Where Do We Stand? Research and Policy Issues Concerning Inequalities in Health and in Healthcare

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There are signs that the seriousness of the challenge posed by social inequalities in health and in healthcare is filtering through to governments in an increasing number of countries. The problem includes a large, and in some cases widening, gap between the health of the rich and the poor within countries, coupled with serious social and economic inequalities across society in general. Healthcare reforms are posing further dilemmas in relation to equity. The first part of this paper outlines some of the latest evidence on the scale and nature of the problem and the key research questions selected for future study in the national research programmes set up on the subject. The second part considers unemployment and health in more detail, illustrating some of the policy issues which this raises. The last part focuses on practical strategies for the health sector to adopt to build a more equitable policy response.

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> Medicine is a social science and politics nothing more than medicine on a grand scale (Rudolf Virchow)

Nowhere is Virchow's perspective more true than in the field of inequalities in health. The focus is at the population level, studying the systematic differentials in health status between different social groups within society; their root causes outside as well as inside the health sector, and how public policy influences those causes, for better or worse. This 'grand scale' is constantly throwing up ethical dilemmas of the utmost importance.

This paper provides an overview of the current situation, focusing mainly on Europe. The first part outlines some of the latest evidence on the scale and nature of the problem in various European countries and the key research questions selected for future study in the national research programmes which have recently been set up on the subject. The second part takes one of the factors in the wider environment that influence health—unemployment—to illustrate the dynamic nature of the social and policy context that needs to be incorporated into any consideration of root causes of health inequalities and what can be done about them. The last part focuses on practical strategies that the health sector can adopt to build a more equitable policy response.

WHERE DO WE STAND ON THE RESEARCH FRONT?

There is currently intense activity on the research front, as more and more countries have become involved in mapping the social patterning of health and disease within their populations (1). In the last decade, a number of countries have made much more systematic assessments of the scale and nature of the problems they face (2–6). In addition, the European Union has commissioned several major cross-country comparative studies on inequalities in health (7–9) to inform EU policy. A common finding is of large, and in some cases widening, gaps between the health of rich and poor within countries, coupled with what appear to be widening social and economic inequalities across society in general. Closer investigation reveals that in some countries it is not just a matter of differentials between the two extremes, but rather that there is a step-wise gradient in health which operates across the whole social spectrum, raising questions about the social mechanisms which could explain this underlying relationship (10, 11).

Figs. 1–4 present some of the findings from Britain and Sweden from studies I have carried out with colleagues in the two countries. The mortality of children from birth to age 14 in the 366 local authority districts in England is

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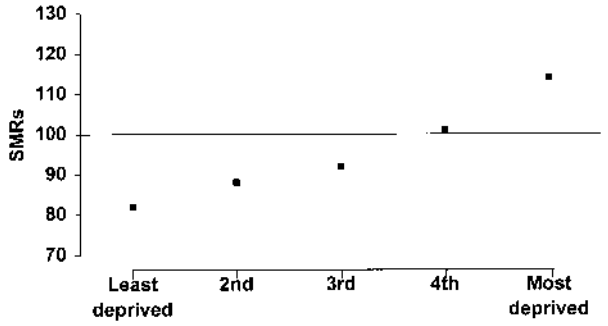

Fig. 1. All-cause SMR for local authorities in England grouped into deprivation clusters. Children 0–14 males. Source: (ref. 12).

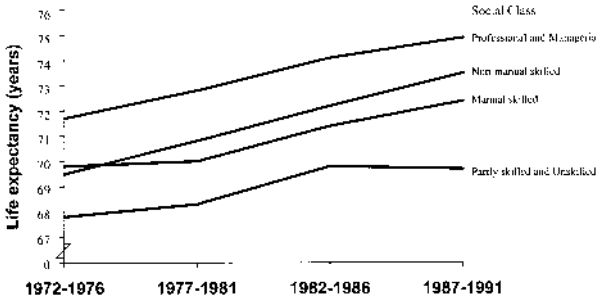

Fig. 3. Life expectancy by social class. Males at birth, England and Wales 1972–91. Source: (ref. 14) using data from ONS Longitudinal Study.

presented in Fig. 1, classified by the districts' level of deprivation (based on an index which includes measures of unemployment, poor housing environment, low income and education). A clear gradient was found with lowest mortality in the least deprived cluster of districts, increasing with rising levels of deprivation. This pattern was apparent for all ages and both sexes (12).

