

# questions

## d'économie de la santé

Issues in health economics

— *synthesis* —

### Background

This analysis is an extension of the communication presented at the Chaire Quetelet 2003 which will be published shortly as: Couffinhal A., Geoffard P.-Y. et al (2004), "Health policies in Europe and social inequalities", Enlargement of the European Union: socio-demographic stakes and implications, Actes de la Chaire Quetelet 2003.

It examines policies for reducing social inequalities in health and the role the healthcare system can play in this. In a preceding issue of "Questions in health economics" we looked at different models explaining social inequalities in health and the possible role played by access to healthcare. In this second of a two part series we will discuss several policies implemented in Europe with the aim of reducing social inequalities in health.

### Policies for reducing inequalities in health, what role can the healthcare system play?

#### A European perspective.

#### Part II: Experience from Europe

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In recent years, a number of European countries have elaborated organized strategies for reducing inequalities in health, notably the United Kingdom, the Netherlands and Sweden.

Some of them, like the United Kingdom, have defined quantifiable objectives for the year 2010. Other countries, like the Netherlands, have embarked on a programme of local experiments with rigorous evaluations. In all three, work is underway to measure the effectiveness of these interventions and provide pertinent information to political decision-makers.

Drawing on research which suggests that a reduction in inequalities in health undoubtedly requires a reduction in overall economic and social inequalities, the different strategies undertaken in these three countries contain elements intended to influence the social determinants of health inequalities outwith the healthcare system.

They also involve actions designed to mobilize the healthcare system, notably through preventive health measures and primary healthcare.

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### The law of August 9, 2004 relating to public health policies

|   | Aim   | Prerequisite aim  | Indicators  |
|---|---|---|---|
| <b>Objectives concerning the theme: precariousness and inequalities (1)</b> | 33. To reduce the financial obstacles in access to care for individuals whose income is slightly above the threshold for UMC entitlement.         | Analyze the consequences of a «threshold» effect related to income on recourse to medical care. |   |
|   | 34. Reduce inequalities in disease and death by increasing the life-expectancy in difference in life expectancy at 35 years is presently 9 years. | Identify the best tools for measuring inequalities and discriminations due to origin.           | Probability of dying and life expectancy by professional, disadvantaged groups: the category, employment stats & place of birth (using longitudinal cohort series). |

(1) The objectives have been classified in different categories within specified themes: objectives which are quantifiable with currently available data, those which require prior epidemiological information or other scientific knowledge before quantification, and finally objectives which will be quantified after assessing programs which are underway or pilot programs. Those which are defined for the theme: «Disadvantage and inequalities» are all objectives which will require the prior acquisition of additional scientific knowledge.

Social inequalities in health have been documented in all countries in Europe during the last twenty years. All of these countries signed the WHO–Europe 1985 declaration of health for all by stipulating that any differences in state of health between countries and between groups within any given country should be reduced by 25 % by the year 2000. However today these countries are at very different stages of implementation of public policies to fight against these inequalities (Mackenbach, and Bakker, 2003).

After describing what is being done in France, we will present the strategies being used by the three trail-blazing countries, the United Kingdom, the Netherlands and Sweden, in order to learn as much as we can from their experiences, by comparing how they elaborate their strategies and what policies they have chosen to help reduce social inequalities in health.

## Public policy on access to healthcare and the fight against exclusion in France

In spite of the fact that, in France, social differences in premature mortality are the highest in Europe (Kunst *et al.*, 2000, cf. QES n° 92,2005), the French have only recently turned their attention to social inequalities in health. It was not until 1994 that the newly created High Committee on Public Health specified the reduction of social inequalities in health as one of four major medium-term objectives<sup>1</sup>. Two intermediate objectives were to provide very disadvantaged individuals in very precarious situations with decent living conditions and encourage their social re-insertion, and to improve access to medical and social care available to the poor.

In 1998, the law concerning the direction to be taken in the fight against exclusion addressed the question of the right to health essentially in terms of access to healthcare, despite the fact that the High Committee on Public Health, in its 1998

report, “The evolution of precariousness in France and its effects on health”, had concluded that access played, at most, a limited role.

