SOCIAL INEQUALITIES IN HEALTH

Should equity in health be target number 1?

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Policy measures to reduce socioeconomic health differences (SEHD) must be preceded by an analysis of the possibilities and desirability of a reduction. This paper argues that it is necessary to pursue equality in health, conceived as equal opportunities to achieve health. This principle is justified as part of the principle of maximizing individual freedom of choice, and requires that everyone has the opportunity to be as healthy as possible. By means of this principle a distinction can be made between unjust, unavoidable, and acceptable health inequalities. The determinants of SEHD which lead to inequalities considered unjust must be subject to policy. These are living conditions (physical and social environment and health care) and conditions of choice (e.g. the knowledge of an individual about the health risks of a certain behaviour). Even if SEHD are considered inequities, sometimes conflicting interests will make it difficult to propose a health policy to redress these inequities. These are partly the consequence of the intersectoral character of a policy aimed at equality of opportunities to attain health, in which the importance of health has to be weighed against other goals. Moreover the impact of such a policy on the individual free choice has to be critically weighed. Finally in the context of health care policy, conflicts between the principle of equality and maximizing health can be expected.

Key words: equity in health, health policy, socioeconomic factors

There is no doubt that socioeconomic differences in health (SEHD) exist, even in welfare states. Empirical studies in different countries show higher morbidity and mortality rates among people with a lower education, lower income, or a lower classified occupation, compared to people in higher socioeconomic groups (Wilkinson 1986, Fox 1989, Illsley & Svensson 1990). Now that the association between socioeconomic position and health seems to be established, a call for a policy response can be observed. Whitehead and Dahlgren (1991), who elaborated policy measures to reduce existing inequalities, summarize this trend as follows: "The debate is no longer about whether inequalities exist but what can be done about them." (p.1059). In the current debate about the policy measures to be taken to reduce SEHD, two important issues have rarely been discussed.

The first concerns the justification of a policy aimed at reducing SEHD: why is it *necessary* to reduce socioeconomic inequalities in health? This question must precede the development of policy measures. Most often the desirability of such measures is simply assumed, even though the justification of policy measures is not necessarily self-evident. We will argue that is necessary to give arguments for the government's responsibility to reduce SEHD and to specify the socioeconomic inequalities in health to which this responsibility applies.

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If one can show that (some) socioeconomic inequalities should be reduced, the second question is what *possibilities* exist to achieve this. Given the intersectoral character of such a policy and the fact that these inequalities in health are inextricably related to socioeconomic structures, conflicts of interests in developing policy measures can be expected. In order to get a realistic idea of the possibilities of a government to reduce SEHD, the potentials for policy measures and the inherent constraints should be explored systematically. In this article we will discuss these two questions.

Two preliminary remarks, however, have to be made. So far equality in public health has mostly been discussed in the context of health care services (Mooney 1983, Mooney et al. 1991, Wagstaff et al. 1991, Culyer et al. 1992). Central issues of this debate are the desirability of pursuing equality in health care, and the implications for health care policy in terms of equal effectiveness or equal access. Although the issue of equality in health is related to equality in health care, the discussion about the justification of policy measures to reduce inequalities in health must not be limited to the area of health care services. Health care is only one of the determinants of socioeconomic inequalities in health. Therefore the debate on the just distribution of health *care* is a 'second order' debate, which is of importance only after one has taken a view on the desirability of equality in health. Furthermore, although the justification of equality has so far hardly been discussed in the context of the distribution of health, political and economic sciences have a long tradition of debate on the justification of equal distribution in general. We can and will draw upon some of the elements from this debate.

SOCIOECONOMIC INEQUALITIES IN HEALTH AND INEQUITIES

Socioeconomic inequalities in health as observed in the western world are generally assumed to be unjust. They are considered socioeconomic *inequities* in health. The underlying logic of most people is that, because of the value of good health for the individual, it is desirable and necessary to pursue equality in health for all (Stronks 1992). Starting from this assumption, they argue that all differences in health have to be eliminated. The justification for a policy to pursue equality in health is not as simple as that. In the first place, the question arises whether one should pursue for instance equality in actual health or equality of opportunity to attain health. Because equality is open to so many interpretations, this principle has to be specified before a policy can be formulated (Whitehead 1990, 1992). Secondly, if a policy is simply based on the desirability of equality in health, one will face conflicts with other societal goals. In the western world equality in health is not automatically seen as the primary goal, to which, for example, economic goals are inevitably subordinate. In this section both the justification and desirable conception of equality in health will be discussed.

