



EQUITY*ACTION*

TOOLS • REGIONS • KNOWLEDGE • STAKEHOLDERS •

Intersectorialidad y promoción de la salud en el ámbito local

1. Determinantes y desigualdades: “El código postal puede influir en el código genético”

Rafael Cofiño.
Servicio de Evaluación de la Salud y Programas.
Dirección General de Salud Pública.
Consejería de Sanidad Asturias.

www.health-inequalities.eu



This work is part of EQUITY ACTION which has received funding from the European Union, in the framework of the Health Programme. The sole responsibility for this work lies with the author



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Diferentes gafas:

Experiencias desde el Observatorio de Salud en Asturias

Planificación de estrategias de salud

Participación comunitaria

Planes municipales de salud

Programa de actividades comunitarias de la
semFYC

Objetivos de la sesión:

1. Exploración y puesta en común sobre la situación actual del trabajo intersectorial en salud y promoción de la salud en el ámbito local.
2. “El código postal influye más en la salud que el código genético”: Revisión general de aspectos relacionados con determinantes de la salud y desigualdades en el ámbito local.
3. Trabajo intersectorial para el abordaje de los determinantes de la salud en el ámbito local. Agenda 21, Ciudades Saludables, Ciudades amigables con los mayores, Smartcities, Ineqcities. ¿es posible conciliar las diferentes estrategias de intervención?
4. Participación y coordinación en intervenciones intersectoriales.

5. Principales ejes para el abordaje de los determinantes de salud desde el ámbito local: actuaciones intersectoriales. Ciclo de intervención para la promoción de la salud en el ámbito local.
6. De la información a la acción: la experiencia inicial del Observatorio de Salud en Asturias. Proporcionando información sobre determinantes de salud para generar actuaciones intersectoriales.
7. Mapas de riesgos de salud y mapas de activos de salud. Los activos de salud como una posibilidad de conectar recursos municipales con la práctica clínica. Metodología para la elaboración de los mapas de activos de salud.
8. Conectando diferentes sectores a través de los mapas de déficits y activos: prescripción de activos de salud.

Documentación de referencia

Documentación complementaria

Taller Intersectorialidad y Promoción de la Salud en el ámbito local.

28 enero 2014

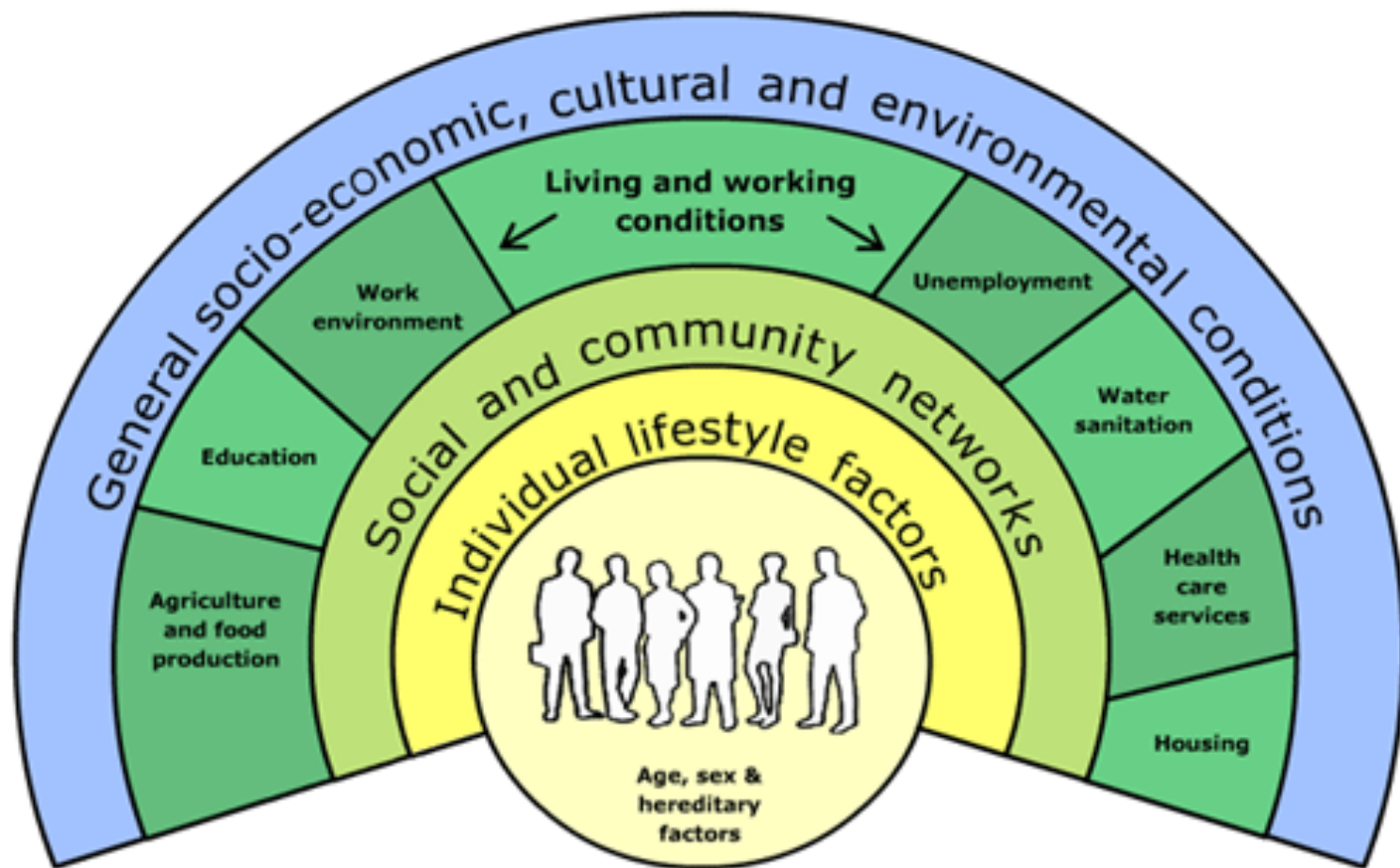
Puntos clave

- La importancia del ámbito local para lograr un impacto en la salud de la población.
- La importancia del trabajo sobre determinantes no clínicos y de actuar desde fuera del sistema sanitario.
- La importancia de las intervenciones poblacionales.
- La necesidad de una mirada en equidad.

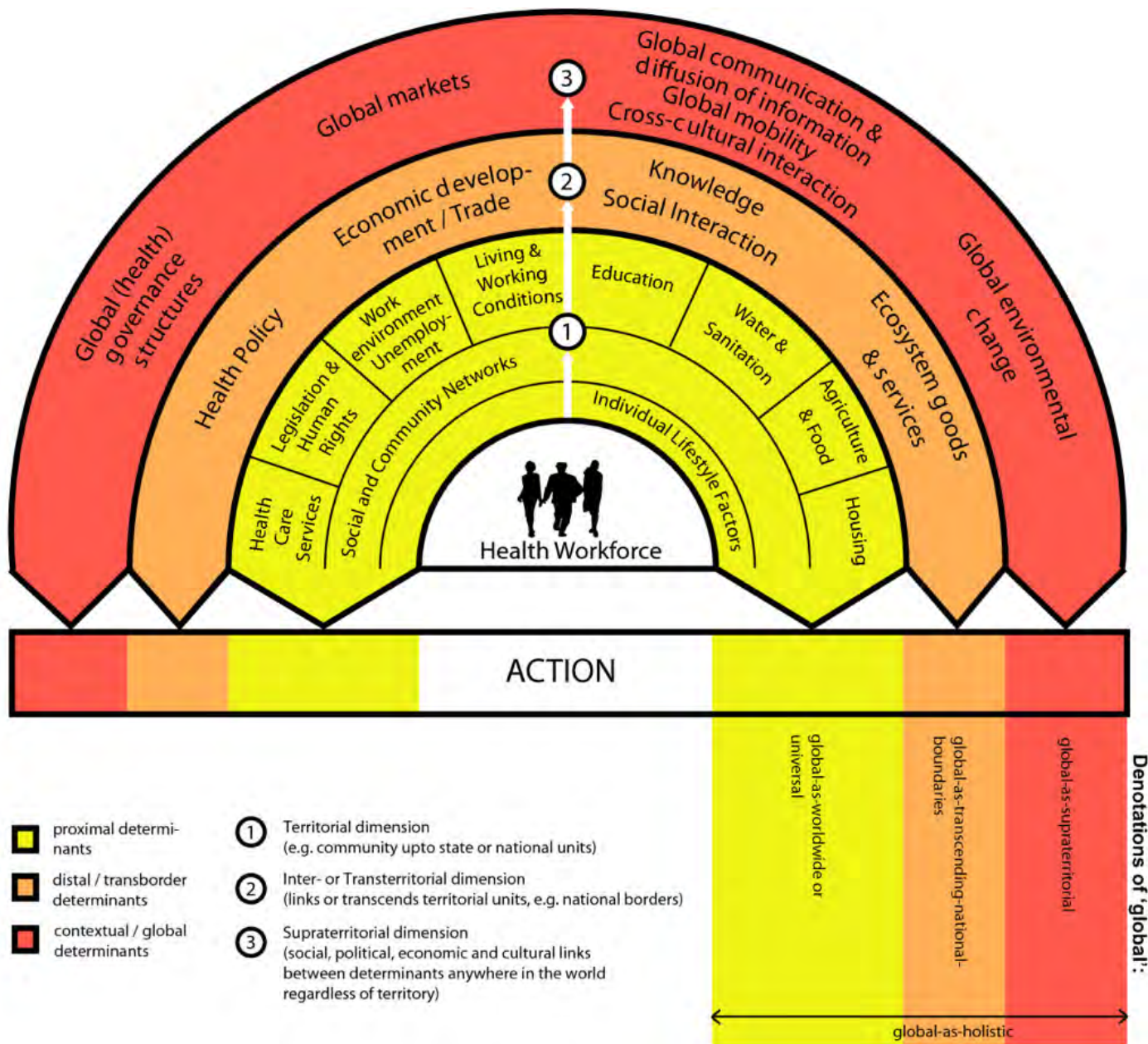
- El trabajo intersectorial y la participación como un elemento central.
- Realizar una aproximación a lo que está pasando en la comunidad con una mirada de problemas y con una mirada de activos en salud.
- Estas miradas pueden ser un punto de encuentro de alianzas entre lo municipal, el sistema sanitario y la salud pública
- Una evaluación integral: la evaluación del impacto en salud.
- Necesidad de tener un proceso estructurado de los siguientes pasos.

¿Qué **factores** influyen actualmente
en el bienestar y la salud de nuestra población ?

The Main Determinants of Health



Dahlgren y Whitehead



Fuente: <http://www.globalizationandhealth.com/>

NO BIENESTAR



BIENESTAR

Modelo de Bronfenbrenner

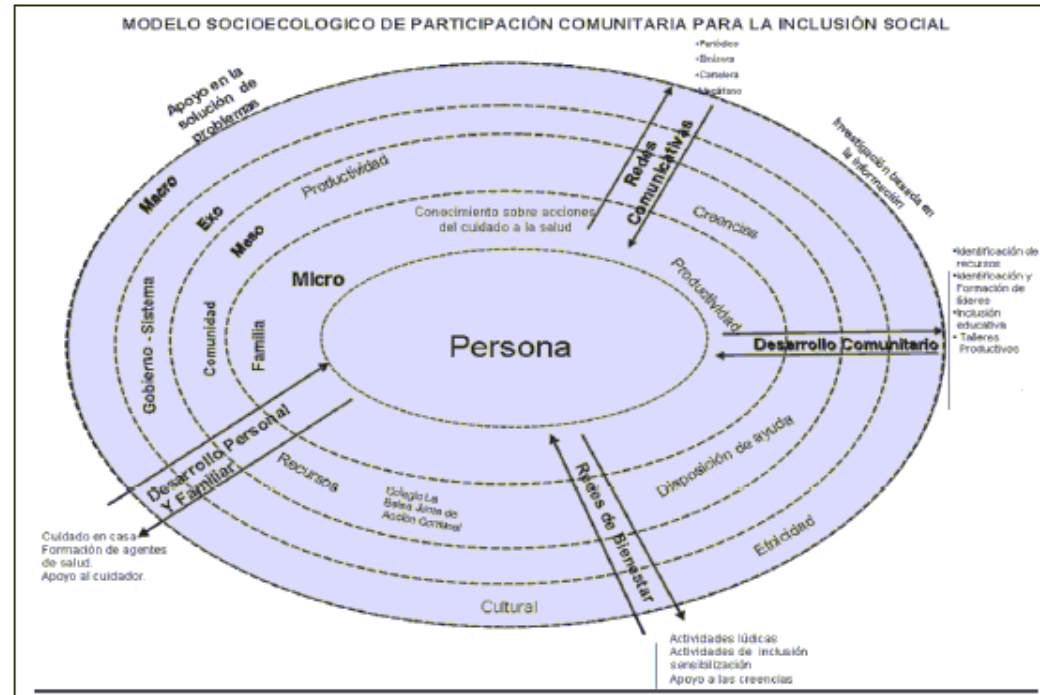


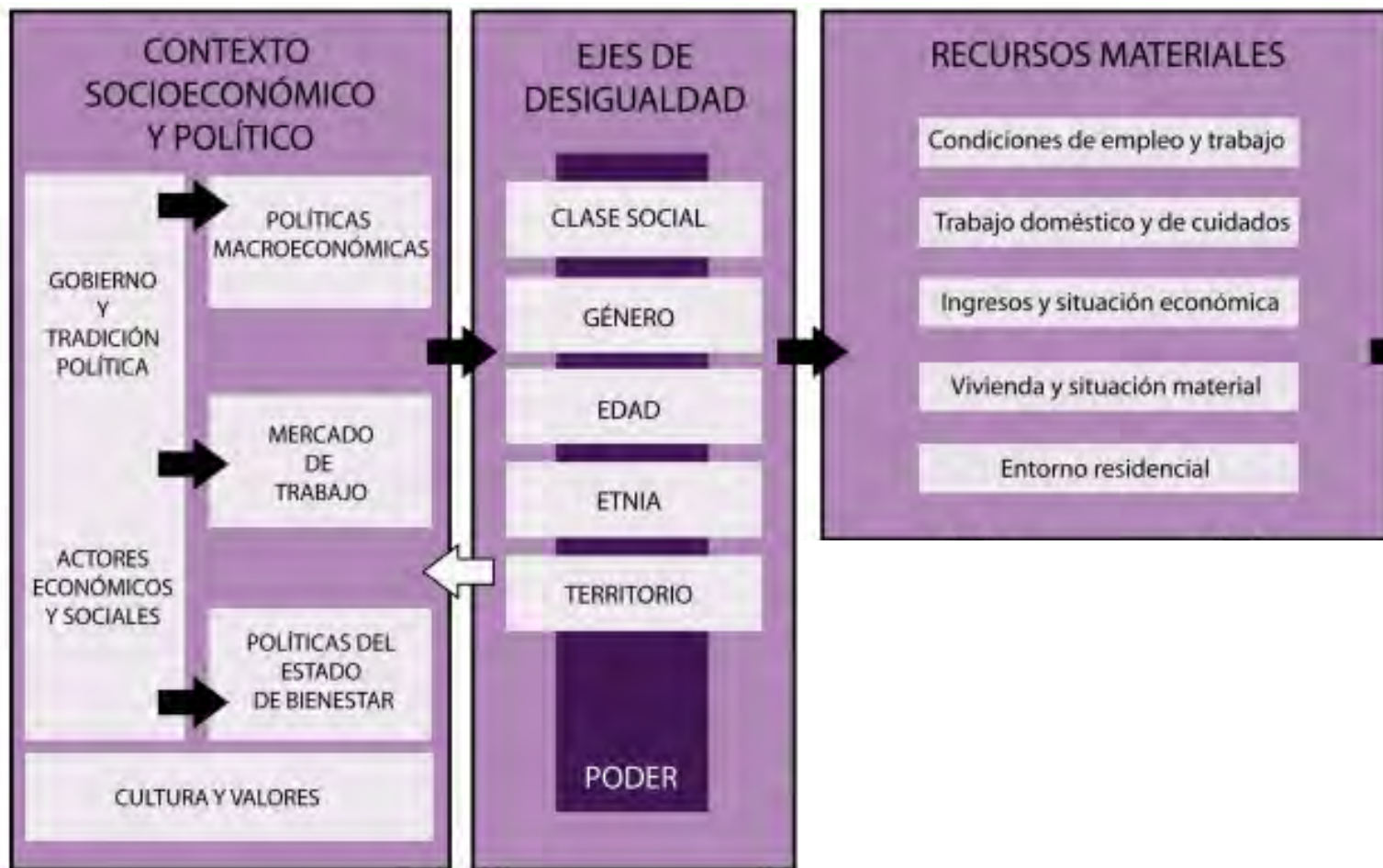
Figura 3. Modelo Socioecológico de Inclusión Social, resultado del trabajo con la comunidad. Adaptado de Mertensmeyer & Fine (2000)



Marco conceptual de los determinantes de las desigualdades sociales en salud.
Comisión para reducir las Desigualdades en Salud, 2010.



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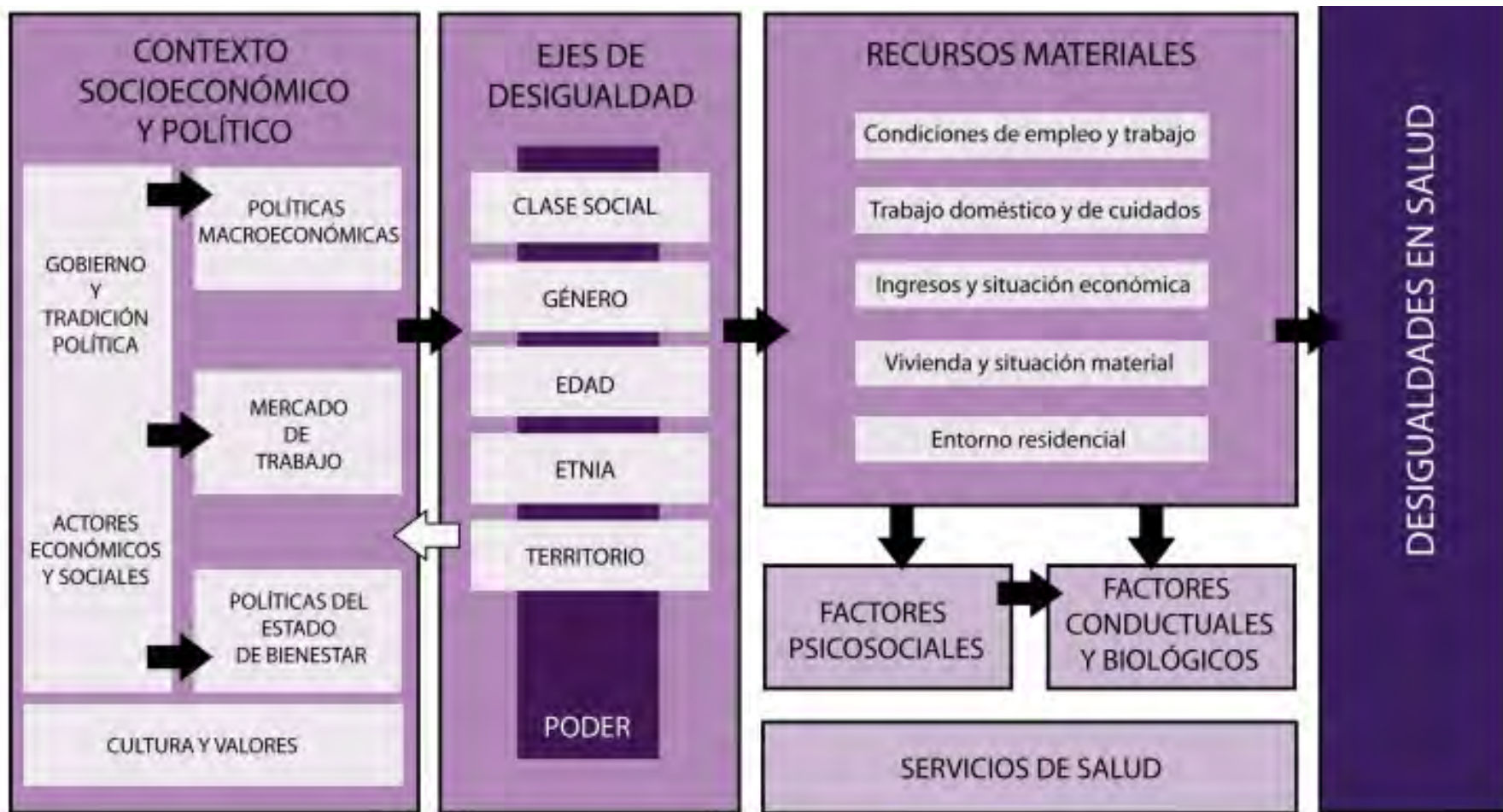
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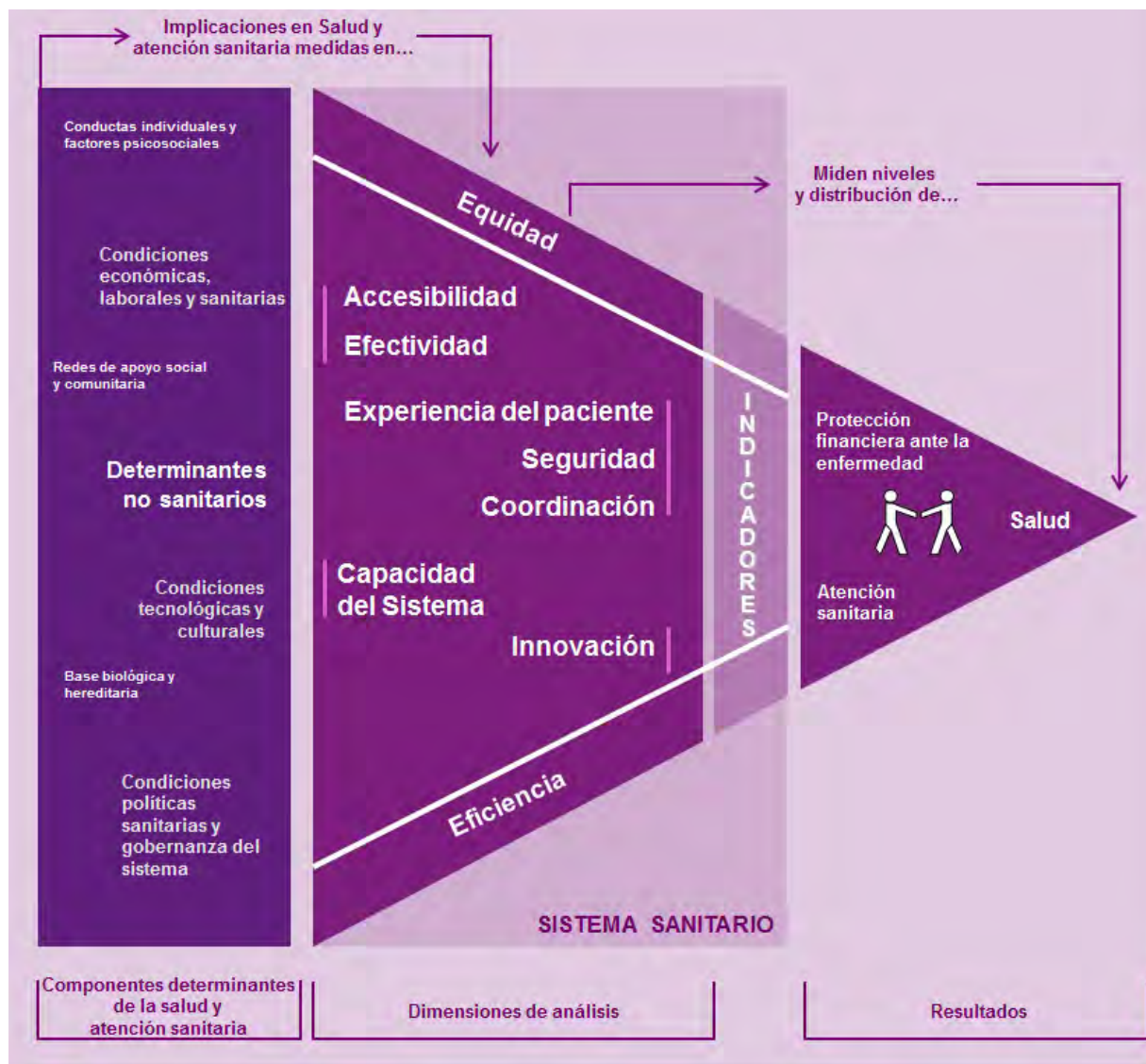
Marco conceptual de los determinantes de las desigualdades sociales en salud.

Comisión para reducir las Desigualdades en Salud, 2010.



Marco conceptual de los determinantes de las desigualdades sociales en salud.

Comisión para reducir las Desigualdades en Salud en España, 2010.



Resultados de Salud

Determinantes de Salud

Políticas y programas

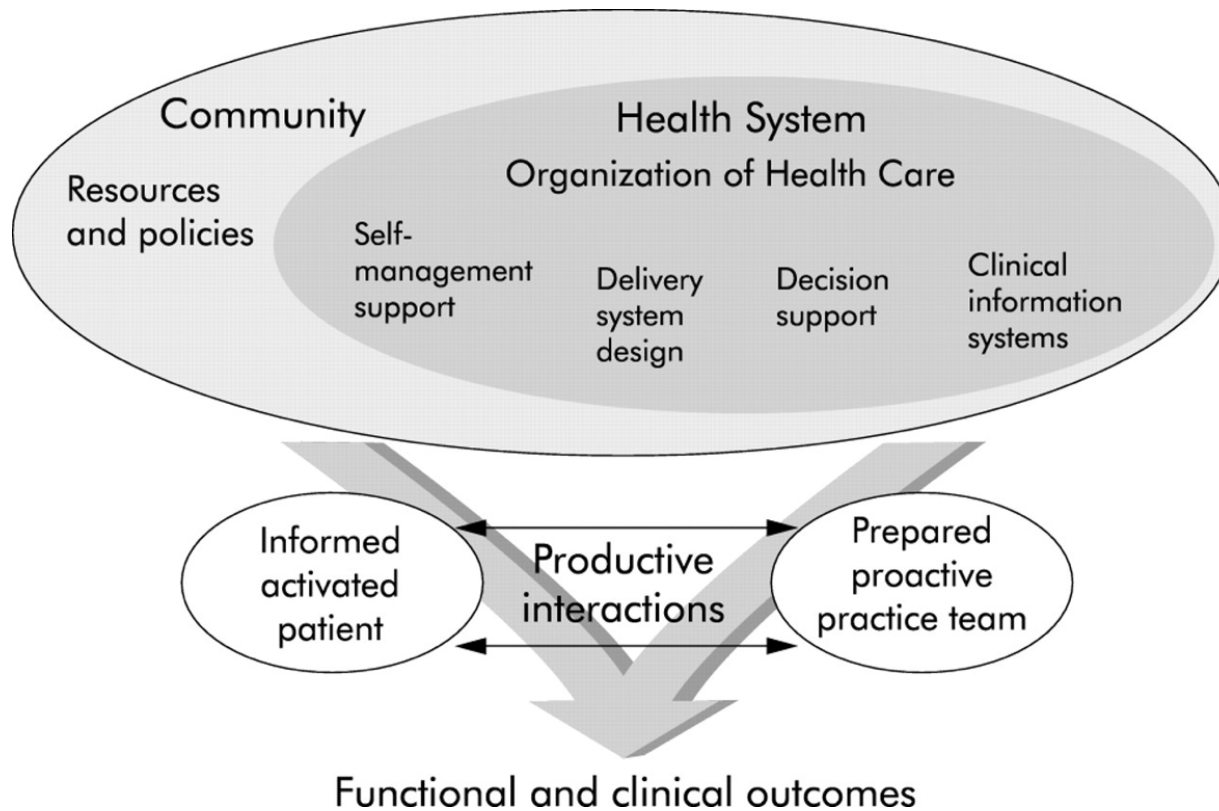
Socioeconómicos 40%

Conductas saludables 40%

Entorno ambiental 10%

Calidad sistema sanitario 10%

Booske BC, Athens JK, Kindig D, Park H, Remington P. Different perspectives for assigning weights to Determinants of Health. Country Health Rankings. Working Paper [Internet]. 2010 Feb; Available from: <http://goo.gl/OQCqn>

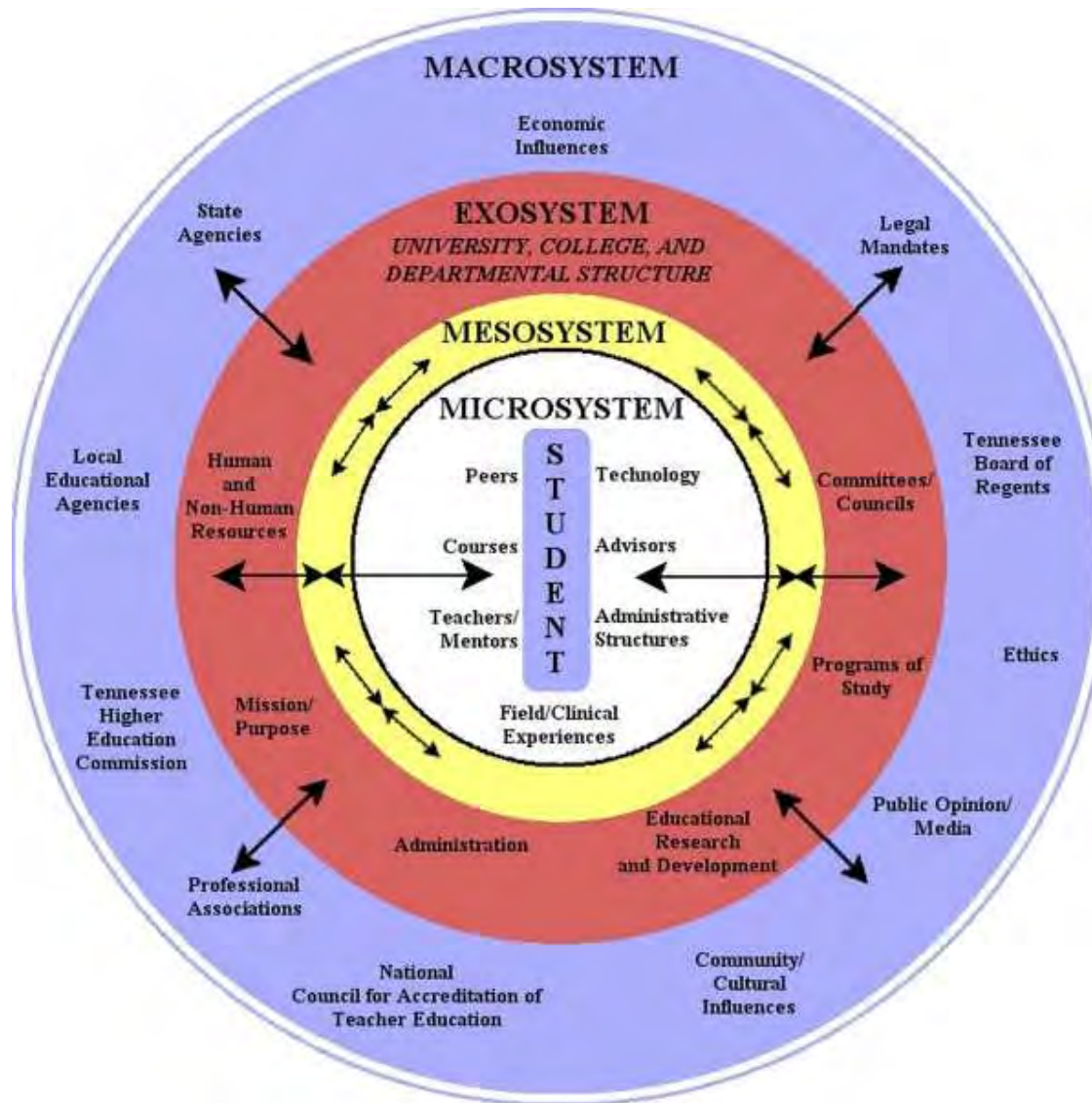


The Chronic Care Model. [Improving the quality of health care for chronic conditions.](#)
J E Epping-Jordan, S D Pruitt, R Bengoa, E H Wagner (2004)
Quality & safety in health care 13 (4) p. 299-305
<http://qualitysafety.bmj.com/content/13/4/299.full>

Pirámide de Kaiser ampliada



Fuente: Kaiser Permanente. Adaptado



Modelo ecológico de Bronfenbrenner.
 (referencia de Nadia Alas y Antón Rodríguez. DGSP Asturias)

Primer punto clave.

