Call for actions for health and equity

This background paper supports the Joint Statement on the same topic by Members of the European Health Policy Platform, to the European Institutions and to EU Member States. It was developed by EuroHealthNet, incorporating comments provided by a number of Health Policy Platform participants.

1. Rationale

1.1 In Europe, income and wealth inequality has been rising since the 1970s. The number of people in the EU living at risk of poverty and social exclusion increased by 4.5 million between 2010-2014.[1] Less visible but closely related are figures that reflect **a growing divide in life expectancy and in the health status of those in our societies who are less or least well of compared to those who are most well off.** [2] While monitoring of socio-economic inequalities in health at EU level is still at an early stage, the evidence available from published studies reveal an increase in health inequalities between social groups in many countries. People across Europe are living longer than ever, but many of the life-years that people are gaining are not being spent in good health, particularly amongst lower socio-economic groups. There are also big differences in health status and mortality rate and in the steepness of socio-economic gradients in health (the systematic correlation between health status and socio-economic status) between EU Member States.[3]

1.2 **Growing levels of health inequalities reflect that our market economies are not delivering well-being in a fair and effective manner and that this can be improved.** Health is an enabler of social and economic participation in daily life, the 'motor' behind our economies, and a key determinant of a person's well-being, happiness and satisfaction. In EU surveys, people systematically value health above all other aspects of their lives.[4] In addition, health inequalities cost EU governments dearly: as growing numbers of people suffer from one or more chronic conditions, the high costs of treatment are increasing pressure on the financial sustainability of health and social systems. Currently public spending on health care and long term care accounts for 8.5% of GDP in the EU. It is expected that this will increase by 1-2% by 2060.[5] Those whose health is less than optimal are less productive and less able to

[1] Communication from the Commission to the European Parliament, the Council, the European Central Bank and the Eurogroup on 2016 European Semester: Assessment of progress on structural reforms, prevention and correction of macroeconomic imbalances, and results of in-depth reviews under Regulation (EU) No 1176/2011, COM(2016) 95 final/2, http://ec.europa.eu/europe2020/pdf/csr2016/cr2016_comm_en.pdf

[2] Studies using data from a wide range of European countries have shown that smoking, excessive alcohol consumption lack of physical exercise, and obesity are all more common in lower socioeconomic groups in most European countries. People in lower socioeconomic groups also suffer from mental health problems, which has been associated with the above-mentioned risk factors and linked to a lack of control over life circumstances and content and conditions of work.

[3] E.g. Marmot M, Allen J, Bell R, Bloomer E, Goldblatt P, Consortium for the European Review of Social Determinants of H, et al. WHO European review of social determinants of health and the health divide. Lancet. 2012;380(9846):1011-29. Epub 2012/09/12; European Commission. Health inequalities in the EU - final report of a consortium. Consortium lead: Sir Michael Marmot. 2013.

[4] EuroFound, 2012. Quality of Life Survey. http://www.eurofound.europa.eu/surveys/egls/index.htm

[5] ECFIN (2016), Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip037_vol1_en.pdf

contribute to government revenues and economic growth.[6] The recently published 'Health at A Glance: Europe 2016' report estimates that the premature deaths of 550,000 working age people across European Union countries from chronic diseases, including heart attacks, strokes, diabetes and cancer, cost EU economies EUR 115 billion or 0.8% of GDP annually. This figure does not include the additional loss in terms of lower employment rates and productivity of people living with chronic health problems. Finally, research shows that high levels of social inequalities, which lead to health inequalities, undermine the well-being of everyone in society by leading to stress, fear and insecurity. [7] **The need to strengthen the health and social dimension of the EU, to avoid widening socio-economic inequalities within and between Member States is clearer today than ever before.**

1.3 **We therefore urge the European Commission and EU Member State governments to stop thinking of health and wellbeing as a 'small' issue amongst EU policy priorities and to close the persistent and growing health divide between the richest and the poorest groups in our societies**. Health and health equity matter not only to individuals, but to society and the economy as a whole, and must be seen as an investment, rather than as a cost.[8] Although the EU's competencies in the area of health care are limited, many policies and actions impact on health and its distribution. The EU can do more to promote 'equality, justice, solidarity and the well-being of its people[9]' and fulfil its duty to protect health by ensuring health and health equity are a more integral part of policy making across the board. It must invest more in measures that maintain, improve and restore health, particularly amongst the less and least well-off members of our society.

The EU's duty to promote good health

The Treaty of the EU states that the European Union aims to promote peace and its values, including respect for human dignity, democracy, equality, justice and solidarity, as well as the well-being of its people.