In Fig. 2 we find a graph of mortality in men of working age by social class, revealing a three-fold differential in all-cause mortality between unskilled manual workers in class V and men in professional occupations in class I. This differential had increased from a two-fold gap at the beginning of the 1970s (13). Even larger differentials were found for specific diseases such as lung cancer and suicide. In Fig. 3 the widening gap in life expectancy at birth by social class over the 20-year period is presented, so that now semi- and unskilled workers can expect to die 5 years sooner than men in professional and managerial jobs (14). Similarly, studies in The Netherlands and Finland have shown that men of high educational status have over 4 extra years of life expectancy and nearly 13 extra years of health expectancy (years free of chronic sickness and disability) than men of low educational status (15).

The pattern is repeated for various measures of morbidity. Figs. 4 and 5 present trends in self-perceived health in Sweden and Britain over a 10-year period by socioeconomic group, showing that prevalence of less than good health was over twice as high in the less skilled group than in the professional group in all three time periods. A similar pattern was found for other measures of self-reported health, including limiting long-standing illness (16). Whereas the prevalence of ill health was generally lower in Sweden than in Britain by various morbidity indicators (and also by mortality), there was still a pronounced gradient in the country, as there was in Britain (16).

These data on morbidity were then used to control for health need in a study of the access of different socioeconomic groups to the national health services in the two countries (with utilization employed as a proxy for access here). The graph depicted in Fig. 6 suggests that inequalities in utilization of care (adjusted for need), favouring the non-manual groups, appeared in Sweden in the 1990s—for the first time in 30 years (16). This raised concerns that required further investigation. Interestingly, the reverse was found in Britain, with a 'pro-poor' bias in general practitioner services in the NHS in the 1990s.

More localized studies, however, have found inequalities in access and provision of care in different parts of Britain; for example, lower than expected referrals to secondary care investigations and elective surgery for older people, women and lower socioeconomic groups, in relation to their levels of morbidity (17–21). Simple mapping of the distribution of primary care services in Glasgow revealed

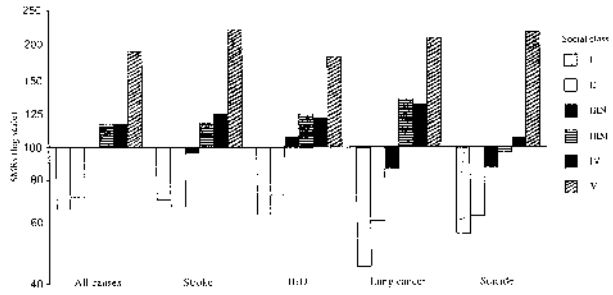

Fig. 2. SMRs from selected causes, by social class (based on occupation), men aged 20–64, England and Wales 1991–93. Source: (ref. 13).

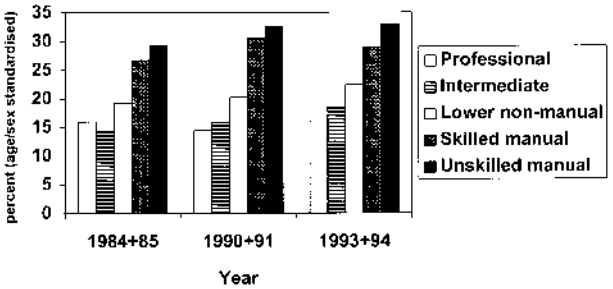

Fig. 4. Percent reporting fair/poor health by socioeconomic group, Sweden 1984–1994. Source: (ref. 16).

