



# **MOVING FORWARD EQUITY IN HEALTH:**

## **MONITORING SOCIAL DETERMINANTS OF HEALTH AND THE REDUCTION OF HEALTH INEQUALITIES**

An independent expert report commissioned through the  
Spanish Presidency of the EU

Discussion draft for the 21 April 2010 Experts' Conference "Moving Forward Equity in Health"

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#### Comments

Comments are welcome on this draft report. Please send them to Daniel Catalán, Ministry of Health and Social Policy, Spain, eu2010\_equality@msps.es by 30 April 2010.

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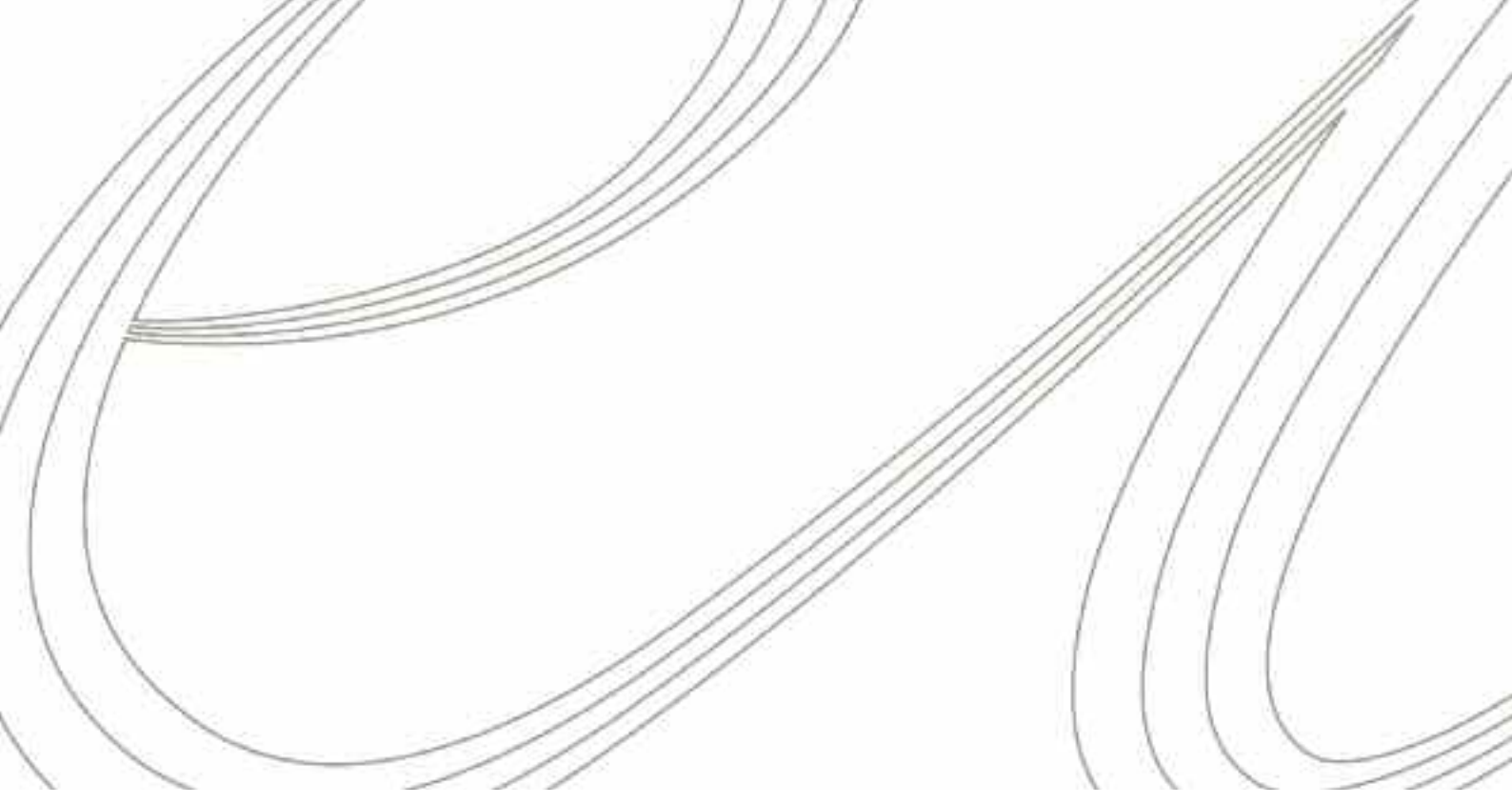
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## ACRONYM LIST

ADL	Activities of Daily Living
AGE	AGE Platform Europe (European network of associations for persons aged 50+)
BHPS	British Household Panel Survey
BMC PUBLIC HEALTH	BioMed Central Public Health British Journal
BMI	Body Mass Index
BRIC	Brazil, Russia, India and China
CAHTAR	Catalan Agency for Health Technology Assessment and Research (Agencia de Evaluación de Tecnología e Investigación Médicas de Cataluña)
CAPS	Cooperation and Help for Health, Complutense University of Madrid (Cooperación y Ayuda para la Salud, Universidad Complutense de Madrid)
CAPS-FJ	Bofill reports on inequalities in health in Catalonia published in 2003 and 2005
CHILD	Child Health Indicators of Life Development
CHIP	Child Health and Illness Profile
CIESIN	Center for International Earth Science Information Network (Earth Institute, Columbia University)
COM/2009/567	Communication from the Commission
CRESIB	Barcelona Centre for International Health Research (Centro de Investigación en Salud Internacional Barcelona)
CSDH	WHO Commission on Social Determinants of Health
DFID	UK Department for International Development
DG	Directorate General
DQAF	Data Quality Assessment Framework
EC	European Community
ECDC	European Centre for Disease Control
ECDKN	Early Child Development Knowledge Network
ECHIM	European Community Health Indicators Monitoring Project
ECHIS	European Core Health Interview Survey
ECHP	European Community Household Panel
ECOSOC	United Nations Economic and Social Council
EE	Eastern Europe
EEA	European Economic Area
EFC	European Foundation Centre
EHEMU	European Health Expectancy Monitoring Unit
ENP	European Neighbourhood Policy
EPGH	European Partnership for Global Health
ESS	European Social Survey
EU	European Union
EU15	Countries belonging to the EU before May 2004
EU27	Countries belonging to the EU after January 2007
EU-LFS	European Union Labour Force Survey
EUR	Euro, European Monetary Unit
EUR/R(52)/R7	WHO Regional Committee for Europe Resolution
EUROMOD	Integrated microsimulation model of the tax-benefit systems in the fifteen (pre-2004) EU Member States
EUROTHINE	Tackling Health Inequalities in Europe Project
EU-SILC	European Union Survey on Income and Living Conditions
FAO	Food and Agriculture Organization
FAS	Family Affluence Scale
GAVI	Global Alliance for Vaccines and Immunisation
GDDS	General Data Dissemination System
GDP	Gross Domestic Product
GFATM	Global Fund to Fight AIDS, Tuberculosis and Malaria
GHI	Global Health Initiative
GNI	Gross National Income
GP	General Practitioner
H8	Health Eight, informal group of eight health-related organisations
HBSC	Health Behaviour in School-aged Children
HFA	Health for All
HFA-DB	European Health for All Database
HIA	Health Impact Assessment
HiAP	Health in All Policies
HIs	Health Inequalities
HIS/HES	Health Interview Survey/ Health Examination Survey
HIV	Human Immunodeficiency Virus
HLY	Healthy Life Years
HMN	Health Metrics Network

Hn	Health net Company
HSE	UK Health and Safety Executive
IADL	Instrumental Activities of Daily Living Scale
IFLS	Indonesian Family Life survey
IHP+	International Health Partnership + related activities
ILO	UN International Labour Organization
IMF	International Monetary Fund
IMIM	Municipal Institute for Medical Research (Instituto Municipal de Investigación Médica Hospital del Mar de Barcelona)
IMR	Infant Mortality Rate
IOM	International Organization for Migration
KIDSCREEN	European Commission Project (Family of questionnaires to evaluate health among children and adolescents)
LE	Life Expectancy
LEB	Life Expectancy at Birth
LFS	Labour Force Survey
M.D	Medical Doctor
MDG	Millennium Development Goal
MDGs	Millennium Development Goals
MEDA (Countries)	The partner states of the EU in the Mediterranean (Algeria, Egypt, Israel, Jordan, Lebanon, Malta, Morocco, Palestinian Authority, Syria, Tunisia, and Turkey)
MEDEA	Spanish Work training project on Dual Methodology: Enterprise-Classroom
MHN INC	Managed HealthCare Northwest, Inc.
MS	Member States
NEWS	The Nordic Experience: Welfare States and Public Health Project
NGO	Nongovernmental Organisation
NS-SEC	National Statistics Socio-Economic Classification
NUTS	Nomenclature of Territorial Units for Statistics
ODA	Overseas Development Assistance
OECD	Organisation for Economic Co-operation and Development
OECD-DAC	OECD's Development Assistance Committee
OHCHR/ UNOHCHR	UN Office of the High Commissioner for Human Rights
OMC	Open Method of Coordination
ORT	Oral Rehydration Therapy
PAHO	Pan American Health Organization
PIRLS	Progress in International Reading Literacy Study
PISA	Programme for International Student Assessment
PLoS MEDICINE	Medicine Journal
PPHC	Priority Public Health Conditions
PSELL	Socio-Economic Panel "Living in Luxembourg"
SDH	Social Determinants of Health
SDHI	Social Determinants and Health Inequalities
SDS	Sustainable Development Strategy
SEKN	Social Exclusion Knowledge Network
SES	Socioeconomic Status
SHARE	Survey of Health, Ageing and Retirement in Europe
SOEP	German Socio-Economic Panel Study
Soc Sci Med	Social Science & Medicine
SPF-I	UN Social Protection Floor Initiative
SP-MIG	Committee of Experts on mobility, migration and access to health care
SP-SSM	Committee of experts on health services in a multicultural society
SWAp	Sector Wide Approach (in Health)
TACIS/MEDA	European cooperation programmes
TB	Tuberculosis
TIMMS	Trends in International Mathematics and Science Study
UFMR	Under-five mortality rate
UK	United Kingdom
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNASUR	Union of South American Nations (Unión de Naciones Suramericanas)
UNESCO	United Nations Educational, Scientific and Cultural Organization
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
US	United States
WE	Western Europe
WE&EE	Western and Eastern Europe
WHA	World Health Assembly
WHO	World Health Organization

## KEY TERMS USED IN THE REPORT

### **Health inequalities (and inequalities in health)**

Taken literally, the term "health inequalities" means differences in health status between individuals or groups, as measured by, for example, life expectancy, mortality or disease. What we are interested in are differences in health that arise not from chance or from the decision of the individual but from avoidable differences in social, economic and environmental variables (e.g. living and working conditions, education, occupation, income, access to quality health care, disease prevention and health promotion services) that are largely beyond individual control and that can be addressed by public policy. Therefore, health inequalities here refer to avoidable and unfair differences in health that are strongly influenced by the actions of governments, stakeholders and communities, and that can be addressed by public policy (European Commission, 2009).