Article 168 of the Treaty states that 'A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.
Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health …'

[6] Mackenbach J P, Meerding W J, Kunst A E. Economic Cost of Health Inequalities in the European Union. 2011
[7] Wilkinson RG, Pickett, K. The Spirit Level: Why More Equal Societies Almost Always Do Better. 2009.
[8] Hedberg A, Hines P. Addressing the crisis of tomorrow. The Sustainability of European Health Systems. European Policy Centre Policy Brief, 21 September 2016
[9] Article 2 and 3, Treaty of the EU: http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=CELEX:12012M/TXT

The potential new European Pillar on Social Rights, an opportunity for health equity?

The potential new social pillar includes three themes (equal opportunities and access to the labour market; fair working conditions; adequate and sustainable social protection), and twenty possible policy domains. Health is explicitly mentioned in the latter theme, under the provision 12 'healthcare and sickness benefits'.[10]

If however the measures addressed by the Pillar are implemented with an 'equity lens' and applied to screen for their impact across socio-economic groups, the application of its provisions could do much to improve health and reduce health inequalities. There is for example evidence that measures that improve gender equality and work-life balance, which are addressed by the Pillar, are very important to addressing health inequalities at early age. Stimulating maternal employment and expanding the provision of quality early child education and care programmes not only improves family incomes, it leads to greater parental involvement in family activities and benefits children overall.[11] [12]

The potential social pillar should make reference to health and health equity at the outset, as one of the social and economic benefits that would come from investing in all of the provisions of the Pillar, and ensuring a health equity lens is applied throughout.[13]

2. Priorities for Action

2.1 Over the past two decades, a considerable body of work has emerged that explains why health inequalities and socio-economic gradients in health occur and how they can be addressed. It reflects that causes of inequalities in health are complex: they cannot be reduced to a single group of risk factors, but develop through the conditions in which people are "born, grow, live work and age", also referred to as the 'social determinants of health'.[14] These determinants are shaped through prevailing

[10] First Preliminary Outline of a European Pillar of Social Rights. Annex accompanying to the Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions, COM(2016) 127 final, http://eur-lex.europa.eu/legal-content/EN/TXT/?uri=COM:2016:127:FIN#document2

[11] Stegeman I and Costongs C, Eds. The Right Start to a Healthy Life. Levelling-up the Health Gradient Among Children, Young People and Families in the European Union – What Works? EuroHealthNet 2012

[12] DRIVERS, Scientific Inequalities in Early Childhood Health and Development : a European-Wide Systematic Review, Final Scientific Report (2014), http://health-gradient.eu/wp-content/uploads/2015/03/DRIVERS_WP2_Early_Child_Development_Final_Report.pdf

[13] Since all EU Member States face health inequalities, and it is important that all EU MS converge around higher social standards, the provisions in the proposed Social Pillar should not just apply to only Eurozone countries but to all EU Member States.

[14] CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization

macro-policies on social protection, taxation, health, education, the environment and from living and working conditions. They also result from lifestyle determinants, or susceptibility to specific risk factors, like alcohol, tobacco consumption, bad nutrition and lack of physical activity, or poor health literacy, which are strongly linked to social and economic conditions.[15] Health inequalities can also result from or be compounded by experiences of discrimination, stigmatisation or social exclusion.

2.2 **There is consensus that reducing health inequalities requires measures that improve the health of those that are worse or worst off at a faster rate than those who already have better health.** This calls for a combination of universal and targeted measures that meet proportionally greater needs with greater intensity, a principle that is referred to as 'proportionate universalism'.[16] It also calls for coordinated and holistic government approaches at national and sub national levels that address not just the symptoms but also the root causes of societal problems, and multipronged, inter-sectoral actions that also involve citizens and the private sector.

2.3 Since health inequalities are shaped by factors that lie far beyond the scope of the health sector, this sector cannot in and of itself address the problem. There is however a great deal that health professionals can do by raising awareness, advocating for, and taking action on those determinants that they can influence. **Reducing health inequalities is a collective responsibility of the health sector and all public and private actors, as a means to and an indicator of sustainable development.**

It is against this background, that Health Policy Platform Members call on EU Institutions and EU Member State governments to join them in intensifying their investments in policies and actions to address health inequalities.

3. Strengthen Action of and within health systems

3.1 **Ensure access to health systems**

Ensuring universal access to high quality health services is key to improving population health and reducing health inequalities. The *Health at a Glance: Europe 2016* report notes that most EU countries have achieved universal (or near universal) coverage of health care costs for a core set of services. However four EU countries (Cyprus, Greece, Bulgaria and Romania) still had more than 10% of their population not regularly covered for health care costs in 2014. The share of the population in most EU countries reporting **unmet care needs** due to financial reasons has gone up since 2009, particularly amongst lowest-income households.[17]

In addition, there is evidence that claims about near-universal access do not adequately take into account the situation of populations, like Roma, undocumented migrants, people with mental illness and those in the LGTB community who face significant structural barriers to accessing health systems .