This law was operationalised through the Regional Programmes of Access for Prevention and Care (PRAPS), which were intended to improve access to curative and preventive medical care to disadvantaged individuals. Accordingly, the different players in healthcare and social programs were consulted and coordinated at local and regional levels in an attempt to identify and initiate changes in the healthcare system which would facilitate access to disadvantaged persons. The results were not particularly encouraging, apart from a few innovative actions and some specific improvements in public access (Bernard Brunhes Consultants 2003, Fourcade *et al.*, 2004). A number of recommendations for developing the programmes were formulated.

The advent of Universal Medical Coverage (UMC) in 2000 constituted a significant advance by providing equal access to healthcare for all. By generalizing basic medical coverage, every individual residing in France gained stable, regular access to care, in addition to free supplementary health insurance based on income. Nearly 5 million people are covered by this program today (Boisguérin, 2005). For an equivalent state of health, its beneficiaries utilize about the same average amount of healthcare as the overall population covered by supplementary health insurance, even though there remain some differences in the structure of care (Raynaud, 2003). However, we are unable to assess the efficacy of this program in reducing social inequalities in health because we do not yet have sufficient information on the effects of UMC on changes in the health status of its beneficiaries.

## Towards public policies for reducing social inequalities in health

Although they are important, these recent advances form part of a general

approach which addresses the question of inequalities uniquely in terms of precariousness and essentially looks at them in the light of access to healthcare.

Social inequalities in health per se have not been a major element in the public debate up until now. For example, the Health Conference in 1999 did not prioritise this issue (Lang *et al.*, 2002).

Nevertheless, the scientific community has shown increasing interest in social inequalities in health; for instance, in 1997, INSERM inaugurated a research programme on this subject which resulted in two publications: “Precariousness, risks and health” (Joubert *et al.*, 2001) and “Social inequalities in health” (Leclerc *et al.*, 2000). These two publications suggest a number of different explanations for the presence of inequalities in addition to access to healthcare, and the latter stresses the notion of a social gradient in health, in addition to the question of precariousness.

The question of inequalities in health is mentioned in the report on public health objectives annexed to the August 9, 2004 law relating to public health policies. This report considers a *reduction in inequalities* to be the most principle underpinning public health policies. According to these principles, *the definition of objectives and the elaboration of strategic plans should systematically take into account the most vulnerable social groups since they are particularly exposed to the specific determinants related to the frequency and/or the gravity of the problem being studied, including geographic determinants.*

Among the 100 objectives which it defined, two directly address inequalities (see the box on page 1). Objective 33 is to reduce the financial obstacles to access to healthcare for individuals whose income

<sup>1</sup> The four objectives are: reduce avoidable deaths, reduce avoidable disabilities, improve the quality of life for the handicapped and chronically ill and reduce inequalities in health

is slightly higher than the threshold for UMC entitlement. From this perspective, even if its effect remains limited, assistance in obtaining supplementary insurance, which is written into the August 2004 law on health insurance reform, constitutes a step in the right direction. Objective 34 is to reduce inequalities in disease and mortality by increasing the life-expectancy of disadvantaged groups. This second objective may be viewed as a first step towards a public policy to reduce inequalities in health - the prior objective being to discover the appropriate tools for measuring these inequalities.

If this strategy is going to become an operational global strategy based on scientific knowledge, it would be helpful to take a good look at the experience of other European countries which have already instituted clear public policies in this area. This is notably the case in the United Kingdom, the Netherlands and Sweden.

### In the United Kingdom: reduce health inequalities by 10 % before 2010

The Black Report (1982), now a classic reference, was commissioned by the labour government and delivered to its conservative successor at the beginning of the 1980s. The conservatives initially neglected it but was resurrected in 1997 when the newly-elected labour government commissioned a new report. The recommendations in this Acheson report, delivered in 1998, underscored the role played by social determinants and the need for policies aiming to reduce poverty and inequalities in income (Acheson, 1998). In June 1999, the government published a white paper based on these recommendations which presented a plan for fighting social inequalities in health (Health inequalities: an action report, 1999).

### Defining quantified objectives

In February 2001, two quantified objectives for inequalities in health were se-

lected among all the performance objectives of the health and social system.

The first objective was to reduce the difference in infant mortality between manual workers and the general population by 10 % by 2010.

The second objective addressed geographic inequalities: to reduce the difference in life-expectancy at birth between the bottom quintile of underprivileged areas and the national average.

