Beyond health inequalities

Complex inequality concerns us all

Raad
Volksgezondheid
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Beyond health inequalities

Complex inequality concerns us all

De Council for Public Health & Society (RVS) inspires and advises about how we can live & care in tomorrow’s world.

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Publication 2020-03
ISBN: 978-90-5732-292-1
© Raad voor Volksgezondheid en Samenleving
Den Haag, 2020

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Table of Content

Introduction **6**

1 Complex inequality **8**

1.1 A broader view 9

2 Historical breakthroughs: focus on society **10**

2.1 First breakthrough: urban hygiene 10

2.2 Second breakthrough: social legislation, starting with industrialisation 10

2.3 The emergence of the welfare state 11

2.4 Third breakthrough: education 11

2.5 What can we learn from this? 11

3 The recent past: focus on the individual **12**

3.1 Inequality in housing and living environment 12

3.2 Problems stacking up 13

3.3 Air quality and green spaces 13

3.4 Inequality in social security 13

3.5 Income insecurity 14

3.6 Insecure housing 14

3.7 A large group of precarious people 14

3.8 Inequality in education 15

3.9 Diploma inflation 15

3.10 Performance pressure 15

3.11 Inequality through equal treatment 16

4 A broader perspective than SEGV **17**

4.1 Basic principles for a new approach 17

4.2 A new contribution to history 17

5 Potential breakthroughs **19**

5.1 Living environment 19

5.2 Social security 19

5.3 The mental resilience of society 20

5.4 Education as a driving force 20

6 A final note **21**

6.1 We ask you to please think along about the following: 21

6.2 Join the discussion 21

Literatuurlijst **22**

Introduction

We are all living in good health for longer than ever before. What's more, we are increasingly able to diagnose and treat disease, even when highly complex care is needed. One might consider this an excellent result.

At the same time, our society has considerable inequalities when it comes to health. These differences have increased rather than decreased in recent decades, in the Netherlands and in other Western countries alike. On average, people with a high income and a high level of education not only live longer, but also longer in good health than people with a low income and a low level of education.[1]

We refer to these differences as 'socio-economic disparities in health' (in Dutch: SEGV). However, health inequalities are not only caused by socio-economic inequality. In reality, the underlying inequality is much more complex and often transcends any individual possibilities to influence it. Until we address this complex inequality, we will not be able to successfully tackle this issue, with all the social consequences and costs this entails. In addition to being unfair for individuals, causing higher health care expenditure and reducing labour participation, this also puts pressure on society's human and social capital. Moreover, such inequality places a burden on social resilience – our society's ability to (proportionally) absorb blows – and our prosperity, in an economic sense and in terms of welfare and happiness.

The Council for Public Health & Society (RVS) states that current national policy is too one-sidedly focused on the individual. In addition, a broader perspective is needed if we want to actively reduce health inequalities and any related disadvantages. Through this essay, we aim to explore this broader perspective, together with you.

Current Policy

There is currently a great deal of attention for health inequalities.[2] The central mission of the Knowledge and Innovation Agenda for the Life Sciences & Health top sector, for example, states that 'by 2040, [...] health inequalities between the lowest and highest socio-economic groups will have decreased by 30%'.[3] This begs the question of whether we will achieve this goal if we (only) continue the current policy?

In recent decades, a great deal of policy has been developed at the local and national level, aimed at reducing health inequalities. Particularly at the national level, this policy has been i) strongly focused on individuals, ii) primarily based on a medical perspective and iii) based on the belief that more knowledge, or the provision of more information, will lead to changes in individual behaviours and lifestyles.[4]

In addition, support for a broader perspective on health inequalities has also slowly grown in recent years, among scientists and health promoters, but also among policymakers. Particularly at the local level, there has been interest in a broader approach to health inequalities that seeks the link with, for example, welfare, housing, the living environment and education. This is also reflected in the National Health Policy Memorandum 2020 - 2024, as drafted by the Ministry of Health, Welfare and Sport in collaboration with municipalities. Unlike previous memorandums, this memorandum pays much more attention to various determinants of health. It proposes a cross-domain agenda with a strong focus on knowledge development,[5] including the explicit ambition to reduce health inequalities. Embracing concepts such as positive health [6] and attention for the living environment should be welcomed. At the same time, we note that the interventions mentioned in the memorandum continue to be mostly focused on the individual and that individual lifestyle is heavily emphasised.

Despite all the efforts of the past decades, reducing health inequalities has proved impossible.[7] In 2018, the Scientific Council for Government Policy (WRR) found that while general measures lead to health gains, those at the top of the social ladder benefited more from these gains than those at the bottom. As a result, the inequalities between groups are barely diminishing and are, in fact, more likely to increase in several areas.[8]

This type of track record begs the question as to whether current policy is focusing on the right issues. Has the term 'socio-economic disparities in health' inadvertently narrowed our understanding of the issue and blinded us to the root causes behind this inequality?

In this essay, the RVS tries to find different ways to turn the tide. To this end, we start by examining the underlying causes that perpetuate health inequalities. Next, we turn our attention to historical breakthroughs that have yielded enormous health gains. And we aim to learn lessons from the more recent past. Finally, we invite you to think about potential breakthroughs that are possible in this day and age to reduce the complex inequalities behind health inequalities.

