

Nordic Leadership and global activity on health equity through action on social determinants of health

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Always a good sleeper, I had many sleepless nights while chairing the Commission on Social Determinants of Health (CSDH)(1). A principal cause of insomnia was worry over the question: why should ministers of education care about health? Why should ministers of environment? Social protection? Finance? The key insight of social determinants of health is that, important as is the health minister, what other ministers do in their day job has vital importance for health equity.

What they 'do in their day job' is crucial. One response of a minister of health, when one talks about education and health, is to allow a little more time for health education on the school curriculum, or to give children space to run around the park. The minister may even go so far as to include health literacy. All useful, but it is not what we mean. Education is important for health. Not just education on the dangers of too many sugar sweetened beverages, or the importance of screening, but education. Education that gives life skills, knowledge, qualifications that lead to better jobs, earning capacity, and ability to negotiate living in a complex world. Really to take action on education as a social determinant of health implies paying great attention to equity and improving educational standards for all. Doing the day job well, with regard to its likely impact on health equity, will advance the cause of social determinants of health.

Nordic Leadership

Nordic countries have, perhaps, gone further along this route than most others. It was not always thus. Since at least the 19th century – going back to William Farr and Florence Nightingale – social inequalities in health have been a feature of British concerns about population health. In the 20th century this took the form of focussing on social class differences, perhaps because we in Britain have been so obsessed by class – to the amusement of global television audiences. A generation ago, we asked Swedish colleagues: do you have social inequalities in health in Sweden? The answer: In egalitarian social democratic Sweden? Of course not. We countered: Do you mean, you have looked and haven't found them, or you haven't looked?

Of course, once this became a focus of concern in Sweden, Denmark, Norway, Finland and Iceland, social inequalities in health were plainly evident and, in some cases, increasing. There have been earnest attempts to demonstrate whether health inequalities are smaller in Nordic countries, with mixed results.(2) As the Figure shows, our own analyses do point to relatively narrow health inequalities in Nordic countries.(3) (Figure) My own view is that Nordic welfare states have much to teach us on how to take action to reduce health inequalities, but even that conclusion has been doubted.(4)

The Commission on Social Determinants of Health (CSDH) convened nine knowledge networks to help with the scientific basis for our recommendations. To that end, we asked for extra help from Nordic colleagues in the form of the NEWS group (Nordic Experience of the Welfare State).(5) In their final report the NEWS group pointed to features characteristic of Nordic welfare states both at institutional level and in policy ambitions: universalistic social programmes, broad scope of public services, provision of services mainly by public sector at local level, important role of tax financing and high taxation. Clear policy goals are gender equity and relatively small inequalities between classes.

Following Nordic leadership

These principles from the NEWS group informed the deliberations of the CSDH. They were also very much in my mind as we deliberated with my English Marmot Review, *Fair Society Healthy Lives* (6). I was asked by the British Government to conduct a review of health inequalities. The explicit question was how could we adapt the recommendations of the global CSDH to one country, England. The default position of British social policy is targeting groups at special needs. When it comes to social inequalities this may include means-testing and services tailored to the poor. In my English Review, we quoted the insight that a health system for the poor is a poor health system; an education system for the poor is likely to be a poor education system. This inclined us towards Nordic-style universalistic approaches. In an attempt to be both British and Nordic at the same time, we recommended **proportionate universalism**. The idea was that we should aim for universal solutions with effort proportional to need.

One particular area of Nordic research that I watch is evidence that proportionate universalism can work to reduce health inequalities.

Another important insight from the NEWS group is that when we evaluate progress on reducing health inequalities, we should, of course, look at the slope of the gradient, or the size of the gap between people high on the social scale and those lower down. But another marker of progress is how well the most disadvantaged are doing. Look again at the Figure. Men with low education in Finland Denmark, Norway and Sweden have relatively long life expectancy compared to men from Central and Eastern Europe. In fact, a particular feature of this Figure is not so much how well the highly educated group are doing in the Nordic countries, but how well the poorly educated are.

It was to Finland, of course, that we looked for the initiative on Health in All Policies. As Nordic Health Promotion research proceeds, it will be important to have evaluations of this approach. We looked to Norway for a public health law that puts health equity at the centre of local government activity; and to Denmark for something similar. Finland blazes a trail with its commitment to equity in education. Iceland, arguably, built on social solidarity to resist the demands of international bankers after the global financial crisis.