Podemos hacer un álbum de cromos con tantos modelos

...generar grupos y facciones...

¿Sois del Frente Judaico Popular? -¡Vete a la mierda!

MrJordisoto



Suscribirse

10 videos ▾



1:25 / 1:41



...o tratar de buscar complementariedad en los enfoques...

(sin perder de vista a los romanos, claro...)

Conceptual Approaches to the Study of Health Disparities

Ana V. Diez Roux

Center for Social Epidemiology and Population Health, Department of Epidemiology,
University of Michigan, Ann Arbor, Michigan 48109; email: adiezrou@umich.edu

Annu. Rev. Public Health 2012. 33:41–58

Referenciado gracias a Manuel Franco. CNIC. Social Epidemiology John Hopkins BSPH

Conceptual Approaches to the Study of Health Disparities

Ana V. Diez Roux

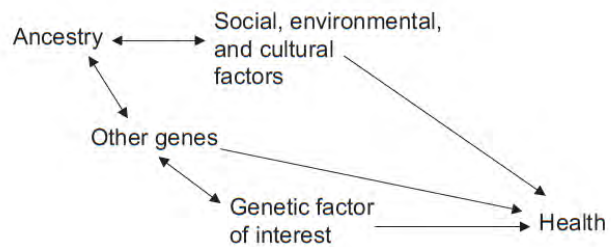
Center for Social Epidemiology and Population Health, Department of Epidemiology,
University of Michigan, Ann Arbor, Michigan 48109; email: adiezrou@umich.edu

Keywords

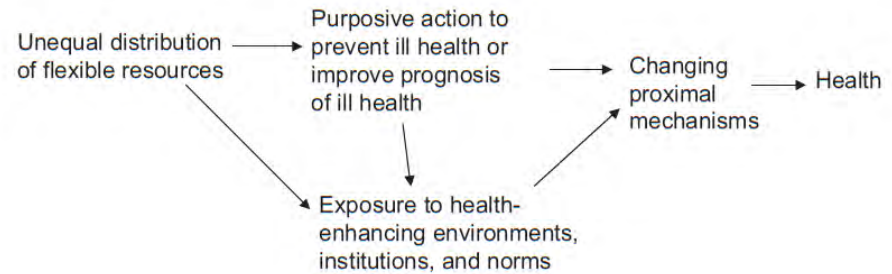
health inequalities, social determinants, systems

Abstract

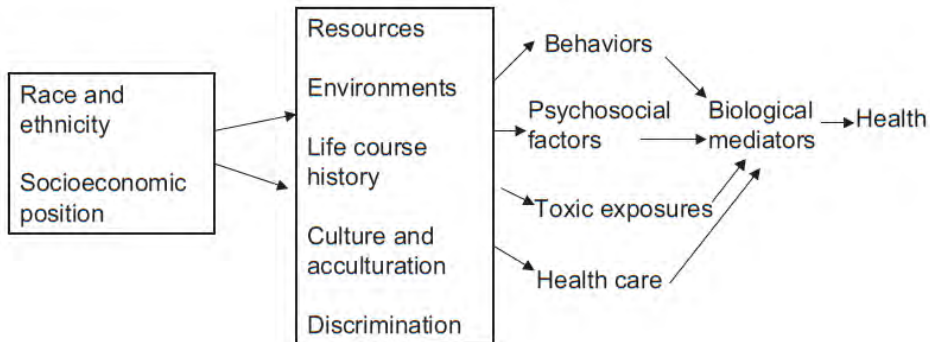
Scientific and policy interest in health disparities, defined as systematic, plausibly avoidable health differences adversely affecting socially dis-



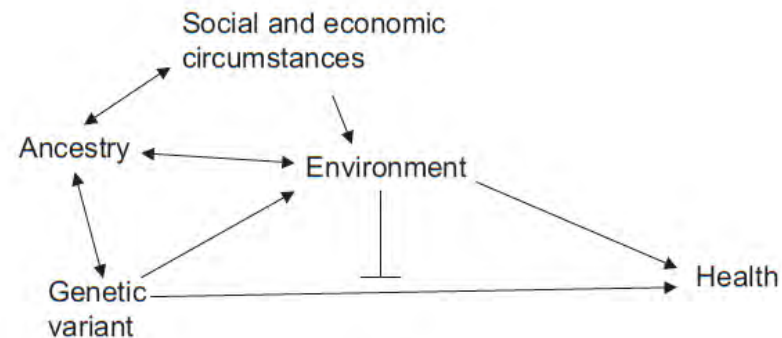
(a)



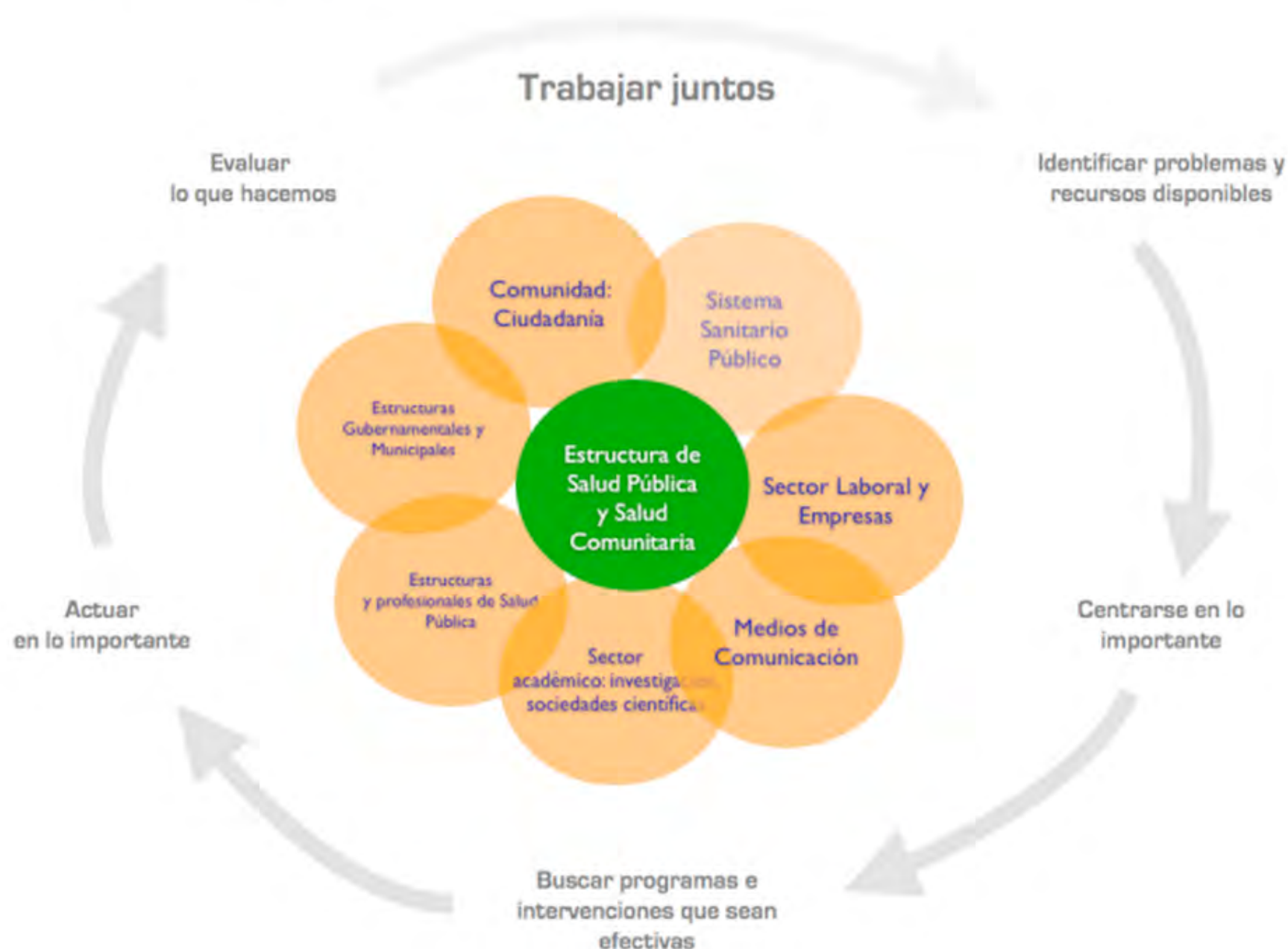
(b)



(c)



(d)



They say we all lose 21 grams
at the exact moment of our death...
everyone.

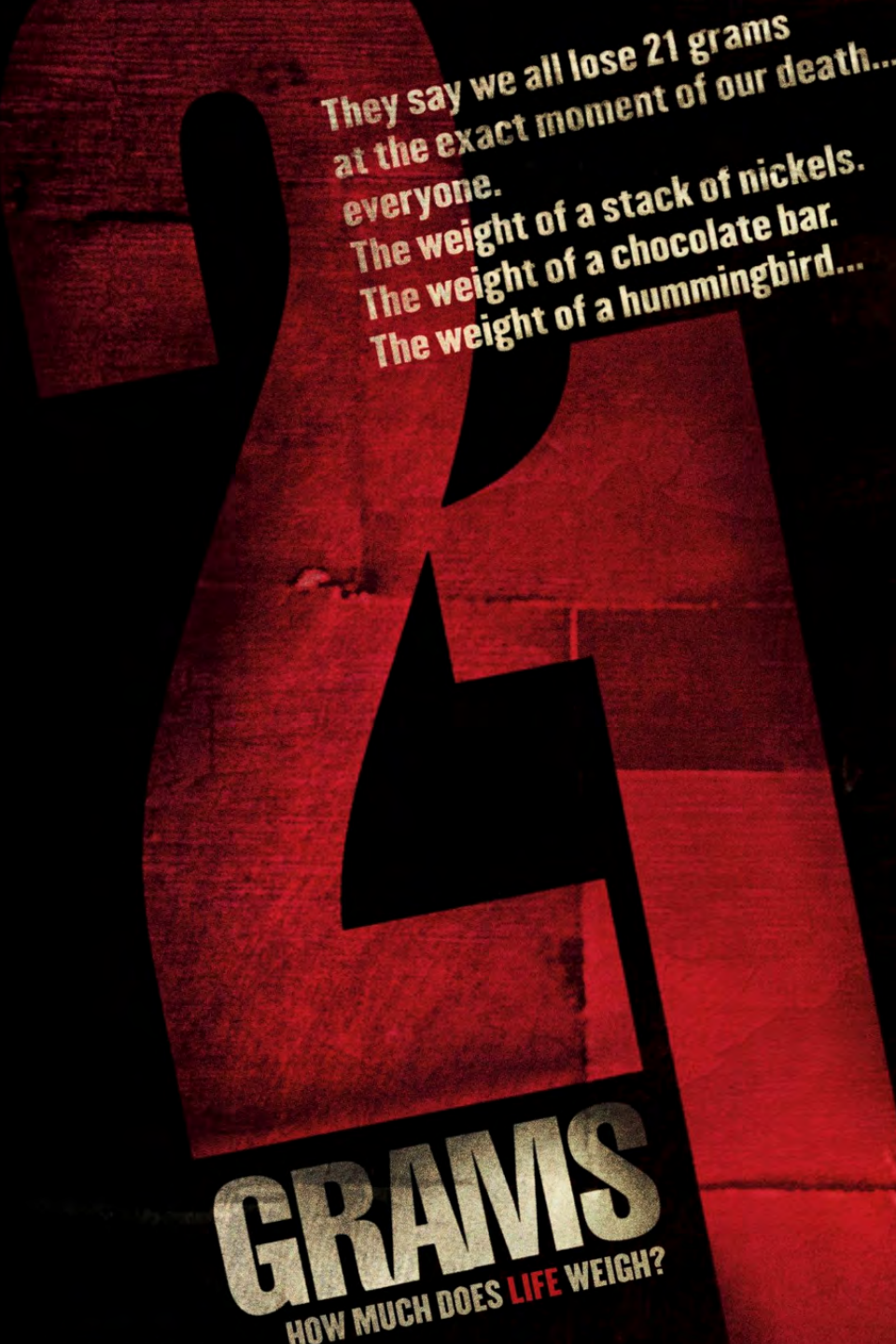
The weight of a stack of nickels.

The weight of a chocolate bar.

The weight of a hummingbird...

GRAMS

HOW MUCH DOES **LIFE** WEIGH?

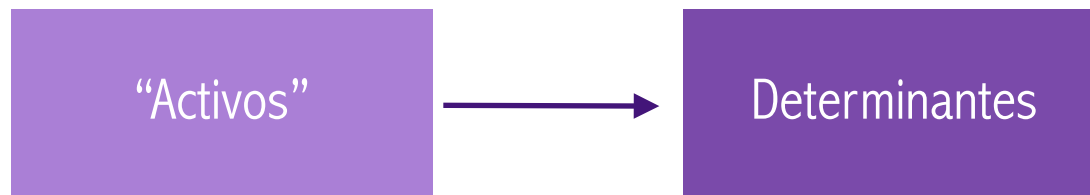


They say we all lose 21 grams
at the exact moment of our death...
everyone.
The weight of a stack of nickels.
The weight of a chocolate bar.
The weight of a hummingbird...

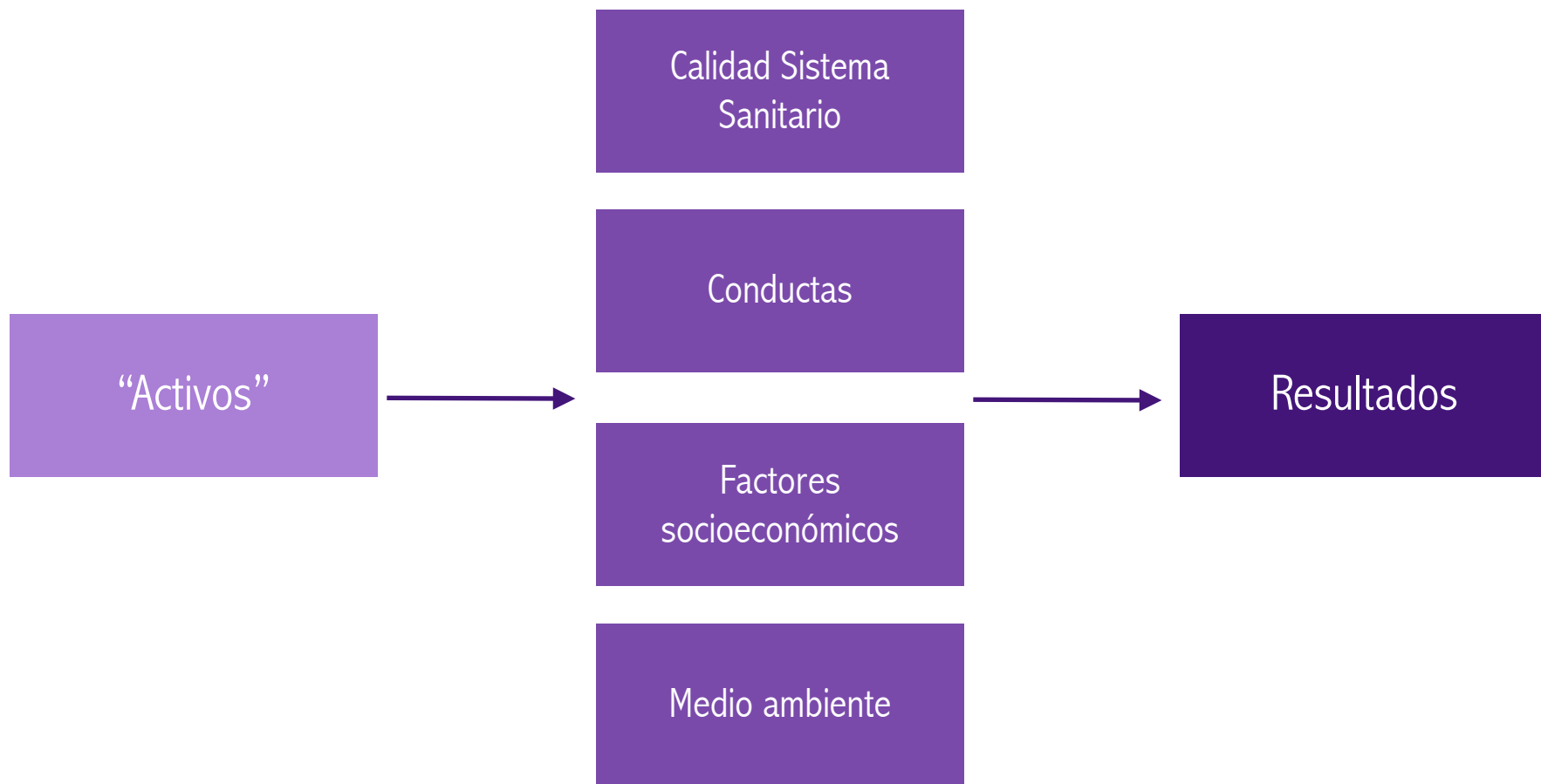
HOW MUCH DOES **HEALTH** WEIGH?

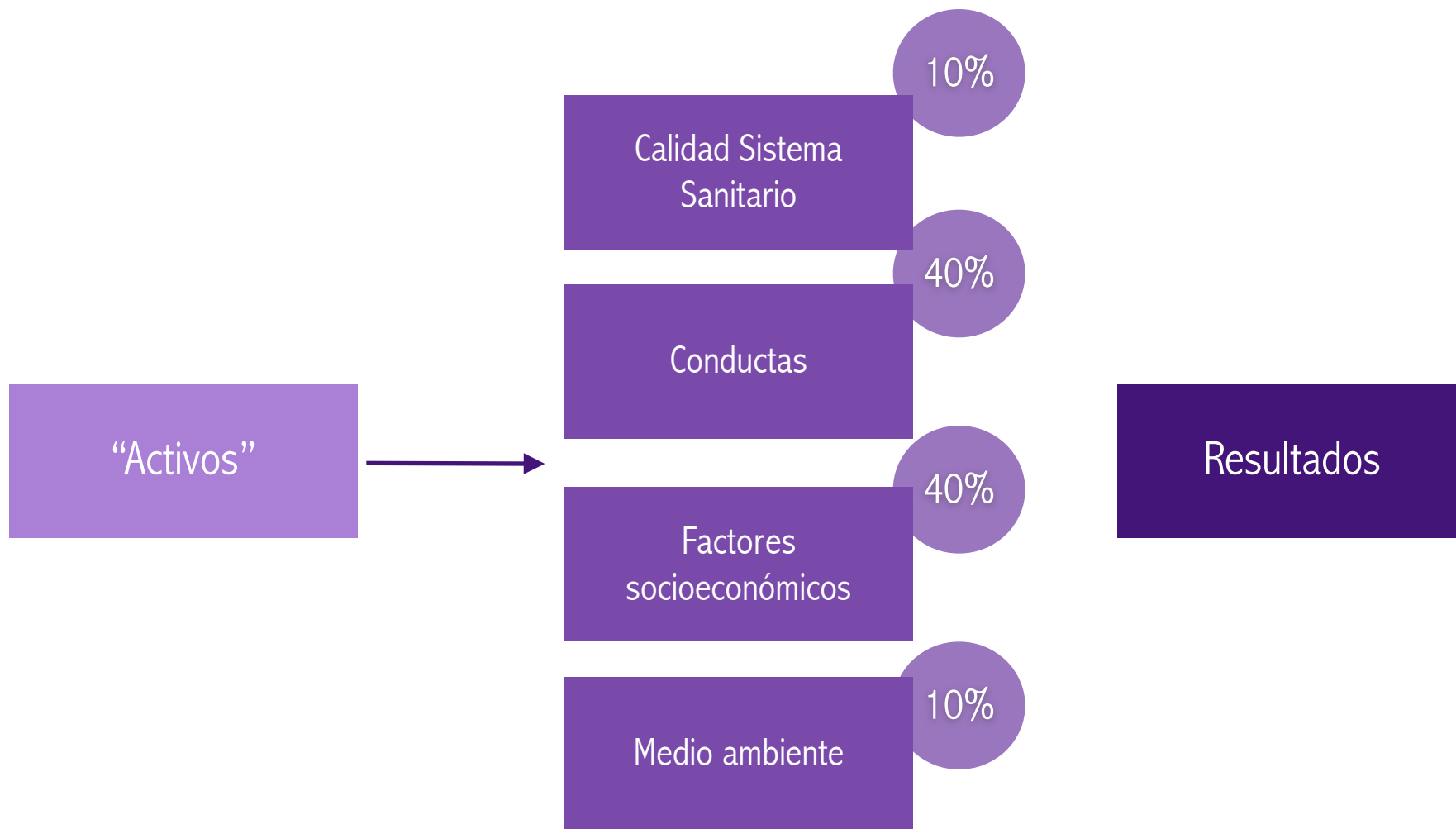
GRAMS
HOW MUCH DOES **LIFE** WEIGH?

