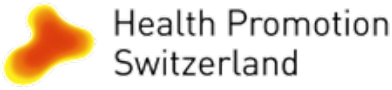
Inequality and Health

Basic document on the relation between social inequality and health

Commissioned by Health Promotion Switzerland



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1. Introduction: Why is inequality such an important issue for health promotion?

Men in Switzerland live on average about five years less (79 years) than women (84 years). Men unfortunate enough to have completed only compulsory education have an even lower life expectancy: thirty-year-old men with only mandatory school education will reach an average age of little over 73, whereas same age female academics will reach an average age of a little over 85.[1] Moreover, the Swiss health survey shows that low income persons feel less healthy, are heavier in weight and have worse smoking habits than high income persons.[2] Finally the study "Sport Schweiz 2008" reveals that the proportion of people who do not engage in sports activities is higher in foreigners as well as in people with low income or low education (see chapter 3)[3].

These few examples demonstrate that there is a clear relation between education, income, sex and national origin, on the one hand, and health, health behaviour and life expectancy, on the other. While this is not a new finding, it is frequently forgotten when it comes to concrete initiatives to improve health. Information on health-related behaviours and new health promoting initiatives are advertised on posters, in the general belief that the messages are equally understood by all and that all share the same willingness for behaviour change. Obviously this is not the case. Depending on social background and position in society, individuals have different health risks and different capabilities of adopting health promoting behaviour. This is why, when planning and implementing programmes of health promotion and prevention, social inequality must always be kept in mind.

Yet this endeavour becomes complicated just by the fact that the general notion of "social inequality" refers to a variety of different influencing factors, with some having conflicting effects on health and health behaviour. In other words: Looking at the differences in education or income does not suffice. Rather, when concluding that not all members of society have the same chances to lead a healthy life, it is important to examine how exactly the different social circumstances affect lives and whether other factors are involved.

This document seeks to bring order into some of these different interactions and relationships. The following chapter clarifies the question as to what social inequality is and how it affects health (chapter 2). Selected results on the extent of inequality and its impact on health in Switzerland are presented in chapter 3. Chapters 4 and 5 present concrete examples of how the problem of inequality can be addressed in health promotion.

As a brief, practice-oriented introduction to the problem of inequality, this text can certainly not replace the abundance of original contributions and text books dealing with this topic. Therefore, the references included in this document point to further worthwhile readings.

2. What is inequality and what effect does is have?

2. 1. From difference to inequality

A review of the history of mankind shows that inequality has been a constant companion of social development for millennia. It is difficult to find an era or society that did not have powerful and powerless, rich and poor, privileged and disadvantaged people. Critics of inequality emerged time and time again – one just has to think of the criticism of the rich in the New Testament, of Jean-Jacques Rousseau's essay on inequality or Karl Marx and his belief in a classless society. In addition, "equality" was the motto of the popular movement during the French Revolution. Nonetheless society has remained one that is marked by a multitude of inequalities.

In addition to the most obvious differences in power, income and wealth, we observe many more inequalities. Examples include children who start life from unequal positions due to their parents' social status (social milieu), the surprisingly resistant beliefs regarding unequal skills due to gender or nationality leading to unequal treatment in everyday life, or occupational and educational differences which both substantially influence social circumstances .

Not every observed difference in life is an inequality. Two conditions have to be fulfilled for differences to become inequalities. They are illustrated in figure 2.1 [4]:

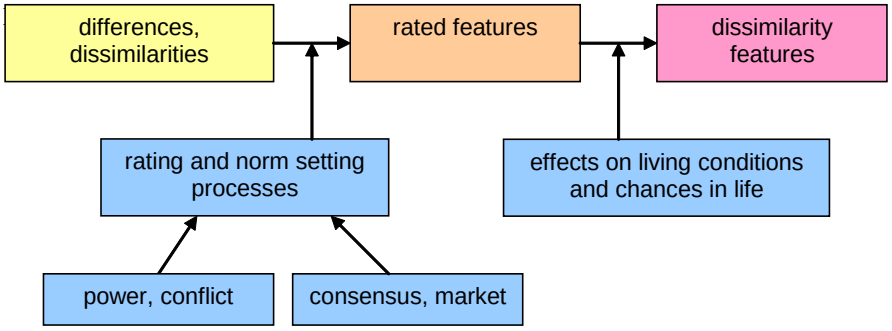
- *First,* the differences need to be perceived and rated as relevant by a population majority. This is to say, the differences have to be such that they can be rated as "more" or "less", or "better" or "worse". As shown in figure 2.1, such ratings are imposed by society and may be based on consensus or by the use of force. The first case would apply when the majority of the population believes it to be right that well trained specialists should earn more than unskilled workers, the second case being when these specialists make sure, through their professional organizations, that their privileges remain untouched.

☐ *Second,* rated differences (depicted orange in figure 2.1) need to have an effect on living conditions and capacities to act. In other words, the fact that something counts as "better" or "worse" only becomes significant when real impacts on life can be observed. In this way, rated and relevant differences become inequalities (depicted red in figure 2.1).

Two examples illustrate these points. Education is, without doubt, a highly valued and positively rated property in society. Higher education counts as something desirable, providing the owner not just with prestige – in that she/he is asked for an opinion or addressed as Dr. So-and-so – but also with privileges in terms of income and good connections. Yet education has a more subtle effect on life than solely via occupation and income. Normally people with a higher education have a better understanding of complex information (e.g. patient information leaflets) and they are much more articulate which makes everyday life easier. So not only is education rated highly, it also influences life in various aspects.

An opposite example would be hair colour. Many men and women prefer either blond or dark-haired partners, yet those are individual preferences and do not express a social consensus regarding the superiority of blond versus dark-haired. Correspondingly, hair colour would not affect the "rest of life". What the example shows, though, is that rating differences may change over time and that cultural differences find access into ratings. In the recent past, red-haired children were stigmatized in Switzerland, while in other countries blond women are considered to be especially beautiful which then gives them better chances on the partner and labour market. Yet even in these contexts, hair colour is not a crucial feature, as hair can be altered by bleaching or colouring.

Figure 2.1: From difference to inequality



Thus, differences need to be rated socially and exert a considerable influence on life before they count as "inequalities". This brings up two related questions which will be discussed in the following chapters:

1. By which rating processes do differences in society become relevant inequalities and what are their effects? So the issue is really to differentiate essential inequalities from less essential ones (such as the ones like hair colour).
2. How do the various inequalities specifically influence life? It is not as if higher education automatically leads to a "happier life". Rather, it is more interesting to ask what kind of effect education and inequalities actually have.

2.2. Inequalities in contemporary society

Let's turn to the first question regarding the relevant inequalities in society. Many markers of inequality are described in scholarly literature,[5] the following are mentioned repeatedly:

- *Education*: Education has an important impact on life in many respects: It opens up chances for jobs and income, influences how well we understand information and generally provides us with knowledge about essential relationships in life. In the debate about inequalities, education is normally equated with formal education, i.e. education which can be measured by grade reports, school diplomas and degrees. However, the recent scientific discussion also emphasises the roles of advanced vocational training and informally acquired education which is gained and exchanged in daily contacts with friends, co-workers or members of the peer group.
- *Occupation.* In the criterion "occupation" there are, strictly speaking, a variety of different inequalities, such as professional activity and title, professional status (superior or subordinate), professional prestige (reputation of the job), the employment status (kind of employment) or extent of employment. Professional occupation, in its various facets, influences income possibilities, social networks, living conditions and a person's "world view". Moreover, different professional activities are associated with different health risks.

  Some criticise at times that "occupation" has been narrowly interpreted to apply to gainful employment only. In fact, volunteer work (e.g. as a trainer in a sports club, or a driver in a social organisation) and housework should also be classed as "occupation", as tasks like these are also manifestations of inequality and may lead to unequal conditions. Housewives and househusbands, for example, have a substantial and specific risk for occupational accidents and may also suffer from considerable stress.

- *Income:* The sociologist Volker Bornschier[6] once called income the "common denominator of stratification" and got to the heart of the observation that much in society is geared towards income and is dependent on it: the goal of acquiring qualifications is to get into a professional career which confers prestige and yields sufficient income. This in turn leads to a higher degree of freedom of choice and a wider scope of action in various areas of life. The rule is: The higher the income, the larger the scope of action on the housing, leisure and health market. Of course, life cannot be reduced to solely money and income. However, the following variation of a popular phrase regarding the significance of income in society says it all: "Money isn't everything – but it helps."
- *Wealth*: Wealth – in form of bonds, savings accounts, art treasures, real estate or factories – has a similar effect like income in that is creates security and options for action. However, wealth is not just personal savings. Frequently, wealth is inherited and therefore cements privileges acquired throughout several generations. In contrast to income, which is often justified by a sophisticated job, special skills and qualifications, wealth is usually inherited and the only requirement is being a daughter or a son. Thus, in contrast to other inequalities, there is a strongly "attributed" and unalterable element to wealth.
- *Social Background:* Similar to wealth, social background is literally "put into one's cradle" and is inalterable, all the while playing a crucial role in determining ones path in life. Parents with a higher education, who are financially well off, are better able to support their children with homework and to provide paid tutoring if necessary. In addition, different social groups each have their specific networks that can be used on the job and marriage market, and finally. Finally, children learn values and behaviours specific to the social class they belong to, and these cannot easily be discarded in later life.

Education, occupation, income, wealth and social background are the classical features of inequality research conducted since the mid 19th century. While Karl Marx, in his class theory, focussed on differences in power and wealth as well as on aspects of social background, 20th century stratification theory concentrated on the triad of education, occupation and income. Yet empirical research during the past decades shows clearly that more features should be classed as "relevant inequalities". Interestingly, these additional features have only more recently been discussed in more systematic ways. They have found their entry into inequality research under the heading of "new" or "horizontal" inequalities. Among these are:

- *Age*: Age causes inequality in different ways. Society distinguishes at least three phases in life, which are marked by differing rights, obligations and role concepts: childhood/youth, active/ family phase and retirement. Yet even within these three significant stages, age causes inequality. Examples are automatic increase of remuneration with age, or age-dependent insurance premiums. .
- *Gender:* While it is obvious that gender influences our chances in life, gender was only added to the list of inequality features through the vigilant work of the emancipation movement and feminist research. Specific attributions, role concepts and personal development opportunities are associated with gender and are discussed in research under the notion of "gender" (offset from the biological term "sex"). In Switzerland, even years following the introduction of equity legislation, these attributions and concepts have proven to be surprisingly resistant. Thus the term "horizontal inequality" proves to be euphemistic, because gender differences still have a strong vertical element in society, in the sense that men are clearly better off in many respects. Due to the significance of the subject, a separate basic document is devoted to the gender issue in more detail.[7]

- *Migration background*: The same goes for migration background, which moulds the chances in life significantly. Social milieu and education effects are elements of the migration background – take the example of migrants with low education and problems adjusting to the culture and language of the host country. On the other hand, a number of very direct consequences of the migration background exist due to lacking political participation rights or to discrimination based on bias towards certain skin colours or nationalities. Since the migration background in Switzerland is an important factor for health, it is discussed in more detail in a separate basic document.[8]

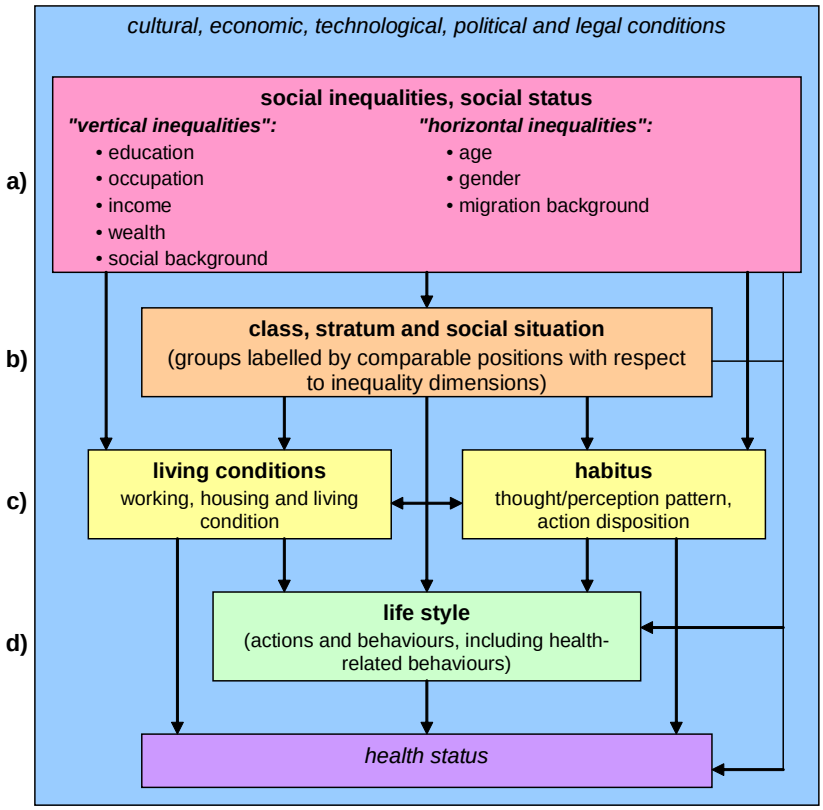
  This overview of inequality features is by no means exhaustive. As to horizontal and new inequalities, the relevant scientific literature points to a number of other factors, such as civil status, affectedness by risk, regional background (urban-rural conflicts, language regions etc.)or physical and mental disability. In the interest of simplicity, this brief introduction is limited to the above mentioned features.