1 Complex inequality

The reality behind health inequalities is highly complex. First of all, because we cannot narrow it down to socio-economic factors alone: people with a high socio-economic status who watch their social network crumble may become lonely and, as a result, fall ill. Secondly, because it concerns an interaction between different factors: inequality in education, the labour market, social security, the living environment, health and social relationships do not stand alone; they affect each other, sometimes in a negative, but sometimes also in a positive sense. Thirdly, because the issue involves a correlation of factors over a long period: inequalities do not come about overnight, and often result from an accumulation of problems during the course of someone's life.[9]

The fact that health is unevenly distributed across the population is, in part, inevitable. Not every person has the same starting position at birth, because people are genetically, biologically and psychologically different from one another. On top of this, there are also social differences. The mere difference between being male or female already affects your health: women live longer but are often less healthy than men. This is not only due to biological differences between the sexes, but also to the fact that men and women are culturally, economically and socially different, or are treated differently.[10]

Besides biological factors, people's health is largely determined by the circumstances in which they are born, grow up, live and work. All these factors have traditionally not been part of the health domain, and not everyone can influence or take responsibility for these factors to the same extent. What makes this so complex, is that it often involves an accumulation and interaction of issues, such as a combination of job insecurity and precarious housing, debts and an unstable family situation, low literacy and a migration background, or a history of migration combined with discrimination.[11] As Jet Bussemaker, chair of the RVS and a professor at Leiden University, said in her inaugural lecture: "health care is therefore also a social issue, not just a medical one".[12] The more people are confronted with an accumulation of problems, which also affect each other, the lower the ability to remedy them on their own, and the greater the effect on health.[13]

What makes this so complex, is that it often involves an accumulation and interaction of issues.

Poor health reduces the chances of employment, and unemployment can affect health.[14] Unemployment and long-term poverty, for example, may lead to debts.[15] As the WRR report *Weten is nog geen doen* (2017) (Knowing is not the same as doing) shows, this may result in people having difficulty adhering to advice, regulations and rules, which in turn may lead to new problems.[16] Poor and insecure housing increases stress and may lead to tension within the family setting. Living next to a motorway causes lung problems.[17] Feelings of insecurity increase the risk of anxiety, mistrust, loneliness and social isolation. Such an accumulation of factors often leads to chronic stress, which increases the risk of cardiovascular disease, diabetes and depression. Moreover, chronic insecurity and stress also affect cognitive abilities and skills to deal with problems, and thus also people's lifestyles.[18]

The reasons why people end up in this type of negative spiral vary widely: from birth to migration, from making bad choices to simple bad luck, and from unwillingness to force majeure or a lack of the necessary mental or physical resilience. Once someone is trapped in a downwards spiral, social marginalisation may be enhanced by the shrinking of one's social network and other available resources. People get stuck in choice stress, withdrawal behaviour, inaction and even social isolation. The Netherlands Institute for Social Research (SCP) calculated in 2014 that more than a quarter of the Dutch population are among the 'laggards' or 'insecure workers'. They have relatively limited resources available, including social and cultural capital.[19] As a result, complex inequality is a social problem that affects collective resilience; a part of the population is falling behind in various areas.

We conclude that for a substantial group, health inequalities are the result of a reality in which various factors stack up and become intertwined. In fact, focusing national policy mainly on individual lifestyle and behaviour mainly treats the symptom and not the disease, to put it bluntly. Just as we have learned in welfare work to examine the question behind the question, we need to examine the causes of the causes when it comes to health inequalities.[20]

1.1 A broader view

Over the last few decades, a certain paradox has crept into our thinking about socio-economic disparities in health. Over time, the indicator we use to visualise vulnerable groups and complex issues has become the explanation of the problem as well as the direction for the solution. That is: the socio-economic status (SES), which is often measured based on education level, income or professional status, is a good predictor of inequalities in (perceived) health. However, it has also led to a narrowing of the approach in many areas. This approach is currently mainly aimed at compensating for a lack of knowledge by providing information, boosting individual skills, and promoting individual healthy behaviour. Although this is good, it is not enough to achieve the set health goals. This realisation is increasingly gaining a foothold.

If we want to tackle health inequalities at the core, a broader view of the resilience of society will be needed to complement existing policies. It is worth remembering that we are currently seeing the results of what happened years ago rather than what is happening now. It is like stargazing: what we are currently observing in terms of health inequalities is partly the result of policy that was initiated years – sometimes decades – ago.[21] This effect also adds to the complexity. In our quest for a broader approach, we ask ourselves the following question:

What can society do to break through the complex inequality behind health inequalities?

2 Historical breakthroughs: focus on society

From a historical perspective, we note that three significant breakthroughs in public health – and, as an indirect consequence, health inequalities – happened outside the scope of individual medical care. The common denominator of these measures was that they were focused primarily on *collective* problems and, initially, mainly on improving citizens' physical and social working and living environment. As a result, individual medical problems were, as it were, included in the approach to significant social issues, which created a kick-start for change.

The steady economic growth as a result of industrialisation also plays a role in this regard. Greater prosperity benefits our health. When this happens, more money becomes available at both the collective and individual level to invest in, for example, improved hygiene, but also in better housing, nutrition, education, occupational safety and health care. Incidentally, this also works the other way around: improvements in public health often lead to higher economic growth as well.[22]

2.1 First breakthrough: urban hygiene

The rise of urban hygiene in the second half of the nineteenth century was the first breakthrough. Epidemics such as dysentery and cholera brought about a debate about what caused them. As a result, a group of a group of people known as hygienists emerged. They aimed for comprehensive public health reform and focused their attention mainly on issues such as sewerage, drinking water supply and public housing. A number of enterprising engineers, physicians and city administrators with radical plans for urban hygiene followed in their wake: Virchow in Berlin, Von Pettenkofer in Munich, Villermé and Parent-Duchâtelet in Paris, Sarphati and Liernur in Amsterdam, Shattuck in Boston and Chadwick in London.[23]

The focus on urban hygiene proved to be successful. The sewerage system, waste disposal and sanitary facilities and fresh drinking water that were introduced in ever more Dutch cities around 1880 marked the beginning of public health care and were increasingly seen as broad social undertakings rather than humanitarian policy for the poor. After all, simply moving to better neighbourhoods did not protect the wealthier class from disease because cholera did not respect physical or social boundaries. This resulted in the introduction of a new way of thinking: "The physician heals the people one at a time, the legislator by the millions," Bentham said around 1770.[24] Or, in the words of Virchow in the revolutionary year 1848: 'Politics is nothing more than medicine on a large scale'.[25]