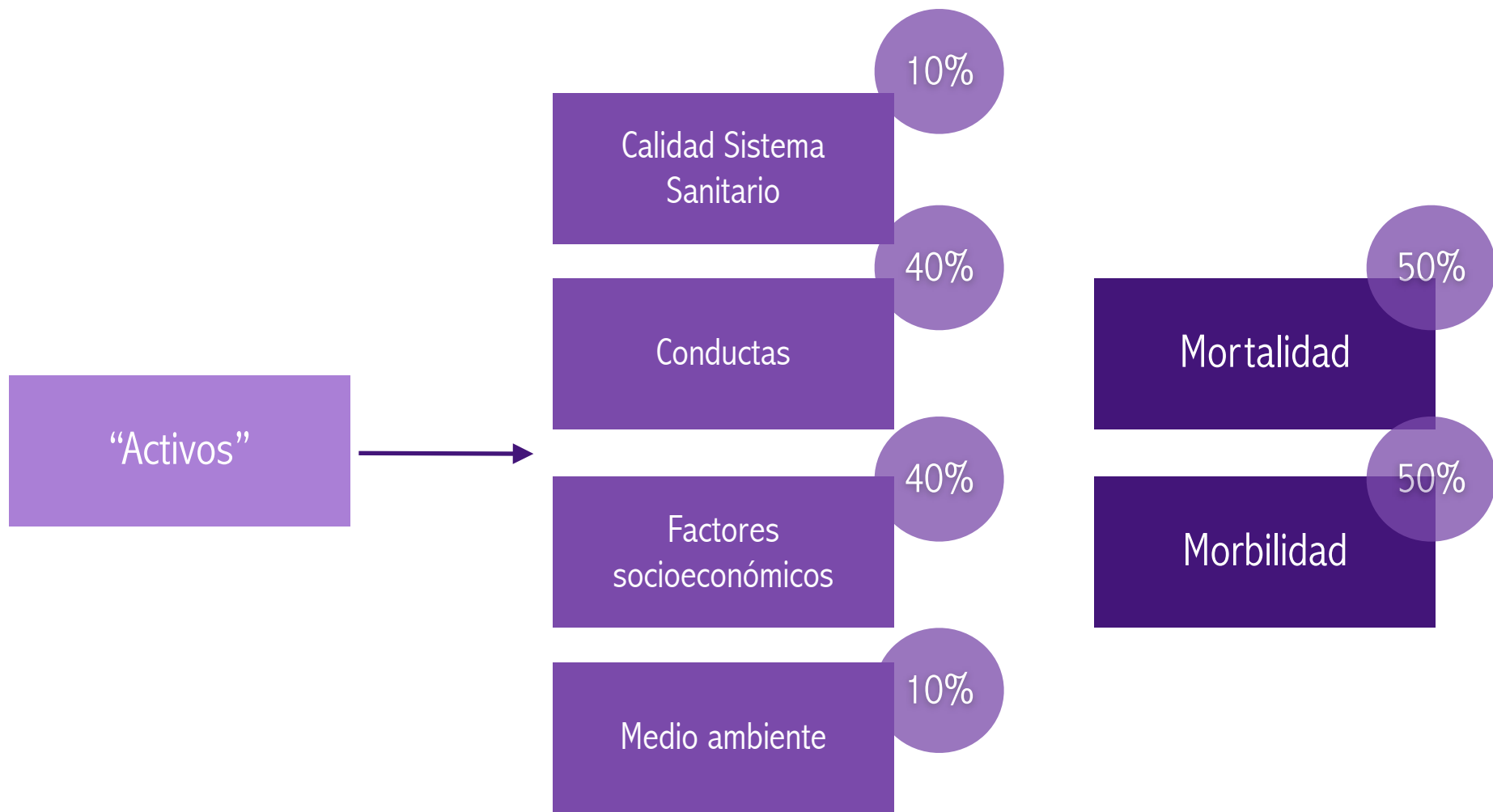
“Activos”













De todas las personas nacidas en mi año:
28% han fallecido



6%

8%

33%

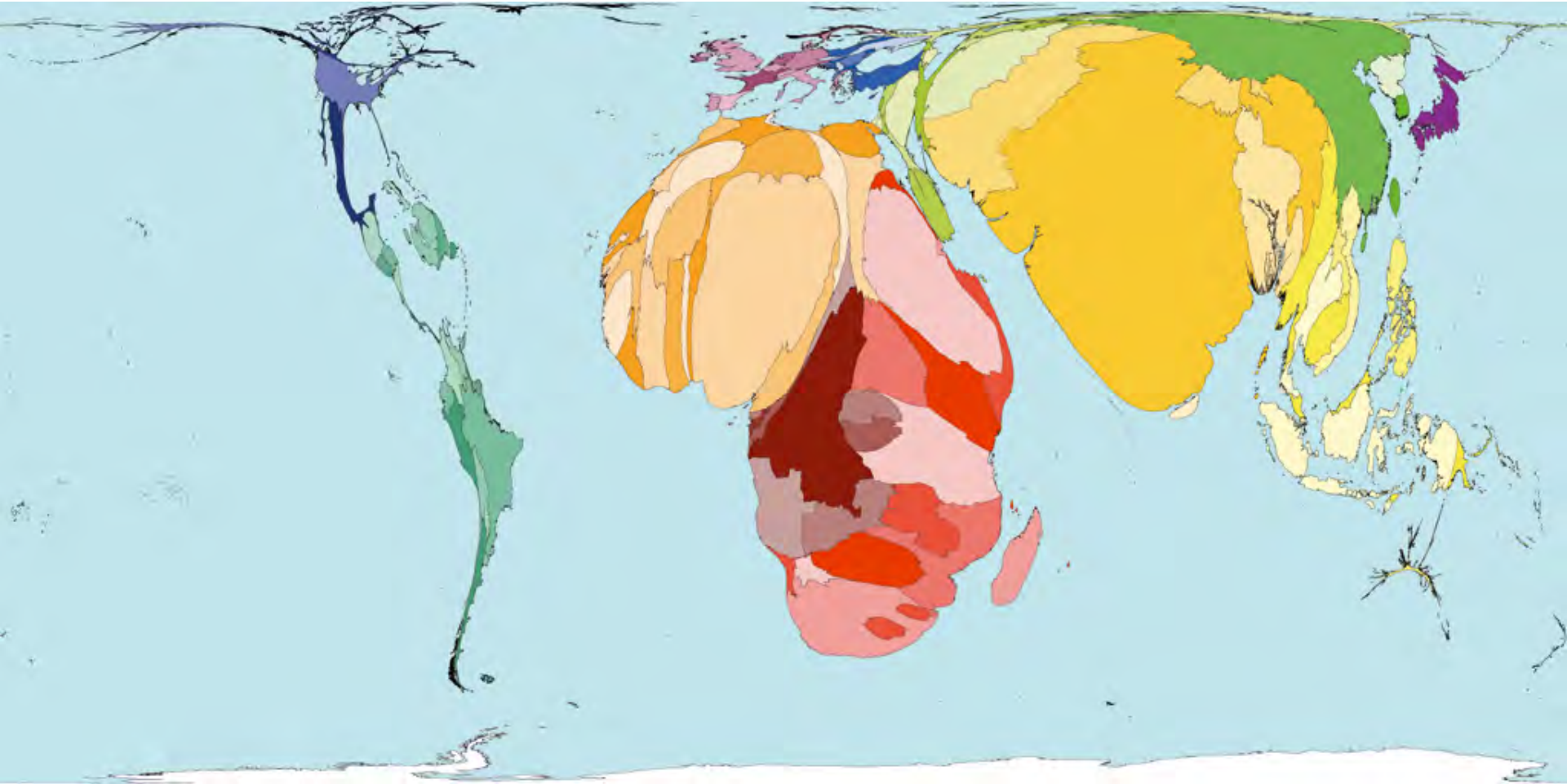
42%

21%

6%

De todas las personas nacidas en mi año:
28% han fallecido

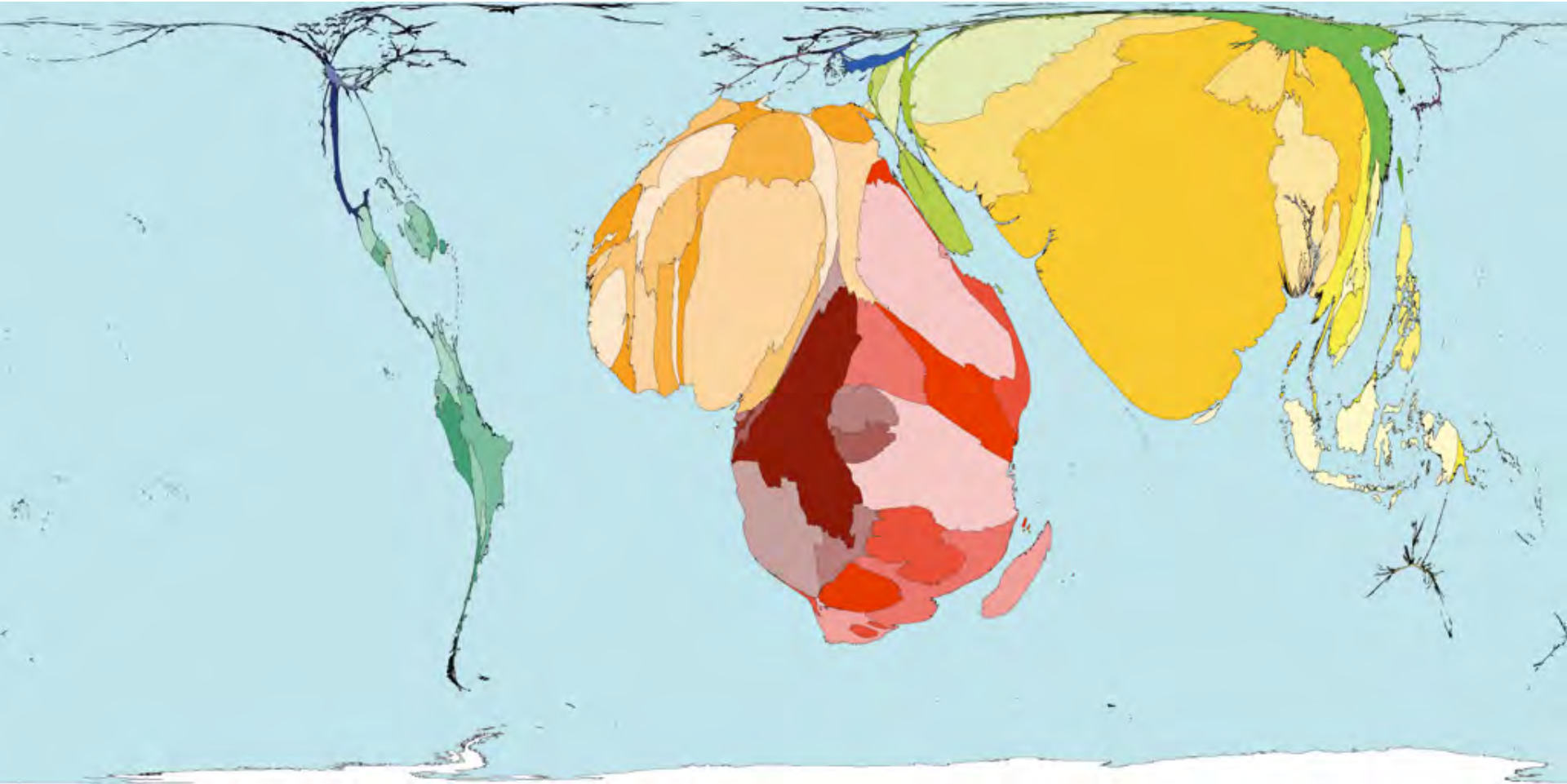
Preventable deaths: world mapper



These conditions caused 32% of all deaths worldwide in 2002, an average of 2968 deaths per million people.

Territories are sized in proportion to the absolute number of people who died from most preventable (communicable infections, maternal, perinatal and nutritional conditions) in one year.

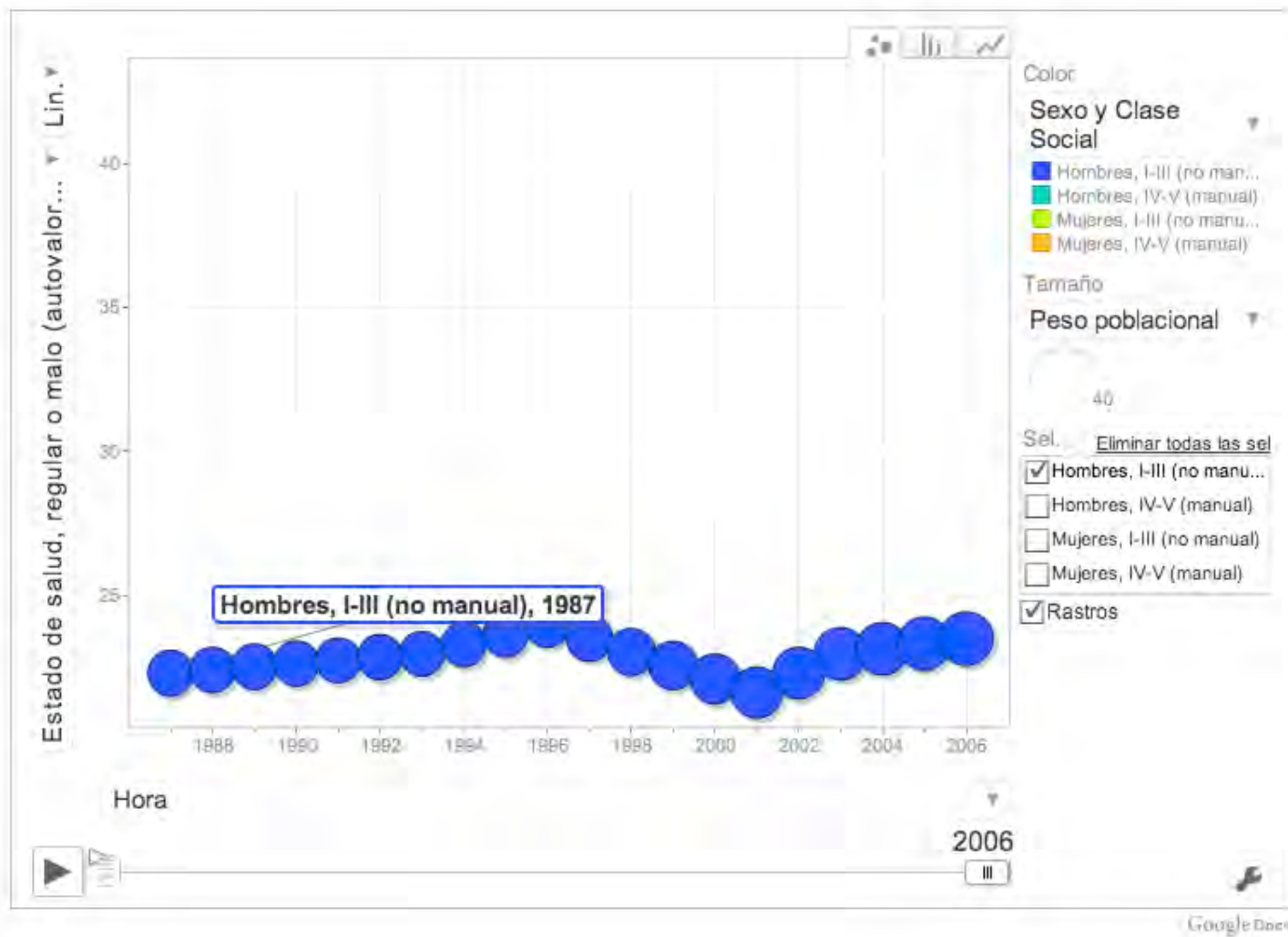
Deaths of Women from Pregnancy: World Mapper

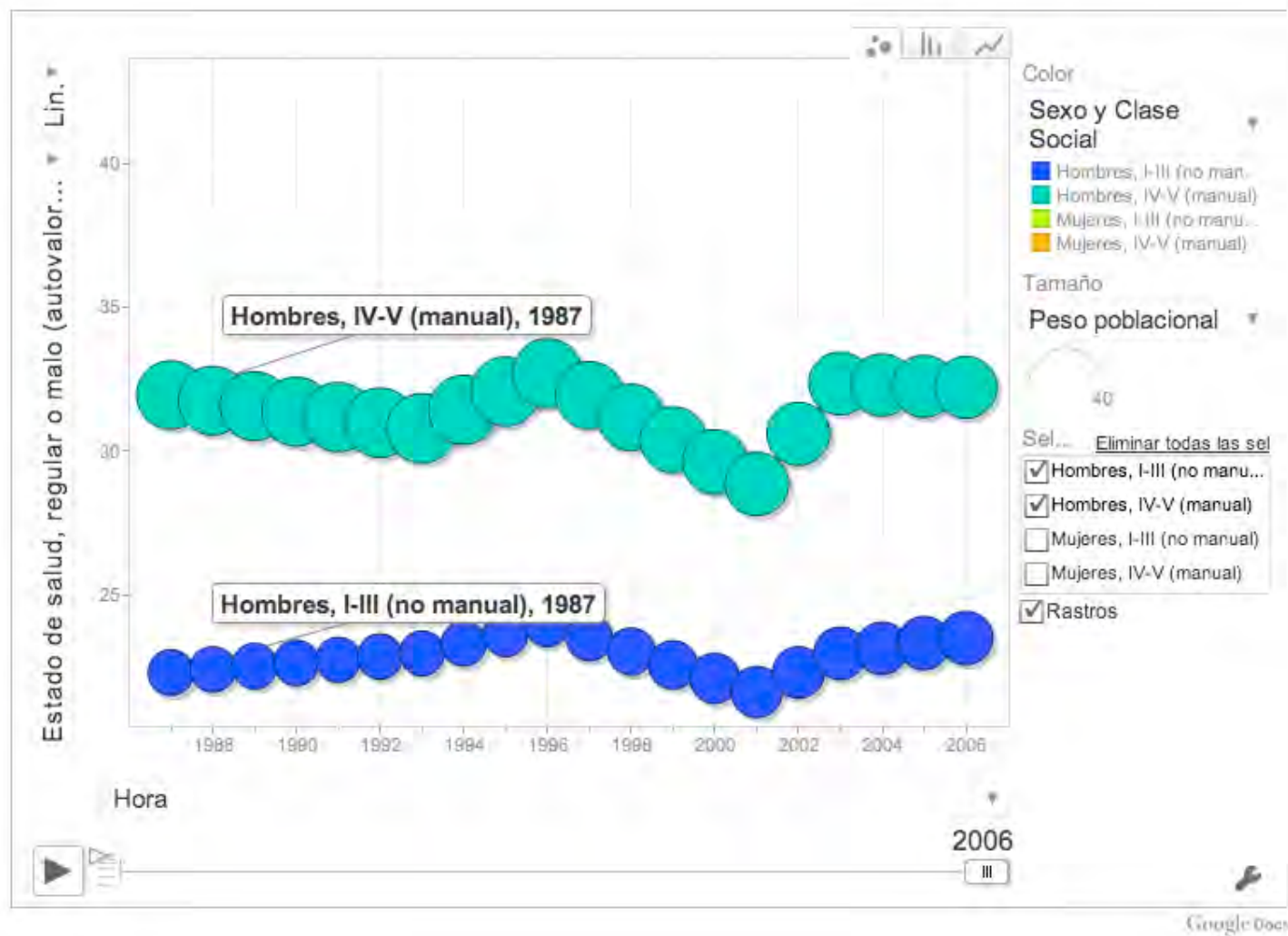


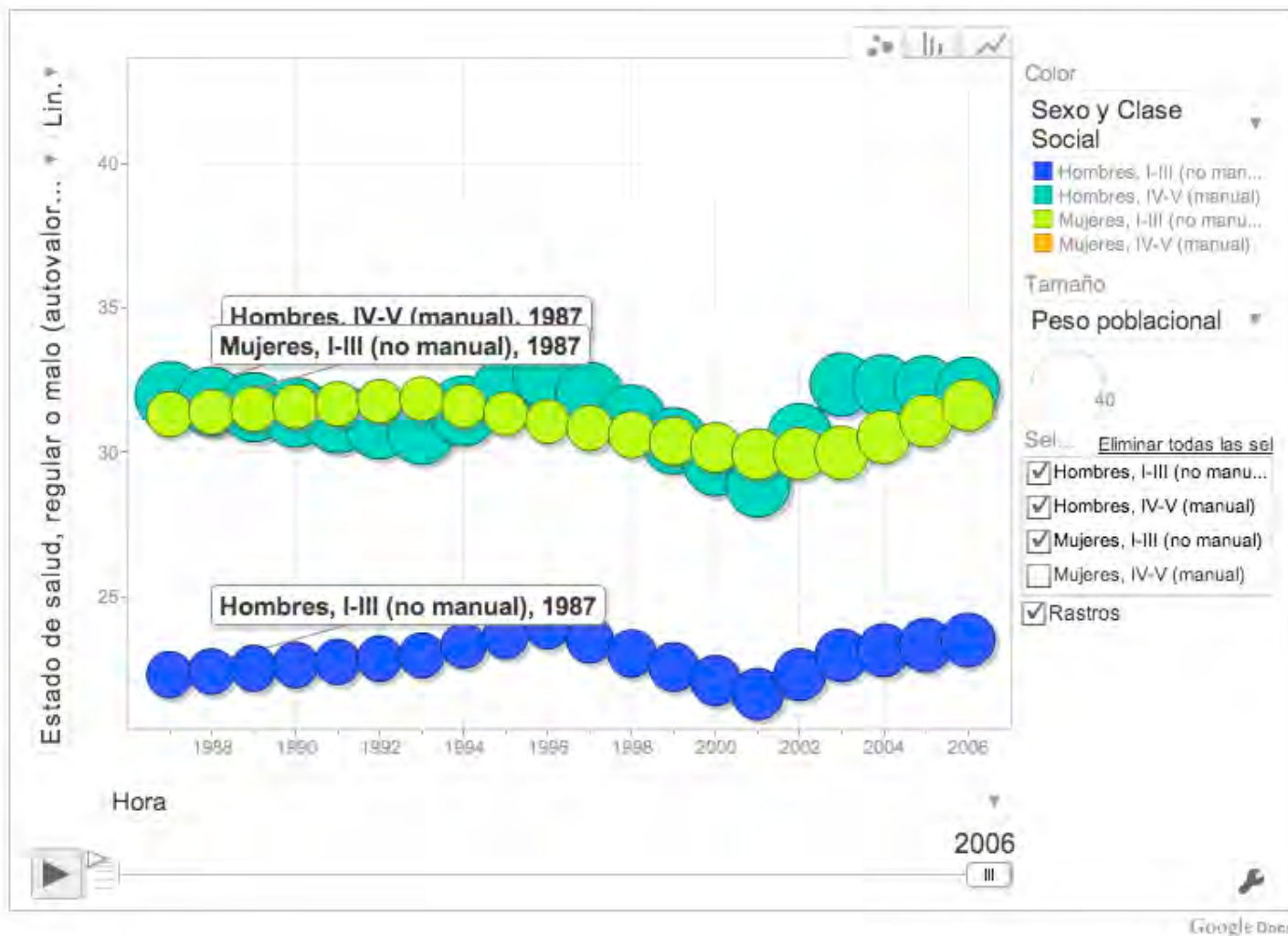
In 2002 Maternal conditions caused 1.9% of all female deaths (table 3) and 3.2% of all deaths among all adults between ages 15 and 59 years. Global Burden of Disease estimated in 2002 Maternal conditions caused 3.3% of all years living with a disability, 6.4% of all female disability (table 6). GBD also estimated it to cause 4.7% of all Female and 3.1% of all Very poor territory burden of disease (Disability Adjusted Lost Years, table 7).

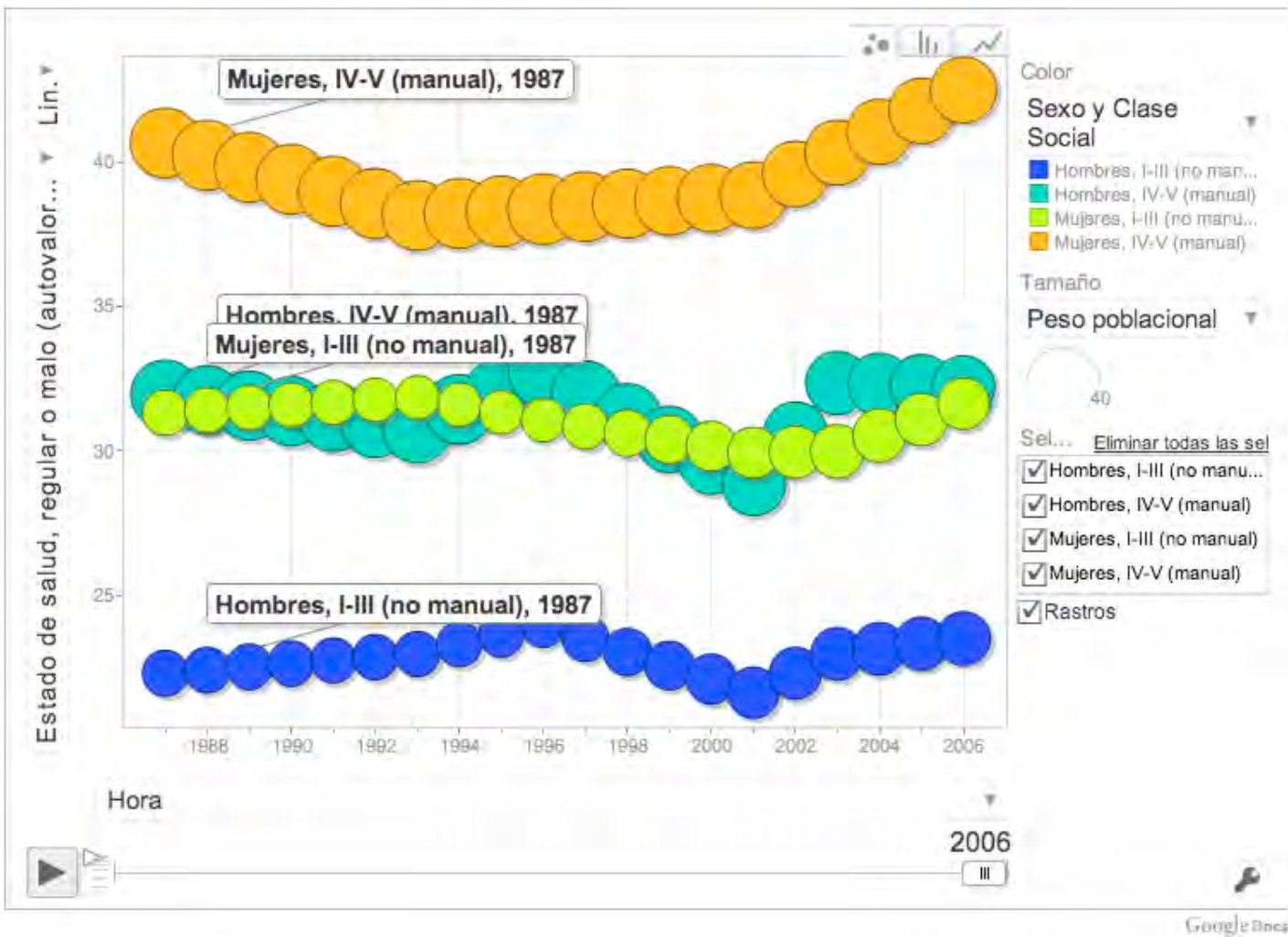
Maternal conditions caused 0.9% of all deaths worldwide in 2002, an average of 82 deaths per million people per year.

Territories are sized in proportion to the absolute number of people who died from maternal conditions in one year.





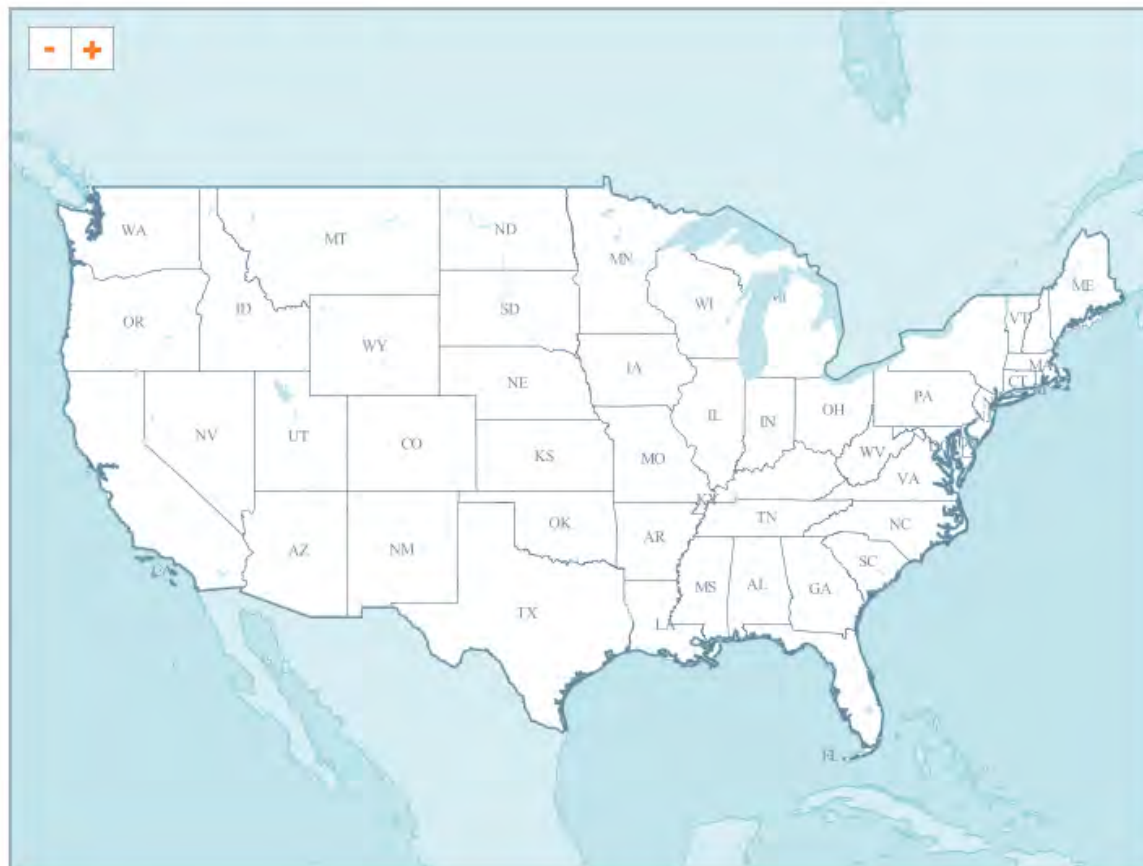




FIND A STATE OR COUNTY

FACT

In the United States, 121,750 lives could be saved if 10% more people had some college education.



Want to improve health? Start with where we live, learn, work and play.

The County Health Calculator is a tool for advocates and policy makers. Health is about more than healthcare. It is about education, income and the environment in which we live. Use the calculator to see how education and income affect health outcomes. Click below to get started.

**WHERE DO
I START?**

Mississippi

Browse to...

EDUCATION Percent of adults with some college education



48%

Worst:	West Virginia 40%
Best:	Utah 65%
Average:	55%

Mississippi

Browse to...