For the sake of completeness, it should be mentioned that where relevant inequalities and their effects are discussed, it is explicitly in reference to the situation in Switzerland. Similarities with many other highly developed countries exist, yet the situation in many third world countries is very different. This means that distinct catalogues of inequality features are needed for other countries: compared to Switzerland, social background might be crucial in some countries (e.g. caste system), whereas religion or the father's occupation might be more significant in others (e.g. guild system). This fact is presented in figure 2.2 with a reference to the *cultural, economic, technological, political and legal conditions* (see also appendix 1).

2.3. What effect does inequality have?

Even if focusing solely on Switzerland and on the presented eight inequality features, it is rather difficult to give a clear-cut answer to the question as to how inequality affects life and health. To provide an example: Imagine a doctor of philosophy who has not found any position in her field and therefore has to clean offices at night. Normally, one would expect her high level of education having a positive effect on her living conditions and health, assuming that she has a high health competence. Ideally, these positive impacts would be even reinforced by a secure, well-paid professorial position at a university. But the relatively low income and the rather unhealthy stressful job (night shifts, dust pollution and exposure to fumes from cleaning agents, lack of safety on the way to work) in our example may outweigh the positive education effects. Suppose also that this woman comes from Southern Europe, she might have more difficulties, being a foreigner, to find a decent comfortable apartment, while her night shifts make it even worse for her to integrate well into her migrant community.

Figure 2.2: Model of the relationship between inequality, life style/health behaviour and health



Source: Lamprecht et al. (2007)

The example points to different kinds of inequality effects which, when assessing a situation, have to be taken into consideration, and which are depicted in figure 2.2 (see appendix 1).[9] The arrows in the figure demonstrate that the inequalities discussed in the previous chapter only partially affect health. Rather they have an indirect impact on health via "class, strata and social situation", via concrete living conditions and the "habitus", and via lifestyle. All the different levels in the model can be interconnected which may lead to complicated interdependencies. How these effects can be conceived of and what the terms in figure 2.2 mean, are explained in the following section:

a) (Direct) effects of individual inequalities: A single inequality feature may have many different effects. As stated above, it can be assumed that higher school education will improve health competence. Yet health competence may mean a range of different things: from a general knowledge of one's own actions on health, to the qualified handling of health information, and up to more competent communication skills when dealing with health professionals. Apart from health competence, staying longer in the educational system tends to have a positive influence on various dimensions of health behaviour. For example, people with higher education on average work out more than those who left the educational system sooner (see chapter 3).

   At least with education the different effects all point in the same direction, whereas the impacts of occupation are somewhat complicated. A management position in a big company, one assumes, should lead to higher stress, but the same manager runs a lower risk of job-related accidents compared to manual workers. Some more differentiated statements would be needed for specific work contexts. This is covered in more detail further on in this chapter and in chapter 3.

b) Interaction between different inequalities: As the example with the female philosopher demonstrates, the individual inequalities don't function alone, but together with others. These joint effects are frequently described by such terms as "class, stratification or situation effects". It is assumed that there are groups of individuals who, due to their comparable features, fall into the same class, strata or situation category and, therefore, are subject to similar inequality effects.

However, in recent years inequality research has proven that a clear identification of privileged and underprivileged individuals and groups in society is very difficult, making assertions about their lifestyle and health impossible. In contrast to the old class and stratification concepts (see figure 2.3 below) which assumed a clear connection between different inequality features in terms of “high education leads to a high professional prestige as well as high income”, other correlation patterns are on the agenda nowadays. In our example, positive education effects are outweighed by a stressful job. In fact, it is not necessary to cite such an extreme example like the one with the philosopher, just looking around among one's own friends and acquaintances reveals: There are women earning less than their male colleagues for the same job, part time employees earning relatively little despite having a highly regarded profession, and persons with just a commercial apprenticeship, who tenaciously worked their way up to the top of a company.

Due to these observations inequality researchers tend to no longer refer to classes and social strata: The idea that our society is layered like a Black Forest cake seems no longer to reflect reality. A cross section through contemporary society would rather correspond to a marble cake: Different groups are coalescing, and it is frequently hard to discern which group is doing better or worse. This fact is better accounted for by terms like “social situation” or “milieu” which describe modern inequality structures more adequately (see figure 2.3).

Figure 2.3: Classes, strata, situations, milieus: Confusion in the discussion of inequalities

Inequality research is characterised by a number of different models and concepts describing and explaining the interaction between various inequality features. The most important of these are briefly presented here:

- Class: Already in the 19th century Karl Marx established the term “class society” in order to point to the fact that society is separated into strictly distinct groups (classes) according to ownership and power structures. Even today, the concept of class is still being used to refer to insurmountable differences and conflicts between different social groups.
- Stratum: The concept of social stratum has been popular since the mid 20th century. In its original version it is clearly distinguished from the concept of class in that strata are determined by at least three factors – education, occupation and income – whereby it is possible for members of society to ascend or descent within the strata (mobility). This means that the concept of stratum - in contrast to that of class - is much more oriented towards individual achievements and chances. On the other hand, today the term stratum is used by many researchers with reservation, since they believe it to fall short of the complicated social reality.

  Nevertheless, Pierre Bourdieu's concept of class is an interesting special case[10]: He builds groups that have similarities with strata, based on a number of cultural (social background, education), economic (income, wealth) and social capital (relations/connections). Unfortunately, Bourdieu bases his interpretation of these groups on class theory, in the sense that his belief in the mobility between groups is somewhat limited.
- Social situation: The discussions evolving around social situations since the 1980s acknowledge the counter-argument that conventional class and strata approaches are too simplified. The definition of social situations includes various characteristics (see figure 2.2), not presuming, of course, that the established groups be separate or irreconcilably opposed to each other. As mentioned above, this concept of society (the ‘social situation’ approach) resembles a marble cake, where layers are coalescing, rather then a layered Black Forest cake which is the model favoured by the stratification approach and which views social strata as clear separate layers.
- Milieu: Similar to social situations, milieus are also defined on the basis of a variety of different (inequality) features. However, one crucial difference to the above mentioned terms is that milieus normally are not described in terms of objective states but in terms of subjectively felt affiliations. When describing milieus, people may, for example, refer to them as "traditionally oriented" or "modern".

  To clarify the difference between milieu and other inequality concepts, take a look at figure 2.2.: While classes, strata and social situations refer to the "objective inequalities" in the upper part of the figure, the levels of life conditions and the habitus are also taken into account when defining the different groups. This leads to a higher complexity of the respective models.

  Further information on the conceptual differences can be found in Burzan (2004) and Stamm et al. (2003).

c) Living conditions and habitus as interceding layers: The problems with contradictory and amplifying effects, or those neutralising each other, are even more exacerbated because most inequalities underlying the classes, strata or situations do not always directly impact life and health. Rather, they have an interceding effect through concrete life situations in which we act. In other words, high education and income do not automatically lead to better health, only when they are used to promote health, i.e. if we really acknowledge health information and act on it according to our capabilities.

As figure 2.2 demonstrates, at least two crucial interceding layers between inequality and concrete behaviours have to be taken into account.

- Living conditions: Our position in the framework of inequality substantially influences our concrete living conditions. Education, occupation, income, gender and migration background are closely linked to the actual working conditions, work-related stress, the housing situation, social networks and the living situation in general. These specific living conditions may amplify inequality effects, for example, by stressful working

conditions, but may also be compensated by the relaxing balance found in the company of friends.

- Habitus: The French sociologist Pierre Bourdieu views “habitus" as a crucial interceding level between social structure and action. What he means are subjective thought, perception and action dispositions, which are shaped by both social background and situation, and which influence our view on life as well as our action preferences. Habits lead individuals from different social backgrounds to perceive situations differently and to make different decisions regarding their actions. To cite another example: A person who during childhood and youth has learned that physical exercise is pleasurable and beneficial, will respond more positively to the health insurance's offer to contribute to the membership fee for a fitness centre than a person who only has had negative associations with exercising.[11]

d) Lifestyle: the lower section of figure 2.3 illustrates that even advantageous living conditions and "health-friendly" habits may only in part lead directly to good health. While it cannot be denied that stressful working conditions or a difficult housing situation may cause illness, conscious or unconscious individual behaviour patterns, too, are of enormous significance in health promotion. This is why figure 2.2 includes an additional box entitled "lifestyle" which entails everyday actions and behaviours. With respect to health, some good examples of lifestyle elements which are co-determined by social inequality would be smoking, exercising or sufficient sleep, etc.

The number of interactions between the model's different levels in figure 2.2 as well as the examples and comments in the text highlight the difficulty of making clear statements regarding the health effects of social inequality. It would be wrong, though, to conclude that effects of social inequality on health cannot be evidenced. Quite the opposite: In recent decades many studies have proven beyond doubt that the correlation between inequality, health behaviour and health are particularly relevant for health promotion.

2.4. How does inequality affect health?

It would exceed the scope of this document to give an overview of all the relevant studies dealing with the interaction between inequality and health, so we are restricting ourselves to two summarising comments which in the next chapter (chapter 3.2) will be supplemented by additional findings from Switzerland.

a) Based on various research overviews[12] the following general conclusions on the correlation of inequality and health can be drawn. First, a number of studies on *mortality* reveal that people from lower social classes have a shorter life expectancy than upper class people, which is to say that, compared to the average population, mortality is higher among individuals with low school education and thus lower occupational status or income.

   The same is true for *morbidity*. Persons from lower social classes have a higher chance of suffering a heart attack, developing certain kinds of cancer or mental health problems than people with a higher educational, occupational or income status. The health-related inequality, incidentally, is already apparent in childhood and adolescence. Students attending secondary schools for average learners suffer more frequently from headache than students attending the 'gymnasium', a secondary school intended for faster learners, and children who have parents with a low school education tend to have more dental problems than children whose parents have a higher education.

   Moreover, various studies suggest a correlation between social situation and health behaviour as well as a number of different risk factors such as smoking, obesity, overall cholesterol, high blood pressure, oral hygiene and nutrition.[13] When all these factors are considered, persons with a higher social status know how to live healthier.

   In summary, with respect to health behaviour and health status it an be concluded that a lower socioeconomic status is generally accompanied by

   ... higher tobacco consumption,
   ... unhealthy eating habits,
   ... less personal hygiene,
   ... less exercise,
   ... less social support,
   ... less knowledge of health,
   ... less use of preventive examinations and early detection programmes,
   ... more stress,
   ... more overweight,
   ... increased hypertension
   ... increased mortality and morbidity risk (increased risk for cardiovascular diseases, metabolic disorders and certain cancers).[14]

b) With respect to health it is true that the effects of various inequality dimensions and layers may overlap, reinforce or neutralise each other. Just think of the female philosopher again who comes from a South-Eastern European country and has to clean offices due to a lack of alternative jobs: The basically positive effect of her high

educational status may be offset by a stressful and badly paid job. In addition, her action preferences, marked by her cultural and social background as well as her concrete living situation, may have an impact on the actual behaviours and strategies she may be able or willing to use in response to a certain situation.

By contrast – since this is admittedly an extreme case – let us assume the case of a female philosopher from Germany who receives a professorship at a Swiss university. She is in a much more advantageous position: While she is also a female and a migrant, she nonetheless has hardly any language problems and will come along just fine with her new environment due to the cultural proximity between her country of origin and host country. She also should not have any problems to come into contact with her well integrated work colleagues and, on top of that, earns a good salary. Those are all factors positively affecting her living conditions and health.

Apart from these two extremes of the female professor and the unfortunate female philosopher, more examples would be conceivable, each featuring specific advantages and disadvantages. The Italian worker living in Ticino, Switzerland at least speaks the population's language. In his new environment, he may also find persons from his region of origin who may have been residing in Switzerland for a while, therefore being able to support him. However, he most likely has a relatively low education and a modest income. The computer specialist from India living in Zurich, on the other hand, may have his privileged income and professional situation to compensate for his language problems and his cultural differences with work colleagues. However, over the years he may have been wrongly perceived in his neighbourhood as 'the Tamil' who is treated with a mixture of reservation and disrespect.