2.2 Second breakthrough: social legislation, starting with industrialisation

The development of the first social laws in the late nineteenth and early twentieth centuries was a second significant breakthrough. The industrialisation of the Netherlands, starting in 1870, was accompanied by deteriorating working and living conditions and increasing social tensions. Workers and their children, who often also worked in the factory, were much more likely to die than their bosses, whether or not as a direct result of their labour.[26] Pressure on the government to intervene was growing. Slowly, the realisation dawned that the risks associated with industrialisation should not be dismissed as individual risks. At the time, this was referred to as the 'social question', a matter of collective importance.[27] Partly under pressure from emerging socialism, support for collective policy measures that regulated housing, working hours and working conditions and was meant to protect workers against the income consequences of accidents at work, (temporary) disability, unemployment and illness was growing gradually. Simultaneously, it was also simply a matter of 'enlightened self-interest' of the ruling elite: a collective approach was required to prevent the indirect consequences of shortages or setbacks (bad luck) of one part of society from spilling over to society as a whole.[28]

Between 1871 and 1930, the average life expectancy at birth in the Netherlands went from under 40 years to 65 years,[29] This was partly due to a decline in the infant mortality rate among the poorer sections of the population, and as a result of improved urban hygiene, better nutrition and clean drinking water.[30] The life expectancy of the elderly also improved, however. Whilst being unable or no longer able to work due to old

age or disability still had far-reaching consequences at the start of the twentieth century, a better social safety net was now available.[31]

2.3 The emergence of the welfare state

This development continued in the 1950s. Right after World War II, political stability and social peace were required for the reconstruction of society. This resulted in support for further intervention in personal areas of life such as health, income, housing and education. Pleas were made for the government to actively interfere in the lives of citizens. Little by little, the welfare state was established 'from the cradle to the grave'.[32] During the German occupation (1941), compulsory social health insurance was introduced for people with an average or below-average income.[33] Thanks to the introduction of the *Old Age Pensions Act* (AOW), poverty among the elderly decreased. The *General Social Security Act* (ABW) marked a turning point for the entire population in the fight against poverty. In addition, the *Exceptional Medical Expenses Act* (AWBZ), made it possible to claim long-term care outside of the traditional frameworks of the family or care for the poor. Moreover, the increase in prosperity also translated into better housing, improved food quality and more room for education.[34] The collective approach to housing, working, learning and improvements in health care and its accessibility led to tremendous health gains and reduced health inequalities.

2.4 Third breakthrough: education

In the same period, education further reduced social inequality. For the generation born after World War II, dropping out of primary school was the exception rather than the rule. As a result, education became the emancipation machine par excellence[35], and the number of highly educated people has been increasing ever since. In turn, this led to rising levels of prosperity and unprecedented social mobility. Whereas in the early 1970s, only 8% of the population was highly educated, currently 30% of the Netherlands' population is highly educated. In the age category of 30 to 35, this amounts to an impressive 49%.[36] In short: increased life expectancy since 1970 has coincided with an increase in the population's education level.

The relationship between life expectancy, health gains, health inequalities and educational levels is a subject of scientific debate.[37] Nevertheless, recent research by epidemiologists and health economists such as Kaplan, Lutz, Luy, Montez and Friedman increasingly shows that improving education levels leads to health gains, both at the individual and the population level. After all, education permanently improves cognitive capabilities as well as control over one's life. In turn, this results in greater prosperity and rising life expectancy.[38]

2.5 What can we learn from this?

These three breakthroughs teach us that some interventions in the past have improved people's health and life expectancy by leaps and bounds, even if doing so was by no means always the primary goal. These interventions were applied in the interest of society as a whole. More specifically,

↳ Breakthroughs in reducing health inequalities can also arise as a side effect of tackling social issues.

3 The recent past: focus on the individual

When we examine the more recent past, we see that thinking in terms of socio-economic disparities in health emerged in the early 1980s. Until then, socio-economic disparities in health in Dutch health policy had been a non-issue.[39] The *Black Report*, released in the United Kingdom in 1980, changed that. This report unequivocally demonstrated that health was unevenly distributed across the British population. Despite the creation of the *National Health Service* (NHS) in 1948, the differences were found to be widening rather than narrowing. The main conclusion was that health was determined by social inequalities in income, housing, education level and working conditions.[40]

In 1985, the *Nota 2000* was published in the Netherlands. For the first time in the Netherlands, socio-economic disparities in health were receiving the necessary attention. However, despite the subsequent decades of interventions and policies in this area, health inequalities have not been reduced. While it is true that in terms of absolute health, everyone made gains, the policy goal of reducing health inequalities was not achieved. On the contrary, in the following years, they appeared to grow.[41] Therefore, if we want to understand what is currently happening with health inequalities, we must examine what has happened in society since the publication of the *Nota 2000*.

- First of all, inequality regarding housing and the living environment has been increasing since the 1980s.
- Secondly, changes in the labour market and in the provisions of the welfare state affect the workers' position.
- Thirdly, thinking in terms of one's own merits affects the emancipatory power of education in the Netherlands. The focus of national policy *and* society as a whole increasingly shifted towards individual responsibility, as explained below.

