Les inégalités sociales de santé concernent l'ensemble de la population

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École des hautes études en santé publique

La Roche-sur-Yon, le mardi 29 avril 2025

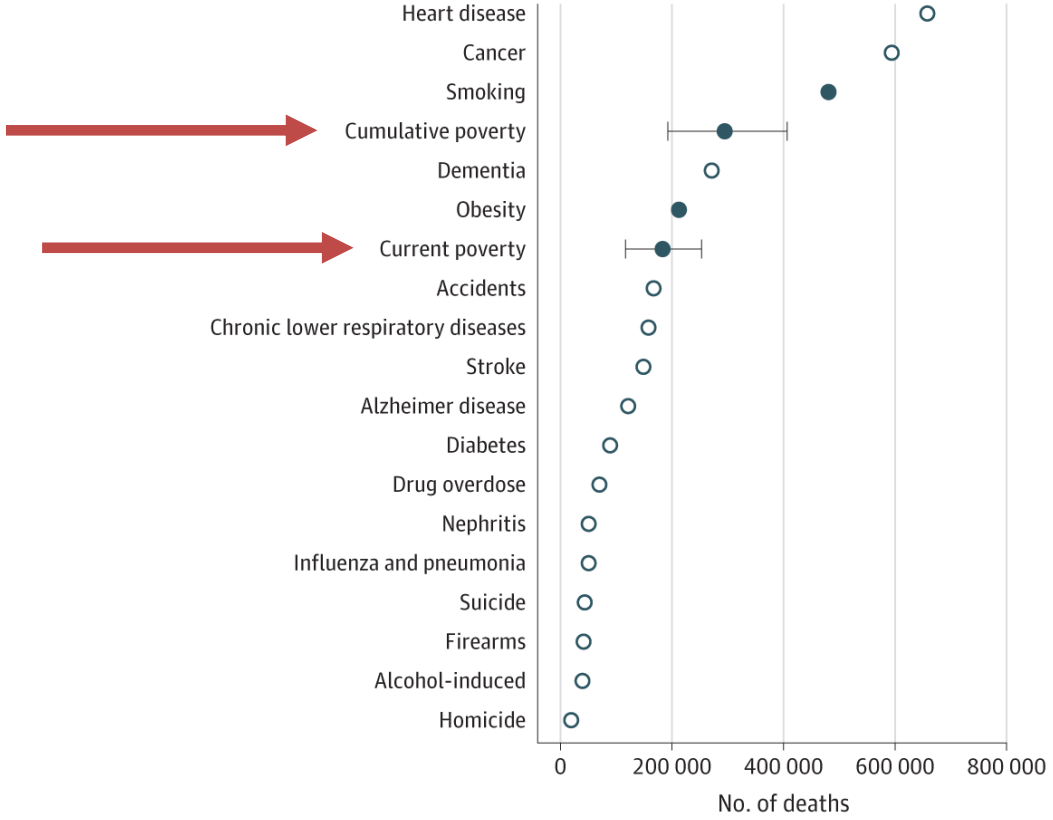
/bretoneric

Les points que je veux défendre aujourd'hui

- Les inégalités sociales de santé: une question de gradient social
- L'action doit donc porter prioritairement sur le gradient social
- Préférable de privilégier des mesures universelles aux effets proportionnés aux besoins
- Difficile de parler d'inégalités sociales de santé sans évoquer la question du pouvoir, de la domination et de l'oppression.

From: **Novel Estimates of Mortality Associated With Poverty in the US**

JAMA Intern Med. 2023;183(6):618-619. doi:10.1001/jamainternmed.2023.0276

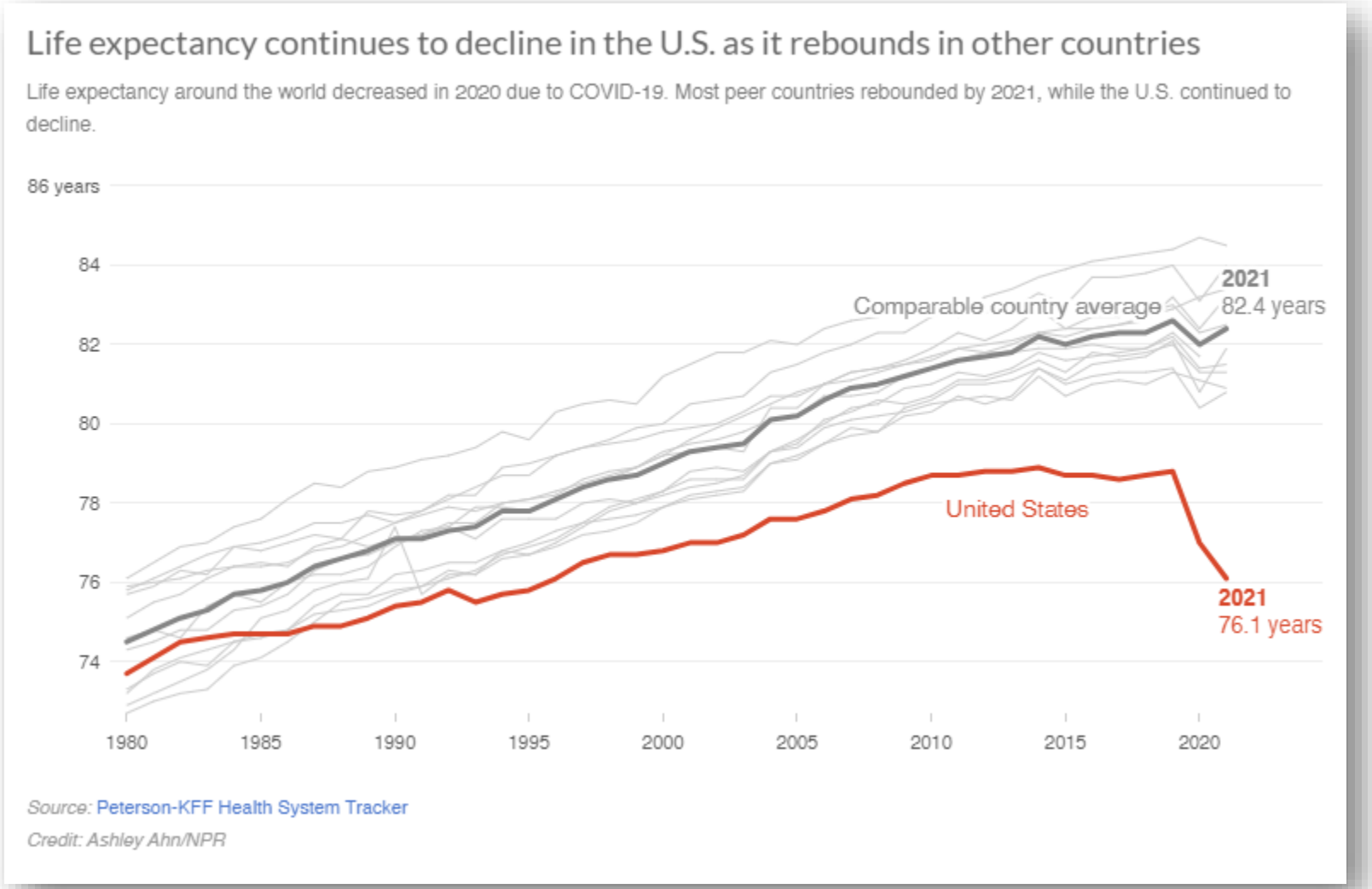


La pauvreté tue

Figure Legend:

Number of Deaths Associated With Cumulative and Current Poverty and the Major Causes (Open Circles) and Risk Factors (Filled Circles) in the US in 2019 Error bars indicate 95% CI. Sources: See eAppendices 1 and 2 in Supplement 1.

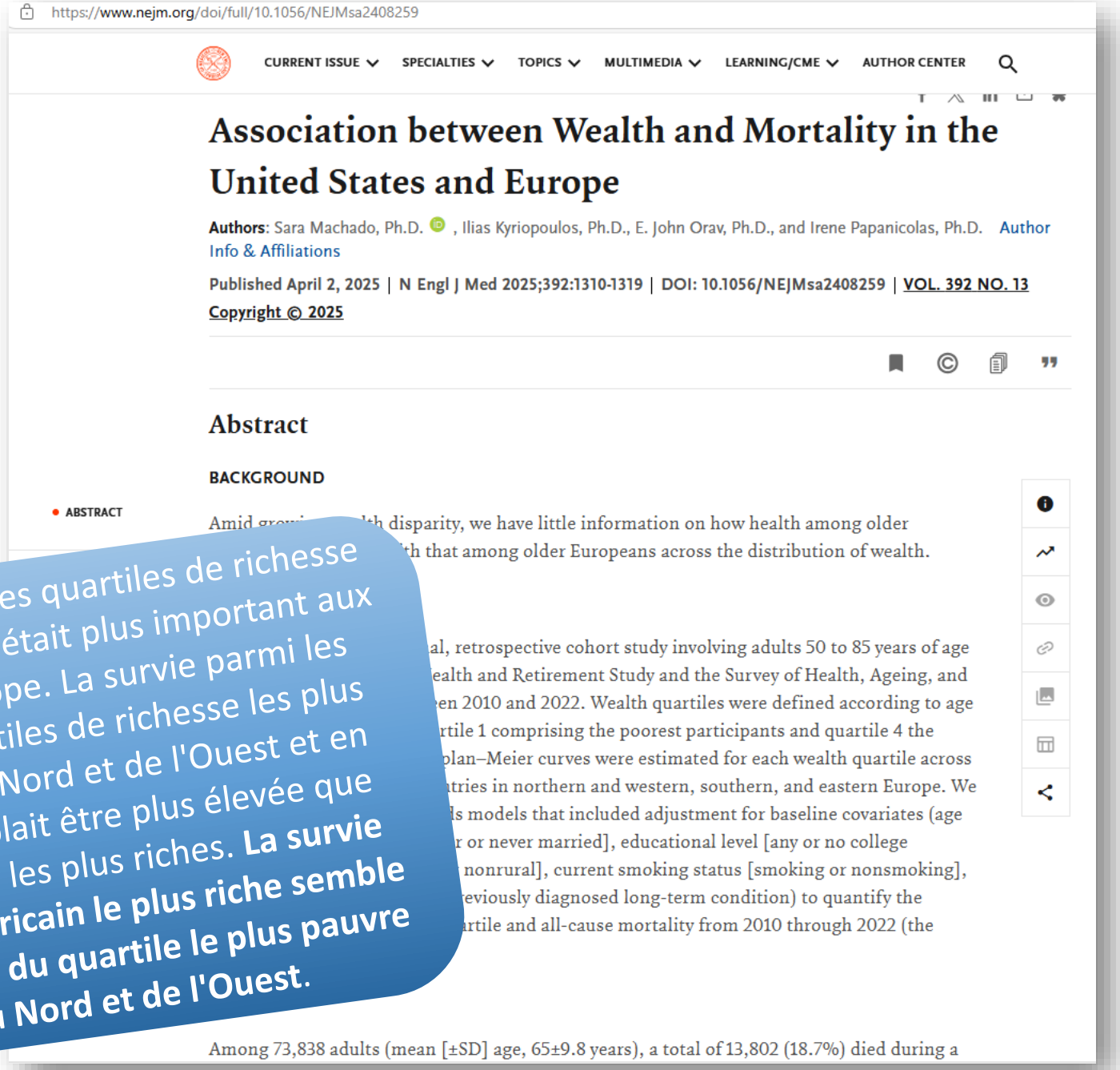
Simmons-Duffin, S. (2023, mars 25). « Live free and die? » The sad state of U.S. life expectancy. *NPR*. www.npr.org/sections/health-shots/2023/03/25/1164819944/live-free-and-die-the-sad-state-of-u-s-life-expectancy



The gap in survival between the top and bottom wealth quartiles was wider in the United States than in Europe. Survival among the participants in the top wealth quartiles in northern and western Europe and southern Europe appeared to be higher than that among the wealthiest Americans. **Survival in the wealthiest U.S. quartile appeared to be similar to that in the poorest quartile in northern and western Europe**.

Conclusions

In cohort studies conducted in the United States and Europe, greater wealth was associated with lower mortality, and the association between wealth and mortality appeared to be more pronounced in the United States than in Europe.


https://www.nejm.org/doi/full/10.1056/NEJMsa2408259

CURRENT ISSUE SPECIALTIES TOPICS MULTIMEDIA LEARNING/CME AUTHOR CENTER

Association between Wealth and Mortality in the United States and Europe

Authors: Sara Machado, Ph.D. , Ilias Kyriopoulos, Ph.D., E. John Orav, Ph.D., and Irene Papanicolas, Ph.D. Author Info & Affiliations

Published April 2, 2025 | N Engl J Med 2025;392:1310-1319 | DOI: 10.1056/NEJMsa2408259 | VOL. 392 NO. 13

Abstract

ABSTRACT

BACKGROUND

Amid gro…lth disparity, we have little information on how health among older …th that among older Europeans across the distribution of wealth.