These examples illustrate the mechanism of the above mentioned inequality model: each individual inequality factor has a certain basic direction with respect to health and health behaviour but their concrete interaction leads to a variety of living conditions whose effects can not necessarily be determined a-priori. This is why it would not work to only pick one feature from the model and look at it in isolation. Just as much as migrants are not a homogenous group, neither are persons with a low education or income. Someone doing manual labour does not have a higher health risk than white collar employees.

The next chapter will deal with Switzerland - a country not only characterized by a considerable degree of inequality, but also one with clear associations between inequality and health. These ought to be taken into account when it comes to interventions of health promotion.

3. Inequality and health in Switzerland

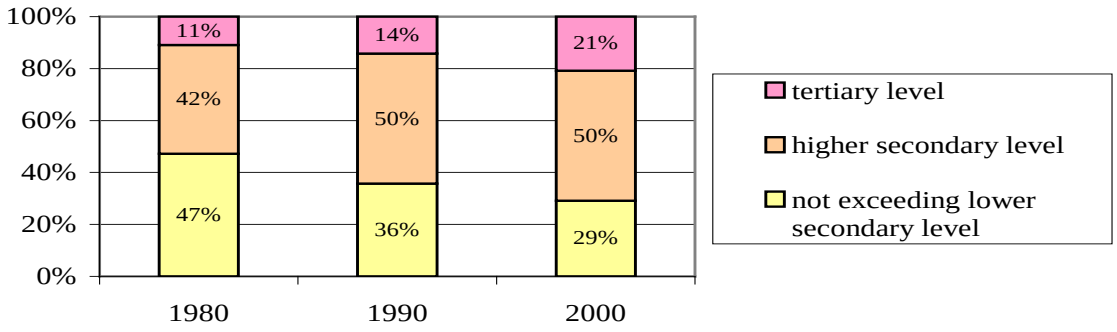
3.1. The extent of inequality

In many respects Switzerland is an enviable country: in terms of living standard it belongs to the richest countries in the world, its citizens enjoy a high level of civil and political liberties as well as an outstanding health care system, and life is usually fairly secure as far as crime and social security is concerned. Despite this advantageous situation, Switzerland is, compared to international standards, marked by various inequalities. This can be demonstrated by a number of findings on inequality dimensions presented in Chapter 2.2:

- Education: In Switzerland adolescents and their parents decide themselves how they would like to continue their educational career after finishing mandatory school. A majority of the population makes use of the advanced educational programmes by completing an apprenticeship or higher secondary school (Maturitätsschule) in order to have the possibility to attend college/university later.

  In recent years, the Swiss education system has expanded which led to an improvement of educational possibilities for the broad population. Figure 3.1 shows that the proportion of people over 25 years having completed only mandatory school (lower secondary level) has decreased from 47 to 29% between 1980 and 2000, whereas the proportion of persons with a university degree has almost doubled (from 11 to 21%). The Federal Agency for Statistics estimates that even in the future the *educational expansion* will continue and that the share of 25 to 64 year-old Swiss with a university degree may grow to between 44 to 51% by 2050.[15] By contrast, the proportion of persons who have no more than a mandatory school education will probably drop to 4 or 5%. Nonetheless, education will remain an unequally distributed good, because at the same rate as university education will expand, new levels will be created (Bachelor, Master, PhD, postgraduate studies) thus leading to the situation that inequality is just shifting to a higher level.

Figure 3.1: over 25 year-old residential population in Switzerland depending on level of education (in %), 1980–2000

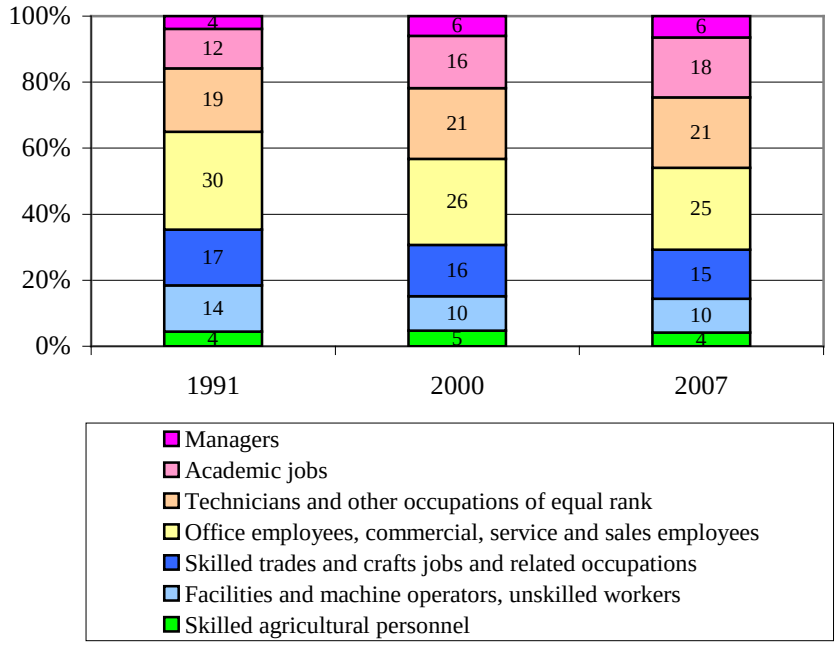


Source: Census by the Federal Agency for Statistics BFS (BFS 2005a, Stamm and Lamprecht 2008)

- Occupation: The system of occupational and professional activities has become more and more complicated in recent decades. If nothing else, a look at the healthcare system proves

this: Nurses and physicians have been replaced by a continuously growing number of specialists so that the requirements of a highly complex healthcare system would be met in a better way. As simple manual tasks do not just disappear, increased occupational differentiation is frequently accompanied by steeper hierarchies and higher income disparities. While no reliable conclusions can be drawn with regard to increasing hierarchies in Switzerland's workforce, the Swiss Labour Force Survey (SAKE) concedes that the share of managers compared to the entire workforce has increased from just under 4% to a little over 6% between 1991 in 2007, whereas the share of persons holding a superior position increased from 30 to 36% in the same period. From figure 3.2 it can be gathered that over time the academic and technical vocations have gained significance at the expense of commercial and service occupations, skilled jobs in crafts and trade as well as less qualified jobs.

Figure 3.2: Proportion of various vocational groups among the employed, 1991-2007

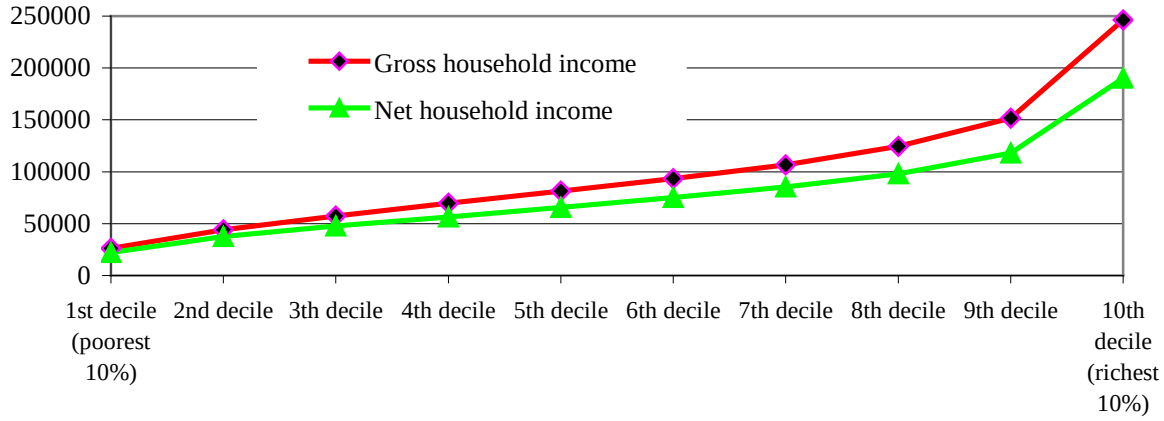


Source: Swiss Workforce Survey (SAKE) by the BFS (Based on: Tables from the BFS website at: http://www.bfs.admin.ch/bfs/portal/de/index/themen/03/02/blank/data/03.html)

- Income: Compared to education and occupation, income is a more visible inequality in Switzerland. Even if one ignores the extreme examples widely discussed in the press and related to top managers' yearly earnings of several million Swiss francs in some large Swiss companies, and instead focuses on the average population, the differences are remarkable. Taking the gross household income as a basis, i.e. the entire income of all members of a given household before taxes and other deductions (red line in figure 3.3), the poorest 10% of households in Switzerland would have reached a yearly income of about SFR. 26,000 in 2005, whereas the corresponding figure for the richest 10% would be a little less than 10 times as much with SFR. 246,000.[16] The richest 2% of households even reached a yearly income of about SFR. 421,000. Even if one considers the gross rather than

the net income, which means income after taxes and other transfer payments (green line in figure 3.3), the differences in income remain substantial. The average income of the top earning 10% of households are, with about SFR. 190,000 yearly income, still over eight times higher than those of the poorest 10% (about SFR. 22,000). Contrary to widespread opinion, the income inequality has not dramatically grown worse during the past years, nonetheless, over 4% of the workforce in this country count as so-called "working poor" who despite having a full-time job do not earn a sufficient income.[17]

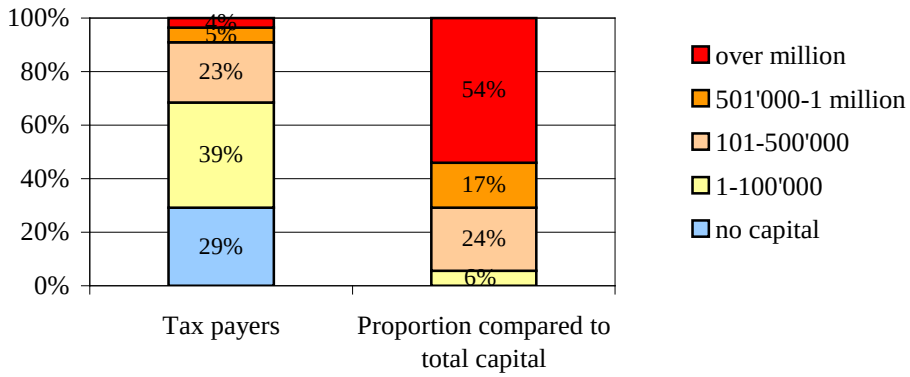
Figure 3.3: Distribution of household income in Switzerland, 2005



Source: The Swiss Household Panel's own analysis (SHP) and CH-SILC, 2005 (Stamm et al. 2007)

- Wealth: As demonstrated by the data from the Swiss Federal Tax Administration presented in figure 3.4, wealth in Switzerland is even more unequally distributed than income. In 2003, 29% of all taxpayers did not declare any capital and less than 40% had a maximum of SFR. 100,000 at their disposal. On the other end of the wealth pyramid, less than 4% of all taxpayers declare wealth of 1 million SFR or more which equals more than half of all private capital.[18] From an international perspective, the difference in wealth is likely to be substantial, even if reliable comparable data from other countries is lacking.

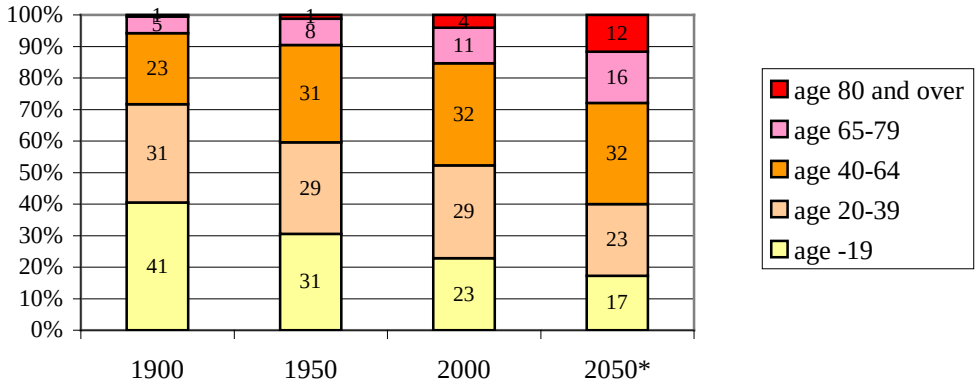
Figure 3.4: Tax payers in various tax brackets and the proportion of their wealth compared to total wealth, 2003



Source: ESTV (2006, p. 14).

- Social background: Inequality regarding education, occupation, income and wealth is reflected in the social background. Particularly well documented are the effects of the correlation between social background and education: despite the above mentioned educational expansion, the chances for children from academic households to reach a university degree are about five times higher than those of children whose parents have only completed an apprenticeship.[19] It has also been demonstrated that school education impacts professional career and therefore income, hence the social background effect clearly leaves marks in later life.
- Age: The inequality effects of age are less obvious to explain than those caused by education, occupation, income and wealth. As mentioned earlier in the text, there are some far-reaching life events such as attaining majority or retirement which may also lead to specific inequalities (political participation, tax duty, claims towards old age insurance). Particularly the transition from the active to the retirement phase is associated with a number of economic changes. While household income will tend to increase in the course of life, it is more likely to decrease with retirement. Even if there is only a small portion of Swiss retirees affected by poverty in old age, this effect should not be forgotten, all the more so because the share of retirees in Switzerland is continuously growing. While according to figure 3.5 only a little under 10% of the Swiss population was aged 65 or more in 1950, this proportion has grown to 15% by 2000 and most likely will increase to almost 30% by the year 2050, according to an estimation by the Swiss Federal Agency for Statistics.