3.1 Inequality in housing and living environment

Many cities have benefited from the economic growth of the 1990s and 2000s. Run-down neighbourhoods were gentrified, and investments were once again made in public transport, green spaces and other facilities. Several cities almost literally revived and became attractive to outsiders. The PBL study *De Verdeelde Triomf* (The Divided Triumph) (2016) made it clear that technological progress, agglomeration advantages and globalisation have resulted in significant growth, particularly in the larger urban regions (the Randstad, but also Eindhoven, Groningen and Arnhem, for example), specifically for highly educated people. However, this growth did not automatically lead to a growth in the number of lower-paid jobs or job prospects for the unemployed.[42]

In addition, impoverishment in social housing and the increasing housing shortage, 'skewed' housing, rising rents, falling rent subsidies and investment activities in the housing market have made living in the city more difficult for certain groups.[43] Initially, these groups moved to the outskirts of the city and then increasingly away from the city. This movement resulted in neighbourhoods and municipalities in which a disproportionately large number of people with similar social positions live and where housing and recreation and public facilities are often of lesser quality. The Education Inspectorate often labels schools in these areas as weak to very weak.[44] This affects not only those neighbourhoods where problems threaten to accumulate but also the city itself.

In cities like Utrecht and Amsterdam, staff shortages in the police force, childcare, education and the care sector are linked to the housing shortage. In Amsterdam, for example, 20% of the population has an average income, while only 7% of the available housing is intended for this group.[45] For some, living in suburban areas is a conscious choice: they will happily trade in a shorter commute for a larger house with a garden, for example. For others, this is an enforced rather than a conscious choice: a home inside the Amsterdam ring road is not always a viable option for a nurse, teacher or bus driver with a family.[46] Moreover, these phenomena are reinforced by a regional shrinkage on the outskirts of the Netherlands that have seen a brain drain of highly educated young people who are moving towards the Randstad area and other cities.[47]

Needless to say, regional differences exist, but the increase in social and societal segregation appears to be a general phenomenon, both between and within regions. Around cities like Amsterdam and Utrecht, economic growth is steadily increasing, whilst in the provinces of Groningen and South Limburg, it is falling. As a result, the generally increasing prosperity is thus unevenly distributed across the country.[48] In the northern Netherlands, the low-paid earn less for the same work than people in the Randstad. This wage inequality can also be observed within central municipalities.[49] In combination with changes at the macro level, such as technology and globalisation, these phenomena directly impact the housing market. Rental and purchase prices are on the rise, first-time buyers get stuck, waiting times for social housing rise sharply. Subdivision of houses in large cities, shrinkage in suburban areas and (social) homogenisation of districts and neighbourhoods are taking place. All these developments have implications for personal opportunities and privacy.

3.2 Problems stacking up

The fact that ever more people with different social problems are living together in the same neighbourhood has significant effects. After years of policy being focused on disadvantaged neighbourhoods, Aedes concluded this year that the situation has only become more urgent. According to the association of housing corporations, in 10% of these neighbourhoods, time is now running out. The quality of life and the sense of safety in these neighbourhoods and districts is visibly eroding due to the increase in residents who are in a vulnerable position due to, for example, a considerable distance from the labour market, mild intellectual disabilities and psychiatric problems.[50]

There are other adverse effects, however. The neighbourhood where people are born, for example, appears to determine their educational success.[51] Health expenditure for babies and children in disadvantaged neighbourhoods can amount to EUR 1,000 per year higher on average compared with neighbourhoods in which there is no accumulation of poverty and unemployment.[52] In addition, children who grow up in multiple-problem families are more likely to develop emotional, behavioural and developmental problems. If four (interrelated) risk factors are present, i.e., poor housing conditions, poverty, divorced parents and limited structure in life or household, the odds that a child will develop problems at a later age are more than 30%.[53] If we do not act now, these people individually and society as a whole will be adversely affected within a few decades.

3.3 Air quality and green spaces

Belgian research shows that children who attend school in areas with poor air quality – often on the outskirts of cities and in the vicinity of arterial roads – achieve poorer school results.[54] More green spaces may be a solution to this issue. Municipalities such as Utrecht, Rotterdam, Amsterdam and Apeldoorn are increasingly tackling this challenge with heavy investments in the construction of more green and blue (water) spaces in the city.[55] This type of broad collective investment in the physical living environment benefits the entire urban community.

This also applies, to a much lesser extent, to well-intentioned government subsidies for the 'greening' of households. These subsidy programs generally require equity capital. The *haves* can afford it, and therefore receive the subsidies, while the *have nots* don't. As a result, any 'profit' from 'greening' is not evenly distributed.[56] CE Delft, a research agency, calculated (2017) that out of EUR 750 million in subsidies and tax benefits, only one fifth made its way to poorer households. This type of subsidy unintentionally widens the gap between the '*greens*' and '*green nots*',[57] a gap that may potentially only widen. After all, sustainable behaviour is often learned behaviour and depends on the level of education. The lower educated, for example, have less confidence in tackling the climate problem than the higher educated. Conscious choices at the checkout are also made more often by higher educated people and young people.[58] It is not without reason that Kim Putters, director of the SCP, warned that the sustainability issue has grown into a social issue.[59]

3.4 Inequality in social security

Initially, collective insurance protected workers against poverty, illness, incapacity for work and (temporary) disability, thus ensuring income security and social stability. Over time, the nature of these measures has changed. Since the 1980s, much has changed in the labour market: there has been a revolutionary increase in the number of women who work; not everyone stays with the same company for a lifetime; part-time work,

self-employment and flexible work – sometimes by choice, sometimes through lack of other perspectives – have boomed.

At the same time, the government has taken a step back in many social domains, public services have been liberalised or privatised, and the focus has shifted to citizens' individual responsibility. Affordability, legitimacy, efficiency and freedom of choice have become important political ambitions.[60] As a result, individual citizens' expectations were raised, including in relation to social services.[61] The fact that government services were increasingly defined as a product, with citizens as customers or consumers, illustrates this. Risks related to income, work and health were linked more closely to individual responsibility and freedom of choice than before. This has resulted in technically detailed but complex facilities, which not everyone knows how to navigate. The consequences include vulnerable young people missing out on youth care, calls for less complex care for the elderly, and increasing waiting lists for people who need complex mental health care.

