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POVERTY – THE MOST IMPORTANT RISK FACTOR FOR INEQUALITY IN HEALTH

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ABSTRACT

Poverty resulting from material shortage and from cultural and social exclusion, which is a conditioning association with a certain socio-economic group, is the biggest health-risk factor. Morbidity or mortality rates are much higher in the socio-economically deprived groups of population than is the case with the groups of population of better socio-economic status. For establishing the inequality in health, the morbidity or mortality rates by gender, age, nationality, geographical area and socio-economic characteristics could be applied. Poor health of people within the society as a whole and within individual social classes is conditioned by the social and economical organisation of the society, therefore the health indicators are also indicators of the socio-economic organisation of a country. The World Health Organization (WHO) is leading its policy on the basis of the fact that the world is one and indivisible and that there are big disparities existing in health condition among different countries as well as within them, representing the main obstacle for development. The data of WHO available are clearly showing big differences among indicators of the health condition between the western and eastern parts of the European Region. The differences are the most evident if following the infant mortality rate (from 3 to 43 per 1000 live births) and the life expectancy at birth (from age 79 to 64). In the year 1998, 11.3 % of Slovene inhabitants were living below the poverty line (measured by the modified OECD equivalence scale) (OECD-Organisation for Economic Co-Operation Development). With such a share, Slovenia is classified among the twelve countries of the EU with the lowest poverty rate, however the data could be misleading since in Slovenia we are not using the uniform methodology.

Socio-economic inequalities in health are a major challenge for health policy, not only because most of these inequalities can be considered unfair, but also because reducing the burden of health problems in disadvantaged groups offers great potential for improving the average health status of the population as a whole. When aiming to reduce inequality in health, a national strategy for combating poverty, awareness of people and increasing the scope of health and social activity is required. Taking such measures is conditioned by the structural and etiological understanding of inequality among individual groups of population within a certain place and time. New databases are being established in

Slovenia and the possibilities are being searched for the connection thereof. We are facing difficulties in defining the variables, in connecting the data among different databases and in efforts towards establishing the information system. At the Institute of Social Medicine of the Faculty of Medicine of Ljubljana and at the Institute of the Republic of Slovenia of Macroeconomic Analysis and Development the research has been started with the purpose of establishing connections among individual socio-economic factors (gender, age, education, profession, activity, marital status, nationality, income, etc.) and the causes of death according to the ICD-10 (International Classification of Diseases), for dead persons across Slovenian municipalities in the years 1992, 1995 and 1998.

KEY WORDS: powerty, health, WHO, Slovenia, social medicine, disease

HOLISTIC UNDERSTANDING OF HEALTH

The contemporary definition of health is no longer formulated by dividing it into physical and mental health, but is characterised by a holistic (integral) comprehension thereof. The World Health Organization's (WHO) definition is very similar: »Health is a state of complete physical, mental and social well being, and not merely the absence of disease or infirmity« (WHO Regional Office for Europe, 1978). For the holistic understanding of health, the importance of the reciprocal dependence of selected levels is stressed; health means a balance between biological and mental impacts as well as a person's active approach to the environment, and also the impact of social and other external factors on health are pointed out. The Ottawa Charter (WHO Regional Office for Europe, 1986) states that to a large extent a person's health depends on the provision of fundamental living conditions and a stable eco-system, such as a place to live, food, education, income, as well as peace and social equity. To improve health, all the above-mentioned preconditions have to be fulfilled. In this context, health is also a source of human life not only a goal of its own. It is one of the foundations enabling a person to fulfil her aspirations, meet her needs, change the environment and play an active part in it. This makes health an important determinant of the quality of life. At the same time, health can be an indicator of the economic efficiency of a country and the welfare of its population (Hanžek 1998).

WHO: HEALTH FOR ALL IN THE 21ST CENTURY

The policy of the World Health Organization (WHO 1998) is based on the fact that the world is one and indivisible. As stated in the 1998 World Health Declaration, the enjoyment of health is one of the fundamental rights of every human being. Health is a precondition for well being and the quality of life. It is a benchmark for measuring progress towards the reduction of poverty, the promotion of social cohesion and the elimination of discrimination.