…al, retrospective cohort study involving adults 50 to 85 years of age …ealth and Retirement Study and the Survey of Health, Ageing, and …en 2010 and 2022. Wealth quartiles were defined according to age …rtile 1 comprising the poorest participants and quartile 4 the …plan–Meier curves were estimated for each wealth quartile across …tries in northern and western, southern, and eastern Europe. We …ls models that included adjustment for baseline covariates (age …r or never married], educational level [any or no college … nonrural], current smoking status [smoking or nonsmoking], …reviously diagnosed long-term condition) to quantify the …rtile and all-cause mortality from 2010 through 2022 (the

Among 73,838 adults (mean [±SD] age, 65±9.8 years), a total of 13,802 (18.7%) died during a

L'écart de survie entre les quartiles de richesse supérieurs et inférieurs était plus important aux États-Unis qu'en Europe. La survie parmi les participants des quartiles de richesse les plus élevés en Europe du Nord et de l'Ouest et en Europe du Sud semblait être plus élevée que celle des Américains les plus riches. **La survie dans le quartile américain le plus riche semble être similaire à celle du quartile le plus pauvre en Europe du Nord et de l'Ouest.**

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RESEARCH

OPEN ACCESS

Changes in mortality inequalities over two decades: register based study of European countries

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Additional material is published online only. To view please visit the journal online.
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http://dx.doi.org/10.1136/bmj.i1732
Accepted: 13 March 2016

ABSTRACT

OBJECTIVE
To determine whether government efforts in reducing inequalities in health in European countries have actually made a difference to mortality inequalities by socioeconomic group.

DESIGN
Register based study.

DATA SOURCE
Mortality data by level of education and occupational class in the period 1990-2010, usually collected in a census linked longitudinal study design. We compared changes in mortality between the lowest and highest socioeconomic groups, and calculated their effect on absolute and relative inequalities in mortality (measured as rate differences and rate ratios, respectively).

SETTING
All European countries for which data on socioeconomic inequalities in mortality were available for the approximate period between years 1990 and 2010. These included Finland, Norway, Sweden, Scotland, England and Wales (data applied to both together), France, Switzerland, Spain (Barcelona), Italy (Turin), Slovenia, and Lithuania.

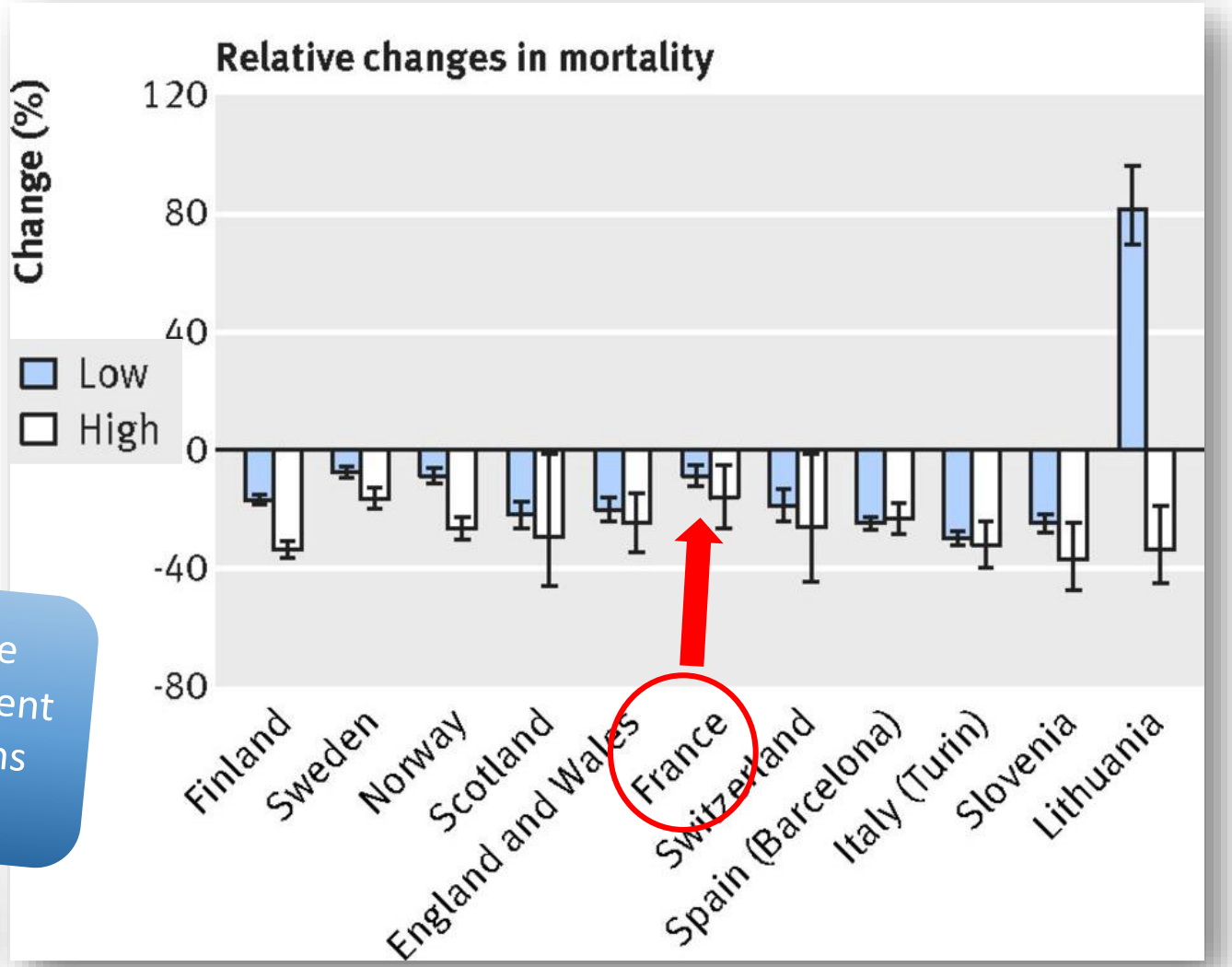
RESULTS
Substantial mortality declines occurred in lower socioeconomic groups in most European countries covered by this study. Relative inequalities in mortality widened almost universally, because percentage declines were usually smaller in lower socioeconomic groups. However, as absolute declines were often smaller in higher socioeconomic groups, absolute inequalities narrowed by up to 35%, particularly among men. Narrowing was partly driven by ischaemic heart disease, smoking related causes, and causes amenable to medical intervention. Progress in reducing absolute inequalities was greatest in Spain (Barcelona), Scotland, England and Wales, and Italy (Turin), and absent in Finland and Norway. More detailed studies preferably using individual level data are necessary to identify the causes of these variations.

CONCLUSIONS
Over the past two decades, trends in inequalities in mortality have been more favourable in most European countries than is commonly assumed. Absolute inequalities have decreased in several countries, probably more as a side effect of population wide behavioural changes and improvements in prevention and treatment, than as an effect of policies explicitly aimed at reducing health inequalities.

WHAT IS ALREADY KNOWN ON THIS TOPIC
A few decades ago, reducing inequalities in health between socioeconomic groups became a priority for health policy makers in many countries
Of studies analysing trends in mortality inequalities since then, most were limited to one country, a few looked at relative and absolute inequalities, and no study has quantitatively compared progress in reducing inequalities between countries

WHAT THIS STUDY ADDS
Since the early 1990s, absolute inequalities in mortality have declined among men in many European countries; relative inequalities in mortality have increased overall; progress in reducing absolute inequalities was largest in Spain (Barcelona), Scotland, England and Wales, and Italy (Turin), but absent in Finland and Norway
Narrowing of absolute inequalities was driven by substantial progress in reducing mortality in lower socioeconomic groups from ischaemic heart disease, smoking related causes, and causes amenable to medical intervention; however, there were substantial setbacks for alcohol related mortality
Recent trends in inequalities in mortality in Europe have been more encouraging than commonly thought, although progress has varied between countries

Introduction
Reducing inequalities in health between socioeconomic groups within a country is one of the greatest challenges for public health, even in the highly developed welfare state countries. Recognising this, several countries have set targets for reducing these inequalities by 25% by 2010 (ABES). We now extend this work by systematically assessing whether progress, and if so, how much, in reducing relative and absolute inequalities in mortality.
There is no agreement among researchers or policy makers on what measures to use for monitoring progress towards the reduction or elimination of health

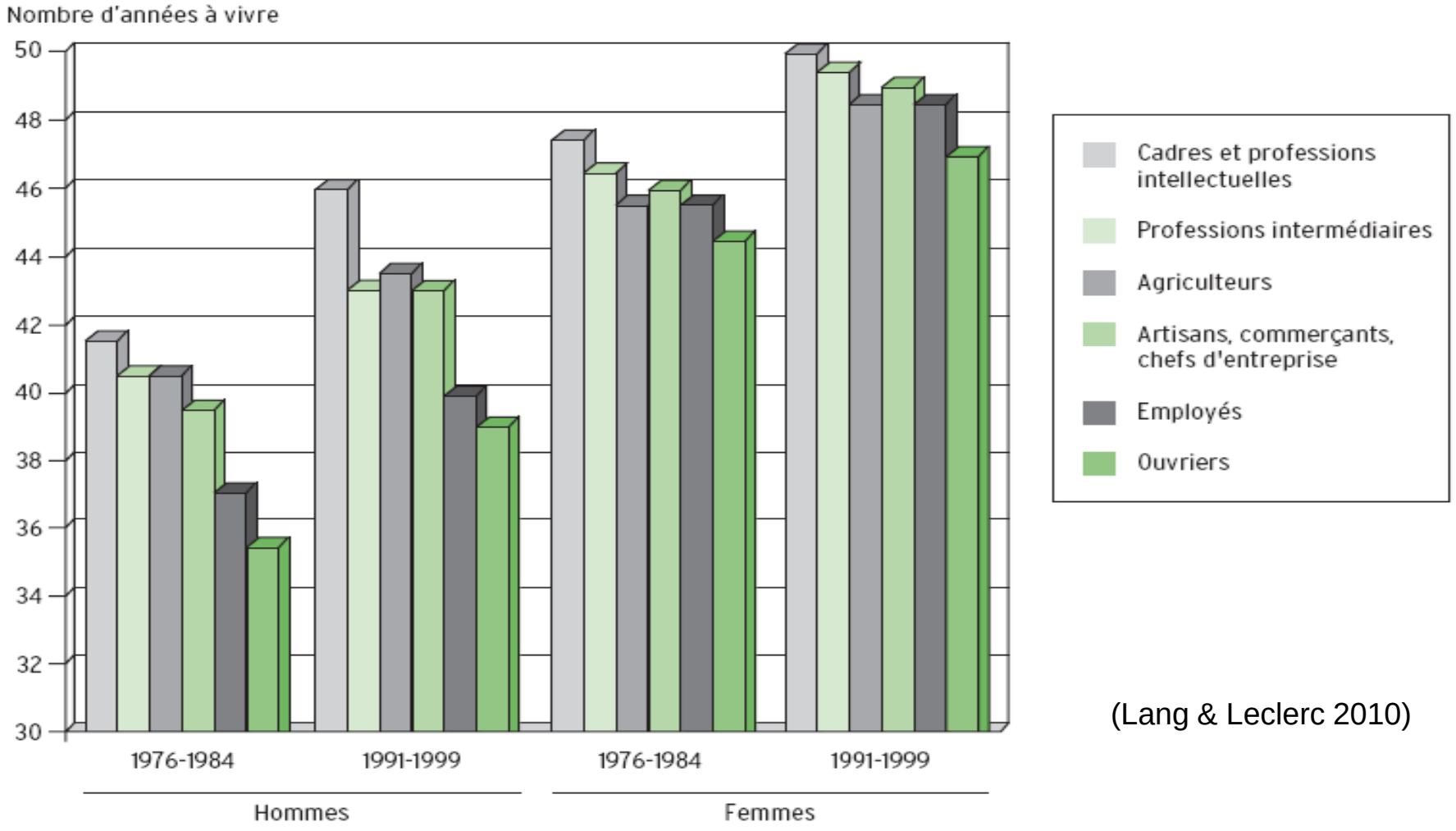


Les inégalités de mortalité demeurent stables… du moins jusqu'ici.