EDUCATION Percent of adults with some college education



48%

Worst: West Virginia 40%
Best: Utah 65%
Average: 55%

INCOME Percent of adults with an income twice the federal poverty level



56%

Worst: Mississippi 56%
Best: Connecticut 80%
Average: 69%

Mississippi

EDUCATION Percent of adults with some college education



48%

Worst: West Virginia 40%
Best: Utah 65%
Average: 55%

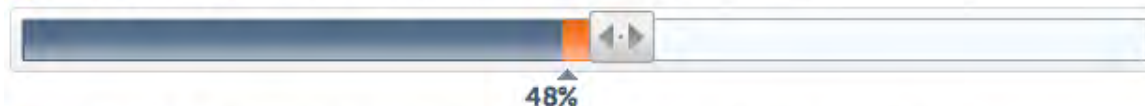
INCOME Percent of adults with an income twice the federal poverty level



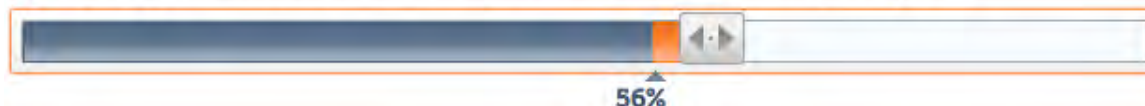
56%

Worst: Mississippi 56%
Best: Connecticut 80%
Average: 69%

	CURRENT VALUES	ADJUSTED VALUES
<u>Deaths</u>	14,700	14,700
<u>Death Rate</u>	536	536
<u>Mortality Rank</u>	51	51
<u>Deaths Averted</u>		0
<u>% Deaths Averted</u>		0%
<u>Diabetes Cases</u>	235,000	235,000
<u>Diabetes Cases Averted</u>		0
<u>Diabetes Care Costs</u>	\$1.6 Billion	\$1.6 Billion
<u>Diabetes Care Costs Saved</u>		\$0

EDUCATION Percent of adults with some college education**53%**

Worst: West Virginia 40%
 Best: Utah 65%
 Average: 55%

INCOME Percent of adults with an income twice the federal poverty level**61%**

Worst: Mississippi 56%
 Best: Connecticut 80%
 Average: 69%

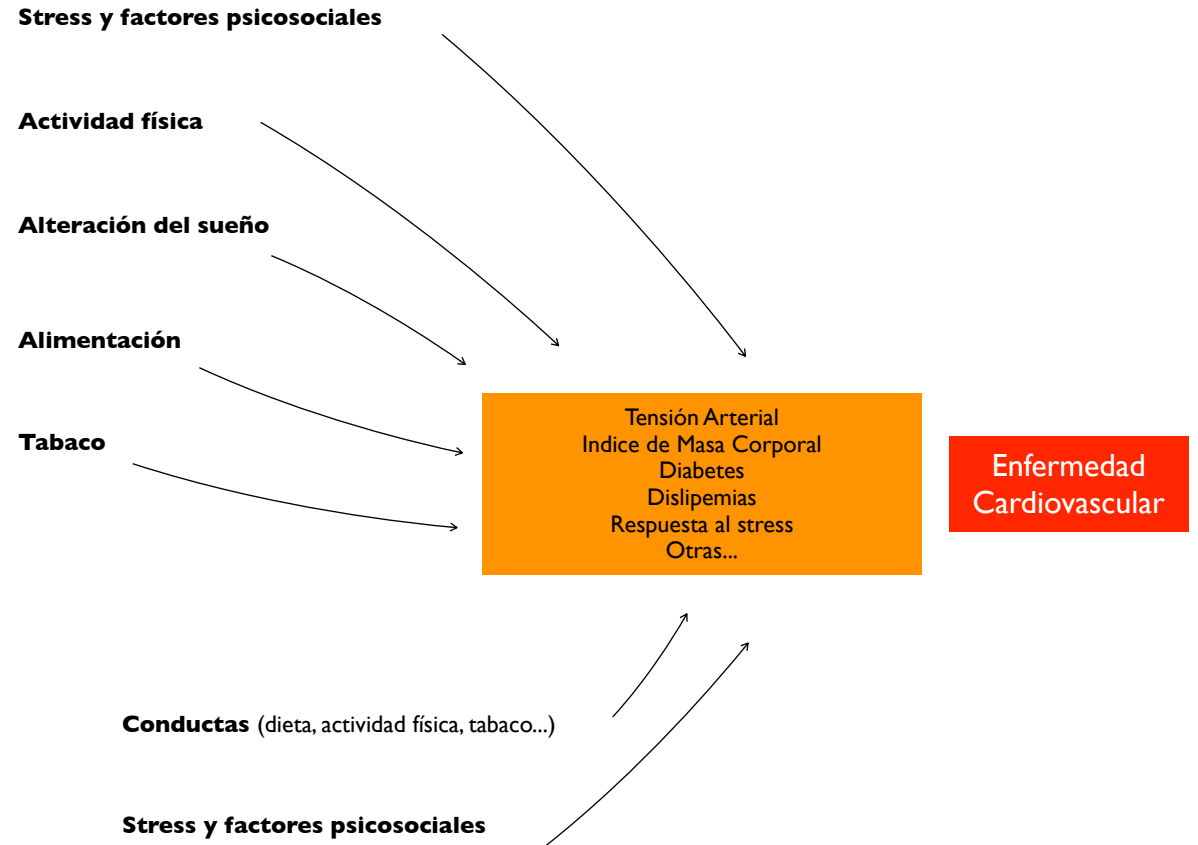
	CURRENT VALUES	ADJUSTED VALUES
<u>Deaths</u>	14,700	13,900
<u>Death Rate</u>	536	504
<u>Mortality Rank</u>	51	48
<u>Deaths Averted</u>		889
<u>% Deaths Averted</u>		6%
<u>Diabetes Cases</u>	235,000	228,000
<u>Diabetes Cases Averted</u>		7,600
<u>Diabetes Care Costs</u>	\$1.6 Billion	\$1.5 Billion
<u>Diabetes Care Costs Saved</u>		\$50.7 Million

In Mississippi, if 5% more people attended some college and 5% more had an income higher than twice the federal poverty level we could expect to save 889 lives, prevent 7,600 cases of diabetes, and eliminate \$50.7 Million in diabetes costs every year.

Enfermedad
Cardiovascular

Tensión Arterial
Índice de Masa Corporal
Diabetes
Dislipemias
Respuesta al stress
Otras...

Enfermedad
Cardiovascular



Entorno físico

Contaminación del aire
Estética del entorno
Diseño urbanístico
Ruido
Control publicidad
Regulación de alimentación saludable
Entorno libre de humos
Acceso a espacios de ocio y tiempo libre

Stress y factores psicosociales

Actividad física

Alteración del sueño

Alimentación

Tabaco

Tensión Arterial
Índice de Masa Corporal
Diabetes
Dislipemias
Respuesta al stress
Otras...

Conductas (dieta, actividad física, tabaco...)

Stress y factores psicosociales

Reacción inflamatoria
Daño endotelial
Alteración frecuencia cardíaca

**Enfermedad
Cardiovascular**

Entorno físico

Contaminación del aire

Estética del entorno

Diseño urbanístico

Ruido

Control publicidad

Regulación de alimentación saludable

Entorno libre de humos

Acceso a espacios de ocio y tiempo libre

Educación ↔ Clase Social

↙ Ingresos ↘

Género

Redes sociales: apoyo y
cohesión

Entorno socioeconómico

Normas/
Oportunidades
sociales

Stress y factores psicosociales

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**Enfermedad
Cardiovascular**

"BOLD, IMIORTANT AND MASTERFUL . . . MARMOT'S MESSAGE IS NOT JUST
TIMELY, IT'S URGENT." —THE WASHINGTON POST BOOK WORLD

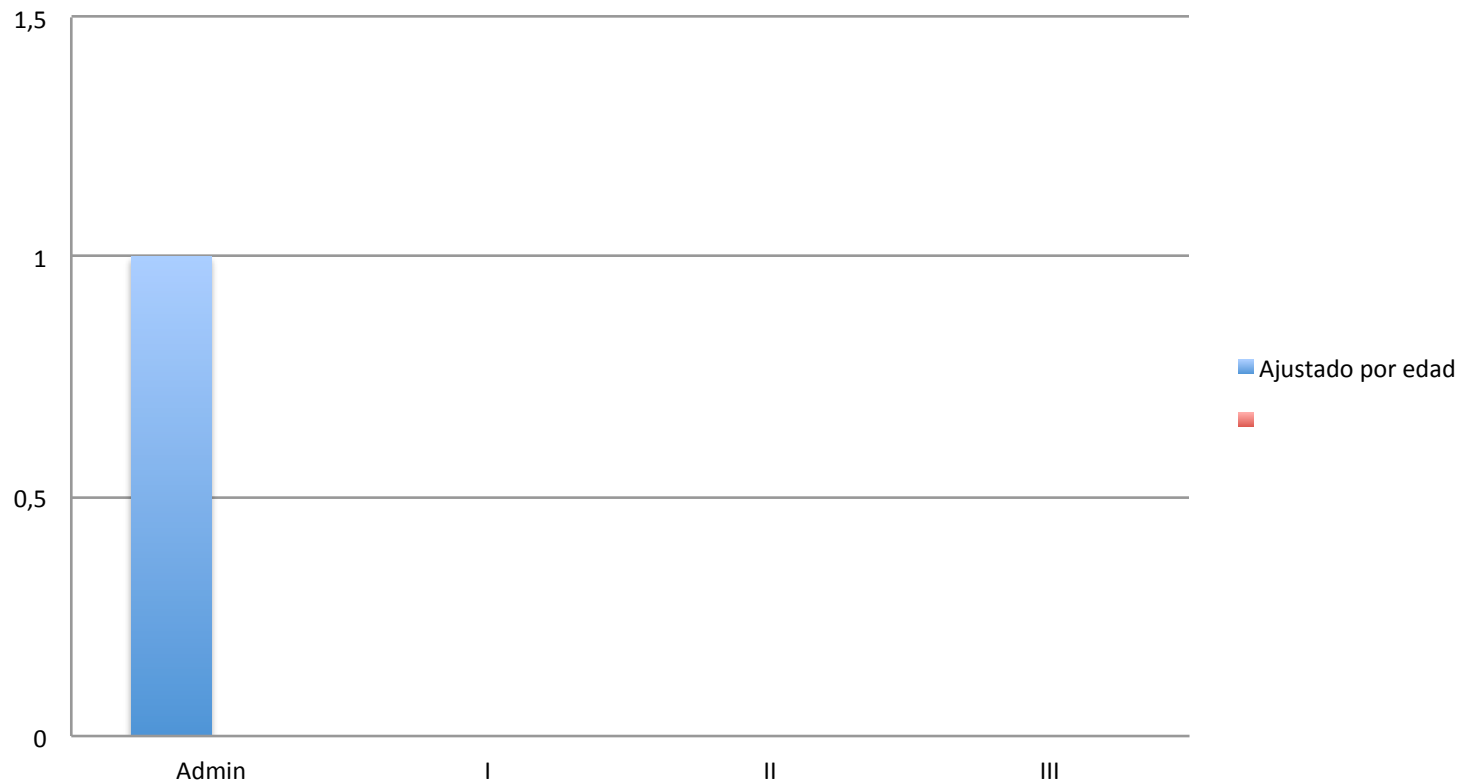
THE STATUS SYNDROME

How Social Standing Affects
Our Health and Longevity



MICHAEL MARMOT

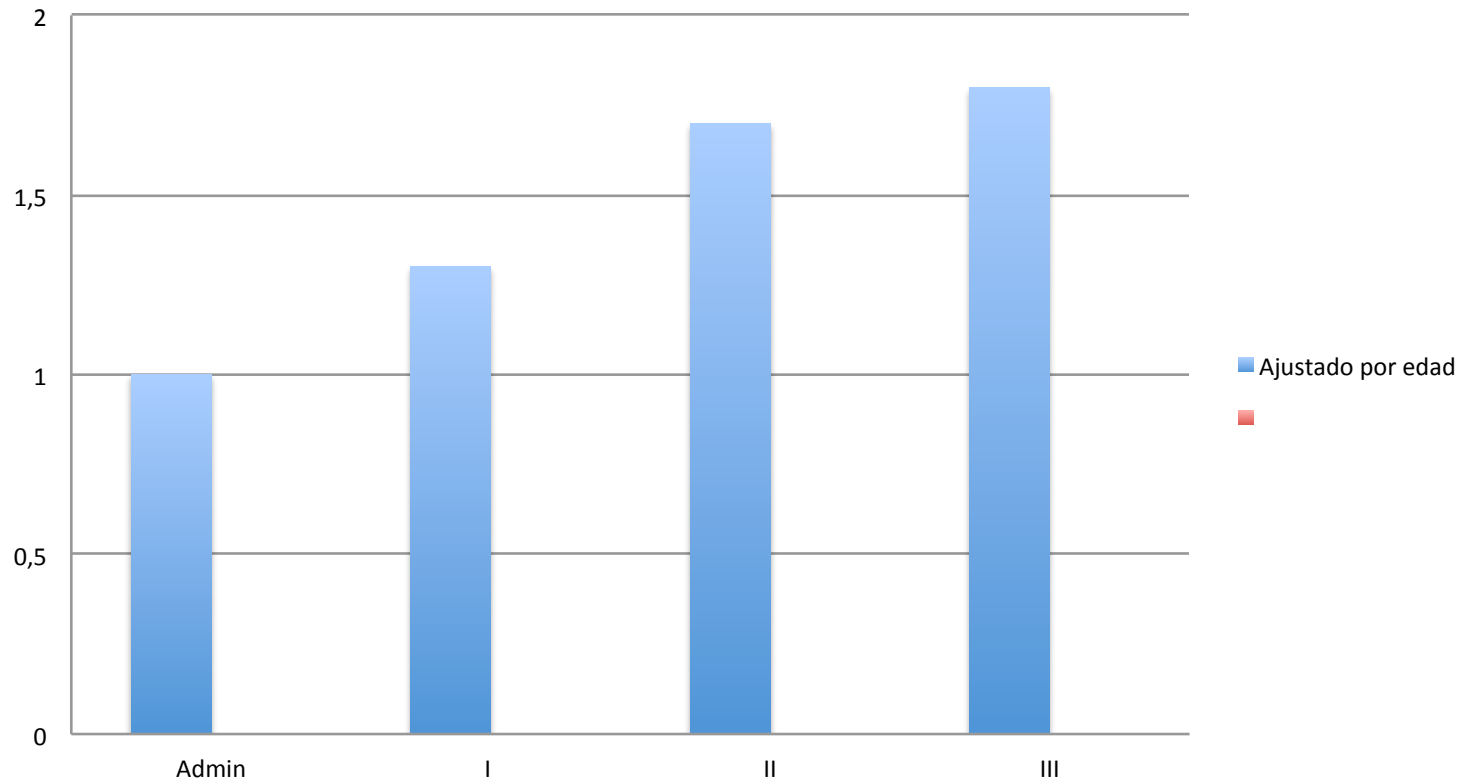
Mortalidad enfermedad coronaria: contribución de los factores de riesgo



van Rossum et al. (2000). Employment grade differences in cause specific mortality. A 25 year follow up of civil servants from the first Whitehall study. Journal of epidemiology and community health, 54(3), 178–84. Retrieved from <http://www.pubmedcentral.nih.gov/articlerender.fcgi?artid=1731642&tool=pmcentrez&rendertype=abstract>

Marmot, M. The Status Syndrome. Holt and company,. New York, 2004.

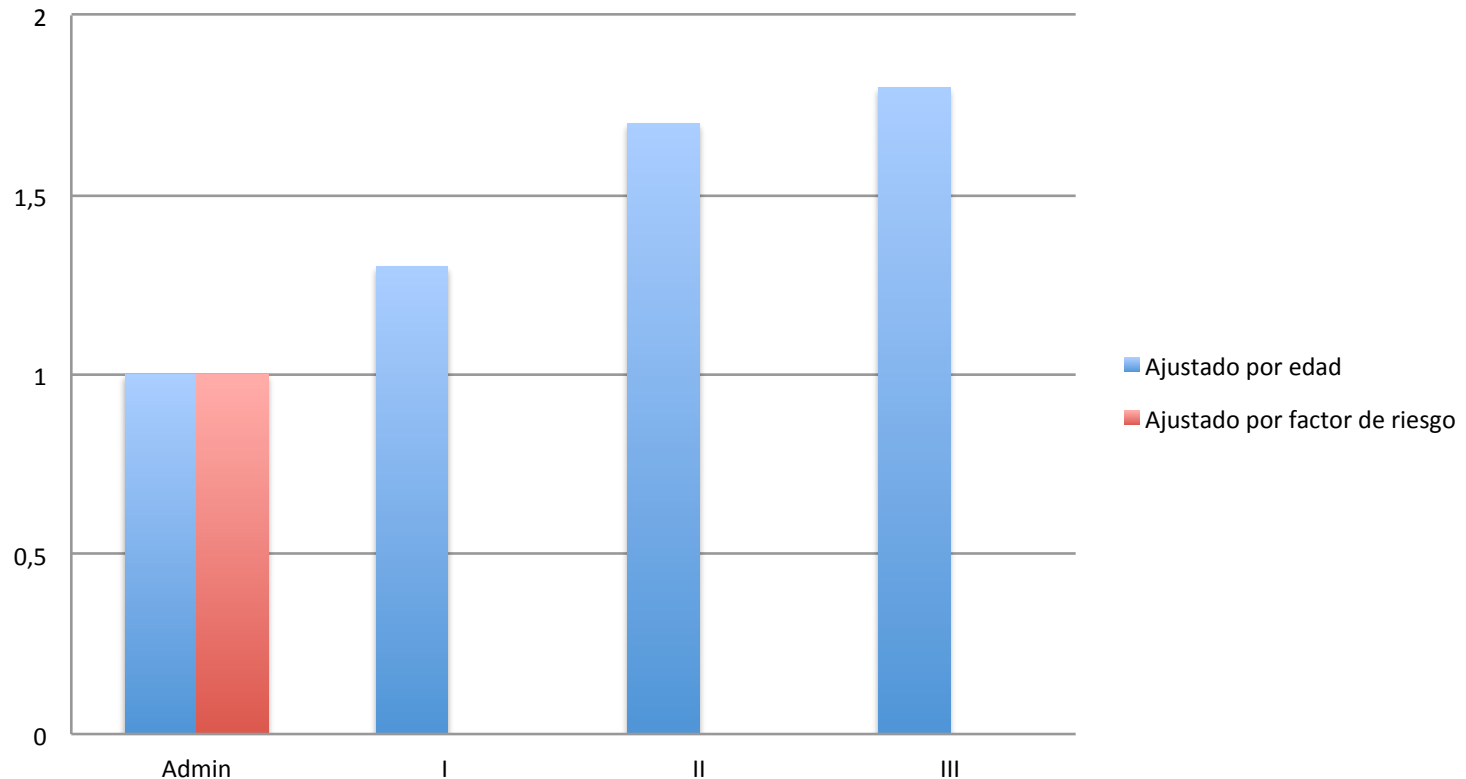
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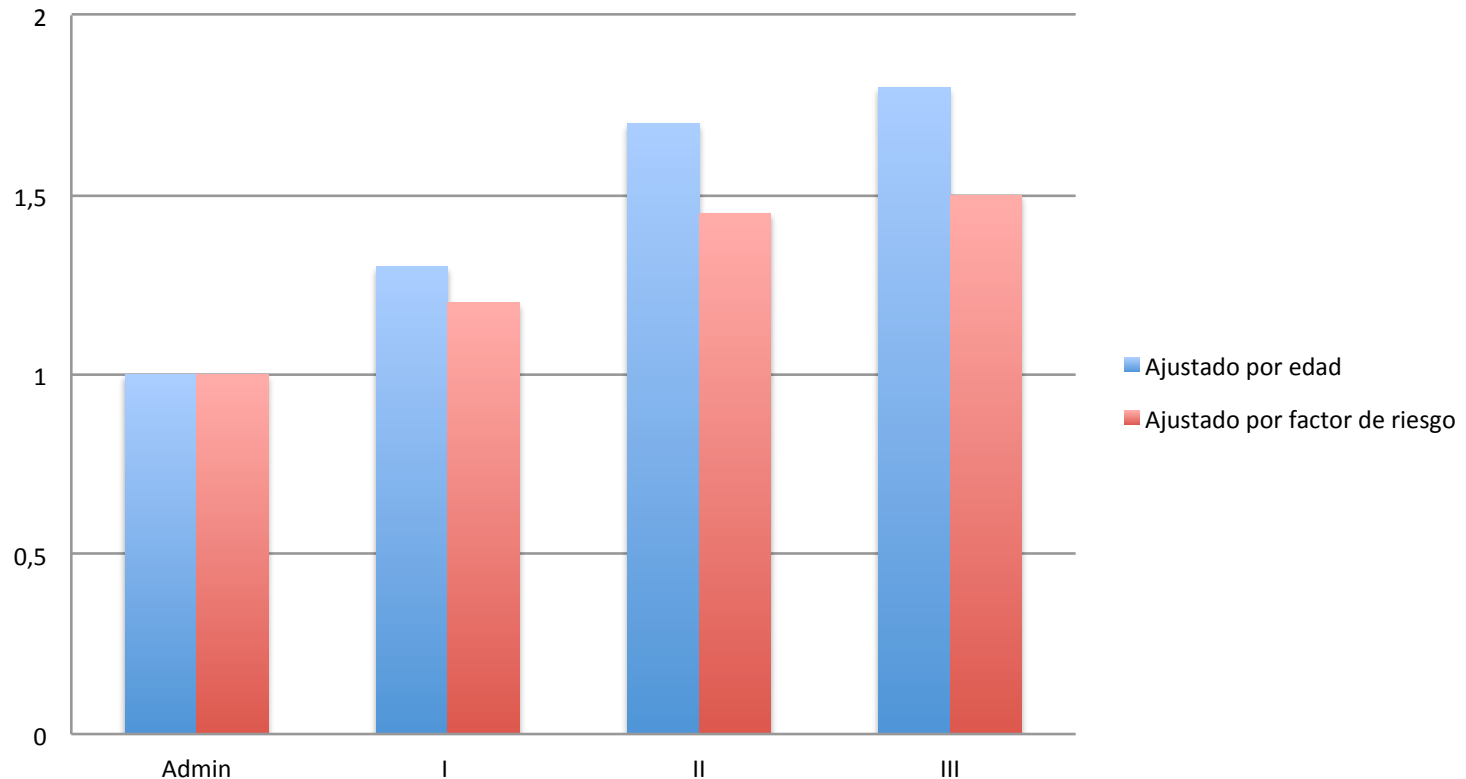
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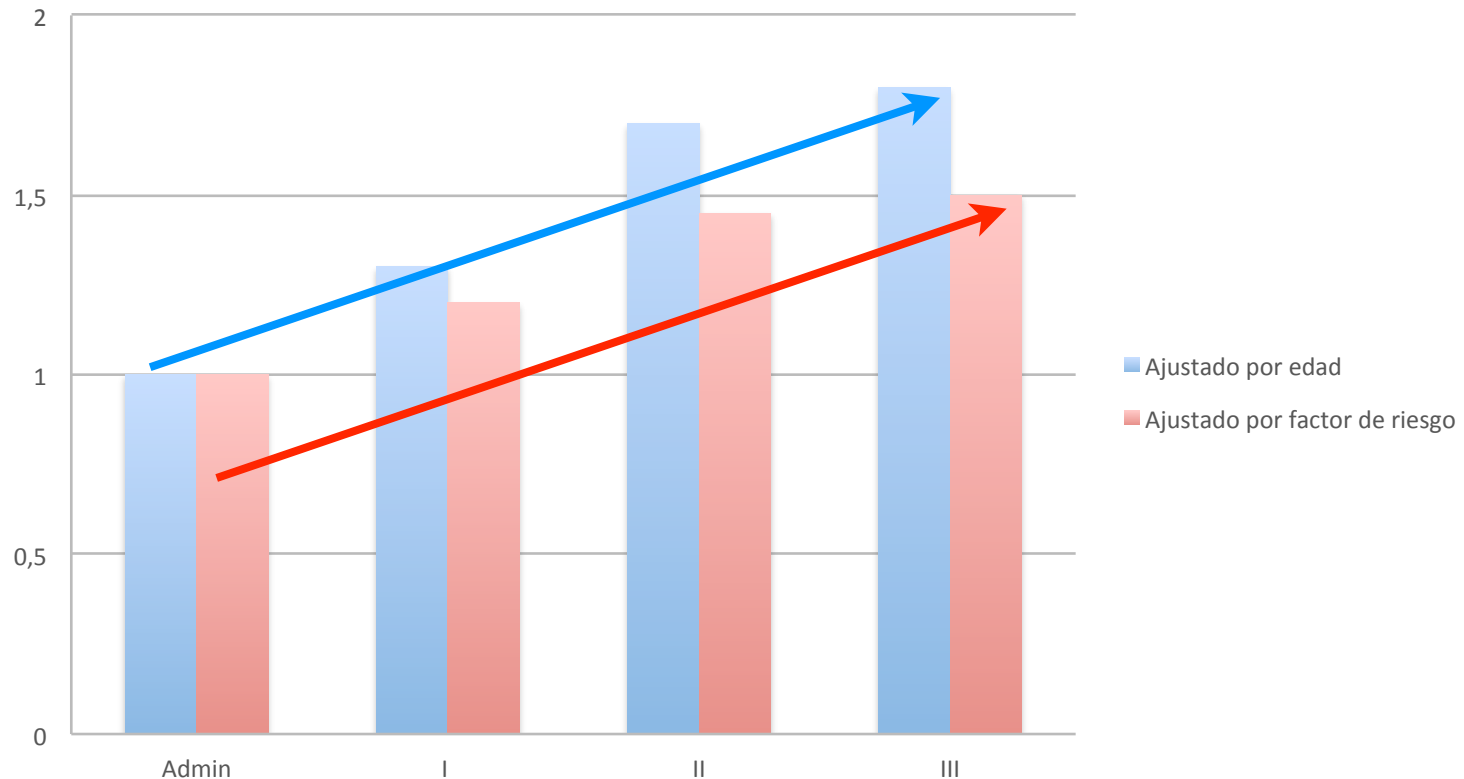
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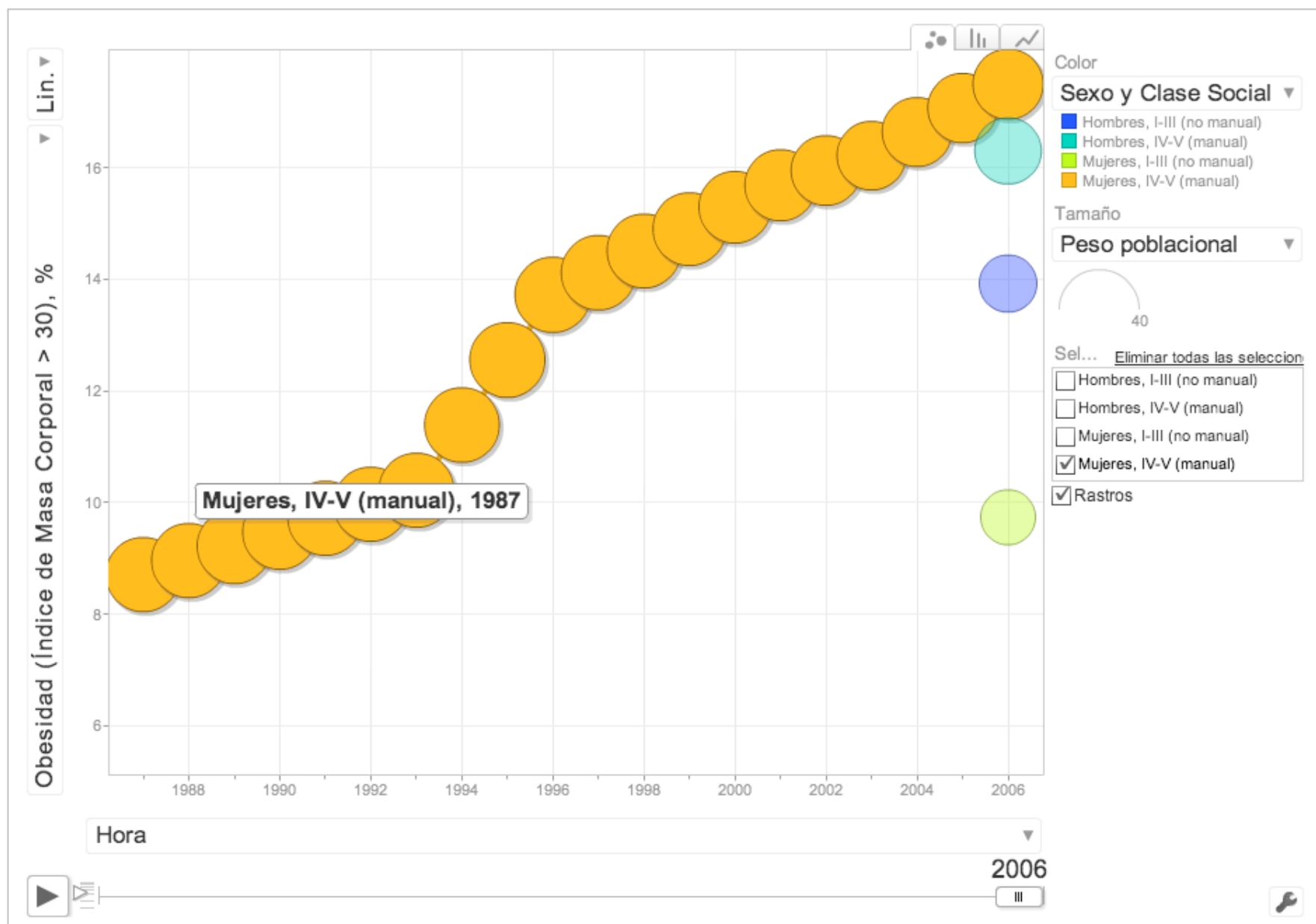
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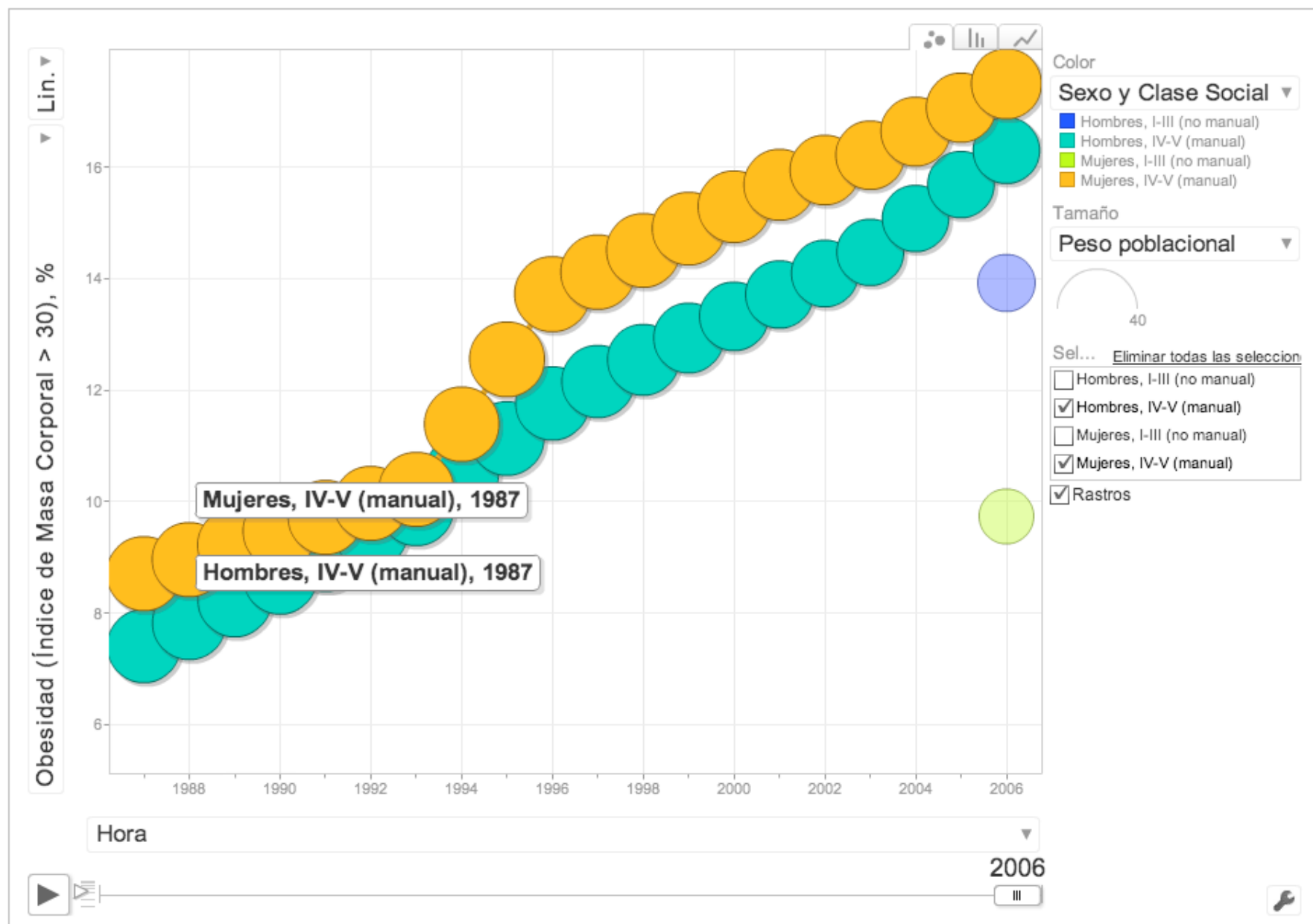
“Un fumador que está en una categoría profesional baja tiene más riesgo de enfermedad coronaria que un fumador que está en un nivel superior...”