The health status differing significantly between the Member States of European Region (51 countries) and within them, is representing the major obstacle to development. The regional policy for health for all is a response to the World Health Declaration (WHO, 1998). To achieve health for all in the 21st century, the European Region of WHO has set

21 targets (WHO Regional Office for Europe, 1998), which Member States are supposed to achieve between the years 2005 and 2020 (depending on the individual target) by the means of the national policy and regional development's orientations. For equity in health, the first two targets are of the main importance. Equity in health is supposed to be attained by means of solidarity at national level and in the European Region as a whole.

Target 1: Solidarity for Health in the European Region

Poverty is the major cause of ill health and lack of social cohesion. One third of the population of the eastern part of the European Region, 120 million people, live in extreme poverty. Health has suffered most where social systems have collapsed, and where natural resources have been poorly managed. This is clearly demonstrated by the wide health gap between the western and eastern parts of the Region. The differences in infant mortality rates are the most significant (from 3 to 43 per 1000 live births) (Fig. 1) as well as in life expectancy at

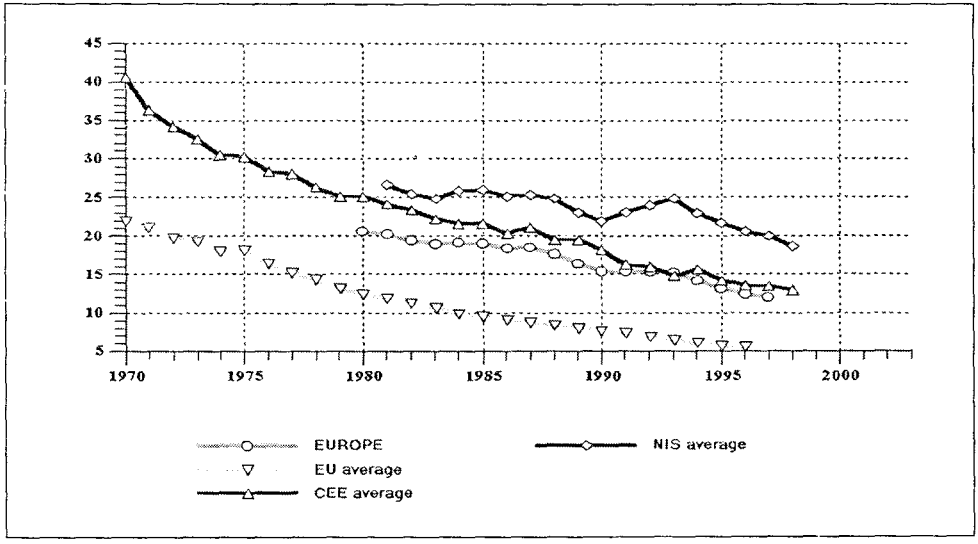

Fig. 1. Infant mortality in subregional groups of countries in the European Region within the period 1970 - 1998.

birth (from 79 to 64 years) (Fig. 2).
According to the plans of the WHO (WHO Regional Office for Europe, 1998), the present gap in health status between Member States of the European Region should be reduced by at least 30 %. In order to reduce these inequities and to maintain the security and cohesion of the European Region, a much stronger collective effort needs to be made by international institutions, funding agencies and donor countries. Furthermore, external support should be much better integrated through joint inputs into government health development programmes that are given high priority and are firmly based on a national health for all policy in the receiving country.