Mackenbach et al. (2016). Changes in mortality inequalities over two decades : Register based study of European countries. *BMJ*, i1732. https://doi.org/10.1136/bmj.i1732

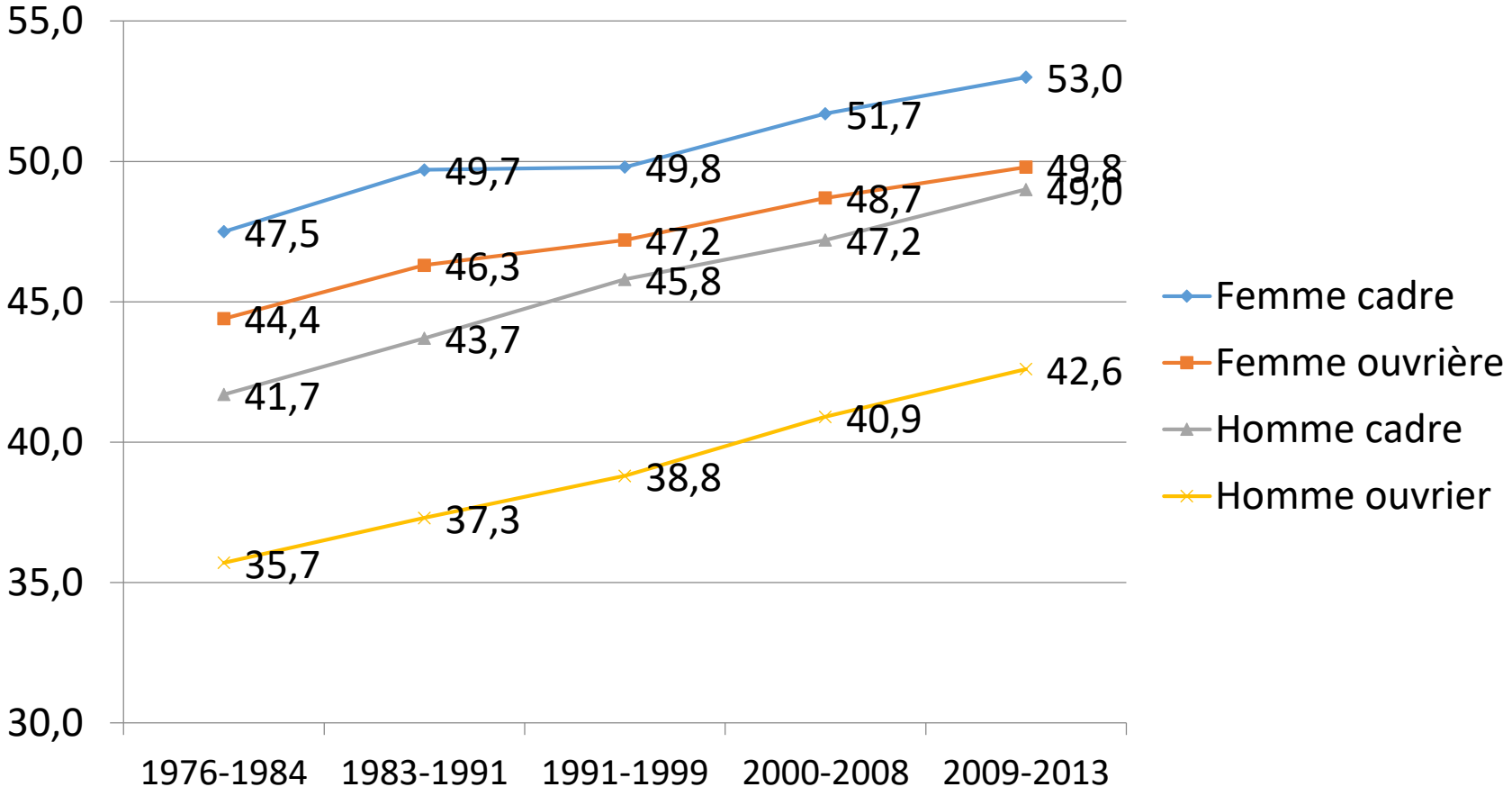
La question du gradient social

Espérance de vie à 35 ans
par groupe socioprofessionnelle



(Lang & Leclerc 2010)

Évolution de l'espérance de vie à 35 ans par sexe pour les cadres et les ouvriers (Blanpain, 2016)



Champ : France métropolitaine.
Lecture : en 2009-2013, l'espérance de vie à 35 ans des femmes cadres est de 53,0 ans.
Source : Insee, Échantillon démographique permanent.

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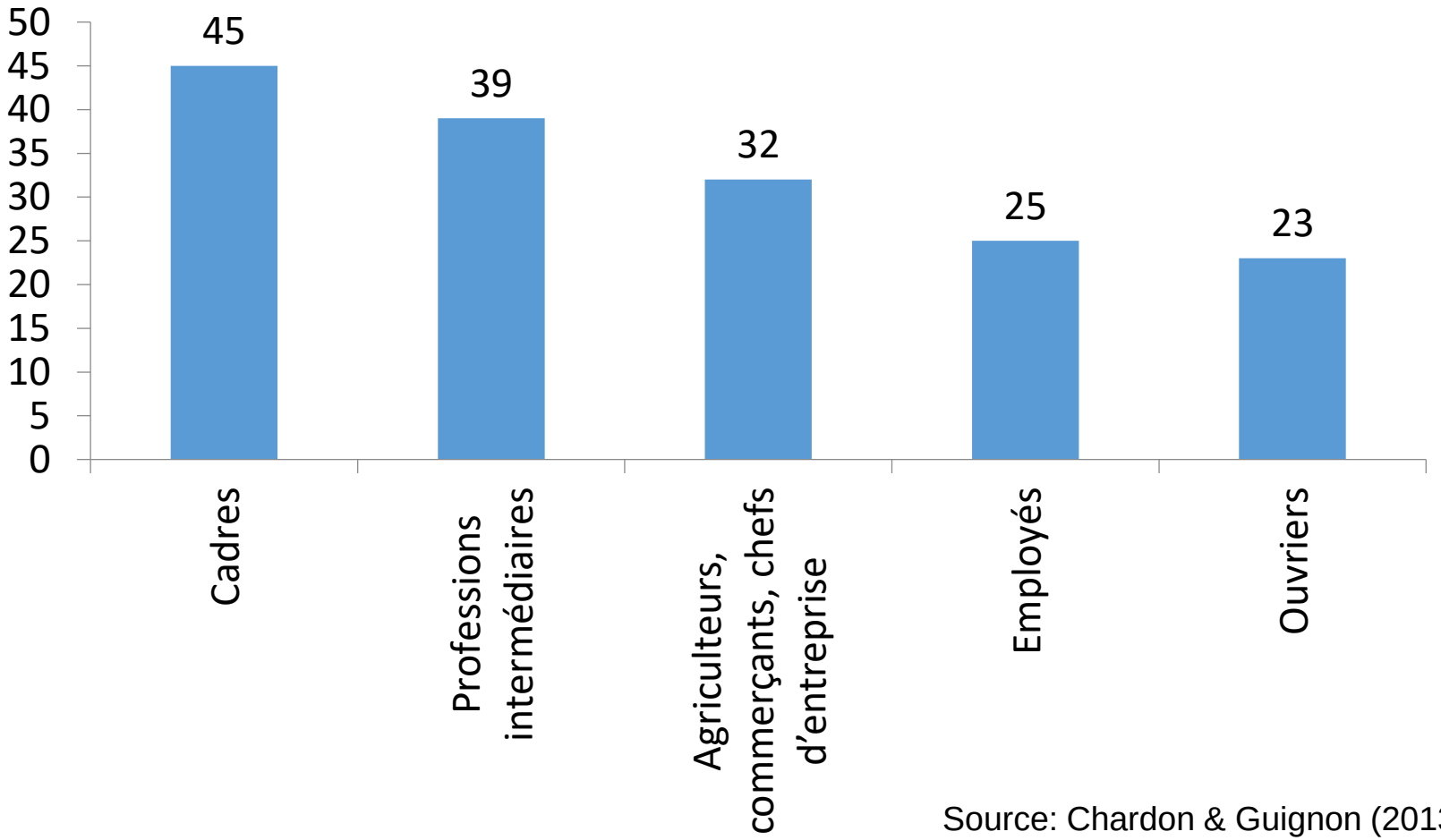
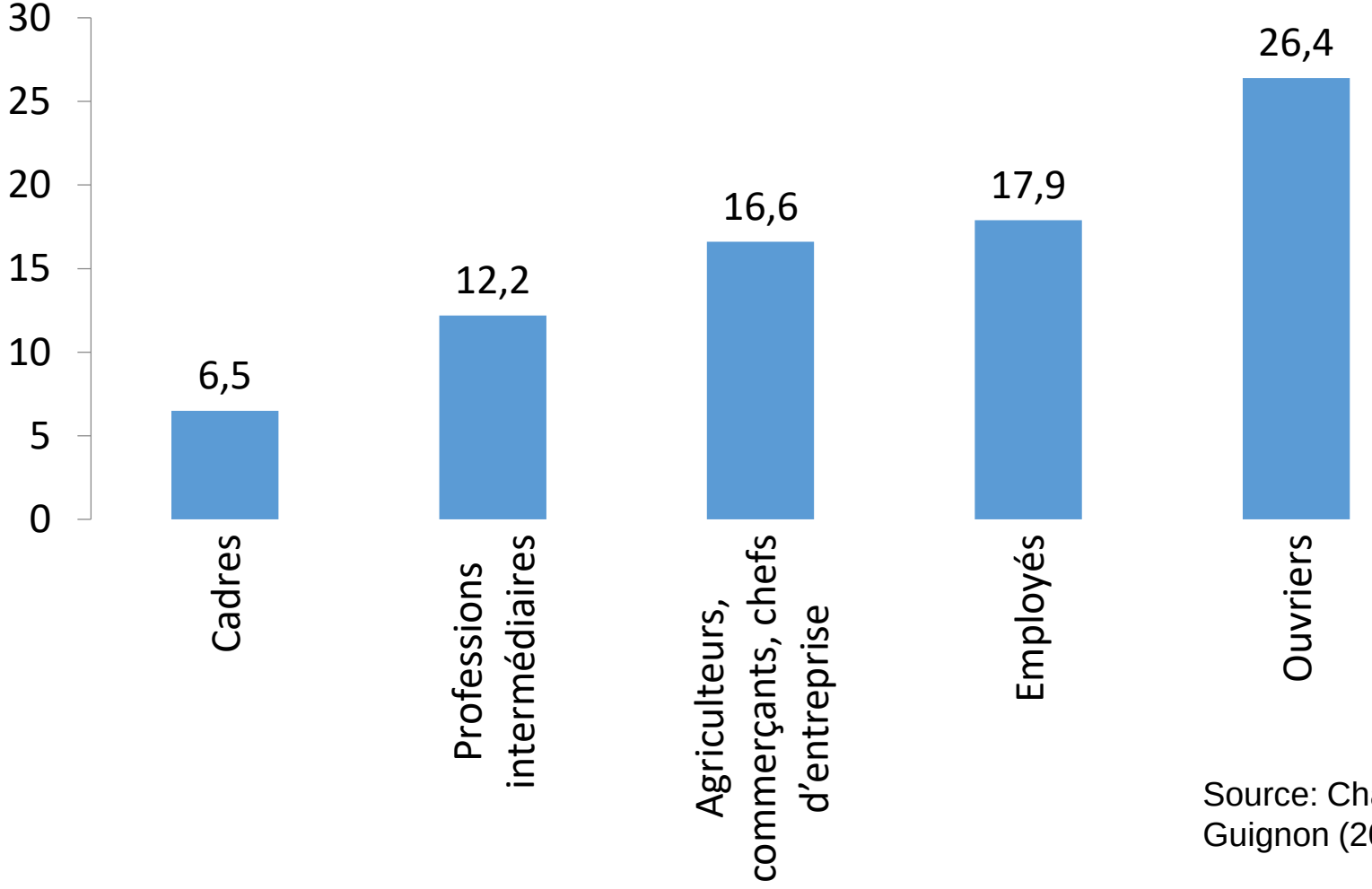
Consommation tous les jours de la semaine de fruits et légumes : élèves de CM2 (2007-2008)



Source: Chardon & Guignon (2013)

Difficultés en lecture selon l'origine sociale : élèves de CM2 (2007-2008)



Source: Chardon & Guignon (2013)

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Les déterminants sociaux de la santé