3.5 Income insecurity

The labour market has become exceedingly flexible in recent years. In no uncertain terms, the Borstlap Committee recently called this 'a new social issue'.[62] According to the Committee, the rise of flexible work has created a new gap, whereby the highly educated enjoy greater income security than the less educated. Together, employees with a flexible employment relationship and the self-employed amount to 3 million flex workers in the Netherlands, or 34% of the working population.[63] This undermines the emancipatory power of labour for a large proportion of the Dutch people and reinforces social dividing lines. The value of labour is declining in social as well as economic terms. By way of example: 25% of freelancers report that they became self-employed out of necessity. They are unable to find a salaried job, which means that many of the rights acquired in recent decades, such as pension accrual, work and care arrangements, unemployment benefits and holiday pay, are not available to them. As a result, different groups feel protected to a different degree. Moreover, not everyone is equally resilient. Regarding the ageing of the knowledge required to practise a profession, the Borstlap Committee states that this should not be an individual risk by definition.

3.6 Insecure housing

Nibud figures (2019) highlight that 50% of tenants in the Netherlands struggle to make ends meet, 40% experience financial scarcity, and 30% have payment arrears. Approximately 30% of tenants in the private sector live in a house that is too expensive given their financial situation. A quarter of tenants, or 800,000 households, have insufficient means to support themselves. This mainly concerns people who live in social housing, singles and tenants between the ages of 25 and 45.[64] In a financial sense, this makes their housing situation permanently vulnerable. In our report 'Recovery starts with a house' (2020), we note that the number of homeless people has doubled in the last decade and that the cliché image of the vagabond no longer holds true. Increasingly, they are people who run into problems after a life event, who see their social network depleted and only then turn to social relief. They are only the tip of the iceberg, however. In the year 2020, we know that a precarious living situation and an uncertain income situation have a significant negative effect on people's physical and mental health.[65]

3.7 A large group of precarious people

As mentioned earlier, more than 25% of Dutch people experience far-reaching problems in various areas of life. The SCP concludes that this group lacks personal, cultural, economic and social capital. More specifically: they have no informal support network, no stable living situation, no work or daytime activities, they are low-educated, often insecure and have insufficient financial resources. In addition, they are dealing with poor physical or mental health.[66] They live with permanent uncertainty about their future, which entails chronic stress and other health problems. The disappearance of stability in social security heralds a decline in health for them.

More than 25% of Dutch people experience far-reaching problems in various areas of life.

3.8 Inequality in education

Recent decades have seen the development of a strong belief in a meritocratic society in which social position is mainly determined by one's own merits, or one's individual knowledge and skills. While this view is obviously not wrong in and of itself, there is a risk that it might reduce a person's socio-economic position to a purely personal achievement *or* failure.[67] It is very doubtful whether this is true. The report *High-quality education with opportunities for all* (2020) shows that the family, street, neighbourhood and environment in which a child grows up *also* significantly contribute to their success later in life. As an individual, people do not (always) have control over these factors. The considerable pressure of diplomas and increasing social segregation – reinforced by the threat of teacher shortages – are leading to increasing inequality in educational opportunities. Here again, the effects are mutually reinforcing; schools in districts with many problems have more trouble finding good teachers. Children from families with limited work experience have more difficulty in making good school and career choices, and are more likely to drop out of school.[68]

Families with higher-educated and higher-income parents will try to compensate for possible shortcomings in mainstream education outside the school. Expenditure on shadow education (e.g. tutoring, study coaching, homework supervision, exam training, etc.) has increased sharply in recent years: from approximately EUR 30 million in 1995 to nearly EUR 200 million in 2016.[69] This increases inequality in educational opportunities.

The cited causes for this increase are diverse and, again, point to an underlying complexity: of general social segregation, alleged lack of quality, overly large classes and insufficient customisation, increased competition and pressure to perform (leading to people trying to achieve higher grades through tutoring) to the use of shadow education as extended childcare because both parents work (and can therefore afford it). One of the concerns associated with the rise of shadow education is that hidden privatisation of the public education system may lead to reduced equality of opportunity, which threatens the accessibility of education as a whole.[70]

3.9 Diploma inflation

As mentioned before, recent decades have seen a tremendous increase in the number of highly educated people, with the paradoxical effect that the value of a diploma has been reduced.[71] In other words, those who have been able to climb the social ladder en masse since the 1960s by obtaining a higher degree have reaped the most benefits. As a result of this diploma inflation, the current generation needs different levers to acquire a favourable social position.[72] A neat diploma on a CV no longer suffices, as volunteer work, internships, part-time jobs or participation in international exchanges are becoming ever more important.

In addition, there is little consideration of differences in young people's circumstances. Young people who grow up in poverty (approximately 8% of all children) or young people with poor health (more than 25% of young people up to 25 years old have a chronic condition) do not always have opportunities for 'additional' activities. It is also more difficult for young carers (approximately 6 to 8% of young people between 13 and 17 years old) to indicate what extras they can offer,[73] even though their efforts are sometimes much more meaningful than the odd additional homework course or extra-curricular activity. As a result, the contribution that education can make to health, as argued above, is not the same for everyone because educational opportunities are not evenly distributed across the population. The meritocratic ideal only tells part of the story.

3.10 Performance pressure

Pupils and students are under considerable pressure to perform well, partly as a result of diploma inflation. The RVS drew attention to this issue as early as 2018 in their essay *Overly concerned. Social expectations and mental pressure among young adults.*[74] According to a recent analysis by the RIVM, the Trimbos Institute and the Amsterdam UMC (2019), the number of young people between 12 and 25 years old suffering from mental health problems has increased compared with ten years ago[75], particularly among women. The fact that it is precisely this group that has obtained an increasingly higher level of education in recent years is no coincidence. The pressure of schoolwork experienced by young people aged between 12 and 16 has also increased sharply in recent years.[76] At primary and secondary school, the pressure to obtain a 'favourable' recommendation for follow-up education is increasing, as is the fear of making the 'wrong' study choice. For university students, more factors are at play: a combination of binding study advice, the loan system, social expectations (such as social media), combined with uncertainty about their future chances on the housing and job market. This is all in line with a broader social trend of increased pressure.