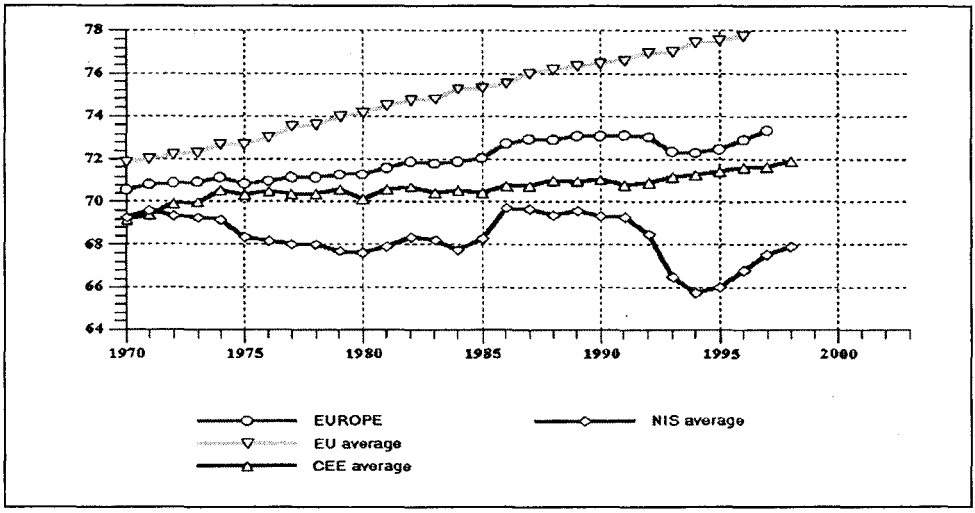

Fig. 2. Life expectancy at birth in subregional groups of countries in the European Region

Target 2: Equity in Health

The second target of the WHO aims to ensure that the differences between socio-economic groups are decreased, since even in the richest countries in the European Region, the better off live several years longer and have fewer illnesses and disabilities than the poor. The health gaps between socio-economic groups within countries are supposed to be reduced by at least one fourth in all Member States, by substantially improving the level of health of disadvantaged groups of inhabitants.

Poverty is the biggest risk factor for health, and income-related differences in health – which stretch in a gradient across all levels of the social hierarchy – are a serious injustice and reflect some of the most powerful influences on health. Financial deprivation also leads to prejudice and social exclusion, with increased level of violence and crime.

There are also great differences in health status between women and men in the European Region. Other health-risk factors which determe association with a certain socio-economic group, are educational level, nationality, etc.

POVERTY AND INEQUALITY IN HEALTH

Definitions

Poverty is considered an extreme form of inequality in ensuring health and social security. The European Council's definition of poverty (also adopted by the Statistical Office of the Republic of Slovenia – SORS) does not encompass only the lack of material resources but also social and cultural exclusion: »A person, family or group of people with resources

(material, cultural and social) too low to ensure a minimum of reasonable living in a certain national environment are classified as poor« (Martin-Guzman, 1993). Cultural and social exclusion are both responsible for and result from material shortage. Poverty is a combination of different types of deprivation (deficits) and limits on life's opportunities. Poverty is connected to a lack of education, unemployment, low income, poor housing conditions, poor health, and low cultural level. All of these shortages are enclosed in a circle of dependency upon the basic sources and living conditions, such as stable eco-system, food, education, income, and first of all peace and social justice and equity. The poor are excluded from social life and prevented from making full use of their cultural and societal possibilities. The poor are thereby exposed to violations of their basic human rights, while their human dignity is undermined. Efforts to reduce poverty and promote human development are therefore efforts to safeguard human, economic, social, and cultural rights (Hanžek & Gregorčič, 2001).

Poverty is such a complex notion that it cannot be studied from one aspect only (Hanžek & Gregorčič, 2001). Different concepts and definitions of poverty, as well as methods of measuring, are used in individual countries. Due to its complexity, different methods and indicators should be applied when measuring poverty, in order to give a clearer picture of its diversity. In order to be able to compare poverty levels in different societies, various measures have been devised which depend on how poverty is defined. The lack of money or material goods can be determined by three definitions: subjective poverty, absolute poverty and relative poverty (Hanžek 1999; Hanžek & Gregorčič, 2001).