[15] Mackenbach JP. The persistence of health inequalities in modern welfare states: the explanation of a paradox. Soc Sci Med. 2012;75(4):761-9. Epub 2012/04/06.
[16] CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization
[17] OECD, EC. Health at a Glance: Europe 2016. State of Health in the EU Cycle. Nov 2016

Their **access to health is restricted through legislation, complex administrative hurdles or through discrimination in practice**. Currently, for example, legal entitlement under national law to health services for migrant workers from outside of the EU, undocumented migrants and destitute EU citizens is often extremely limited. This means that individuals often avoid seeking care until their condition reaches the point of crisis. Besides the devastating human cost to individuals and families, this has implications for public health, it leads to higher overall health-care costs and it violates fundamental rights. [18] [19]

Strong primary care systems can play an important role in reducing health inequalities and in tackling the changing needs of an ageing European population. Ensuring that primary care providers are accessible to everyone, wherever people live, be it in rural and remote areas or in poor city neighbourhoods, is crucial to reducing health inequalities and the number of avoidable hospitalizations across EU countries.

Ensuring access to health care also calls for stronger measures to address the challenges that EU Member States faces in relation to **unmet needs for health workers** . Due to rising healthcare demands in an ageing Europe it is estimated that there will be a shortage of up to one million health workers in the EU by 2020, with certain Member States being particularly affected.[20] In addition, **health workforce mobility** feeds disparities as flows redistribute resources from poorer to wealthier EU countries. Between 2007 and 2013 for example, 20% of doctors and 28% of nurses left the Romanian health care system. Nearly 80% of graduating youn professioals in Bulgaria tend to leave the country, mainly due to low salaries and few opportunities to obtain specialisations. A 20% cut to Spanish health sector budgets following the economic crisis led to a loss of 5,000 jobs in the health sector and new healthcare access problems.[21] In addition,migrant health workers are often not granted equal rights in their destination countries. These factors put access to healthcare at risk and could worsen health inequalities.

These challenges call for measures to improve recruitment and retention conditions to make professions in the health sector more attractive and to reduce the pressures and incentives for outward migration While health workers, as EU citizens have the right to migrate to seek better work opportunities, measures can be taken to mitigate outflows that undermine the stability of health systems, along the lines of those set out in the WHO Global Code of Practice on the International Recruitment of Health Personnel. At the EU level, the proper use of EU Structural and Investment Funds to support sustainable health systems, and legislation like the Professional Qualifications and Posted Workers Directives are

[18] EC Expert Panel on Effective ways of Investing in Health : http://ec.europa.eu/health/expert_panel/sites/expertpanel/files/015_access_healthservices_en.pdf

[19] IOM expert guidelines on the provision of health to undocumented migrants: http://equi-health.eea.iom.int/index.php/9-uncategorised/336-expert-consensus

[20] See: http://ec.europa.eu/health/workforce/policy_en and http://healthworkforce.eu/

[21] http://www.epsu.org/sites/default/files/article/files/05-05-15-Brussels-RT-EP-WEMOS_EPHA_EPSU-Detailed-Minutes.pdf

important mechanisms for change.[22] Collaboration across EU Member States to exchange good practice and studies on effective measures that involve financial and non-financial incentives can also be useful.

3.2 **Recognise the contribution of all actors within health systems**

There are many kinds of professionals working in health systems, like doctors, nurses, administrators, people working in the field of public health, health promotion and disease prevention, as well as in e.g. early intervention and other services that provide support to e.g. children or people with disabilities. All of these people are important agents of change.

Health systems are however too often reduced to health-*care* systems, with the focus placed on the primary and secondary care physicians and hospitals that are responsible for managing and treating disease. **The role of many of the people involved in health systems in promoting and maintaining health, preventing disease and providing general support to people with health needs and disabilities, is often overlooked and undervalued.** It is important that all people working in health systems have an understanding of health inequalities and the skills, corresponding to their profession and their duties, to act on them.[23] This can be achieved by ensuring that public health and health inequalities are a part of the core competencies of all health professionals.

What does the Potential EU Pillar of Social Rights say?

Provision 12 of the Social Pillar refers mostly to health-*care* systems, rather than the broader definition of health systems, and there is much focus in the text on access to health *care* i.e. treatment of disease.

Since health inequalities are raised only in the context of this provision, it suggests that health-care systems should/can in and of themselves address health inequalities, while this requires a whole of government and society approach. The provision should therefore also call for strengthening actions by other sectors to address social determinants of health and reduce health inequalities.

