Diffusion of Ideas on Social Inequalities in Health: A European Perspective*

MARGARET WHITEHEAD

King's Fund, London; Karolinska Institute, Stockholm

The growing gaps in health status between people in different groups is a serious and a major concern for the government. We cannot accept that the richer get healthier and the poorer get sicker. Not in our country, nor in the world.

Carlsson (1995)

THIS QUOTATION FROM AN ADDRESS BY INGVAR Carlsson when he was prime minister of Sweden is but one illustration of a remarkable shift to serious concern about social inequalities in health that has taken place in Europe during the 1990s. This European development during the past two decades in part resulted from a fascinating interaction between the research evidence and public health advocates amid a rapidly changing socioeconomic climate.

From a policy perspective, it is important to understand history in order to build for the future. I wish to address the question of how research evidence and ideas have diffused into national policy arenas,

*In Europe, the term "social inequalities in health" denotes systematic, avoidable, and important disparities in health status between different socioeconomic groups in the population and will be retained here. In the United States, the term "socioeconomic status and health" is more commonly used in a similar context.

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leading to action—or at least to a greater willingness to take action—on inequalities in health. The relevance of the activities I will be reviewing here extends beyond Europe to other parts of the world that also recognize the challenge to public health and public policy posed by the issue of inequality.

The Action Spectrum

Drawing from the definition set forth by Rogers (1983), I use the word “diffusion” in this paper to refer to the process by which research evidence and general awareness of the seriousness of the issue of social inequalities in health have come to the attention of European policy makers at both the national and the international levels. My evaluation of the evidence that diffusion has taken place, therefore, will be based on indicators that reflect official commitment to action by national or international bodies. These include the establishment of national research programs or commissions of inquiry; official modification of national information systems to facilitate measurement and monitoring of the issue; the publication of government reports; and parliamentary statements or bills that establish the topic as a priority and signal a commitment to policy development.

When these indicators are used to survey the countries of Europe, a whole spectrum of readiness and receptivity to the subject of social inequalities in health can be found (see fig. 1). At one end are the countries that do not even measure, let alone recognize, that social differentials exist within their boundaries; at the other end of the spectrum, a few countries are devising a coordinated national strategy to attack the problem.

Spain exemplifies a country that has moved rapidly from having no measurement or monitoring of health differentials (where, in fact, under the Franco dictatorship, information gathering of this sort was actively discouraged) to one that can boast a small, but active, research program in several centers. This new interest recently culminated in the establishment of a national Scientific Commission on Inequalities in Health, which has published its own report (Navarro and Benach 1997).

Until the end of the 1980s, when the Soviet Union was dismantled, many countries of Central and Eastern Europe were located at the point in the spectrum labeled “measurement but no recognition.” This means

FIG. 1. Action spectrum on inequalities in health.

they were at the stage where sophisticated information and monitoring systems were measuring health differentials across the population, but the data were kept secret. Aided by the European office of the World Health Organization (WHO), these statistics are now being published, and they indicate a situation of grave concern (Wnuk-Lipinski and Illsley 1990; Cornia and Panicla 1995).

Some countries have been stuck in the “denial/indifference” phase, during which even regular monitoring and airing of the issue produce little reaction. Sweden remained in this phase for a time during the 1980s. However, it progressed rapidly through the spectrum to a heightened level of awareness and a willingness to tackle the issue during the 1990s. Britain also appeared to be indifferent at the level of its national government throughout the 1980s and most of the 1990s. The country seems to have been suffering from a split personality. At the local level, for example, some regions have been actively promoting awareness of inequality in health for years, in contrast to other, often similar, administrative sectors that have ignored the issue altogether.

Some countries have become more aware of the inequality existing within their borders, only then to construct a mental block in response to the complexity of the problem, falling back on calls for more research rather than arriving at decisions about what to do. Fortunately, there are

now signs of movement along the alternative pathway: taking some action, even if it is at first piecemeal and uncoordinated. The Netherlands, Sweden, and Britain are taking this path; case studies of these three countries are presented below. In some countries at least, it has become politically more feasible to consider taking action on inequalities than has been the case for many decades.