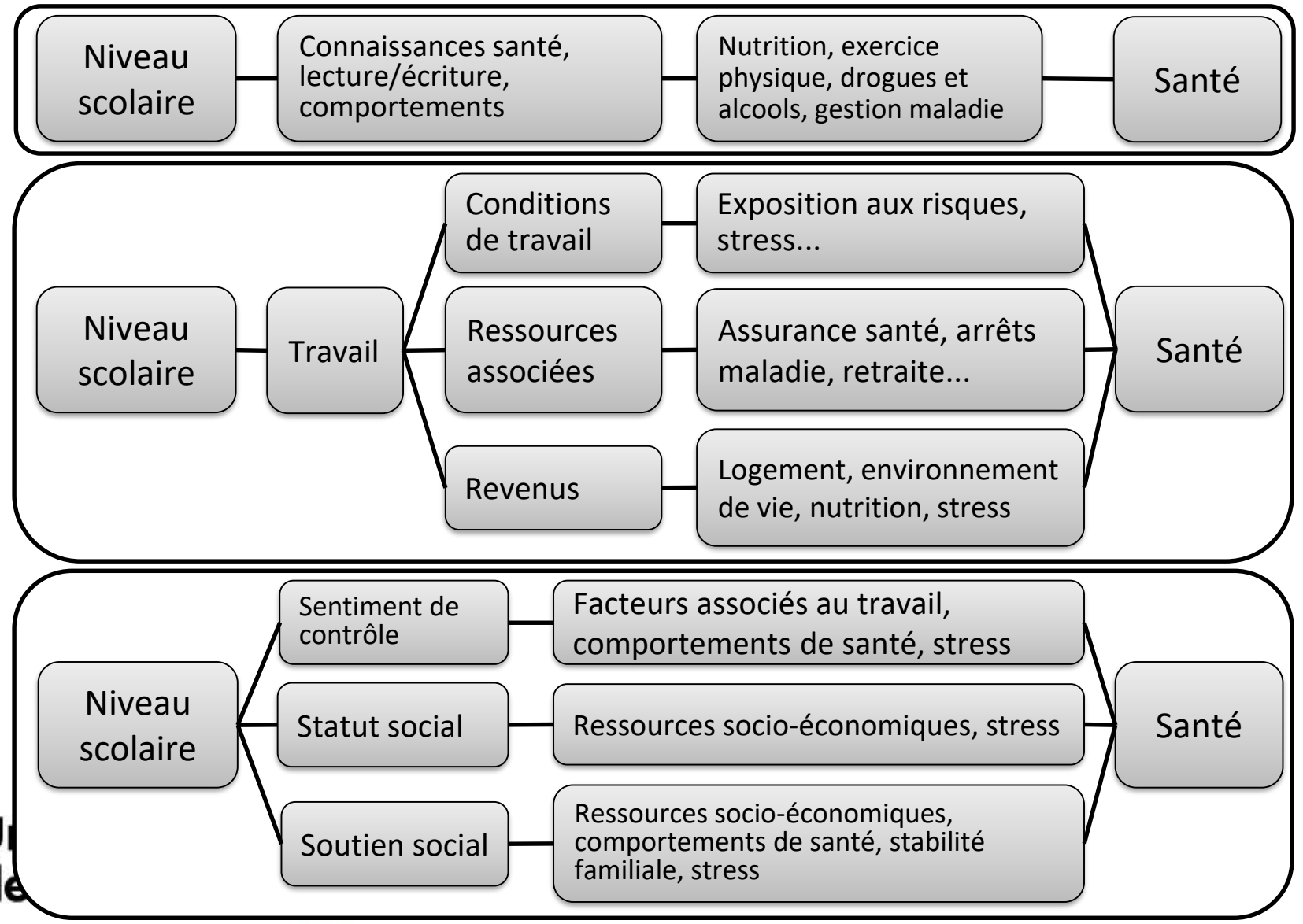
E. Breton, EHESP

Les déterminants sociaux de la santé…

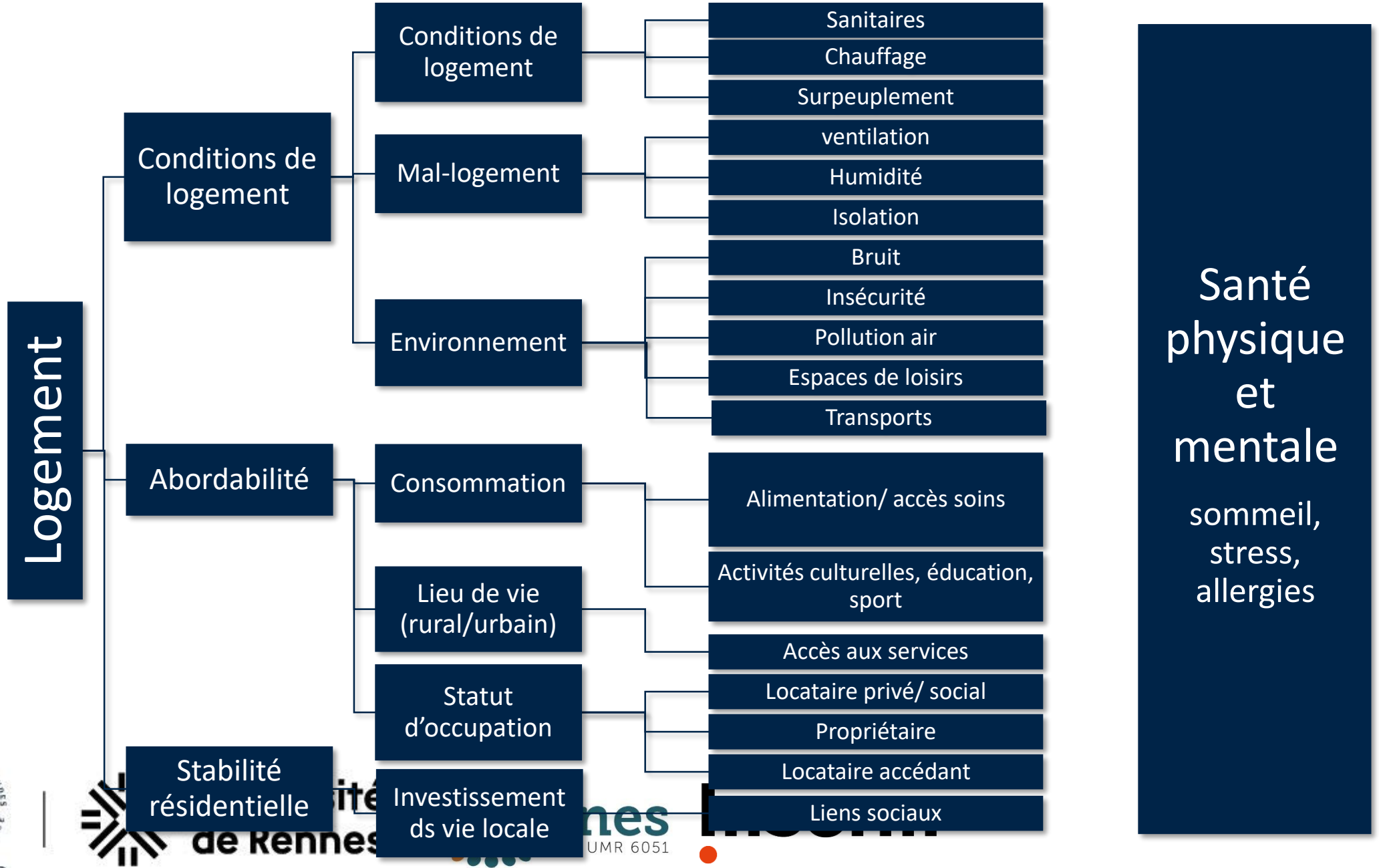
«… sont les circonstances dans lesquelles les individus naissent, grandissent, vivent, travaillent et vieillissent, ainsi que les systèmes de soins qui leur sont offerts. À leur tour, ces circonstances dépendent d'un ensemble de forces plus vastes : l'économie, les politiques sociales et la politique. »

Commission des déterminants sociaux de la santé de l'Organisation mondiale de la Santé. (2016). *Déterminants sociaux de la santé : Principaux concepts relatifs aux déterminants sociaux de la santé*. Genève : Organisation mondiale de la Santé.

De multiples pistes relient le niveau d'éducation à la santé



Adapté de Braveman, Egerter & Williams (2011)



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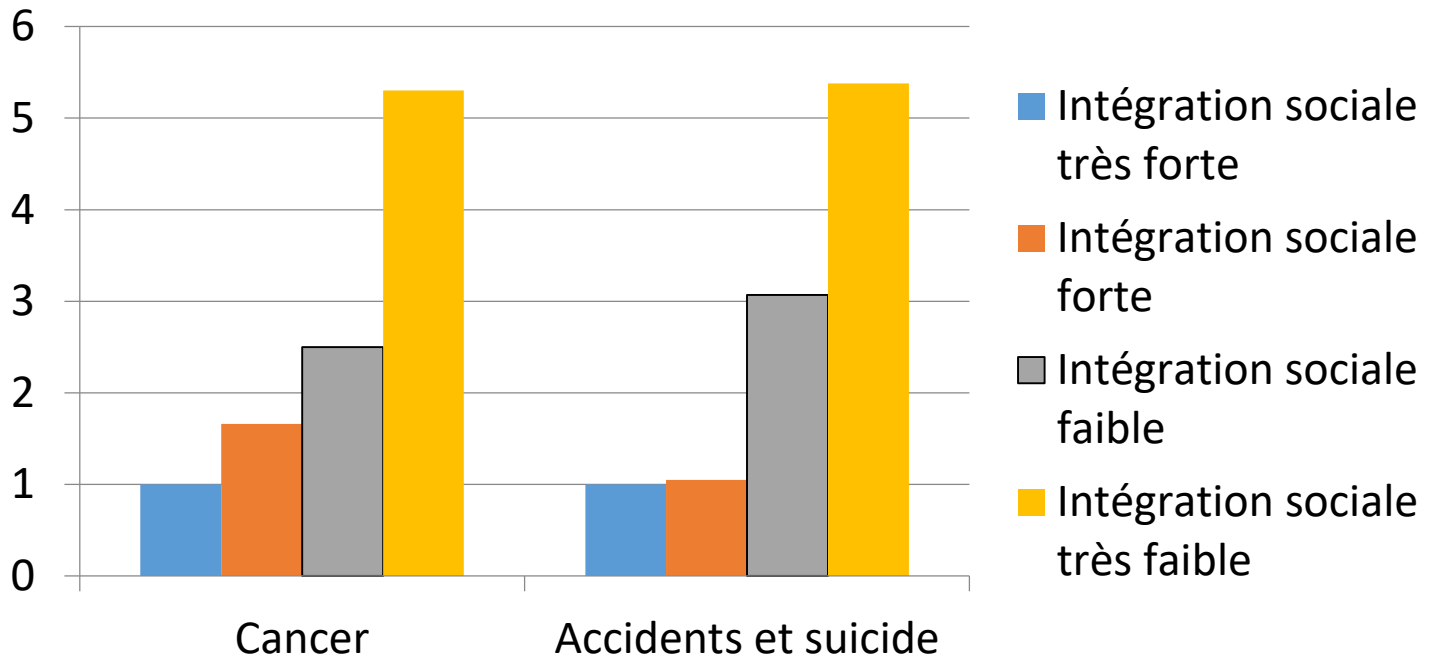
Remerciements à Martina Serra pour la synthèse des échanges d'un atelier sur le logement tenu le 11/09/2018 dans le cadre du Certificat Promotion de la santé des populations de l'EHESP.

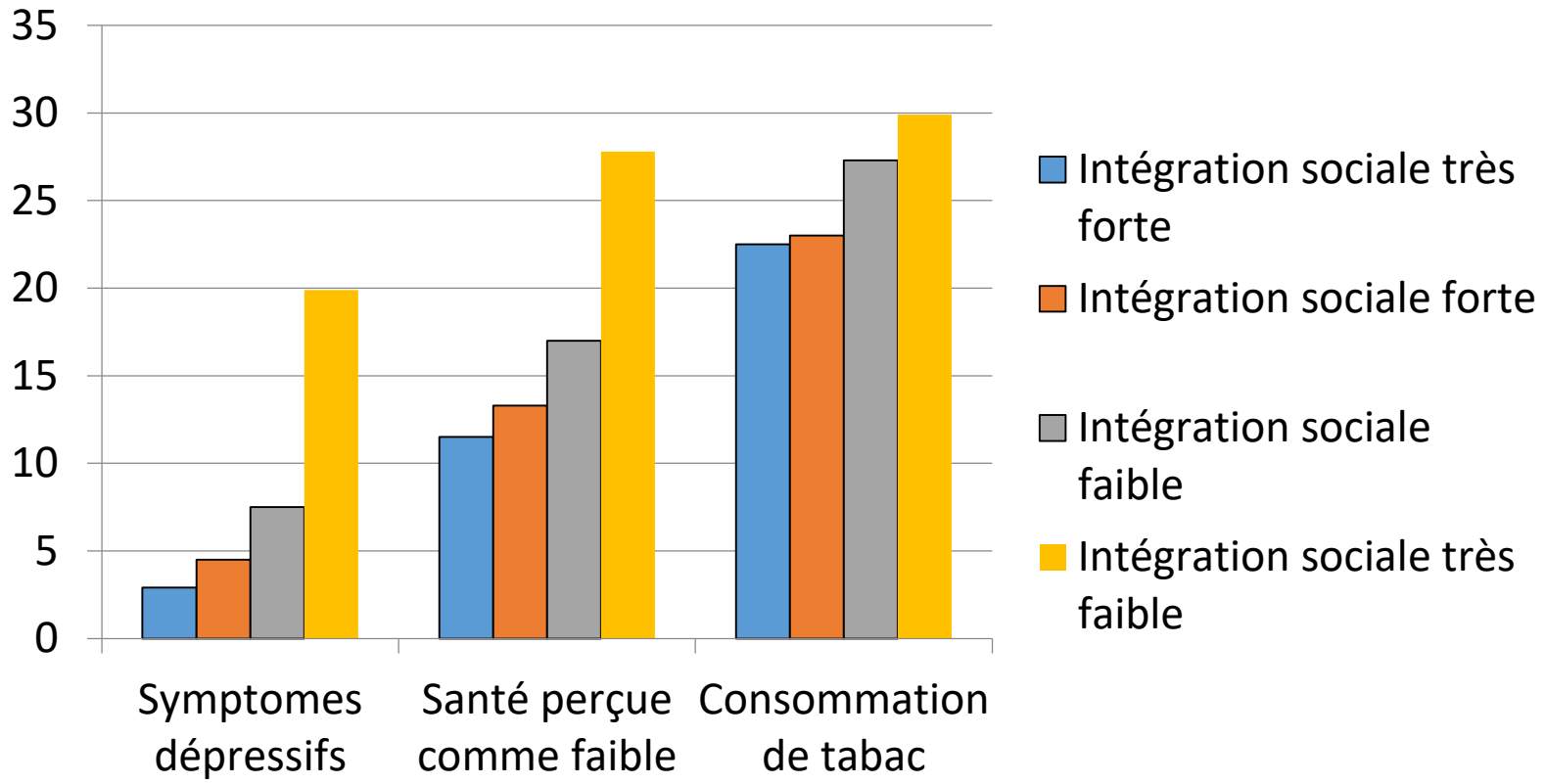
Relation entre le niveau d'intégration sociale et risque de mortalité par cancer, et par suicide et accidents, ajusté avec l'âge, chez les hommes de la cohorte GAZEL en France entre 1993 et 1999.



