Population Europe

Demographic Insights

HEALTH & ECONOMY

On average, Europeans can expect increasingly long and healthy lives. Yet some countries have significantly higher mortality rates than others, and in many countries health is distributed very unevenly across society. And whilst economic factors play an important role there is no simple causal relationship. Recent research helps to disentangle the complex connection between health and money. Find some of it here and more on our website: www.population-europe.eu.

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Persistent Inequalities

Five questions for demographer Pekka Martikainen

Where do we find the largest health inequalities: between countries, between men and women, or between rich and poor?

All of these three dimensions of health inequalities have been really persistent in western European countries over the last 100 years or so. The differences between the rich and poor in the same country but also between countries are easily 5 years and in some cases up to 10 years in life expectancy. That is equivalent to being a lifelong smoker in comparison with a lifelong non-smoker – so these are large and significant mortality differences. Those countries that have good and detailed data can see that there is actually a tendency of these social differences increasing rather than decreasing over time.

Is low household income a cause of bad health?

I would say that the association goes both ways, particularly at working age. If people have to leave the labour market and enter disability retirement because of health problems they receive lower incomes, and the same applies to unemployment to some extent. People with low incomes tend to be also those least educated, and it is education and the skills and knowledge that education brings that is at least partially behind the income-health association. However, income does provide individuals with significant health promoting resources and when mortality is studied the causal effects of income appear to be particularly strong for mortality from accidental and violent causes.

Income inequalities are on the rise in many European countries. Will this automatically result in increasing inequalities in health?

There does not seem to be an easy and straightforward relationship: In Finland for example, like in many other high-income countries, the restructuring of the welfare state and changes in the economy have been driving increasing income inequalities since the 90s. But the social inequalities in mortality had already increased 10 to 15 years before that; they increased particularly rapidly in the 80s.

Where could policies intervene?

There is still a lack of research in that area, but there are also certain disappointments, or unintended consequences of many policies: When new interventions are introduced and they are not specifically targeted to those of lower social standing, the people who benefit the most are normally those who need it the least: the well educated and wealthy. A more positive view of this is that they are the forerunners of healthy behavioural change and later other segments of the population might follow.

Are there any "best practice" countries you can name?

Social inequalities in mortality are much smaller in some of the southern European countries like Italy. One of the big reasons for that is the much smaller social differences in cardiovascular diseases. That appears to be due to smaller differences in healthy diets and smoking. But this is more likely to reflect the long-term historical development of the smoking epidemic and long established dietary traditions, rather than a policy or intervention that has been devised to achieve this.

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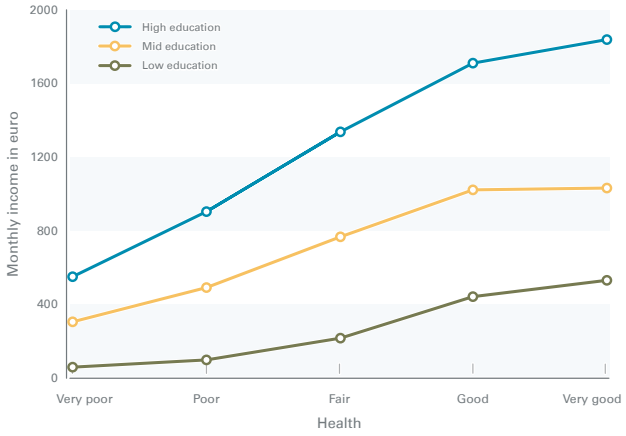
Poor Health is Expensive

Economic costs of health inequalities in the European Union are substantial, says a new study by Johan P. Mackenbach and others. Persons with 'very good' or 'good' health have about four times higher earnings than those with 'poor' and 'very poor' health (figure 1). The main cause of lower earnings among those with poor health is their lower labour force participation: People with 'very poor' health are about two times less likely to participate in the labour force than those with 'very good' health.



Source 5th Wave of the European Community Household Panel
Graphics Population Europe

Figure 1. Large differences in the level of personal earnings according to the general health of people

How much does it cost when health problems cause part of the population to be less likely to be productive and engage in labour activities? Such estimates of inequality-related losses to health as a 'capital good' seem to be modest in relative terms (1.4% of gross domestic product (GDP) each year), but are already large in absolute terms (€141 billion).

In addition, health directly contributes to an individual's happiness and satisfaction, given that a good health status enables the enjoyment of work and leisure activities. Valuing health as such ('consumption good'), the monetary value of health inequality-related welfare losses is estimated to be €980 billion per year or 9.4% of GDP. These losses account for 15% of the total costs of social security systems (e.g. unemployment and disability benefits) and 20% of the total costs of healthcare systems (e.g. physician and hospital services).

The authors emphasise that all the estimates represent only yearly values. As long as health inequalities persist, losses will continue to accumulate over the years. Although the estimates should be seen as a first attempt and are surrounded by considerable uncertainty, the results suggest that the economic costs of health inequalities are substantial and, if confirmed in further studies, should warrant significant investments in policies and interventions to reduce them.

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22.2 more years without activity restrictions: Swiss women can expect this on average at age 50, while Polish women can look forward to only half as many healthy years of life, namely 11.1 years. This is only one of the substantial inequalities in a range of health expectancies between European countries that Carol Jagger and colleagues found in a recent study. The results also suggest that countries with the longest life expectancies were not necessarily those with the most years of health. Therefore a better understanding of different measures and of the progression from disease to disability is essential for setting health priorities in ageing societies.

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Behind the Mortality Crisis

For more than 20 years mortality in the post-communist region has been much higher than in the rest of Europe. This mortality crisis is most frequently related to either excessive alcohol consumption or stress, and it is often restricted to the male population. Sunnee Billingsley provides new insights and shows that the mortality developments in the Eastern Bloc countries can be well explained by economic context.

She argues that following the post-communist countries' mortality trajectories from 1990 to 2003, three clusters can be identified: The first group of countries is situated in the farthest west, where the economy is doing relatively well. There only a very small increase in mortality for a very short period of time was reported. The second cluster comprises countries that are located on the periphery of the former Soviet Union. These countries experienced more severe increases in mortality for a longer period, yet these increases are still relatively short when compared to the third cluster. The last cluster includes Russia and its closest neighbours. These countries with difficult economic conditions recorded a spectacular increase in mortality rates immediately after the start of the transition period. Furthermore, some of these countries either saved a second crisis later in the 90s or their mortality rates did not decline to pre-transition levels in the studied period.

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Event Report

Healthy ageing and policy strategies to support it were the topics of the conference "Long Live Europe - Demographic Prospects for Europe in the Next Decades" organised by Population Europe and Charles University Prague. One important message was that governments need to be better informed about health and quality of life of the elderly, about their limitations and chronic illnesses. The online conference report provides an overview of the key issues discussed.

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