This new reality is also reflected in the changed stance of leading international agencies in the region. The European Union (EU), which incorporates 15 of the more affluent western and northern European countries, has identified research on inequalities in health as a priority for its public health program. It is funding several major international investigations of inequalities in morbidity and mortality among its member states and is assessing how equitably the health care system in each country is being financed and delivered (Mielck and Giraldez 1993, 1994; Kunst et al. 1997; van Doorslaer et al. 1993, 1997). A report on the health implications of EU policies in their totality must be presented annually, a requirement that has had the effect of alerting members to the fact that many policies, particularly in the areas of social security, social action, employment, and agriculture, can influence the health of different groups within the population (Dahlgren, Nordgren, and Whitehead 1997).

Influential Factors

It is instructive to consider the factors that have brought about this more favorable climate. Three parallel developments during the past decade can be identified as interacting to trigger decisive official action.

Deteriorating Socioeconomic Conditions

A major reason for the heightened political interest and more receptive atmosphere in many countries is the deterioration in socioeconomic conditions, leading sometimes to crises, that has occurred in Europe during the 1980s and into the 1990s.

The scale of deterioration in Central and Eastern Europe has sent warning signals throughout the continent. The regional map is now being redrawn: in 1980 the WHO European region contained 32 coun-

tries, but as a result of its reconfiguration following the break-up of the U.S.S.R., the number of member nations has increased to 51. Sometimes this process has involved bitter, armed conflict, as occurred in Bosnia and, most recently, in Albania. Even when there is no open fighting, the countries of the former Soviet Union have faced disruption, if not total disintegration, of their social and economic infrastructures, as well as periods of negative economic growth (World Health Organization 1994; Levin, McMahon, and Ziglio 1994; Cornia 1996).

At the same time, many Western European countries have been persistently facing the common challenges of economic recession and unemployment. The average unemployment rate in the EU, for example, rose from 8 percent in 1990 to exceed 11 percent in 1994, a level more than three times higher than existed in the 1970s; such levels have prevailed in many EU countries for more than a decade (Mitchie and Wilkinson 1994). Of special concern are the rates of long-term unemployment, which also rose during the 1990s recession, and of youth unemployment, which climbed to 30 percent in France, Italy, and Spain (World Health Organization 1994).

The effects of recession have been felt even in Scandinavia, which has traditionally experienced low levels of unemployment and high standards of living. Unemployment in Finland, for example, which approached 4 percent in the 1980s, surpassed 20 percent during the four-year period from 1990 to 1994. Concern about what effects these trends might have on health and welfare is contributing to the upsurge of interest in health inequalities in these countries (Levin, McMahon, and Ziglio 1994).

Added to this picture are the common demographic trends, particularly the aging of the European populations, which have widespread implications, not only for health care systems, but also for social and labor market policies. One concern is that the more vulnerable sectors of the population may face restrictions on access to health and social services. Some countries have even openly posed the question: can we afford a welfare state? Others prefer to phrase the question the other way round: can we afford *not* to have one? The question of equitable access for all within the health care systems has emerged as a major theme of such discussions.

Worsening Health Trends

In parallel with the socioeconomic changes, a deterioration in health status and widening gaps in the health of different sections of the pop-

ulation within countries have become apparent. Central and Eastern Europe have displayed the most disturbing indicators of a decline in health (see fig. 2). The dramatic decline in life expectancy in the Russian Federation and the newly independent states of the former U.S.S.R. is unprecedented in the developed world during this century (World Health

A. Men

B. Women

FIG. 2. Trends in life expectancy at birth, in years in the European Union and the former Soviet Union (World Health Organization 1996).

Organization 1994, 1996). This reality has been coupled with upsurges in infectious diseases that were once thought to be under control. The worsening trends have hit hardest at the more disadvantaged populations within these countries (Shkolnikov 1996).

