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Beyond Health Care — Socioeconomic Status and Health

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The article by Mackenbach et al. in this issue of the *Journal*¹ documents the extraordinary pervasiveness of socioeconomic inequalities in health as well as the varying magnitude of risks among countries. The compilation of data from western and eastern European countries on mortality, morbidity, smoking, and obesity in relation to socioeconomic status allows the authors to provide the broadest international portrait to date of the association between socioeconomic status and health. The link between socioeconomic disadvantage and poor health has been observed repeatedly,² but until now we have lacked data that would permit us to make consistent comparisons of these linkages across many countries. Comparisons among countries invite us to examine the features that are shared from country to country that contribute to the overall patterns of disease, as well as to explore the unique features of a nation that contribute to variability in the magnitude of the risks across countries. Mackenbach et al. provide us with a comparative inter-country study that harmonizes data and analytic approaches, allowing reasonable comparisons. The results are provocative for what they tell us, as well as for what they do not tell us.

First, the results show that in all 16 countries with mortality data, socioeconomically disadvantaged men and women had higher overall mortality rates than did persons with a higher socioeconomic status. The universal link between social class and mortality seems remarkable, given the

differing disease prevalence and risk factors in these countries. Moreover, relationships between class and mortality are consistent for almost every cause of death, with only a few exceptions, notably certain cancers.

Second, the study clearly shows that the magnitude of risks varies substantially across countries. The ratio in overall mortality rates between those at opposite ends of the socioeconomic spectrum ranged from just over 1.0 (women in Basque country) to nearly 5.0 (men in the Czech Republic). In many instances, the patterns of variation are not easy to explain. For example, the risk of death according to class in Nordic countries is greater than that in southern Europe, despite welfare policies in the north, particularly for the most disadvantaged persons, that are aimed at reducing socioeconomic differences. In the United States, socioeconomic conditions are usually most strongly related to the risk of cardiovascular disease, yet in countries such as France and Italy, socioeconomic conditions are more strongly related to the risk of cancer than to the risk of cardiovascular disease. Socioeconomic status as it relates to differences in rates of smoking also does not appear to explain differences in mortality from causes generally attributable to smoking (e.g., chronic obstructive pulmonary disease and various cancers). For example, in Hungary, differences in rates of smoking according to socioeconomic status are very small, whereas dif-

ferences in mortality according to socioeconomic status for conditions related to smoking are large.

Finally, the study shows that among men and women in lower socioeconomic positions, the proportion of excess deaths related to diseases that are potentially amenable to medical intervention was strikingly low. This proportion was somewhat higher in eastern European countries, but no more than 10% in any country. Although one could argue that the list of medical conditions identified as potentially amenable to medical intervention was too restricted, the findings are consistent with those of previous studies.³ In the United States we have very few examples of health care interventions that have reduced disparities in health care, not to mention health.⁴

There are limits to the sort of broad epidemiologic investigation represented by Mackenbach et al. The data do not tell us much about what is causing socioeconomic disparities in health or what we can do about them. The next phase of comparative work in this area must focus more systematically on characteristics at the country level, including social and economic policies as well as demographic, environmental, social, and cultural differences that could explain the patterning of health. Building on health outcomes from 22 countries, as opposed to 2 or 3, better enables us to examine specific country-level characteristics to understand what shapes the magnitude of health disparities across countries. Both absolute and relative risks are critical to consider, since some country-level strategies may focus on improving health for all citizens and other strategies may focus on reducing socioeconomic disparities in outcomes.

Judging from the results of Mackenbach et al., policies related to preventive social, economic, and behavioral interventions might well have a greater effect on reducing disparities than traditional medical interventions, even if as an unintended by-product.

The need to focus on non-health care interventions is also in line with the 1998 Acheson report in Britain⁵ and the World Health Organization (WHO) Commission on Social Determinants of Health. The Acheson report proposed 39 different policy strategies aimed at improving health, especially the health of disadvantaged persons; only 3 of the 39 were based on traditional medical care.⁶ Others addressed policies in areas such

as poverty and income, education, unemployment, housing, transportation, the environment (including pollution), and nutrition. The WHO report is not yet complete but is likely to propose a complementary set of recommendations.^{7,8}

The article by Mackenbach et al. also helps frame the debate around health and health care in the upcoming presidential elections in the United States. Thus far, the presidential candidates have focused largely on health insurance and health care as the way to improve health, especially for the most disadvantaged citizens. Almost all the countries examined by Mackenbach et al. have some kind of national health insurance or health care policy, yet wide socioeconomic disparities in health persist in each of these countries. Although national health coverage is important for many reasons, we should not count on it to reduce more than a small part of the socioeconomic, racial, and ethnic disparities we see in the United States. We will need additional and broader policy changes to reduce disparities and improve the health of the population.

As we continue to look for ways to reduce socioeconomic differences in health, we must face the reality that there will be no magic bullet. Disparities in socioeconomic status result from numerous risk factors and differential access to a broad range of resources. Socioeconomic inequalities in health are ubiquitous and yet highly variable. Our challenge now is to identify conditions at the country level that produce large risks and social policies that can remedy them.

No potential conflict of interest relevant to this article was reported.

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