Figure 3.5: Age structure of the Swiss residential population, 1900-2050

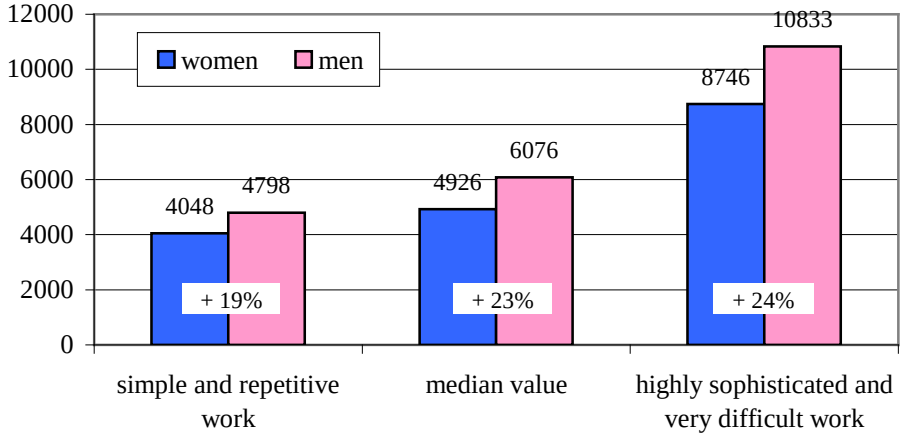


* median scenario of the population development according to BFS (2007)

Source: Federal Agency for Statistics (2007) as well as tables at: http://www.bfs.admin.ch/bfs/portal/de/index/themen/01/02/blank/key/bevoelkerungsstand.html

Figure 3.6: Gross monthly income of men and women working in full-time jobs, by different occupations, 2006

Women, Men



Source: Swiss Wages Structure Survey 2006 (BFS 2008a, see also BFS 2008b)

- Gender: Gender equality has progressed rapidly in Switzerland during the past decades. This can be demonstrated by the fact that by now evidence for gender differences can no longer be found with respect to educational opportunities, and that access to employment has become easier for women. However, with regard to the labour market different inequalities persist. There are still female and male occupations, and women's wages are still 25% lower than those of men, as can be shown by figure 3.6. Detailed information about gender inequality in Switzerland can be found in the basic document "Gender".[20]
- Migration background: As shown by the above mentioned examples and in the basic document "Migration", the effects of a migration background have to be more closely analysed. At the one end of the spectrum, there is a rather underprivileged migration

population from Southern and Eastern Europe or from various third world countries, a rather disproportionately privileged group from Central and Northern Europe or Anglo-Saxon countries, at the other.[21] A reference to a country-specific background may fall short, as migrants do not represent a homogeneous group: the Spanish manager may get along in Swiss society much better than the nurse from Austria. Furthermore, the so-called „Secondos", i.e. foreigners who are born and raised in Switzerland, play a special role. Analyses of the census 2000 have demonstrated that this group tends to be more successful than Swiss children in the Swiss educational system. [22]

This brief overview reveals that inequality is widely spread in Switzerland. At one end of the spectrum there are partial successes achieved in educational, equity and integration policy and, at the other end, there are relatively constant income inequalities as well as wealth inequalities with a tendency of a growing gap.

According to the model introduced in chapter 2.3 the different inequalities do not function in an isolated way, but condense to "social situations" which then exert an influence on concrete life conditions and habitus, ultimately leading to a specific lifestyle. To illustrate the many correlations of the model with empirical data would lead too far at this point. Yet many studies confirm the existence and significance of these relationships. It can be shown, for instance, that systematic associations between educational level, occupation and income exist in Switzerland, leading to no longer clearly separated strata but rather to complex social situations which can be further modified in terms of age, gender and migration background.[23] Such complex relations also manifest themselves with respect to lifestyle, health behaviour and health. The following chapter will take a look at that.

3.2. Health inequalities in Switzerland

There are many studies in Switzerland which evidence the relation between inequality, health behaviour and health. For space reasons we restrict ourselves to some brief illustrations.

a) Health competence

Research on health competence and health knowledge is still in its early stages in Switzerland. The first comprehensive health competence study launched by the Institute for Social and Preventive Medicine at the University of Zurich in 2006 confirms a clear association between health competence and educational level. Of great significance is the finding that around a quarter of the population views health information spread by the media as "difficult to grasp". [24]

b) Health behaviour

The relation between social inequality and various aspects of health and risk behaviour are well documented, and those in Switzerland essentially follow the patterns outlined in Chapter

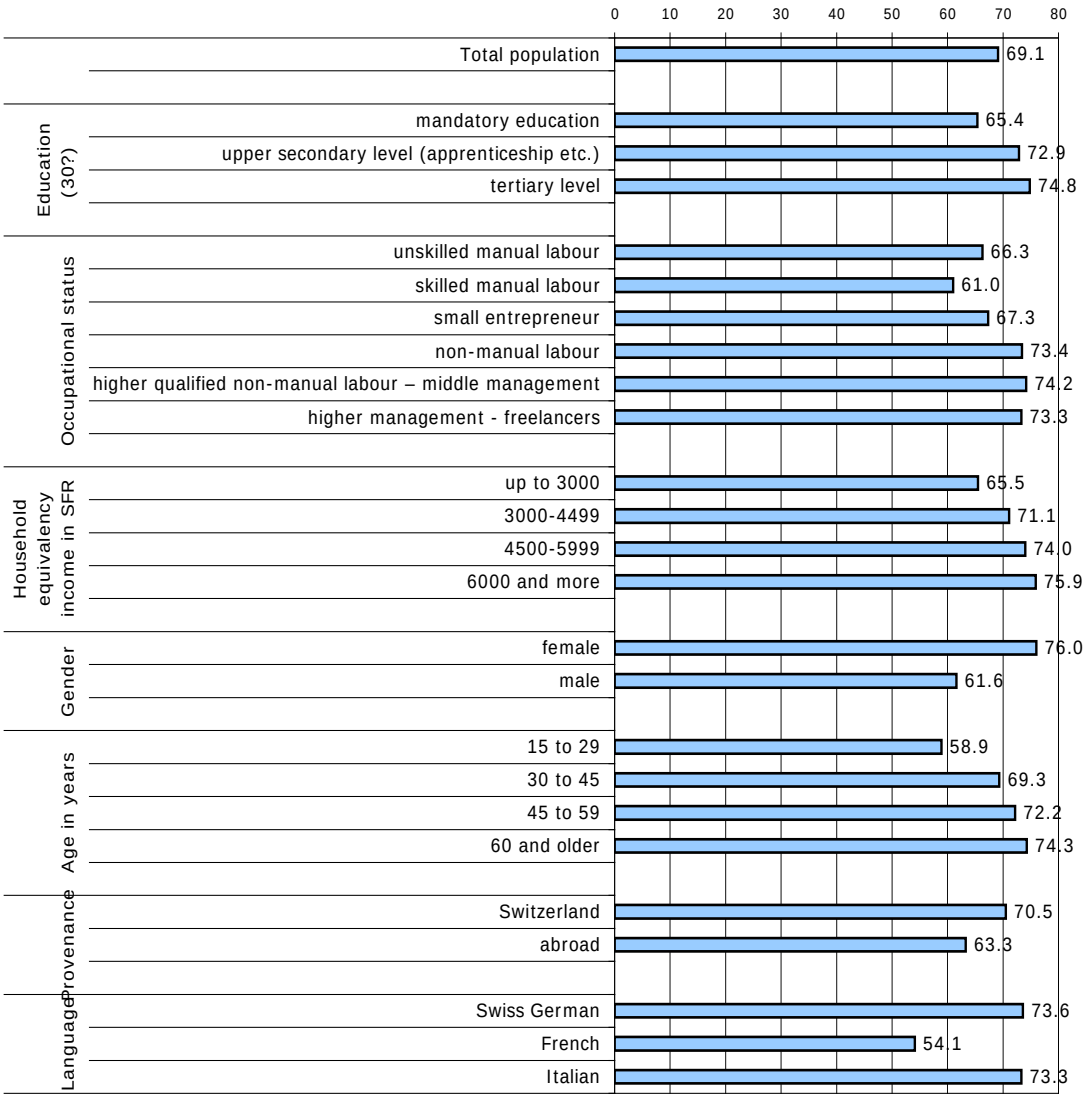
2.4: Only higher social status and better living conditions are usually associated with a more health-conscious lifestyle.[25] This will be illustrated with the help of two examples.

The *first example* is located at the interface between health competence and health behaviour and is related to nutritional awareness. In the 2002 health survey (SGB 2002) launched by the Federal Agency for Statistics (BFS), a representative sample of the population living in Switzerland was confronted with the question whether one "did" or "did not" pay attention to their diet. Figure 3.7 depicts the percentage of those persons stating to pay attention to their nutrition; whereby the answers were categorized according to different inequality features.

Almost 70% of the interviewees stated to pay attention to their diet. However, the proportion varied between just under 54% in the west of Switzerland, 59% among the youngest age group interviewed and 76% among women and persons with a higher household income. As far as education is concerned, the difference between the lowest and the middle group was most pronounced, whereas the nutritional awareness of the middle and highest group differed only slightly. With regard to occupations, the group of trained or unskilled manual workers had a slightly higher nutritional awareness than the group of skilled manual workers. By contrast, the three non-manual groups hardly differed.

A similar effect can be found with regard to income: Nutritional awareness increases with growing income, yet the increase is more pronounced in the lower versus the higher income groups. The same applies to age, whereas there are quite clear differences regarding gender and nationality. Surprisingly enough, there is a clearly lower nutritional awareness in French-speaking Switzerland which may be ascribed to specific cultural preferences. This example shows that depending on social inequality features substantial differences in nutritional awareness can be found.

Figure 3.7.: Social differences in nutritional awareness, SGB 2002



Note: Answers to the question: ”Do you pay special attention to your diet?“ Case figures depending on feature between 16,827 (education, only persons aged 30 years and more) and 19,690 (gender, age); percentages are based on weighted data provided by SGB 2002.