Subjective poverty is measured by surveys. It is based on the data given by individuals or all members of a household about their income position or their needs. The notion of subjective poverty is important mainly because it reflects the self-assessment of individuals or groups and their self-definition or self-ranking. This has a number of shortcomings: people are reluctant to give a clear opinion about such intimate issues, and the feeling of poverty also varies between individuals. The latter is supported by information stemming from the Slovene Public Opinion Poll (Toš, 1998), since during the last 20 years the share of people claiming to be poor has never reached the value of 1 %, which is absolutely not the realistic value.

Absolute poverty is defined by a lack of basic goods and services essential to meet minimum biological needs: food, housing, clothing and heating. Absolute poverty shows the share of those who live below the line denoting the shortage of minimum goods and services essential to survival. This line is fixed and is independent of changes in the income position of individuals or households.

Relative poverty is a condition of relative deprivation compared to a certain level of well being in a particular society. It measures inequality within a society rather than the actual poverty. One way of determining relative poverty is based on the households' income or expenditure distribution; poverty is changing in step with changes in income distribution. The most widely used method has been the setting of the poverty line: a certain percentage (40, 50, or 60 %) of the average or median income or expenditure of households in equivalent form is the poverty line. Households living below this line are considered to be poor. International comparisons are most frequently based on relative poverty.

Equivalent income is the ratio of household income to the number of equivalent household members. Equivalent income can be calculated on the basis of two scales: the OECD scale (Organisation for Economic Co-Operation and Development), which gives a

weight of 1.0 to the first adult, a weight of 0.7 to other adult members, and a weight of 0.5 to a child below 16 years of age; or the modified OECD scale, which gives a weight of 1.0 to the first adult, a weight of 0.5 to other adult members, and 0.3 to each child below 14 years of age.

All these measures are no more than technical tools used in taking appropriate steps and allowing comparison. They are based on the assumption that poverty only entails lack of money. However, poverty is a more complex notion and includes other forms of deprivation (poor health, shortage of social contacts, information, knowledge, values, etc.); the United Nations (Ross-Larson, 2000) has devised two complex indices of human poverty, one for poor and one for rich countries. The indices contain information about the health of people, functional illiteracy, income distribution, and unemployment. According to these calculations, the highest rate of poverty among the rich countries is recorded in the USA – 16.5 and the lowest in Sweden – 6.8. The poverty rate in Slovenia amounts to 18.1 mainly because of its high functional illiteracy.

POVERTY IN THE EU COUNTRIES AND IN SLOVENIA

In Slovenia, the poverty rate was first assessed by the SORS in 1993 on the basis of data from the Households Expenditure Survey using the modified OECD equivalence scale, and the poverty line was drawn at 50 % of the average expenses of households (unit of observation: a household). The calculations showed that 13.6 % of households were poor in Slovenia in 1993 (Hanžek, 1998; National programme on the fight against poverty and social exclusion 2000).

In the nineties, the Statistical Office of the European Communities (Eurostat) began to use in its analysis a slightly modified method of calculating poverty. Calculations are still made on the basis of the modified OECD equivalence scale, but examine household incomes (unit of observation: a person). The poverty line was set at 60 % of the median equivalent income. At this point I would like to stress that the poverty rates calculated on the basis of household incomes are as a rule higher than those calculated on the basis of expenditure.

Direct comparison of calculations of the poverty rate for Slovenia with calculations carried out for the twelve countries of the EU is not possible, since the EU countries ceased to use the old methodology already in the years 1987-1989. Nevertheless the calculations can be used for comparison with other countries. On such a basis, Slovenia can be listed among the countries with a relatively low poverty rate. The poverty rate was in Slovenia nearly one half lower in comparison to the EU country with the highest poverty rate, Portugal, but more than three times higher if compared to Denmark with a poverty rate amounting to only 4.2 % (Hanžek 1998, National programme on the fight against poverty and social exclusion 2000) (table 1)

For carrying out international comparison of the poverty rate with regard to households' incomes, the calculation from the years 1997/98 can be applied (the last calculation for Slovenia) and compared to the accessible data from the year 1999 for the EU countries (table 2) (Hanžek & Gregorčič, 2001). At that time, 11.3 % of inhabitants of Slovenia were living below the poverty line. With such a share, Slovenia is classified among the twelve countries of the EU with the lowest poverty rate. However, such a good position is in part

Table 1: Poverty rate for households (modified OECD equivalence scale) in the EU countries and in Slovenia, based on households' expenditure (Reference: National programme on the fight against poverty and social exclusion 2000).