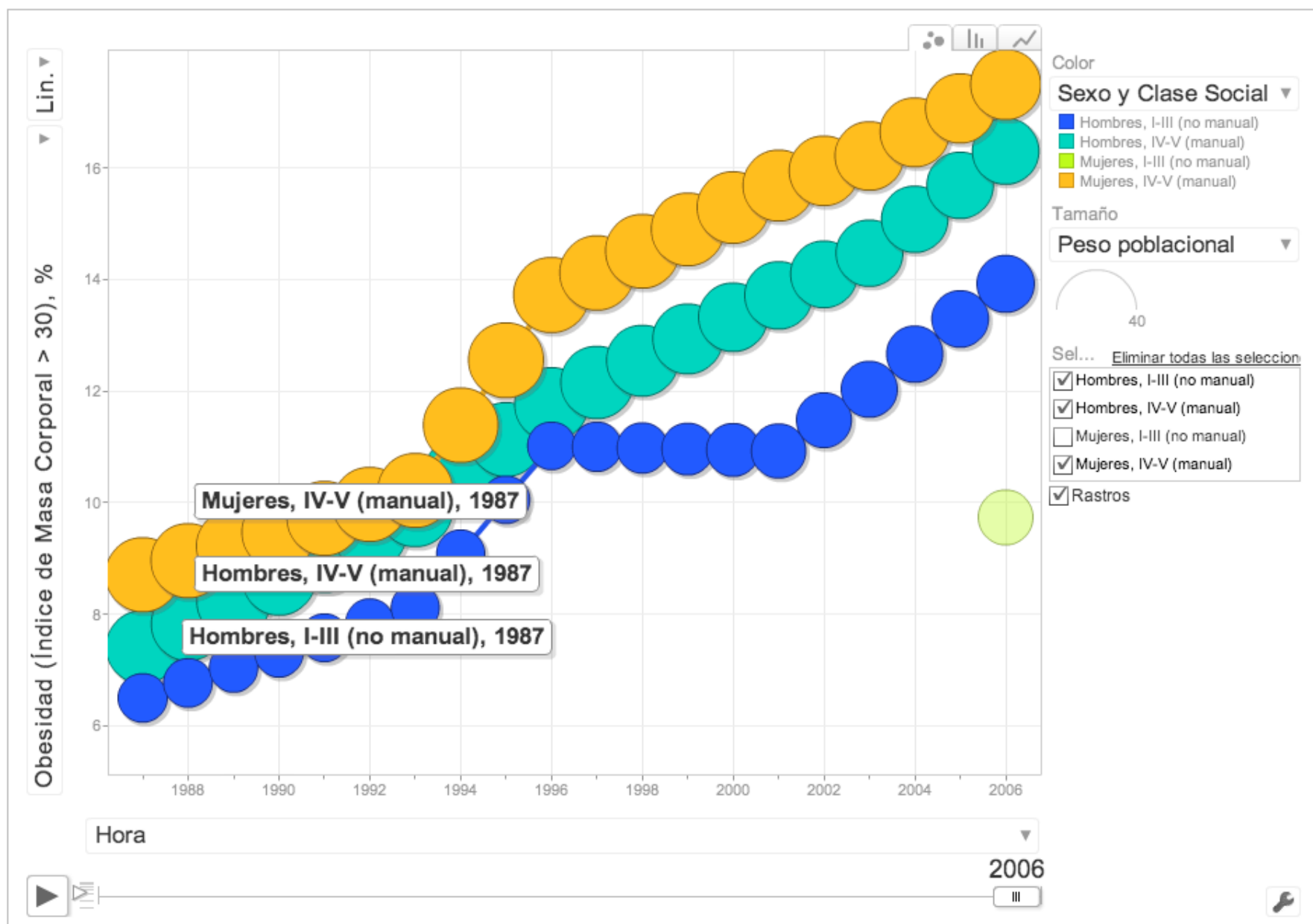
Michael Marmot. The Status Syndrome.

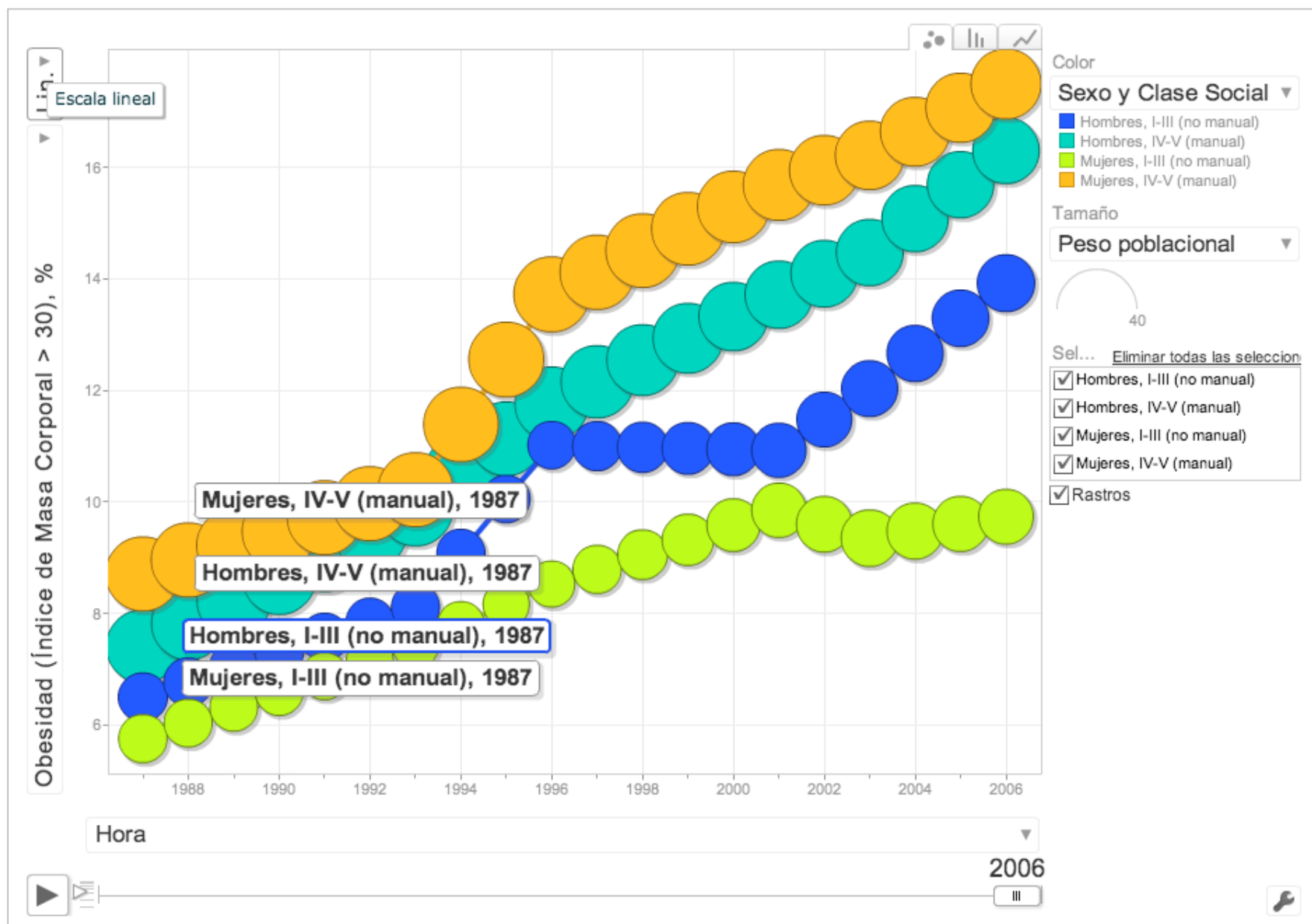
“Un no fumador que está en una categoría profesional baja tiene un riesgo mayor de enfermedad coronaria que un no fumador que tiene un nivel superior....”

Michael Marmot. The Status Syndrome.

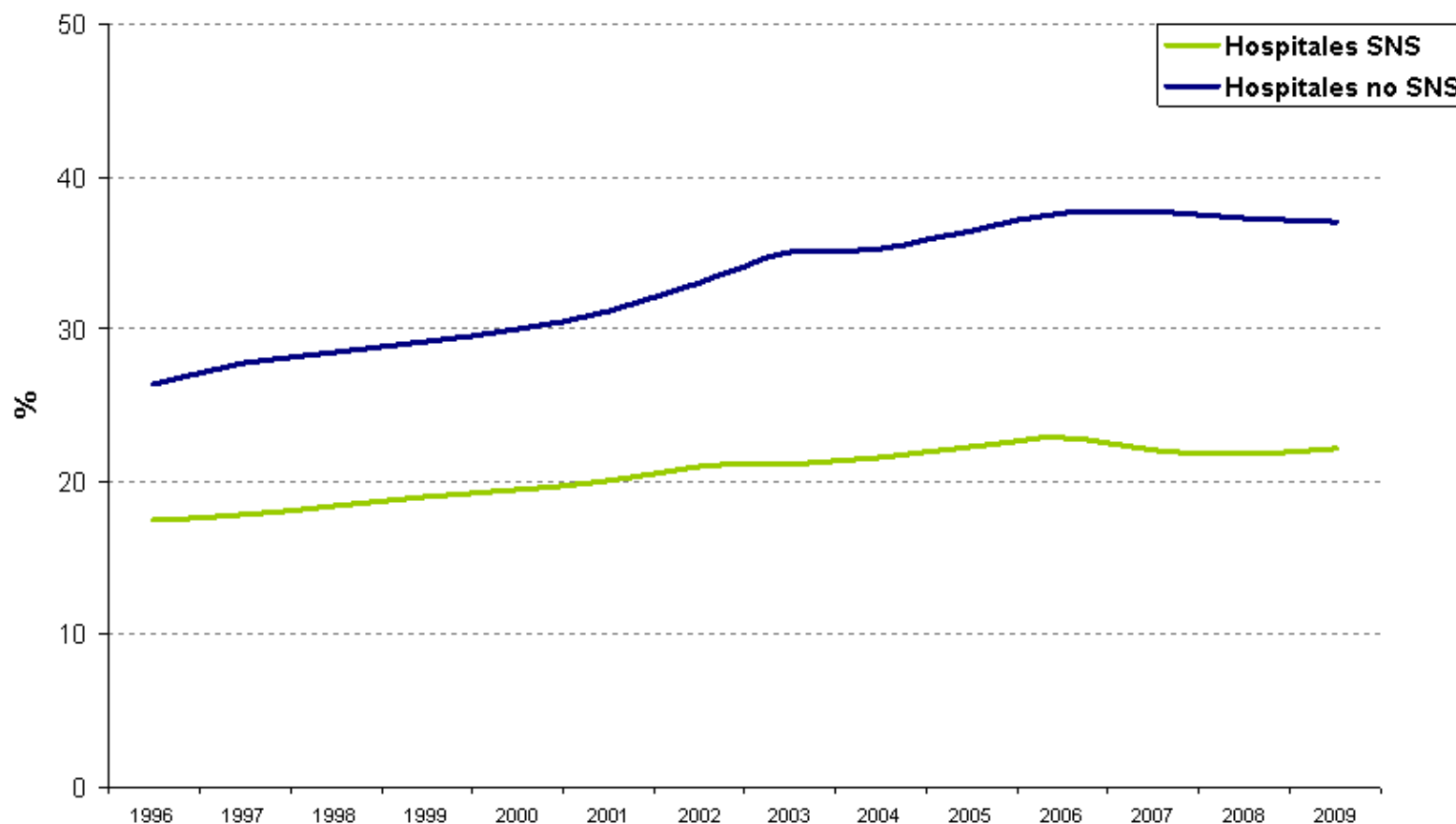






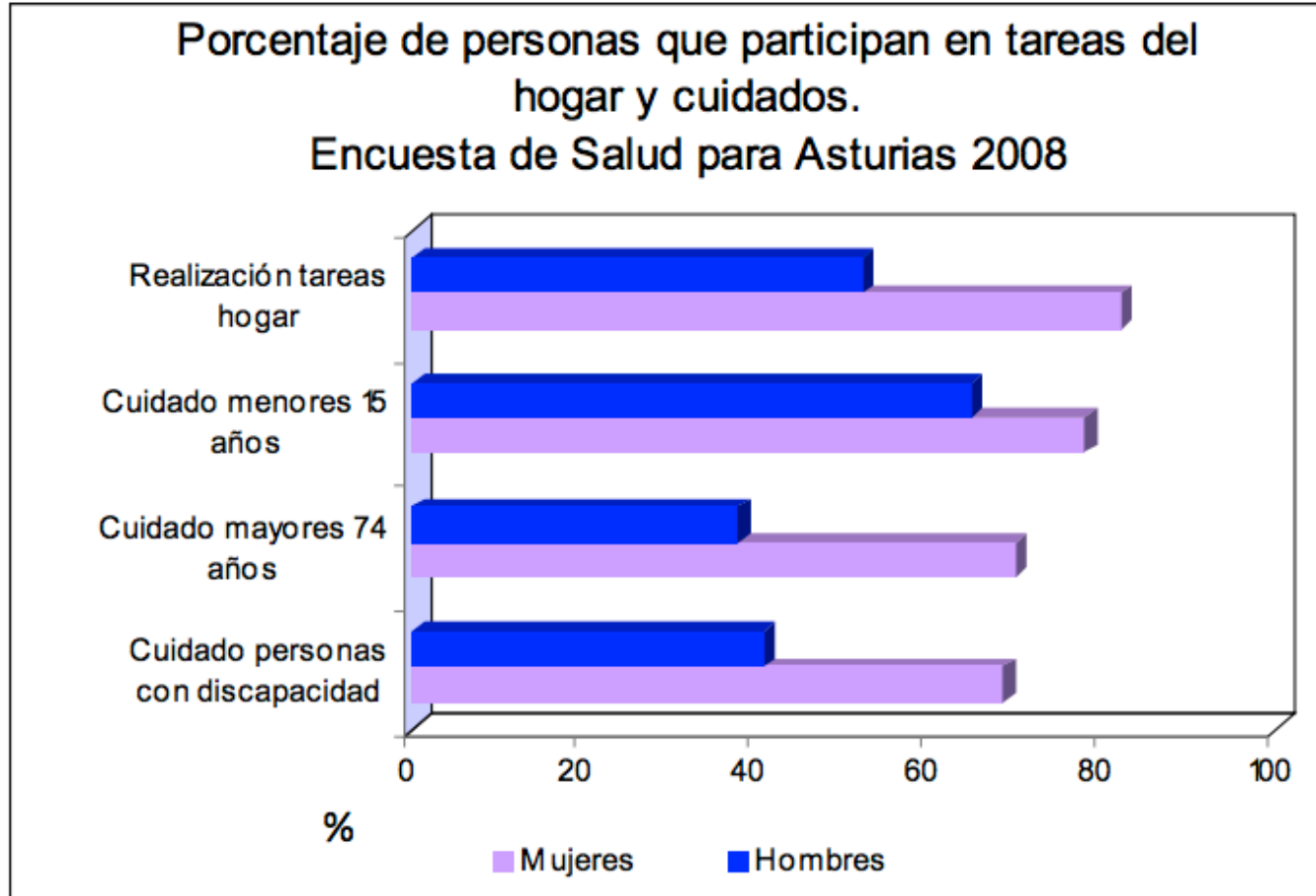


% de cesáreas respecto al total de partos
Comparación de datos en hospitales del SNS y no SNS España,
1996-2009



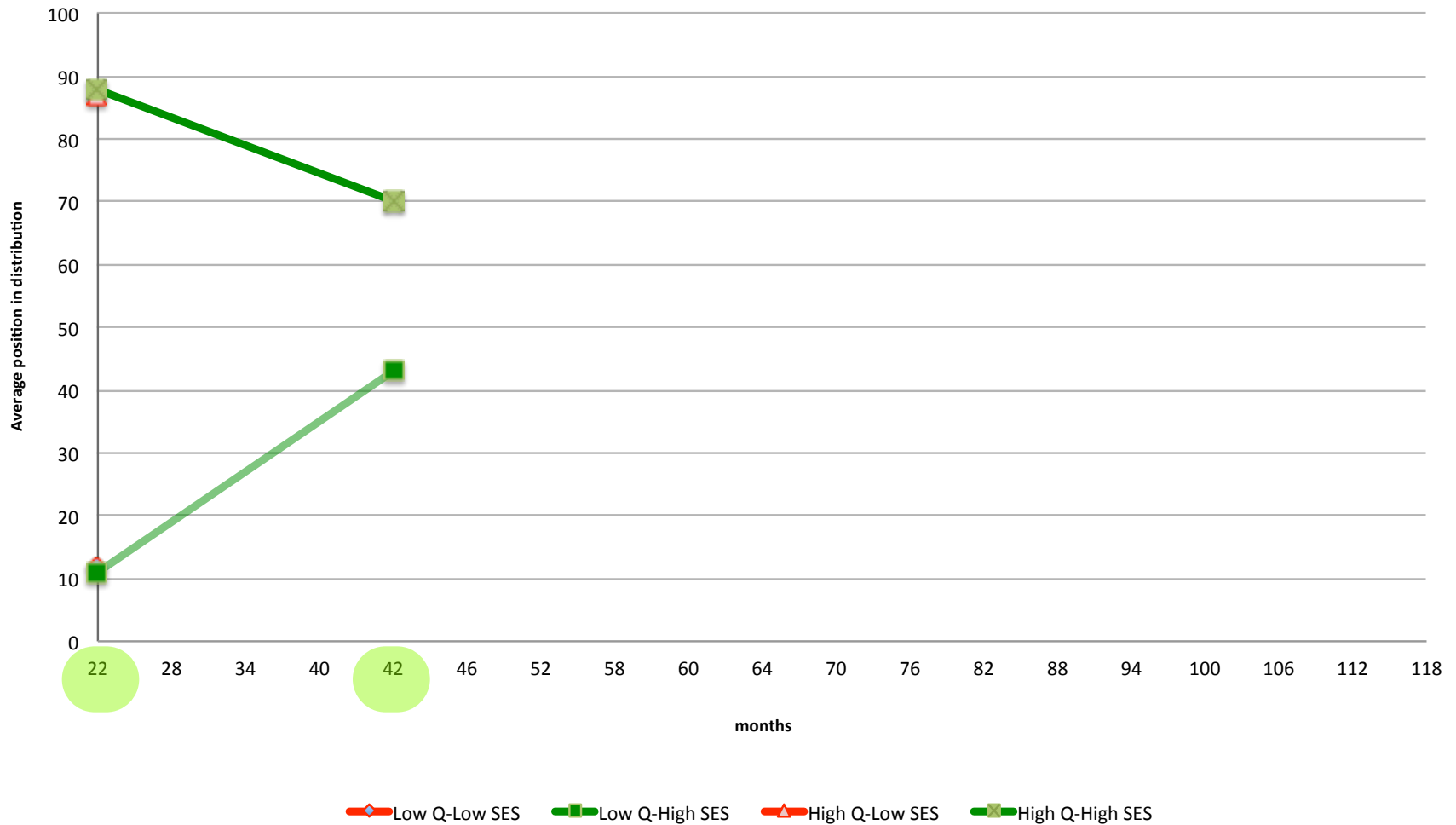
Fuente: [Indicadores Clave del Sistema Nacional de Salud \(INCLASNS-BD\)](#)

Figura 3.1.

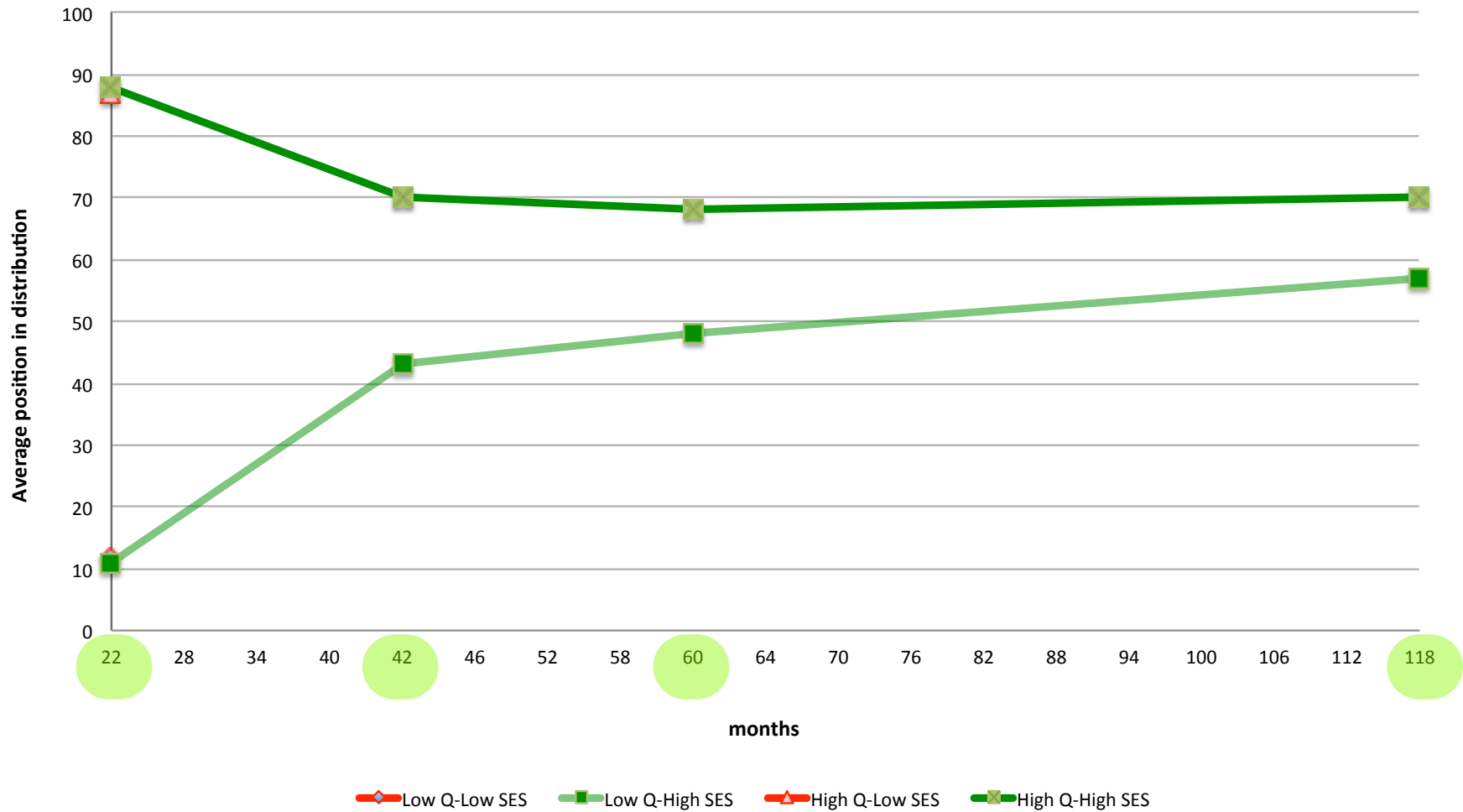


Fuente Encuesta de Salud para Asturias 2008

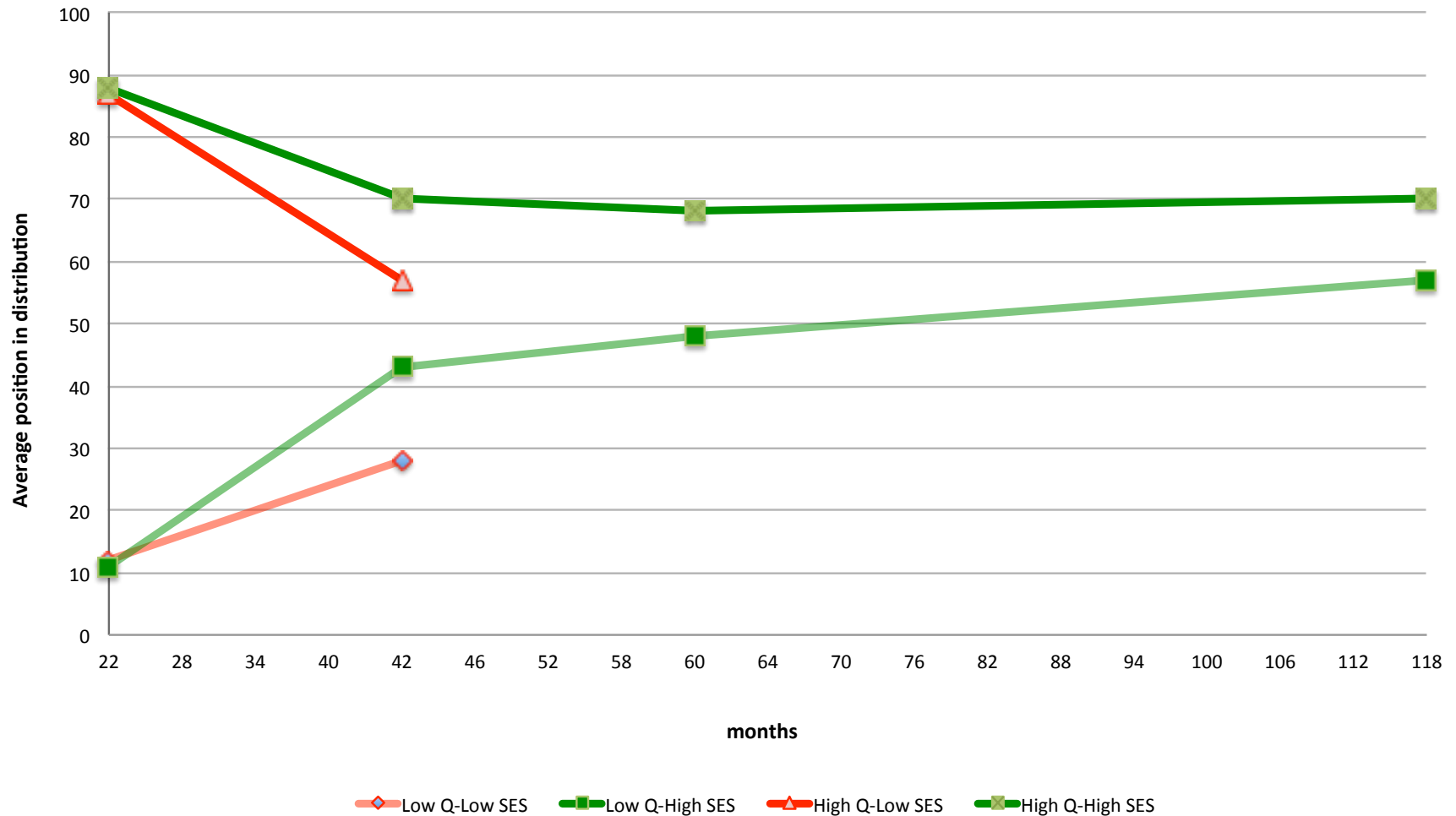
Inequality in early cognitive development of British Children in the 1970 Cohort