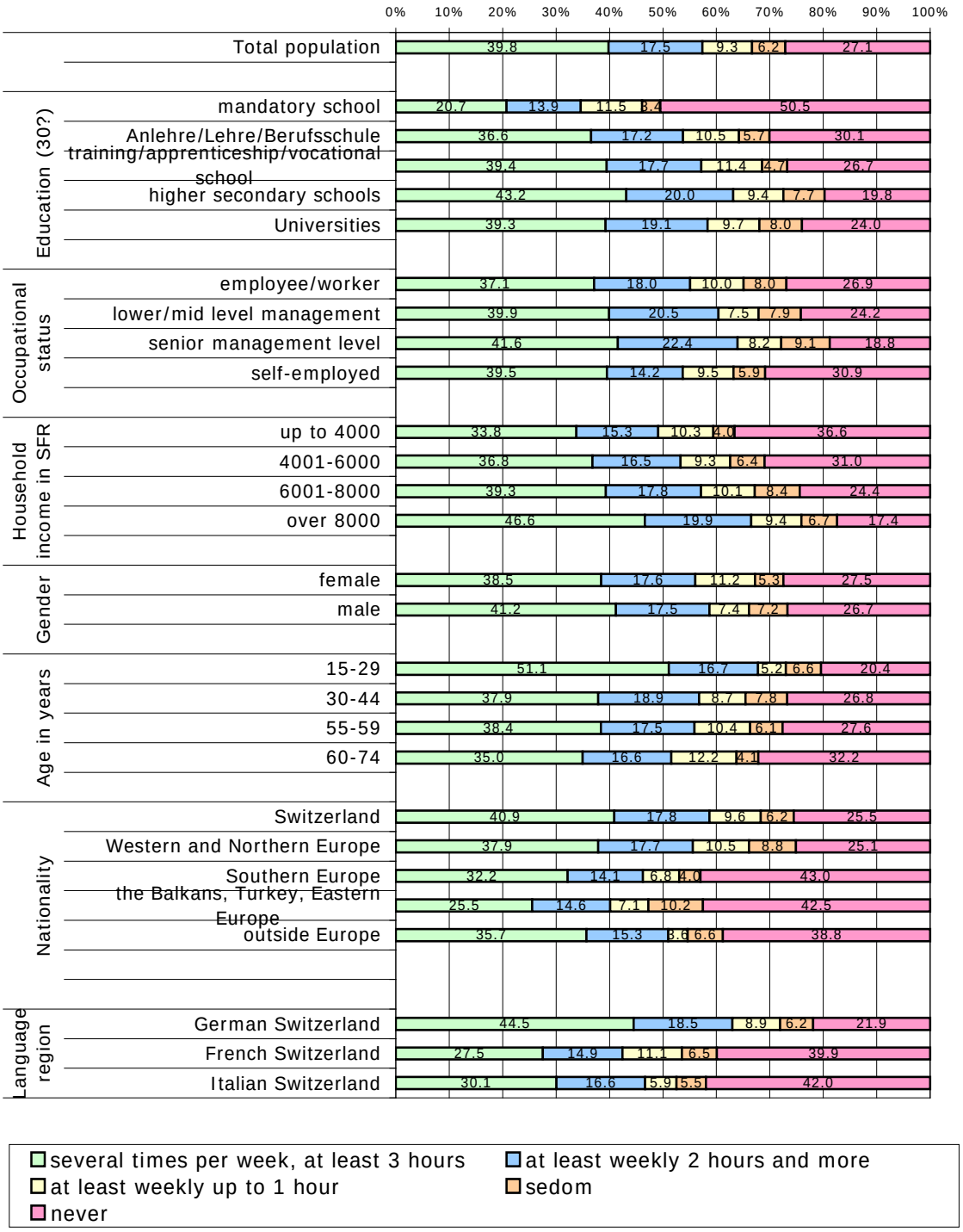
Source: Analysis by SGB 2002

There are also differences concerning physical exercise and sports activities which both count as crucial elements of a health-conscious lifestyle and are the subject of our second *example*. Information on physical activity can be found in the 2002 Swiss Health Survey.[1] At this point, we like to limit our focus to sporting activities in the strict sense and present some current data from the study “Sport Schweiz 2008”.[27] Figure 3.8 offers an overview on the relationship between the different aspects of social inequalities and the intensity of sporting activities. From the upper section of the figure we gather that just like in the health survey about two fifth of the population practise a sport several times per week, whereas a little over a quarter does not engage in any sports activity at all.

In some places, we observe considerable differences in the level of sporting activity between groups. There is, for example, a distinctive education effect. However, the correlation is not strictly linear in the sense that sports activity does not proportionally increase with a higher educational level. Instead there is a clear difference between persons who completed mandatory school only and then stopped their educational career, and those who went through an apprenticeship. At higher educational levels, sporting activity slightly increases again, whereas general university graduates exercised slightly less in comparison to graduates from institutions of applied sciences.

The same holds true regarding the occupational status. It is noteworthy that a particularly high proportion of inactive persons is found among freelancers, a fact that is most likely a result of their very time-consuming workload. Increased sporting activity related to income, however, is clearly linear: the higher the household income, the higher the percentage of (regularly) active persons.

Figure 3.8.: Relation between different dimensions of social inequality and sporting activity 2007



Note: The extent of sporting activity was based on and determined by various information about frequency and duration

Source: Sport Schweiz 2008 (Lamprecht et al. 2008a).

It should also be mentioned that the striking gender effect, still present throughout the 1990s, has now completely evaporated: today's women exercise almost as frequently as men. However, a detailed analysis shows that younger men are clearly more active than women of the same age, but they reduce their activity in their mid-stage of live, only to increase exercising again after retirement.[28] Such biographical effects are clearly visible in the section of figure 3.8 which illustrates the activity level according to age groups. The situation is similar to the one in education, only in the opposite direction: the most major break in activity happens in the transition from the youngest to the middle age group of the 30 to 44-year-olds, whereas the situation remains relatively stable in the further course of life.

Finally, the lower section of the figure lists the influence of nationality on sports activities. This part shows that the migration population is by no means a homogeneous group. Whereas people from Northern and Western Europe have similar sporting activity habits as Swiss people, migrants from Southern and Eastern Europe demonstrate a comparably low level of activity. Finally, once again the differences in language regions stand out - they could be at least partially explained by the different sports culture prevailing in different regions. Although ”language region“ does not involve inequality in the actual sense, the example demonstrates that such additional factors have to be considered in the promotion of sport and physical activity.

Thus, the expected inequality effects are confirmed with respect to health behaviour. However, it is important to emphasize that, in many instances, associations or correlations are not strictly linear. Occasionally, there are even effects working in the opposite direction and sometimes there are breaks in the so-called social gradient in the sense that the difference between the “low” and “middle” groups are more pronounced than those between the “middle” and “high” groups. This finding is significant for health promotion, because it shows particular promise for interventions aimed at underprivileged members of society.

c) Morbidity

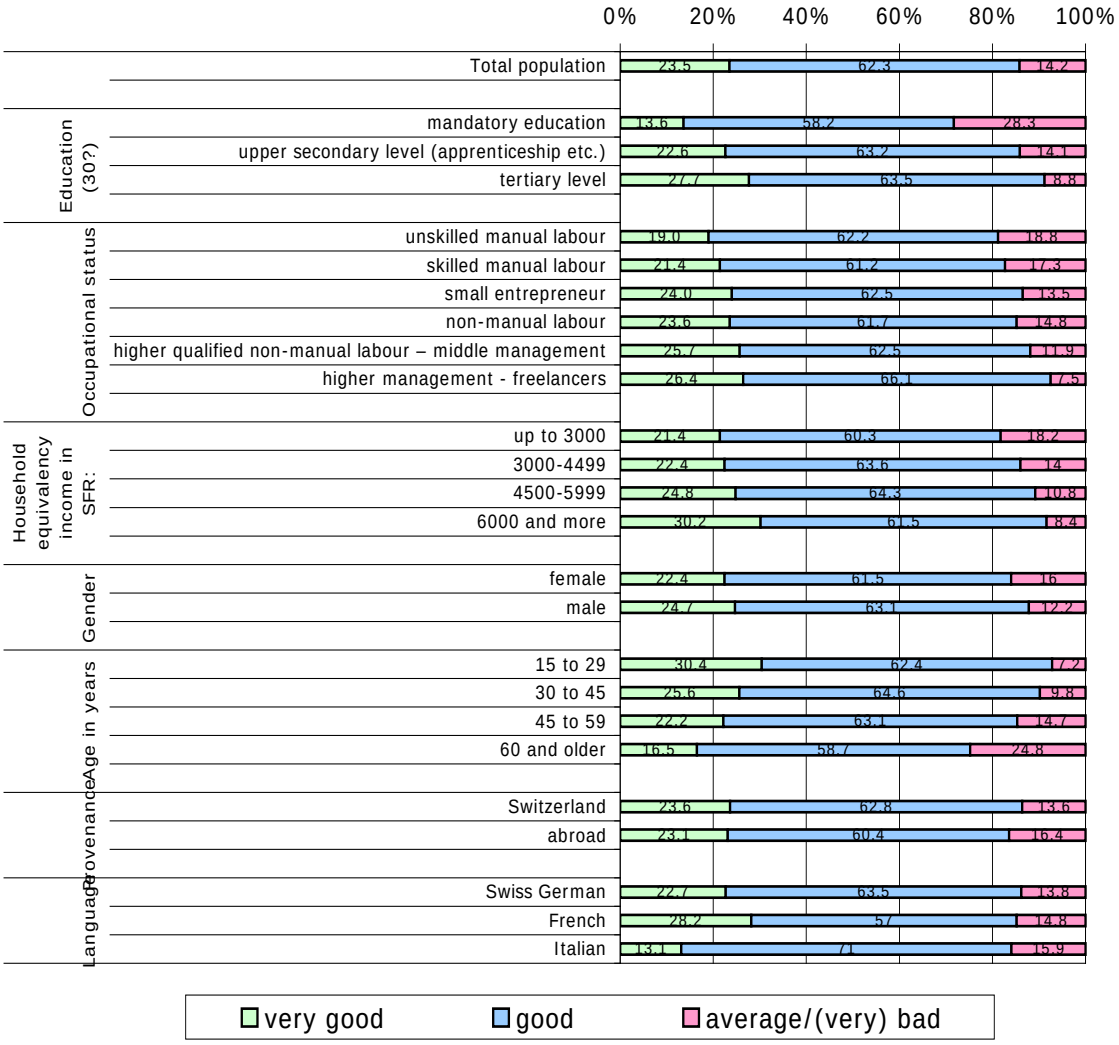
Swiss studies dealing with health status and risk of disease essentially confirm international results. Various chronic diseases (angina pectoris, bronchitis, ulcers) can be related to the educational, for example, and as well as the probability to develop cancer is different depending upon region, state (canton), occupational group and social stratum.[29] Compared to academics, men with a lower school education have twice the risk of dying from cancer.

To illustrate these correlations, we take another look at the 2002 Swiss Health Survey which contains information on the subjective health status as reported by the residential population. As shown in the upper section of figure 3.9, about 85% of the population respond to the question: “How is your general health?” with “very good” (23.5%) or “good” (62.3%). However, only a minority of 14.2% describe their health status as “average”, “bad” or “very bad”.

Figure 3.9 shows that the subjective health status varies with different features of social inequality: persons with a higher education, members of the mid-level cadre, better earning and younger persons describe their health status more frequently as (very) good. In contrast, the difference between men and women is only minimal, and for once, there are hardly any

differences between the language regions. This is more pronounced when focusing only on statements regarding average or (very) bad health. Results are similar when inquiring about general physical problems or mental balance – the latter clearly increasing with age. [30]

Figure 3.9: Relation between different features of social inequality and subjective health status, SGB 2002



Note: Answers to the question: „ How do you rate your general health?“ Case figures depending on feature between 16,857 (education, only persons aged 30 years and more) and 19,701(gender, age); percentages are based on weighted data provided by SGB 2002.

Source: Analysis by the SGB 2002

d) Mortality

The final point concerns life expectancy and mortality which is also associated with the social situation. In Switzerland, the correlation between mortality and occupational status was first confirmed in the 1980s. More recently, the effects of the educational level on the mortality of women and men were examined in more detail.[31] In the 1990s, the remaining life expectancy of 30-year-old men without more than the mandatory school education was 43.3 years (women 51.5 years), among men with a university degree, on the other hand, 50.4 years (women 55.1). While these differences decrease with age, they do not disappear altogether. The difference in mortality therefore cannot be attributed to occupational risk only, but it is also related to cultural and social resources which in turn influence living conditions and coping with the demands of life.

These results are confirmed and complemented by recent results from the Swiss national cohort study, with data gathered between 2001and 2004.[32] In terms of occupational groups, academics have the lowest, manual labourers, however, the highest mortality risk. Mortality risks are clearly increased among the unemployed. Interestingly, this time the migration status has a positive effect in the sense that the foreign residential population has a slightly lower mortality risk than Swiss people.

As far as life expectancy and mortality are concerned, obvious correlations with social inequality can be demonstrated. Again, it is rather delicate to consider only one inequality dimension for explaining differences, because of the different inequalities overlapping. A final example may demonstrate this more clearly. Let us take the subjective health status again and compare the two extreme groups: One of the groups is characterized by a combination of low education and low income (household equivalency income below fr.3000), while the other group involves university graduates with high income (over fr.6000). Only 12% of the members of the first group describe their health status as being very good, whereas 29% assess their health status as average or (very) bad. However, the corresponding values for the second group amount to 31% (very good) and 7% (average to very bad).