COUNTRY	POVERTY RATE IN %
Portugal (1989)	26.5
Italy (1988)	22.0
Greece (1988)	20.8
Spain (1988)	17.5
Great Britain (1988)	17.0
Ireland (1987)	16.4
France (1989)	14.9
Slovenia (1993)	13.6
Germany (1988)	12.0
Luxembourg (1987)	9.2
Belgium (1988)	6.6
The Netherlands (1988)	6.2
Denmark (1987)	4.2

Table 2: Poverty rate for persons (modified OECD equivalence scale) in the EU countries and in Slovenia, based on households' income (Reference: Hanžek & Gregorčič, 2001).

COUNTRY	POVERTY RATE IN %
Portugal	22
Greece	21
Italy	19
Great Britain	19
Spain	18
Ireland	18
Belgium	17
EU 12 (1999)	17
Germany	16
France	16
Denmark	12
Luxembourg	12
The Netherlands	12
Slovenia (1997/98)	11

due to the fact that the figures for Slovenia include households' own production and benefits in total income. Eurostat does not include these types of income (yet). Besides that, the poverty line in Slovenia is still drawn at 50 % of the average expenditure while Eurostat set the poverty line at 60 % of median income.

SOCIO-ECONOMIC INEQUALITIES

The term social exclusion has become widely used with reference to developed countries, which covers not only material deprivation, but also the shortage of social contacts, and the feeling of helplessness. Shortage is well known to represent a direct risk to health, and health risk is known to differ between groups of people (Gillespie & Prior, 1995; Wilkinson, 1997; Bobak et al., 1998). Socio-economic inequalities can be therefore defined as differences in prevalence or incidence of health problems between individual people of higher or lower

socio-economic status (Kunst & Mackenbach, 1994). It is possible for inequality in health to be registered in many ways. For measuring and evaluating the differences (inequalities) in health, the morbidity or mortality rates by gender, age, nationality, geographical area and socio-economic characteristics such as education, profession, income, employment, property, social reputation, etc., could be applied. Socio-economically deprived groups of inhabitants are characterised by the higher morbidity and mortality rates than groups of people of better socio-economic status (Illsley, 1990; Whitehead 1992; Moelek & Rosario Giraldes, 1993). Difference in mortality between lower and higher social classes is still increasing. The mortality rate is usually connected with the cause of death and is therefore usually higher with adult persons than with children (except for babies). Patterns of morbidity are following similar trends as mortality, however the inequality being bigger with children than with adults. In all groups and social classes, mortality is bigger with men than with women. Patterns of inequality in health associated with race and ethnical groups are not so clear (Whitehead, 1990).

Furthermore, health is influenced by behavioural patterns and life-style, which are also conditioning social problems of certain socio-economic groups. Habits injurious to health (smoking, improper nutrition, alcoholism, physical inactivity) can be used as indicators of psycho-social stress affecting the poorer and less educated due to the relative shortage of material goods and social and psychical deprivation (Kunst & Mackenbach 1994). However, the society is placing the blame on the victims and is re-regulating the social and health policy.

Thus classification of people into socio-economic groups is also caused by (not only the consequence of) ill health due to social selection occurring, which is supported also by the natural selection. The health of an individual is strongly negatively linked with his educational and material possibilities. The poor health of people within the society as a whole and within individual social classes is conditioned by the social and economical organisation of the society, therefore the health indicators are also indicators of the socio-economical organisation of a country (Hanžek, 1999).