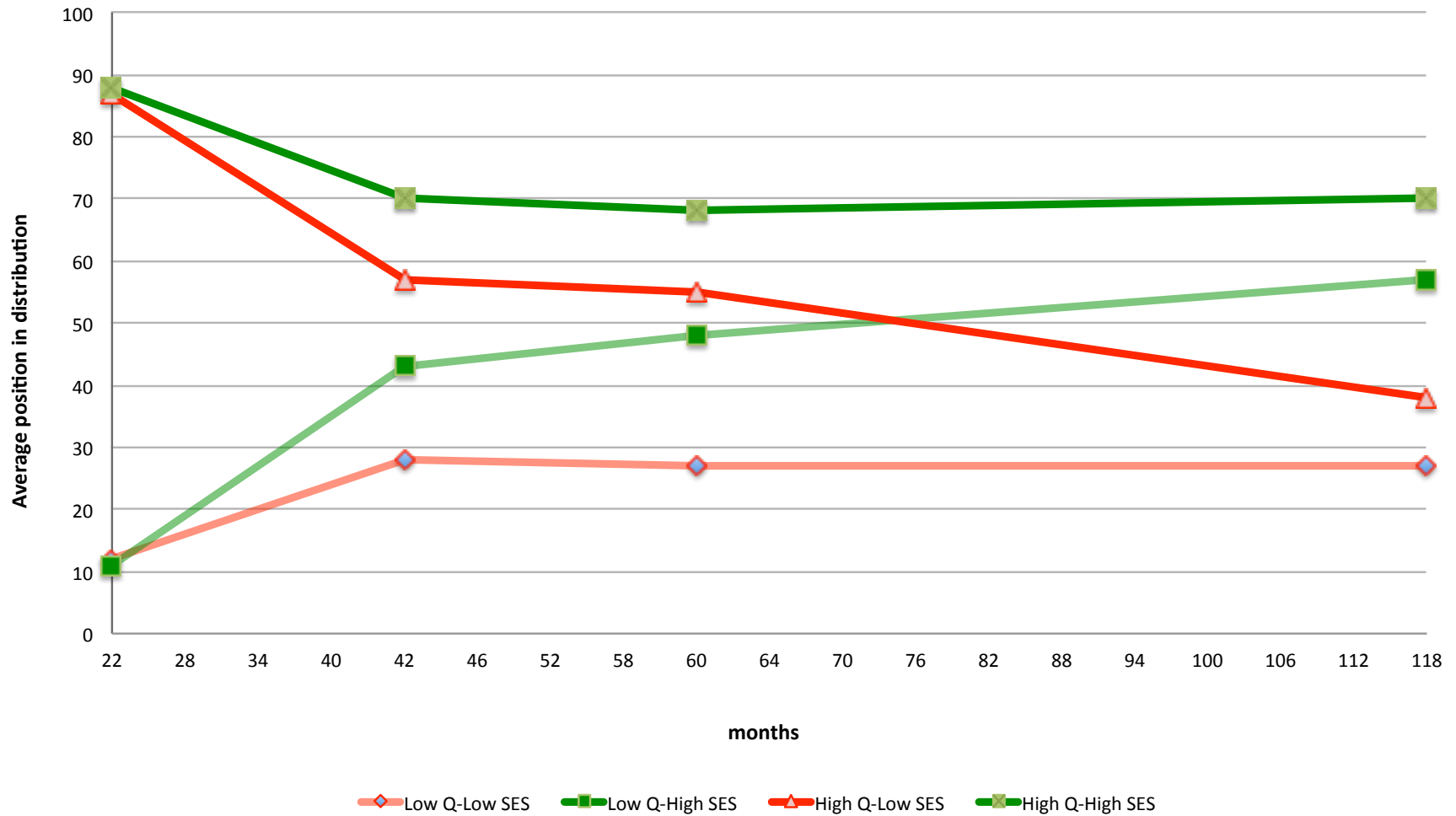
Inequality in early cognitive development of British Children in the 1970 Cohort



Inequality in early cognitive development of British Children in the 1970 Cohort



Inequality in early cognitive development of British Children in the 1970 Cohort





RESEARCH ARTICLE



Social Relationships and Mortality Risk: A Meta-analytic Review

Article

Metrics

Related Content

Comments: 2

[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](#)

Tras la revisión de 148 estudios en el metanálisis la OR de 1,5 señala que las **personas con redes sociales más fuertes tienen un 50% más** de probabilidad de supervivencia que aquellos con redes sociales más débiles

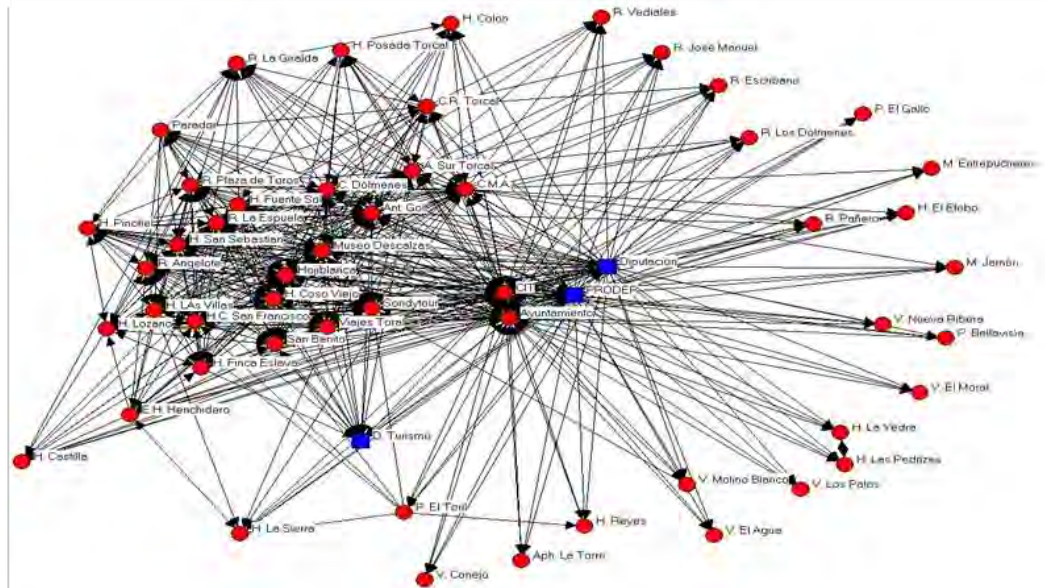


Estos resultados señalan que la influencia de las relaciones sociales con el riesgo de muerte son **comparables con factores bien establecidos de mortalidad tales como el consumo de tabaco y alcohol** y que superan la influencia de otros factores de riesgo como la inactividad física y la obesidad.

[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](https://doi.org/10.1371/journal.pmed.1000316)

Análisis del capital social, de la capacidad “salutogénica”

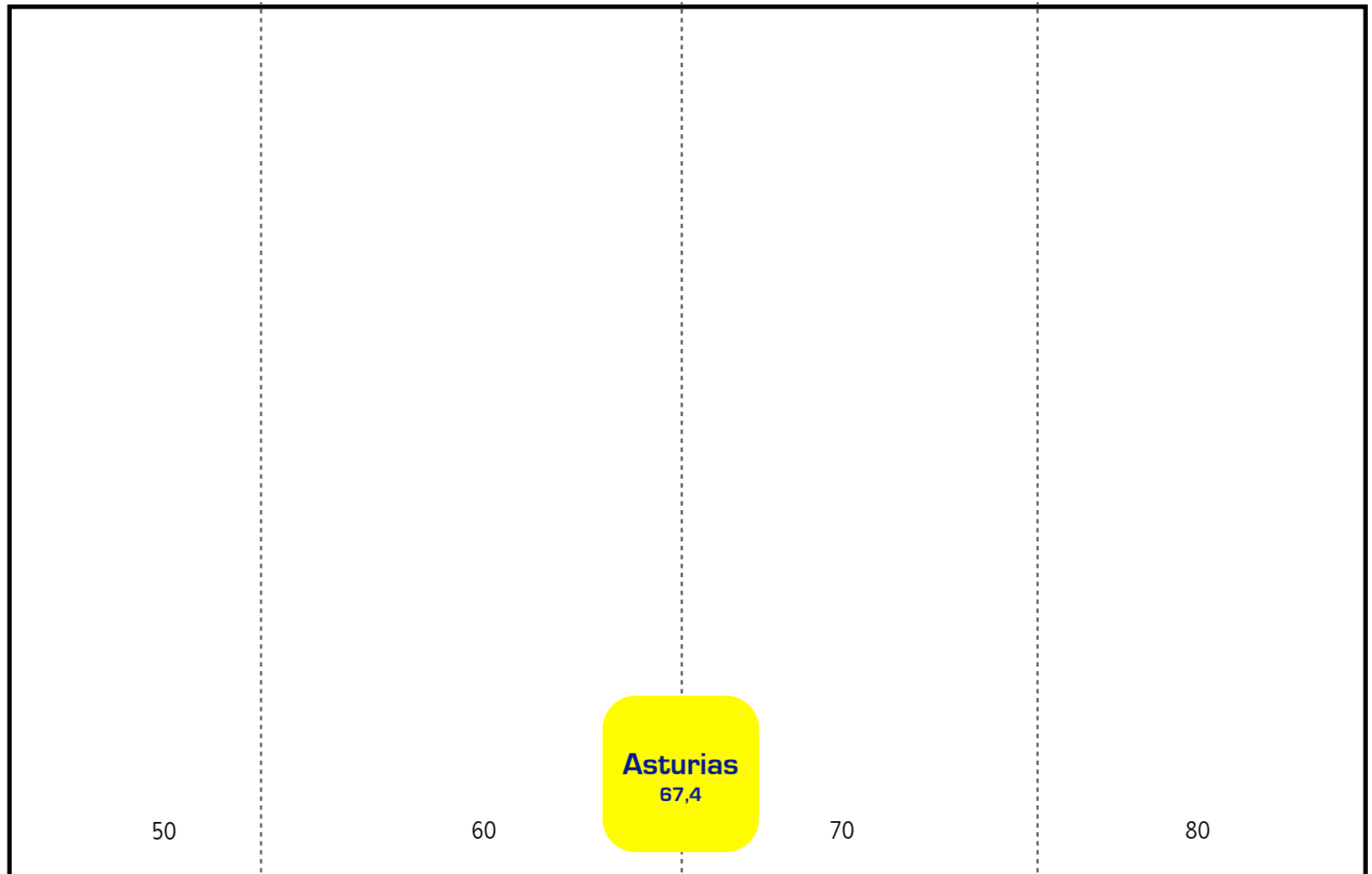
Gráfico 1: Valores medios de indicadores seleccionados de capital social, 2007



The networks of actors as key items in local development. Contributions from sociology and anthropology of development
Rafael Merinero Rodríguez

Nunca han recibido exposición al humo del tabaco.

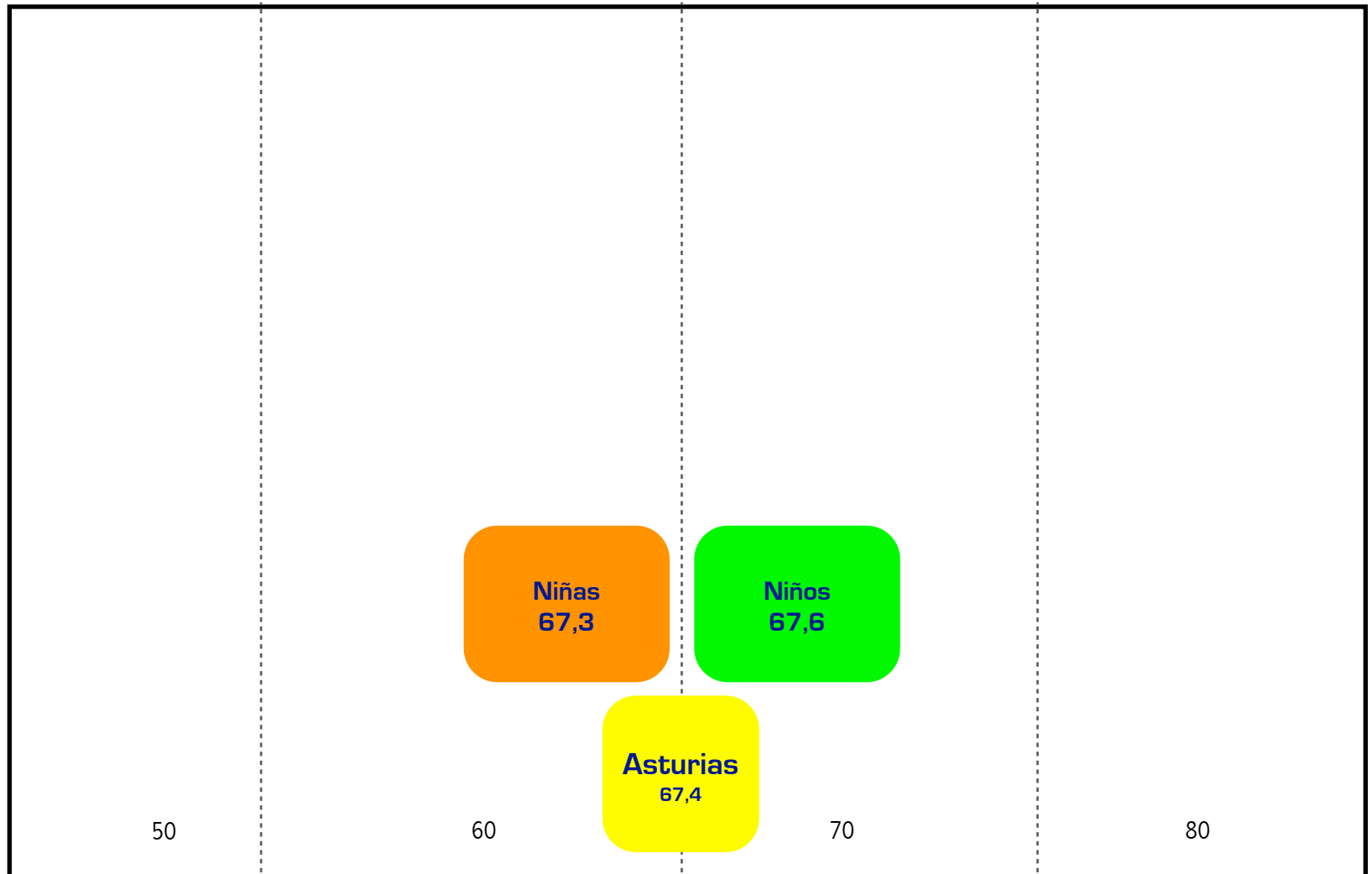
Margolles M, Donate I. Encuesta de Salud Infantil Asturias 2009



Valores (0-100)

Nunca han recibido exposición al humo del tabaco.

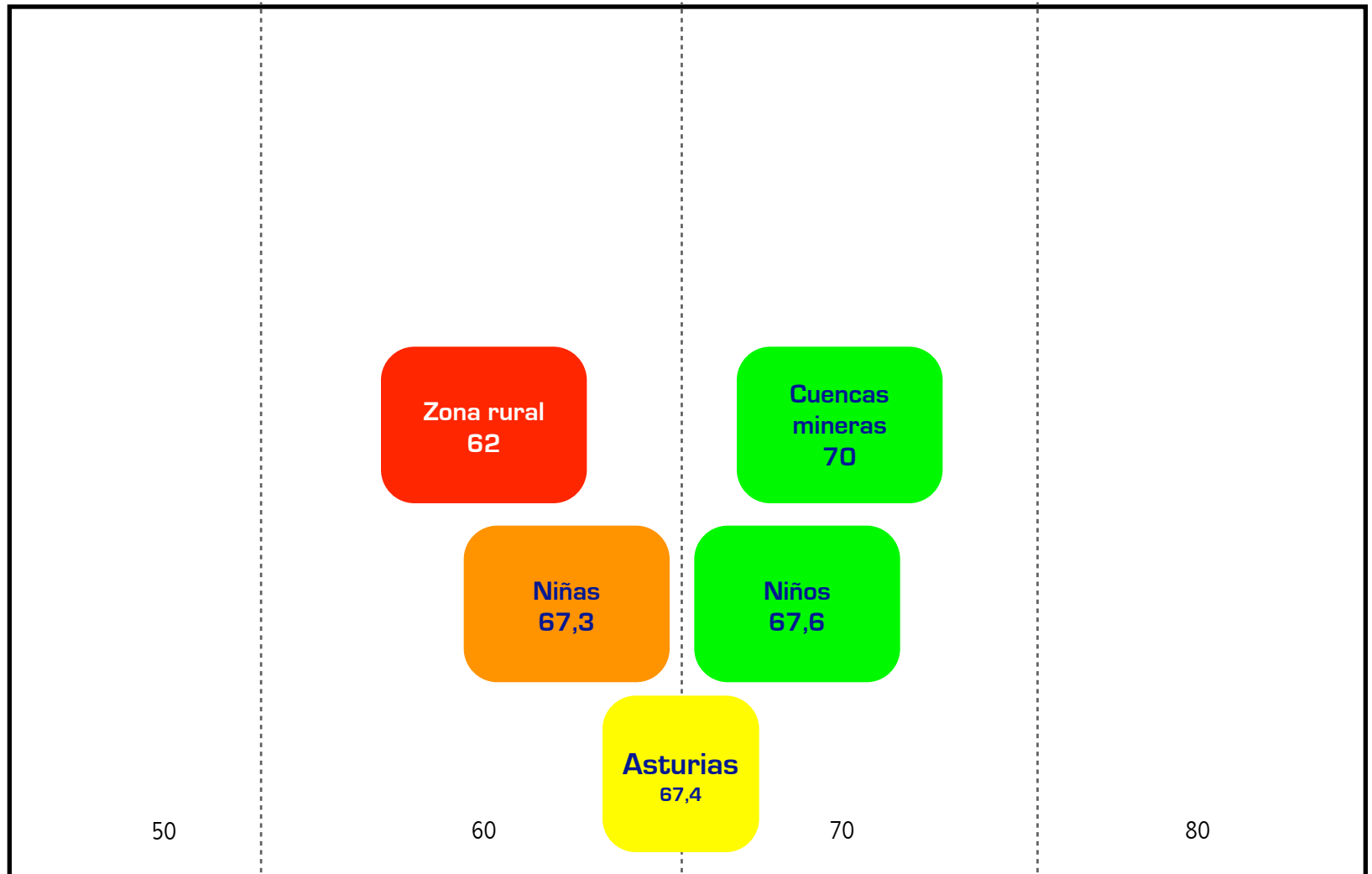
Margolles M, Donate I. Encuesta de Salud Infantil Asturias 2009



Valores (0-100)

Nunca han recibido exposición al humo del tabaco.

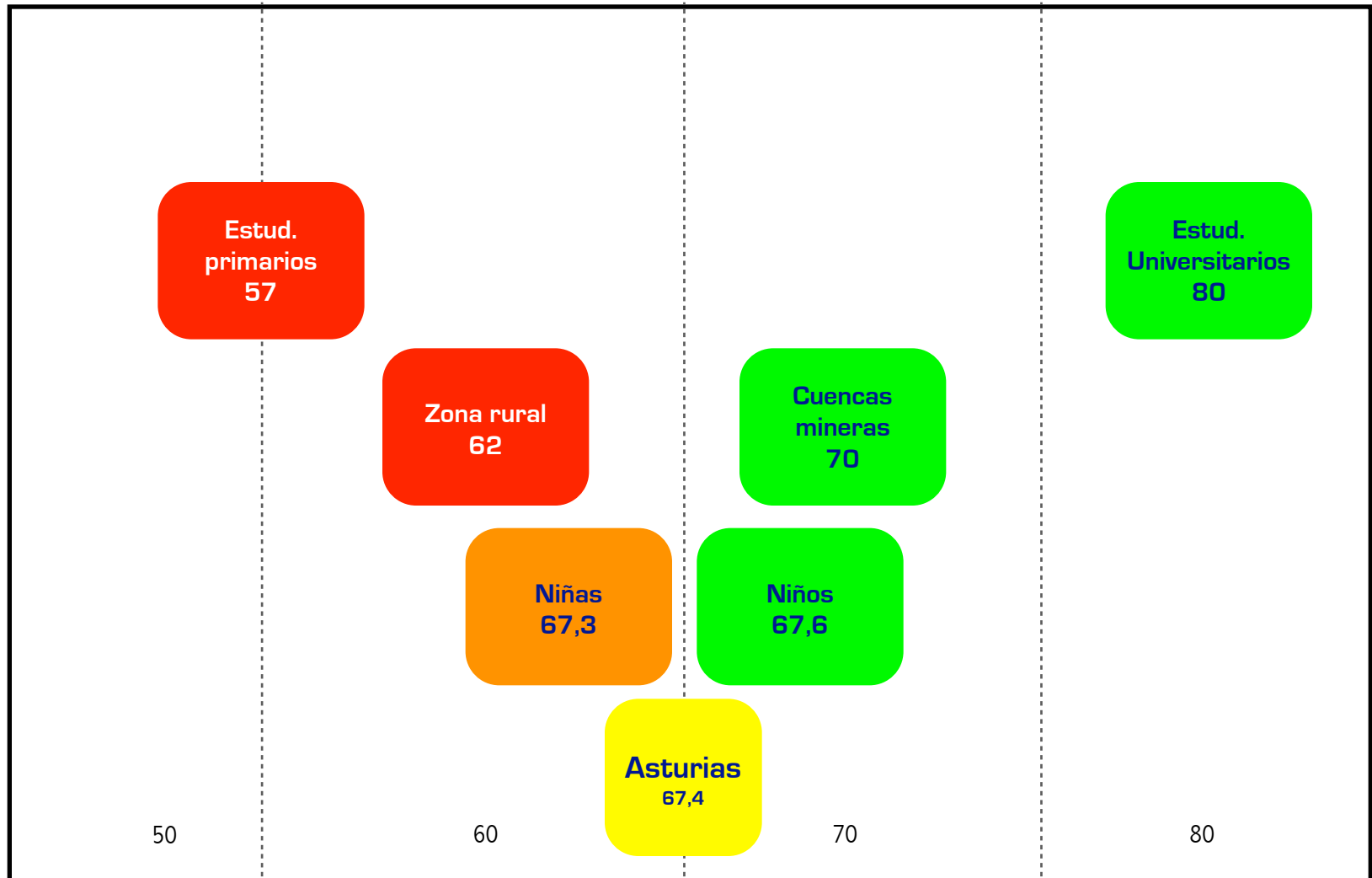
Margolles M, Donate I. Encuesta de Salud Infantil Asturias 2009



Valores (0-100)

Nunca han recibido exposición al humo del tabaco.

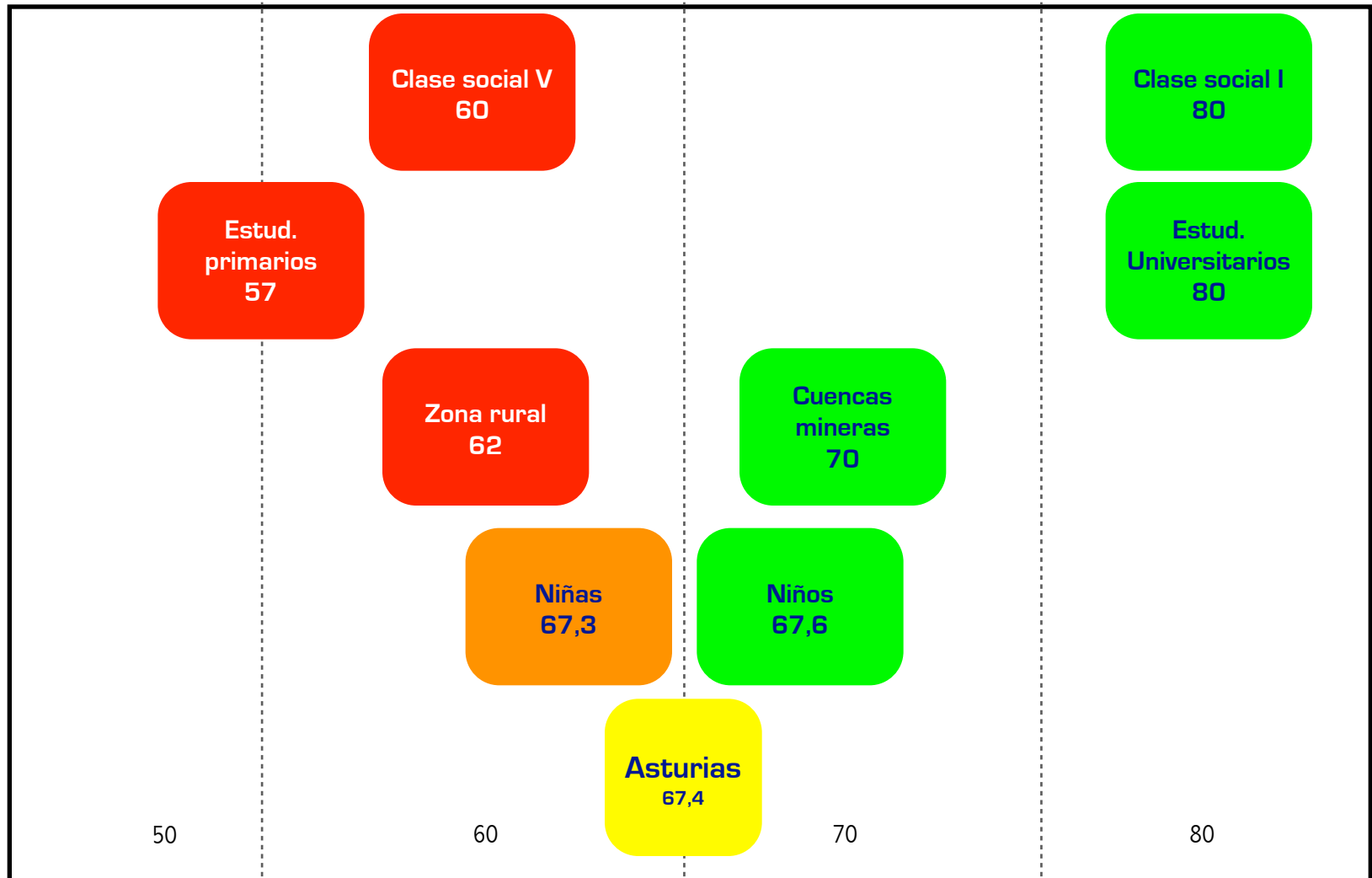
Margolles M, Donate I. Encuesta de Salud Infantil Asturias 2009