The justification of the principle of equality in health is dependent on the reason why health is valued. The intrinsic value of health must be distinguished from the instrumental one. If health is appreciated because of its intrinsic value, health is considered to be worthwhile *per se*. Valuing health on account of its instrumental value means considering health to be important because it enables the individual to pursue other values. Health is defined then as the capability to act or to realize personal goals (Nordenfelt 1987).

Each of these values leads to different conceptions of equality in health. The consequence of appreciating health by its intrinsic value is that equality in health has to be realized irrespective of other goals a society may value. Pursuing health becomes a primary goal under all circumstances. If an instrumental value is attached to health, equality in health is no longer the primary goal, but has to compete with other principles like equal opportunities of education.

In applying the arguments used in political philosophy to inequality in health, it can be shown that health must be viewed as a means to realize other goals, and not as a value on its own. We will base the justification of the principle of equality in health on the ideas of Sen.

The responsibility of the government to guarantee equality in health, defined as the capability to act or to realize personal goals, can be subsumed under the responsibility of guaranteeing each individual the opportunities to realize his personal goals, also called his individual life plan. If the latter has been justified, the obligation to pursue equality in health follows logically from this justification.

Sen argues that each individual has to be guaranteed freedom of choice. The justification of this ideal can be based on the principle of equal concern and respect (Larmore 1987, Dworkin 1987). According to that principle each individual is due equal respect, by virtue of his capacity to work out his own conception of the good life: "To have respect for a person is to view him as capable of elaborating beliefs that we would respect." (Larmore 1987, p.64).

As a consequence each person should have the opportunity to plan his own life. The government is not allowed to favour some groups or persons above others, for example because it believes the ideas of the former are better than those of the latter. As a consequence of the principle of equal concern and respect, the individual freedom has to be valued highly. Freedom based on the wish to show every individual equal concern and respect is called *positive freedom* and can be described as follows. The ideal of the individual who has the freedom to lead the life he considers worthwhile requires a minimal interference by others. There must be some area in which the individual is free to decide. Neither the government nor any other citizen is allowed to prevent the individual inside this area from doing the things he wants to do. This is called negative freedom. However, being free in the 'negative' sense is not sufficient to work out a lifeplan. This ideal requires more than the absence of interference by others. It shifts the attention from interference by others to the things an individual can actually do. Firstly, a person must have an opportunity to choose between different ways of living which are all meaningful to him. He must have the freedom to choose from these different life plans the plan which agrees most with his own conception of the good life. Furthermore he must be able to realize his own life plan as much as possible. If these conditions are met, an individual is free in the positive sense (Berlin 1969, Benn & Weinstein 1971).

Positive freedom can therefore be formulated as *freedom of choice*. Justice through the ideal of positive freedom means guaranteeing each individual an equal ability to choose freely. This implies that conditions have to be created that make it possible for each individual to choose the life plan that seems the best to him. Moreover, each individual must have equal prospects of realizing this life plan.

Sen (1985, 1988, 1990) argues that the freedom a person has is reflected in the different ways of living from which he can choose. These different ways of living can be phrased in terms of alternative combinations of functionings or doings and beings. Examples of these are: being adequately nourished and having the opportunity to follow (qualified) education. These so-called 'capabilities' determine the range and content of the life plans an individual can choose from. Maximizing the individual freedom of choice therefore means guaranteeing each individual as many ways of functionings and beings as possible. The possibility to lead a long and healthy life then becomes just another condition for individual freedom of choice. In other words, good health can be defined as a *'basic capability'*. The absence or presence of this capability determines the life plans from which an individual can choose and a restriction of this capability implies a reduction of the alternative.