ADVISABLE GUIDELINES FOR REDUCING INEQUALITIES IN HEALTH

Socio-economic inequalities in health are a major challenge for health policy, not only because most of these inequalities can be considered unfair (Whitehead, 1990), but also because reducing the burden of health problems in disadvantaged groups offers great potential for improving the average health status of the population as a whole (Kunst & Mackenbach, 1994). Action should be taken at different levels. Inequalities should be reduced by means of the state strategy (national strategy on the fight against poverty, equity in health, health and social security, etc.), city and community policies, protection of children and families, intersectional co-operation. The extent of the health and social activities should be planned, co-ordinated and enlarged in a professional and precise manner, with special emphasis laid on children, invalids, pregnant women and elder persons. People as individuals should be aware of and ensured better information on the growth and development of children, life-style and health, endangerment at work, etc. Taking the measures stated hereabove is conditioned by structural and etiological familiarity with inequality between individual groups of population at a certain place and time.

The international community and national governments are turning to the scientific community for advice on how to reduce inequalities in health. Governments are looking, in the words of WHO's strategy for Europe, for »a scientific framework for decision makers« and »a science-based guide to better health development« (WHO Regional Office for Europe, 1998). As recommended by the WHO for European Region (WHO Regional Office for Europe, 1998), policy-makers should develop a systematic strategy for monitoring socio-economic inequalities in health, following four steps:

Assessing the data currently available;
Collecting additional data if necessary;
Analysing, interpreting and presenting the data;
Formulating a policy response to the results.

NATIONAL POLICIES FOR REDUCING HEALTH INEQUALITIES

Research programmes for studying the condition and for reducing health inequalities have already been introduced by the Netherlands, Finland, New Zealand (Mackenbach et al. 1994; Kunst 1997; Arve-Pares 1998; New Zealand National Advisory Committee on Health and Disability 1998). These countries were recently jointed by the UK Government with its programme (Great Britain Independent Inquiry into inequalities in health 1998).

Health policy in the development of health care and health insurance in the Republic of Slovenia until the year 2004, which is determined in the National Health Care Programme of the Republic of Slovenia – Health For All By 2004 (2000) is based on the strategy of increasing the quality of health of the Slovenian inhabitants and adjusting and improving the system's operating in accordance with financial possibilities. For the strategy and development orientations to be realised, numerous tasks are prioritised. The programme is taking into consideration strategic orientation of the document of the WHO Health for All by 2000 (WHO Regional Office for Europe 1989) or its successor Health for All in the 21st Century (WHO Regional Office for Europe 1998). It is stated already in the introduction thereof, that one of the fundamental social objectives of the Republic of Slovenia is to preserve, promote and restore the health of its inhabitants. Reduction of differences in health care and the state of health of the public is stated as one of the priority objectives (second priority objective). As the first measure, the adopted act is stipulating causes for differences to be sought and be reduced.

Presently Slovenia is going through the transitional period by establishing new databases and searching for new possibilities for connecting them. We are facing difficulties in defining the variables, in connecting the data between different databases and with efforts to establish the information system. Since no research has been carried out yet in Slovenia which would present to a wider extent the inequality in health between different socio-economic groups in our country, the Institute of Social Medicine of the Faculty of Medicine in Ljubljana and the Institute of Macroeconomic Analyses and Development decided to analyse the already available data sources and inter-connect them. The research is aimed at investigating the connections between individual socio-economic factors (gender, age, education, profession, activity, marital status, nationality, income, etc.) and causes of death according to the ICD-10 (International Classification of Diseases) for dead persons across Slovenian municipalities in the years 1992, 1995 and 1998. The research is legally

based also on the National Health Care Programme of the Republic of Slovenia – Health For All By 2004 (2000) which is analysing the measures for reducing the differences in health of inhabitants and states as follows: »We will produce research into differences in health care and the state of health of different population groups according to sex, age, social status, qualifications and region. The research will also be aimed at studying the different risk factors that most threaten the health and lives of the inhabitants of individual regions. Measures will be aimed at reducing these. Proposals will be made on the basis of this research to reduce the differences.«

This research will contribute to getting familiar with influences of social and economic factors on inequality in health in Slovenia. Estimating the condition of inter-connectedness of socio-economic factors with health condition of the population with regard to the causes of death will also contribute to planning and forming the national programme health for all for the Slovene population so as to attain better health in the future.