3.2 **Strengthen the ability of health professionals to address specific needs of vulnerable groups**

It is important to raise awareness of health inequalities amongst health service providers to reduce conscious or unconscious bias and improve the quality and effectiveness of care they provide to people

[22] See: www.epsu.org/article/mobility-health-professionals-eu-ethical-recruitment-and-policy-coherence.
[23] Institute of Health Equity and WMA. Doctors for Health Equity. 2016 http://www.instituteofhealthequity.org/Content/FileManager/wma-ihe-report_-doctors-for-health-equity-2016.pdf

with lower socio-economic status and other vulnerable groups. Within countries, for example, increasing socio-economic deprivation may be associated with shorter consultations.[24]

Amongst the evidence-based actions that health service providers can apply that can contribute to reducing health inequalities and levelling health gradients are: recording extensive social history at the outset of service provision, focusing on e.g. life-circumstances, emotional health, health related behaviour, and access to and utilisation of health care.[25] On the basis of the information gained, they can provide targeted, person centred services that are based on the real needs of patients and their carers (e.g. additional diabetes or HIV screening and counselling for at risk patients, referral to other services or social prescribing, like exercise or volunteering on prescription), whilst avoiding the development of 'poor services for the poor'. Health service providers can adapt services to meet the needs of disabled patients or vulnerable groups by e.g. adapting the formats of consultations (e.g. over e-mail or skype) .[26]

It may also be necessary for service providers to become more skilled in communicating to patients and their carers in ways that are clear, and that enable them to retain the information provided. It is also, in this respect, key to invest in programmes to improve health literacy, particularly of those in lower-socio-economic groups.

3.3 **Strengthen the role of health promotion and disease prevention within health systems**

According to WHO 86% of deaths in the EU are due to chronic Non Communicable Diseases (NCDs), often caused by unhealthy behaviour, smoking, bad diets, alcohol consumption, lack of physical activity. *Health at a Glance: Europe 2016* reports that one in six adults across EU countries were obese in 2014, up from one in nine in 2009. The burden of ill-health on social benefit expenditures is huge, with 1.7% of GDP spent on disability and paid sick leave each year on average in EU countries, more than what is spent on unemployment benefits.

There is considerable evidence that such costs can be reduced through investment in community-based prevention and health promotion programmes. Preventative measures such as smoking bans, tackling problem drinking, increasing physical activity as well as screening and vaccination programmes can significantly reduce the burden of morbidity and mortality of non-communicable diseases in Europe.[27] It Use of complementary health care practices which focus on maintenance of health may also play a role. It is well known, however, that such programmes are more likely to be taken up by higher socio-economic groups, and can thereby widen the health gap. More must be done to invest the resources that are available in this field to ensure effective take-up where it is most needed. **Currently, public**

[24] Ibid.
[25] ibid.
[26] ibid
[27] See e.g. European Observatory on Health Systems and Policy, Promoting Health, Preventing Disease. The economic case. McDaid D, Sassi F, Merkur S eds. WHO 2015

spending on health promotion and disease prevention remains under resourced[28] and still only accounts for just 2-3% of health budgets.[29] [30]

European Funds investing in health equity

EFSI Investments to contribute to Healthy Ireland approach
Ireland is the first eligible EU Member State eligible applying the European Fund for Strategic Investments (EFSI) to build fourteen new Primary Care Centres, following a EUR 70 million, 27-year loan from the European Investment Bank. The new PPP-based scheme will support the shift from hospital based healthcare to community based care centres that provide basic health services including GP surgeries, occupational therapy, social work and dietary advice. In some locations additional services will also be provided, including mental health and addiction services. This is the first dedicated backing for Primary Health Care anywhere in Europe by the EIB, which will finance 49% of the total investment costs of the new facilities. This investment contributes to achieving a Healthy Ireland, a national framework for action to improve the health and well-being of the people of Ireland, which takes a whole-of-government and a whole-of-society approach.

European Social Funds support Health Promoting Offices in Hungary
In 2013 and 2014, 61 Health Promotion Offices (HPOs) were established throughout Hungary as a result of a dedicated grant scheme financed from the European Social Fund. HPOs work with local communities at the level of micro-regions, and bring low-threshold health promotion, lifestyle and health behaviour change programs as close to people as possible, in order reduce the incidence of chronic and non-communicable diseases and avoid early and preventable mortality. All HPO offices tailor their structure and programmes to the specific needs of the communities that they serve. Twenty of these offices are in the most disadvantaged micro-regions of Hungary.[31]

3.4 **Improve the capacity of health professionals to play a 'bridging role'**
Professionals are needed that can recognise the ways in which social determinants impact on the lives of people at national, regional or local level and collaborate and negotiate with other policy sectors (e.g. schools, urban planners, housing providers, transport sector) so that they can deliver the best possible outcomes for people across the socio-economic gradient. Building and maintaining relationships is a crucial aspect of advocating for values and approaches within and beyond traditional health sectors. This