In this view promoting positive freedom therefore means enhancing human capabilities, among others the capability of being in good health. Given these capabilities, individuals can differ in the value they attach to different ways of functioning, for example to being as healthy as possible. In the notion of positive freedom, they are entitled to do so. Each person then has the right *not* to define his life in terms of a long and healthy life, but to choose for say a 'burgundian' lifestyle. Consequently equality of health is interpreted as equality of *opportunity* to be as healthy as possible. This principle does not require everyone to have the same level of health, but it demands such a distribution of determinants of health, to the extent that they can be controlled, that every individual has the same possibilities to lead a long and healthy life. Given those opportunities, the individual reserves the right to decide whether to use them or not. As a consequence, equality in health justified on the notion of positive freedom, may well coincide with differences in actual health.

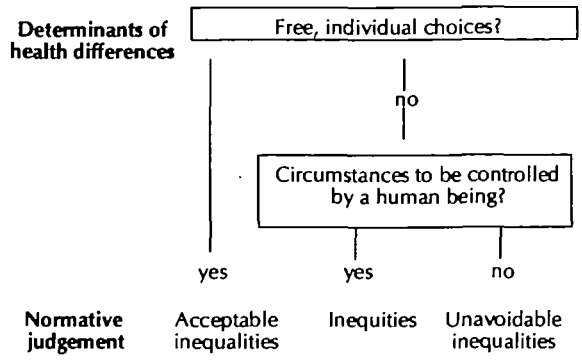
The definition of equity in health achieved by this argument is the same as the one used by Whitehead (1990, 1992), but here it is based on theories of social justice.

The justification of the desirability to pursue equality in health, perceived as equality of opportunity to attain health, is consistent with the value the western world attaches to the principle of 'equal concern and respect', and to positive freedom. Because the government is not supposed to promote a particular conception of the good life, each individual should have the right to determine whether he lives a healthy life or prefers a lifestyle which can be hazardous to his health. The only thing a government is entitled to do is to create conditions that make it possible for the individual to choose the life plan which seems best to him. The capability to be as healthy as possible is such a condition. Health is thus pursued in this argument for its instrumental value. If we had chosen to pursue health for its intrinsic value, health would become a primary goal. A policy to reduce SEHD would then aim at equality of actual health rather than opportunity for health. In that case the principle of equality in health requires everyone to have the same level of health. We argue that this principle is not compatible with the ideas on freedom we have in the western world.

If one accepts the principle of equality of opportunities to attain health, differences in health as observed in western countries cannot be considered unjust in advance. Whether inequalities are unjust or not depends on their origins.

Inequalities that are the result of free choices made by an individual are *acceptable*. If the society attaches value to health in order to promote individual freedom of choice, one must accept the consequence that some people will not choose good health as their primary goal.

Differences in health, in our context, are *unjust* if they result from a situation of inequality of opportunities for health. That inequality is reflected in an unequal distribution of determinants of health if these health-influencing factors are beyond the control of the individual. This applies to most health-influencing circumstances in which an individual lives. This is of course conditional. If the distribution of a certain determinant of health is beyond the control of a human being, like the age distribution, it cannot be defined in terms of justice or injustice, if justice is defined as a situation in which equal cases are treated equally and unequal cases unequally. This definition already shows that justice presupposes the acting of a human being. If the distribution of a certain good is determined by nature, like the distribution of genetic factors, one may at most judge it unfair. Such an unequal distribution will be called *unavoidable* in our terminology.



This argument can be shown schematically; see figure.

In order to determine which determinants of SEHD result in acceptable inequalities, unavoidable inequalities or in inequities, they have to be classified in one of these categories. When the causes of existing socioeconomic health differences have been obtained, it is possible to determine which part of the existing inequalities must be seen as acceptable, unavoidable, or unjust. Furthermore policy measures to reduce unjust inequalities can be elaborated.

POSSIBILITIES TO REDUCE SEHD

In the previous pages we have argued that the causes or determinants of SEHD will determine whether we consider SEHD avoidable and unjust, therefore also inequities. Interventions on these same determinants also offer us the possibility to influence the existence of SEHD. However, also the *intervention mode* itself needs to be critically weighed and valued to see if it is acceptable to society. Sometimes conflicting interests will make it difficult to propose a health policy to redress SEHD even if they are considered an inequity (Gunning-Schepers 1991).

