



EDITORIAL COMMENT

Equity, socioeconomic inequalities and cardiovascular disease[☆]



Desigualdades socioeconómicas e doenças cardiovasculares

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It is well known that cardiovascular disease (CVD) is the leading cause of mortality and morbidity in both developed and developing countries, representing a considerable social and economic burden, and is thus a major public health issue that requires an urgent response.^{1–3} According to a recent World Health Organization (WHO) report, this trend will continue until at least 2030.⁴

At the same time, various factors have created a series of challenges in CVD at both national and international level, including: (1) advances in knowledge arising from biomedical research; (2) changes in the disease over time; (3) demographic changes, particularly the profound implications of increased life expectancy; (4) lifestyles and increases in risk factors, including smoking, physical inactivity, diabetes, obesity and hypertension; (5) greater use of new technologies and different therapeutic options in clinical practice, which are increasingly more advanced, sophisticated and costly; (6) the quest for maximum quality and safety in health provision systems; (7) the spiraling costs of health care; and (8) the possible association between CVD and socioeconomic status, which requires more thorough study of inequalities.

Inequalities in infancy and development, which affect education, occupation and housing, arise at a macro level, in public, social, and economic policies, in societal values, and in the sociopolitical context.⁵ An individual's socioeconomic status can expose them to factors that may affect their health status, lifestyle, choices and access to health care.

The individual characteristics that can affect the use of health care services can be classified as predisposing or empowering factors. The former include educational and cultural level, occupation, ethnicity, and social and family networks. These influence attitudes to health and health care, which can affect the perceived need for and use of health care services. According to Pereira and Furtado, these factors determine empowerment of the individual in the use of available health care services.⁶

Empowering factors include the necessary means to access health care services, such as income (ability to pay) and area of residence. The characteristics of the patient and of the health provision system will affect the use of such services.

Health inequalities arise from social determinants such as education and occupation, as well as lifestyles and particularly access to health care. A population's health status should thus be seen not only in terms of health services but also of the conditions in which people are born, grow up, live and work.⁷ Health inequalities can be reduced by intervening in the determinants, particularly access to health care, although this is only one factor in the promotion of equality in health status.

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Although ensuring equality in health and in access to health care is a stated objective of health policies and planning documents in Portugal, there is as yet no coordinated strategy aimed at achieving this end.

Such a strategy should preferentially be applied in clinical areas where the disease burden is significant, in terms of epidemiology (incidence and prevalence) and of associated costs, as well as in areas where there is a body of evidence showing the existence of inequalities, whether in how the disease is distributed (at-risk or vulnerable groups) or in health care access.

The burden of CVD in developed societies and its socio-economic impact is such that investment is needed in disease prevention and health promotion (adapted to the different educational, social, economic, geographical and cultural characteristics of the target populations), as well as to ensure equal access to health care.

While the concept of equality is established in legislation concerning the Portuguese health system, particularly in article 64 of the Constitution – the right to health – and in the Basic Health Law, little attention has been paid to promoting, achieving or monitoring this goal. The WHO recently evaluated the 2004–2010 Portuguese National Health Plan and identified certain strengths and weaknesses. According to this report, the NHP paid little attention to health equality in terms of strategies and programs designed to combat inequalities.⁸ Another WHO document, assessing the performance of the Portuguese health system, reported notable improvements but highlighted continuing significant differences in the health status of the Portuguese population according to gender, geographical region and socioeconomic status as assessed by educational and income level.⁹ It stated that in order to consolidate and improve Portuguese citizens' health status, the

health system faces the challenge of decreasing inequality between groups and of improving its responses to people's expectations.

The results of investigative studies such as that by Ribeiro et al. in this issue of the *Journal* deepen our knowledge and help to define strategies aimed at decreasing inequalities in access to health care, thus contributing to a more effective, efficient and equitable health system, and indirectly to a more just, united and caring society.

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