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# Editorial

# Re-thinking health inequalities

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The world we live in is hugely unequal, not only in terms of income and wealth, but also in terms of life-span and health. What makes it worse is that the two are correlated: people who have less material resources also tend to die younger and to have more health problems within their shorter lives. Wide-spread concern with these health inequalities has over the past decades led to an impressive stream of increasingly sophisticated research to find explanations. The growth in scientific understanding has also inspired confidence that we can reduce health inequalities. Many policy proposals have been made, both nationally and internationally, culminating in the World Health Organization's report 'Closing the gap in a generation'.[1] Yet, progress in reducing health inequalities has been disappointing, and on some measures health inequalities have even widened over time. So the question is: what went wrong?

There is, as always, not one single answer. In hindsight, we—the public health community—underestimated the task: in most European countries, efforts to reduce health inequalities were too small scale to have measurable impact, and even in England where a relatively well-funded strategy was implemented, population-level effects were limited. We were also swimming against the current: inequalities in socioeconomic conditions, such as income and education, were generally widening, creating an upward pressure on health inequalities. But—and this is what I would like to focus on here—we also selectively ignored parts of the scientific evidence which contradicted mainstream thinking but, if it had been taken seriously, could have guided us in a more successful direction. In my view, three of such 'inconvenient truths' stand out.[2]

The first is that there is surprisingly little robust evidence that the correlation between socioeconomic inequalities and health inequalities is causal, in the sense that socioeconomic (dis)advantage produces health (dis)advantage. Studies using rigorous analytic methods have had trouble identifying a causal effect of education and, particularly, income on health, whereas evidence for 'reverse' pathways has been more easy to find. Furthermore, genetic studies have demonstrated that individual variation in cognitive ability and other personal characteristics underlying people's educational and income trajectories, is partly genetically determined, suggesting that part of the correlation between socioeconomic position and health is due to confounding by genetic factors. 'Non-causal' pathways, which cannot be blocked by policies tackling the direct health effects of social disadvantage, but which can perhaps be blocked by targeted compensatory policies, have too often been overlooked.[2]

The second 'inconvenient truth' is that health inequalities are not smaller in countries with more advanced welfare states, such as the Nordic countries. Under social-democratic governments, these countries have long and effectively pursued egalitarian policies, as a result of which they have smaller income inequalities and lower levels of poverty than most other European countries. However, their health inequalities are as large or larger than elsewhere, partly due to larger inequalities in smoking, excessive alcohol consumption and other health-related behaviours, against which the welfare state apparently does not provide protection.[3] This is easy to ignore, particularly for those of us who devote their professional lives to the challenge of health inequalities precisely because of their egalitarian convictions. Nevertheless, conventional left-wing politics is clearly not the (only) solution.

The third problem is that we were often obsessed with relative inequalities in morbidity or mortality, believing that true progress in the fight against these 'inequities' requires relative inequalities to come down, regardless of what happens to the over-all frequency of health problems in a population. However, it can easily be shown mathematically that a reduction of relative inequalities is very difficult when over-all rates of morbidity and mortality go down, as has been the case for most European countries for most of the time.[4] Aiming for a reduction of relative inequalities is therefore a recipe for frustration—and indeed, over the past decades no European country has managed to achieve this. While relative inequalities uniformly went up, some countries did see their absolute inequalities go down, by making sure that effective health and medical interventions had sufficient reach in lower socioeconomic groups.[5] When we focus on absolute inequalities, tackling health inequalities will no longer be 'swimming against the current', but will be like 'riding the waves'.

It is of course impossible to know whether more progress would have been made, if these 'inconvenient truths' had not been ignored. What the above does illustrate, however, is that some re-thinking is necessary if we want to have more success in the future. Let us try to find ways to tackle 'non-causal' and non-material pathways, and let us also try to build a broader democratic mandate for tackling health inequalities by avoiding a 'leftist' discourse. Let us relax about relative inequalities, and measure our success primarily in terms of absolute inequalities. Is not it time for a little bit of success?

*Conflicts of interest*: None declared.

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