doi 10.2478/v10152-012-0001-4 Zdrav Var 2012; 51: 1-2

DRUŽBENI DEJAVNIKI NEENAKOSTI V ZDRAVJU

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Uvodnik

Družbeni dejavniki neenakosti v zdravju so prišli v ospredje akademskih razprav in javnih politik v zadnjih dveh desetletjih, ko so študije pokazale velike razlike v zdravju glede na razlike v socialno-ekonomskem statusu med državami in znotraj držav (1). Ena prvih študij, ki je opozorila na ta problem, je bila t. i. Black Report iz leta 1980. Dokazala je močno povezavo med stopnjo umrljivosti in razredno pripadnostjo v Angliji (2). Od takrat se epidemiologija tesneje nasloni na družboslovne znanosti. Dobi tudi znak socialna epidemiologija, ker zdravje obravnava širše kot tradicionalne epidemiološke študije, s širšim naborom družbenih kazalnikov, da bi bolje razložila razlike v zdravju med posamezniki in skupinami. (3) Večanje razlik v zdravju po eni strani in hkrati rast povprečja pričakovane življenjske dobe na drugi strani govorita o tem, da se zdravstveno stanje ljudi izboljšuje pri določeni populaciji, ne pa pri vseh (4).

V razmerju med zdravjem in življenjskim standardom se kaže zanimiv paradoks. V bogatih deželah se zdi, da ima izboljšanje življenjskih standardov majhen vpliv na zdravje. Ko dosežejo prag, ki zagotavlja osnovni materialni standard za vse, premožnost države ne vpliva več na izboljševanje temeljnega zdravja ljudi (5). Ta točka označuje epidemiološko tranzicijo, ko infekcijske bolezni odstopijo prostor boleznim »obilja« (npr. raku in degenerativnim boleznim) kot najpogostejšim vzrokom smrti. Bolezen »bogatih« postane bolezen revnih v bogatih državah. V Sloveniji, na primer, je bila prezgodnja umrljivost v obdobju 2004–2008 v občinah s slabšim socialno-ekonomskim stanjem (občine severovzhodne Slovenije) tudi do 60 odstotkov višja kot v občinah z boljšim (občine osrednje in zahodne Slovenije), umrljivost zaradi možgansko-žilnih bolezni (npr. možganska kap, možganska krvavitev) in umrljivost zaradi samomora pa sta bili višji skoraj za dvakrat (6).

Med razvitimi državami najboljše zdravje in dobro počutje ni značilno za najbogatejše države, ampak predvsem za tiste, ki imajo najmanjše razlike med bogatimi in revnimi (7). Tako v razvitem svetu nimajo najboljšega zdravja države z najvišjim GDP, ampak države, ki so najbolj egalitarne (5, 8). Tudi najnovejše raziskave dobrega počutja in kakovosti življenja v evropskih državah kažejo, da so samoocene zdravja, ki so zanesljivi napovedovalci objektivnega zdravja in obolevnosti (9), najvišje v skandinavskih in severnoevropskih državah ter najnižje v južno- in vzhodnoevropskih državah. To pripisujejo predvsem dvema dejavnikoma: manjši stopnji neenakosti in večji egalitarnosti v severnoevropskih državah ter posledično večji stopnji socialne kohezivnosti in solidarnosti v teh državah, univerzalnosti socialnih politik in usmerjenosti teh politik na posameznika oz. posameznico, ne pa na družino. Nasprotno pa vzhodnoevropske države kažejo izgubo prednosti v zdravju, ki so jih socialistične države imele, podobno kot preostale, egalitarnejše družbe (5). Ta izguba je povezana z večjo stopnjo notranje tekmovalnosti, upadanjem življenja v javni sferi in skupnostnega življenja. Javna sfera zaradi negativnih tranzicijskih procesov postaja vir stresov in potencialnih konfliktov. Egalitarne družbe so torej bolj socialno kohezivne in imajo močnejše skupnostno življenje, posledično pa tudi boljše zdravje; na to so prve opozorile raziskave vpliva socialnih omrežij na zdravje (10), to vez pa danes najizraziteje izpostavljajo študije socialnega kapitala (11). Psihosocialni dejavniki tveganja za zdravje tako prihajajo v ospredje pozornosti; evidenca psiholoških kanalov, skozi katere kronični stres vpliva na endokrine in imunološke procese, narašča.