POVZETEK

Revščina je zaradi materialnega pomanjkanja ter kulturne in socialne izključenosti, ki pogojuje pripadnost določeni družbeno-ekonomski skupini največji dejavnik tveganja za zdravje. Družbeno-ekonomsko prikrajšane skupine prebivalstva pogosteje zbolevajo in imajo višjo stopnjo umrljivosti kot skupine prebivalstva z boljšim družbeno-ekonomskim statusom. Za ugotavljanje razlik v zdravju uporabljamo kazalce (indicators) umrljivosti in zbolevnosti, ločeno po spolu, starosti, etnični pripadnosti, geografskemu območju in družbeno-ekonomskih značilnostih. Slabo zdravstveno stanje ljudi v družbi kot celoti in v posameznih socialnih slojih je odvisno od socialne in ekonomske organiziranosti družbe, zato kazalci zdravstvenega stanja kažejo tudi na družbeno-ekonomsko organiziranost države. Politika Svetovne zdravstvene organizacije (SZO) (World Health Organization - WHO) izhaja iz spoznanja, da je svet eden in nedeljiv ter da so velike razlike v zdravstvenem stanju med državami in znotraj njih glavna ovira napredka. Iz razpoložljivih podatkov SZO so jasno vidne velike razlike v kazalcih zdravstvenega stanja med zahodnimi in vzhodnimi evropskimi državami. Najbolj očitne so razlike v umrljivosti dojenčkov (od 3 do 43 na 1000 živorojenih) in v pričakovani življenjski dobi ob rojstvu (od 79 do 64 let). V Sloveniji je leta 1998 živelo pod mejo revščine (merjene z OECD-jevo prirejeno ekvivalenčno lestvico) (OECD-Organisation for Economic Co-Operation Development) 11,3 % oseb. Ta delež uvršča Slovenijo med države evropske dvanajsterice z najnižjo stopnjo revščine, kar je lahko zavajajoče, ker ne uporabljamo enotne metodologije.

Družbeno-ekonomska neenakost zdravja je velik izziv za načrtovanje zdravstvene politike ne le zato, ker je takšna neenakost nepravična, ampak tudi zato, ker bi zmanjšanje zdravstvenih problemov med prikrajšanimi skupinami lahko prispevalo tudi k izboljšanju zdravstvenega stanja celotne populacije. Za zmanjševanje neenakosti do zdravja je treba izdelati nacionalno strategijo boja proti revščini, ozaveščati ljudi ter povečati obseg zdravstvene in socialne dejavnosti. Pogoj za tako ukrepanje je strukturno in etiološko poznavanje neenakosti med posameznimi skupinami populacije v določenem kraju in času. V Sloveniji vzpostavljamo nove baze podatkov in iščemo možnosti povezovanja med njimi. Srečujemo se s težavami v definiranju spremenljivk, v povezovanju podatkov med različnimi bazami podatkov in z napori pri vzpostavljanju informacijskega sis-

tema. Na Inštitutu za socialno medicino Medicinske fakultete v Ljubljani in Uradu R Slovenije za makroekonomske analize in razvoj (Institute of Macroeconomic Analysis and Development) smo začeli z raziskavo, katere namen je ugotavljanje povezav med posameznimi družbeno-ekonomskimi dejavniki (spol, starost, izobrazba, poklic, aktivnost, zakonski status, narodnost, dohodek, itn.) in vzroki smrti po MKB-10 (Mednarodna klasifikacija bolezni - International Classification of Diseases) za umrle v Sloveniji po posameznih regijah v letih 1992, 1995 in 1998.

KLJUČNE BESEDE: revščina, zdravje, WHO, Slovenija, socialna medicina, bolezen

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