In 2004, additional, more detailed objectives were added to the two objectives on infant mortality and life-expectancy (Spending Review 2004 Public Service Agreement<sup>2</sup>):

- by 2010, reduce the difference in mortality for cardiovascular diseases between disadvantaged areas and the rest of the country by 40 %;
- by 2010, reduce the difference in mortality from cancer between these same areas and the rest of the country by 6 %.

The Public Service Agreement also contains other objectives targeting certain determinants of inequalities in health:

- either directly: a 26 % reduction in the prevalence of smoking in manual workers (the prevalence is 21 % in the general adult population),
- or indirectly: by targeting groups of impoverished individuals:
  - a 50 % reduction in unwanted pregnancies in women less than 18 years old,
  - halt the increase in prevalence of obesity in children aged 11 or less.

The objectives for geographic inequalities are directed at areas with the worst health and poverty indicators and in particular, those areas which were in the lowest quintile for at least three of the following indicators: life expectancy at birth in both men and women, and mortality before 75 years due to cancer and cardiovascular diseases, which constitute a composite “disadvantage” indicator. Eighty-eight primary care groups were

targeted and the objective for reducing differences in life-expectancy has been extended to include these areas.

### Action programs

The strategies for attaining these objectives were progressively elaborated and fine-tuned by a cooperative effort which included an inter-ministerial taskforce, public consultants and the advice of experts. They subsequently appeared in a number of successive governmental documents and notably in the ministerial document published in July 2003 “Tackling Health Inequalities: A Programme for Action”. This program defined the four principal avenues to be explored: assistance to families, mothers and children; encouraging community involvement; prevention and access to efficacious medical care and actions aimed at the social determinants of health.

This action programme was cross-sectional and involved other ministries in addition to the Department of Health, hence the inter-ministerial task force. Consequently, some of the interventions proposed lie outside the healthcare system and involve reducing poverty, improvements in living conditions and housing, better education, access to public services in general with an emphasis on children. These actions were placed under the responsibility of different ministries and pre-existing national programs (*Sure Start*, *Neighbourhood Renewal* or improvements in housing for poor families).

However the key role played by the National Health Service in the fight against inequalities has also been stressed, notably in disadvantaged neighborhoods. *Primary care trusts* were mobilized to develop a number of preventive actions aimed particularly at the target populations: smoking cessation (a specific program has been

<sup>2</sup> This is a budgetary procedure which sets provisional expenditures for the ministries for a three year period; it includes objectives for improvements in corresponding public services.

organized in this area), improvements in nutrition, encouraging breast-feeding in newborns and physical activity for all adults. The different players in primary care were asked to work in collaboration with a variety of associations. Access to screening and treatment in poorly-served areas was also stressed: access to neonatology services (related to the objective for infant mortality), improved access to screening and to treatment for cancer and cardiovascular diseases (objective for life-expectancy). In the Department of Health's words, the system needs to deal directly with the "law of inverse care", referring to the fact that areas with the most cardiovascular disease receive the worst care. A programme for renovating primary care centres in disadvantaged areas has also been put into place. In short, a general mobilization is underway to spearhead the fight against inequalities through political campaigns and national programs, starting at the ministerial level and extending down to the local level where elected officials and health professionals working in primary care are asked to cooperate with local officials.

Indeed, tangible results can only be obtained through local actions which are particularly adapted to the specific local context: local officials are requested to implement "local public service agreements" which have been agreed with the central government. They are rewarded if the objectives are achieved. The performance of primary care groups is also assessed in this way. The Department of Health provides local players in healthcare with appropriate guides and analytic tools (for example a guide for performing an "equity audit", a database for studying one geographic area in comparison to the national average with respect to a series of health markers, sharing the results of interesting local initiatives, etc.).

#### **Towards a revision of criteria for the geographic allocation of resources?**

Simultaneously, the allocation criteria for expenditure between the regions and primary care groups have been modified.

The actual criteria are based on a long process which began in the 1980s according to the principle of "equal need, equal resources". These needs are defined by using indicators of health status and precariousness for the inhabitants of a particular geographic area. A new criterion is due to be introduced: "contribution to the reduction of avoidable health inequalities". 130 million pounds have been allocated to the geographic areas which have the highest avoidable mortality rate. Even if the sum involved is relatively small, this positive discrimination constitutes a real change with respect to previous policies<sup>3</sup>.