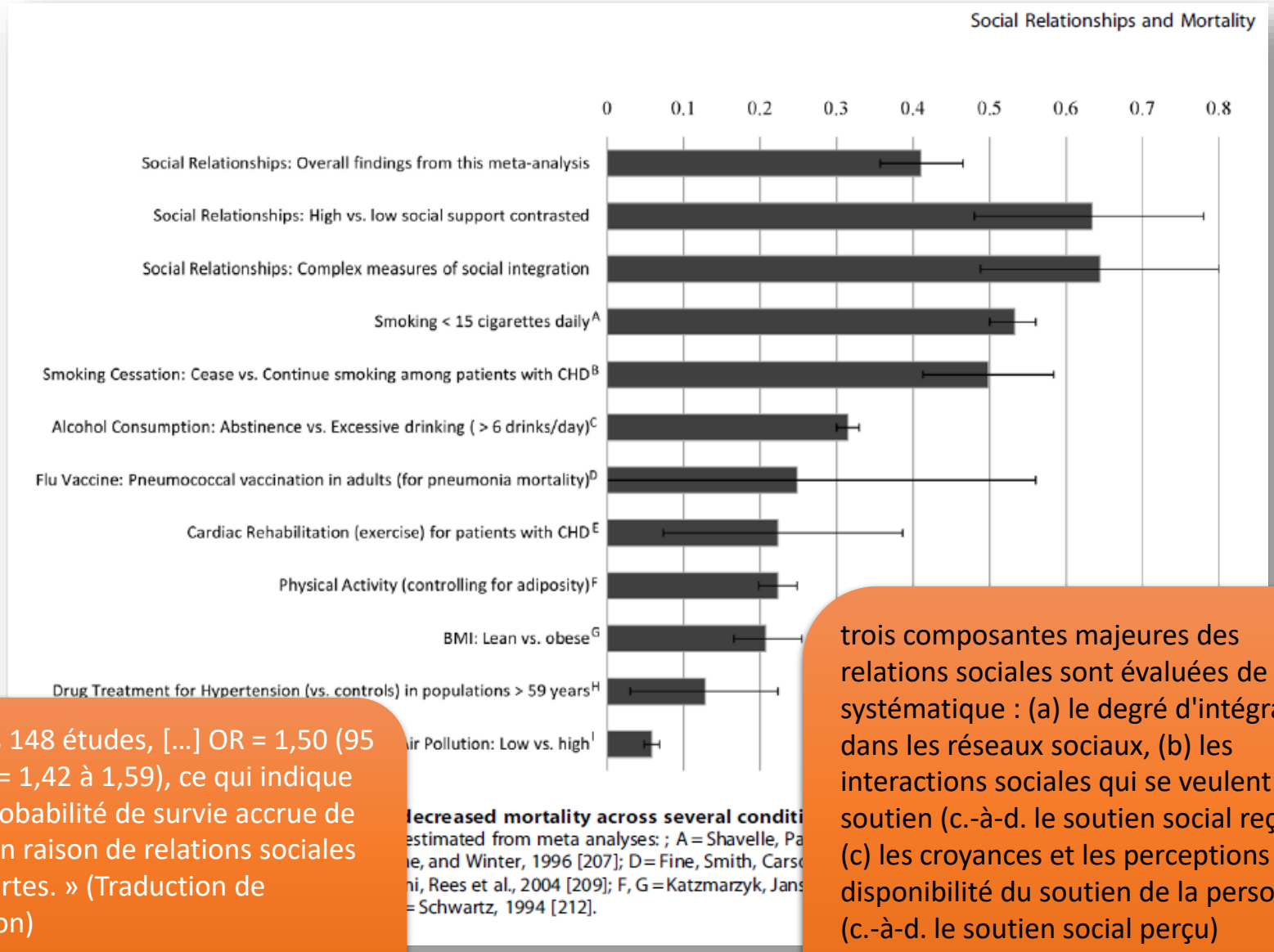
Niveau de référence étant de 1 et celui des employés très fortement intégré socialement.

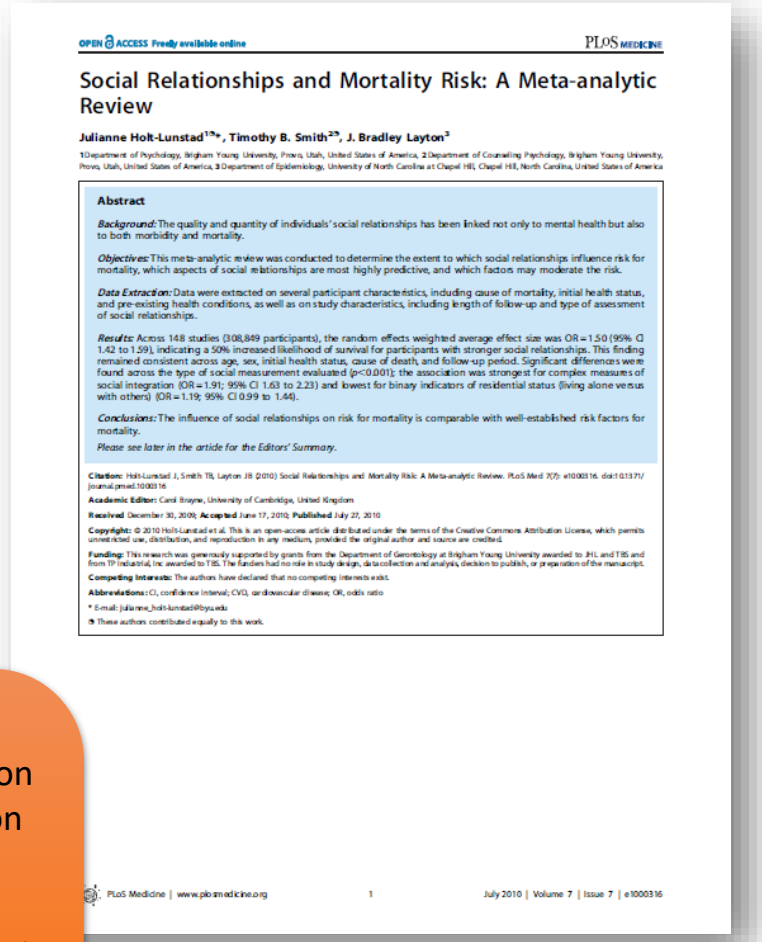
Source: Berkman, L. F., Melchior, M., Chastang, J.-F., Niedhammer, I., Leclerc, A., & Goldberg, M. (2004). Social Integration and Mortality: A Prospective Study of French Employees of Electricity of France–Gas of France. *American Journal of Epidemiology*, *159*(2), 167 –174.
Adapté par la Chaire Santé publique France « Promotion de la santé » à l'EHESP

Relation entre caractéristiques de santé, mortalité et intégration sociale, chez les hommes de la cohorte GAZEL en France en 1991.



Source: Berkman, L. F., Melchior, M., Chastang, J.-F., Niedhammer, I., Leclerc, A., & Goldberg, M. (2004). Social Integration and Mortality: A Prospective Study of French Employees of Electricity of France–Gas of France. *American Journal of Epidemiology*, *159*(2), 167 –174.
Adapté par la Chaire Santé publique France « Promotion de la santé » à l'EHESP

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Social Relationships and Mortality Risk: A Meta-analytic Review

Julianne Holt-Lunstad[1]*, Timothy B. Smith[2]*, J. Bradley Layton[3]

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Abstract

Background: The quality and quantity of individuals' social relationships has been linked not only to mental health but also to both morbidity and mortality.

Objectives: This meta-analytic review was conducted to determine the extent to which social relationships influence risk for mortality, which aspects of social relationships are most highly predictive, and which factors may moderate the risk.

Data Extraction: Data were extracted on several participant characteristics, including cause of mortality, initial health status, and pre-existing health conditions, as well as on study characteristics, including length of follow-up and type of assessment of social relationships.

Results: Across 148 studies (308,849 participants), the random effects weighted average effect size was OR = 1.50 (95% CI 1.42 to 1.59), indicating a 50% increased likelihood of survival for participants with stronger social relationships. This finding remained consistent across age, sex, initial health status, cause of death, and follow-up period. Significant differences were found across the type of social measurement evaluated ($p<0.001$); the association was strongest for complex measures of social integration (OR = 1.91; 95% CI 1.63 to 2.23) and lowest for binary indicators of residential status (living alone versus with others) (OR = 1.19; 95% CI 0.99 to 1.44).

Conclusions: The influence of social relationships on risk for mortality is comparable with well-established risk factors for mortality.

Please see later in the article for the Editors' Summary.

Citation: Holt-Lunstad J, Smith TB, Layton JB (2010) Social Relationships and Mortality Risk: A Meta-analytic Review. PLoS Med 7(7): e1000316. doi:10.1371/journal.pmed.1000316

Academic Editor: Carol Brayne, University of Cambridge, United Kingdom

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Competing Interests: The authors have declared that no competing interests exist.

Abbreviations: CI, confidence interval; CVD, cardiovascular disease; OR, odds ratio

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These authors contributed equally to this work.

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« Dans 148 études, […] OR = 1,50 (95 % [IC] = 1,42 à 1,59), ce qui indique une probabilité de survie accrue de 50 % en raison de relations sociales plus fortes. » (Traduction de E.Breton)

trois composantes majeures des relations sociales sont évaluées de façon systématique : (a) le degré d'intégration dans les réseaux sociaux, (b) les interactions sociales qui se veulent de soutien (c.-à-d. le soutien social reçu), et (c) les croyances et les perceptions de la disponibilité du soutien de la personne (c.-à-d. le soutien social perçu) (Traduction E.Breton)

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Source: p. 14 de Holt-Lunstad, J., Smith, T. B., & Layton, J. B. (2010). Social Relationships and Mortality Risk: A Meta-analytic Review. *PLoS Medicine*, *7*(7), e1000316. https://doi.org/10.1371/journal.pmed.1000316