### **Health equity (and equity in health)**

Equity is the absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically (WHO, 2009a). "Health equity" or "equity in health" implies that ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically, that no one should be disadvantaged from achieving this potential (WHO, 2009b). Therefore, health equity is the absence of health inequalities (applying the aforementioned definition).

### **Health system**

As stated in The Tallinn Charter: health systems for health and wealth, "a health system is the ensemble of all public and private organisations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health" (WHO Regional Office for Europe, 2008).

### **Vulnerable groups (or socially disadvantaged groups)**

Vulnerable groups suffer a markedly greater burden of mortality and disease. They may include socially excluded migrant groups and ethnic minorities, people living in deprived urban and rural areas and in poverty, the long-term unemployed, those informally employed, seasonal/daily workers and subsistence farmers, those further from the labour market, jobless households, the homeless, the disabled, those suffering from mental or chronic illnesses, elderly pensioners on minimum pensions, and single parents). For example, the Roma can expect to live 10 years less than the majority population in some countries (European Commission, 2009).



### **Social determinants of health**

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices (WHO, 2009c).

### **Social exclusion**

Exclusion consists of dynamic, multidimensional processes driven by unequal power relationships interacting across four main dimensions (economic, political, social and cultural) and at different levels including individual, household, group, community, country and global levels. It results in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities (SEKN, 2008). Social exclusion distances people from employment, income and education and training opportunities, as well as from social and community networks and activities. Socially excluded persons have little access to power and decision-making bodies and thus often feel powerless and unable to take control over the decisions that affect their day-to-day lives (European Commission, 2004).

### **Social gradient in health**

The term social gradient in health refers to the stepwise or linear decrease in health that comes with decreasing social position (Marmot, 2004). The impact of the social gradient is sometimes expressed as a shortfall in health, that is, the number of lives that would have been saved if all groups in society had the same high level of health as the most advantaged group (Whitehead M, Dahlgren G, 2006).

### **Roma**

Drawing from the Council of Europe's glossary on Roma and Travellers, in this report the encompassing term Roma refers to various communities that self-identify as Roma and others (such as Ashkali) that resemble Roma in certain aspects but insist on their ethnic difference (Council of Europe, 2006).

### **Migrant**

At the international level, no universally accepted definition of migrant exists. The term migrant is usually understood to cover all cases where the decision to migrate is taken freely by the individual concerned for reasons of "personal convenience" and without the intervention of an external compelling factor. This term therefore applies to persons and family members moving to another country or region to better their material or social conditions and to improve prospects for themselves or their family (IOM, 2004).

### **National minority**

In keeping with Recommendation 1201 (1993) of the Parliamentary Assembly of the Council of Europe, the expression "national minority" refers to a group of persons in a State who: reside in the territory of that State and are citizens thereof; maintain longstanding, firm and lasting ties with that State; display distinctive ethnic, cultural, religious or linguistic characteristics; are sufficiently representative, although smaller in number than the rest of the population of that State or of a region of that State; and are motivated by a concern to preserve together that which constitutes their common identity, including their culture, their traditions, their religion or their language (Council of Europe, 1993).

### **Resilience**

Resilience is the dynamic process of adapting well in the face of adversity, trauma, tragedy, threats, or even significant sources of stress. Therefore, it is a two-dimensional construct concerning to two questions: 1/ Is there any adversity, stress, risk or disadvantage present in the life of the person? 2/ Is the person doing well despite of it? (Luthar & Cicchetti, 2000; Luthar, Cicchetti & Becker, 2000; Masten y Powell, 2003).



# I. INTRODUCTION: MOVING FORWARD EQUITY IN HEALTH

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## Equity and health in Europe

Europe can and must demonstrate the potential of policies in terms of their gains for equity and health. Today, we realize that equity is inseparable from the health of the population and that both are required for efficient and sustainable development, as well as to guarantee well-being. The health sector can make a decisive contribution to ensuring that equity and health together constitute an essential ingredient of many government policies.

The citizens of the European Union (EU) live on average for longer and with better health than previous generations thanks to advances in the living conditions of the population and greater access to goods and services. Despite this, the existence of great gaps in health has been detected in Europe, both between different countries and within each country, conditioned by the social determinants of health. The lower down on the social scale, the worse the health outcomes typically are throughout the population. Furthermore, there are especially vulnerable groups. The current economic crisis and rising unemployment, together with the associated uncertainty, are making this situation even more acute.

Most health problems and most of the main causes of premature death are conditioned by social factors such as education, employment and working conditions, income, environment, local area and social exclusion, which affect the population unequally and are largely outside of the remit of the health sector. Dealing adequately with the social determinants of health and working to achieve health equity are among the greatest challenges facing public health in the 21st century.

## Setting the agenda: scaling up action on social determinants of health

Attaining equity in health by taking action on the social determinants of health has increased its profile as a priority on the international agenda, both for the EU and for the World Health Organization (WHO).

WHO has driven forward policies to promote equity over the past twenty years. In 2005, it set up the Commission on Social Determinants of Health, the final report of which "Closing the gap in a generation", published in 2008, constituted a notable advance in legitimizing the study of health inequalities and the relationship between policy and health. In May 2009, the 62nd World Health Assembly adopted Resolution WHA62.14, through which Member States are clearly called to take action to "reduce health inequalities through action on the social determinants of health".

The EU has an Expert Group on Social Determinants and Health Inequalities, whose purpose is to facilitate the exchange of good practices in reducing health inequalities. Moreover, as described in the next chapter, the particular initiatives of several EU Presidencies have contributed in recent years to giving priority to and developing equity in health on the European agenda. Recently, in October 2009, the European Commission communication "Solidarity in Health: Reducing Health Inequalities in the EU" was launched, constituting a great step in the commitment of Member States to equity in health.

In this context, the coming into force of the new Lisbon Treaty represents a real boost in terms of advancing equal opportunities in health at European level. The Treaty adopts a stance of utmost respect towards the health and well-being of society, and a multi-sectoral approach to health (Health in All Policies). If European societies wish to defend their values of social justice, solidarity and socioeconomic cohesion, as stated in various European treaties, it is crucial to ensure equal opportunities in health for all.

This favorable international and European scenario represents a real opportunity to advance equity in health on the political agenda. This is the final objective of the priority of the Ministry of Health and Social Policy for the Spanish Presidency of the EU in 2010: "Innovation in Public Health: monitoring the social determinants of health and the reduction of health inequalities".

## **Equity and health in all policies: information systems**

To understand the impacts of public policies, whether regarding health or other areas, on health and well-being of the population, adequate information is required not only on their effectiveness (how they are working) but also in terms of equity (for whom they are working). Such information is necessary to design, evaluate, redefine and redirect interventions.

Adequate and timely information is a key element for action in public health. The lack of indicators on the impact of different policies on social determinants of health and their effects, along with a lack of timely and comparable data within each country and among the countries of the EU, constitutes an obstacle to the gain in health and equity.

In the EU, differences exist concerning the level of development of policy evaluation and information systems. On the road towards equity as a cornerstone of European policies, and in monitoring the impact of these policies on health inequalities, we face the challenge of developing homogenous indicators and information systems that enable comparisons between countries.

The present report aims to highlight the most relevant aspects of work carried out in the area of health intelligence in relation to the monitoring of social determinants of health and the reduction of health inequalities. It also aims to

encourage reflection on the next steps to be taken to make progress in this area.

The document reviews the current systems for monitoring social determinants of health and the reduction of health inequalities in a routine manner. It considers methodological aspects, such as the disaggregation of data, the health surveys of the EU, the selection of objectives and indicators of results, and evaluation of the impact on health and health equity of public policies. It then makes a further analysis of three areas (childhood, employment conditions, and social exclusion) particularly relevant to the current European context. Last of all, the document focuses on aspects related to opportunities for the EU to contribute to the monitoring of social determinants of health and the reduction of health inequalities worldwide, as well as reflecting on the capacity of the EU to influence global health policies.

This report has been produced through a participative process, with the collaboration of multiple national and international experts, during the October 2009 to February 2010 period. It is an open document that will be enriched with the contributions of experts and politicians during the events scheduled in the agenda of the EU Spanish Presidency 2010.

## **Considering the future**

For the purposes of effectiveness and sustainability, health policy and those responsible for it must move on from a biomedical paradigm focused on health problems that places the main responsibility on the health sector, to another model based on the social determinants of health. This requires a high degree of political commitment from all the areas of government, as well as citizen participation. That is why, as an initial step, it is necessary to make progress in developing monitoring systems that enable the gain in health of public policies to be quantified, broadening the area and the analysis of public health monitoring, and promoting the management of population-level information in the short and medium term, enabling the right political decisions to be made.

Improving the overall health status of the population by reducing health inequalities has positive repercussions for society as a whole, as well as for development and the economy. More egalitarian societies become better performing societies in every sense. Traditionally, the development of a country is measured in economic terms, using indicators such as per capita income or Gross Domestic Product. However, it is necessary to adopt a broader perspective that includes demographic, social and cultural indicators and evaluates social progress by associating indicators of well-being and health, sustainability and equity. The monitoring of social determinants is important not only as a predictive indicator of health but also as a target in itself for policies that must achieve economic efficiency, ensuring sustainable development based on social justice.

In this context, the role of the health sector is not to focus directly on the transformation of social determinants but rather to take a role of shared leadership in an inter-sectoral approach to health, raising awareness and advocating action in other sectors in order to implement policies geared towards equity and health, and in order to act together in reducing health inequalities. The key to this lies in integration and in working with other government sectors to synergize their objectives in a way that optimizes health and equity.

In order to ensure that the actions of the EU government bodies find their way onto the media and political agenda of Member States, equity and health policies require citizen participation and public debate. This crucial challenge of involving citizens also requires the structuring of effective participation channels and exemplary democratic transparency, among other factors. The perception of proximity and benefit in respect of EU decisions can generate a favorable social and political environment for incorporating health and equity in all European policies.

