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Re-thinking health inequalities is necessary

These thoughtful comments by Ramune Kalediene, Alastair Leyland, Olle Lundberg and Johannes Siegrist illustrate how necessary a re-think of the conventional wisdom on health inequalities is. Kalediene seems to mostly agree with me, and there is little in the others' responses to my—somewhat provocative—editorial that suggests that we can do without such a fundamental re-think.

Take Leyland's statement 'If it is possible to reduce mortality by *x*% among an advantaged population then the inability to reduce mortality by at least this amount in a disadvantaged population—despite this being the focus of our greatest efforts—must be seen as a failure'. Has anyone ever seriously considered what it would mean to reduce mortality (or any other adverse health outcome) by at least the same percentage in a disadvantaged population? Everything, from higher rates of comorbidity to less compliance with drug prescriptions, and from higher levels of psychosocial stress to lower health literacy, conspires against such equality of outcomes. 'Proportionate universalism', the currently popular idea that we must allocate remedial efforts according to need,[1] will certainly not be sufficient. In order to achieve equal percentage declines we would need to allocate far more resources per unit of need to disadvantaged populations, which would require a complete re-think of how we run our health and social systems.[2]

Or take Siegrist's emphasis on the '[t]oxic [...] non-material characteristics of work', such as 'low control and autonomy, and [...] low reward and recognition'. I completely agree that inequalities in these less tangible factors likely play a role in generating health inequalities, and may have replaced inequalities in injury risks and physical exposures as the main occupational pathways to disparities in ill-health. But although several European countries have tried to design comprehensive policies to tackle health inequalities, I have seen very few attempts to systematically address these 'new' inequalities.[3] This is, of course, unsurprising: we do not yet know how to effectively change these non-material working conditions for the better, and deep in our hearts we know that this would require a radical change to existing work relations, for which probably no European government has ever had a democratic mandate. Here again, I believe that some deeper thinking is necessary to determine what the policy options are.

Finally, I am inclined to read Lundberg's response as a first and important step towards re-thinking health inequalities. It is undoubtedly true that the failure of counterfactual approaches to produce robust evidence for a causal effect of socioeconomic position on health is partly due to the complexity of the phenomenon-to-be-explained.[4] The 'generative process' includes bi-directional relationships, reinforcing each other, and is further complicated by the fact that human beings are not only passive recipients, but also act on their circumstances. However, this is exactly what I meant to say: the conventional wisdom is that if we change people's living circumstances, health will automatically improve and health inequalities will diminish. *Quod non*. If we really want to tackle health inequalities, we need to do more, and we need to also address the other mechanisms which have too often been ignored.

Conflicts of interest: None declared.

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