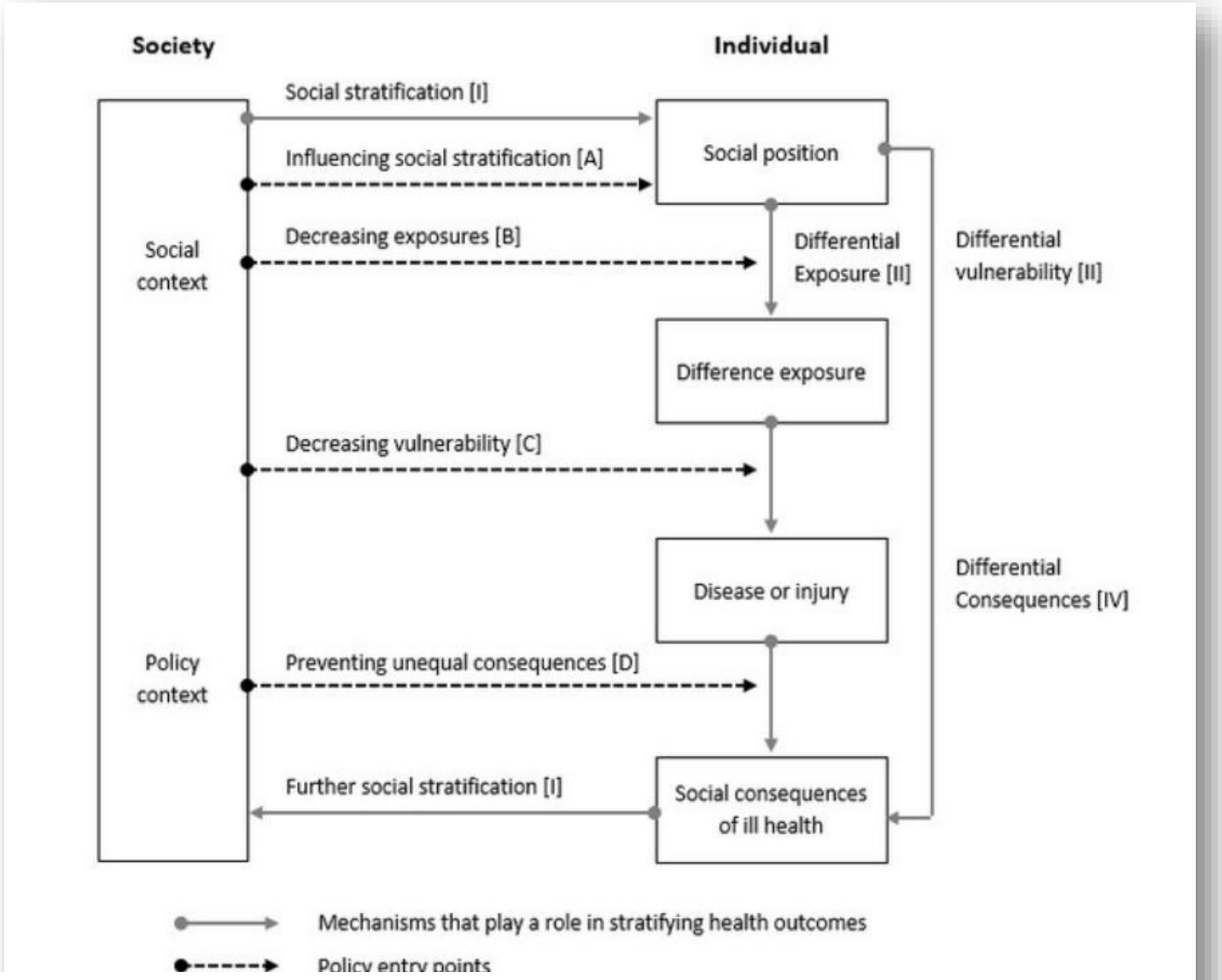
Ce qui explique les inégalités sociales de santé

E. Breton, EHESP

Théories sur les inégalités sociales de santé pointent vers des différences :

- D'accès aux ressources (information, argent, réseau, espace vert…) ;
- D'exposition aux conditions néfastes pour la santé (inquiétudes face à l'emploi, moisissures, pollution…) et ;
- D'usure des corps par le stress généré par la position sociale, la discrimination.

Le modèle de Diderichsen: les fondements sociaux des inégalités de santé



Source de la figure: A. S. Mathiesen 2019 Vulnerable people with type 2 diabetes: Implications and feasibility of a guided self-determination intervention for reducing diabetes distress. University of Copenhagen

La théorie des causes fondamentales de Link & Pheland (1995)

Le gradient social s'accompagne d'un gradient de ressources…

Des ressources sous formes de connaissances, argent, pouvoir, prestige, réseaux sociaux...

Qu'arrive-t-il si les ressources conférées par le statut socio-économique sont inutiles dans un cas donné?

ASA

Journal of Health and Social Behavior
51(S) S28–S40
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DOI: 10.1177/0022146510383498
http://jhsb.sagepub.com
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Social Conditions as Fundamental Causes of Health Inequalities: Theory, Evidence, and Policy Implications

Jo C. Phelan[1], Bruce G. Link[1,2], and Parisa Tehranifar[1]

Abstract

Link and Phelan (1995) developed the theory of fundamental causes to explain why the association between socioeconomic status (SES) and mortality has persisted despite radical changes in the diseases and risk factors that are presumed to explain it. They proposed that the enduring association results because SES embodies an array of resources, such as money, knowledge, prestige, power, and beneficial social connections that protect health no matter what mechanisms are relevant at any given time. In this article, we explicate the theory, review key findings, discuss refinements and limits to the theory, and discuss implications for health policies that might reduce health inequalities. We advocate policies that encourage medical and other health-promoting advances while at the same time breaking or weakening the link between these advances and socioeconomic resources. This can be accomplished either by reducing disparities in socioeconomic resources themselves or by developing interventions that, by their nature, are more equally distributed across SES groups.

Keywords:

health disparities, social stratification, fundamental causes, health, mortality

As we mark the fiftieth anniversary of the Medical Sociology Section of the American Sociological Association, one of the most basic and critical problems addressed by medical sociologists is a very old one: the fact that society's poorer and less privileged members live in worse health and die much younger than the rich and more privileged ones. Socioeconomic inequalities in health and mortality are very large, very robust, and very well documented. Typically, age-adjusted risk of death for those in the lowest socioeconomic level is double to triple that for the highest level (Antonovsky 1967; Sorlie, Backlund, and Keller 1995; Kunst, Feikje, and Mackenbach 1998). To illustrate, in 2005, all-cause, age-adjusted death rates for individuals between the ages of 25 and 64 were strongly related to education level for both men (at < 12 years, 821 per 100,000; at 12 years, 605; and at > 12 years, 249) and women (at < 12 years, 472; at 12 years, 352; and at > 12 years, 165) (National Center for Health Statistics 2008). Similar levels of inequality are observed between income groups.

These inequalities in overall health and mortality are not only very common in modern times, but they have persisted at similar levels at least since the early nineteenth century (Antonovsky 1967). This persistence is puzzling because major diseases and risk factors that appeared to account for the

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[2]New York State Psychiatric Institute

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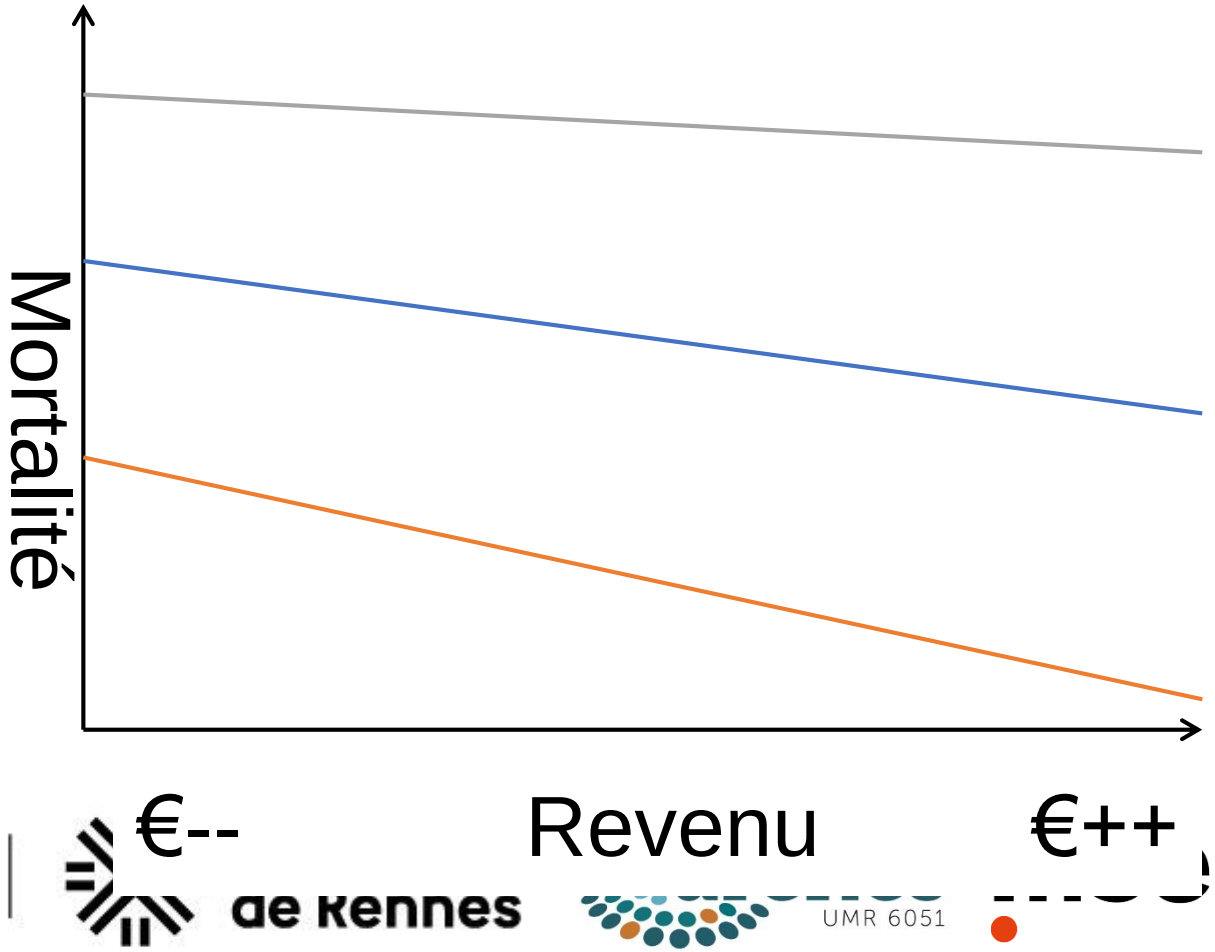
Les inégalités socioéconomiques comme causes profondes des inégalités de mortalité dues au SIDA



Des 1er cas documentés en 1981 à 1984

De la découverte du VIH en 1984 à 1996

Des débuts des thérapies antirétrovirales en 1996 à aujourd'hui

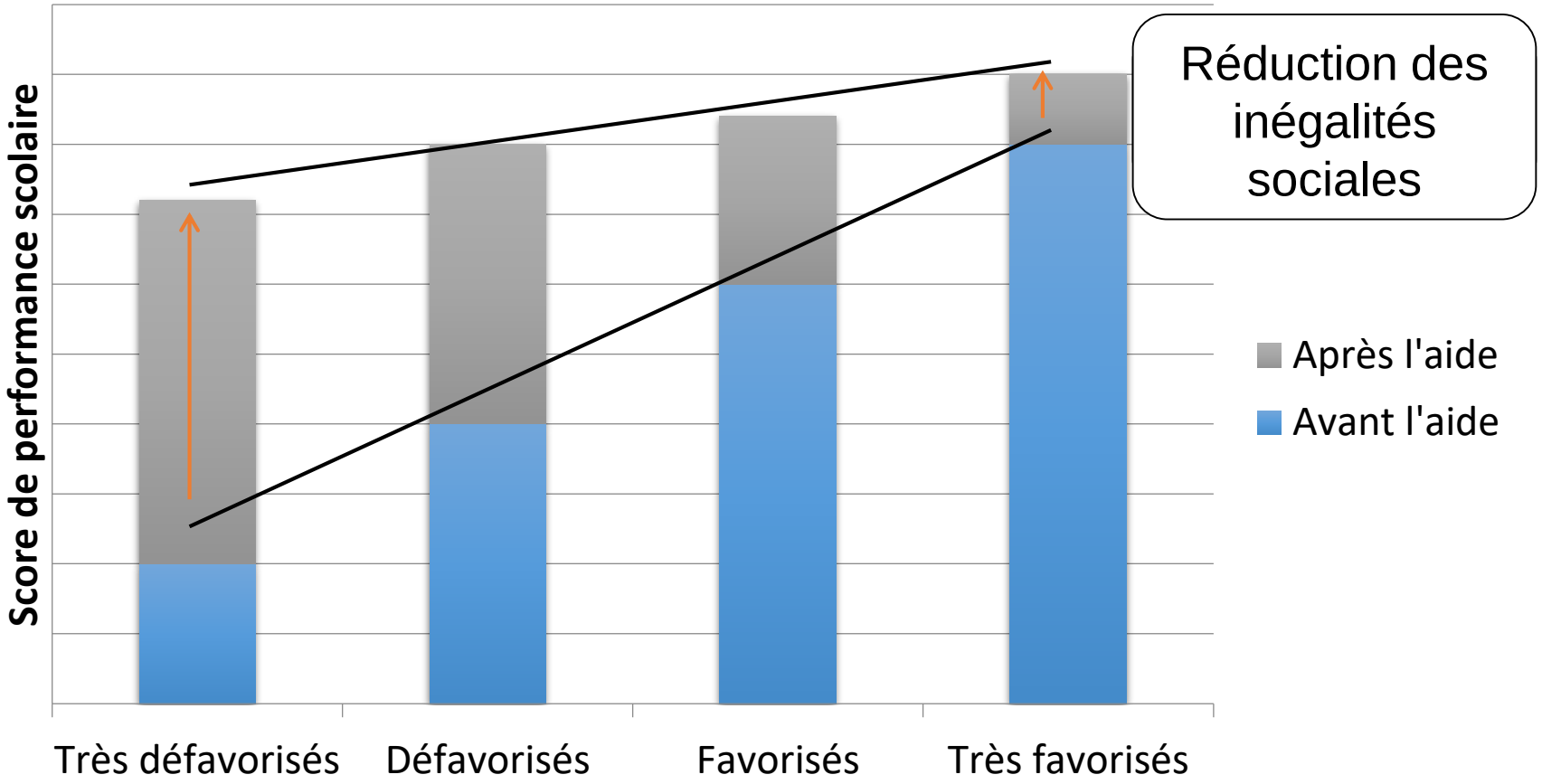
Agir par des mesures universelles aux effets proportionnés aux besoins

Deux grands types mesures universelles proportionnées…

1er type de mesure universelle aux effets proportionnés aux besoins

Une intervention qui touche toute la population mais pour laquelle on modifie la dose/ l'offre en fonction des besoins…

Effet théorique d'une mesure universelle d'aide au devoir déployée dans une école élémentaire



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2ème type de mesure universelle aux effets proportionnés aux besoins

Une intervention qui touche toute la population et qui a pour propriété intrinsèque de générer davantage de gain chez ceux et celles qui en ont le plus besoin…

Je la surnomme la stratégie de la balle magique (magic bullet en anglais).