To je povezano tudi z velikim pomenom, ki ga ima zdravje za ljudi v sodobnih družbah. Zdravje pomeni za sodobnega človeka veliko več kot samo odsotnost bolezni. Je celota varnosti v sedanjosti in zavarovanj za prihodnost (12). Je tolerančna meja zoper nezanesljivosti okolja. Vsaka bolezen zmanjša moč obrambe pred drugimi boleznimi, izrablja začetno biološko zavarovanje, zato je bolezen grožnja zdravju in posledično človekovi eksistenci. Od tod izhaja tudi preobrat v vrednotnih orientacijah ljudi v sodobnih družbah, kot ga zaznavajo vse mnenjske raziskave ter raziskave vrednotnih in življenjskih orientacij pri nas in v nam podobnih kulturah sodobnega sveta (10). Ikone sodobnega človeka so postale varnost, telo in predvsem zdravje. Počitek, dobra hrana, odpoved kajenju, pijači itn. so bistvene navade za ohranjanje dobrega zdravja in normalnega življenja. So pa tudi znak discipliniranja telesa in samonadzorovanja življenjskih navad ter odgovor na težje ekonomske in življenjske pogoje, ki terjajo od ljudi več vsakdanjih naporov. Ker ne moremo nadzorovati sil, ki so zunaj naših moči, skušamo toliko bolj nadzorovati to, kar je v našem

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dosegu (13). Ritualizirani odgovor na ekonomsko krizo najde ustrezno simbolno polje v zdravju in dobri telesni kondiciji.

Normativistični pritiski, ki jih nosijo s seboj zdravstvena priporočila, lahko povzročajo nove stiske in kronični stres pri tistih, ki ne morejo slediti zahtevam ideologije zdravja in normalnosti ali jim ustreči. Pozabljamo, da ta ideologija povzema in idealizira določene predstave, razmisleke, vrednote, ki so predvsem »lastni« srednjemu razredu oz. bolje izobraženim, mlajšim, zaposlenim ljudem, in da tem standardom težko sledijo vse kategorije ljudi. Ti še vedno v veliki meri doživljajo svoje bolezni kot »usodo«. Ne moremo razumeti stresov in stisk posameznikov brez upoštevanja družbenih in kulturnih okvirov njihovega doživljanja in izražanja.

Vsa ta dejstva so nas vodila pri pripravi tematske številke o družbenih vidikih neenakostih v zdravju. Tako članek o gibanju ocen subjektivnega zdravja v zadnjih 30 letih avtorjev Malnar in Kurdija pokaže vztrajajoče neenakosti v zdravju. Največje razlike med sloji so v starostnem obdobju od 30. do 60. leta, torej med največjo izpostavljenostjo stresom, povezanim s trgom dela. V članku »Družbene determinante zdravja« avtorica Leskošek razvija nabor kazalnikov za merjenje vpliva revščine na zdravje. V prispevku o indikatorjih duševnega zdravja žensk avtorji Kamin, Berzelak in Ule ugotavljajo, da socialno-ekonomski in kulturni dejavniki, med njimi predvsem izobrazba, izraziteje vplivajo na depresivnost pri ženskah kot pri moških. V članku »Vpliv delovnopravnega, državljanskega in družinskopravnega statusa na (ne)enako obravnavo pri zdravstvenem zavarovanju« se avtorica Rajgelj ukvarja z vplivom pravnega statusa posameznika na uveljavljanje pravic iz zdravstvenega zavarovanja. V prispevku »Zaupanje v zdravnika in njegova protislovja« avtorici Mencin in Hlebec analizirata ključna protislovja fenomena zaupanja in vprašanja, s čimer se zaradi teh protislovij spoprijema empirično raziskovanje na področju zdravja in zdravstva.

Z zbranimi prispevki želimo opozoriti na nekaj področij neenakosti v zdravju in poudariti potrebo po poglobljenem razmisleku o podatkih o neenakosti v zdravju, ki jih zaznavamo s številnimi raziskavami. Šele ko te podatke umestimo v družbeni kontekst, ko skušamo razumeti globino njihove pojavnosti, lahko razmislimo tudi o ustreznih intervencijah, ki bodo vodile k izboljšanju zdravja vseh, ne le že privilegiranih.

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doi 10.2478/v10152-012-0001-4 Zdrav Var 2012; 51: 3-4

SOCIAL DETERMINANTS OF HEALTH INEQUALITIES

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Editorial

Social determinants of health inequalities have gain importance in academic discussions and public policies in the last two decades, when different studies have shown major health differences between people with regard to differences in socioeconomic status both cross-nationally and nationally (1). One of the first studies to point out this problem was the Black Report published in 1980 that showed a strong correlation between mortality rates and social class in Great Britain (2). Epidemiology has ever since been relying more on social sciences. It has also been termed social epidemiology, as it studies health more broadly than traditional epidemiologic studies addressing a wider range of social factors in order to better explain health inequalities between individuals and groups (3). The growth of health inequalities on the one hand and the simultaneous growth of life expectancy on the other indicate that health is improving only for a specific population and not for all (4).