[28] ECFIN (2016), Joint Report on Health Care and Long-Term Care Systems & Fiscal Sustainability, http://ec.europa.eu/economy_finance/publications/eeip/pdf/ip037_vol1_en.pdf
[29] The Final Report on the EU's Reflection Process on Chronic Diseases, 2013 http://ec.europa.eu/health/major_chronic_diseases/docs/reflection_process_cd_final_report_en.pdf
[30] JA-CHRODIS. Health Promotion and Primary Prevention in 14 EU Countries. A comparative overview of key policies, approaches, gaps and needs. 2015. http://www.chrodis.eu/wp-content/uploads/2015/07/FinalFinalSummaryofWP5CountryReports.pdf
[31] For more information see: http://www.eurohealthnet-magazine.eu/interview/health-promoting-offices/
The HPO's grew out of the 'Public Health Focused Model Programme for Primary Care Development' launched in 2012 under the Swiss-Hungarian Cooperation Programme: http://www.alapellatasimodell.hu/index.php/en/about-the-model-programme

calls for new forms of training, including advocacy, communications and social mobilization, within and beyond health professions.

The need to strengthen the integration of health and other social services is of particular importance, particularly in the context of our ageing societies. Too often social benefits and services, healthcare and sickness benefits, and 'long term care' are still treated as separate categories, leading to inefficient and ineffective service provision and complications for service users, especially for vulnerable groups with accumulated difficulties. It is also important that health professionals help define a care trajectory with patients and their carers that take into account all service providers within and beyond the health system that they can benefit from. Health professionals should also engage in 'social prescribing', which involves identifying non-clinical needs of patients that impact on their health, and refer them to the appropriate non-clinical support (e.g. exercise classes, debt relief services, educational services.)

3.5 **Improve Health Literacy**

Education is fundamental to the success of measures to maintain, improve and restore health. A topic that is closely related to the points raised above is the need to improve literacy rates in general as well as *health* literacy in particular, to reduce health inequalities. Health literacy refers to people having the appropriate skills, knowledge, understanding and confidence to access, understand, evaluate, use and navigate health and social care information and services. It is also influenced by the way services engage users and the provision of clear, accessible information for all. Limited health literacy is linked with unhealthy lifestyle behaviours like poor diet, smoking, lack of physical activity and increased risk of morbidity and premature death. According to WHO, health literacy is a main factor in preventing and managing non-communicable diseases. People with limited health literacy are more likely to use emergency services and less likely to successfully manage long term health conditions and incur higher health care costs.[32]

Health literacy is a challenge for everyone. The HLS EU report, which measured Health Literacy in eight EU member states, found that every second respondent (47.6%) in the total sample had limited (inadequate or problematic) health literacy, with the prevalence ranging from 28.7% in the Netherlands to more than 62.1% in Bulgaria.[33]

People with limited financial and social resources and lower educational levels are even more likely to have limited health literacy. This limits opportunities for vulnerable people to take control over their health and the conditions that affect their health. Strategies to improve health literacy are important empowerment tools with the potential to reduce health inequalities. They must take a whole of society approach, and consider both an individual's level of health literacy as well as the complexities of the

[32]UCL Institute of Health Equity and Public Health England. *Local action on health inequalities Improving health literacy to reduce health inequalities*, 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/460710/4b_Health_LiteracyBriefing.pdf

[33] KristineSørensen,Jürgen M.Pelikan,FlorianRöthlin: Health literacy in Europe: comparative results of the European health literacy survey (HLS-EU),2015 See: http://www.healthliteracyeurope.net/hls-eu

contexts within which people act, and involve politicians, professionals and society.[34] Promising approaches include the use of simple, effective teach-back methods to check service users understanding and early intervention approaches, and ensuring health literacy is fully integrated into early year and school curriculums. Use of complementary healthcare practices which include health education and self-empowerment may also play an important role. Community based peer support approaches may also help to distribute health literacy amongst social networks.[35] Alongside such measures, more large-scale research is needed to better understand how to improve health literacy of disadvantaged and vulnerable people.

3.6 **Improve tools available to diagnose health inequalities and to determine need**

To act on health inequalities, health and local authorities must have the tools to understand what they are, to diagnose social determinants of health, and to design appropriate services and interventions to address need. They must have the skills to e.g. bring together population and health statistics, and to apply tools like health inequalities impact assessments (HIIA) that measure the distributional impact of policies on health, to develop policies and interventions that are effective amongst vulnerable groups, and to evaluate these policies and practices (ex post HIIA). Improving health and social equity calls for strengthened capacities in these areas.