3.11 Inequality through equal treatment

Based on the constitutional principle of equality, equal cases are treated equally in the Netherlands. Treating unequal cases unequally proves more difficult, however. The welfare state is not adept at responding to differences between people. Particularly where complex issues are concerned, we see different logics of the care system clashing with each other. The result is expensive but inefficient assistance, as demonstrated by the RVS report *Complex care, easy access* (2019).[77] And this is particularly problematic when it comes to health inequalities. This is the so-called Matthew-effect: policies and measures aimed at groups with lower socio-economic status have a favourable effect on those groups due to their universal character, but an even greater positive effect on groups that are already doing well.[78] This implies that universal health policy effectively contributes to better health for everyone while also leading to greater inequality at the same time.

4 A broader perspective than SEGV

Given the complex reality behind health inequalities, the RVS thinks that the term 'socio-economic disparities in health' is now due for reconsideration. For years, a person's socio-economic status was the indicator of social inequality – income and education levels gradually became the determining factors from which other differences arose, as it were. However, in today's society, people also need skills to give direction to their lives and deal with complex problems, including finding their way in a complex society.

A look at the past teaches us that socio-economic disparities in health were most strongly reduced by approaches that affected society as a whole rather than approaches aimed at the individual or a limited group. It also teaches us that this approach was not by definition intended to reduce those disparities. Both observations confirm that the reasons why people are healthy or unhealthy go beyond purely individual behaviour or the lack of a sports field in a neighbourhood.

↳ However, in today's society, people also need skills to give direction to their lives and deal with complex problems, including finding their way in a complex society.

The broad view yields the conclusion that we need to pay more attention to interventions that are collectively focused as well as to cultural and mental aspects. As long as the focus remains on the individual, based on income and cognitive skills, the health inequalities we know today will continue to persist for a long time to come. The WRR seeks a different perspective by focusing on health potential rather than on health inequalities and asking where and with whom the greatest health gains can be achieved. Moreover, the WRR argues for a universal approach to health and health inequalities with additional attention for 'laggards'. The WRR refers to this approach as 'universal proportionalism'.[79] While this is a step forward compared with the government's traditional approach to socio-economic disparities in health, it remains confined within healthcare. As mentioned earlier, the National Health Policy Memorandum 2020 – 2024 [80] is also a step in the right direction.

The RVS wants to continue to build on this but opts for an even broader perspective in which the 'complex inequality' behind health inequalities is paramount rather than the individual, health care and prevention. We should focus on 'the causes of the causes', as the physician and epidemiologist Michael Marmot put it in 2010.[81] Focusing our attention on this inequality is more helpful and accurate in understanding, interpreting and addressing health inequalities by governments, professionals and civil society organisations than focusing on the term 'socio-economic'. When we talk about this complex inequality, we mean society as a whole, the care for all of us, which is social, societal and medical. This makes complex inequality perhaps the main social issue of our time.

4.1 Basic principles for a new approach

In conclusion of this essay, we want to explore breakthroughs that are possible today to reduce the complex inequality behind health inequalities. The stakes are broader than health alone, the policy area is broader than just healthcare, and the scope is collective rather than individual. In order to make sense of these, we start by proposing some basic principles for new, additional policy.

4.2 A new contribution to history

What we need is a breakthrough that targets the complex inequality that underlies health inequalities. Take the first historic breakthrough, for example, the provision of sewerage, waste disposal and clean drinking water benefited everyone and promoted health almost as a pleasant side effect. Recognising that complex inequalities are detrimental to our social welfare, resilience and public health is in our enlightened self-

interest as well as our common interest. Tackling this complexity is deserving of its own long-term goal. In other words, we have to look for the sewerage system of our time.

1. In this regard, policy sustainability and continuity are necessary first and foremost since the results of interventions in complex inequality only become visible years later. As recently advocated by the Social and Economic Council (SER), this policy requires a long-term vision and long-term financing as well as administrative perseverance.[82] Policymakers, particularly at the national level, should not be afraid to look beyond what one government or municipal council term can achieve. This applies to individual as well as collective interventions. Just like climate objectives, the objectives relating to Broad Prosperity, or the *Sustainable Development Goals* Knowledge and Innovation Agenda for the Life Sciences & Health Top Sector[83], we can also set objectives relating to complex inequality. This should not only be focused on reducing health inequalities per se but also on the factors that make these inequalities so persistent and culturally ingrained.

2. We also need additional policy aimed at the collective and society: policy regarding complex inequality requires cooperation across professional departments. There is a reason, after all, why social legislation managed to reduce significant inequalities in health. However, this does not mean that this policy should be left to politicians exclusively. It may be politicians who cure by the millions, but it was the physicians who discovered the cause of cholera, and it was the architects and designers who came up with the solution. In this way, we can all contribute to eliminating complex inequality: business, civil society organisations and citizens: *it takes a society to fight complex inequality*, as reflected in the notion of *health in all policies* and the Broad Prosperity Monitor. While this is a wonderful development, a *resilient society in all policies* would be even better.

3. A third aspect is that, in addition to current policy, interventions should be less focused on reducing health inequalities as a goal in themselves. Broader ambitions may indirectly have a far more positive effect. By recognising that complex inequality underlies health inequalities, we acknowledge that not only individual citizens are responsible but also society as a whole.

In recent years, we have become more aware that health is affected by a variety of factors outside the health and care domain.