Beyond the influence that health policies may have on other political sectors, we must not forget that within the health system itself there is room for improvement in order to make progress towards health equity, promoting the redistribution of opportunities in health, basing the provision of services on the need for care rather than on demand, and improving the accessibility, quality, and effectiveness of health care services, taking into account the criterion of social equity.

The Spanish contribution to the European Presidency is merely one component of the obstinate action for public health; there is still a long way to go and each action must pave the way for subsequent ones. That is why we must continue to work within health services and in all of the areas where public health has a potential influence, tirelessly pushing for equity in our societies and the highest attainable level of health for all people.

The references for the Introduction are included in the overarching suggested key reading included in Annex V.



## II. BACKGROUND: PUTTING SOCIAL DETERMINANTS AND HEALTH EQUITY ON THE EU AGENDA

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While giving a brief introduction to the concept of health policy particularly with regard to social determinants of health equity, this chapter describes how health, health determinants and health equity have been introduced on the EU agenda. This is seen on the one hand as a reflection of the changes in the public health discourse during recent decades, in particular within WHO, and, on the other hand, as a result of the considerable attention paid to the issue by the different players in the EU arena.

### Introduction: on the nature and characteristics of health policy

In principle, health policy should not be very different from other fields of public policy in terms of either research or action (Wilensky et al, 1987). It deals with goals and means, policy environments and instruments, processes and styles of decision-making, implementation and assessment. It deals with institutions, political power and influence, people and professionals, at different levels from local to global.

What is specific, however, to health policy, is its objective, which makes the field extremely complex. The objective may be either health itself, or in public health terms, highest possible level and equitable distribution of health in the population. On the other hand, very often the expression health policy is used predominantly to mean issues related to the health care system.

Both approaches are legitimate but very different. If our starting point is the level and distribution of health in the population, our policy concerns focus on determinants of ill health. If we focus on the health care system, we are mainly dealing with the consequences of ill health. The determinants of health may be social, physical, or biological. Dealing with the consequences of ill health necessarily involves taking into account social factors influencing access to care, related costs and the required support. Seen in this light, both maintaining health and restoring it must be seen in a social context. Social determinants of health lie across a number of sectors of public policy. Therefore, serious attempts to improve public health go far beyond sectoral policies to encompass very broad inter-sectoral ones.

Policy processes are always driven by values and power, hopefully informed by evidence. The key value issue here is equity. Equity means fairness or social justice, however defined. In practice it means striving to level off avoidable differences in health between socioeconomic or other groupings of society. There is no country in Europe where considerable differences of this kind do not exist, taking the form of a social gradient.

For experts in public health it is self-evident that only through concerted efforts across different sectors can the health challenges of today and tomorrow be tackled successfully. However, health policy makers in many countries of Europe do not seem to grasp this concept clearly. Much of the thinking and action in many Ministries of Health is still narrowly curative and geared solely towards the health care system.

## **Policies tackling determinants of health**

The range of social determinants of health is very broad. Some of the most important include general living conditions, such as work, housing and standard of living. The role of education is crucial. Food and nutrition are a prerequisite of life, and both their quantity and quality are important from the health point of view. Environmental issues of classical nature (water and sanitation) still prevail in some parts of Europe, but more emphasis in most countries must be attached to pollution from various sources, air, noise, and chemical exposures. Traffic and transport influence health and safety in many ways. The whole psycho-social environment, including patterns of coping with stress, for instance through smoking and substance abuse, poses major challenges in most highly developed countries.

What is special in health policies tackling social determinants of health of this kind is that there are usually multiple actors in each of the chosen target areas. To work through the issues together with relevant stakeholders requires many skills in building confidence, carrying out analytical work and offering proposals for problem-solving that are both feasible and acceptable. Such exercises can be called health diplomacy. Since negotiation processes take time and effort, one cannot proceed on all fronts simultaneously but rather one must focus on priorities based on the public health situation at hand.

Another feature is that the time frames are long. It takes usually several years from policy decisions to visible outcomes, which may be politically problematic. Indicators of process and progress may be useful. Sometimes specific instruments without considerable time lags can be used; these include price policy measures concerning tobacco or alcohol.

The question of levels of action depends on the issues at hand. Many inter-sectoral issues can be handled below a national level, for instance at local government level. This is common in Europe with regard to housing and some environmental health problems. Very often the key level is decision-making by a national government. However, public health has become increasingly international in

nature, or even supranational, as in the case of the EU. The key fora internationally are WHO and the EU. The division of power between actors is not always clear-cut. This calls for the clarification of roles and the involvement of stakeholders at different levels. It is a common experience that policies are easier to design and agree upon than to implement.

This necessitates a particular emphasis not only on the preparatory phase of policy-making, including the anticipation of possible constraints or obstacles, but also on the careful planning of the stages of implementation and follow-up. There is constant risk in policy development at all levels that policies are adopted for rhetoric but not for reality. The only way out is to ensure effective mechanisms for implementation and follow-up. In any case, the assessment of an adopted policy cannot be a one-off exercise. By necessity, built-in monitoring is required to make sure that the policy process is on the right track or verify whether modifications are needed.

## **Health inequalities on the European Union Agenda**

Before the Maastricht Treaty (1992), which provided for specific competence for public health at EU level, there were a number of important health initiatives on issues including but not limited to: health care for citizens moving from one part of the Community to another, emergency health care for people on holiday, mutual recognition of professional qualifications, health and safety at work legislation, and action against cancer.

The Amsterdam Treaty (1997) strengthened the Union's action on health by creating a legal basis for harmonising the legislation of the Member States in relation to blood, human tissues and organs. The requirement to guarantee a high level of health protection across all policies and activities, a unique legal measure (even in a global comparison) was included in the Amsterdam Treaty. It has been considered as an effort to restore the trust of citizens in the Union after the so-called mad cow disease crisis (Koivusalo, 2006). The Lisbon Treaty (2007) increased somewhat the legal basis for harmonisation, strengthened the role of the Union in the coordination of Member State's public health activities, and clarified the mandate of Member States in the management and financing of health care services.

Over the past decade the issue of equity in health has been firmly secured on the European Union's agenda by the European Commission and the Council, both in terms of political debate and the norms adopted, and even values have received attention. At the Barcelona Summit of the

European Union in 2000, Heads of States adopted Conclusions. These called for all health systems of all European Union countries to be based on the core values and principles of universality (services for all), equity (in access), solidarity (in funding) and quality (European Council, 2002). These values were restated in 2006 by health ministers (Council of the European Union, 2006a).

The high political commitment to health equity of the Commission and the Council is essential for advancing work in this area, and this commitment has been expressed through a still-ongoing political dialogue. The dialogue can be considered relatively intensive, both in the health policy sphere but also in other policy areas, such as social policy and workplace health. It has produced rich material that draws from a wide range of sources. Due to space constraints, it is not possible to describe in detail in this chapter the reciprocal process and dialogue on health inequality between the Commission and the Council beyond its general features. On one hand, Commission actions often result in a response by the Council, i.e. Member States, in the form of a Resolution or Council Conclusions, where the Member States give their feedback to the Commission's initiative and identify what they see as feasible or, possibly, complementary or alternative approaches. On the other hand, an informal initiative by the EU Presidency, a Member State presiding over the Council, in the form of a Conference and a Publication on a particular issue, and consequent Council Conclusions, may result respectively in Commission action; the Commission alone has the right of initiative in the European Union. A number of EU Presidencies have proposed a political reaction in the Health Council in the form of Council Conclusions that either directly address health equity or focus on a health theme where relevance to health equity is stressed.

## Health inequalities and EU Presidency agendas

The role of the EU Presidencies has been central in bringing health equity onto the EU Agenda. A very important initial boost to this process was given by the Portuguese Presidency of the EU in 2000, which emphasised the role of health determinants in influencing health. During the preparations of the community public health programme, the Presidency drew attention to the importance of acting across Community policy sectors on central health determinants, and thus assuring a high level of health protection across all Community policies (as required by the Amsterdam Treaty). In addition to emphasising essential areas of health and their determinants, health equity was stressed more directly and clearly than it had been previously in this political context: "A key point that cannot be over-emphasised is that ... there are large inequalities in the EU both among Member States' populations and among different population groups in each country... and between the EU Member States and the accession countries..." "All European Countries have substantial differences in health between males and females, socioeconomic groups and

regions. The health disadvantage of socially excluded people, such as migrants, the homeless and the long-term unemployed is particularly striking and seems to occur everywhere, irrespective of the country's wealth" (Portugal MoH).

While this chapter aims to constitute an overall introduction, one detail brought up in connection with the 2000 Portuguese Presidency deserves attention as an important contribution to the European Union health policy discourse. It is generally assumed that changes in population health take place slowly, over time, with a long delay after any intervention. There are interesting findings on life expectancy in the former Soviet Union and Russia that contradict this belief. Life expectancy increased significantly and rapidly during the perestroika years and plummeted after the collapse of the Soviet Union. Despite a slow, continuous increase, life expectancy at birth in Russia has not yet reached the level it was at before the collapse. These changes were originally thought to come mainly from alcohol consumption (Leon D. et al, 1997). During the perestroika period, the government introduced wide restrictions in access to alcohol, which is considered to have caused the rapid increase in life expectancy (Vågerö, 2000). On the other hand, the present understanding is that the decrease of life expectancy after the political change came from an increase in alcohol intake, in addition to a substantive and rapid deterioration of living conditions (Alam, Murthi & Yemtsov, 2005). This dramatic and tragic case constitutes a significant opening for a wider discussion on health determinants and equity in health and needs to be borne in mind in the planning, implementation and evaluation of policy initiatives on population health and equity.

In October 2005 the UK Presidency of the EU organised the summit 'Tackling Health Inequalities – Governing For Health', which was supported by two background documents written by experts. Professor Johan P. Mackenbach sketched out a full picture of health inequalities in Europe in the publication 'Health Inequalities: Europe in Profile'. The central message was that "People with a lower level of education, a lower occupational class, or a lower level of income tend to die at a younger age, and to have a higher prevalence of most types of health problems" (Mackenbach, 2006). Professor Ken Judge and colleagues mapped the policy options of Member States and reflected on related challenges and opportunities in the publication 'Health Inequalities: a Challenge for Europe', which was produced as a part of an EU-funded project on Health Inequalities. This publication highlighted the fight against poverty and social exclusion as crucial for tackling health inequalities. Considerable differences were seen in how Member States had so far responded to the challenge. Only a few of them had put special mechanisms in place to coordinate the implementation of policy on health inequalities and none of them had considered setting explicit goals or targets related to the gradient between socioeconomic position and health status across the whole population (Judge et al, 2006).



