Social ulighed i sundhed

En artikel fra KRITISK DEBAT

Social ulighed i sundhed: Interview med professor Richard Wilkinson (UK)*

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Introduktion
Beskæftiger man sig med forskningen i social ulighed i sundhed, så komme man ikke uden om den engelske professor Richard Wilkinsons omfangsrige studier. Wilkinson har beskæftiget sig med sundhedens sociale determinanter i mere end 30 år og har spillet en afgørende rolle for forskningen, såvel som for offentlighedens kendskab til social ulighed i sundhed. Han var endvidere en af de drivende kræfter i lanceringen af den arbejdsgruppe, som i 1980 indleverede den banebrydende "Black Report on Health Inequalities" i England - en rapport som har haft stor betydning for både den videnskabelige og politiske udvikling inden for området.

Meget af Wilkinsons forskning retter sig mod de sundhedsmæssige konsekvenser af indkomstfordeling og ulighed, og selvom det ikke lader sig gøre her at opremse samtlige af Wilkinsons arbejder, så vi kan dog nævne de to seneste bøger som han har udgivet, nemlig "Social determinants of health: the solid facts", 2004, (redigeret i samarbejde med Michael Marmot) og "The Impact of Inequality: how to make sick societies healthier", New Press, NY, 2005.

I det nærværende interview har vi bl.a. bedt Wilkinson om at forklare dels, hvordan vores sociale miljø påvirker vores sundhed, dvs. gennem hvilke mekanismer foregår denne påvirkning, hvilke konsekvenser det har og hvad man kan og bør gøre for at komme problemet til livs.

I næste udgave af Kritisk Debat følger en dansk oversættelse af samme interview.

Ivan Christensen

Social ulighed i sundhed: årsager, konsekvenser og perspektiver
- interview med professor Richard Wilkinson

I.C.: *One of the main themes of your research has been the importance of relative inequality to health status. What are the primary mechanisms of the relationship between relative inequality and health status as you see it?*

R.W.: First, I think it is worth noting that the evidence that inequality and relative incomes are important does not rest just on the evidence that more equal societies tend to be healthier. It is also that among the 25 or 30 richest developed societies there is almost no relation between Gross National Income per head and life expectancy, yet within all these countries if you group people by household income or neighbourhood income per head, there is an almost perfect relation between higher incomes and higher life expectancy. Income matters within the rich countries but not between them because we are dealing with relative income. In addition, some observations of non-human primates show that if you give them all the same diets and keep them in the same compounds to ensure material conditions are the same, social status is still linked to health risk factors - even when social status is experimentally manipulated. So our task is to try, as you asked me, to understand why social status and inequality matter so much.

In his book, *The Status Syndrome* (1), Michael Marmot argues that a very important part of the social gradient in health in each society is related to social status, and my view is simply that greater

inequality makes social status differences more important. In more unequal societies there is more status competition and where you come in society matters more. You are perhaps less likely to feel people accept you simply as an equal human being. One has to see human beings as having a particular sensitivity to status differences because, in our evolutionary past, status was so important. As human beings there are particular aspects of our social environment to which we pay special attention. One is social status and another is friendship. Both are extremely important psychosocial determinants of health because low social status and absence of friends are sources of stress.

Within any species there is always a potential for conflict: members of the same species all have the same needs and can compete with each other for everything. But among human beings, other people not only have the potential to be our worst rivals and worst threat to our wellbeing, they also have the potential to be the greatest source of cooperation, help and assistance, learning and love. Because other people have the potential to be the best or the worst, we have become highly sensitive to the nature of social relationships. Social status hierarchies are essentially - at least among animals - about power, coercion and privileged access to scarce resources. Friendship is exactly the opposite: about sharing and reciprocity, about mutual support and a recognition of each others needs.

Our sensitivity to early life, both the developmental effects of maternal stress in pregnancy and things like poor attachment in early childhood, are surely part of the way we are prepared for the kind of social relationships we are likely to have to deal with in adulthood. Are we going to have to deal with a society in which we have to fight for everything we can get, a very individualistic society in which we have to watch our backs, or are we to be members of a very egalitarian cooperative society, in which we need to empathise with each other and depend on reciprocity, a society in which our security depends on maintaining good relations with others? These two extremes need quite different social strategies, hence the evidence suggesting that early life affects the development of our social capacities and stress responses.

The importance of social relationships is the basis for another element in this; we are of course very sensitive to how others see us. As social beings we monitor how other people respond to us. We want to be thought well of and to feel valued, so much so that it is sometimes as if we experience ourselves through each other's eyes. Friendship, social status and early childhood, all affects our sense of confidence and security. They are perhaps all related to one underlying source of social anxiety. The insecurities which we may bring with us from a difficult early childhood are not unlike the insecurities which can be induced by low social status. Friendship is an important protective factor because we get positive feedbacks from our friends, we feel valued by them. If we lack friends or feel people avoid us, we are immediately filled with self-doubts about whether we are unattractive, boring, stupid or socially inept. The higher status you are, the more you feel valued, looked up to and appreciated, whereas the lower your status, the more likely you are to feel devalued and a failure. So I think that those things are important to health because there are important stressors, and they are important stressors because we have an evolved sensitivity to particular dimensions of our social environment.