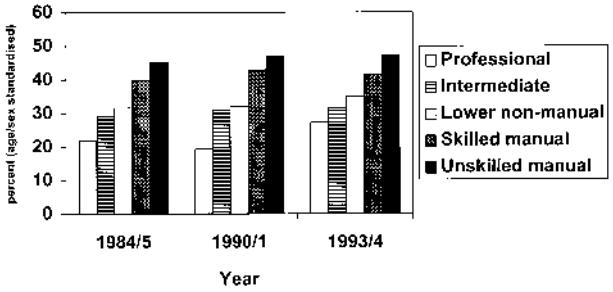

Fig. 5. Trends in self-reported general health by socioeconomic group. Percent reporting fair/poor health, Great Britain 1984–1994. Source: (ref. 16).

double or treble the number of doctors, dentists, and opticians in the more affluent neighbourhoods than in the more deprived ones, despite the higher morbidity and mortality in the deprived areas. The same was true for recreation facilities and opportunities for health-promoting activities, including access to food shops and transport (22–24). These are manifestations of the 'inverse care law', which notes that 'the provision of healthcare is inversely related to the need for it' (25). This has been found to operate even in countries that have had universal services for many years: universal access appears to reduce, but not eliminate inequalities in care (26). Barriers to access are not only financial, but also geographic and cultural.

Evidence of this kind has pricked political consciences. The basic unfairness of some of these situations is starting to filter through. The evidence has reached a level where several governments have been convinced of the need to set up national research programmes—The Netherlands, Britain, Finland and now Sweden. In reviewing progress since the seminal Black report of 1980, Macintyre sums up two big questions for future research:

> What are the precise mechanisms or pathways by which social inequalities in health are generated? and what effective actions, if any, can be taken to reduce, or ameliorate the effects of, social inequalities in health? (27)

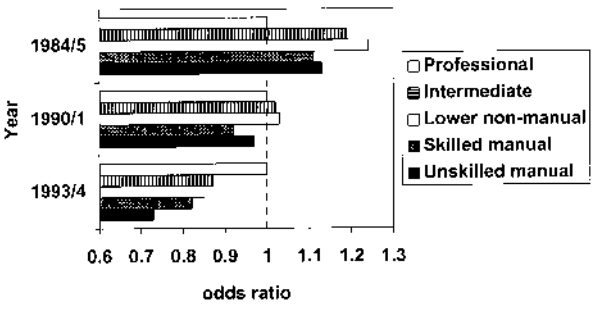

Fig. 6. Trends in health service use by socioeconomic group. Odds ratio of consulting a doctor, Sweden 1984–1994. Odds ratio adjusted for age, sex, marital status, region and health status. Source: (ref. 16).

In one form or another, these two questions appear on the agenda of all the national research programmes. The first 5 years of the Dutch research programme, which started in 1989, concentrated on generating more knowledge about the size and nature of the problem in the country and explanations for the observed patterns, acknowledging that the causes may not be the same for the Dutch population as found in studies from other countries. The programme investigated the possible determinants of the health problems, in particular lifestyle factors, living and working conditions, and psychosocial factors. The second phase of the programme, running from 1995 to 1999, is aimed at quantifying the contribution of various mechanisms to the explanation, and focusing on the development and evaluation of interventions to reduce inequalities in health (28).

In Britain, the Economic and Social Research Council has commissioned a 5-year Health Variations Research Programme, to run from 1996 to 2001, to enhance understanding of the overarching research question: 'Why are there persisting and widening socioeconomic variations in health in advanced industrial societies?'. Under that heading, 23 different research teams are looking at the areas listed in Table 1. Phase one of the programme included studies on the role of lifestyles, social settings, deprivation and social policies in shaping socioeconomic circumstances and health. Phase two will be commissioned to begin in October 1998, focusing in particular on mental health (how does gender, ethnic identity and age influence the socioeconomic gradient in different dimensions of mental health? What are the processes that link low socioeconomic status to poor mental health? What are the points in this process that offer scope for intervention?); psychological factors (how do psychological factors contribute to health variations? What are the triggers for change in these factors? Does the process of change differ within and between socioeconomic groups?); and workplace influences on health (do workplace effects vary between industrial sectors and by age, gender and ethnic group? How does the workplace produce, maintain or even widen differentials?) On the policy front, studies are sought which address questions such as: are socioeconomic differentials in health responsive to the provision of health and welfare services? Has the organization of the health services affected socioeconomic health differentials? What are the appropriate time-scales and methodologies for evaluating the impact of policies? (ESRC, Unpublished report, 1997).