During its EU Presidency in 2006, Finland raised 'Health in All Policies' (HiAP) to show the importance of dealing with horizontal, inter-sectoral or interdepartmental issues of relevance for population health, and to illustrate options for how to do so in practice. The Amsterdam Treaty, which came into force in 2006, and its requirement to guarantee a high level of health protection in all EU policies and actions, was the main motivation for the initiative, but it also drew from the long-standing experience of Finland in inter-sectoral policy for health, as well as the increasing emphasis on health as a source of wealth. A couple of main messages emerged from this Presidency priority, among them that health is both a value and an asset, that policies have an effect on health, that health determinants are the mediators between policies and health outcomes and their distribution among population groups, and (importantly) that policies can affect health, health determinants and health equity positively or negatively. Special emphasis was given to the fact that HiAP is feasible and that there are mechanisms and instruments for its implementation. However, it was noted that a deliberate effort was needed to promote HiAP, and that sufficient capacity in the Ministry of Health (which should be the main advocate for HiAP) is essential (Ollila et al, 2006).

Several EU Presidencies have addressed health equity through a focus on the needs of disadvantaged population groups. The Portuguese Presidency of the EU in 2007 addressed health inequalities by focusing on the needs of excluded migrants, who can be disproportionately exposed to threats to health due to processes of social exclusion that cross sectoral divides. The Presidency stressed the importance of health, access to health systems, and addressing health determinants as crucial factors for the integration and well-being of all migrants. A conference on Health and Migration in the European Union was convened and multiple publications, including *Health and Migration in the European Union: Better Health for All in an Inclusive Society* (Alexandre Fernandes & Pereira Miguel, 2008), were released. During the French Presidency of the EU in 2008, the first EU Roma Summit was convened, addressing how to scale up action across sectors to improve the living conditions of the Roma population. While not focusing specifically on health, it was among the areas addressed in discussions and a focus on health has subsequently been further integrated in the follow-up to the Summit (including at the first meeting of the EU Platform on Roma Inclusion which was held during the Czech Republic EU Presidency).

## **The Commission as a promoter of equity in health**

The European Union's approach to health has been described in Health Strategies presented by the Commission. One of the main issues emphasised by Commissioner David Byrne in 2004, when initiating the discussions on a new European Union health strategy, was the growing gap between those in good health and those in ill health (Byrne, 2004). After a broad consultation, in 2007 the Commission launched the European Union

Health Strategy 2008-2013. The Strategy is based on shared values, one of which is equity. Reducing health inequalities was considered essential due to differences in health between population groups and Member States. Targeted health promotion and best practice exchange are mentioned as the main measures to address the problem, whereas health equity is not (yet) explicitly included in the section on Health in All Policies (Commission of the European Communities, 2007).

Despite the visibility given to equity in health in recent years, at least in terms of funding mechanisms of the European Union for public health it has not always been self-evident on the agenda but rather it appeared there in a stepwise manner, most probably reflecting trends in the global discourse of public health. The predecessor of the comprehensive health programmes, the Health Promotion Programme (1996-2002), did not contain any explicit reference to health equity though it did include as one of its main actions: "encouraging inter-sectoral and multidisciplinary approaches to health promotion, taking into account the socioeconomic factors and the physical environment necessary for the health of the individual and the community, especially for disadvantaged groups" (European Parliament, 1996).

The Public Health Programme 2002-2007 identifies tackling inequalities as one of the three overarching ways in which it aims to contribute (article 2, 3b) and includes further details under one of its three action stands, Health Determinants: "analysing the situation and developing strategies on social and economic health determinants, in order to identify and combat inequalities in health and to assess the impact of social and economic factors on health" (European Parliament, Council of the European Union, 2002). In the current Health Programme (2008-2013), health equity, or rather health inequalities, is one of the main action strands and is thus upgraded to the company of action against health threats, health promotion and health monitoring and information (European Parliament, Council of the European Union, 2007).

One of the main goals of the European Union Health Programmes has been to produce data, information and tools at two levels: for European Union policy-making and for the benefit of EU Member States and citizens. Major activities on equity in health have been financed through the programmes, and some of them have already finalised and reported on activities. One of the key activities on health equity is a project called Determine, which aims to describe and share good policy practices not only in the sphere of health, but also in other sectors, and provides information on its website (Determine). Other projects focus on specific groups such as children and young people, the elderly, Roma, and migrants; on health issues such as smoking and alcohol; or on settings such as the workplace. The monitoring of health equity, the development of indicators for it, and the presentation of the results are extensively covered by the projects. Health equity-related activities are being funded also from other European Union

funding mechanisms, for example from the employment and social solidarity programme PROGRESS (European Parliament, Council of the European Union, 2006).

A High-Level Group on Health, an advisory group consisting of Senior Civil Servants from the Member States and convened by the Commission, set up an EU expert group on social determinants and health inequalities in March 2006. This expert group provides a forum for the exchange of information and good practice between Member States on social determinants of health and health inequalities. The group has regularly monitored activities on health equity within Europe and has proved to be useful for the exchange of information on the activities of the Member States.

As a culmination of discussions that spanned almost a decade, the Commission published in October 2009 a specific Communication on action for health equity: 'Solidarity in health: Reducing health inequalities in the EU (Commission of the European Communities, 2009a). This communication, which was launched together with a staff working document (Commission of the European Communities, 2009b) describing the impact assessment for the communication that contains relevant background information and data, summarises the European Union's actions for health equity to date, and puts in place a framework for future action. The following areas are being raised as key issues:

- The link between health and wealth: an equitable distribution of health is an essential part of overall social and economic development;
- The improvement of the data, knowledge base and mechanisms for measuring, monitoring, evaluating and reporting;
- A focus on policies in all sectors at all levels;
- Paying attention to the needs of vulnerable groups; and
- Developing the contribution of other EU policies.

## Health equity in other European Union policy areas

Health equity has not only been on the Public Health Agenda of the European Union. The challenge has tackled in other policy areas too. Extensive attention to health equity has been paid in social policy, and health equity is increasingly present in discussions on some horizontal policy areas. Of these, the Lisbon Agenda and the Sustainable Development Policy are discussed below as examples.

Health equity receives perhaps the greatest political visibility and value in the Open Method of Coordination, which is applied to Social Protection and Social Inclusion (social OMC). In this process, which concerns areas that fall within national competence, Member States have agreed to present and discuss their national policies, programmes and interventions in the European arena and compare them

with those of other Member States. Mutual learning and a natural process of harmonisation is expected as a result. National reports are being analysed and discussed by an expert committee, which presents a joint report annually to the European Council's spring meeting, where Heads of State meet. Health equity has received increasing attention in this process, where commonly agreed indicators are established for the monitoring process carried out by Eurostat. An explicit reference to health inequalities and Health in All Policies as a counter-measure was made in the 2008 report (Council of the European Union, 2008). The 2009 report includes a more definite statement on the role of the health system in producing health equity (Council of the European Union, 2009). Likewise, the Commission's draft proposal for the 2010 report (European Commission, 2010) is complemented by an accompanying document that presents a broad analysis of health inequalities with social inequalities as the background.

Health was "upgraded" to the sphere of economic policy in the Lisbon Agenda, which aims to make the EU a competitive economic actor at the global level. It focuses on economic growth, but with greater social cohesion. Healthy life years is currently one of the indicators used to monitor the progress of the Lisbon Agenda in its health dimension, but the Commission has opened a discussion on "whether a sound monitoring of health inequalities indicators would be a useful tool to monitor its (the Lisbon Agenda's) social dimension" (Commission of the European Communities, 2009a).

Although health should play a significant role in the sustainable development process, if not constitute one its cornerstones, it has generally been given surprisingly little emphasis, despite the fact that the objectives of promoting health of the population and sustainable development in many cases fully overlap. The revision of the European Union Sustainable Development Strategy in 2006 was an exception, as it paid significant attention to health and health impacts in general. A particular commitment is made to promote health equity: "Reducing health inequalities within and between Member States by addressing the wider determinants of health and appropriate health promotion and disease prevention strategies. Actions should take into account international cooperation in fora such as the World Health Organization (WHO), the Council of Europe, the OECD and UNESCO." The decision thus interestingly applies the concept of Health in All Policies not only with regard to horizontal action across EU policies, but also to the interaction between global level actors. Also in this domain, there is an ongoing discussion on whether health inequality indicators should be included in the monitoring of progress" (Council of the European Union, 2006b).

An impact analysis is carried out on most important Commission initiatives and health is included as one of the areas for consideration. In principle, this would provide an excellent instrument to look at health and the health equity impact of legislation in areas other than health. According to a recent review, impact analysis focusing on health seems

to be a rather under-used opportunity (Ståhl, 2009).

## WHO and health inequalities

WHO has in many ways provided direction to the European Union and its Member States concerning health equity. Whereas the latter only relatively recently stated the basic values of health systems in the European Council Conclusions and in the Resolution of the Health Council linked with the discussion on patient mobility, a strong value basis was already at the core of operations of WHO, which is the specialised health agency in the UN family. The Constitution of the Organisation, after giving a comprehensive and positive definition of health, states that "The enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being...". Health is not only emphasised as a value but also health equity between countries is raised in the Constitution: "Unequal development in different countries in the promotion of health and control of disease, especially communicable disease, is a common danger."

In 1977, the World Health Assembly resolution WHA30.43 (World Health Assembly 1977) decided that the main social target of governments and WHO in the coming decades should be "the attainment by all the citizens of the world by the year 2000 of a level of health that will permit them to live socially and economically productive lives". Subsequently, in 1979 the World Health Assembly resolution WHA32.30 (World Health Assembly 1979) urged the Member States to define and implement national, regional, and global strategies for attaining the goal of "health for all by the year 2000. In 1981, WHO launched a "Global Strategy for Health for All by the year 2000" (HFA). Health equity was not among the specified objectives. Since then, this has changed and health equity and health determinants have been given a higher profile at global level. For instance, Strategic Objective 7 of the WHO Medium-Term Strategic Plan (2008-2013) is: "To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches" (WHO, 2008a). In parallel, equity and concern for the most vulnerable populations is reflected across the other Objectives. One of the lines of action, where equity has systematically been referred to as one of the main values, is the series of Global Health Promotion Conferences.