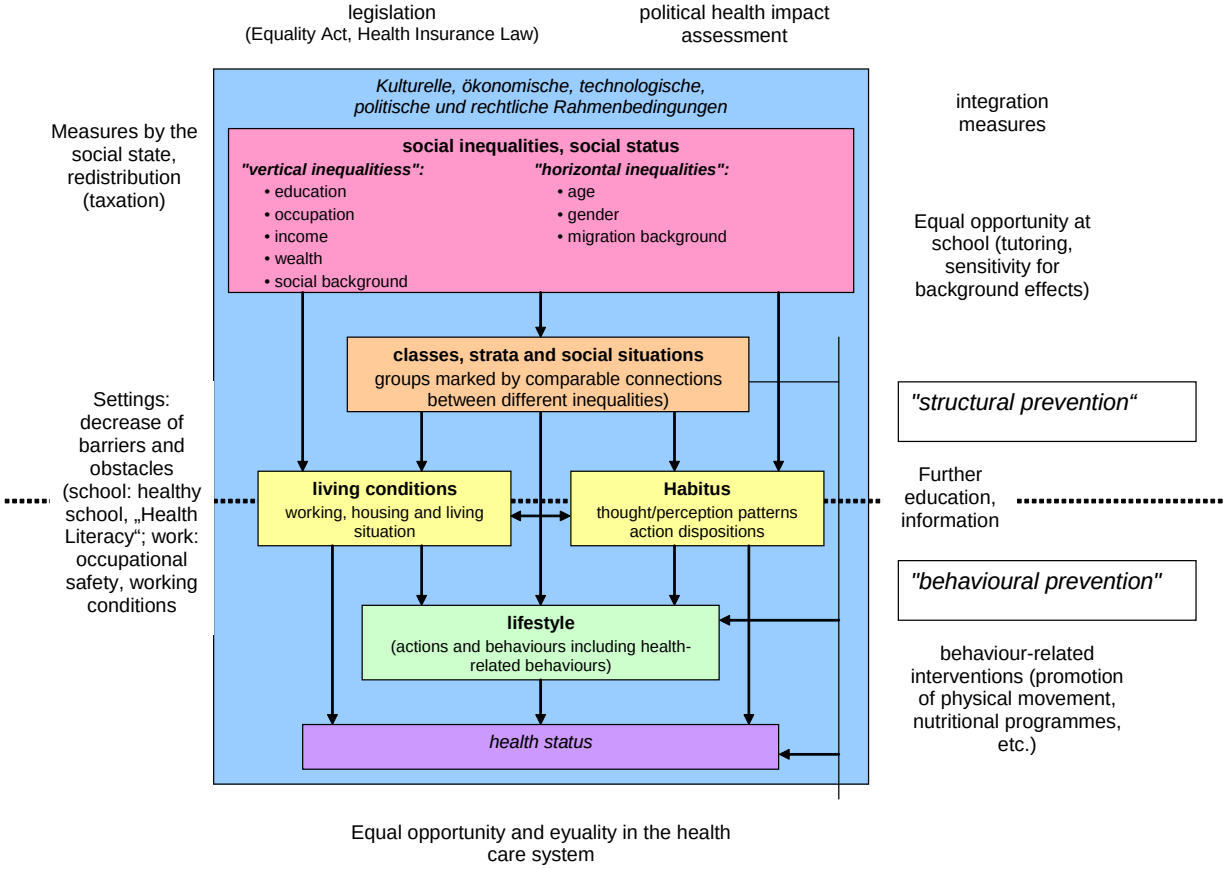
4. What can and should health promotion do?

Concerns of health promotion are closely linked with the problem of inequality. The 1986 Ottawa-Charta of the World Health Organization (WHO) acknowledges this by stating that " health promotion action aims at reducing differences in current health status and ensuring equal opportunities and resources to enable all people to achieve their fullest health potential". [33]

This quote points to two approaches in health promotion: Health promotion can either try to alleviate inequalities directly thereby creating more health-related quality, or it can focus on creating equal opportunities. Examples for the first approach would be, for instance, that health insurance law guarantees adequate healthcare coverage for all, independent of background and social position, or redistribution measures by the social state with the goal of decreasing income differences, thereby creating more equality (see also the examples in figure 4.1.)

The postulate of equity, on the other hand, implies that the rules determining an individual's success or failure should be equal for all. Equity is based on equal treatment and same starting positions, but accepts differences and inequalities which may arise as a result. [34] Such approaches can be found in the educational system where access and success opportunities for children coming from less privileged families were increased during the past decades. Many other measures in health promotion – e.g. the ones specifically aimed at particular target groups or settings) aim at increasing equity. We will come back to these measures later (see figure 4.1).

Figure 4.1: Examples for inequality-oriented approaches in politics and health promotion



This demonstrates that health promotion should not only focus on health inequality in the narrower sense, but it also has to address social inequalities. If education, income, occupation etc. have health effects as shown above, it is very promising to exercise an influence on these features. Or using the terminology of prevention: Behavioural prevention or structural prevention in health settings alone are insufficient. A more general setting-oriented prevention is required in the sense that the population's living conditions are improved. Correspondingly, health promotion is an inter-sectoral concern which has to work in close collaboration with social, employment and education policy. A crucial key word in this context is the so-called health impact assessment which is used to examine general political programmes and interventions for their health effects. [35]

The concrete interventions of health promotion, however, usually concentrate on specific target groups or specific settings. The problem of inequality can be found in most of them. Yet the projects differ in that they may or may not explicitly address the problem of inequality, they may refer to different aspects of inequality, they may address the structural level or take health related issues as a direct starting point and finally, they may target equity versus the creation of equality.

Appendix 2 of this document contains a list of current projects dealing with one or more inequality dimensions from which we would like to single out some examples here.

- In the first phase of the project *„FemmesTische“* panels were set up for female migrants to share knowledge on educational and health issues. As a next step and supported by the Addiction Prevention Centre in Uster, similar panels are planned in the Zurich Oberland, offering female migrants and Swiss women the possibility for exchange.

  This project, primarily aimed at health-related equity (better chances for participation), focuses explicitly on the features gender and migration background, but implicitly addresses a number of other features. At least in its initial phase the project was strongly oriented towards female migrants from lower income and occupational levels who had educational deficits, a special (culturally influenced) habitus, and a specific life situation. The goal was to teach these persons health competences which would reduce health inequalities and generally improve participation in social life.

  Similarly – yet without the close focus on gender – the project *„Saglik“* (Health Services Basel) wants to contribute to growing health competence among a portion of the Basel migration population with the help of a Turkish language health magazine.

- The projects *„Les recettes à quat'sous“* (Service Social de la Ville de Genève) and *„Gesundheitliche Chancengleichheit im Billigtrend“* (Low-cost trend and health equality, ISPM University of Bern) both address the question of nutrition in low income groups. The first project uses a similar approach as „FemmeTische“ and focuses on creating equity by using multiplier facilitators, who are responsible for teaching health-related skills to people on a low income. It is noteworthy that the aspects of gender and migration background are mentioned as important extra criteria.

  The second project's approach is oriented toward tackling basic inequalities, cooperating with large distributors and organisations in the field of nutrition. Proceeding from the hypothesis that low cost products are in high demand particularly by low income population groups, the project will examine products from a nutritional science perspective and formulate recommendations for adjustments. If large distributors can be convinced to produce healthy low cost products, the project may not just achieve the equity mentioned in its title, but will also contribute to the reduction of basic inequalities arising from income differences.

- Similar issues are pursued by Health Promotion Switzerland. Under the heading "Strengthening health promotion and prevention", the above mentioned "Health Impact Assessment" is employed and lobbying at various political levels is focussed on the reduction of health equality

- The features age and income, as well as the interceding levels of living conditions and habitus are the central focus of various youth projects such as *"Bientraitance – un antidote à la maltraitance"* (Fondation Charlotte Olivier, Fribourg) and *"Porta Nova"* (Infoclick.ch). Both projects start at the general population level, because they create general platforms for information exchange, contribute to the integration and equal opportunities of (disabled) adolescents, dealing with the subject of health inequality only secondly.

The brief overview shows that inequality is an important subject in all projects mentioned, whereby different features and levels of inequality are addressed. In fact, maybe apart from some very generally oriented campaigns, there probably is hardly a health promotion project or programme in place which does not refer to inequality.

In all the mentioned examples, it is regrettable that little explicit reference is made to issues of inequality. If the issue is addressed at all, it is often just casually mentioned. They are three reasons for this omission: *First,* it is frequently assumed that the suggested inequalities and implied effects are already obvious, therefore needing no further explicit discussion. *Second,* the missing reference may frequently be the result of an insufficient sensitisation for the inequality problem or incomplete knowledge of the mechanisms of different inequality dimensions as well as the relations between them. Finally, the deficit may be closely associated with insecurity about how to gauge the significance of the inequality problem for project planning and implementation. This becomes obvious when we investigate the place that is given to inequality in the Best Practice concept of Health Promotion Switzerland.[36] According to the concept "Best Practice" means (p. 7):

> "[...] systematically considering values and principles of health promotion and public health, taking current scientific (expert) knowledge and experience into account, paying attention to the relevant *context factors* as well as making sure the intended effects are achieved." (highlighted in the original)

With this definition, it is obvious that inequality plays a crucial role in all of the described dimensions:

- *Value:* One of the major goals of health promotion is reducing inequality and creating equity; essentially health promotion is based on the value of equality.
- *Knowledge:* This document demonstrates that fundamental knowledge on the mechanism of inequality is of vital importance for strategic decisions and planning of concrete health promotion measures. Only those who are able to explain why given inequality structures are health damaging or contradict health equity, have a chance to make their opinions known and to plan successful interventions.
- *Context:* Inequality is a major context factor of health promotion. Even when measures, at first glance, have very little to do with inequality, the existing inequality structures represent important conditions influencing the success of the measure. By the way, it should be emphasised that when target groups and their specific living conditions are identified, a reference to one or several inequality features is usually made, but often unknowingly.

Finally, the different impact levels mentioned in the citation should not be ignored. In the most favourable case, health promotion always positively affects inequality - by reducing structural or health-related inequalities or by creating a higher degree of equity.

One of the goals of this document is to sensitise the reader for questions of inequality, thereby advancing the Best Practice concepts of Health Promotion Switzerland. It is by systematic reflection of important inequality dimensions and their effects on health and health promotion that concrete projects and interventions can be more easily singled out from other measures.

This will improve both target group adequacy and chances of success. With this in mind, the final chapter will offer some more information on important questions emerging in conjunction with "Inequality and health promotion".

5. Summary and outlook

Despite the demands for equality, modern societies are marked by a considerable degree of social inequality. Both with regard to “traditional inequalities”, such as education, occupation, income and wealth, and “new inequalities”, such as age, gender and migration background, strong differences can be identified between various population groups in Switzerland that impact health behaviour and health status.

It is important to remember that high education or above-average income do not necessarily lead to a healthier lifestyle or better health, but that instead, the effects of inequality may be indirectly influenced and modified by the actual living situation and by behavioural preferences (habitus). This has a series of consequences for health promotion. To recapitulate:

a) *Health promotion and questions of inequality cannot be isolated:* When it comes to the Ottawa Charta of health promotion and the relevant research results, a major goal of health promotion is reducing health inequality, which in turn is closely linked with fundamental social inequalities. Hence health promotion comes down to “equality promotion“. This is one of the reasons why deliberations on inequality are relevant in Best Practice approaches.

b) *Inequality related health promotion starts both at the general societal level and at the level of health behaviour and health:* Health promotion may attempt to directly reduce health inequality by, for example, expanding healthcare or launching target group specific measures encouraging healthy behaviour. On the other hand, inter-sectoral approaches with the goal of improving the distribution structure in society by reducing income disparities or alleviating discrimination in professional life, may - indirectly facilitated by improved living conditions and changed action preferences – also cause a reduction in health inequality. There are two ways to reach goals in health promotion: first, through direct influence on relevant inequality dimensions *(direct reduction of inequality)* or through creating *equity*.

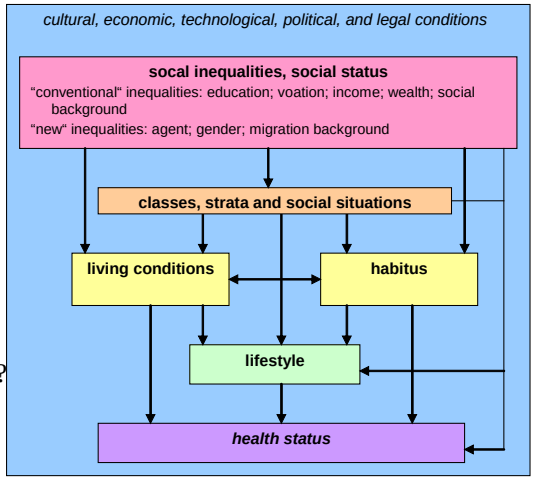
c) *Practitioners of health promotion must develop an awareness for the effects of inequality and systematically integrate the problem of inequality into project planning and implementation:* We all have an intuitive comprehension of what inequality entails. Without any major problems, we are able to identify and locate problems of inequality in most situations. Yet a systematic insight into more complex relations and the connection between different inequality dimensions are often missing. We may observe wage disparities at work, yet ignore that behind these disparities lie diverse qualifications and experiences. We may also look at the precarious living conditions of asylum seekers and foreign workers, prematurely concluding comprehensive problems in the migration population, completely forgetting about the well integrated migrants at universities and in the top management of large enterprises.

When planning and implementing a project, it may be helpful to supplement the general guidelines of the Best Practice concepts of Health Promotion Switzerland by a number of concrete questions regarding the structure and effects of inequality within the context of the project. This can be done, for example, by taking another look at the inequality model presented above and depicted in simplified form in figure 5.1.

The first question to pose is which inequality-related goals the project pursues, whereas questions 2 to 4 refer to the different levels of the model. It may be practical to work through the different levels using the eight inequalities discussed in Chapter 2 and to ask each time what kinds of effect the inequalities have at the different levels of the model. The last question completes the circle and goes back to the first question by readdressing the approaches and effects of both project and project organisation.