Europe is the home of many of the healthiest countries in the world, but even the more fortunate nations have discovered substantial differentials in the health of their citizens at the top and bottom of the social scale, and many are now reporting a widening gap. Illustrative of the emerging pattern in the Scandinavian countries of the North is the growing difference in health-weighted years of life among different occupational groups in Sweden, particularly among women (National Board of Health and Welfare 1995). Sweden is now engaged in discussions of how to deal with this situation. In the West, the latest evidence from Britain during the 1990s reveals a threefold gap in mortality between professional men in social class I and men in social class V who perform unskilled, manual labor (Drever, Whitehead, and Roden 1996), an increase from the twofold differential that existed in the 1970s (fig. 3). In the South, the Spanish Scientific Commission on Social Inequalities in Health reported at the beginning of 1997 on the differentials in adult mortality that developed in Spain during the 1980s (Navarro and Benach 1997).

FIG. 3. Standardized mortality ratio (SMR), by social class, of men aged 20 to 64, in England and Wales: all causes, 1991-93 (Drever, Whitehead, and Roden 1996).

These health trends are repeated right across Europe (Whitehead and Diderichsen 1997), reinforcing the impression that this subject should be taken more seriously.

Strategies to Promote Awareness

Added to these deteriorating socioeconomic and health trends, and partly in response to them, is a third influential factor, which has pushed the issue to the forefront of the research and political agendas. This is the development of deliberate strategies to bring the research evidence to the attention of the decision-makers. I will examine this process, both at the international level—in the work of the WHO Regional Office for Europe—and in individual countries—presented as case studies to illustrate the diverse methods that have been adopted to reach similar goals.

WHO's Approach: Moving from Evidence to Action

Responding to worsening conditions during the 1980s, WHO's European office set up its own program. It concentrated on descriptive analyses of the size and nature of health inequalities, starting with the health effects of unemployment and poverty. Later it went on to examine the health of migrants and refugees when their plight emerged as a prominent issue in the region. The work of WHO fed into discussions on formulating a common health policy for the region—a "European Health for All" Strategy—that would narrowly target certain goals. When 38 European targets were itemized in 1984 as part of this strategy, reduction of social inequalities in health led the list and constituted its central theme.

"European Health for All" Strategy: Target 1

By the year 2000, the actual differences in health status between countries and between groups within countries should be reduced by at least 25% by improving the level of health of disadvantaged nations and groups. (World Health Organization 1985)

All the countries in the region agreed to work toward this central goal, some more enthusiastically than others. The target is largely symbolic, as its intention is to inspire, motivate, and encourage cooperation between agencies, rather than to produce precisely measurable results (Whitehead, Scott-Samuel, and Dahlgren 1998). Publication of the WHO equity target has added legitimacy to, and justified work on, poverty and health at the local level in countries whose national governments were displaying attitudes of clear hostility toward such activity, as occurred in Britain throughout the 1980s (Whitehead 1992; Scott-Samuel 1987).

By 1989, the WHO European Office decided to move from descriptive analysis of the problem of inequalities in health to open encouragement of policy for reducing the observed disparities. To aid policy makers in this process, WHO sponsored the development and dissemination of a group of papers that explored the following questions:

- What does the concept of equity mean in everyday terms, and why is it important to increase equity in health? (Whitehead 1990)
- What kinds of policies and strategies would help to promote equity? (Dahlgren and Whitehead 1992)
- How can inequalities in health be measured and monitored over time? (Kunst and Mackenbach 1995)

These papers were written in nontechnical language and illustrated with examples that were chosen on the basis of their appeal to policy makers at different organizational levels. To encourage dissemination of the papers beyond a small, English-speaking elite in each country, translation into as many European languages as possible was encouraged.