We will explore the possible causes of the existing socioeconomic health differences and therefore the possible options for interventions, according to the traditional division in health determinants used in health policy making. Determinants of health are often grouped into five main categories: genetic predisposition, physical environment, lifestyles, social environment, and health care (Gunning-Schepers & Hagen 1987). For each determinant we will try to show to what extent resulting inequalities are inequities, and what policy options are available to reduce inequities. Furthermore we will show the inher-

ent policy dilemmas when an intervention to reduce inequities in health through that determinant is placed in the wider spectrum of just social policy.

Genetic predisposition

- Causes

Genetic predisposition, as well as biological factors such as ageing, determine much of the variability of health seen in a population. However so far there is no evidence that these health differences are systematic nor that they are unequally distributed over the various socioeconomic groups (Mascie-Taylor & McManus 1984). If genetic factors were to be found essential in the explanation of socioeconomic health differences, resulting inequalities must be considered unavoidable, because most of these health-influencing factors are beyond the control of a human being.

- Policy options

Although their current unavoidability would not warrant interventions in this area, this option is further complicated by the fact that genetic interventions encounter very strong opposition in most societies on ethical grounds.

- Policy dilemmas

So if in the near future it would be possible to change genetic configurations, there are ethical choices to be made about the acceptability to society of these technological possibilities, before their use to reduce socioeconomic health differences may be envisaged.

Physical environment

- Causes

Risk factors in the physical environment are seldom unevenly distributed over socioeconomic groups in the population by nature (Fox & Goldblatt 1982, Whitehead 1988). It usually requires social elements to achieve skewed distributions. These are most notable in the risk factors associated with poor housing, working conditions and such basic requirements for health as clean drinking water and adequate sewers. According to the principle of positive freedom it is the government's responsibility to achieve an equal distribution of these conditions. Differences in health resulting from an unequal distribution are therefore inequities.

- Policy options

The physical environment is an essential element in the health protection policies that were so crucial to the first public health revolution. Since infectious diseases were the most dangerous threats to public health in that period, much of the policy tradition is still geared towards achieving herd immunity. That implies aiming at a broad protection in the population, if only out of self interest. Because of that tradition, there is a longstanding political consensus to achieve an equal distribution of these risk factors.

- Policy dilemmas

They are often the easiest determinants for which a policy response can be envisaged. However, implementation will often involve intersectoral action, and thus may interfere with other socioeconomic goals. Sometimes the health goals and the other interests of society coincide, as in the clean drinking water and sewage systems, which helped increase the productivity of workers by reducing endemic infectious diseases. However, more often there are conflicting interests, such as in improving working conditions while maintaining a healthy cost-benefit ratio, or in weighing the health costs and the economic benefits of polluting industries or major transport centres in our current societies. It is when such basic capabilities, each necessary for the individual to be able to choose his preferred life plan conflict that government encounters a major policy dilemma.

Lifestyles

- Causes

In discussions about the reduction of socioeconomic differences in health, lifestyles are often considered the most important determinant (Morris 1990). Not only is the variation in disease frequency for the most important causes of death explained to a certain extent by risk factors connected to lifestyles, but we also know that these risk factors and the causes of mortality influenced by these risk factors are unevenly distributed over socioeconomic groups (Rose & Marmot 1981, Blaxter 1990).

Smoking is more prevalent among the lower socioeconomic groups, healthy nutritional habits are not evenly distributed in society, and alcohol abuse appears to be more frequently found in lower socioeconomic groups (although the evidence is mixed on this risk factor). 'If only the lower socioeconomic groups would adopt healthier lifestyles' seems to be a recurrent theme in many a political debate on socioeconomic differences in health. Of course, just the fact that these are avoidable inequalities in health is not sufficient to make them inequities, as we argued earlier. The crucial element is whether these are determined by free choice or not. Only if lifestyles are *not* the individual's free choice will a government policy to interfere with lifestyles be acceptable. Reasons to believe that lifestyles are not determined by free choice may be because the knowledge about the health risks of certain lifestyles appears to be unevenly distributed, or because one believes there are structural limitations to the freedom of choice, as for instance in pricing policies of certain foods. Furthermore, lifestyles may be partly determined by the social environment, by definition unevenly distributed among socioeconomic groups.