Thus, on paper at least, the programme outlined in the United Kingdom is one of the most coherent and ambitious to date. It clearly states that inequalities are unacceptable and that the government is ready to fight against them through quantified objectives and actions targeted at social determinants, combined with the mobilization of health services, and with a particular emphasis on incentives. Only time will tell if this program produces the expected results. Nevertheless, one wonders whether the National Health Service will be capable of pursuing all these objectives, targets, action plans and performance indicators at the same time.

#### **The experimental approach used in the Netherlands**

In the Netherlands, public opinion began to focus on the problem in 1980 following the publication of the Black Report and the realization that there were inequalities between different neighborhoods in Amsterdam. Unlike in the UK there was no political resistance to dealing with it: both public opinion and the principle political parties agreed that social inequalities were unacceptable and could endanger social cohesion (Stronks, 2002). Thus, as early as 1985, the government adopted the WHO objective of "Health for all by the year 2000" and the health ministry published a report in 1986 which included a paragraph speci-

fically referring to social inequalities in health.

#### **The experiments**

The first research program began in 1989 and was designed to identify and measure the social determinants of health inequalities in the Netherlands. It was followed by an experimental programme between 1995 and 2001 which consisted of twelve local experiments aimed at assessing the impact of different interventions on social inequalities.

#### **These interventions involved four strategies:**

- improve the socioeconomic status of disadvantaged individuals by providing a special allocation to parents living in poverty.
- reduce the effects of poor health on socioeconomic status by offering specific school tutoring to children who often miss school because of illness.
- reduce exposure to the risk factors which contribute to social inequalities in health by decreasing physical constraints in the workplace and making changes in the organization of work in order to diminish stress at work through preventive campaigns directed at the working population, as well as other prevention campaigns targeting schools and disadvantaged neighborhoods (smoking, dental hygiene, better nutrition prior to pregnancy...);
- finally, improve the quality of and access to medical care by setting up local care networks in order to ensure that patients suffering from chronic psychiatric disorders are not excluded, by increased health education for Turkish residents who have diabetes and by better nursing care and improved follow-up by general practitioners for patients with asthma or other chronic respiratory diseases in disadvantaged areas.

<sup>3</sup> Nevertheless, some authors underline the fact that a policy with specific allocations to disadvantaged areas (which, as a function of the existing allocation criteria, already receive higher allocations) presumes that these allocations are given for interventions that are well-targeted and known to be effective in reducing inequalities (Shaw and Smith, 2002).



At the outset, precise assessment protocols were established for each of these interventions.

Most of the results of these experiments were available by the end of 2000 (Mackenbach and Stronks, 2004). Seven of the twelve interventions obtained positive results, two produced no tangible results and the remaining three could not be properly assessed. In particular, it was shown that interventions in conditions in the workplace were effective, and that local and well-targeted interventions were the most promising for both prevention and for psychiatric assistance or aid to patients. In contrast, the specific allocation given to disadvantaged parents and the mass prevention campaign did not appear to be effective.

### Quantified objectives and recommendations

As early as the beginning of 2001, a commission composed of experts and politicians from the different parties met in order to fix quantified objectives and recommendations.

The general objective, based on the WHO objective, was to reduce the *difference in life-expectancy without disability* from 12 to 9 years between individuals in the highest and lowest socio-economic groups by the year 2020, by substantially increasing healthy life years for the most disadvantaged group. Eleven intermediate objectives, quantifiable with available data, were also chosen; they corresponded to the four action strategies selected during the experimentation phase (Mackenbach and Stronks, 2004):

- reduce the number of poor families, increase the percentage of disadvantaged children in secondary education and maintain inequalities in income at the 1996 level;
- diminish the differences in education, smoking rate, sedentary lifestyle, obesity, exposure to physical constraints in the workplace and workstation surveillance by the employer editor's note: what is

this? observed between the groups;

- maintain the differences in use of health services between the groups at the 1998 level.