There are several indications that policy makers have been persuaded by this approach and that the level of awareness has risen in Europe. For example, WHO monitoring reports show that ministries of health and national professional organizations in a number of European countries have requested and commissioned translations of the publications into their own languages, thereby ensuring wider circulation of the ideas contained in them. To date, the materials have been translated into 18 European languages and comprise the publications that are most frequently requested from the European office (Anna Ritsatakis 1997: personal communication regarding unpublished WHO monitoring report). They have been used as the basis for debate in formal international

meetings of member states and in conferences sponsored by governments to plan national health strategies that address the issue of social inequalities in health. In addition, WHO monitoring reports show that they have been reprinted and used in student and professional training materials, not only in Europe, but also further afield: in Canada, the United States, South America, Hong Kong, and South Africa. A small, independent evaluation conducted in 1994 by the National Library of Health Sciences among policy makers in Finland concluded that these WHO materials helped to clarify concepts and principles and to raise awareness of health inequality issues (Pekkarinen 1995).

This is just one aspect of the drive to raise awareness. WHO is helping to create networks of researchers, politicians, and policy makers in Europe to tackle the problem of inequalities in health.

Strategies in Individual Countries

Alongside the pan-European efforts, individual countries have been creating and following their own agendas. In the course of doing so, an action taken in one country may trigger an action in another. Three contrasting case studies from the Netherlands, Britain, and Sweden are presented here.

The Netherlands: A Consensus Strategy

Box 1 outlines the progress of the equity debate in the Netherlands, which developed a *consensus* strategy. Official attitudes toward inequalities in health have been transformed since the 1970s, when it was a nonissue. Information alone did not stimulate the change. In 1980, for example, an academic conference and the emergence of new evidence on health inequalities failed to engender a political response. By 1987, however, the situation had changed markedly. The coalition government of Christian Democrats and Conservatives sponsored a national conference of all the major political parties, trade unions, employers' organizations, and health sector associations; the outcome was adoption of a plan of action to address health inequalities. One component of the plan was a five-year national research program, jointly conducted by all the universities in the country under the direction of a steering com-

1970s - Social inequalities in health are a nonissue.

1980 - An academic conference is held and new evidence is presented by researchers, but there is no political follow-up.

1985 - The Netherlands agrees to be a test country for the WHO European Health for All Strategy. The British *Black Report* on health inequalities, among others, attracts the attention of policy analysts.

1987 - The coalition government of Christian Democrats and Conservatives calls a national conference on the issue for key policy makers, a broad plan of action is adopted, and a five-year national research program is commissioned on health inequalities.

1989 - Following the election of a Labour government, support for the research program continues.

1991 - The government calls a conference of all political parties and many sectors, which agree to take coordinated action on health inequalities.

1993-97 - The government initiates a second five-year research and development program, focusing on causal mechanisms and an evaluation of interventions to address health inequalities.

BOX 1. Diffusion of the health inequalities issue in the Netherlands.

mittee chaired by a senior politician of the right-wing Conservative Party. The committee issued reports regularly to members of Parliament.

Even after the left-wing Labour party assumed control of the government in 1989, support for the program continued. The new government held a follow-up conference in 1991 of four government ministries and a broad spectrum of private and public policy makers. The participants agreed on the evidence: that health disparities in the country had been increasing since 1960; that an action program with clearly stated priorities was needed; that it was necessary to adopt an integrated, coordinated approach; and that another five-year research program (1993–97) should be instituted, this time for the purpose of evaluating causal mechanisms and practical interventions (Mackenbach 1994).

The transformation from indifference to evident concern did not occur by chance. Dutch public health commentators agree that there were several decisive catalysts for change (Gunning-Schepers 1989; Macken-

bach 1994). The WHO European Health for All targets and the *Black Report* on health inequalities in Britain were cited as having had a strong influence on awareness. Stimulated by these outside developments, a think tank within the Ministry of Health and Cultural Affairs set out to activate national debate on the issue. Its approach from the start was to build a political consensus, based on several carefully structured elements:

- The problem was defined in politically neutral terms.
- More energy was devoted to publicizing the issue.
- The evidence was made available at politically opportune times (for example, just before a parliamentary debate on health care reform).
- The responsibility for reducing inequalities was shared by all parties concerned.
- Follow-up actions were prepared in advance of possible decisions (Gunning-Schepers 1989).