I.C.: *How would you explain the link between social circumstances and health?*

R.W.: Over the last couple of decades it has become clear that stress affects many physiological processes, including both the immune system and cardiovascular systems. In emergencies, such as when we face some threat or attack, physiological priorities shift to make us very alert and to mobilise energy for muscular activity. All sorts of other things - like tissue maintenance and repair, digestion, immunity, growth, reproductive functions, which are not important during a brief emergency - are down regulated. That doesn't matter if the stress is fairly brief but if, as human

beings, we go on worrying about things for weeks and months and years, then the health costs are very widespread. Indeed, chronic stress seems to act as a general vulnerability factor because it affects so many biological systems. Its effects are perhaps analogous to more rapid ageing.

I.C: *What characterises the diseases and health problems of the societies with the highest degree of social inequality?*

R.W.: One of the important things here is that if we are talking about an effect of chronic stress on death rates, it is unlikely that this stress will affect health and nothing else. When I first started to recognise that health was better in more egalitarian societies, I think I was very slow to recognise that this wasn't something unique about health, but that most of the social problems which have social gradients, and are more common in the poorer and more deprived areas in our societies, show similar relationships. So you can look at a great range of problems, not only health, but also violence or teenage birth rates or the size of prison populations in each country, or how well children do in international math and literacy tests. All these problems seem to be less common in more egalitarian societies.

I think that this helps us understand what is going on: it is the problems of relative deprivation - the ones with social gradients - which are more serious in more unequal societies. We have recently done some work looking at different death rates, and it seems as if the death rates for which there is a steeper social gradient are the ones most closely related to inequality on a national level and that makes good intuitive sense. For example, national rates of breast cancer, which is just as common among the rich as the poor, seem unaffected by income inequality. But mortality among people of working age, which has a steep social gradient, seems strongly affected at the national level by income inequality. Homicide also has a steep social gradient and is strongly related to inequality. That tells us quite a bit about the kind of social processes which are involved. It also means that the causal processes which account for the social gradient in health are closely related to those which explain why more equal societies are healthier.

I.C.: *Even in welfare states where there is a high degree of income redistribution, social inequality in health remains a problem. How should we understand the relationship between income distribution and social inequality in health?*

R.W.: Yes, at first that sounds inconsistent with what I have just said. Some of the more egalitarian societies still seem to have large relative differences in death rates, maybe a twofold difference in death rates between people lower down and further up the social hierarchy. Usually of course the absolute differences in death rates are smaller in the more egalitarian countries, but the relative differences remain large. We have done some research using US data (2), looking to see what effect different degrees of inequality in each of the states has on social gradients in health within each state. What we find is that the whole of the gradient seems to shift downwards. The benefits of greater equality are not confined to the poorest people. Instead they are spread very widely and extend to a large majority of the population. Rather than more equal societies doing better mainly because they have fewer poor people, it looks as if the most important reason is that it benefits people at most income levels. Subramanian and Kawachi (3) have called this a social 'pollution effect' of inequality.

What I think is happening is that lower levels of inequality make social differentiation and status less important right across the social hierarchy. Status competition and the sense of being judged according to where you are in society is reduced everywhere - among the better off as well as among less well off people. And if reducing inequality improves death rates throughout society, it means it does less to diminish health inequalities than if it just helped the poor. Comparisons among US states, or between Sweden and Britain, or between the US and Britain, all suggest that people in

more equal societies do better at all levels in the social hierarchy. So although inequality reduces health inequalities measured in absolute terms, it may not make much difference when they are expressed in relative terms. So social class death rates in one society may for example be 3 and 6, while in another they are 5 and 10. In both societies there is a two fold difference in death rates, but in the first - the more equal one - the absolute difference is only 3, whereas in the other it is 5.

I.C.: *what are in your opinion the most necessary and feasible political initiatives to counter social inequality in health?*

R.W.: Well the quick solution I suppose, if you want to reduce income inequality, is simply redistribution through taxes and benefits. The disadvantage of that, however, is that just as they can easily be made more progressive, providing better safety nets, so they can also be easily reversed by successive governments. It is important that greater equality should somehow be more built into the institutional structure of our societies, in ways that it's difficult for successive governments to undo. That means we need to be thinking much more fundamentally, for instance, about employee ownership or employee control of companies. The productive system is after all the source of wealth and the inequalities in its distribution. We need to find ways of democratizing economic life - in as many ways as we can.