The commission recommended initiating sixteen different policies and interventions, in other words four for each strategy, and assessment of their impact (Mackenbach and Stronks, 2004). However, the total cost was not estimated. The recommendations were often expressed in general terms (for example: to continue the policies which help children from disadvantaged families gain access to education or to institute technical measures and appropriate changes in organization in order to reduce workplace constraints for manual workers) and constituted a kind of "operating manual". One of the original aspects of this undertaking, which was specific to the Netherlands, was to underline the necessity of maintaining a number of social benefits (for example: to maintain the pension levels of individuals who are not working because of illness or disability, to ensure adequate financial access to medical care for people in the lower socio-economic groups).

The report was delivered to the parliament late in 2001. It was widely promulgated in spite of the fact that the policies designed to reduce unhealthy behaviour were sharply criticized because they did not concur with the principle of individual responsibility, a principle generally taken for granted in the Netherlands. The period of political instability which followed in 2002-2003 slowed down efforts to institute these measures although a few of them were put into place on a large scale, for example, the prevention of smoking in school-age children and the development of local networks for patients with chronic psychiatric disorders.

### Sweden: health in the same terms for all

Sweden is a country which has had a social policy based on equity for a long time (Burstöm *et al.*, 2002). Curiously however,

inequalities in health seem to be as great in Sweden as in most other countries: a difference of 40 % in mortality between manual and non-manual workers according to statistics from the European Union (Kunst *et al.*, 2000).

The strategy employed in Sweden is different from those extant in Great Britain or in the Netherlands: the Swedes do not try to reduce inequalities *per se*; rather they are guided by a public health policy strongly imbued with objectives designed to ensure equity.

This public health policy began in 1997 when a national public health commission composed of representatives from the different political parties and experts was convened and mandated to define the nation's objectives for developing health and the best strategy for attaining those objectives. The commission's work culminated in a law voted in 2003. The concept of social justice underlying this law is based on the notion that health is one of the conditions needed for the complete expression of one's citizenship. Following two years of work and assisted by various experts' reports, a preliminary report suggested a list of objectives in addition to a number of indicators (Ostlin *et al.*, 2001). After broad public consultation, the final report, "Health on the same terms for all: national public health objectives", was delivered to the government in 2000.

It contained 18 broad objectives and approximately fifty secondary objectives. The commission chose to express the objectives in terms of determinants rather than in terms of health outcomes. In part, they addressed general social determinants which operate outside the healthcare and prevention systems. Accordingly, social cohesion, social participation and self-fulfillment, living conditions during childhood, full employment, a healthy work or living environment, and parks and playgrounds for all, were considered essential factors for improving the health of the entire population. A series of other objectives aimed to reduce risk factors in individual behavior: nutrition, physical exercise, smoking, alco-

hol abuse, sexual practices and drug use. A number of more cross-sectional objectives were also mentioned: the recommendation that health services do more to promote prevention and good health, better coordination and more investment in long-term research, particularly for determining the cost effectiveness of different interventions in public health.

Thus, the public health policy finally voted in April 2003 grouped these eighteen themes into eleven major approaches. Three of these dealt with the general economic and social environment (participation and influence in society, social and economic security, security and living conditions which are beneficial to children and adolescents) while seven addressed collective or individual risk factors (healthier working conditions, better general environment and safer consumer products, more efficient protection against communicable diseases, safer sexual practices, increased physical activity, better nutrition and healthier foods and reduction in substance abuse). A final one aimed at promoting health services to be "more actively involved in good health".

While the strategy which emerged from this process is not explicitly centered on the fight against inequalities in health as in the United Kingdom and the Netherlands, this orientation nonetheless underlies many of the stated objectives. Thus, objective 1 (participation and influence in society) explicitly refers to research on psychosocial determinants of inequalities in health (individuals' position in society and the feeling that they can directly influence their own existence). The public health law gives prime importance to reinforcing democracy, social capital<sup>4</sup>, and defending individual rights (the fight against discrimination because of gender, handicap or immigrant origin) in the fight to improve the overall health of vulnerable populations in particular, and in the country in general. Objective 2 (social and economic security) states that differences in the distribution of wealth and poverty and economic inse-

curity are determining factors of poor health.