"Water fluoridation appears to reduce the social class gradient between deprivation and caries experience when considering caries into dentine. However, this was associated with an increased risk of developing mild fluorosis."

In McGrady, M. G., Ellwood, R. P., Maguire, A., Goodwin, M., Boothman, N., & Pretty, I. A. (2012). The association between social deprivation and the prevalence and severity of dental caries and fluorosis in populations with and without water fluoridation. *BMC Public Health*, *12*(1), 1122.

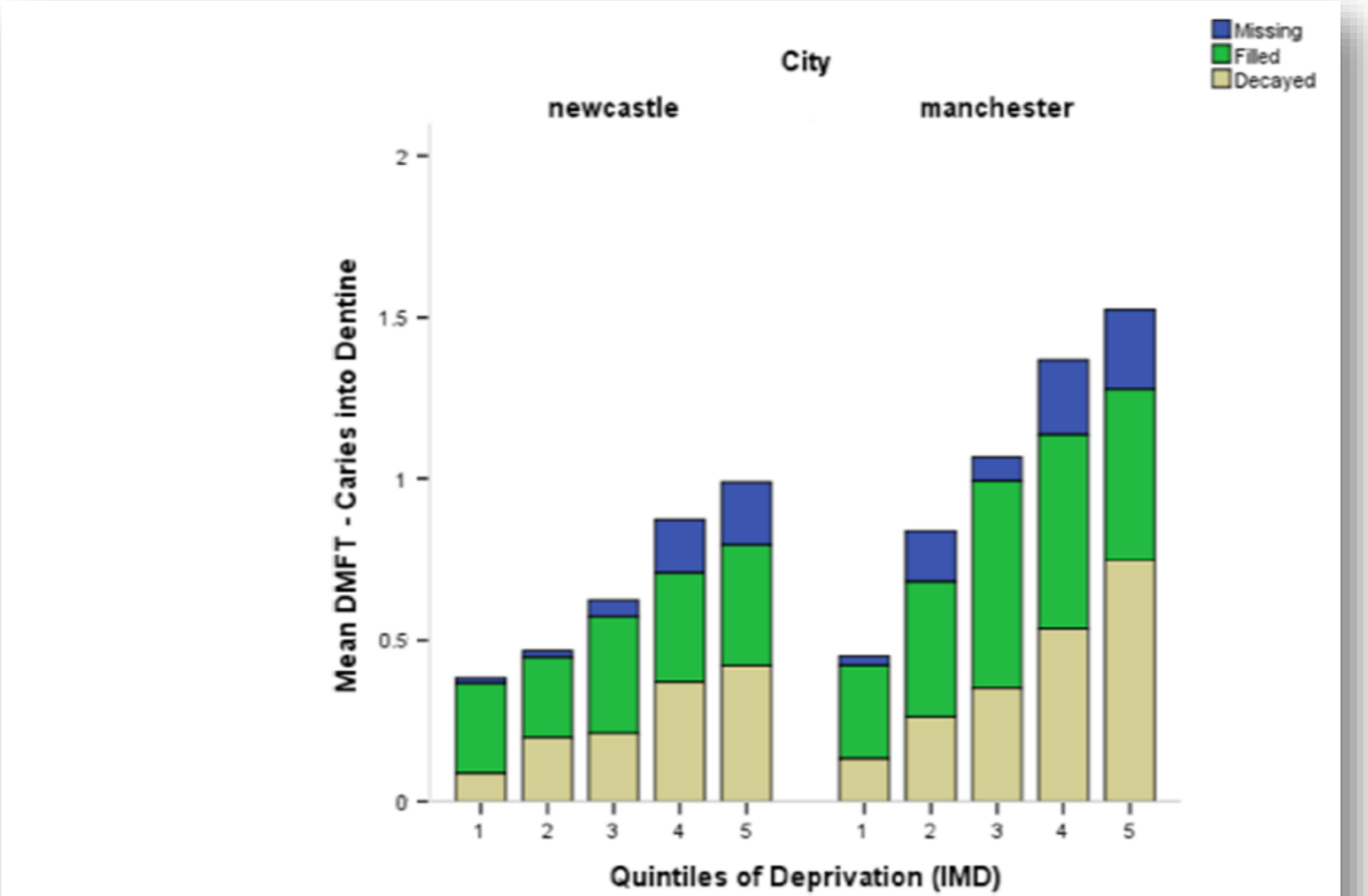

Figure 2 Components of DMFT over each quintile of deprivation depicted for each city.

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Un exemple de mesure universelle aux effets proportionnés: l'expansion du programme d'école maternelle à 3 ans

« Nous avons trouvé que l'accès à l'école maternelle a généré des effets significatifs et à long terme et aidé les enfants à réussir à l'école et à obtenir des revenus plus élevés sur le marché du travail. […] L'effet n'est pas le même entre les différents groupes sociaux : l'effet est essentiellement concentré sur les enfants des classes sociales moyennes et inférieures. Pour ceux des classes supérieures, ils ont tiré peu de la maternelle. » (Dumas et Lefranc, 2010, p.22-23)

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Un exemple de mesure universelle proportionnée

"The report found some of London's poorest communities were experiencing some of the biggest benefits. It found that for the most deprived communities living near London's busiest roads, there was an estimated 80% reduction in people exposed to illegal levels of pollution in 2023 – this increased to 82% in outer London, compared with a scenario without the Ulez."

https://www.theguardian.com/environment/2025/mar/07/london-air-pollution-down-since-ulez-expansion-study?CMP=Share_AndroidApp_Other

Low emission zones

Dramatic fall in London's levels of deadly pollutants after Ulez expansion

People in capital breathing much cleaner air, with significant improvements in capital's most deprived areas

Matthew Taylor

Fri 7 Mar 2025 10.39 CET

Share

Ulez has improved London's air quality across the board. Photograph: Yui Mok/PA

People in London have been breathing significantly cleaner air since the expansion of the ultra low emission zone (Ulez), a study has found.

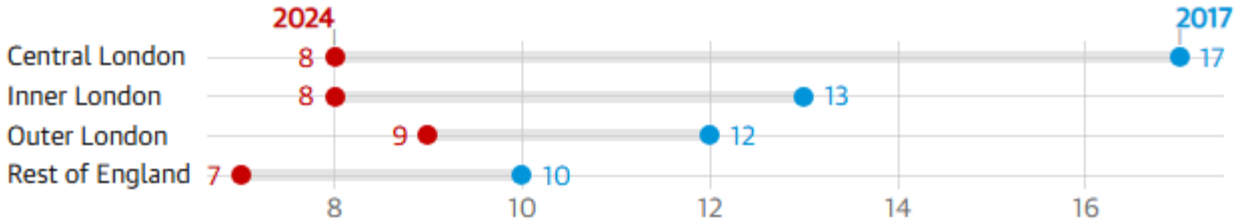
Levels of deadly pollutants that are linked to a wide range of health problems - from cancer to impaired lung development, heart attacks to premature births - have dropped, with some of the biggest improvements coming in the capital's most deprived areas.

Sadiq Khan had faced severe opposition to the 2023 expansion of Ulez to outer London boroughs. But on Friday as the report was published, the mayor of London said the scheme had driven down pollution, taken old polluting cars off the roads and brought cleaner air to millions more people.

He said: "When I was first elected, evidence showed it would take 193 years to bring London's air pollution within legal limits if the current efforts

Roadside pollution levels have fallen the most in central London

Annual average roadside PM2.5 concentration, micrograms per cubic metre



Guardian graphic. Source: Greater London Authority, data to Sep 2024. Note: PM2.5 refers to particulate matter in the air measuring 2.5 microns or less in diameter

Limites des actions centrées exclusivement sur les groupes vulnérables (Breton, 2015)

Elles se limitent souvent à intervenir sur les **symptômes plutôt que sur les causes** (ex. aide au logement aux SDF vs. Intervenir sur les conditions structurelles de l'offre de logement abordable) ;

Elles **excluent** de nos actions **d'autres groupes moins vulnérables**, mais dont la fragilité les expose (ou leurs descendants) au risque de basculer à leur tour du côté des plus vulnérables ;

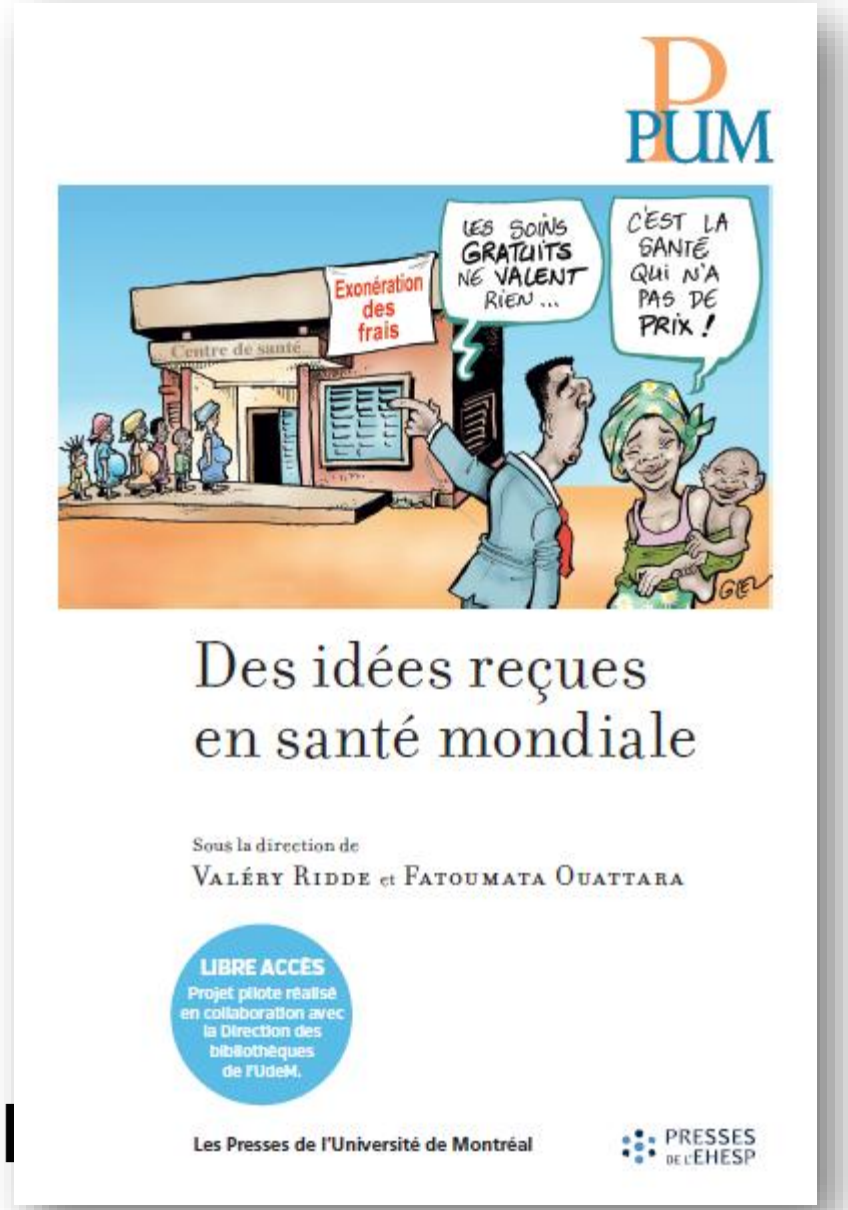
Elles sont généralement **mal financées** et sujettes aux aléas des choix politiques ;

Elles contribuent à **stigmatiser** les individus qu'elles visent et à construire une citoyenneté de seconde classe.