Capacity building for health equity

The POAT Salute refers to the 'Plan for Re-organisation and Capacity Building' of Southern Italy's health care systems. The Plan, which has been co-financed by EU Structural Funds since 2010, does not focus on health infrastructure, but on addressing deficits in knowledge and skills that limit the health-systems range of action and effectiveness. This includes strengthening the capacities of the public administration to cope with social inequalities in health, and promoting a series of technical assistance interventions aimed at increasing technical and specialist skills on this topic.

In Sicily, a pilot project was implemented that aimed to strengthen health authorities' capacities to implement action to tackle social inequalities in health, to evaluate interventions and their impact on different socio-economic groups and to apply the equity lens systematically in health programming.

3.7 **Improve employment conditions within the health sector and take into account the social value of**

[34] Ilona Kickbusch, Jürgen M. Pelikan, Franklin Apfel& Agis D. Tsouros: WHO Health Literacy The Solid Facts: Developing policies for health literacy at the local, national and European Region levels, 2013

[35] UCL Institute of Health Equity and Public Health England. *Local action on health inequalities Improving health literacy to reduce health inequalities*, 2015
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/460710/4b_Health_LiteracyBriefing.pdf

goods and services commissioned

Health systems employ a large number of people in many communities, which gives this sector an important responsibility to reduce health inequalities by providing good quality work and good employment terms and conditions, as well as working to increase employment opportunities for people from disadvantaged background [36].

In addition, those working in the health sector often commission and procure services from third parties, indirectly affecting the pay and conditions of many workers and, consequently, health outcomes. A significant way in which the health sector can affect the social determinants of health is to consider local employment conditions when allocating resources. In England, research has shown that by allocating additional investment and resources to areas with higher levels of socioeconomic deprivation, the health service has likely reduced inequalities in population ill health. The National Health Service in England must, by law, take into consideration the social value of commissioning, to encourage commissioning and procurement practices to directly improve conditions in social determinants and reduce health inequalities.[37]

4. Strengthen action and funding for health equity beyond the Health Systems

While a great deal can be done by health systems to advocate for and address health inequalities, the most effective measures to promote health, prevent disease and reduce the unequal distribution of health lie beyond the scope of health systems.[38]

4.1 **Make health inequalities a strategic objective at all levels of government**

Action to reduce health inequalities can only be effective if it is recognised as a cross-sectoral issue that is appropriated by different policy sectors. The WHO Commission of the Social Determinants of Health (2008) and the Marmot Review on 'Fair Societies, Healthy Lives' (2010)[39] in the UK found that measures that contribute to, for example, giving children the best start in life, ensuring a healthy standard of living for all, creating fairer employment conditions all and creating sustainable communities, would have the biggest impact on reducing health inequalities. This means the finance, education, employment and environment sectors must also consider the reduction of health inequalities as a priority, and engage

[36] Institute of Health Equity and WMA. Doctors for Health Equity. 2016 http://www.instituteofhealthequity.org/Content/FileManager/wma-ihe-report -doctors-for-health-equity-2016.pdf

[37] ibid

[38] The most effective public health actions are those that that lie beyond the scope of health care systems and change the context of individual behaviour. The WHO's health impact pyramid reflects how addressing socio-economic factors and interventions that change the context for individual behaviour are generally the most effective public health actions. See: Frieden, T. A Framework for Public Health Action: The Health Impact Pyramid. Am J Public Health. 2010 April; 100(4): 590-595

[39] http://www.local.gov.uk/health/-/journal_content/56/10180/3510094/ARTICLE

with the health sector to determine and monitor effective courses of action. This entails inter-sectoral collaboration and putting the concept of Health in All Policies (HIAP) into practice.

There is great scope for improvement in linking agendas across sectors. There are many inspiring examples in EU Member States of how these concepts can be put into practice, along the lines of the WHO Europe Health 2020 Strategy.[40]

Health inequalities as a strategic objective

In Scotland and Wales devolved central governments have established overriding strategic objectives that both incorporate and contribute to reducing health inequalities. Scotland and Wales also have specific strategies on health inequalities that call for collaboration between relevant sectors at the national and the local level.[41]

In Finland, there are multi-sectoral 'health and well-being' groups at the supra-regional, the regional and the municipal level that bring together all actors responsible for promoting health and well-being, which have been given the statutory task of processing and considering information on socio-economic differences in health and, on the basis of this information, engaging in cross-sectoral co-operation in health.[42]

The work of the WHO Commission on the Social Determinants of Health (2005-2008) has inspired a number of EU Member States (UK[43], Sweden, Denmark[44], Slovenia, Poland, Italy[45]) that have completed or are undertaking similar processes at a national and subnational level, to investigate the specific factors driving health inequalities in their countries or localities, and to determine effective levers and actions for change.