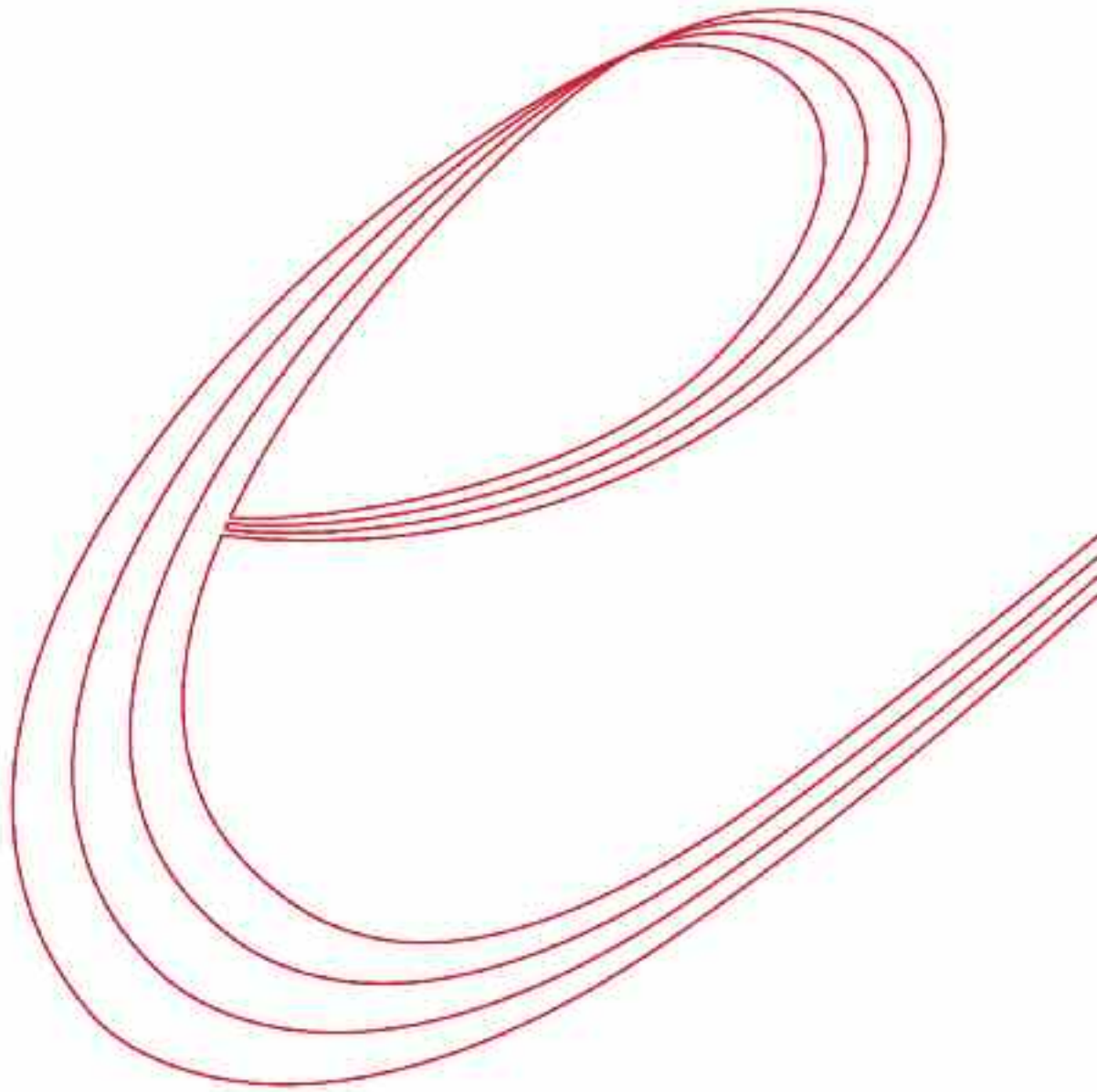
The WHO Regional Office for Europe has a long-standing history of including equity in strategy documents. In the European Regional HFA Strategy, health equity was included since it was set up in 1980 and through the series of three updates, the latest of which was in 2005 (WHO Regional Office for Europe, 1982, 1985, 1999, 2005). The most recent update underlines the value basis (equity, in particular) and includes measurable targets with regard to levelling up the health of the most disadvantaged populations. It is also noteworthy that the first Health Promotion Conference (with equity as an underlying value

as stated above) was an initiative of the WHO Regional Office for Europe in 1984.

Another concrete and visible recent endeavour reflecting WHO's value basis in terms of health equity was introduced at the global level by the late Director-General Lee Jong-wook, who drew attention to the fact that throughout the world, poor people and those from socially disadvantaged groups get sicker and die sooner than people in more privileged social positions. In 2005 Dr Lee launched the Commission on Social Determinants of Health. This Commission collected a massive amount of evidence on the social determinants of health with the support of several worldwide knowledge networks and other initiatives. The Commission's final report was launched in August 2008, and contained three overarching recommendations: to improve daily living conditions; to tackle the inequitable distribution of power, money, and resources; and to measure and understand the problem and assess the impact of action. The World Health Assembly discussed the report in its sixty-second session, recommended actions to the Member States (World Health Assembly, 2009) and requested the Director General to take the work forward and report to the Assembly after three years. Again, in the European Region, action was taken early: in 2002 the regional committee adopted a Resolution on poverty and health (Regional Committee, 2002) and (in cooperation with the Italian Government) designated an office entrusted with supporting Member States to address the social determinants of health.

The WHO Regional Office for Europe also seems to be a forerunner on the issue of wealth from health. Whereas public health (disregarding the area of health care services), and in particular, health promotion enjoyed a strong value basis during the latter half of the 20th century, relatively little emphasis was given to health as a source of wealth. Extensive work has since been done in the Regional Office, partially with the support of and in collaboration with the European Union in order to understand the economic impacts of health both at the societal and individual levels. This was further raised to the political agenda at the Tallinn Conference of Health Systems, organised by the Regional Office for Europe in 2008. The Tallinn Charter connected the value of health and its impact on wealth: "Beyond its intrinsic value, improved health contributes to social well-being through its impact on economic development, competitiveness and productivity. High-performing health systems contribute to economic development and wealth." Likewise: "...today, it is unacceptable that people become poor as a result of ill health". A definite commitment was made to equity: "We, the Member States, commit ourselves to... "promoting shared values of solidarity, equity and participation through health policies, resource allocation and other actions, ensuring due attention is paid to the needs of the poor and other vulnerable groups..." (WHO Regional Office for Europe, 2008).

## Considerations for moving forward



The public health discourse has changed remarkably at the global level since the 1990s (McQueen et al, 2007). Attention has been drawn increasingly to health systems, their impact on population health and society as a whole (including economy); the broad determination or “production” of health and equity in health; and, consequently, inter-sectoral action for health or HiAP, as suggested by the Finnish Presidency of the European Union. As individualist and collectivist approaches in health seem to oscillate, the mix of concepts currently characterising public health reflect some kind of new collective agenda, without forgetting health as a basic value and human right, but paying attention to the realities of the society. Interestingly, health seems at the same time to become increasingly politicised.

The European Union’s increasing commitment to work on health equity is remarkable, as the primary objective of the Union is to promote economic growth. In order to turn this political commitment into action that also genuinely covers the core areas of European Union policies, it is necessary to include good data collection, data analysis and its

presentation to decision makers and citizens. Data and information also need to be collected not only on ill health outcomes but also on policies and measures and on health outcomes. Health ministries in the Member States need to be capable of grasping, understanding and turning this information into actions in their various social, cultural and political contexts.

The challenge to close the gap is great and cannot be achieved by the health sector alone. Inter-sectoral action is needed at the global level among international organisations, at the European Union level across policy sectors, and at the national and regional level across government sectors. Inter-sectoral mechanisms exist in all Member States but efforts are needed to use them better and develop new formal and informal functional links with other sectors to create health-conducive societal policies, and this requires both capacity and resources. There is no single recipe that can be recommended: one size does not fit all. However, comparable and reliable information is an important starting point.

### III. OVERVIEW: MONITORING OF SOCIAL DETERMINANTS OF HEALTH AND THE REDUCTION OF HEALTH INEQUALITIES IN THE EU

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This chapter explores challenges and opportunities related to monitoring social determinants of health (SDH) and the reduction of health inequalities in the EU. It addresses the following issues: selection of targets and indicators to monitor social determinants of health and health equity; opportunities to strengthen monitoring and evaluation efforts, including improving and linking data sources and increasing disaggregate data; strengthening EU surveys to cover more countries and monitor more effectively the implementation of policies across sectors and their impact on health inequalities; shaping policies and informing actions on social determinants of health that incorporate an equity perspective; and approaches to influencing research priorities towards improving the monitoring of health inequalities. The chapter concludes with options for moving forward an EU agenda in this area. Annex III, sub-annex A supplements the chapter with information on identifying the appropriate measurement approach.

#### **The importance of monitoring social determinants of health and health inequalities in the EU across the population**

Large, avoidable differences in health outcomes exist between and within EU Member States with signs that these are growing in many countries. There are gaps in existing knowledge, particularly regarding the impact and effectiveness of health policies and policies of other sectors in reducing health inequalities. The lack of appropriate, routinely available and comparable data within each country and across the EU is one of the key barriers to greater knowledge and effective analysis of how to reduce health inequalities.

Monitoring systems collect data on specified indicators to provide stakeholders with information on the extent of progress and the achievement of objectives at any given time or over time (OECD, 2001). The improved monitoring of health inequalities and of the social determinants of these inequalities is necessary to support the formulation and evaluation of policies and interventions of the scale, size and intensity needed across a range of sectors. Appropriate data enhances target-setting, helps increase transparency and accountability by revealing progress towards health equity targets both within and outside of the health sector, and enables better allocation of resources by documenting the extent of the need for and the potential benefits of public spending. It also provides a useful basis for evaluation, i.e. the systematic and objective assessment of an ongoing or completed project, programme or policy, including its design, implementation, outputs and outcomes (OECD, 2001).

The reduction of health inequalities requires action on social determinants of health (SDH), and these actions involve not only the health sector but the whole of society (CSDH, 2008). Sectors beyond health have a direct or indirect impact on SDH and on the pathways to equitable and inequitable outcomes. Without an explicit picture of the distribution of health and its social determinants through adequate monitoring, awareness and responsibility for reducing absolute and relative health inequalities are limited. There is limited accountability for the injustices created or perpetuated by policies and programmes within and across sectors, while the evaluation of interventions often ignores whether inequalities increase, decrease or remain stagnant over time (Sadana et al, 2007a). Monitoring systems should include indicators that measure SDH and methods for linking data from different sectors to understand their impact in reducing or perpetuating health inequalities. These should also include a balance of measures reflecting factors that increase the risk of ill health and those that protect and promote the wellbeing and development of populations throughout their lifecourse.