Thus it was considered important both that all the political parties participate in the initial conference and that no party be singled out as responsible for the current pattern of health inequalities. Arguments based on human rights and fairness were played down, in favor of concentrating on the wasted potential that was reflected in the excess morbidity and mortality of the more disadvantaged social groups.

This slow, cautious building of a consensus has paid off over a period of years, as commitment to the task has remained, even with a change of government. The British case stands in stark contrast to the Dutch experience.

The British Approach: Confrontation

In Britain, the situation has been characterized by *confrontation*, which in recent years has shifted to *pragmatism*. Before describing the situation there, it is important to highlight Britain's long tradition of measuring social inequalities in health, particularly by social class based on occupation, and to recollect that Britain's pioneering collectors of statistics also offered social commentary on the data they gathered. For example, William Farr, the first "superintendent of statistics," started this tradi-

tion more than 150 years ago when he published devastating accounts of the excess deaths among the poorer sections of the population (Farr 1839). The sheer volume of information collected in Britain since that time may therefore create the impression that it has a more serious problem than other nations that do not bother to collect any information on the issue.

Box 2 illustrates the progress of the debate in Britain. In contrast to

1970s - Health professionals become aware of evidence that Britain is slipping behind other countries in population health. Leading medical researchers point to wide inequalities as a possible contributory factor.

1977 - The Labour government establishes the Inequalities in Health Research Working Group, under Sir Douglas Black, to review evidence and advise on policy to address the problem.

1980 - *The Black Report* is published, concluding that there is a serious problem to address, but the new Conservative government tries to “bury” the report. Public health bodies object. Opposition parties adopt the health inequalities issue as a propaganda weapon against the government.

Mid-1980s - Political confrontation is met with denial. Any mention of health inequalities disappears from official vocabulary and statistics. A stream of health reports is published, backed by national medical and nursing organizations, stressing the seriousness of the problem. A severe economic recession extends from 1984 to 1988.

1990 - Margaret Thatcher resigns. The official approach relaxes to a degree.

1995-7 - There is a noticeable change. Official reports are commissioned on what the National Health Service could do about health inequalities; national research programs are announced.

1997-8 - A Labour government is elected, which commissions an independent inquiry into health inequalities and sets the reduction of health inequalities as one of the two main goals of the new national health strategy.

BOX 2. Diffusion of the health inequalities issue in Britain.

the Netherlands, voices of concern were raised in the 1970s about the extent of inequalities in health. Some were of the opinion that they constituted one reason for the country's failure to keep pace with other nations in the life expectancy of its populace and other health indicators (Brotherston 1976).

Concern reached such a level by 1977 that the Labour government was persuaded to set up the Research Working Group, under the chairmanship of Sir Douglas Black, president of the Royal College of Physicians, to examine the evidence and recommend policy. The working group deliberated for three years and published its eponymous report just as a Conservative government was coming to power under the leadership of Margaret Thatcher. The new government was not only indifferent to the issue; it also tried to "bury" the report. National medical and nursing bodies objected to this high-handed tactic, and the other political parties "adopted" the report (and health inequalities in general) as a cause. Thus the scene was set for a decade marked by confrontation and denial (Townsend, Whitehead, and Davison 1992).

Throughout the 1980s, public health organizations, together with left and center groups, challenged the government on its lack of action in confronting the worsening situation in the country. The government, in turn, denied the existence of a problem, effectively erasing even the words "inequalities in health" and "poverty" from the official vocabulary and deemphasizing the concepts in its presentation of national statistics (Townsend, Whitehead, and Davison 1992).

With the resignation of Margaret Thatcher as prime minister in 1990, the rigid official approach slowly relaxed: for a start, the link between poverty and ill health was no longer vehemently denied. Since the end of 1994, the issue has been at least acknowledged at the national level, although to a subtle degree that may not be appreciated by an outside observer. Although "inequalities in health" remained a sensitive phrase right up to the election of the new Labour government in May 1997, discussion of "social variation" crept into the official vocabulary. Indeed, in 1995 a "variations" subgroup was created by the Department of Health to investigate the question of what the department, working with the National Health Service, could do about variations in health (Department of Health 1995). This initiative was linked to the national health strategy, which originally did not cover action on inequalities in health but has since incorporated the topic into the agenda as a result of intense lobbying by public health agencies. This group's report, pub-

lished in October 1995, recommended immediate steps that the health sector in Britain could take to tackle socioeconomic and ethnic differentials in health and access to care, and it also listed areas that would benefit from research and development.