Commission for a Socially Sustainable Malmö

In 2010 Malmö City Executive Board appointed a commission to propose actions to reduce health inequities in the city by making the social determinants of health more equitable. The Commission was led by Professor Sir Michael Marmot. Its Final Report (Dec 2013) contains two overarching

[40] The WHO Europe Health 2020 health policy framework recognizes that governments can achieve real improvements in health if they work across government to fulfil two linked strategic objectives: to improve health for all and reduce health inequalities; to improve leadership and participatory governance for health by supporting action across government and society. See: http://www.euro.who.int/en/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being

[41] See: Stegeman,I and Kuipers Y. Health Equity and Regional Development in the EU. Applying EU Structural Funds. Equity Action. 2013

[42] Ibid

[43] See 'Fair Society Healthy Lives' report: https://www.instituteofhealthequity.org/projects/fair-society-healthy-lives-the-marmot-review

[44] See : http://ec.europa.eu/health/social_determinants/docs/ev_20120619_co12.pdf

[45] See : http://ec.europa.eu/health/social_determinants/docs/ev_20151117_co06_en.pdf

recommendations: firstly, that the City of Malmö establishes a social investment policy that can reduce the differences in living conditions and make societal systems more equitable. Secondly, that changes take place to the processes that these systems are part of through the creation of knowledge alliances, co-operation on equal terms between researchers and stakeholders from, for example, the public sector, the voluntary sector and the business community, and a democratisation of management. The latter also involves the need for continuous monitoring of how inequality and segregation develop in Malmö. The Commission's two overarching recommendations cover a total of 24 objectives and 72 actions, divided into six domains: improving conditions in childhood and adolescence; residential environment and urban planning; education; income and work; health care as well as transformed processes for sustainable development.[46]

The National Commission for equity in health in Sweden was established in 2015 with a remit until 2017 to close gaps in health status, in the face of increasing and persistent inequalities. It will be a knowledge platform for action building on global principles, including the WHO Charter for Health Promotion and the UN Sustainable Development Goals, and will take into account learning from other national and European reviews.

4.2 **Encourage cooperation between sectors by adapting approaches to funding**

Sectors can be encouraged to cooperate for health equity if governments change traditional ways of funding and encourage sectors to share funding to achieve shared priorities or implement shared programmes.

Programme rather than sector-based funding for health inequalities

In Slovenia, inter-sectoral action is still under development; cooperation between sectors is a novelty and as yet not a generally accepted practice. This is mainly a consequence of the long-term operation of the state administration within the framework of individual sectors that were often competitors when acquiring funds from the state budget. Only now, when it is becoming increasingly clear that funds must be provided for programmes and not for administrative offices, cooperation is easier because programmes are interwoven and co-dependent. Slovenia has already made the first steps in the right direction in this area when the programme-based distribution of budget funds was first implemented in 2009.

In the Netherlands, the government invested in total 70 million euros in a programme *healthy in…* to tackle health inequalities in 164 disadvantaged communities in cities as well as in rural areas, for the period of 2014-2017. Their approach is that every community is different, has their own needs and that solutions should be demand driven. Local government in close cooperation with stakeholders from various sectors (education, employment, housing etc.) and with the participation of vulnerable, local people themselves decide how best to invest this money so that it contributes to more health equity and wellbeing. www.gezondin.nu

[46] See: http://malmo.se/Kommun--politik/Socialt-hallbart-Malmo/Kommission-for-ett-socialt-hallbart-Malmo/Commission-for-a-Socially-Sustainable-Malmoe-in-English.html

4.3 **Encourage governments to legislate for health and health equity**

The WHO's health impact pyramid[47] reflects how addressing socio-economic factors and interventions that change the context for individual behaviour (e.g. clean water, safe roads) are generally the most effective public health actions, because they reach broader segments of society and require less individual effort. Governments should therefore consider evidence-based measures such as adopting smoke free legislation, minimum unit pricing (MUP) for alcohol, sugar taxes or subsidies for fruits and vegetables to prevent ill health across the population. Often such measures have the biggest impact on lower socio-economic groups, who are the most price-sensitive. In cases where governments cannot take such measures due to internal market rules, they should be considered public health measures. The European Commission should accept them as such and actively support them.