- Policy options

Health education campaigns aim at influencing people's individual choices in lifestyles, through information. As such they can contribute to the necessary knowledge about the health consequences of such choices. They are often viewed as the back bone of policies to decrease SEHD. Unfortunately we also know that health education campaigns do not always reach everyone, nor is their effectiveness equal in different socioeconomic groups (Holme et al. 1985).

Policy measures aimed at more structural changes, such as pricing policies, are another option. Because of their economic character, they require intersectoral action.

To the extent that lifestyles are determined by social environment, the policy response will be quite different and should concentrate on changing social structures rather than guiding individual preferences. The determinant then is no longer lifestyles but the social environment, and will be discussed there.

- Policy dilemmas

A policy to change peoples lifestyles, beyond giving information, very soon interferes with an essential political good, that of the freedom to act. Interference with free choice in our societies is usually unacceptable, unless the health risks involved will affect others in society. The state has rights to limit the freedom of the individual for the good of society, for instance in the case of epidemic disease. Also in some societies the free choice of parents is limited if it threatens the health of dependent children, although interestingly enough in The Netherlands vaccination of children has never been compulsory, for the simple reason that the state was not allowed to interfere with the parents free choice based on religious beliefs.

Furthermore, in some cases interference with free choice can be justified on the paternalistic argument: interference for the individual's own good. An example of a paternalistic policy is the obligation to use seat belts. Given the value attached in the western world to individual freedom, only liberal paternalistic policies seem to be acceptable, for instance pricing policies. For some even pricing measures to make unhealthy lifestyles less attractive, as opposed to pricing policies to give healthy choices a fair chance, are rejected for that reason.

Another dilemma concerning pricing policies is the possible conflict between the potential health benefit and other policy goals. The EC subsidies to tobacco farmers are a good example of a choice against health in favour of economic growth.

Social environment

- Causes

The health determinants in the social environment are really at the centre of the socioeconomic differences in health problems (Marmot & Morris 1984). They are essential for the very existence of socioeconomic differences in health since education, income, and occupation are but proxies which identify groups in society with distinct cultures and lifestyles. It is often these distinct cultures and lifestyles which are in themselves determinants of health. The health beliefs and attitudes are the legacy of the social environment of childhood; lifestyles and the ability to change them are clearly elements of social structures. In our view it is the government's responsibility to strive for an equal distribution of these structures. However, a large part of them cannot be changed, and resulting inequalities in health must be conceived as unavoidable. As a consequence, inequalities resulting from differences in lifestyle, so far as these are embedded in social structures, are also partly unavoidable.

- Policy options

Social structure is the result of political decisions that have very little to do with health. Social structures may cause health differences but health differences will seldom be the reason for major social reforms. Sometimes however decisions are taken in social and economic policy that may have far-reaching effects on health, without taking the health impact into account. Since health has long been viewed as a randomly distributed good rather than a basic capability in society of which the quantity and the distribution can be influenced by policy, policy decisions made to influence other basic capabilities have not been considered in the light of their effect on health. A very real policy option is to make the impact on the distribution of health a point to be considered in the general policy making process.

- Policy dilemmas

Some of the socioeconomic differences in health caused by social environmental factors may be considered unavoidable, any policy to change social structures to reduce socioeconomic differences in health will definitely have to take the competing societal goals into account. Differences in health are at best weighed against other effects such as economic growth and employment, all factors that influence (the distribution of) basic capabilities. If one wants to incorporate changes in the social environment, other than indirect changes through lifestyles or exposure to physical risk factors, into a policy to reduce socioeconomic differences in health, the key question to ask would be at what point health differences become so pronounced that they can no longer be ignored in the socioeconomic policy making.