There were other positive indications of diffusion at the national level:

- The chief medical officer for England acknowledged in his 1995 annual report that targets for national health would only be achieved if inequalities in health were addressed.
- The Office for National Statistics prepared a special volume, *Health Inequalities*, made up entirely of analysis and commentary on social disparities in health in England and Wales (Drever and Whitehead 1997). This marked a significant departure from the previous decade, which produced no official statistical reports on the issue.
- The national research councils and the English Department of Health announced, in 1995 and 1997, that they were commissioning and funding long-term programs of research and development on the issue.
- Professional associations and health organizations became less confrontational and began to look more closely into what could be achieved through policy.
- The new government created a task force in July 1997 that was assigned to conduct an Independent Inquiry into Inequalities in Health and to report to the government by the summer of 1998 on its scientific assessment of the areas most urgently requiring policy development.
- The government drafted a national health strategy in February 1998, which acknowledged the major problem of health inequalities in Britain and the causal role of socioeconomic factors. It declared that one of the two key aims of the national strategy was “to improve the health of the worst off in society and to narrow the health gap” (British Government 1998).

The factors that led to this thaw in the official climate in Britain included: intense professional pressure from health-related bodies and medical journals (see, for example, Haines and Smith 1997; Horton 1997); a stream of high-profile, authoritative reports (see, for example, Black et al. 1980; British Medical Association 1987; Townsend, White-

head, and Davidson 1992; Benzeval, Judge, and Whitehead 1995); public outcry over policies that penalized the poor; and growing public perceptions of a divided society. Social divisions had become more obvious as poverty, income inequality, insecure employment patterns, and homelessness grew during the 1980s (Hutton 1995).

Sweden: Emphasizing Social Justice and Solidarity

Sweden provides an example of a third, distinctive approach that emphasizes the unfairness implied by large disparities in health (see Carlsson 1995). The thrust of the unfairness argument is that health is a basic human right that also influences access to other basic rights, such as the freedom to participate fully in society. It follows, then, that resources for health should be organized equitably.

Interest in health inequalities in Sweden has fluctuated greatly over the century, as Box 3 outlines. It was a hot political issue in the 1930s, when differentials in infant mortality between rich and poor were viewed as particularly unjust, and the government set goals for reducing them through better housing, social security, and provisions for maternal and child health (Dahlgren and Diderichsen 1986).

During the 1950s and 1960s, a mood of complacency set in, partly encouraged by an awareness that Swedish society had become more egalitarian; most assumed, on the basis of a few isolated studies, that this situation applied to health. One study, for example, found no difference in the heights of children from varying social backgrounds (Lindgren 1976). In the mid-1970s, evidence of health differentials was emerging but was not taken seriously.

This attitude changed markedly by the mid-1980s. Studies began to show that manual workers were experiencing poorer health than salaried employees, which stirred the concern of the blue-collar unions. A series of work-related initiatives was set in motion, and the Swedish Parliament passed a bill enunciating its major policy objective of reducing inequalities.¹ The bill stipulated that reports on the status of health and social differentials were to be presented to Parliament every three years.

By 1991, a second policy bill was passed, which stressed the importance of taking health into consideration when making policy for the

¹Swedish Government. 1984/85. Government policy bill 181: *Guidelines for the Development of Health and Health Care*. Stockholm (in Swedish).

1930s - Health inequalities are a hot political issue, triggered by evidence of large disparities in infant mortality between rich and poor. Goals are set for the reduction of inequalities, and a range of policies, focused on the health of mothers, is adopted.