Although the experience of employee-owned and cooperative companies used not to be good (largely because cooperatives were often set up in an attempt to save jobs when firms were going under), several studies now show that a combination of employee ownership with participative management systems produce reliable improvements in productivity. It redistributes wealth, profits, and power, and places income distribution in each company under direct democratic control.

But politics for the next generation or so is going to be dominated by issues related to global warming. I suspect that the people who are talking about the need for individual carbon rations are right: we will need a system of individual carbon rations which can be bought and sold, so if a poorer person who travels less and has a smaller house does not use his or her carbon ration, they can sell it back to the carbon bank from where someone who exceeds their ration will have to buy it. That in itself would contribute to redistributing income. If everyone starts with the same ration, people who do a lot of flying or drive big cars will effectively be transferring money to poorer people who are more economical.

Another way in which greater equality is related to environmental issues is that greater inequality increases status competition and the pressure to consume as a way of keeping up, or expressing, status. Great inequality almost certainly adds to wasteful consumption and it is difficult to believe that a very unequal society could ever be compatible with a sustainable economic system.

We have to recognize that health inequalities are not going to be solved with some quick or easy solution which leaves most of the social system unchanged. Johan Mackenbach in a recent report said that Britain was further ahead in terms of policy initiatives intended to tackle health inequalities than any other country. But even if that is true, our health inequalities show no sign of diminishing and I think that is substantially because a lot of the policies are attempts to stop relative deprivation having an effect on health: instead of reducing relative deprivation itself, most of the approach has been to try to improve health related behaviour among people who remain deprived. The reduction in child poverty is however an important area where the government has had some success.

The great advantage of tackling relative deprivation itself, as a means of reducing health inequalities, is that all the other problems related to relative deprivation are also reduced. Reductions of inequality and relative deprivation would not only improve health; it would also reduce violence and teenage pregnancies as well as improving the educational performance of school

children which we know is strongly affected by a deprived home background. A paper of ours, soon to be published in *Social Science and Medicine* (4), shows the range of problems which seem to be less common in more equal countries.

I.C.: *Taking the current political development (in the western societies) into consideration, how do you predict the situation of social inequality in health to be, in say 20 years?*

R.W.: As I said earlier, I expect politics over next generation to be dominated by issues related to global warming and think that policies to tackle it should have important egalitarian components. As the current period, marked by dominance of neoliberalism and monetarism, draws to a close, we are becoming more aware of how we are not simply materially self-interested individuals, and becoming more aware of our fundamentally social needs. What research on health inequality and the social determinants of health tells us is how important our social needs are. Other areas of academic research are also rediscovering our deeply social nature.

Linked with that is our gradual recognition that we have got to the end of what economic growth can do for the rich societies. Increases in GNP per capita no longer bring improvements in health, wellbeing or happiness. Instead, we have seen rises in rates of depression and anxiety - despite continued economic growth. The disappearing benefits of economic growth and the increasing environmental threats mean that we are the first generation to have to look somewhere else for improvements to the real quality of live in modern societies: simply raising material living standards may seem to work for individuals, but at the societal level it is a zero-sum game.

So I think I feel some optimism: we now know that continued economic growth is not the answer and that we need instead to address our social needs and improve the social environment. At the same time, I think that if you look historically you can see that we are part of what has been an almost unstoppable movement towards greater equality. It started perhaps with limitations on the divine right of kings to rule arbitrarily, from there to the development of the principle of equality before the Law, to the beginnings of democracy, the abolition of slavery, the outlawing of forms of racial, religious and sexual discrimination, and now the increasing concern about inequality and deprivation - of which the concern with health inequalities is one manifestation. Although income differences have not got smaller and there have been substantial periods when progress has ceased or gone backwards, the long term direction of change is clear. Partly through inheritance taxes, the twentieth century saw a very substantial redistribution of wealth and a reduction in many outward signs of class differentiation and social inequality. So I take some confidence from thinking that maybe there are some historical forces moving in the right direction even though there are periods when that is hard to remember.

What is important about our growing awareness of the effects of very large inequalities, is that it changes the nature of the debate about poverty and deprivation. Instead of asking the majority to be altruistic and vote for better income support for a poor minority, this is now about how to improve the quality of life and social relations for the vast majority.

NOTES

1) Marmot MG. *Status Syndrome - how your social standing directly affects your health and life expectancy*, Bloomsbury Publishing, 2004.
2) Wilkinson RG, Pickett KE. Income inequality and social gradients in mortality. *American Journal of Public Health* (in press, 2007.)
3) Subramanian SV, Kawachi I. Whose health is affected by income inequality? A multilevel interaction analysis of contemporaneous and lagged effects of state income inequality on individual self-rated health in the United States. Health and Place 2006; 12: 141-56.

4) Wilkinson RG, Pickett KE. The problems of relative deprivation: why some societies do better than others. *Social Science and Medicine*, special issue (in press 2007).
5) Wilkinson RG. *The Impact of Inequality: how to make sick societies healthier*. New Press, New York 2005

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