4.4 **Strengthen health information systems and policy monitoring for health equity**

A considerable amount of data is available on health inequalities in the EU, but there are huge variations in the extent to which relevant data is collected and knowledge is applied within and between Member States. Although most member states have national level data on health inequalities via, at least, health and social data collected through EU level surveys (e.g. European Statistics of Income and Living Conditions [EU-SILC], the European Health Interview Survey [EHIS] and the European Core health Indicators [ECHI]), this data is not being collected and presented on a systematic basis. In some countries it is only possible to correlate health and socio-economic data at the more generalised community level. The European Commission is currently proposing merging work on seven social surveys for better and quicker data harmonisation. [48] This should lead to more comparable data to measure health inequalities that can be used as a central indicator to measure trends resulting from policy measures within and between EU Member States.

4.5 **Evaluate more policies and programmes for impact on health equity**

Evaluation of policies and programmes is critical to measure if and what kinds of universal and selective measures most effectively improve the health of those facing the greatest disadvantage. Yet there are many complexities around evaluating policies and measures' impact on health inequalities, relating to the availability of data, the time it takes for outcomes to become evident and the difficulty of isolating causal relationships. As a result, activities are patchy and variable.[49] There are, for example, a limited number of published studies of health related interventions that focus on equity or the distribution of impacts within the population, and few interventions have been evaluated for their effectiveness in low socio-economic groups.[50] [51] There are also very few societal-level interventions looking at the effects on health

[47] Frieden, T. A Framework for Public Health Action: The Health Impact Pyramid. Am J Public Health. 2010 April; 100(4): 590-595

[48] European Commission – Press Release, Towards Better Social Statistics for a Social Europe, http://europa.eu/rapid/press-release_IP-16-2867_en.htm

[49] JA-CHRODIS. Health Promotion and Primary Prevention in 14 EU Countries. A comparative overview of key policies, approaches, gaps and needs. 2015. http://www.chrodis.eu/wp-content/uploads/2015/07/FinalFinalSummaryofWP5CountryReports.pdf

[50] WHO Europe, Alcohol and inequities. Guidance for addressing inequalities in alcohol-related harm. 2014

[51] WHO Europe. Obesity and inequities. Guidance for addressing inequities in overweight and obesity. 2014

inequalities. [52] There is a need for longitudinal studies and for more sources of data (through e.g. collaboration with commercial sector) to get a better understanding of trends in relation to health inequalities.

5. Conclusions – The role of the EU

5.1 Levels of health equity in a society are an important indicator not only of how health systems are performing, but of whether the EU is achieving its stated aims of promoting peace and its values, including respect for human dignity, equality, justice and solidarity as well as the well-being of its peoples.

5.2 While we have more insight than ever into what needs to be done to tackle health inequalities, and action is being taken across the EU at local, regional and national level, it has in most cases not been enough to make sufficient difference. Greater and more consistent efforts are urgently needed to apply and shift conceptual knowledge and to reform structures, to implement the kinds of actions within health systems and beyond that help ensure that good health is not simply a prerogative of the well-off, but of everyone.

5.3 At EU level this means that all stakeholders, including the Member States, EU Commission and Parliaments, must **counter resistance to change to ensure that greater social and health equity become explicit priorities** across relevant policies and programmes.

The EU should make better use of the policy and funding mechanisms that it has available to it to achieve real breakthroughs in tackling health inequalities. It can for example harmonise existing Health System Performance Analysis (HSPA) tools and agree on common indicators and methodologies to assess national healthcare systems performances. Health inequalities must be included as a central indicator. The outcomes of these assessments can serve as an objective benchmark for health systems and enable them to compare good practices.

How EU Member States are preforming in relation to health systems and on delivering health equity should be core to the annual European Semester process. Where needed, the EU should issue Country Specific Recommendations on this topic, and engage in dialogue with EU Member States on how they can improve. Public financing, including European Structural and Investment Funds (ESIF) and Strategic Funds for Investment (EFSI), can and should be applied to contribute to the goal of delivering greater health equity.

The potential EU Pillar on Social Rights could also help to strengthen the health and social dimension of the EU and to reducing health inequalities within and between EU Member States. It must, however, embrace a '(health) equity lens' and contribute to a more social and sustainable approach, including social investments, cross-sector cooperation and proportionate universal services sensitive to vulnerable

[52] Bambra C et al. How effective are interventions at reducing socioeconomic inequalities in obesity among children and adults? Two systematic reviews. Public Health Research, 2015.

groups.
It is in these ways that the EU can fulfil its duty of protecting health and making a measurable contribution to promoting equality, solidarity and the well-being of its people.

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-Eurocarers
-European Association of Service Providers for Persons with Disabilities
-European Community of Consumer Cooperatives
-European Federation for Complementary and Alternative Medicine
-European Federation of Nurses
-International Federation for Spina Bifida and Hydrocephalus
-European Heart Network
-European Public Health Alliance
-Equality for lesbian, gay, bisexual,, trans and intersex people in Europe (ILGA-Europe)
-Platform for International Cooperation on Undocumented Migrants

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