The indicators used to assess the impact of the law directly concern the reduction of poverty. Indeed, some contain target measures aimed at a reduction in socio-economic inequalities, such as lowering the concentration index of wealth<sup>5</sup> to below 0.25, reducing the percentage of people living below the poverty threshold from 4.8 % to below 4 %, reducing long-term unemployment from 1.4 % to 0.5 %. Others address the effects of sickness on an individual's socio-economic status (for example: increase the percentage in employment of persons with a chronic disease or a handicap from 53 % to 70 %) or aim to decrease risk factors for the entire population (for example: diminish the percentage of severely overweight adults from 8 % to 5 % and from 7 % to less than 5 % of moderately overweight children, or finally, to reduce the percentage of people who smoke daily by 1 % each year and totally eliminate smoking in pregnant women and people younger than 19 years by the year 2010.

The law voted in 2003 mandated the National Institute of Public Health to make the final decision on which indicators to use but apparently without fixing any specific target levels, or recommending any particular operational method. Since the objectives are very cross-sectional, they will certainly require cooperation between a number of different ministerial departments. Even though the Institute of Public Health will be called on to follow the different sectoral actions, no specific political structure is designated to coordinate inter-ministerial co-operation; this is certainly one of the strategy's weak points, as is the case for the Netherlands.

### What lessons can we learn from these experiments?

The United Kingdom and the Netherlands offer two examples of public policies explicitly aimed at the

reduction of inequalities in health. The Swedish approach – like the French approach – stresses a global public health policy. However, in Sweden, equity seems to be a more important preoccupation; it played an important role in preparatory discussions and is at the center of certain objectives targeting the social determinants of health (social capital, economic security...).

A consideration of these different experiments leads us to examine the process used to elaborate different public policies intended to reduce both the nature and the impact of inequalities in health.

### The elaboration process

The processes involved in developing public policies aimed at reducing social inequalities in health in various countries can be analyzed by using the phases suggested by Whitehead (1998): the measurement and awareness of the existence of social inequalities in health, the understanding that they constitute an important stake in public policy, and finally, the willingness to develop a progressive and constructive policy which is both global and coordinated.

According to this analysis grid, the United Kingdom is the country which has advanced the most: after becoming aware of the problem at the beginning of the 1980s and the publication of a number of government and independent reports, specific and coordinated policies were effectively put into place. Following a phase of scientific investigation and public debate, the Netherlands and Sweden seem to be in the developmental phase of a structured policy. France is less advanced in the process since social inequalities in health have only recently become part of public health policies, with the advent of the 2004 public health law.

<sup>4</sup>In Robert Putnam's sense (2000), in other words, the importance of social networks, relationships and confidence between individuals in a given society.

<sup>5</sup>This index is calculated from the income concentration curve. It is higher when the distribution of wealth in unequal. It equals 0 when distribution is perfectly egalitarian.

Development of our knowledge base and public debate are undeniably needed before these policies can be put into place (Mackenbach and Bakker, 2003). In all three countries, political awareness of this problem was preceded and accompanied by important studies and research designed to determine the magnitude of the inequalities, gain better knowledge of their determinants and to acquire a certain expertise in the effectiveness of possible corrective interventions. This sequence of events was particularly evident in the Netherlands, where a preliminary research phase was followed by a phase of local experiments and assessments before large-scale political policies were elaborated. A similar path was followed in Great Britain where a very large amount of significant research was undertaken in the 1990s; in Sweden, fourteen groups of experts were given the responsibility of gathering the necessary scientific evidence to identify the different determinants of health. Fortunately, research continued well after the publication of the strategies and programs which were finally chosen, since our knowledge in this domain is still embryonic. A recent report by the Health Development Agency summarised the most effective interventions used to date, but showed that much remains unclear (Hunter, Killoran, 2004). The remaining uncertainties have led the Dutch commission to recommend that both descriptive and explanatory research on social inequalities in health continue.

A second factor which placed the question of inequalities in health to the forefront of the political agenda was the consensus that these inequalities are unacceptable. This consensus seems to have played an important role in both the Dutch and Swedish processes (even if the Swedish conservative party was not totally in favour of a number of the social measures suggested). The Thatcher government also failed to fully react to the publication of the Black Report. A third aspect of the elaboration of these public health policies in the three countries

studied was the important role of prior, concerted political discussion which involved experts, political leaders, the diffusion of information and public consultation (for instance in the United Kingdom, where the government's first suggestions were debated in regional meetings and written consultations).

Lastly, the cross-sectional aspect of the policies meant that a number of different ministerial departments, in addition to the health ministry, had to become involved. This required political coordination at the highest governmental level. This is undoubtedly why the British seem to have had the most success in coordinating their different programs in the fight against inequalities in health.