Health inequalities in Europe are found among the most disadvantaged and the rest of the population, as well as across different population groups and all socio-economic groups (Donkin, Goldblatt & Lynch, 2002; Kunst, 2008; Marmot et al, 1997a; Marmot, 2005; Mackenbach et al, 2008). A social gradient exists whether comparing life expectancy, health risks or morbidity levels across population sub-groups based on various socioeconomic indicators (Commission of European Communities, 2009). A traditional focus on aggregate health outcomes or simple averages in official data means that health equity and its economic, social and political causes remain relatively invisible (Whitehead 2009). As such, monitoring systems need to be sensitive in order to capture inequalities across the entire social gradient, rather than focus only on population averages or known vulnerable groups.

### **Selection of targets and indicators relevant to health equity**

The strengthening of national, regional and global systems to monitor SDH and to catalyse actions to reduce health inequalities requires the establishment of norms and standards for key targets and indicators. These should enable the monitoring of progress and the evaluation of what works and what does not in different contexts and over time (Murray, Lopez & Wibulpolprasert, 2004). For health equity, agreed targets and indicators could illustrate health distribution, the achievement of human rights and barriers to access, as well as providing insights on cross-sectoral approaches in planning interventions to support the most vulnerable populations and those across the entire social gradient (Bambas, 2005).

Targets are what could be achieved by a country, society or organisation within a specific timeframe. They also identify the expected and desired outcome of a programme,

intervention or policy. Typically they reflect outcomes and require baselines (OECD, 2001). Indicators are the quantitative or qualitative measurements that provide a valid and reliable means to measure progress towards or achievement of the stated target and outcome (OECD, 2001).

The selection of targets can be based on sub-national, national, regional or global development and policy priorities, or the context of the country or region, and often reflect existing indicators measured within a defined area. National political processes are important in selecting targets, establishing approaches to meet targets and ensuring accountability towards progress. The global health equity targets proposed in the CSDH report (2008, page 197) are illustrative of what could be used as common points. However, they would require adaptation to the EU context, including its epidemiological profile, and would be driven by national or sub-national processes. Targets relevant to Europe would certainly build on the debates and advances outlined in recent years (Whitehead, Scott-Samuel, & Dahlgren, 1998; Marmot et al, 2010).

The usefulness of an indicator reflects what it actually measures and how this information can be used, whether for advocacy, agenda setting, inputs for priority setting, policies, or accountability frameworks. The challenge is to identify data and measures for each indicator that are clearly understood by several different target groups and stakeholders. For health equity monitoring, simpler measures may be more transparent and easier to interpret than complex summary measures. This is even more important when using and communicating data across national boundaries, given the questions of comparability and interpretation that are inevitably raised (HMN, 2008). Within Europe, the selection of indicators could also reflect what is useful both within the EU and for other Member States of the WHO European Region.

The framework describing the production of health inequalities (Figure 1) adapted from the Diderichsen model (Diderichsen & Hallqvist, 1998; Diderichsen, Evans & Whitehead, 2001; Solar & Irwin, 2007) helps to identify indicators for monitoring systems that address SDH and resulting inequalities.

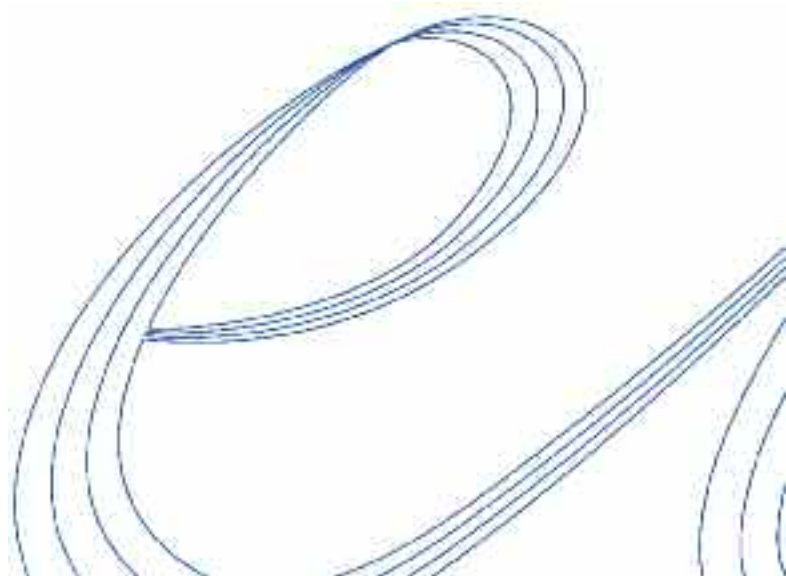
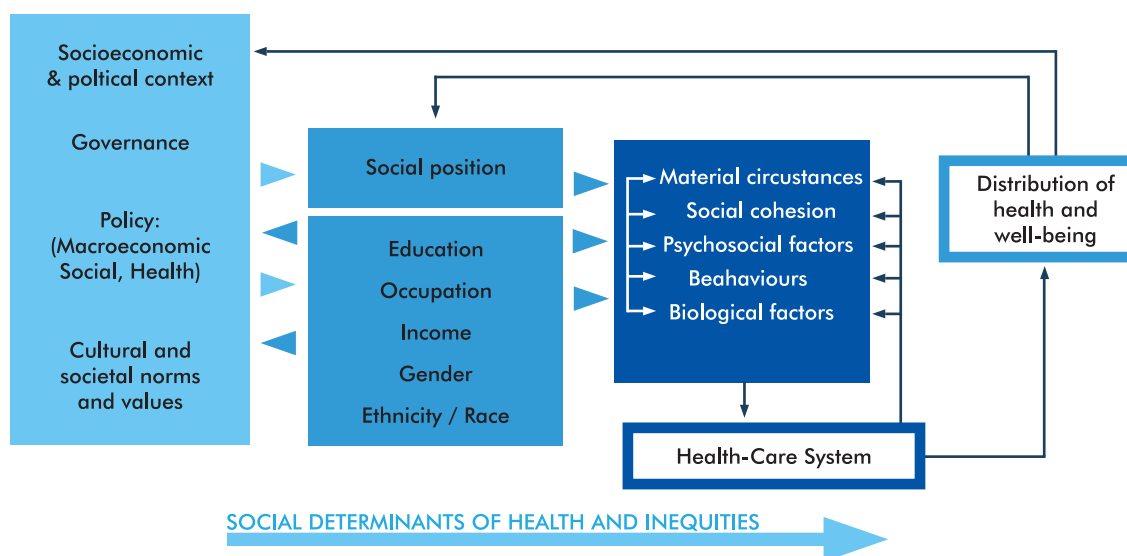


Figure 1. Commission on Social Determinants of Health (CSDH) framework linking social determinants of health and distribution of health  
 Source: CSDH, 2008 (p 43). Permission to reprint is being requested.



The framework has four components. The social, economic, and political 'context' within a society determines to what extent societies are stratified, how a range of assets or deficits are distributed and used among a population, and the resulting distribution of health. Intermediary determinants are the pathways that lead from root causes to differences in health. These increase or lessen differential exposures or vulnerabilities, such as material circumstances (e.g. housing, environment, consumption potential for food, clothing, etc.), psychosocial factors (negative life events, job strain, etc), and the interactions between behavioural factors (e.g. smoking, diet, alcohol consumption) and biological factors. Health systems are also an important determinant of health that can mitigate or worsen the effects of adverse material, psycho-social and behavioural conditions.

To support the CSDH, WHO compiled criteria for addressing global monitoring and health statistics specific to health equity and SDH (Sadana et al, 2007a). Based on the available data, recommended indicators for monitoring global health inequalities cover a broad spectrum of types of determinants (root causes to risk conditions) and a range of health outcomes, directly linked to the CSDH framework. Based on a review of the existing global data, some 25 indicators covering each of the framework's four components were identified as potential candidates for global monitoring (Sadana et al, 2007b), e.g. within the WHO's Global Health Observatory, currently under construction. A review of the available European data, identifying appropriate equity stratifiers (e.g. sex, education, occupation, income, ethnicity, place of residence, etc.) may provide a basis for selecting indicators relevant for the EU.

EU policies confirm the need to incorporate equity and social determinants dimensions within existing European-

wide monitoring mechanisms. The Lisbon Strategy (2000-2010), as the broad overarching strategic policy objective of the EU, aims to stimulate economic growth and employment while maintaining high levels of social protection. The inclusion of healthy years of life as a key structural indicator of success is an important element of the strategy. The social (and health) components of the Lisbon Strategy could be strengthened by ensuring greater complementarities with the EU Sustainable Development Strategy (SDS) (2006-2010), which emphasises environmental, public health and social principles. Guiding principle 6 (of 10) of this strategy notes that "the Commission and Member States will promote better health and disease prevention by addressing health determinants across all relevant policies and activities" (Lavin & Metcalfe 2008). In some cases, new indicators might be developed to monitor progress towards EU policy objectives.

At the national level, some countries across Europe have set policy targets to reduce health inequalities on a limited number of indicators, such as the infant mortality rate or life expectancy. Within the health sector, EU Member States have already agreed to the objective of addressing inequalities in health outcomes by supporting a common set of indicators based on Eurostat's public health statistics.

### Opportunities to strengthen monitoring efforts and the role of the EU

A clear vision is needed to go beyond marginally or incrementally improving existing data sources and to consider innovations that offer a paradigmatic shift in the approach to data collection, analysis and application, perhaps reflecting a combination of statistical methods and technological improvements coordinated across Europe,

e.g. involving the EU, the Organisation for Economic Co-operation and Development, and the WHO Regional Office for Europe.

Health data is usually generated either directly from populations or from institutions (HMN 2008), with typical

sources shown in Table 1. Population-based data sources include censuses, civil registrations, and household and other population surveys, where data relates to the whole population and not only to users of the services of institutions. Institution-based sources generate data as a result of administrative and operational activities.