1950s-1960s - Research and political interest subsides as the problem is thought to be solved.

Mid-1970s - Some evidence of health inequalities is presented, but it is ignored.

Mid-1980s - Evidence of health inequalities is accepted by the government under pressure from labor unions. The first policy bill on the topic is presented in Parliament, with “reducing inequities a major policy objective.”

1991 - A second policy bill promotes equity in health as a priority, but the new Conservative-Liberal government does not give the issue a high priority.

1992 - Sweden experiences a severe economic recession.

1995 - A new Social Democrat government is elected. A parliamentary committee is announced to formulate national health objectives, focusing on reducing health inequalities. In 1997 a commission is set up for this purpose, with a mandate to report by the year 2000.

1996 - Parliament passes a bill that establishes long-term research plans for the country. It announces a national research program that emphasizes better monitoring of health inequalities and commissions studies to inform policy development.

BOX 3. Diffusion of the health inequalities issue in Sweden.

other sectors. The bill also provided for the establishment of a National Institute of Public Health, whose central focus would be equity in health. However, when the Conservative–Liberal party was elected in September 1991, it accorded less priority to these plans.

Since then, Sweden has experienced a severe recession, rising unemployment, and the return of a Social Democratic government, circumstances that combined to rekindle interest in health inequalities. For example, in December 1995, the government announced the establishment of a parliamentary commission to define national objectives for

health development. The committee was instructed to be “particularly concerned with reducing the class- and gender-related differences existing in matters of health” (Swedish Ministry of Health and Social Affairs 1995). At the same time, it gave the National Institute of Public Health the task of devising multisectoral strategies to promote equity in health. Tackling the problem of health inequalities was acknowledged to be a way of uniting various sections of society at a time of concern about growing social and economic divisions.

In December 1996, Parliament passed a national research policy bill that included the establishment of a program of health inequalities research. In its justification for adopting this measure, the government cited the following evidence of a growing health divide in Sweden:

Health developments have been least favourable for women in manual occupations. There is a serious risk of social differences continuing to increase. High unemployment, increased economic stress and socio-economically related changes in smoking habits and alcohol consumption are threatening to augment health inequality. Viewed in this perspective, knowledge concerning mechanisms and processes influencing the social distributions of ill health are of strategic importance. It is essential for knowledge to be developed on the basis of an integrated gender and class perspective because the reasons for the observed social differences in health differ between men and women. . . .²

By 1997, three national bodies—the Social Research Council, the Medical Research Council, and the National Institute of Public Health—had been commissioned to draw up and oversee the national program. What distinguishes the Swedish approach, therefore, is its strong emphasis on social justice, its incorporation of a gender perspective, and its consideration of wider structural policies as central to the emerging strategy.

Learning from These Experiences

Returning to the central question of how research evidence is diffused into the national policy arena, what lessons can be gleaned from these

²Swedish Government. 1996/97. Government policy bill SOU: 5: *Research and Society*. Stockholm (in Swedish).

experiences? The two most striking features of the European developments are the diverse approaches and the reinforcing effect of events in one country on the situation in the others.

When confronting the subject of diversity, individual countries have raised awareness on the issue through very different methods, according to the dictates of prevailing circumstances and political climate. Each tactic has its advantages and disadvantages, so it is essentially a matter of carefully assessing what is most feasible in a particular place and time.

At one extreme, there is the Dutch strategy of taking the time to build a careful consensus, which has obvious merits. However, it is of necessity slow and cautious and requires downplaying any controversy.

At the other extreme, Britain's strategy has been characterized by outright confrontation and official disapproval. Some have questioned whether the aggressive stance taken by British public health advocates has been counterproductive, inhibiting realistic political action during the 1980s. Another interpretation of events, and the one that I favor, is that there was no real alternative to confrontation. Consensus was not a viable option, given the political climate in Britain during the 1980s. Attempts to compromise by seeking a consensus would have been fruitless, and might have dampened enthusiasm for action when more favorable conditions arose in the 1990s. The reinforcing effect of activities in Britain on the course of events in other parts of Europe also must be considered.