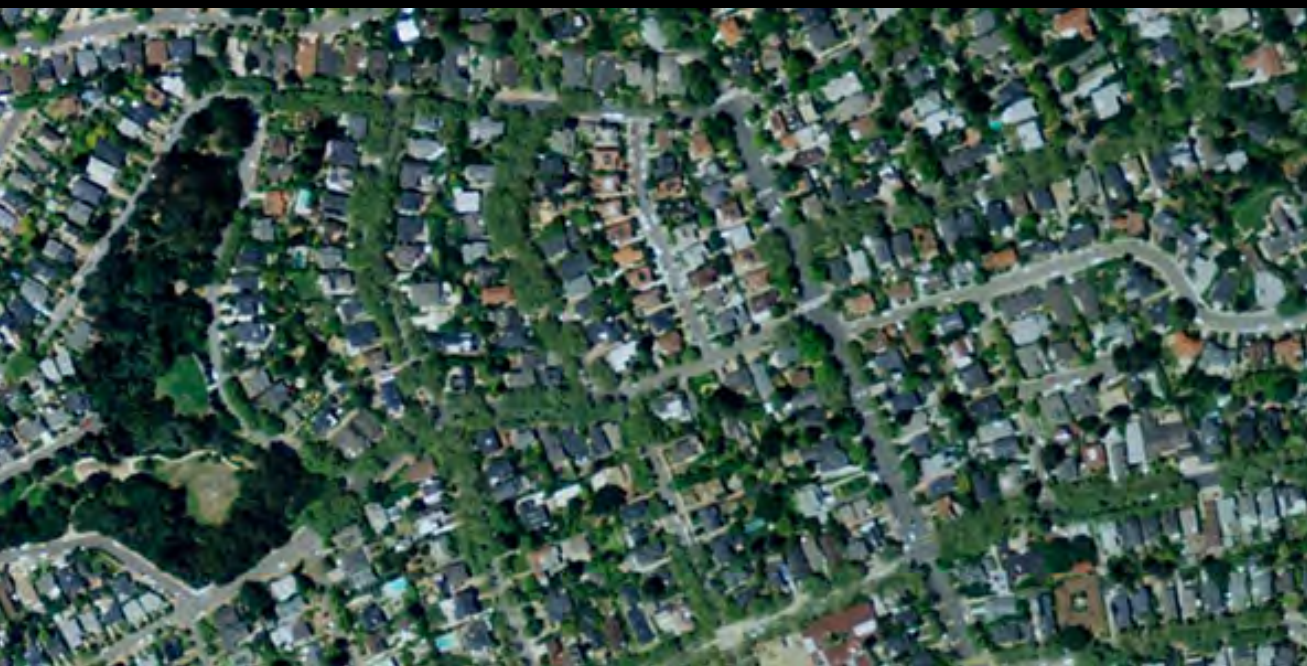
Valores (0-100)

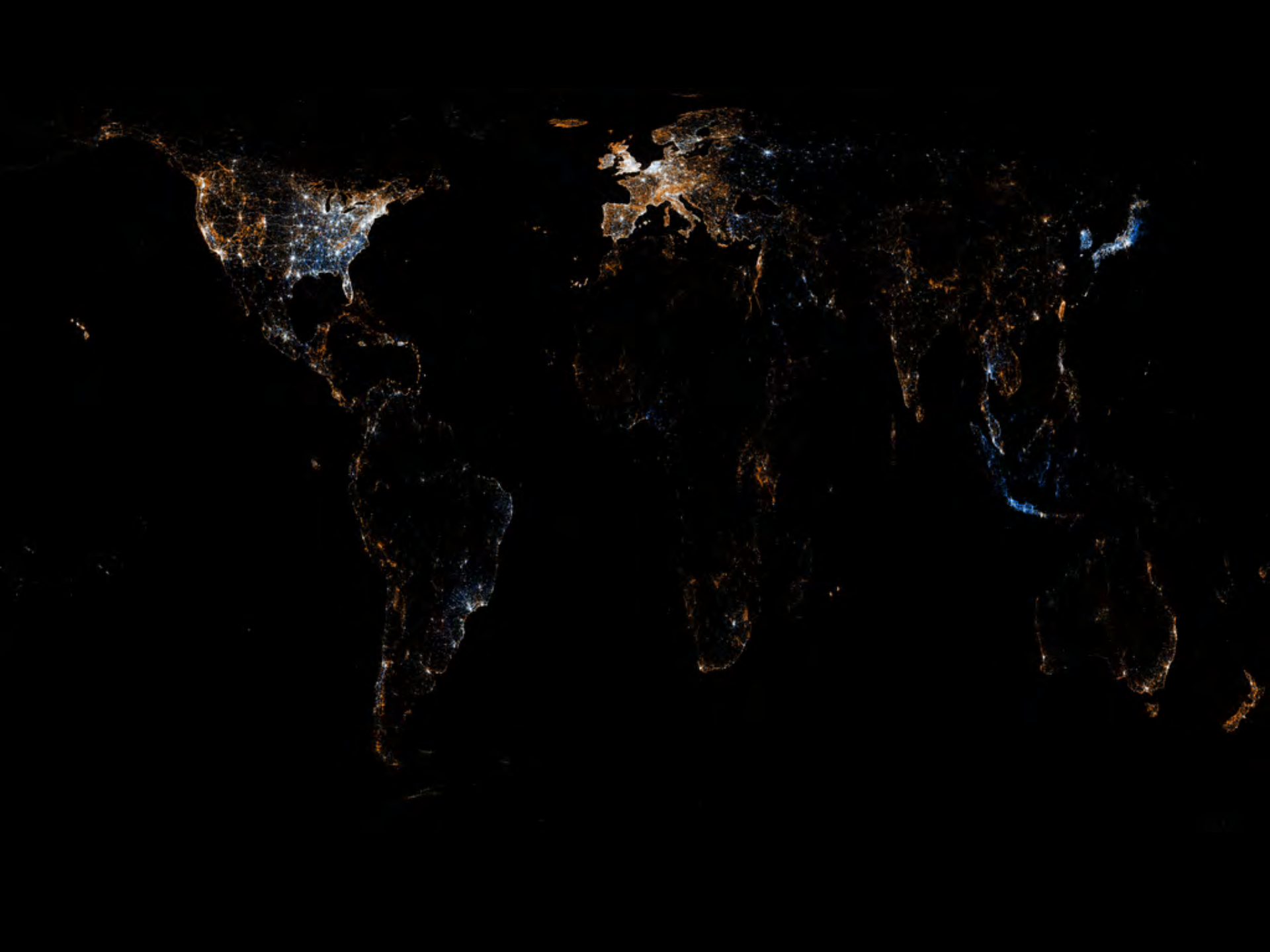
Nunca han recibido exposición al humo del tabaco.

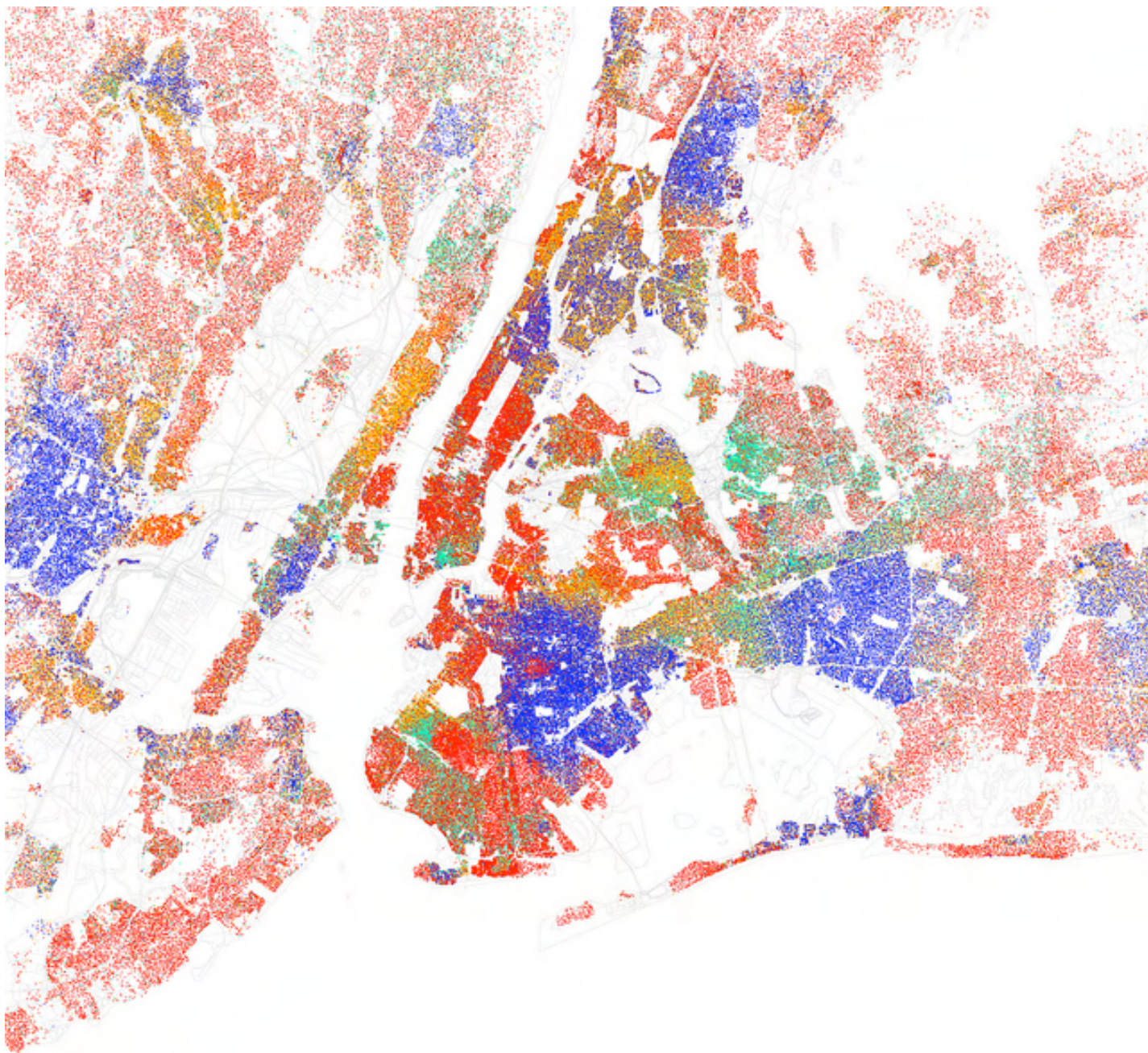
Margolles M, Donate I. Encuesta de Salud Infantil Asturias 2009



Valores (0-100)







Eric Fisher Race and ethnicity. <http://saludcomunitaria.wordpress.com/2012/05/26/arboles/>

The Jubilee Line of Health Inequality

Travelling east from Westminster, each tube stop represents up to one year of male life expectancy lost at birth (2002-06)



London Health Observatory

Male Life
Expectancy
78.6 (CI 76.0-81.2)

Female Life Expectancy
84.6 (CI 82.5-86.7)

Westminster

Waterloo

Southwark

London Bridge

Bermondsey
Canada Water

Canning Town

Canary Wharf

North
Greenwich

Male Life
Expectancy
72.8 (CI 71.1-74.6)

Female Life
Expectancy
81.4 (CI 79.3-83.6)

London Underground Jubilee Line

Electoral wards just a few miles apart geographically have life expectancy spans varying by years. For instance, there are eight stops between Westminster and Canning Town on the Jubilee Line – so as one travels east, each stop, on average, marks up a year of shortened lifespan.¹

¹ Source: Analysis by London Health Observatory using Office for National Statistics data revised for 2002-06. Diagram produced by Department of Health



**Life Expectancy at Birth
(surrounding station)**

79 or less
80 to 81
82 to 83
84 or older

Child Poverty

Most deprived
Least deprived

Read more...

**Switch to
Life Expectancy**

SMITH
PATEL SMITH
PATEL SMITH
PATEL BROWN SMITH
BEGUM
SMITH
SMITH SMITH
BEGUM
BEGUM

Mapping London

....Comprar el pan, la leche, las galletas del desayuno, el café, el aceite, azúcar, sal, el resto de la comida, algún regalo para los nietos, pagar la luz, el agua, el alquiler, ayudar algo a su hija que no acaba de encontrar trabajo, algo para las navidades, la ropa, las zapatillas, revisar las gafas, arreglar la dentadura, tomar el autobús para ir a las revisiones en el hospital, aprender a hacer la dieta y caminar algo todos los días, controlar la tensión, cuidar las piernas, una crema para los pies, arreglar las uñas, no conseguir el recambio para las audioprótesis, hacer la limpieza de la casa, sacar a pasear a su madre por el barrio en la silla de ruedas, manejar este dolor de espalda y los problemas para dormir y descansar por las noches y vivir casi sola. Y con 418 euros de pensión mínima de viudedad....

...Comprar cereales con fibra, leche de soja, verduras, vino, reservar para cenar el viernes, frutas exóticas para el plato que proponía el suplemento del domingo, llevar cinco años sin fumar, haber vuelto a practicar deporte, algo de gimnasio, yoga y natación, pasar unos días de vacaciones en algún lugar tranquilo, preparar los regalos de navidades, pagar los estudios de mi hijo en el extranjero, comprar varios libros al cabo del mes, pertenecer a distintos colectivos, tener influencia y asumir cierto prestigio profesional, quitar la sal de las comidas y tener cuidado con el LDL, plantearme las pruebas de cribado que se recomiendan, cuestionarme si todo lo anterior realmente tiene un peso importante en mi salud, cambiar las ruedas del coche, pintar la casa, ir a varios conciertos y no vivir casi solo. Y con 6.180 euros de mi puesto de alto cargo directivo...



"Ya somos todo aquello contra lo que
luchamos a los veinte años"

José Emilio Pacheco

“el progreso de la medicina debiera eventualmente prolongar la vida humana, pero la mejoría de las condiciones sociales podría obtener este resultado con mayor éxito y rapidez”

Rudolf Virchow 1821-1902



Fair Society, Healthy Lives

The Marmot Review Executive Summary



Strategic Review of Health Inequalities
in England post-2010

THE SOLID FACTS

SECOND EDITION



International
Centre for

Health in All Policies

Prospects and potentials

Edited by

Timo Ståhl, Matthias Wismar, Eeva Ollila,
Eero Lahtinen & Kimmo Leppo



MINISTRY OF
SOCIAL AFFAIRS AND HEALTH
Finland



European

Observatory



on Health Systems and Policies

Avanzando hacia la equidad

PROPUESTA DE POLÍTICAS E INTERVENCIONES PARA REDUCIR LAS DESIGUALDADES SOCIALES EN SALUD EN ESPAÑA.

Comisión para Reducir las Desigualdades Sociales en Salud en España

Comisionado por:

Dirección General de Salud Pública y Sanidad Exterior

Ministerio de Sanidad y Política Social



GOBIERNO
DE ESPAÑA

MINISTERIO
DE SANIDAD
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health leaders & taking
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Higher income & education levels linked to better health, says @CDC [ht.ly/aXqjI](https://t.co/aXqjI) #sdoh

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NEWS

Austerity measures will lead to rise in unemployment and suicides, says Marmot

Matthew Limb

London

European austerity programmes are a “ghastly experiment” that will lead to more citizens’ deaths, says a leading expert on health inequalities.

Michael Marmot spoke about the link between rising unemployment and higher mortality rates, including suicides.

He warned of the effects of government policies in countries such as Spain and Portugal that he said were being pursued at the behest of financial markets and central banks.

“If unemployment rises as a result of government policy that is

But he said child poverty was predicted to rise in the UK under coalition policies. “If you put fairness at the heart of all policy making it wouldn’t do that,” he said.

David Buck, a senior fellow at the King’s Fund, said that life expectancy, one of the main indicators of health inequalities, was still improving in England.

But he said that there remained large inequalities within neighbourhoods and that more research was needed to find out why some areas fared better than others.

“en términos de salud, el código postal es más importante que el código genético”

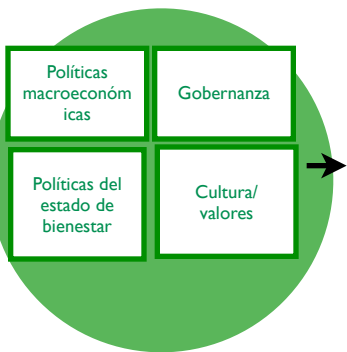
Robert Wood Johnson Foundation

Nuestro contexto

**Nosotros y
nuestras condiciones de vida**

Nuestra biología y conducta

**Nuestros
resultados de salud**

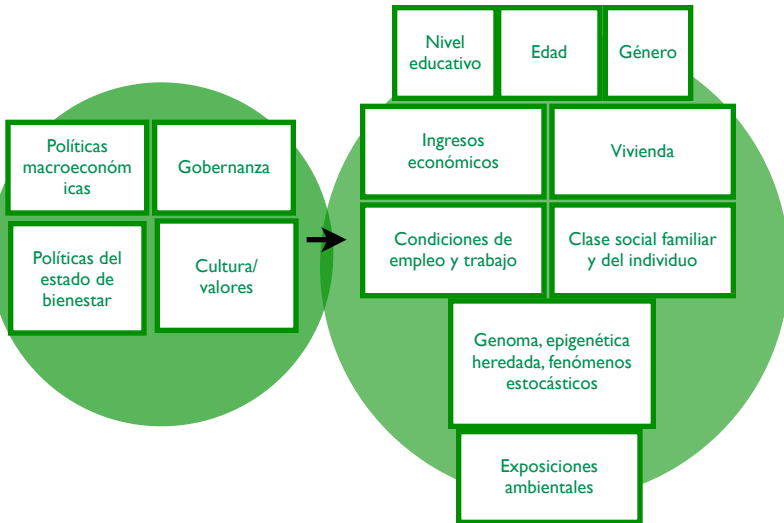


Nuestro contexto

Nosotros y nuestras condiciones de vida

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Nuestros resultados de salud



Nuestro contexto

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**Nuestros
resultados de salud**

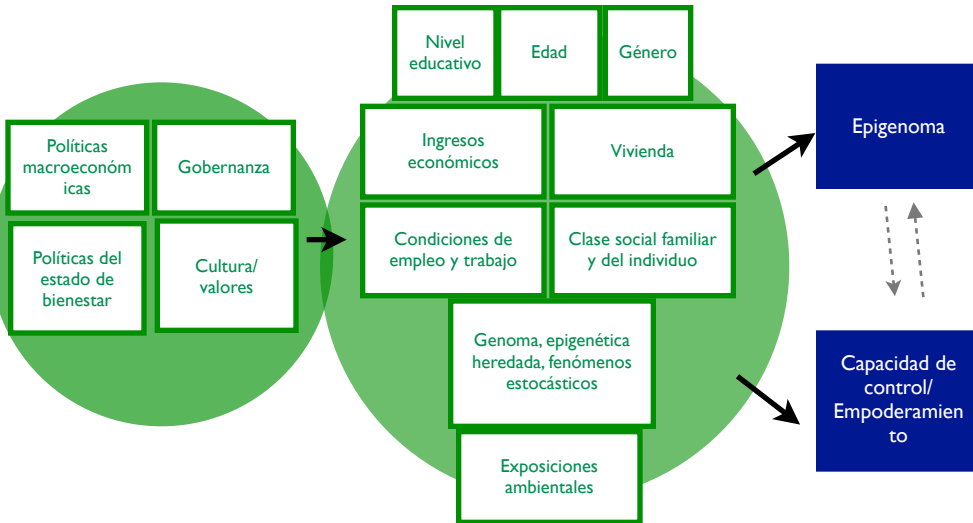
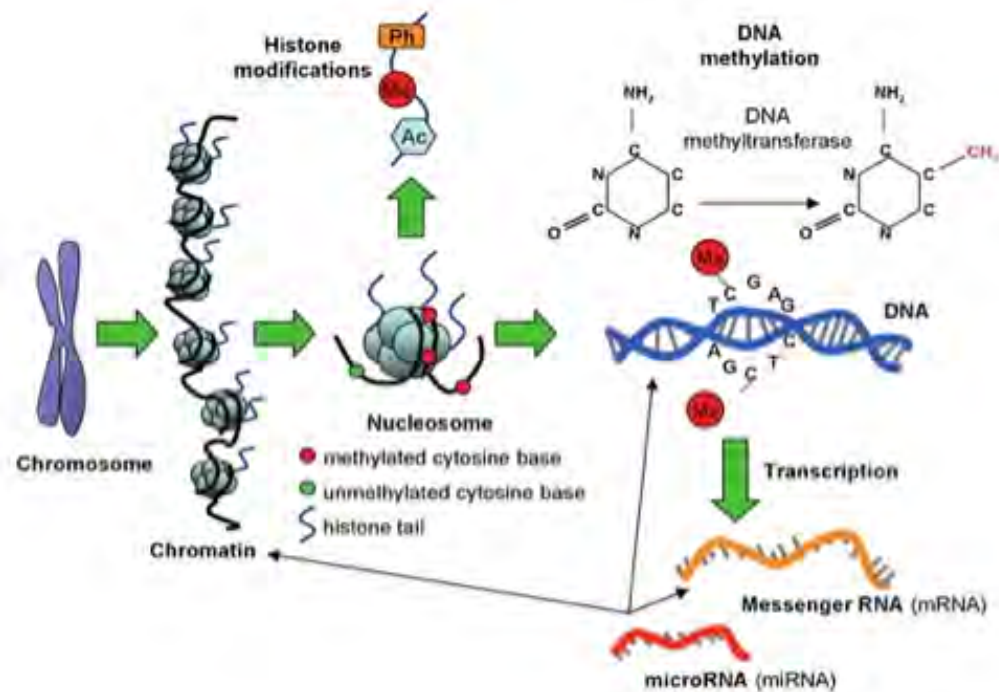


Figure 1. Epigenetic modifications.



Relton CL, Davey Smith G (2010) Epigenetic Epidemiology of Common Complex Disease: Prospects for Prediction, Prevention, and Treatment. *PLoS Med* 7(10): e1000356. doi:10.1371/journal.pmed.1000356
<http://www.plosmedicine.org/article/info:doi/10.1371/journal.pmed.1000356>

Associations with early-life socio-economic position in adult DNA methylation

Nada Borghol^{1,2,†}, Matthew Suderman^{1,2,3,†}, Wendy McArdle⁴, Ariane Racine^{1,2}, Michael Hallett³, Marcus Pembrey^{5,*}, Clyde Hertzman^{6,*}, Chris Power^{7,*} and Moshe Szyf^{1,2,*}

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Accepted August 25, 2011.

Abstract

Background Disadvantaged socio-economic position (SEP) in childhood is associated with increased adult mortality and morbidity. We aimed to establish whether childhood SEP was associated with differential methylation of adult DNA.

Methods Forty adult males from the 1958 British Birth Cohort Study were selected from SEP extremes in both early childhood and mid-adulthood. We performed genome-wide methylation analysis on blood DNA taken at 45 years using MeDIP (methylated DNA immunoprecipitation). We mapped in triplicate the methylation state of

Socio-economic status is associated with epigenetic differences in the pSoBid cohort

Dagmara McGuinness¹, Liane M McGlynn¹, Paul CD Johnson², Alan MacIntyre¹, G David Batty³, Harry Burns⁴, Jonathan Cavanagh⁵, Kevin A Deans⁶, Ian Ford², Alex McConnachie², Agnes McGinty⁷, Jennifer S McLean⁸, Keith Millar⁵, Chris J Packard⁹, Naveed A Sattar⁹, Carol Tannahill^{8,10}, Yoga N Velupillai^{8,11} and Paul G Shiels^{1,*}

+ Author Affiliations

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Accepted November 29,

Abstract

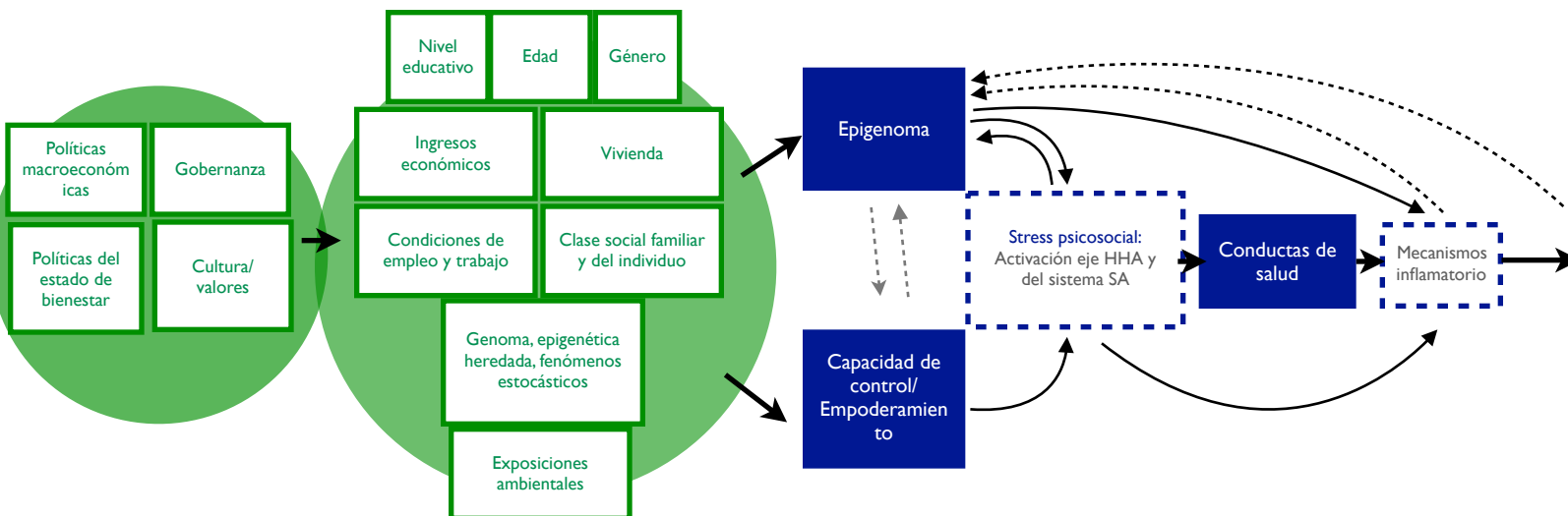
Background Epigenetic programming and epigenetic mechanisms driven by environmental factors are thought to play an important role in human health and ageing. Global DNA methylation has been postulated as an epigenetic marker for epidemiological studies as it is reflective of changes in gene expression linked to disease. How epigenetic mechanisms are affected by psychological, sociological and biological determinants of health still remains unclear. The aim of this study was to investigate the relationship

Nuestro contexto

Nosotros y nuestras condiciones de vida

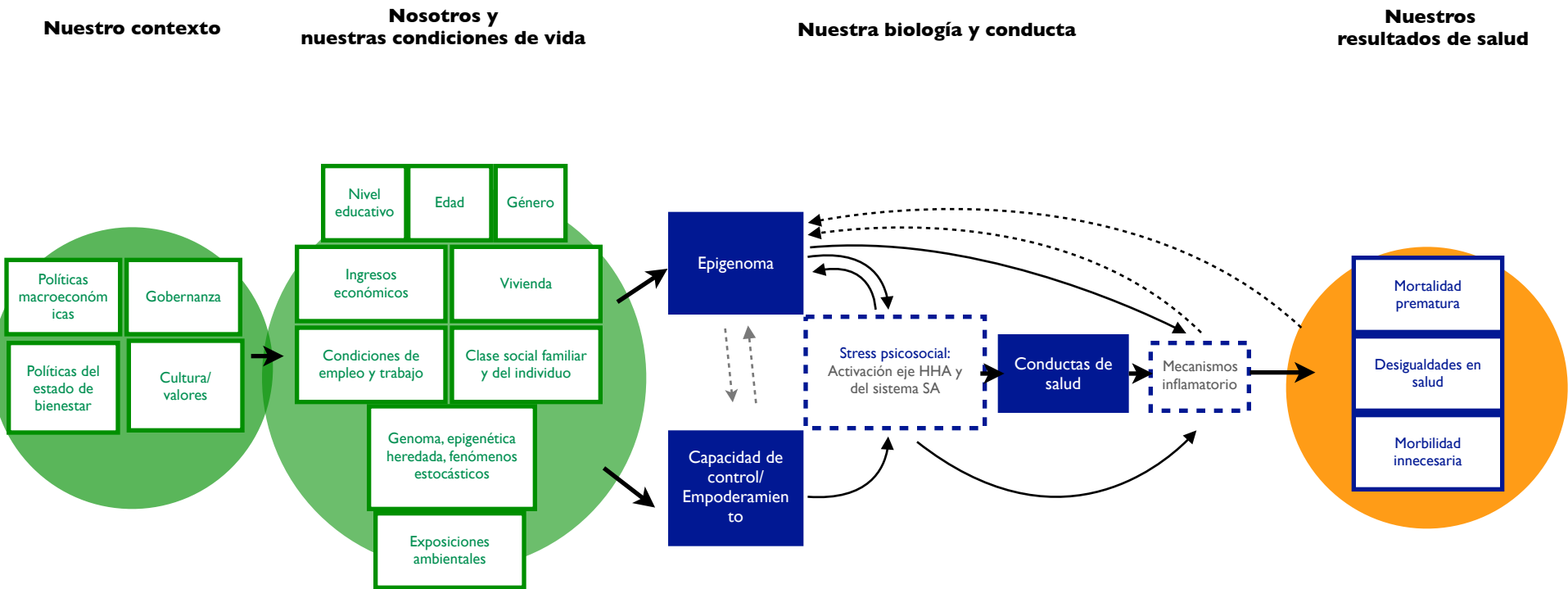
Nuestra biología y conducta

Nuestros resultados de salud



Cofiño, R. Tú código postal puede modificar tu código genético. AMF. En prensa

Eje HHA: Eje hipotálamo-pituitario-adrenocortical
Sistema MA: Sistema simpático adrenal



Cofiño, R. Tú código postal puede modificar tu código genético. AMF. En prensa

Eje HHA: Eje hipotálamo-pituitario-adrenocortical
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Entorno físico

Contaminación del aire

Estética del entorno

Diseño urbanístico

Ruido

Control publicidad

Regulación de alimentación saludable

Entorno libre de humos

Acceso a espacios de ocio y tiempo libre

Educación ↔ Clase Social

↙ Ingresos ↘

Normas/
Oportunidades
sociales

Redes sociales: apoyo y
cohesión

Entorno socioeconómico

Stress y factores psicosociales

Actividad física

Alteración del sueño

Alimentación

Tabaco

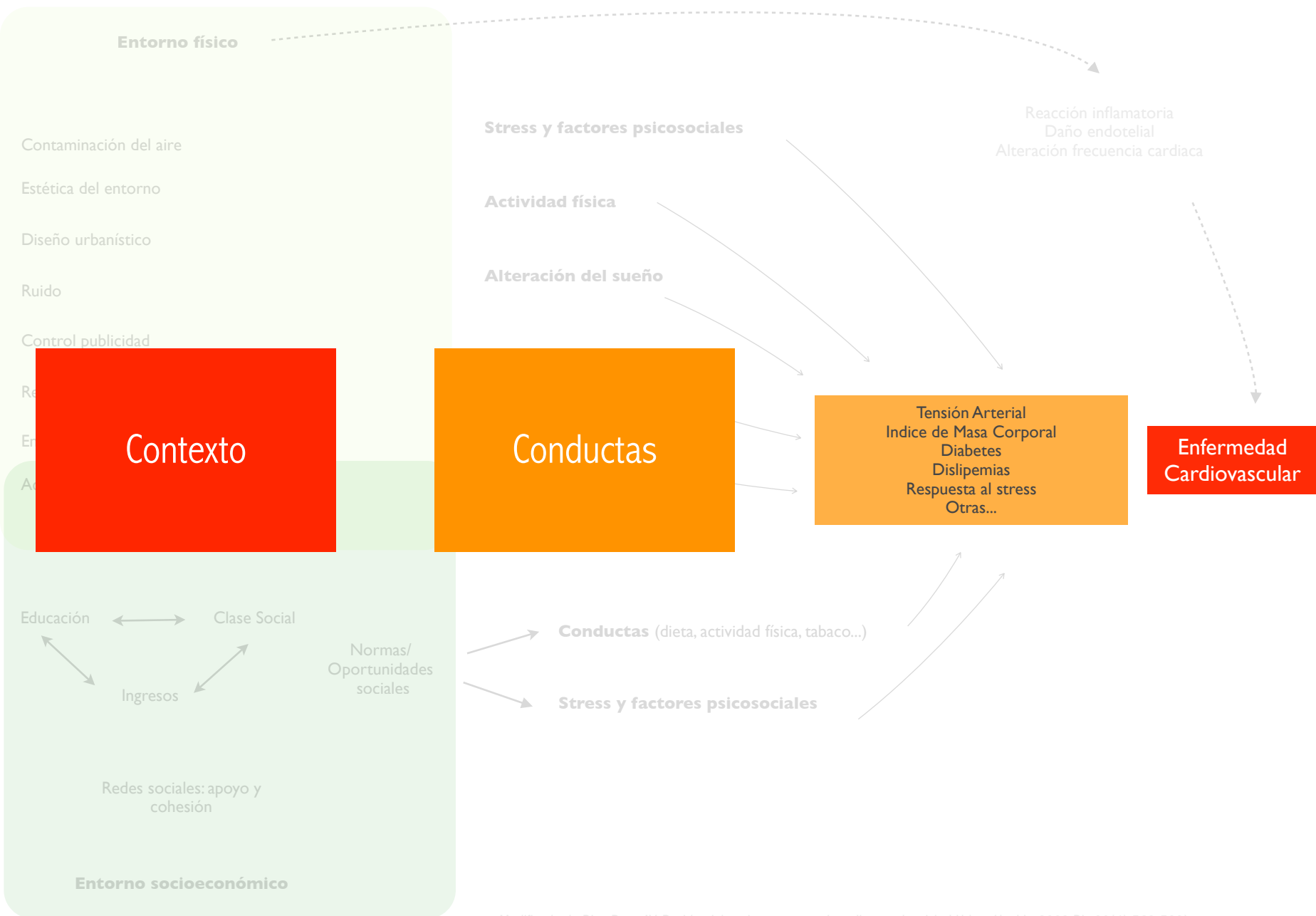
Tensión Arterial
Índice de Masa Corporal
Diabetes
Dislipemias
Respuesta al stress
Otras...