Complementary to this social research, is a national programme of NHS-based research commissioned by the Department of Health in the UK, to run from 1998 to 2003, concentrating on operational research to guide more equitable policy-making in the NHS; for example, the evaluation of the impact of an equity audit; assessing the impact on health inequalities of urban regeneration policy; commissioning for equity—how can local health authorities become more effective in tackling inequalities in health?

Table 1

British and Finnish research programme themes

British Economic and Social Research Council Programme themes
The role of psychological factors and pathways in the socioeconomic patterning of health
The role of lifestyles and how health behaviour is shaped by socioeconomic circumstances
How does the workplace (paid and unpaid) produce, maintain or widen health differentials?
The relationship between wealth and health, income dynamics and health inequalities
The nature and determinants of socioeconomic differentials in mental health
Factors affecting different social groups' attitudes to health
The interaction between people, places and time in the generation and maintenance of differentials
What we can learn from other countries' health differentials and trends?
The role of social welfare policies and other interventions in addressing health inequalities.
Finnish National Research Programme themes
The effects of unemployment and other marginalization processes on welfare in the long term
Effects of changes in the workplace
Effects of early life events on health and other welfare differences in adulthood
Health and welfare differences in the elderly population and the current and earlier factors influencing those differences
Effects of social and health policy and other public policy on health and welfare differences
Opportunities of the service system to influence inequalities
Meanings and consequences of health and welfare shortcomings (violence, marginalization) (Koskinen, 1997)

The Finnish research programme, commissioned by the Board of the Academy of Finland, will run from 1998 to 2000, with the stated aims of shedding more light on the causes of welfare differences and to look into ways in which they could be reduced, particularly related to social segregation and marginalization, as these are considered to reflect inequity. The issues to be investigated include the main themes listed in Table 1, with a strong emphasis on the effects of unemployment and other marginalization processes, early life events, and the influence of public policy (Koskinen, Unpublished report, 1997).

The latest country to announce such a programme is Sweden. The Government passed a Parliamentary Bill in December 1996, to set up a National Research Programme on Inequalities in Health, to be implemented from 1998 onwards. The Swedish programme has a strong gender-perspective and a focus on studying the broader social and policy context (B. Arve-Parès, Unpublished report, 1998).

It can be seen that, to a certain extent, they all converge on similar key issues for intensive study, but differ in where they put the emphasis and priority. This intensity of effort should make a significant difference to the progress that can be made, with scope for much international policy-learning over the next decade as these programmes unfold.

WHERE DO WE STAND ON POLICY ISSUES? UNEMPLOYMENT AS A CASE STUDY

While these national research efforts hold long-term potential, the macroeconomic trends continue to unfold and policy continues to be made, with or without the benefits of research findings. Of concern is that things may be getting worse on some fronts and exacerbating the current situation. Unemployment is taken as an example here, to demonstrate the complexities in the pathways to ill health which need to be considered when studying trends, but also to illustrate policy issues and strategies which could begin to be adopted more immediately.

Unemployment is a serious problem for many industrialized countries, and has been for the past 20 years. In Fig. 7 we can see the rising trend in the number of people unemployed in the OECD—remaining fairly stable at around 10 million from 1950 to 1974, but then increasing dramatically after the first oil crisis in 1974 and again after the second crisis in 1979, to stand at more than 30 million by the mid-1990s. The level has remained stubbornly high in many countries, and has not settled back to its original level after each peak (29). Within the industrialized world, European countries have been the hardest hit: the unemployment rate in the EU has risen from less than 3% in the early 1970s to around 11% by the mid-1990s (encompassing over 18 million people) (30). The European Commission acknowledges that 'unemployment remains the major economic—and social problem confronting the Union' (31) (p. 7). The significance of these trends was summed up in the report of the OECD Jobs Study, which stressed that the scale of unemployment:

> …represents an enormous waste of resources…It reflects both economic inefficiency and human distress.