5 Potential breakthroughs

We have examined the complex causes of health inequalities and learned lessons from historical breakthroughs and developments in the more recent past. *Finally, we want to invite you to join us in the search for potential breakthroughs that will actually reduce health inequalities*. We hope that you will not hesitate to think radically about this issue.

Some social and economic perspectives may appear radical because they want to make far-reaching changes to the status quo. 'Enlightened self-interest', however, can also be the guiding principle for collective measures.

And a radical breakthrough is needed: after all, how resilient can a society possibly be if a quarter of its citizens live in far-reaching uncertainty? And how resilient can the labour market be when its flexibility is considered a new social issue? How much purchasing power does a society have if a quarter of its people lives with social insecurity, while the number of very wealthy people increases? How can we facilitate a meeting of minds and social cohesion if citizens do not meet each other of their own accord? How can people thrive when problematic debt is rising year on year? Below, we make suggestions for potential breakthroughs.

5.1 Living environment

When we consider the consequences of policy that was implemented several decades ago, we note that health and the living environment are interconnected. Cleaner air and a green environment, for example, benefit all of us. Health gains can be achieved with changes in the climate and living environment at the neighbourhood, city or regional level. Incidentally, this is not necessarily achieved solely by municipalities, as showcased by the Tilburg rail park, which is one of the biggest citizens' initiatives in the country. Encouraging public-private partnerships for the design of public space transcends political interests.[84] This is why we must continue to focus on a healthy living environment that stimulates individuals and their networks to participate, meet and develop a healthy lifestyle, as indicated in the *National Health Policy Memorandum*.

The Environmental Act, which will come into effect in 2021, offers plenty of opportunity to link health to spatial planning. Moreover, numerous national, regional and local organisations, municipalities and knowledge institutions are already busy making this connection and offering inspiration.[85]

Resources available to individuals or neighbourhoods to invest in sustainability are unevenly distributed. Addressing neighbourhood issues in terms of sustainability must, therefore, go hand in hand with an approach in terms of the liveability of the neighbourhoods. This means that collective sustainability is the starting point – by analogy with the commitment to the collective improvement of public hygiene of the mid-nineteenth century. Instead of additional financial compensation for individual sustainable behaviour, governments can also choose to invest collectively in making public spaces more sustainable.

5.2 Social security

It is conceivable that new policy will promote social security in a different manner, just like the emergence of protection against labour and subsistence risks did in the early 1900s. At the moment, a person who is living on the subsistence level can, in principle, be 'assisted' by an impressive 27 income-supporting measures.[86] Whether this is the right way remains to be seen. Aren't radical ideas, such as a basic job[87] or a basic income still worth considering, particularly in view of their significance for public health? And might a reconfiguration of education not be the emancipatory force of the future once again?

Investing in citizens' social security means investing in people, society and the economy. It is not without reason that after the first social laws were passed, Pierson's liberal government came to be known as the social justice government. Perhaps this will require moving away from paradigms that have been leading for decades without managing to narrow the inequalities.

5.3 The mental resilience of society

Health inequalities weaken the sense of solidarity and, as a result, the resilience of society. Only a resilient society is able to absorb blows. Rather than focusing on care, we could – by analogy with the importance of education after World War II – give welfare and youth work, sports clubs and other social organisations a more prominent role, in addition to education, in developing the mental resilience of society.

During their school years, children build up mental resilience that helps them find their way in a complex society. At the next stage, the focus will be less on cognitive skills and more on relational and reflective skills. In addition to putting educational inequalities in a different light, this also affects health inequalities: the dividing lines that mental health problems entail, and how collective resources are distributed. But here, too, the key is not education alone. Focusing on sports, welfare initiatives tailored to the neighbourhood, creating informal social networks and encouraging citizen participation must also be done with the aim of promoting collective mental resilience.[88]

Before such a vista can come any closer, we will have to accept that unequal cases are, in some respects, deserving of unequal treatment. This entails customisation, whereby the individual needs rather than protocols should be the guideline. This means that we do not prescribe medicines for everyone with the same symptoms but examine how, for example, social networks can take on the role of medicine. Initiatives to this end already exist (such as *Welfare on prescription* [89]), and their principles deserve to be widely implemented. This means that we do not depart from the question of what someone is entitled to or which *evidence-based* treatment is applied to this group, but rather from the question of what a person needs. In other words: sustainable investment in people, not with a view to improving the present situation, but rather to offer perspective in the future. In a nutshell, this means investing in the causes of problems, not in eliminating symptoms.

5.4 Education as a driving force

A new approach should, therefore, focus on a different way of living together: it should no longer be about how we can live together within the current situation, but about how we want to live together, now and in the future. The starting point is then learning to collaborate across and in connection with domains: art and science or healthcare and technology, for example. In addition to gathering knowledge, we should also create room for imagination. A meeting of the minds is essential in this regard, between different disciplines, different generations, different world views and different social classes.

Although education was the engine of emancipation par excellence of the twentieth century, that engine appears to have come to a standstill. Equality and inequality of opportunity now appear to be the accidental result of an education system whose core task is to impart knowledge. Equality of opportunity should be an essential part of education, however. This requires a balance between the transfer of knowledge, connection and *Bildung* in education, as well as a reappraisal of craftsmanship and practical skills, e.g. manual labour. And sometimes, it may also require a certain way of changing structures, for example, when early selection impedes talent development. The *capability approach* offers inspiration to depart from the possibilities of the individual student: what a person can do, rather than what they cannot do. Doing so promotes self-confidence and resilience in young people, which in turn benefits society. Just like offering access to education for all and the abolition of child labour in the past brought much to us all: equality and dignity first.