Health services

- Causes

The provision of health care services is the central element and responsibility of health policy. The equal distribution and access of health services has long been the most important subject for debate on the just distribution of health. Many industrialized countries have found a system whereby at least the essentials of medical care are available to all, regardless of income. The importance attached to equal access to care is easily defended by the notion that health is a basic capability and that everyone should have equal opportunity to attain it. If health care contributes to the attainment of health it should rightly be equally accessible to all.

However, even in countries which have gone much further in their policy of equal access, either through a national health service or through obligatory social insurance, health differences persist. Some of these are the result of unequal use of the available services, others appear to be related to unequal effectiveness of services (Yelin et al. 1983, Leon & Wilkinson 1989, Mackenbach et al. 1989). Use of available services may in part reflect individual preferences and would therefore in our concept not be a subject for policy measures. Unequal effectiveness of available services on the other hand, is unlikely to be intended, either by the user or the provider. In fact it reduces the individual's capability of attaining health. As such it would be just to strive for equal effectiveness of care.

The same applies to preventive care. Many preventive programmes are based on the premise that all those at risk are reached by their efforts. The estimates of effect on which decisions to invest are often made assume not only an even distribution of risk factors in the population, but certainly an average effectiveness for all population groups.

We know, however, that the risk factors are not equally distributed in the population. If we could assume equal effectiveness of preventive interventions on these risk factors we could therefore expect a reduction of socio-economic differences in health as a result of any such programme. Reality is different. Women in the lower socioeconomic groups are least likely to respond to an invitation for a PAP smear, compliance with anti-hypertension medication is not equal in all socioeconomic groups, children of migrant families are less likely to attend child clinics and receive total vaccination (Gunning-Schepers 1981). There are apparently constraints that mean that preventive services do not reach the general population as they were intended to. Because of their unequal effectiveness, these very preventive services may be one the reason for the unequal distribution of risk factors, and thus of socioeconomic inequities in health.

- Policy options

Although health care is probably not the most important determinant of SEHD, health care policy will obviously be a major channel to reduce socioeconomic differences in health. The potentials for reducing socioeconomic differences in health through health care policies are in the reduction of the unequal distribution of incidence of ill health through health promotion and disease prevention, or in the reduction of the unequal distribution of the outcome of health care, the prognosis of the patient.

To adequately reduce inequities, health services policies will have to look beyond equal distribution and access to equal effectiveness. Of course the same applies to preventive services, which may also influence the lifestyle determinants.

- Policy dilemmas

In most cases tailor made preventive programmes will cost more than one uniform campaign. It is a political decision to what extent these extra investments are justified, whereby they will have to take into account what other services are forgone in doing so. In this weighing of cost-effectiveness, the ultimate goal either of maximizing health or of achieving an equal distribution of health will play a role. Since health is a basic capability necessary to attain other goods such as economic wealth, reducing the overall potential to attain such other goods may limit society more than the existence of health differences will. In that case the obvious justification for the reduction of socioeconomic health differences may cease to exist.

As with the preventive services, investments in time and personnel to achieve equal effectiveness of curative services will again have to be weighed against the effect we wish to achieve. However, more than with preventive services the ultimate goal will be equal distribution rather than maximizing health since, having made the decision to supply health services, unequal effectiveness can never be considered positively. Once a person is ill many elements of free choice are eliminated and the outcome is very much in hands of the health care professionals. They therefore have the first responsibility in seeing that the patient gets adequate care, irrespective of income or education. This becomes especially important in situations where financial resources are becoming increasingly scarce. When rationing of some sort begins to apply in health care, equal treatment to all patients may no longer be guaranteed. Those are the situations in which socio-economic differences in health are most likely to be sustained through health policy.

CONCLUSIONS

In the first part of this article we argued that (socioeconomic) health differences are not necessarily inequities. Striving for the reduction and prevention of *all* SEHD would result in an unacceptable interference with individual freedom. Starting from the ideas we have in the western world on freedom, the principle of equality in health can only be conceived as a means to guarantee each individual freedom of choice, based on the conception of health as a basic capability. Therefore, only inequalities resulting from an unequal distribution of *opportunities* to be as healthy as possible, to the extent that this distribution can be controlled, must be conceived as inequities.