Nordic countries building on global leadership

A most welcome feature of the scientific and public health world that we now inhabit is the strength of our partnerships and communications. Communications flow all ways. When we published the CSDH Report, *Closing the Gap in a Generation*, a question was whether anyone was listening. The government of Sweden had some reluctance to act on our report but the city of Malmö was enthusiastic and, in effect, said that they could do it at city level. The city convened a cross-sectoral

Commission for a Socially Sustainable Malmö under the chairmanship of Sven-Olaf Isaacson(7). It built on the CSDH tailoring its recommendations for implementation at city level. Following Malmö, Linköping and Norköping did something similar; as did Gothenburg. I am told that there are social determinants of health reviews (Marmot Reviews) in as many ten Swedish cities and regions. My visits to the three just mentioned were inspiring.

An important task for Nordic Health Promotion Research is to evaluate these landmark initiatives and learn lessons from successes and, importantly, failures.

Building on these regional initiatives, the government of Sweden set up a national Commission under the chairmanship of Olle Lundberg.(8) It illustrates the global sharing of knowledge. The conclusions of the CSDH were informed by a global network of scholars, experts and practitioners – overlap in these categories. In turn, the English Marmot Review was influenced by the CSDH report and by a further nine networks of scholars. Then, the Swedish national review built on the conclusions of the English Review, *Fair Society Healthy Lives*.

The first six domains of recommendations in the Swedish national review align with my English Review:

- Give every child the best start in life
- Education and skills
- Employment and working conditions
- Incomes and economic resources
- Housing and neighbourhood conditions
- Health factors. In England, we called this taking a social determinants approach to prevention – looking at the causes of the causes.

A seventh domain in the Swedish report was ‘control, influence and participation’. In *Fair Society Healthy Lives*, we didn’t list this explicitly as one of our six domains, but it ran right through the report. In the CSDH we said that empowerment was central.

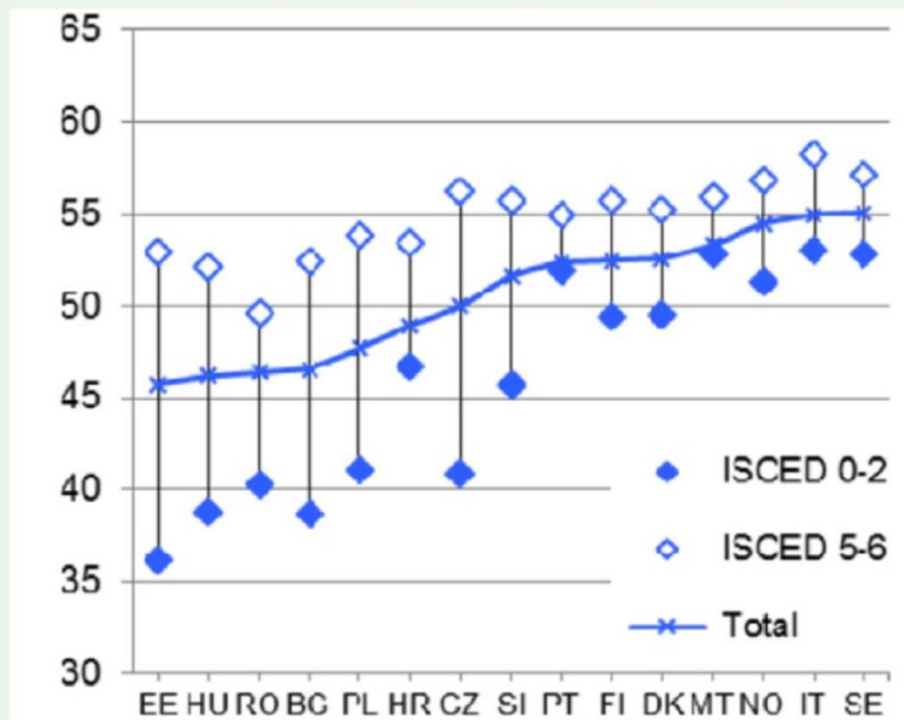
The Swedish report had an eighth: equitable health and medical care that promotes good health. Again, highly consistent with approaches being taken in the UK.

I have highlighted Sweden but I know that there is genuine interest in health equity and social determinants of health at national and local level in Norway, Denmark, Finland and Iceland. Genuine interest and a great deal of activity. Nordic health promotion research is in the vanguard of contributing to the evidence base, evaluating what works, and laying the basis for further action.

There is a tendency for outsiders to idealise the situation in Nordic countries compared to what is happening in so many other countries of the world. I am well aware that, seen from the inside, there are considerable problems of inequity to be addressed.

That said, all of this work on Nordic Health Promotion is informed by a most welcome commitment to social justice and a fairer distribution of health.

Life expectancy at age 25 by education, men



Life expectancy at age 25, men, by education in 15 European countries. ISCED 0–2 is primary education; 5–6 is tertiary education. Data obtained from Health inequalities in the EU 2013.

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