6 A final note

With this essay, we want to invite you to think along with us about the complex inequality that underlies health inequalities and find potential breakthroughs to reduce those inequalities. For this approach, we encourage learning lessons from historical breakthroughs and taking a broader view. We consider this a starting point for a reconsideration of the current narrow focus. As far as the RVS is concerned, the question is what type of society we want in the long term and how we want to shape it. This is not only a task for politicians but also for society as a whole, including you. The central question of this essay has been: what can society do to break through the complex inequality that underlies health inequalities? So, it is also up to you.

6.1 We ask you to please think along about the following:

By examining historical breakthroughs, we have demonstrated that reducing health inequalities was often not a goal in itself. In fact, decades of policy that was explicitly aimed at reducing socio-economic disparities in health have not managed to reduce the problem. This convinced us to start writing this essay; this is our 'why'. *In your opinion, why should or should we not drop the term socio-economic disparities in health?*

The logical next step is 'how'. Just as we increasingly see the use of indicators other than the gross domestic product to measure and interpret prosperity, we have demonstrated that socio-economic status as a concept no longer suffices to interpret the complex inequality that underlies health inequalities. We must look for indicators of complex inequality, whereby reducing them is in our enlightened self-interest. *How do you think we can further enhance the concept of complex inequality while taking into account enlightened self-interest?*

Finally, there is the question of 'what'. In time, it should be possible to combat the various determinants of complex inequality in a broad manner. In a prosperous country such as the Netherlands, this issue deserves a formal assignment to our policymakers, as well as an assignment to ourselves. A broadly supported mission on complex inequality is then necessary. In order to end complex inequality, we must challenge ourselves and each other across professional groups, sectors, social classes, social positions and subject-specific knowledge. *In your opinion, what should be included in a national mission that makes reducing complex inequality a top priority?*

6.2 Join the discussion

With this essay, we aim to visualise different perspectives on complex inequality. We look forward to hearing your ideas and insights after reading this essay. We invite you to join our LinkedIn discussion group to discuss, among other things, how we should address socio-economic disparities in health, and which priorities should be central in this regard.

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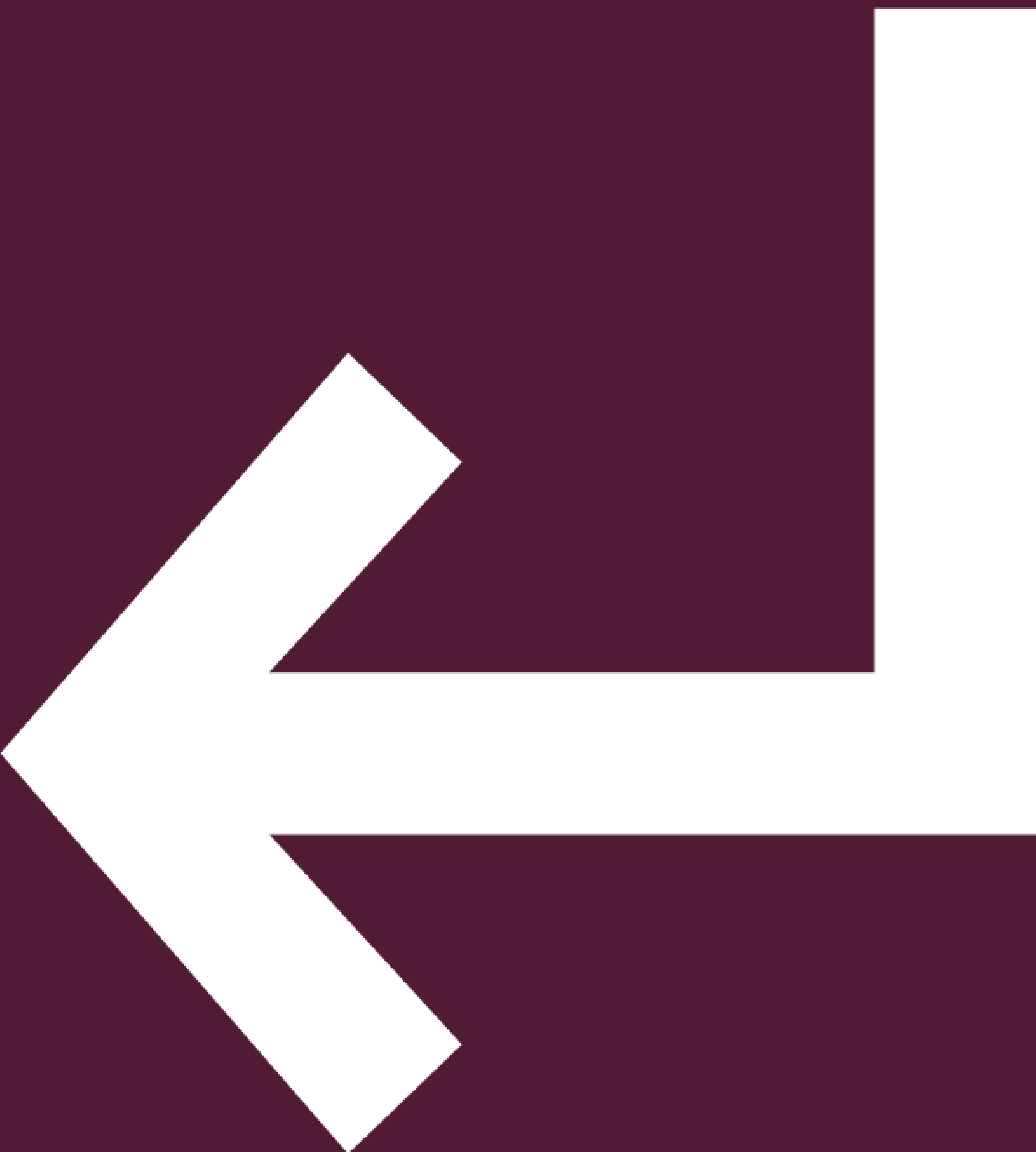

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