Figure 5.1: Inequality-oriented questions in the planning and implementation of health promotion projects

The following questions need to be answered in reference to the inequality model on the right:



1. *Project goals*
   What is the project's goal with regard to inequality?
   Does the project focus on general inequalities (for example, education or income disparities) or on health inequalities (health behaviour/health status) in the strict sense?
   Does the project focus on improving equal opportunity or rather on directly reducing inequality?
2. *Target groups*
   What are the project's target groups?
   Where do the target groups stand in terms of the different inequality dimensions? Do these target groups have special features with regard to social background, education, occupation, income, wealth, age, gender, and migration background?
   Which target group features constitute resources, which constitute disadvantages?
   Can the target groups be attributed to specific classes, strata, social situations or social milieus?
3. *Indirect levels:*
   How are the inequality positions reinforced or modified by concrete living conditions and the target group's habitus?
4. *Lifestyle, health behaviour and health status*
   Which known effects do the inequalities identified under Item 2) and 3) have on lifestyle, health behaviour and health status? What evidence exists for these effects?
5. *Project impacts and project organisation*
   What are the expectations in regard to the project's impact? (impact model)
   Which inequality dimensions and effects can be modified by the intervention? How can they be modified? At what level should one start?
   Are the addressed inequalities adequately taken into account in the project organisation, for example, by including members of the target group or experts?

Health promotion sensitized for questions of inequality almost automatically contributes to more (equal) opportunities in society. However, such a health promotion programme has to rely on more social actors and organisations in order to perform its tasks. Particularly important is the co-operation with the political level, since inequality is a highly charged political issue in our society. Therefore, health promotion would be well advised to also consider possible alliances and political frameworks in order to avoid being in the line of fire of anti-egalitarian political attitudes.

References

a) Recommended introductory literature

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Stamm, Hanspeter, Markus Lamprecht und Rolf Nef (2003): Ungleichheit in der Schweiz. Strukturen und Wahrnehmungen. Zürich: Seismo.	Empirical data on inequality in Switzerland
Levy, René, Dominique Joye, Olivier Guye und Vincent Kaufmann (1997): Tous égaux? De la stratification aux représentations. Zürich: Seismo.	French reference book on inequality in Switzerland
Bihr, Alain et Roland Pfefferkorn (1995): Déchiffrer les inégalités. Paris: Syros.	Introduction to the discussion on inequality, including a chapter on health inequality
Marmot, Michael (2005): "Social determinants of health inequalities". The Lancet 365: 1099-1104.	Excellent summary of important determinants of health inequality
Mielck, Andreas (2000): Soziale Ungleichheit und Gesundheit. Bern: Hans Huber. Mielck, Andreas (2005): Soziale Ungleichheit und Gesundheit. Einführung in die aktuelle Diskussion. Bern: Huber.	German standard work on the relation between inequality and health including many empirical findings; the 2005 title contains an “abbreviated version”
Recommended introductions to the subject of health inequalities can also be found in the following reference list. Noteworthy are Siegrist (2005) and the anthology by Richter and Hurrelmann (2006) (in particular the contribution by Hradil) as well as – in English – Bartley (2004), Budrys (2003) and Graham (2007).	

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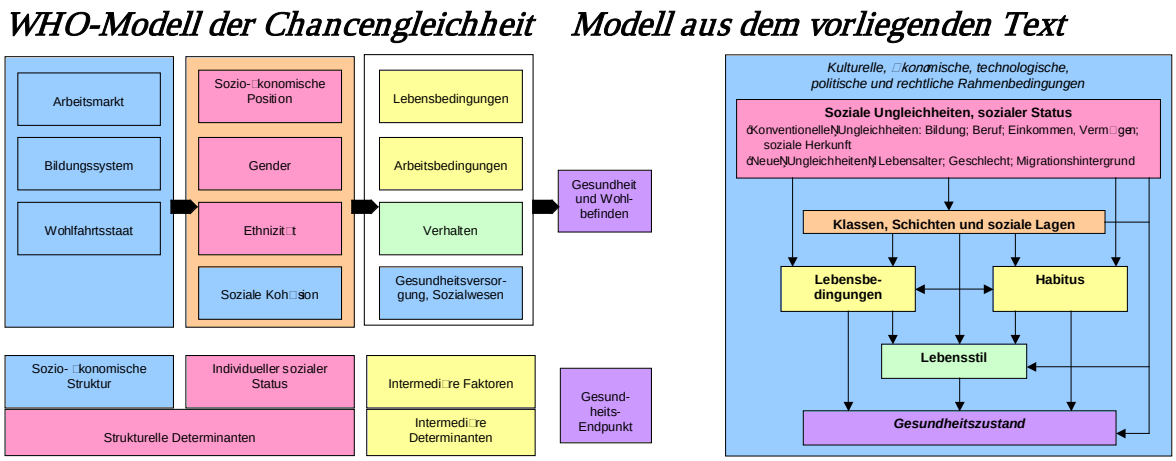
Anhang 1: Hinweise zum Ungleichheitsmodell von WHO und BAG

Das im vorliegenden Dokument vorgestellte und auf der rechten Seite von Abbildung A1 zusammengefasste Ungleicheitsmodell ist nur eines von vielen Modellen, die in der Fachdiskussion verwendet werden. Einige Prominenz hat in den vergangenen Jahren ein Modell erlangt, das von der WHO (2007) entwickelt wurde und in einer jüngeren Publikation des BAG (2008) verwendet wird. Das im linken Teil von Abbildung A1 dargestellte WHO-Modell der Chancengleichheit scheint sich auf den ersten Blick stark vom hier verwendeten Modell zu unterschieden. Ein näherer Blick zeigt allerdings erheblich Parallelen auf, die in der Abbildung zusätzlich dadurch hervorgehoben wurden, dass inhaltlich vergleichbare Teile der beiden Modell mit denselben Farben versehen wurden.

Beide Modelle verweisen zunächst auf die Hintergrundbedingungen (blau dargestellt), die bei der WHO als "sozio-ökonomische Struktur", im vorliegenden Modell als "Rahmenbedingungen" bezeichnet werden. Ebenfalls in beiden Modellen werden einzelne Ungleichheitsdimensionen (rot) und die vermittelnden Ebenen der Lebensbedingungen (gelb) und des Verhaltens/Lebensstils (grün) auf die Gesundheit (lila) thematisiert. Die Abfolge der Dimensionen und Verknüpfungen ist in den beiden Modellen vergleichbar und läuft von übergeordneten (blauen) Strukturen, zu (roten) Ungleichheitsmerkmalen, (gelben) intermediären Bedingungen und (grünen) Verhaltens- und (lila) Gesundheitskonsequenzen.

Abbildung A1: Vergleich des verwendeten Ungleichheitsmodells mit dem WHO-Modell



Quelle: BAG/ISPM (2008:

Allerdings gibt es eine Reihe von Unterschieden, die primär auf den unterschiedlichen Fokus der beiden Modelle zurückzuführen sind. Das WHO-Modell versucht die Chancengleichheitsproblematik so umfassend und allgemein wie möglich abzubilden, wobei auch Unterschieden zwischen den verschiedenen Mitgliedländern Rechnung getragen werden soll. Dagegen beschränkt sich das vorliegende Modell auf die Analyse der Ungleichheitssituation in der Schweiz, die allerdings differenzierter dargestellt wird, als dies im allgemeiner ausgerichteten WHO-Modell möglich ist.

Als Folge werden im hier verwendeten Modell das Wechselspiel und die Verdichtung verschiedener Ungleichheitsdimensionen zu sozialen Lagen und Schichten expliziter thematisiert als im WHO-Modell. Ausserdem wird der Habitus als zusätzliche, stark subjektiv geprägte vermittelnde Dimension eingeführt. Demgegenüber verwendet die WHO das Konzept der sozialen Kohäsion (Zusammenhalt) als wesentliche Ungleichheitsdimension und fügt die Gesundheitsversorgung und das Sozialwesen als unabhängige Einflussfaktoren auf der Ebene der intermediären Faktoren ein. Beide Dimensionen sind auf der internationalen Ebene von erheblicher Bedeutung, können für die Schweiz jedoch der Einfachheit halber zu den blau markierten, relativ konstanten Rahmenbedingungen gezählt werden. Gesamthaft betrachtet sind die beiden Modelle jedoch sehr ähnlich und führen damit auch zu vergleichbaren Aussagen.

Anhang 2: Ausgewählte Schweizer Gesundheitsförderungsprojekte mit einem Bezug zur Ungleichheitsproblematik

Projektname und Trägerschaft	*Zentrale Merkmale, Zielgruppe*	*Kurzbeschrieb*
Gesundheitliche Chancengleichheit im Billig-Trend ISPM Institut für Sozial- und Präventivmedizin, Bern	- Einkommen - allgemeine Rahmenbedingungen	Im Sinne der gesundheitlichen Chancengleichheit für sozial schwächere Bevölkerungsschichten werden die Billiglinien der Grossverteiler dahin gehend untersucht, ob und inwiefern sie für die VerbraucherInnen gesundheitliche Nachteile mit sich bringen. Durch die kritische Beurteilung von Inhaltsstoffen, Nährwerten, Packungsgrössen und Sortiments¬zusammensetzung dieser Lebensmittel sollen die für die öffentliche Gesundheit relevanten Zusammenhänge aufgezeigt werden. Im Hinblick auf eine Sensibilisierung der wichtigen Akteure werden die Ergebnisse bei einem Round-Table-Gespräch mit Vertretern der Grossverteiler, Gesundheitsför¬derung Schweiz, der Schweiz. Gesellschaft für Ernährung sowie Konsu¬mentenschutzorganisationen präsentiert und danach veröffentlicht.
Les recettes à quat'sous Service Sociale de la Ville de Genève	- Einkommen - Lebensbedingungen	Objectif: Créer des espace et des moments de rencontre autour de l'alimentation saine et équilibrée à moindre coût. Ce projet vise à aborder cette problématique par l'intervention de multiplicateurs appartenant eux-mêmes aux publics cibles. Ces personnes sont recrutées par l'entremise d'associations d'entraide. Elles s'engagent dans un processus solidaire consistant à recevoir une courte formation sur l'alimentation équilibrée dont elles se serviront, ainsi que de leurs propres compétences, pour animer à leur tour des ateliers ouverts à toute la population, mais prioritairement à des groupes cibles pré-définis (familles ou individus à revenu modeste ou d'origine étrangère). Ces animations vont associer théorie et pratique autour de l'alimentation et lien social et de proximité à l'intérieur des quartiers.
Présence bénévole Association Neuchâteloise de Services Bénévoles ANSB	- Lebensalter - Lebensbedingungen	Die Association neuchâteloise de services bénévoles ANSB möchte mit dem Projket 'présence bénévole' älteren oft vereinsamten Menschen die zu Hause wohnen Kontaktmöglichkeiten ausserhalb der familiären und professionellen Strukturen anbieten, die sich nicht um Pflege und Haushalt etc. drehen, ohne diese ersetzen zu wollen. Ziel des Projketes ist es, soziale Beziehungen zu Menschen zu unterhalten, welche selbst nicht mehr Kraft oder Mittel dazu haben. Die Freiwilligen können sich dadurch in einer sinnvollen Tätigkeit wiederfinden und neue Kompetenzen entwickeln. Die Ausarbeitung und Umsetzung des Konzeptes inkl. Schulungsprogrammem (monatlich 1 Tg.) und Supervision ist über 3 Jahre angelegt und soll jährlich evaluiert werden.
Bientraitance – un antidote à la maltraitance Fondation Charlotte Olivier, Fribourg	- Lebensalter - Einkommen - Lebensbedingungen - Habitus	Hauptziel des Projekts 'Bientraitance' ist es, den Zugang und die Teilnahme von Kindern und Jugendlichen zwischen 7-17Jahren, insbesondere aus sozial benachteiligten Familien, zu entwicklungsfördernden gemeinschaftlichen Aktivitäten zu erhöhen und damit zu einer gesundheitsfördernden Umwelt beizutragen. Dafür soll ein dauerhaftes Dispositiv entwickelt, angewendet und evaluiert werden, das die Anbieter von gemeinschaftlichen Aktivitäten (ehernamtliche Gruppen und Vereine) unterstützt. Dem Projekt liegt das neuartige Paradigma der 'bientraitance' zugrunde, die eine optimale Entwicklung der Kinder und Jugendlichen gewährleisten soll. Ausgehend von der These, dass die Teilnahme an geeigneten Gruppenaktivitäten einen gesundheitsfördernden Aspekt (Wertschätzung der eigenen Person, des Körpers, eigener Ressourcen, Anerkennung von Grenzen, Thema Emotionen, Frustrationstoleranz, Konflikt- und Gewaltverhalten) aufweist, möchte das Projekt die ungenutzten Ressourcen identifizieren und mobilisieren. Die Gewährleistung einer gesunden Entwicklung für Kinder und Jugendliche ist im Projekt nicht ausschliessliche Angelegenheit von Fachleuten, Schule und Familie, sondern auch von Organisationen wie Gruppensportclubs, Musikgruppen und Gruppen mit anderen gemeinschaftlichen künstlerischen Aktivitäten, Jugendverbänden, Kulturvereinen.