If a distribution of opportunities for health cannot be controlled, resulting inequalities are unavoidable. At least some determinants of SEHD lead to unavoidable inequalities. The possibilities for controlling the social environment in particular, by definition a crucial determinant of socioeconomic differences in health, should not be overestimated. Because some differences in life styles are embedded in the social environment, the same doubts apply to life styles as an option to reduce SEHD.

The possibilities to achieve equity in health was the second main issue of this article. Although there is great *potential* for improving the distribution of health through intersectoral action, given the determinants of socio-economic differences in health discussed earlier, there very often will be a conflict of interest with other societal goals. We identified four dilemmas, which show that equity in health cannot always be target number 1.

The major constraint in trying to redress SEHD results from the fact that interventions on most determinants of health will have to come from departments other than the department for public health. We argued that health should be pursued for its instrumental value in the context of the principle of attaining equality in basic capabilities. Whereas the primary goal of health policy is (equality in) health, other policy fields have *other primary goals*, and health effects and distributional effects on health are side effects: income distribution is not determined by its health effects, educational policies are not primarily aimed at reducing socio-economic differences in health, employment may be considered more important than the reduction of work related risks. In *intersectoral* action conflicts between the goal of equality in health and goals in other

policy fields, especially economic policies, are therefore to be expected.

Although sometimes policy measures in several policy fields will positively influence the distribution of opportunities for health, the difficult choices occur when one basic capability has to be foregone for another one. The theories on social justice are useful in determining what basic capabilities are, but they do not offer much help in creating a hierarchy within these basic capabilities. What should society choose: equal opportunities to achieve health or equal opportunities to achieve gainful employment? The predominance of economic interest will be especially noticeable in differences in health between socioeconomic groups, because these inequalities in health are inextricably related to socioeconomic structures. Placed in the wider spectrum of social policy, equity in health may therefore not always be given highest priority. However, what we can aim for is to include the health effects in the decision making process. Given the skewed distribution of the determinants of socioeconomic differences in health that are influenced by intersectoral action, a concern for the health effects of such decisions will almost always reduce socioeconomic differences in health even if the distribution of health effects is not directly addressed.

Conflicts between health policy and other policy goals are absent in the context of health care policy. Because health is the primary goal in the policy of the public health department, we should at any rate strive for the realization of the equality principle in this context, interpreted as equal access and effectiveness. However, here the principle of equality in health care has to compete with the principle of *maximizing* health. If one accepts that health is a basic capability, equality should prevail over efficiency, at least in curative care. In case of preventive health care, giving priority to maximizing health can sometimes be useful, as this may in the long run contribute to a situation with greater freedom of choice for each individual.

A third dilemma we pointed out applies to interventions on the determinant life style. Before implementing such interventions, their impact on the *free choice* of an individual has to be assessed. Given the high value we attach in the western world to free choice, policy measures aimed at improving health related behaviour should in first instance be aimed at the determinants of this behaviour, like knowledge about health risks. Interventions that strongly interfere with the individual free choice could to some extent be justified on the harm of certain behaviour to others, or to the individual himself, so-called paternalistic intervention. But, in general, the individual's free choice should be respected in policy measures, and equity in health should be made subordinate to that.

A fourth and last dilemma concerns the conflict between the wish to control the distribution of genetic factors and *ethical principles*. If genetic factors appear to be important in the explanation of SEHD, a policy to 'redistribute' these characteristics among socioeconomic groups will be constrained by ethical considerations.

If we accept that the principle of equal opportunities to attain health should be the main goal of health policy, one should not expect this goal to be fully realized. Not only will some determinants of SEHD, especially social structures, hardly be open to intervention, but conflicts between health policy goals and other societal goals can also be expected. Because health is not always the primary concern in intersectoral action, we should not be too optimistic towards the possibilities to reduce or prevent SEHD in western countries. The most policy makers can strive for is making the topic of health, and, more specifically, the topic of equal opportunities to attain health, an issue in the intersectoral policy making process.

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