**Table 1. Health Information Data Sources and Social Position/Equity Stratifiers**  
Source: Adapted from HMN (2008).

Type	Health indicators	Equity Stratifiers
<b>Population-based</b>		
Surveys	a broad range of health outcome and service indicators, e.g. mortality, morbidity, access to, utilization and cost of health services	usually most stratifiers: sex, socioeconomic status, ethnicity/race, geographical area
Censuses	limited information on health status; maternal mortality	major stratifiers: sex (always), socioeconomic status, ethnicity/race, geographical area (most of the time)
Civil registration	mortality, cause of death (sometimes)	Sex and geographical area (usually) education / occupation (sometimes)
<b>Institution-based</b>		
Individual records	a wide range of indicators depending on the institution, individual cases of disease and other health events captured by surveillance systems and condition specific disease programmes;	geographical area sex (sometimes)
Service records	events with important health consequences produced in other sectors (e.g., unintentional injuries, homicides, suicides, road traffic accidents, environmental and meteorological incidents and alerts on food and product safety)	
Financial and resource tracking information	data on the density and distribution of health facilities, human resources for health, budgets and expenditures, drugs and other core commodities, and key services	

### Challenges facing current monitoring efforts

In most countries, health information systems are not designed to routinely generate, synthesise or disseminate data and information on 1) SDH; 2) health inequalities; or 3) the associations between the two (Sadana et al. 2007a; Abouzahr & Boerma 2005). These limitations are found within the health sector as well as across other sectors that contribute to health.

Health measures are not usually well linked to the policy monitoring systems of other sectors and, in cases where they are, access and use in policy decision making is limited. This presents a major barrier to gaining greater understanding and targeting policies to address SDH and health inequalities. Countries that do not have data that technically enables a link to be made between health and social conditions or in which access is limited also face an increased likelihood of bias in reporting of health inequalities and a potential mismatch in subsequent policy

responses and programme investment. A study by Shkolnikov et al. (2007) documents how studies based on unlinked data led to an underestimate of mortality in disadvantaged groups and an overestimate of mortality in advantaged groups.

Across Europe, it is usually the case that 1) broader policies tend to target vulnerable groups rather than the entire social gradient; 2) monitoring average improvements remains the standard rather than monitoring how improvements are distributed across the population, and 3) health equity is seldom used as a standard measurement of the progress and impact of development policies, since these tend to focus on economic development goals.

Many existing national and EU surveys and data sources lack equity stratifiers, resulting in the inability to disaggregate health status in population or institution-based monitoring. Despite the efforts of many national statistics offices to increase harmonisation, they have not enabled



the measurement of health inequalities across the social gradient (Finnish National Public Health Institute 2002). Nevertheless, existing mechanisms for data collection at the EU level record information at the Nomenclature of Territorial Units for Statistics (NUTS) levels, even if limited data exists for understanding variations between social groups and between localities in each administrative area.

Measuring equity stratifiers is not always a clear-cut process without common norms or standard data sets, e.g. measuring economic status when data on income or expenditure is not available. Depending upon the stratification approach, the social pattern of each health measure, determinant, or consequence will take on a different shape. Although education, income, and occupational class are often used interchangeably for socioeconomic status, the relationship between these measures and health outcomes reflects different phenomena and different causal mechanisms (Geyer et al 2006). All three should be used whenever possible (Masseria 2009). Moreover, complex interactions between gender, sex and other social stratifiers need to be acknowledged. For example, the adverse impact of low socioeconomic status on women's health is further compounded by gender inequalities (WHO 2009). Disaggregating data according to sex, while constituting one of the first steps in an analysis of gender-based health inequalities, is not sufficient for understanding and documenting all contributing social determinants (Rohlf et al 2007).

All countries have health surveys but in many, particularly in the case of newer EU members, there are limitations concerning the size and representative nature of the samples and regarding the nature and frequency of follow-up (Bobak 2009). Apart from the 27 EU Member States, there are some 25 additional countries that belong to the WHO European Region in which national or cross-national comparative data on health inequalities is equally limited. However, mechanisms such as EU collaborative work through the EU Neighbourhood Policy, EU development cooperation assistance and accession tools could help to improve this situation. A systematic overview of the pros and cons of current EU surveys for the collection of health information is available (Masseria et al 2007).

### **Ways to strengthen EU monitoring systems**

EU-wide data collection can be an economical way to improve the knowledge base for national policymaking and to enable countries to learn from each other (Xavier, Price & von Nordheim 2009). Ways to improve data availability include the wider implementation of existing EU surveys (e.g. EU Statistics on Income and Living Conditions (EU-SILC), European Health Interview Survey and EU survey on disability) and a greater adherence to regulations addressing all fields of public health statistics. These advances could be used to identify indicators that are comparable over time and across the EU (Masseria et al 2007). Moreover, coherence with other cross-national or

global datasets could also be pursued. Advances in comparable data across Europe should supplement rather than undermine the status or standards of existing in-depth national surveys that enable valid and detailed disaggregated analyses of sub-populations.

The future international coordination of survey design (such as a core set indicators and equity stratifiers) and implementation could facilitate and improve cross-country comparisons and strengthen EU monitoring systems. Seminal studies by researchers in the EU on socioeconomic inequalities and health outcomes have produced key findings on the relationship between socioeconomic status and health outcomes, regarding which sub-groups to compare, the identification of indicators, and the development and recommendations of new methodologies for analysis (Marmot et al. 1991; Mackenbach & Kunst 1997; Kunst 2008) (See Annex II, sub-annex B). This work has influenced broader European and global monitoring of health inequalities and could constitute a basis for strengthening future efforts both regionally and globally.

Other steps have been taken across the EU to improve monitoring and the networking of Member States and key stakeholders. Measuring and fostering the progress of societies in all dimensions (economic, social, and environmental) through global accountability and development mechanisms is gaining importance. The Millennium Development Goals are a key step in this direction. Several institutions and organisations, including the EC, have also signed the Istanbul Declaration to support broader national monitoring efforts (De Looper & Lafortune 2009). The recent report by the Sarkozy Commission also favours equitable and sustainable development indicators over the primacy of GDP (Stiglitz, Sen & Fitoussi 2008). A measurement of health across the population which extends beyond mortality, such as the distribution of Healthy Life Years (HLY) analysed by social conditions, would also be a major step forward.

The quality of health-related data and indicators across EU health information systems could benefit from improvements in the following criteria, which build on the IMF Data Quality Assessment Framework (DQAF) and the IMF General Data Dissemination System (GDDS) (HMN 2008).

- *Timeliness and Periodicity.* All countries need a nationally defined, minimum set of health indicators used regularly in national programme planning, monitoring and evaluation. Data on these indicators should be collected routinely to enable the assessment of trends, with reporting frequency depending upon the type of indicators and the likelihood of change (HMN 2008).
- *Comparability and Harmonisation.* Good quality data does not necessarily equate with comparable data. Harmonisation efforts need to be improved to facilitate measurement of a broader set of social inequalities. Other sources of data within and outside the health sector could

be used to assess the association between health and social conditions, while the gold standard would be through a unique identifier, as employed by several EU countries. A common protocol, harmonisation of terms and data collection standards would enhance comparability yet are dependent on agreed policy priorities across the region (Masseria et al. 2007).

- *Accessibility.* Given the barriers posed by EU regulations on access to and use of disaggregated data, there is an expressed need for the development of international standards for the collection and sharing of disaggregated data and its use to facilitate accessibility while ensuring the protection, privacy and security of personal information.

Efforts have been made to improve health information systems across the EU. The EU has facilitated mechanisms across the region to improve data collection, standardisation, comparability, quality, utilisation and dissemination of social and health-related topics. An expert group was established in 2005 to review evidence and exchange information on policies and practice, with a number of EU health programmes supporting initiatives on health inequalities:

- The Working Party on Health Indicators co-ordinates horizontally all the activities of the Health Information Strand of the EU Public Health Programme to ensure that indicators are developed in line with the needs of European health information and knowledge systems, and that the prerequisites for indicator implementation are created. The European Community Health Indicators Monitoring (ECHIM) is a three-year project (December 2011) aimed at developing and implementing health indicators and health monitoring across the EU and within all EU Member States.

- Additionally, the European Community Household Panel (ECHP) survey and its successor, the EU Statistics on Income and Living Conditions (EU-SILC) survey, were established and special health modules were included in the Eurobarometer surveys. European funding has also enabled the creation of the Survey of Health, Ageing and Retirement in Europe (SHARE), which collects panel data on individuals aged 50 and over, and the recent development of the European Core Health Interview Survey (ECHIS). Efforts to collect macro-level health indicators disaggregated according to educational or income level and regional level within the I2SARE project are under way (Health Inequalities Indicators in the Regions of Europe) (Masseria 2009)

- The EUROTHINE project, supported by the EU public health programme, has collected and analysed information on socioeconomic inequalities in health from a wide range of European countries to facilitate mutual learning and to help policy makers develop rational strategies for tackling health inequalities. The project built on existing networks to develop health inequalities indicators; to provide benchmarking data on inequalities in health and health determinants; to assess evidence on the effectiveness of policies and interventions to tackle the determinants of

health inequalities; and to develop a European clearing house for tackling health inequalities. The results of the project continue to inform research activities across Europe on social determinants of health and equity.

- The European Health for All Database (HFA-DB) is a central database of independent, comparable and up-to-date basic national health statistics; disaggregation at the sub-national level according to equity stratifiers is limited. DevInfo provides mechanisms both for facilitating country-level compatible data shared between government sectors and development partners, and for monitoring subgroups according to equity stratifiers.

- The Task Force on Health Expectancies was established in 2005 by DG Health and Consumer Protection to ensure that Healthy Life Years (HLY) move forward towards meeting the Grade A criteria for Structural Indicators and to prepare for the next cycle of summary measures of population health (SMPH).

- The main aim of the European Health Expectancy Monitoring Unit (EHEMU) is to provide a central facility for the coordinated analysis and synthesis of life and health expectancies, to provide evidence of inequalities between Member States (MS) and to highlight potential targets for public health strategies both nationally and at a pan-European level.

## Informing action on social determinants and health inequalities

Monitoring and analysis without a link to policy action has limited value in tackling socially determined inequalities in health and needs to be seen as integral to the ongoing cycle of policy setting and evaluation. Similarly, the availability of policy intelligence that demonstrates clear links between health and social inequalities is a factor likely to contribute to action on social determinants and health inequalities (SDHI). While not all Member States have the same available resources, tools or pools of expertise to address the different causes of health inequalities (EC 2009), countries can use existing data and tools to formulate, monitor and evaluate policy and programmes that address equity and SDH.

In each country the choice of what to monitor varies, as do the techniques employed. This partially reflects different explanations for health inequalities within national policies and goals in different countries, the range of policy sectors and other stakeholders involved, and historical approaches to monitoring. Across the EU there is a predominant policy concern to reduce poverty-related inequalities in health. Subsequent targets and monitoring are directed at reducing gaps between the most and least well-off groups in society or in geographical regions of a country (Department of Public Health, 2007). While poverty is one of the main reasons for explaining socially determined health inequalities in poorer countries, this does not explain the persistence or scale of health inequalities in middle and

higher income countries, which is the case of most EU Member States. Europe as a whole would benefit from scaling up existing approaches to monitor the social gradient of health inequalities and from progressively implementing actions to reduce inequalities across all groups, not only the poorest or most vulnerable.