There is an interesting paradox when observing the relationship between health and the standard of living. It appears that among the wealthier countries, an improved standard of living has limited effect on health. When societies reach a threshold level that ensures basic material standards for all, the country's wealth no longer significantly affects the improvement of basic health of the whole population (5). This point is marked by the epidemiological transition, when infectious diseases give way to non-communicable diseases or so called "diseases of affluence" (e.g. type 2 diabetes, coronary heart disease, peripheral vascular disease, cancer and other degenerative diseases) as the main causes of death. The "diseases of affluence" become diseases of the poor in affluent countries. In Slovenia, for example, the premature mortality rate in the 2004 – 2008 period in municipalities with the lowest socioeconomic status (north-eastern Slovenian municipalities) was even up to 60 percent higher than in municipalities with the highest socioeconomic status (municipalities of central and western Slovenia). Mortality from cerebrovascular diseases (e.g. stroke and cerebral haemorrhage) and suicide mortality were almost twice as high (6).

Among developed countries, the best health status is not characteristic of the richest countries but of the countries with the smallest socioeconomic inequalities, e.g. the smallest differences between the rich and the poor (7). In the developed world, it is not the countries with the highest GDP that have the best health, but the most egalitarian ones (5, 8). Studies on wellbeing and quality of life in European countries show that self-rated health, which is a reliable predictor of objective health and morbidity (9), is the highest in Scandinavian and north European countries and the lowest in southern and eastern European countries. This is predominantly influenced by two factors: the lower level of inequality and greater egalitarian principles in northern European countries. Consequently there are higher levels of social cohesion and solidarity in these countries as well as the universal and inclusive nature of social policies, which is focused on individuals and not families. Eastern European countries on the other hand indicate a loss of advantages in health that they used to hold as socialist countries, similarly to other more egalitarian societies (5). This loss is related to a higher level of internal competitiveness, alienation from activity in the public sphere and decrease of community life. Due to the transition processes, the public sphere is becoming a source of stress and potential conflicts. Egalitarian societies are thus more socially cohesive, have a stronger community life and consequently also better health. This was initially pointed out by studies investigating the effect of social networks on health (10), and further developed by studies of social capital (11). Psychosocial health risk factors are increasingly at the forefront of attention, since records of psychosocial channels, through which chronic stress effects endocrine and immunological processes, are growing. This is also connected to the growing symbolic importance of health for people in modern societies. For modern men and women, health means much more than just the absence of illness. Health has become a unity of security in the present and insurance for the future (12). It is a tolerance limit against the environment's uncertainties. Each disease reduces the defence mechanism against other diseases and utilises the initial biologic protection. The disease thus represents a threat to human health and consequently person's existence. This is also the origin of the shift in the value orientation of people in modern societies as noticed by all opinion studies and studies on the values and life orientations conducted in our country

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and in similar cultures around the world (10). Security, the body and health have become the icons of modern societies. Rest, good food, relinquishment of smoking and alcohol are all essential habits that are necessary for maintaining good health and a normal life. They are also a sign of discipline over one's body and the self-control of life's habits as well as an answer to the more strenuous economic and living conditions that require people to daily put in more effort. As we are unable to control the forces that are outside our power, we try to control what is within our reach (13). The ritualised answer to the economic crisis finds its corresponding symbolic field in health and good physical condition.

The pressures of norms imposed by health recommendations can cause new distress and chronic stress in people who are unable to follow or comply with the demands of the health ideology and the ideology of normality. We forget that this ideology epitomises and idealises certain notions, deliberations and values that are "inherent" to the middle class or the more educated, younger and employed population and that these standards are difficult to follow for all categories of the population. They still largely see their diseases as "destiny". We cannot understand the distress and strains of individuals without considering the social and cultural frameworks of their experiences and expression.

All these facts have led us to prepare this themed issue on the social aspects of health inequalities. The article on the trends in subjective health in the last thirty years written by Malnar and Kurdija shows the persisting health inequalities. The greatest differences are evident in the 30 to 60 age group, i.e. at the time of major stress exposure related to the labour market. The "Social Determinants of Health" (Družbene detreminante zdravja) by Leskovšek unfolds a range of factors for measuring the effect of poverty on health. The article on the indicators of women's mental health by Kamin, Berzelak and Ule establishes that socioeconomic and cultural factors, especially education, have a more distinct effect on depression in women than in men. The "Effects of Labour, Citizenship and Family Status on the Un/Equal Treatment in Health Insurance" (Vpliv delovnopravnega, državljanskega in družinskopravnega statusa na ne/enako obravnavo pri zdravstvenem zavarovanju) by Rajgelj deals with the effect of an individual's legal status on the enforcement of health insurance rights. The "Trust in the Doctor and Its Contradictions" (Zaupanje v zdravnika in njegova protislovja) by Mencin and Hlebec analyses the main contradiction of the phenomenon of trust and the dilemma that these contradictions cause to empirical studies in the field of health and healthcare.

These articles address some issues in health inequalities and stress the need for an in-depth deliberation of the data on health inequalities that are available from numerous studies. Only once these data are placed in a social context and we try to understand the depth of their occurrence, can we consider appropriate interventions that will lead to health improvements for all and not just the privileged population.

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