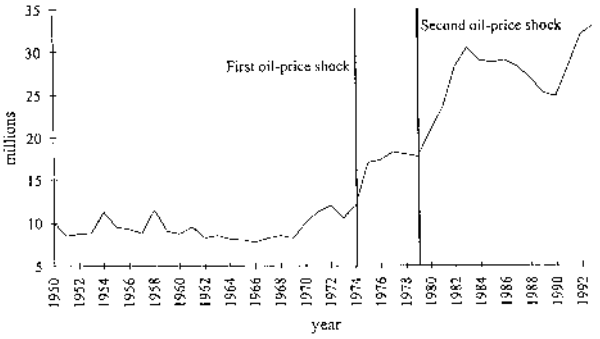

Fig. 7. Unemployment in the OECD Area, 1950–93. Note: Including eastern Germany from 1991 onwards. Source: (ref. 29).

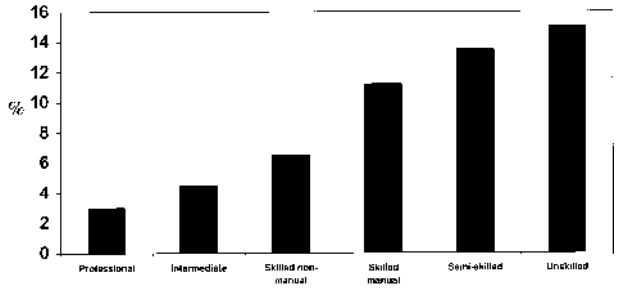

Fig. 8. Unemployment rates by occupation and skill level, Great Britain, 1992. Source: (ref. 33).

> Its persistence is bound to undermine social cohesion and confidence in democratic institutions and market economies (29) (p. 2).

It is important to note that there has been an unequal spread of unemployment within societies. The effect has been much greater in the industrial sector, hitting manual workers with less skill and education the most, with the collapse in demand for unskilled labour across the region. A major decline in industrial employment has resulted in large-scale redundancies concentrated in certain geographic areas, flooding the local labour markets with less skilled workers (32). Fig. 8 shows unemployment by occupational level in Britain—ranging from 3% for professionals to 14% for unskilled workers (33). British data also show that the prevalence of low pay, unemployment, and long-term unemployment is greater in groups with lower education and skill. Within these skill groups, young people and ethnic minorities represent an even higher rate. One in five young people under 25 is without a job in the EU as a whole, rising to over 40% of young people in Spain and Finland (30). A cumulative effect can also be identified: for example, people who are exposed to greater risk of unemployment also tend to be at greater risk of inadequate housing, and more dangerous working conditions (34, 35).

In many countries, joblessness carries with it a greatly increased risk of poverty. In 1997, the Irish Government set out a National Anti-Poverty Strategy, and acknowledged that 'unemployment is the main factor causing poverty in Ireland…and the main reason for the high level of child poverty' (36) (pp. 44–45). When the unemployment rate in Ireland stood at 12%, 60% of households with an unemployed head were poor. This highlights another point: the effect extends to other family members, including children and the surrounding community, and is not just limited to those officially counted as unemployed.

In health terms, recession and unemployment on the scale experienced in Europe pose a significant threat, not only by reducing access to the prerequisites for health such as adequate housing and income to buy food, but also through the damage to mental health associated with the stress and stigma of being unemployed in a European society. Various models have been put forward to chart the social and health repercussions of such developments and to identify points for closer investigation. For example, Fig. 9 shows the Unemployment and Health Study Group's model, showing a series of direct and indirect effects of recession and unemployment (37). Following the central, vertical line in the figure, the model proposes that unemployment and recession may lead directly to rising poverty, which in turn, through reduced resources, may lead to poorer housing, fuel poverty and inadequate nutrition, with attendant effects on physical health. But unemployment can also be a profoundly stressful experience, which can lead to mental health problems in the form of greater anxiety, depression, and even to suicide. In addition, it may have an effect on health behaviour, because of increased social isolation, and substance misuse in attempts to escape, at least in mind, from the experience of hardship. These behavioural changes, in turn, can lead to well-documented physical health effects—including an increased risk of lung cancer, heart diseases, and accidents.