Breton, E. (2015). Une idée reçue : La réduction des inégalités sociales de santé passe principalement par des actions en faveur des plus vulnérables [Chap.29]. In V. Ridde & F. Ouattara (Eds.). www.pum.umontreal.ca

« cette vision dichotomique [groupes vulnérables-reste de la population] apparaît […] porteuse d'un préjugé implicite qu'il y a chez les personnes incluses dans des groupes dits vulnérables quelque chose qui les distingue du reste du corps social. Cette conception d'un *eux-nous* devrait donc plutôt laisser place à un *nous* multiple […] une population dont les conditions quotidiennes d'existence de ses individus, et donc ultimement leur santé […], sont fortement déterminées par leurs positions dans l'organisation sociale. »

Breton, E. (2015). Une idée reçue : La réduction des inégalités sociales de santé passe principalement par des actions en faveur des plus vulnérables [Chap.29]. In V. Ridde & F. Ouattara (Eds.). www.pum.umontreal.ca

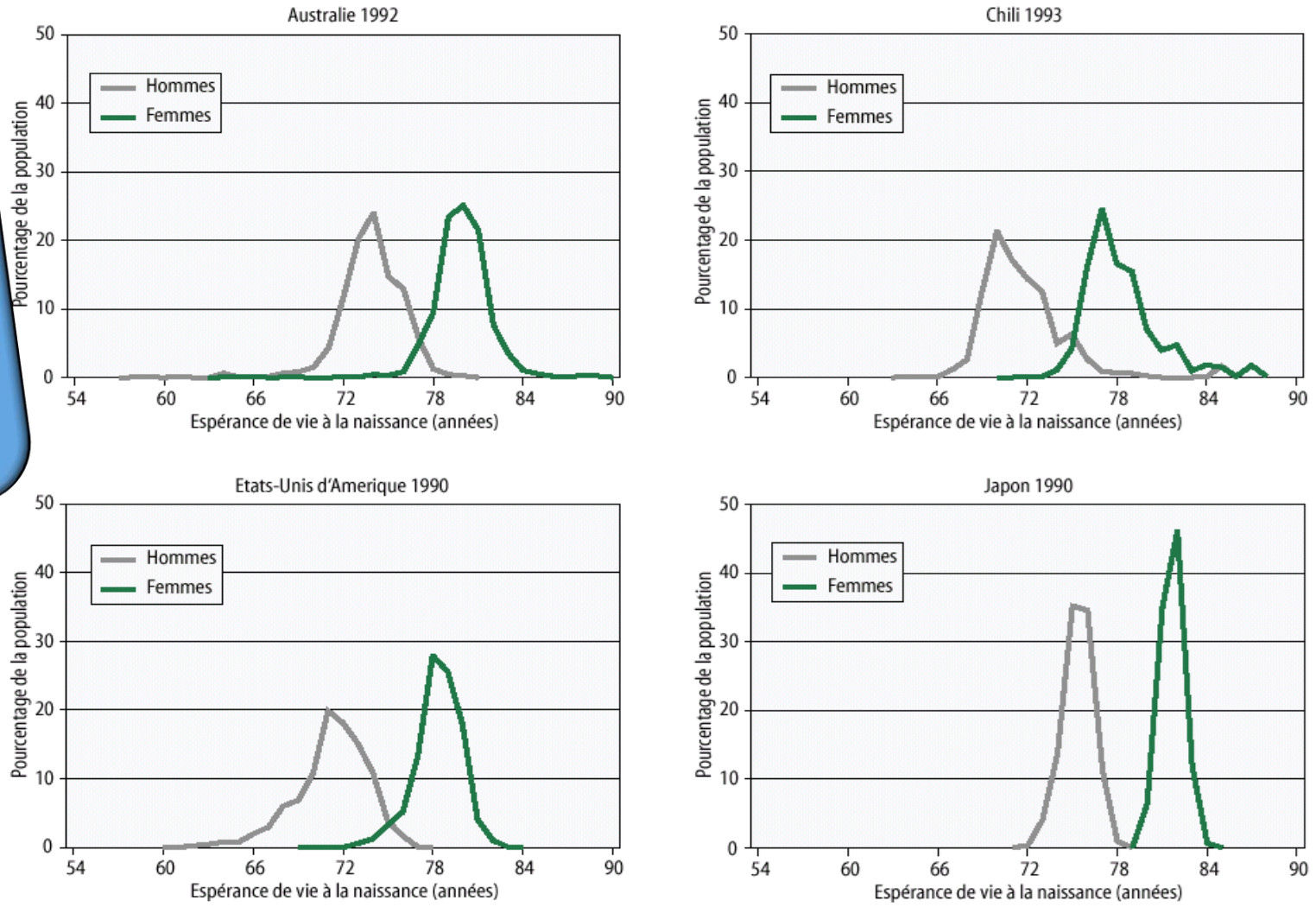


Conclusion

Courbes de mortalité

Si on ne peut pas éliminer complètement les ISS on peut tout de même aspirer à les réduire au niveau du Japon….

Figure 2.3 Inégalité de l'espérance de vie à la naissance, par sexe, dans six pays



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Bambra, C. (2022) identifie 5 exemples nationaux de réduction des inégalités sociales de santé

- Les États-providence sociaux-démocrates nordiques des années 1950 aux années 1970 ;
- Les programmes de la "Great Society" des années 1960 aux États-Unis ;
- La démocratisation au Brésil dans les années 1980 ;
- La réunification allemande dans les années 1990 ;
- La stratégie anglaise de lutte contre les inégalités de santé dans les années 2000.

Trois moteurs : l'expansion de l'État-providence, l'amélioration de l'accès aux soins de santé et le renforcement de l'intégration politique des classes populaires et des minorités.

The JAMA Network

From: **The Association Between Income and Life Expectancy in the United States, 2001-2014**

JAMA. Published online April 10, 2016. doi:10.1001/jama.2016.4226

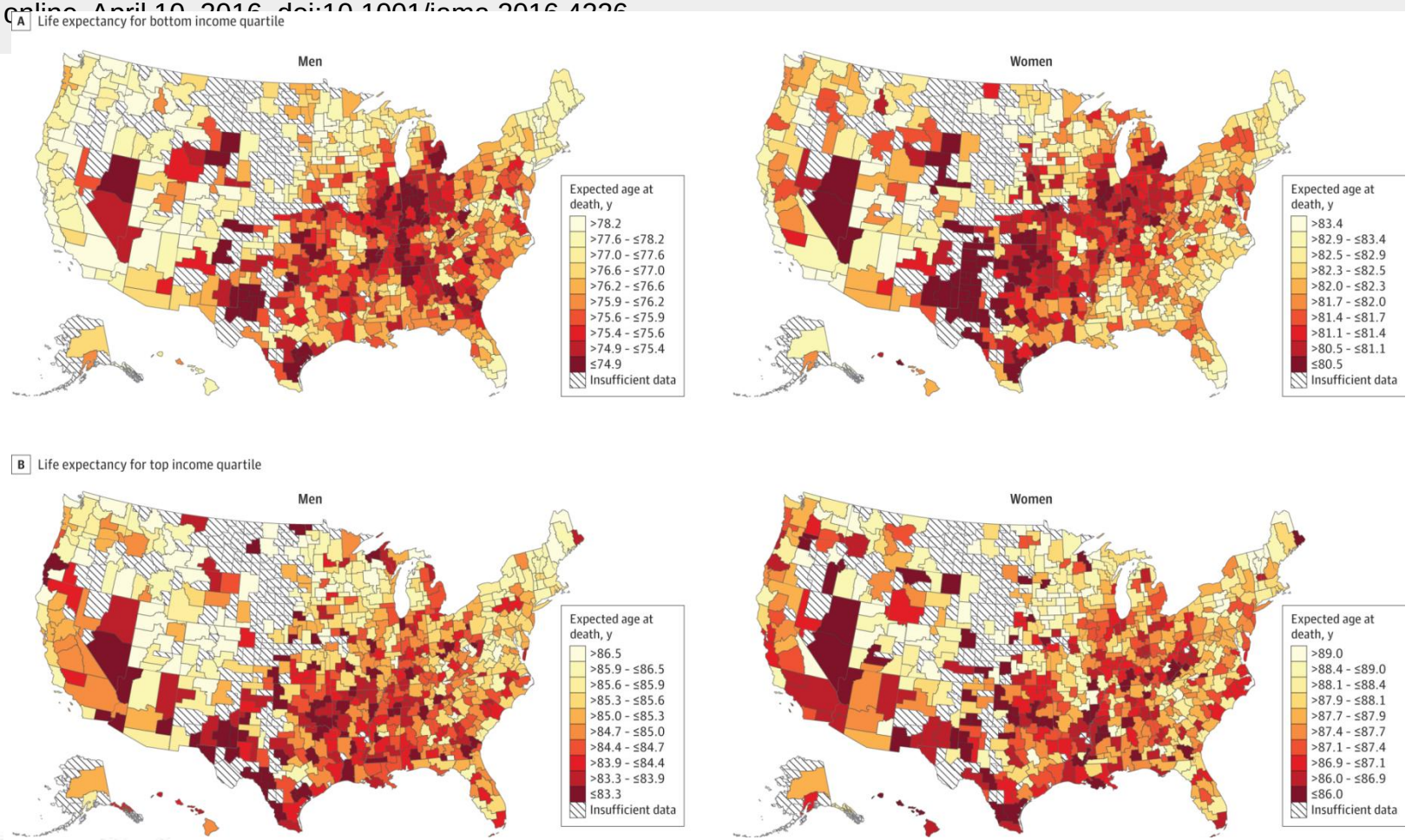


Figure Legend:

Race- and Ethnicity-Adjusted Life Expectancy by Commuting Zone and Income Quartile, 2001-2014Estimates of race- and ethnicity-adjusted expected age at death for 40-year-olds computed by commuting zone. The 595 commuting zones with populations above 25 000 are grouped into deciles and colored from dark to light as expected age at death increases. The second and third quartiles appear in eFigure 10 in the Supplement.

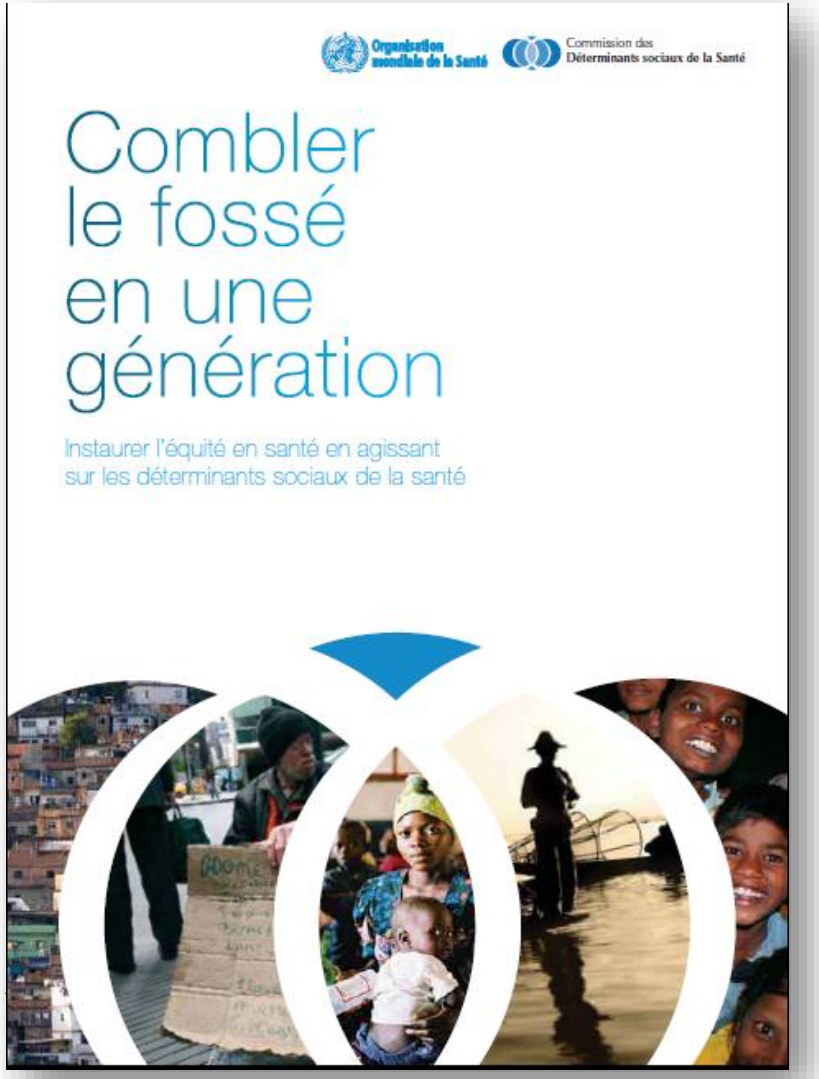
Commission des Déterminants sociaux de la santé (OMS, 2009)

Trois recommandations

1. Améliorer les conditions de vie quotidiennes

2. Lutter contre les inégalités dans la répartition du pouvoir, de l'argent et des ressources

3. Mesurer le problème, l'analyser et évaluer l'efficacité de l'action



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Breton, E. (2020). Les déterminants de la santé des populations. In E. Breton, F. Jabot, J. Pommier, & W. Sherlaw (Éds.), *La promotion de la santé. Comprendre pour agir dans le monde francophone* (2e éd., p. 91-116). Presses de l'EHESP. www.presses.ehesp.fr

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Pour de plus amples informations…

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Projet sur la taxation des boissons sucrées SODA-TAX

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