These reinforcing, cross-border effects have been a striking feature of the European scene, affecting both research and advocacy. Certain key reports and active public health lobbying campaigns have had a slow, but steady, impact on attitudes across Europe. The classic example is the *Black Report*. Although the British government evinced no interest in the *Black Report* when it was published in 1980, paradoxically it was taken seriously in a number of other countries, where it stimulated investigations of the extent and nature of inequalities in health (Macintyre 1997). The steady flow of reports on inequalities in health issuing from the WHO European office, and the selection of a target for equity in the European common health policy, helped to maintain a high profile for the issue.

The role that professional advocacy has played in pushing national governments to act should not be underestimated. The impact of the reports described here has been magnified by the fact that they have issued from serious, well-respected sources, backed by authoritative medical and scientific organizations.

This activity has led to better measurement of the extent of social inequalities in health, which, in turn, has raised awareness still further. If the facts relating to the social distribution of health are not recorded, the problem can remain invisible. Once the data are available in a country or region, however, they can be presented to policy makers. The European experience has shown that, although information alone is not sufficient to trigger action, its availability in the right form can be a powerful tool for advocacy.

The cross-fertilization of research among countries has also been important in furthering the debate. The effect within the international research community has been cumulative; initially, a small body of researchers published their work, thereby stimulating more studies at a pace that accelerated during the 1990s. Spain and Germany are the latest countries to engage in research on the subject.

Commenting on the situation in the Netherlands, Mackenbach suggests that since the Dutch government set up an initial research program under a prestigious committee, "research in this area has become legitimate and maybe even a little fashionable" (Mackenbach 1994). This point is illustrated by table 1, which shows the increase in journal publications on the subject in English or Dutch as recorded by the International Documentation Centre on Social Inequalities in Health in Rotterdam. The legitimacy of the Dutch program has helped to persuade other governments of the need to fund their own research in this area. The fact that there are now national research programs on inequalities in health in Sweden, Finland, and Britain, as well as in the Netherlands, owes much to this mutual reinforcing effect. One indicator of

TABLE 1
Number of Journal Articles Published from 1985 to 1996
on Social Inequalities in Health, in selected Countries^a

Period	U.S.A.	U.K.	Netherlands	Sweden	Total for all countries
1985-88	181	182	61	19	633
1989-92	244	183	86	32	760
1993-96	243	222	102	26	803

^aPublished in English or Dutch.

Source: International Documentation Centre on Socioeconomic Inequalities in Health, Erasmus University, Rotterdam.

cooperation is that each country has formally sought advice from the others when developing its own research programs.

It is clear that this is an area in which international cooperation can make a valuable contribution in the future. For example, the evaluation of policies to tackle inequalities requires the exploitation of the "natural experiments" that are taking place because of the fact that different policies are operating according to geographic region or point in time. Cross-country policy evaluations are now being initiated, and cooperation among the various national research programs is spreading. A European network of researchers has recently been formed to work out this agenda, and a coalition of European policy makers and politicians has organized itself into a network to advocate action. This cooperation is now extending beyond Europe to encompass the important work being done in the United States and the southern hemisphere (Action in International Medicine 1995; Braveman et al. 1996).

Although many of these developments are positive, a daunting task remains. It is still the case that the social and economic conditions for many people are becoming worse, not better. Many of the dominant policies, like the continued retrenchment in the face of immense pressures on social welfare systems and safety nets, are working against long-term public health interests. It is not only the loss of personal (individual) guarantees of health care support that is at stake, but also the diminished resources available to protect the environment, adding further to disparities in health because low-income people inevitably suffer the most from environmental stressors. This overarching situation in Europe, and elsewhere in the world, limits the impact of actions to reduce health inequalities, regardless of the current surge of positive thinking outlined here. In such circumstances, the pooling of international experiences and expertise to tackle the health divide becomes more crucial than ever.

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Address correspondence to: Margaret Whitehead, King's Fund, 11-13 Cavendish Square, London W1M 0AN, England.