Projektname und Trägerschaft	*Zentrale Merkmale, Zielgruppe*	*Kurzbeschrieb*
Donna, Nonna, ma Donna Berner Gesundheit	- Geschlecht - Bildung	Im Projekt "Donna, Nonna, ma Donna", das innerhalb von Betrieben und sozialen Institutionen durchgeführt wird, geht es um Verminderung des riskanten Medikamentengebrauchs bei Frauen ab 60, aus sogenannt tieferen Bildungsschichten. Mit Informationsveranstaltungen und vertiefenden Gruppenangeboten sollen die Selbsthilfepotentiale der Frauen gestärkt werden.
FemmesTische mit Migrantinnen interkulturell Suchtpräventionsstelle, Uster	- Geschlecht - Migration - Bildung - Einkommen - Lebenssituation - Habitus	Dieses in Anlehnung an das erfolgreiche niederschwellige Mütterbildungsprojekt « Femmes-Tische mit Migrantinnen im Zürcher Oberland » umgesetzte Pilotprojekt führt als neues, ergänzendes Angebot interkulturelle Gesprächsrunden auf Deutsch für Schweizerinnen und Migrantinnen verschiedener Herkunft durch. Ziel dieser Gesprächsrunden am Stubentisch ist es, den Müttern Wissen zu Erziehungs- und Gesundheits¬the¬men zu vermitteln und sie dadurch in ihrer Elternrolle zu stärken, ihnen aber insbesondere auch Gelegenheit zum Knüpfen von Kontakten mit Migrantinnen anderer Herkunft und mit Schweizerinnen zu geben. Für die Leitung der Gesprächsgruppen bilden die Projektverantwortlichen eine Reihe von Migrantinnen mit guten Deutschkenntnissen zu Moderatorinnen aus und begleiten und unterstützen diese während ihrer Tätigkeit. Mit dem neuen Fokus auf dem interkulturellen Dialog ist das auf dem bewährten Konzept der FemmesTische beruhende Projekt speziell auf die Förderung des gegenseitigen Verständnisses zwischen den Migrantinnen unterschiedlicher Herkunft untereinander und den Schweizerinnen ausgerichtet.
Gesundheits-Ratgeber Arbeitstitel "Roter Faden" dialog-gesundheit Schweiz, Zollikofen	- Migration - Lebensalter - Bildung - Lebensbedingungen	dialog-gesundheit Schweiz möchte einen Ratgeber für Gesundheitsförderung entwickeln, der als gesamtschweizerisches Pilotprojekt dienen soll. Die BenutzerInnen des Ratgebers/roten Fadens sollen zu Verantwortungsübernahme für die eigene Gesundheit animiert werden. Das Informationsinstrument soll, um wirksam zu sein, gemeinsam mit der Bevölkerung erarbeitet werden, der Wunsch nach besseren Informationen über GF, therapeutische und soziale Angebote und deren besseren Vernetzung ist im Forum dialog-gesundheit Zollikofen geäussert worden. Text und Illustrationen sollen für alle verständlich aufbereitet werden, Konzeptgrundlage bildet der Gesundheitsratgeber der Universität Berkeley, die dialog-gesundheit Schweiz das Lizenzrecht offiziell erteilte. Eine Planungsgruppe bestehend aus BürgerInnen der Gemeinde und Region erarbeitet seit 2 Jahren zusammen mit versch. Organisationen (Spitex...) in freiwilliger Arbeit die Inhalte, schon bestehende Leitfäden werden miteinbezogen und sinnvoll ergänzt.
Saglik - deutsch-türkische Gesundheitszeitung Gesundheitsdienste Basel	- Migration - Bildung	Stadt herausgegebene Gesundheitszeitung Saglik legt ihren Fokus auf die zugezogene, fremdsprachige Bevölkerung und will ihr den Einstieg in die vielfältigen Gesundheitsförderungsangebote erleichtern. Das Magazin wird deshalb zweisprachig herausgegeben. In der vorliegenden Pilotausgabe ist es neben der deutschen die türkische Sprache. Im Vordergrund steht die alltagsbezogene Gesundheitsförderung, weshalb besonders auf lokale Angebote hingewiesen wird. Die Leitidee der Zeitung ist, dass die Förderung der Gesundheit beim eigenen Verhalten beginnt. In der Zeitschrift Saglik werden deshalb viele basisnahe Präventionsangebote vorgestellt, welche von der ganzen Bevölkerung in Anspruch genommen werden können. Gesundheitsförderung und Prävention soll in der Zeitschrift aber nicht mit dem Drohfinger zeigen. Die Leserinnen und Leser sollen vielmehr lustvoll unterstützt und motiviert werden, die Gesundheit in die eigenen Hände zu nehmen.

Projektname und Trägerschaft	*Zentrale Merkmale, Zielgruppe*	*Kurzbeschrieb*
Porta Nova Infoklick.ch	- Behinderung (Gesundheit) - Lebensalter - Bildung	Das Projekt will in der Deutschschweiz einen Beitrag leisten zur tatsächlichen Öffnung der „offenen Jugendarbeit“ für junge Menschen mit Behinderung und ebenso zur Öffnung von Projekten von Behinderten¬ein¬richtungen für Nichtbehinderte. Dazu ist die Schaffung von Bildungsprogrammemen und Instrumentarien (im Internet und in anderen geeigneten Medien wie Broschüren, Handbücher) vorgesehen, die es den Akteuren der Offenen Jugendarbeit und im Behindertenbereich ermöglichen, ihre Projekte entsprechend zu öffnen. Das Instrumentarium wird unter Mitwirkung von Behinderten und Nichtbehinderten entwickelt. Ziel des Projekts sind die Förderung des gegenseitigen Verständnisses, von Respekt und Toleranz, die Erschliessung neuer Ressourcen und die praktizierte Chancengleichheit für Behinderte und Nichtbehinderte in ausserschulischen Aktivitäten.
Agir pour la promotion de la santé en surdité Association romande pour la promotion de la santé des personnes sourdes	- Behinderung (Gesundheit) - Lebensbedingungen	A. La communauté des sourds de Suisse romande participe activement aux activités de PS développés par Les Mains pour le Dire. -> Une formation d'ahnimateurs/trices de santé en surdité est mise en œuvre -> Un pool de compétence est constitué -> Engagement des sites surdité dans la démarche de promotion de la santé -> Des animateurs/trices de santé du pool de compétence sont actifs B. Création d'un fonds de projet; d'ici fin 2004, 6 à 10 projet de PS ont été réalisé par les animateurs/trices de santé en surdité grâce à ce fonds
Die Anderen Verein Die Anderen	- Behinderung (Gesundheit) - Habitus	Ausgehend von der Band DIE ANDEREN wurde ein Verein gleichen Namens gegründet. Entstanden ist daraufhin eine eigenständige und schräge Kulturszene, die Behinderte und Nichtbehinderte zusammenbringt. Bei den Anlässen und Ausstellungen verwischen die Grenzen zwischen normal und anders. Barrieren, Vorurteile und Ängste der "Normalen" gegenüber Behinderten verschwinden. Behinderte werden vom Publikum als Künstler/-innen wahrgenommen. DIE ANDEREN leisten mit ihrem Engagement zudem einen wichtigen Beitrag gegen Gewalt und Übergriffe an behinderten Menschen.
Neustart Verein Neustar	- Lebensbedingungen - Habitus	Die freiwilligen Bewährungshelfer/-innen von NEUSTART sind für Handfestes zuständig: Finanzen, Wohnung, Arbeit. Fern von Sozial-Romantik leisten sie Hilfe zur Integration von Strafentlassenen in unsere Gesellschaft. Aufgaben wie Begleitung bei der Arbeits- oder Wohnungssuche, der Freizeitgestaltung, Unterstützung bei Finanzfragen und Schuldenprobleme sind je nach Klient/-in typische Tätigkeiten. Die Freiwilligen absolvieren eine anspruchsvolle Ausbildung. Sie werden zudem mittels Supervision und Coaching unterstützt. Für Personen mit delinquentem Vorleben wirkt die Beziehung zu uns Freiwilligen sehr positiv. Sie erhalten individuell und jenseits von Bürozeiten die notwendigen Hilfestellungen.

Endnotes

1 Vgl. Bopp und Minder (2003) sowie Lebenserwartung bei der Geburt im Jahr 2006 gemäss Bundesamt für Statistik: http://www.bfs.admin.ch/bfs/portal/de/index/themen/01/06/blank/key/04.html
2 BFS (2005a)
3 Lamprecht et al. (2008a)
4 Vgl. Stamm et al. (2003).
5 Vgl. z.B. Bosc (1993), Bihr und Pfefferkorn (1995), Levy et al. (1997), Burzan (2004), Stamm et al. (2003)
6 Bornschier (1996)
7 Vgl. Jahn und Kolip (2002) sowie die Dokumente auf www.quint-essenz.ch; weitere Hinweise zur Gender-Thematik finden sich auch in Cyba (2000), Babitsch (2005) und Pfefferkorn (2007).
8 Vgl. Kaya (2007) sowie die weiteren Hinweise auf www.quint-essenz.ch

[9] Abbildung 2.2 stellt eine von vielen möglichen schematischen Darstellungen des Zusammenhangs zwischen Ungleichheit und Gesundheit dar. An dieser Stelle ist auf ein Modell hinzuweisen, das von der WHO (2007) entwickelt wurde und unter anderem auch vom Bundesamt für Gesundheit (BAG) verwendet wird (vgl. BAG/ISPM 2008) und eine sehr ähnliche Auswahl an Ungleichheitsdimensionen und Verknüpfungen enthält. Ein Vergleich jenes Modells mit dem hier vorgestellten findet sich in Anhang 1.

[10] Vgl. Bourdieu (1979, 1983)

[11] Der Habitusbegriff weist eine gewisse Nähe zu verschiedenen psychologischen Konzepten (z.B. kognitive Ressourcen, Bewältigungskompetenz oder Selbstkonzept) auf. Tatsächlich lassen sich verschiedene psychologische Argumente unter dem Stichwort des Habitus diskutieren, der für den vorliegenden Beitrag jedoch den Vorteil hat, dass er explizit auf die Auswirkungen sozialer Ungleichheit Bezug nimmt.

[12] Vgl. z.B. Mielck (2000, 2005) und Marmot (2005), Budrys (2003), Graham (2007).

[13] Vgl. z.B. Mackenbach (1998), Mielck (2005).

[14] Vgl. Lamprecht et al. (2006).

[15] BFS (2007).

[16] Ein genauerer Blick auf die Daten zeigt, dass die "reicheren" Haushalte tendenziell eher etwas grösser sind als die ärmeren. Das heisst, dass die höheren Einkommen auch für mehr Personen reichen müssen. Stellt man dies in Rechnung und berechnet man die um die Anzahl Haushaltsmitglieder korrigierten "Haushaltsäquivalenzeinkommen" so reduziert sich die Spanne zwischen den ärmsten und reichsten zehn Prozent der Haushalte auf rund einen Faktor von etwas über 7 (ärmste 10%: rund SFR. 21'000.-; reichste 10%: rund SFR. 152'000.-; reichste 2%: SFR. 252'000.-, vgl. Stamm et al. 2007).

[17] BFS (2008b, 2008c).

[18] Die "Multimillionäre" mit einem Vermögen von über 10 Mio. Franken machen nur ein Promille aller Steuerpflichtigen aus, versteuern aber knapp ein Fünftel des Gesamtvermögens in der Schweiz.

[19] Vgl. BFS (2005b).

[20] Jahn und Kolip (2002).

[21] BFS (2005b, c), Stamm et al. (2003)

[22] Vgl. BFS (2005b, c) sowie das Grundlagendokument von Kaya (2007).

[23] Vgl. Levi et al. (1997), Stamm et al. (2003)

[24] Wang und Schmid (o.J.)

[25] Vgl. z.B. BFS (2005a, 2006).

[26] Vgl. BFS (2006)

[27] Vgl. Lamprecht et al. (2008a).

[28] Vgl. auch Lamprecht et al. (2008b)

[29] Vgl. Bisig und Gutzwillller (1999), Bisig et al. (2001), Lehmann et al. (1990), Schopper und Obrist (2005)

[30] In der jüngsten Altersgruppe der unter 30-Jährigen gelten 41.4 % als sehr ausgeglichen, während dieser Anteil in der Gruppe der 60-Jährigen und Älteren 67.2 % beträgt.

[31] Lehmann et al. (1988), Vader et. al. (1993), Bopp und Minder (2003).

[32] Bopp und Minder (2003) sowie aktuelle Resultate, die uns vom Schweizerischen Gesundheitsobservatorium freundlicherweise zur Verfügung gestellt wurden.

[33] http://www.euro.who.int/AboutWHO/Policy/20010827_2?language=German

[34] Vgl. Altgeld (2006), Boudon (1973),

[35] http://www.who.int/hia/en/

[36] Vgl. Gesundheitsförderung Schweiz (2007)