The unemployment situation can also influence the working environment for those who manage to keep their jobs, with complex impacts on the determinants of health, as illustrated in Fig. 9. For example, in times of recession, the labour market can experience increased marginalization, with greater job insecurity, the creation of more low-paid jobs, and less strict adherence to occupational health and safety regulations. These effects may lead to greater poverty through lower wages, with an associated risk of health damage, and also directly to physical health effects in terms of increased occupational hazards, and accidents. A body of literature is building up on the

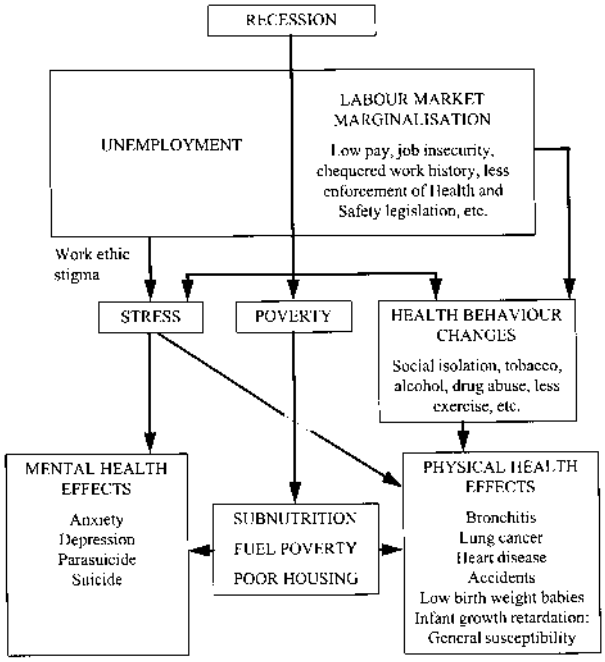

Fig. 9. How might unemployment lead to poor health? Source: Unemployment and Health Study Group (ref. 37).

relationship between poor psychosocial working conditions and diseases such as coronary heart disease (CHD) (38, 39). Greater understanding of these complex pathways is needed, together with insight into the interaction of policy with these pathways.

The common policy response. Is it ethical?

Persistent unemployment on this scale has led in many instances to pressure on related areas of social policy. For example, in some countries it has led to attempts to reduce social welfare and employment protection, as well as to lower wages, leading to greater poverty and increased exposure to health hazards (40). In effect, this response cuts support mechanisms to those in the worst conditions, with the poorest health, at the very time that they need that support the most—another variation on the 'Inverse Care Law'.

At the same time, policies may be introduced which tend to favour middle-income and richer groups in the population; for example, tax cuts and subsidies for house loans, shares and wealth-creation perks. These policies are justified by the assertion that all aspirations on social and health goals have to be subordinated until the economy is sorted out and that is best done by stimulating wealth creation and enterprise at the top (41).

Cost-containment and healthcare reforms may weaken the ability of the health sector to carry out its role at the very time when it is needed the most. In the worst instances, policy changes may even make the situation worse by adding to the social costs. Indiscriminate cuts in the healthcare budget, for instance, can cut essential public health and preventive work which in the past has tended to be of most benefit to the people living in the worst conditions (42).

Some cost-containment measures which have been adopted have involved shifting costs from the state to the individual, and in so doing have the greatest impact on some sections of the population more than others. For example, the introduction of extra user charges for some services carries the risk of reducing access to healthcare for the low-income sections of the population, while having little effect on the more affluent (43). It also involves making the sickest people pay the most, instead of sharing the financial risk over the population as a whole.

Many healthcare reforms include the introduction of a greater role for market forces and financial incentives to modify services in response to competition. However, if not coupled with very tight controls and regulation, the market can send the wrong signals as far as access to healthcare is concerned. For example, there is a danger that the incentives will encourage providers of services to 'cream-skim'—to seek out and concentrate on groups that are more profitable than others, leading to the neglect of people in the worst circumstances (44).

The thinking behind these common policy responses can be challenged and indeed their ethical basis should be laid open to scrutiny. Is it right, for example, that those in the weakest position in society should bear the brunt of the effects of recession so that the comfortable majority can ride out the storm? Are citizens of a country or a district not entitled to expect that when hardship strikes, the burden will be shared out fairly and the weakest protected from the worst effects? The same applies to health and social welfare reforms. If greater competition and market-oriented reforms lead to attempts by public services to concentrate on the healthier, more prosperous sections of the population, is this ethical? Is this fair?

