All</td>
<td>29.7</td>
<td>0.7</td>
</tr>
</tbody>
</table>
Well being

- Well-being - a multidimensional construct, including
  - satisfaction with life,
  - sense of autonomy,
  - control and self-realisation, and the
  - absence of depression and loneliness.
Cross-wave analysis
(comparing wave 2* to wave 4)

* We used data from wave 2 and not from wave 1 (baseline) because satisfaction with life and loneliness were not measured at wave 1
Wave 4: well-being by access to amenities and services (number of access problems) and age

- “HOW EASY OR DIFFICULT WOULD IT BE FOR YOU TO GET TO EACH OF THE FOLLOWING PLACES, USING YOUR USUAL FORM OF TRANSPORT? “

  - Bank
  - General Practitioner
  - Hospital
  - Supermarket

ANY OF THE FOLLOWING RESPONSES WAS CODED AS AN ACCESS PROBLEM: ‘quite difficult’, ‘very difficult’ and ‘unable to go’
Wave 4: well-being by access to amenities and services (number of access problems) and age

Elevated depressive symptoms by access to services/amenities and age in wave 4

Mean score (possible range: 5-35)

<table>
<thead>
<tr>
<th>Age: 50-64</th>
<th>Age: 65-74</th>
<th>Age: 75+</th>
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<tr>
<td>No problem</td>
<td>1 access problem</td>
<td>&gt;=2 access problems</td>
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Life satisfaction by access to services/amenities and age in wave 4

Mean score (possible range: 5-35)

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Action on the wider determinants - to tackle health inequalities

• “Every sector a health sector”

• Local authorities, Health and Social Services, Voluntary Sector have a key role to play at local level

• Empower individuals and communities – create the conditions for people to take responsibility
Rio Political Declaration on Social Determinants of Health

Rio de Janeiro, Brazil, 21 October 2011

1. Invited by the World Health Organization, we, Heads of Government, Ministers and government representatives came together on the 21st day of October 2011 in Rio de Janeiro to express our determination to achieve social and health equity through action on social determinants of health and well-being by a comprehensive intersectoral approach.

2. We understand that health equity is a shared responsibility and requires the engagement of all sectors of government, of all segments of society, and of all members of the international community, in an "all for equity" and "health for all" global action.
• Health inequalities are not inevitable or immutable
Age standardised mortality rates by socioeconomic (NS SEC) in the North East and South West regions, men aged 25-64, 2001-03

Notes: NS-SEC = National Statistics Socio-economic Classification
Source: Office for National Statistics6
Glasgow relative to Liverpool & Manchester

All ages, both sexes: cause-specific standardised mortality ratios 2003-07, Glasgow relative to Liverpool & Manchester, standardised by age, sex and deprivation decile

Calculated from various sources

Health improvement in difficult times

• A major element of the excess risk of premature death seen in Scotland is psychosocially determined

• Study evidence of low sense of control, self efficacy and self esteem in population in these areas

Source: H. Burns, CMO Scotland
A Fair Society

Conditions in which individuals & communities:

Have control over their lives

and

Participate fully in society

Website  www.marmotreview.org