In addition to these strong similarities, there are a few differences:

- the Dutch seem to have preferred an experimental research approach aimed at various objectives to assess the effectiveness and efficacy of different interventions while the British chose to explore a directly operational avenue in an effort to rapidly put into place policies based on recommendations, using their understanding of the determinants involved and the relative efficacy of the interventions;
- the United Kingdom and the Netherlands both chose to fix a very global objective for reducing social inequalities in health (respectively, 10 % by 2010 and 25 % by 2020) while Sweden has officially limited its policies to somewhat more general, non-quantifiable objectives.

### The contents of these policies

The content of these policies can be analyzed on two dimensions: the determinants of social inequalities and the populations targeted (Mackenbach, Bakker, Sihto, Diderichsen, 2002). Accordingly, we can compare measures which aim to reduce social inequalities themselves, those designed to improve access to healthcare downstream and intermediate measures intended to diminish exposure to social risk factors in health. In addition,

we need to distinguish universal policies from selective policies aimed at disadvantaged social groups or areas, or groups which have the poorest health records.

The strategies in the United Kingdom, the Netherlands and Sweden combine all the prior, intermediary and downstream measures. The British and Dutch programs put more of an accent on the quality and accessibility of healthcare than the Swedish program. In passing, we should mention that French policies have stressed access to curative and preventive healthcare while simultaneously fighting poverty and economic inequality (without considering that these actions can be effective tools to combat inequalities in health).

One of the most original aspects of the Dutch approach is that fact that it addresses both the effect of social inequalities on health and the converse, the effects of health on social status. It does this through objectives and interventions to increase disability pensions, to adapt the workplace for the handicapped and the chronically ill and increase school tutoring for sick children. These preoccupations are also part of the Swedish approach which is reflected in other areas, like handicaps. One of the fundamental principles underlying their reforms is the notion that society needs to do everything possible to reduce the consequences of poor health on each individual's ability to control his or her own life and attain fulfillment. To this end, one of the primary objectives is to abolish discrimination in employment.

The Dutch are particularly interested in interventions aimed at improving conditions in the workplace. In addition, the objectives they target are designed to both improve and, in many cases, to maintain, existing benefits. Accordingly, their programme recommends that inequalities in income should not worsen and that equity needs to be maintained with respect to the financing of and access to healthcare.

## The role of the healthcare system

While all three countries consider that the healthcare system has a role to play, they differ in their interpretation of that role. Swedish public health policy stresses the need for healthcare services (particularly primary care) to include more prevention and health promotion in daily practice by encouraging healthcare professionals, who are close to and have regular contact with target populations, to provide more counselling. In the United Kingdom, the National Health Service and in particular primary care groups, have been assigned a major role in implementing recommendations for the prevention and treatment of important diseases like cancer and coronary artery disease. Another specific objective is improving access to healthcare in disadvantaged areas. Similarly, the Dutch program aims at reinforcing primary care in these areas, notably with respect to the prevention and treatment of chronic diseases. In both cases, primary care is considered to be the cornerstone of a comprehensive programme of prevention and medical care for improving a population's health. In all three countries, the organization of the healthcare system means that policies designed to reduce inequality are implemented first and foremost through the primary care system. Primary care is well-structured and its healthcare professionals, who have already assumed major responsibility for these disadvantaged groups, can readily undertake appropriate action strategies thanks to the privileged relationship they share with patients.

## The impact of public policies

It is too early to determine the effective impact of these policies on social inequalities in health since they have only recently been defined and are not yet fully operational. Nonetheless, a few observations can be made:

– Encouragingly, local experiments in the Netherlands and the results obtained in the United Kingdom show that appropriate interventions can at

least attain intermediate objectives;

– effective interventions are generally those that are well-targeted and aimed at both factors within the healthcare system and outside it;

– finally, a general comment: in the three countries studied, the policies which have been suggested or put into place require the broad involvement

and coordination of all political players, ministries and government agencies from the local to the national level, in order to effectively achieve a specific objective for a reduction of inequalities in health. As the experts in different systems have stated, this is not a simple task (Mackenbach and Stronks, 2004; Ostlin and Diderichsen, 2001).

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