AN ALTERNATIVE POLICY AGENDA

Such questioning of the common policy approaches has begun, and alternatives with a more ethical foundation are being proposed. The basic question being asked is: What role can the health sector play in reducing the health and social costs of inequality and disadvantage? The contribution of the health sector has to be put into perspective from the outset. Healthcare does not, on the whole, have a direct effect on access to most of the prerequisites for health. The healthcare system does not usually have a direct influence on the creation of satisfying jobs for unemployed people, on providing a warm dry place to live; on putting money in people's pockets to buy food and to participate in the life of the community. However, its indirect influence on some of these factors can be considerable and should not be underrated. Essentially, there are three main strategies that the health sector could adopt as a proactive response to the observed inequalities in health:

- ensuring that services are matched to increased needs in groups and areas experiencing increased disadvantage;
- anticipating and ameliorating health damage caused by social inequalities in society;
- appraising the health impact of policies outside the health sector and the promotion of healthier public policies.

Each could make a useful contribution to the overall problem, as outlined below.

1. Matching services to increased needs

Healthcare strategies can recognize that some places or groups in society suffer disproportionately in terms of ill health, and planning for increased services in areas of increased needs is particularly important. This requires a careful assessment of need. Areas of high unemployment and deprivation, for example, record high rates of morbidity, mortality and healthcare use, and would require suitably matched resources (45, 46). These are the very places, however, that tend to suffer from the 'inverse care law', with poorer quantity and quality of services than in health-

Table 2

Need indicators used in allocating resources to health service purchasers in the British and Swedish NHSs

Britain: the 'York' formula: need indicators (47)
All cause SMR
Proportion of people of pensionable age living alone
Proportion of dependents living in households with only one carer
Standardized limiting long-standing illness ratio
Proportion of economically active persons unemployed
Sweden: the Stockholm model (48)
The Swedish approach does not use direct health indicators, but concentrates entirely on socioeconomic factors:
Age
Socioeconomic group based on occupation and employment
Cohabitation and marital status
Housing conditions, based on tenure and size of dwelling

ier localities. Tackling this inverse care law, through more equitable resource allocation mechanisms and audit of provision for example, would help improve the experiences of people living in these areas.

Equitable resource allocation. Healthcare needs vary between social groups and the geographical distribution of such groups also varies. At the very least, therefore, it is important to ensure that the healthcare resources are distributed in proportion to the relative needs of local populations. Several countries are now seeking to develop ways of doing this, with equity as an explicit aim. Both Sweden and Britain, for example, have developed resource allocation formulae for secondary care services based on weighted capitation. Both have tried to identify, using routinely available statistics, indicators of increased need for care, over and above demographic factors. Both take into account the higher needs and use by lower socioeconomic groups—and build these factors into the weighted capitation. Table 2, for instance, lists the factors used in both models to adjust for differential need. In Britain, for example, the latest model for allocating resources to health authorities, the 'York formula', incorporates a mixture of health and socioeconomic indicators of need, including unemployment rates (47). The 'Stockholm model' for the same purpose, takes into account the extra costs incurred for services for people who are not employed or living alone (48). These models continually need refining, but they show that attempts at equitable resource allocation can and should be made—this is becoming more important with the adoption of purchaser/provider splits in health systems.

Equity audit of access and provision of care. Even if healthcare services were distributed between areas in direct proportion to the relative needs of their populations, this would not automatically result in equal access to care for all. Services may not be arranged in a convenient way and some social groups could face greater barriers to access than others.

Recent work from Finland uses CHD mortality rates in different socioeconomic groups as a measure of need for a specific procedure—coronary artery bypass grafts (CABG)—and calculated rates of access to this procedure for those groups. The study found that upper white-collar workers and those with more years of education had the highest rates of CABG, even though they had the lowest rates of CHD mortality (49), flagging up possible inequities of access that would need to be investigated further.