Conductas (dieta, actividad física, tabaco...)

Stress y factores psicosociales

Reacción inflamatoria
Daño endotelial
Alteración frecuencia cardíaca

**Enfermedad
Cardiovascular**



Socioeconomic Position, Co-Occurrence of Behavior-Related Risk Factors, and Coronary Heart Disease: the Finnish Public Sector Study

Mika Kivimäki, PhD, Debbie A. Lawlor, PhD, George Davey Smith, DSc, Anne Kouvonen, PhD, Marianna Virtanen, PhD, Marko Elovainio, PhD, Jussi Vahtera, MD

Coronary heart disease (CHD), a leading cause of morbidity and mortality in all Western countries, is more prevalent among lower socioeconomic position (SEP) groups than among groups that have higher SEP.¹⁻⁷ Although the evidence of such a socioeconomic gradient in CHD is robust, the extent to which this gradient is the result of different distributions of coronary risk factors between SEP groups remains controversial. Several epidemiological studies suggested that most (60%–95%) of the CHD burden can be attributed to established risk factors: smoking, hypertension, diabetes, unfavorable cholesterol profile, and physical inactivity; appropriately, public health interventions target these risk factors to reduce the CHD epidemic.⁸⁻¹³ However, several studies that compare the magnitude of the socioeconomic gradient before and after adjustment for these risk factors suggest that they ex-

Objectives. We examined the associations between socioeconomic position, co-occurrence of behavior-related risk factors, and the effect of these factors on the relative and absolute socioeconomic gradients in coronary heart disease.

Methods. We obtained the socioeconomic position of 9337 men and 39255 women who were local government employees aged 17–65 years from employers' records (the Public Sector Study, Finland). A questionnaire survey in 2000–2002 was used to collect data about smoking, heavy alcohol consumption, physical inactivity, obesity, and prevalence of coronary heart disease (myocardial infarction or angina pectoris).

Results. The age-adjusted risk of CHD was higher for low-income groups. After adjustment for risk factors, the risk was no further attenuated. The co-occurrence of multiple risk factors was associated with a higher risk of CHD. The co-occurrence of multiple risk factors was associated with a higher risk of CHD. The co-occurrence of multiple risk factors was associated with a higher risk of CHD.

Conclusions. Interventions that target not completely remove the socioeconomic gradient in CHD risk. *Health. 2007;97:874–879*

Neighborhood Psychosocial Hazards and Cardiovascular Disease: The Baltimore Memory Study

Toms Augustin, MD, MPH, Thomas A. Glass, PhD, Bryan D. James, MBE, and Brian S. Schwartz, MD

The effect on health of the places in which people live—apart from individual, genetic, or lifestyle characteristics—is of increasing interest to researchers.¹ A new wave of research is examining the health consequences of various aspects of residential neighborhoods. Moving beyond the study of individual risk factors to the study of neighborhoods may be a key to understanding widening health disparities across racial/ethnic and sociodemographic groups.^{2,3}

Many aspects of neighborhoods are hypothesized to influence cardiovascular disease (CVD) risk through several different and potentially interrelated mechanisms.⁴⁻⁶ Health behavior has received significant attention. Some data suggest that residents of socioeconomically deprived neighborhoods are more likely to engage in high-risk health behaviors, including inactivity,^{7,8} poor diet,⁹ illicit drug use,^{10,11} and smoking.¹² However, studies that found an association between neighborhood of residence and CVD after adjustment for

Objectives. We examined associations between cardiovascular disease and neighborhood psychosocial hazards, such as violent crime, abandoned buildings, and signs of incivility, to evaluate whether features of place are associated with older adult health.

Methods. We analyzed first-visit data from the Baltimore Memory Study of randomly selected residents aged 50 to 70 years (n=1140) of 65 contiguous neighborhoods in Baltimore, Maryland. We looked for associations between self-reports of history of selected cardiovascular diseases and scores on the 12-item neighborhood psychosocial hazards scale.

Results. After adjustment for established individual risk factors for cardiovascular disease, residents in neighborhoods with scores in the highest quartile of the psychosocial hazards scale had more than 4 times higher odds of a history of myocardial infarction and more than 3 times higher odds of myocardial infarction, stroke, transient ischemic attack, or intermittent claudication compared with residents living in neighborhoods scoring in the lowest quartile.

Conclusions. Neighborhood psychosocial hazards were significantly associated with self-reported cardiovascular disease after adjustment for individual-level risk factors. This is consistent with the hypothesis that environmental stress plays a role in the etiology of cardiovascular disease. (*Am J Public Health. 2008; 98:1664–1670. doi:10.2105/AJPH.2007.125138*)

physiological stress response.^{21,22} Chronic stress study area were linked to telephone numbers.

Entorno físico

Contaminación del aire

Estética del entorno

Diseño urbanístico

Ruido

Control publicidad

Re...

En...

Al...

Contexto

Educación

Clase Social

Ingresos

Normas/
Oportunidades
sociales

Redes sociales: apoyo y
cohesión

Entorno socioeconómico

Stress y factores psicosociales

Actividad física

Alteración del sueño

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Tabaco

Conductas

Tensión Arterial
Índice de Masa Corporal
Diabetes
Dislipemias
Respuesta al stress
Otras...

Enfermedad Cardiovascular

Reacción inflamatoria
Daño endotelial
Alteración frecuencia cardiaca

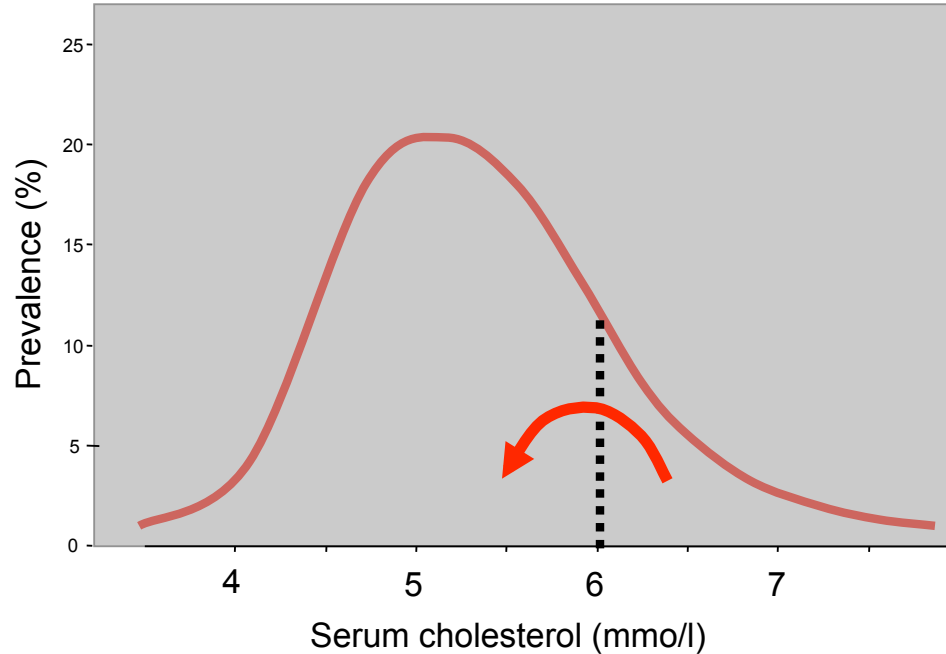
Conductas (dieta, actividad física, tabaco...)

Stress y factores psicosociales

Clinical Preventive Medicine

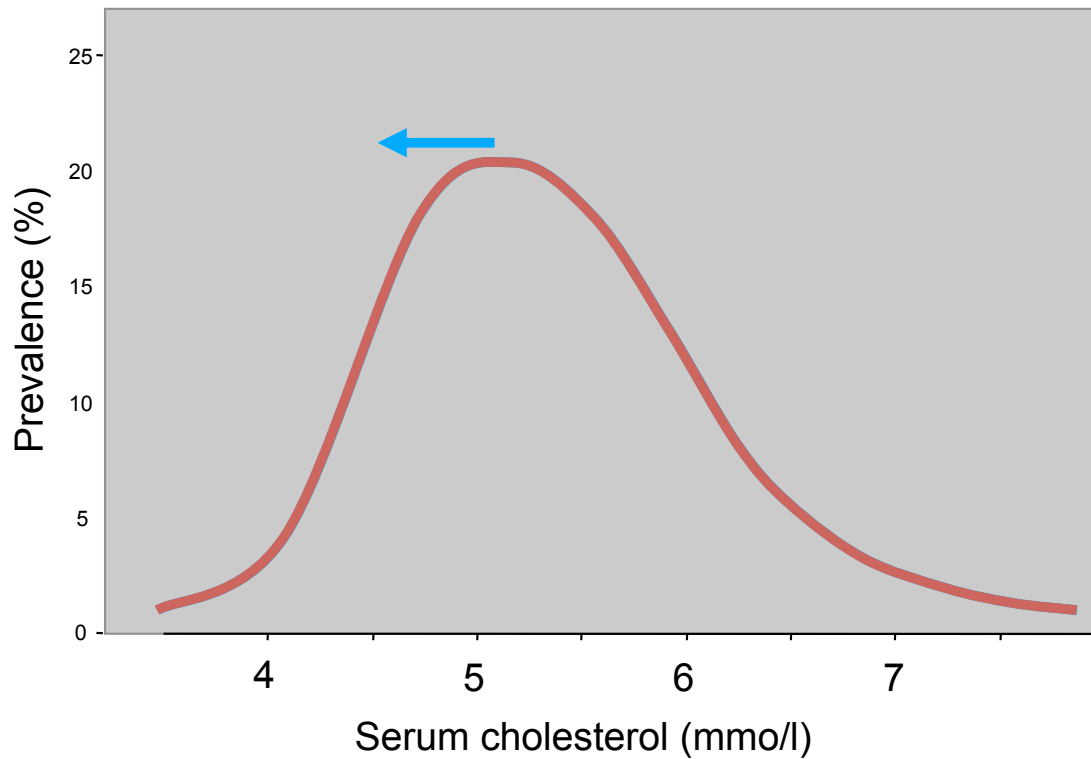
Focus on “high risk” individuals

- Screening
- Lipid lowering Rx for > cholesterol subjects

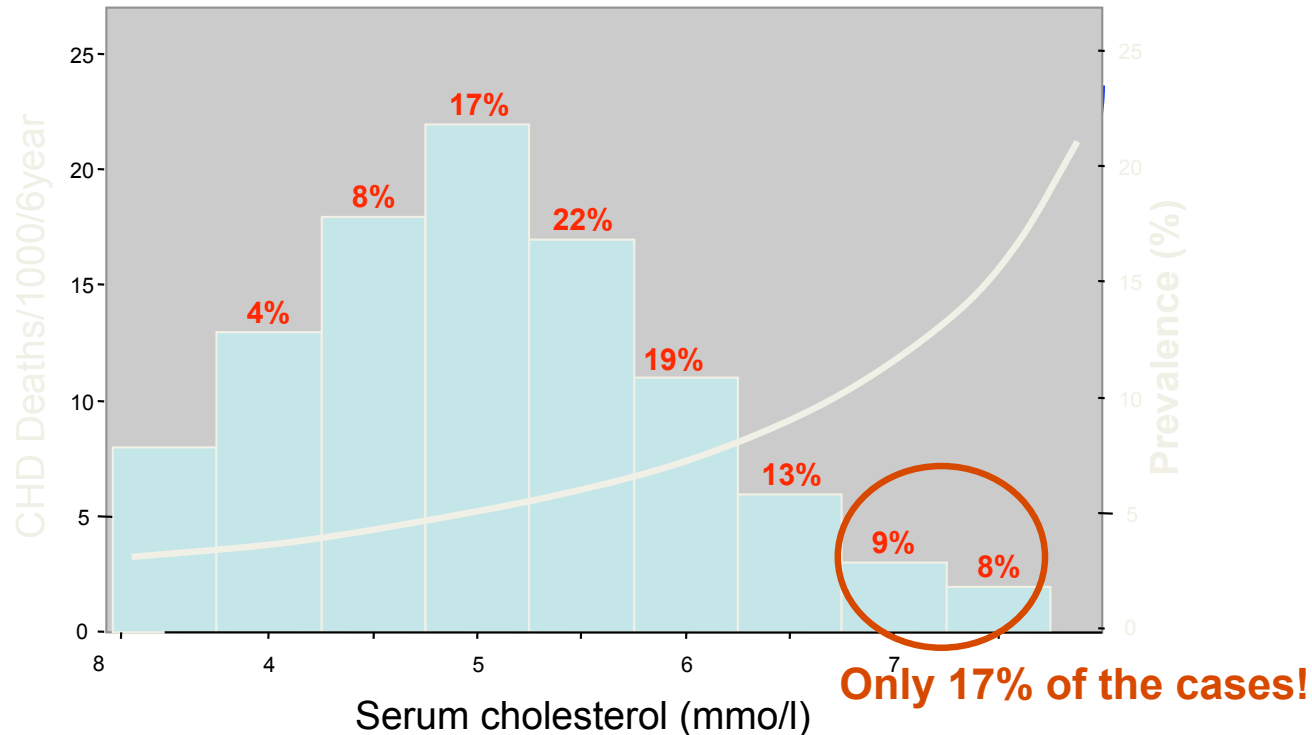


Population-Based Prevention

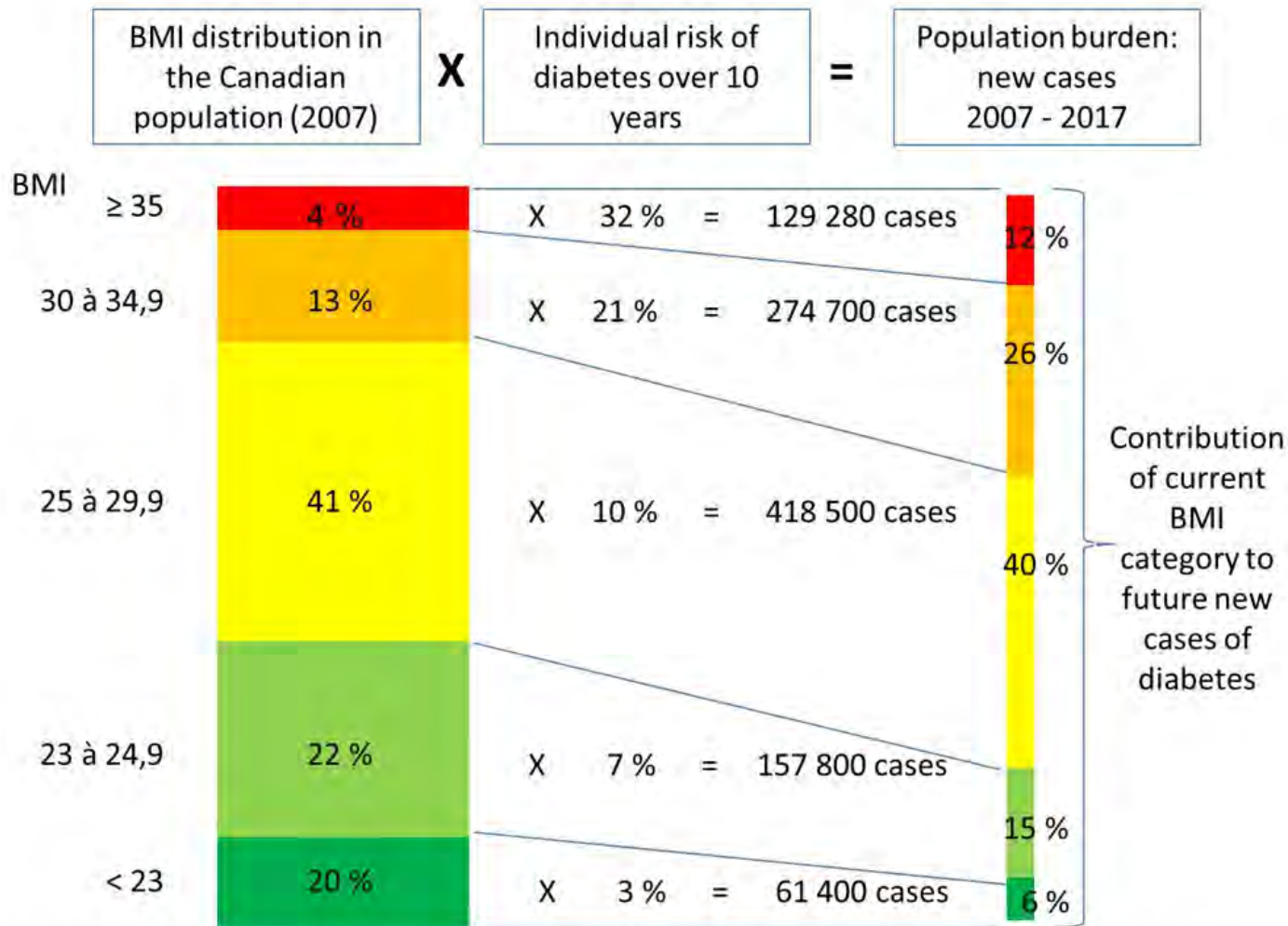
- Shifting the distribution of cholesterol in the population



Proportion of CHD cases attributable to elevated cholesterol within each cholesterol level category



$$\text{Pop Attributable Risk} = f[RR, \text{Prevalence}] = \frac{p(RR - 1)}{p(RR - 1) + 1}$$



Source of statistics: ICES Investigative Report, June 2010: "How many Canadians will be diagnosed with diabetes between 2007 and 2017?"



las gafas para mirar las desigualdades



A new typology of policies to tackle health inequalities and scenarios of impact based on Rose's population approach

Joan Benach,^{1,2} Davide Malmusi,^{2,3,4} Yutaka Yasui,⁵ José Miguel Martínez^{1,2,6}

¹Health Inequalities Research Group, Employment Conditions Knowledge Network (GREDS-EMCONET), Department of Political and Social Sciences, Universitat Pompeu Fabra, Barcelona, Spain

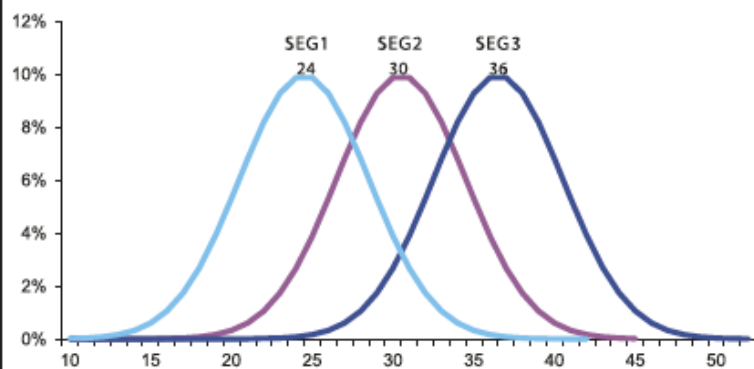
ABSTRACT

The last decade has witnessed a surge in interest for policies to tackle health inequalities. Adequate theoretical development of policy models is needed to understand how to design and evaluate equity-oriented health policies. In this paper we review Graham's

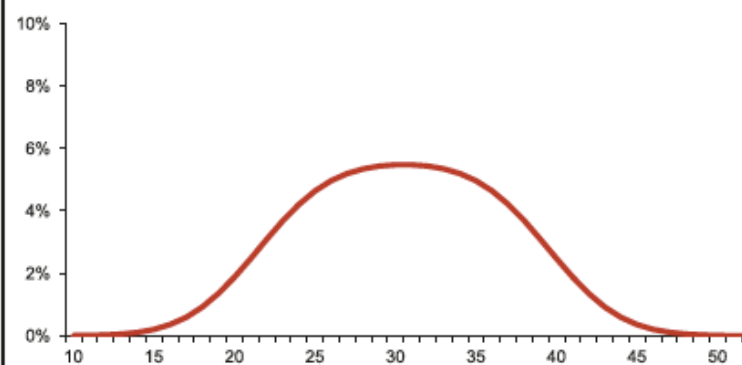
subpopulations or neighbourhoods. On the other hand, this approach on specific subpopulations has some policy disadvantages. First, it may undermine the politics of solidarity that is the key to maintaining support for public provision.¹⁰ Second, this approach does not commit itself to bringing levels

1.0
Baseline

Distribution by SEG

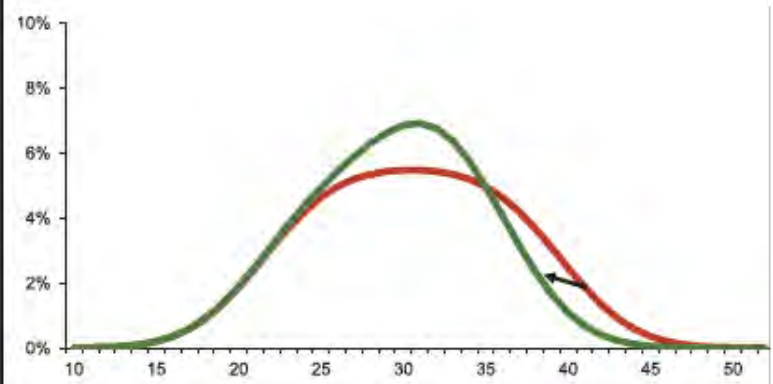
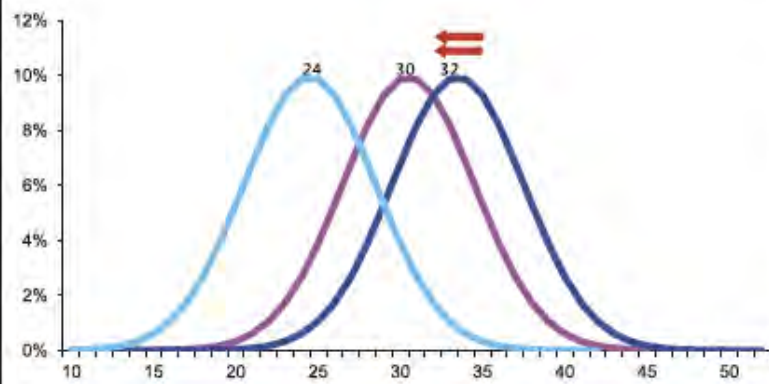


Population distribution

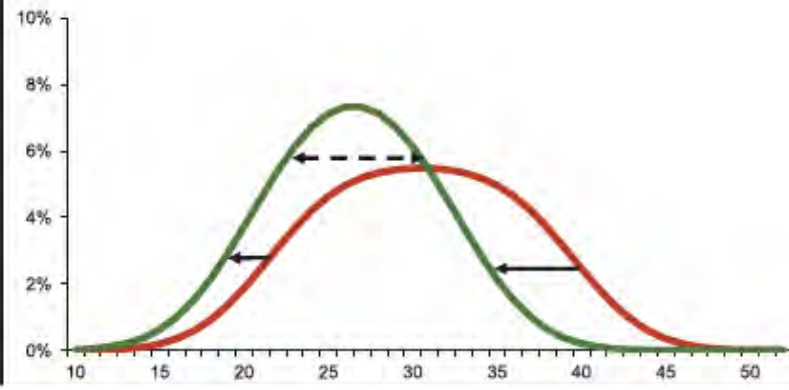
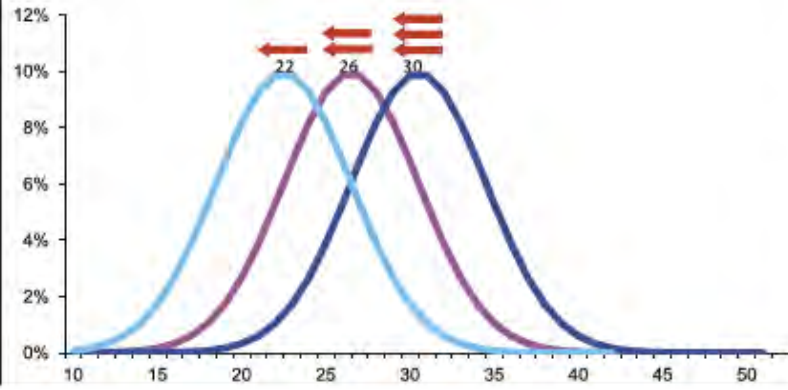


1.1

Targeted
interventions on
worst-off only



1.4
Proportionate
universalism



Avanzando hacia la equidad

PROPUESTA DE POLÍTICAS E INTERVENCIONES PARA REDUCIR LAS DESIGUALDADES SOCIALES EN SALUD EN ESPAÑA.

Comisión para Reducir las Desigualdades Sociales en Salud en España

Comisionado por:

Dirección General de Salud Pública y Sanidad Exterior

Ministerio de Sanidad y Política Social



GOBIERNO
DE ESPAÑA

MINISTERIO
DE SANIDAD
Y POLÍTICA SOCIAL