It is being increasingly recognized that there is a need to develop ways of assessing access of specific groups, using methodologies that can be routinely applied at the local administrative level. The concept of the equity audit stems from this need—entailing a systematic review of health, socioeconomic conditions and services in a locality, and such audits are now being developed and evaluated, in local health authorities in England (50), for example.

2. Anticipating and ameliorating health damage

From evidence available already, the health sector should be able to predict some of the likely health damage arising from changes in socioeconomic circumstances in an area, and to devise services that seek to prevent the worst effects or at least to ameliorate them—being more proactive in developing appropriate services. As well as curative services, these may range from sensitive and supportive services aiming to prevent mental health decline following unemployment, to strengthening rehabilitation services to improve people's quality of life and chances of getting back into employment (51). These address some of the pathways leading from stress and behavioural factors to health outcomes (see Fig. 9).

Maintaining access to a strong social welfare system is a priority for preventing the poverty and hardship that commonly accompany unemployment and recession. At times of social and economic crises, when morbidity and even mortality may increase in the population, the need for healthcare is greater than ever for all sections of the population, and a renewed focus on ensuring that everyone has access is essential. International studies can be particularly valuable here in assessing whether some systems and approaches are more effective than others in supporting the groups in the population hardest hit by macroeconomic developments—intercepting the pathway from unemployment to poverty, for example. Some studies are starting to investigate this in Finnish, Swedish and British national research programmes. This strategy also includes maintaining public health and preventive services that influence the wider prerequisites for health. Some of the 'classic' public health functions acquire added urgency

when there is extra pressure on living and working conditions and when the standard of living is declining, for example: control of infectious disease when poverty and overcrowding is increasing; monitoring and maintaining safe water and food supplies and sanitation, pollution control, occupational health and the control of hazards in the workplace.

There is a growing body of work from countries in Europe and North America on interventions to improve identified inequities in access to and uptake of services, particularly preventive and health promotion services. There are major Dutch and British reviews of this evidence (51–53). Some interventions have proved effective in increasing uptake among hard-to-reach segments of the population. A number of common characteristics of the effective interventions has been identified and show that it is possible to improve access and uptake of essential services, but it requires carefully planned, systematic and intensive action (51–53).

3. Appraising the health impact of wider policies in other sectors

Monitoring and health impact assessment may help to alert policy-makers to the social costs of their policies and help them devise less damaging ones. This is the health sector's special responsibility, given the expertise within the sector in health-related measurement and relative lack of experience elsewhere. It bears the major responsibility for encouraging the development of an equity orientation across the whole range of public policies that have an impact on health and inequalities.

One aspect of this task is documenting the realities of the conditions under which people live and work and the changes over time in the determinants of health and in health status that they experience. It is important, for instance, to record and raise awareness of the fact that some groups in society or residents of particular geographical areas are much further away from achieving access to the prerequisites for health than other groups. Setting goals and targets for raising them up to the level of the more fortunate groups is another important strategy (54).

Monitoring health status and access to the prerequisites for health is, however, not enough. Health impact assessments on policies in different sectors are needed, particularly assessing the effects on the most vulnerable groups in society. Such analyses are beginning to be made, for example, in relation to the EU's Common Agricultural Policy (55). At a national level, many countries are considering proposals for major changes in public policy—in education, welfare, healthcare, even restructuring the economy as a whole. Crucial questions have to be asked of these policy proposals concerning their impact on living standards, on access to the prerequisites for health, on quality standards for the most vulnerable groups in the population, who may be losers rather than winners in any competitive system. The same applies to local and regional policy decisions that may, at a municipal level for example, have a great impact on local living and working conditions and access to public health systems.

SO, WHERE DO WE STAND?

The issue of social inequalities in health and healthcare is now more widely recognized as a major challenge to public health. Furthermore, there are concerns that the situation may deteriorate with the unfavourable economic climate and with the retrenchment that has characterized policy responses both inside and outside the health sector over the past decade. Some debate has now opened up about the need to develop more equitable alternatives and how to go about it. This is clearly filtering though to a number of national research commissioners, who have set up programmes of research which should yield valuable results, though over a long time span. In the meantime, sufficient is known to make a start on a policy development process, informed by both technical and ethical considerations. Inaction is not an option.

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