### **Tools, mechanisms and policy intelligence to inform action on SDH/HI**

There is a demand for tools and intelligence that could inform decision makers on sustaining, scaling up and/ or institutionalising actions to address SDHI. In a significant number of EU countries the necessary expertise and infrastructure for performing policy analysis, particularly linking health equity and its social determinants, is limited. EU grants and programmes could usefully incorporate measures of capacity support in this area, for example through calls for applications in the EU Regional Structural Funds or the Public Health Programme.

In response, several collaborative initiatives are under way or already completed, and inform the European (and global) knowledge base on policies and actions addressing the social determinants of health inequalities, including the Health Equity Project 2008–2010 (WHO Regional Office for Europe), European Country Policy Learning Reviews on addressing Social Inequalities in Health (WHO Regional Office for Europe), and others:

- A WHO global Scientific Resource Group that addresses monitoring, analysis, research and policy also involves experts and institutions from across Europe including the EC and Organisation for Economic Co-operation and Development. In cooperation with Member States, the group will recommend global norms and measurement standards and strengthen available intelligence and tools for the evaluation of cross-sectoral policies and mechanisms with a focus on addressing SDHI.
- The EU GRADIENT project is a 3-year initiative to synthesise which public policies are effective in tackling the gradient in children's health and to develop a consensus-based European evaluation framework as a tool to support countries in monitoring and evaluating policy impact on reducing the gradient in children's health.
- 'Health Assets in a Global context' is an initiative to support the systematic collection and collation of evidence and knowledge that demonstrates the benefits of investing in the assets of individuals, communities and organisations. This is a collaborative effort by the University of Seville and the University of Hertfordshire. To date, many policies and programmes that aim to address health inequalities focus on identifying the problems and needs of populations that require professional resources and high levels of dependence on hospital and welfare services. This leads to a situation in which policy development concentrates on the failure of individuals and local communities to avoid disease, rather than on their potential to create and sustain

health and continued development. This initiative will identify new indicators and develop new methods for monitoring and evaluating asset-based approaches for health and development with a particular emphasis on young people.

- At the national level, the Marmot Review in England is an example of a comprehensive cross-government review that analyses how current policies are performing in order to address the social gradient in health in England. It makes recommendations for remedying or refining policies and investments to strengthen impact on reducing health inequalities in the future, implementing progressive universalism. A tool for use by other countries interested in carrying out similar national reviews is also planned.
- A 2009 study in the UK found that major initiatives to address SDHI, such as the CSDH, the Acheson report and the Black report, have not included an economic analysis of different policy options (Epstein et al. 2009). New work in this area incorporates this perspective, including that carried out by the WHO Regional Office for Europe, the UK Marmot Review, and EuroHealthNet.

Another tool to assess the potential health equity impacts of existing and proposed policies within and outside of the health sector include Health Impact Assessment (HIA). HIA is a decision support tool that provides an analysis of the potential effects of a planned policy, programme or project on health dimensions (Davenport, Mathers & Parry 2006). HIA may also lead to a better consideration of health impacts in policy development carried out by other sectors and encourage cross-sectoral work (Davenport, Mathers & Parry 2006; Den Broeder, Penris & Put 2003).

- Across EU Member States, HIA has been adopted and applied over the past 15 years as a structured process to guide and inform decision-making and as part of an overall process of development of healthy public policy (Metcalf & Higgins 2009a; Metcalf & Higgins 2009b; Davenport, Mathers & Parry 2006; Elliott & Francis 2005). In addition, the European Commission requires all major policy initiatives and legislative proposals to undergo an impact assessment using an integrated approach that identifies the potential economic, social and environmental consequences (European Commission 2009).

### **Influencing research priorities to improve monitoring of health inequalities**

One of the CSDH's overarching recommendations is a call for continued monitoring and research: "to measure and understand the problem and assess the impact of action" (CSDH 2008). Research on social determinants and health inequalities has described the size and nature of the problem, knowing which social structures, indicators, and processes are causally related to health inequalities. Significant findings have provided evidence across Europe regarding the extent to which social determinants contribute to health inequalities, even though important issues remain

less well understood, such as why health inequalities are persistently reproduced across generations in spite of changing disease profiles and radical social changes. At this critical juncture, the EU has an opportunity to support an expanding body of research addressing the solutions to problems: assessing the strategic drivers of reductions in health inequalities, the differential health effects of policy interventions and the impact of alternative options for enhancing equity.

Improving research requires several components: (1) coordinated research priorities that are funded, (2) implemented with appropriate human and institutional capacities, (3) results that are synthesised and widely shared with different sub-populations, and (4) knowledge developed and used by a wide range of stakeholders and decision makers to improve policies and programmes. This research needs to be linked to the evaluation of pilot initiatives to reduce inequality and must lead to action to increase the scale and intensity of initiatives that work. Given the possibility that research findings fail to capture women's and men's differential realities and potentially introduce systematic gender biases, a careful review of research methods and data is warranted (Östlin, Sen, & George 2004).

Nationally funded and EU-funded health research during the past six frameworks have addressed some of these issues; the Seventh Framework (2007-2013) could offer a powerful platform to strengthen research efforts on the monitoring of health inequalities, given its aim to improve the health of all European citizens and to achieve improvements in global health. Adopting a social determinants approach to research priorities and funding in practice could mean that 1) methods to improve the monitoring of health inequalities are strengthened for health topics that address vulnerable and marginalised groups (such as the EU-funded projects EUROTHINE and I2SHARE), 2) more systematic approaches are adopted to monitor health gradients across society linked to broader socio-economic determinants of health, and 3) this research is mainstreamed in other sectors beyond health.

Opportunities for European-wide investment in research on strategies, designs and methods to advance monitoring of health inequalities include:

- 1) designs and methods that enable the measurement of policy processes, drawing on and linking a wide range of data, including making better use of qualitative data (Bonney et al. 2007; Kelly et al. 2007; Marmot & Friel 2008), extending beyond behavioural and other individual determinants of illness, and norms for indicators and measures to monitor health inequalities (Östlin et al. 2009);
- 2) approaches to stratify, analyse and communicate disaggregated data within and across populations, including intersections between different social hierarchies, such as gender and wealth (Iyer, Sen & Östlin 2008);
- 3) approaches to synthesise research findings on what works to reduce health inequalities, enabling greater clarity

on what can be transferred to other settings, the dynamic nature of equity, and what is context-specific; and 4) ensuring that collected data enables the identification of policies and interventions that reduce health inequalities within and outside the health sector, and beyond national borders (CSDH 2008; Östlin et al. 2009, Tugwell et al. 2006, Schrecker 2008).

Research advances are needed to inform monitoring that takes into account multilevel perspectives, linking social system characteristics, health interventions and individual health outcomes.

## Considerations for moving forward

### *The importance of monitoring social determinants of health and health inequalities in the EU across the population*

Given the avoidable differences in health within and across countries, monitoring across the entire population can support the formulation and evaluation of policies and interventions of the scale, size and intensity needed across a range of sectors to improve health and health equity. More emphasis is needed on outputs from a number of sectors (e.g. employment rates, educational performance, pre-school participation, tax and social protection systems) across the entire social gradient, broadening the current focus on health outcomes and vulnerable groups.

### *Selection of targets and indicators relevant to health equity*

Targets and indicators can reflect sub-national to global development policy priorities. Targets proposed in the CSDH report (with indicators adapted from its framework in order to reflect a European epidemiologic profile and national or sub-national efforts) could be used as a basis for developing measures that are relevant across Europe, covering EU and Member States of the WHO Regional Office for Europe.

### *Opportunities to strengthen monitoring efforts and the role of the EU*

Current challenges facing EU monitoring systems include the inability to collect and analyse data from health and other sectors and a lack of adequate equity stratifiers. The priority of strengthening monitoring within and across countries would benefit from increasing coordination, harmonisation and the accessibility of data from population and institution-based sources that complement rather than replace in-depth existing mechanisms at the national level.

### *Informing Action on Social Determinants and Health Inequalities*

Traditional monitoring systems do not always provide timely information needed to evaluate policies and to identify actions that work in different settings. Given the differences in health between countries there is a need for the ongoing publishing of how these differences change over time and

for a discussion of how European policies influence them. Further investment and support is needed to facilitate the systematic use of tools and intelligence to inform decision making involving actors across political, technical, programme and social domains of governance. The said tools and intelligence need to be based on the analysis and evaluation of 'live' policies and interventions.

#### *Influencing research priorities to improve monitoring of health inequalities*

Indicators, associated research and evaluation also need to focus on identifying what works on a sufficient scale to make a difference. Innovations are needed to identify the strategic drivers of reductions in health inequalities, the differential health effects of policy interventions, and the impact of alternative options for enhancing equity. The Seventh Framework (2007-2013) could offer a powerful platform for strengthening research efforts on the monitoring of health inequalities, given its aim to improve the health of all European citizens and achieve improvements in global health.

### **Options**

#### *Policy / Mechanisms*

- The EU and Member States should agree on objectives and milestones for long-term monitoring that is not constrained by existing data. An initial step could be to support the development of a set of indicators to monitor important policy targets and illustrate the social gradient of each health measure across countries and over time.
- Guidance for the collection and sharing of disaggregated data and its use should be developed further, while ensuring the protection, privacy and security of personal information.
- Existing instruments should be used, such as structural funds and those for countries that are candidates for EU accession, to support and encourage countries to strengthen their capacity and data for the monitoring and analysis of inequalities as part of the mainstream harmonisation process.
- Policy and practices should be shaped so that EU-funded research or the evaluation of programmes link together action on broader determinants of health and reduction in health inequalities.
- EU and Member States should support an expanding body of research addressing solutions to the identified problems: assessing the strategic drivers of reductions in health inequalities, the differential health effects of policy interventions, and the impact of alternative options for enhancing equity.

#### *Methods*

- National census data should be strengthened (with

information including equity stratifiers), as should annual cause-of-death data that can be individually linked. For example, an important stratifier, such as educational level, can be selected and in the short term death records and annual population data can be disaggregated while in the longer term death certificates can be linked with census information.

- Norms and standards should be adopted for data collection and analysis in order to monitor progress and trends in the reduction of inequalities.
- The EU should map national data sources, including health and other social indicators and equity stratifiers, and compare this list with country-specific health priorities in order to indicate whether the required data for measuring inequalities already exists or needs to be collected.

#### *Collaboration*

- Collaboration between the EU and international organizations such as WHO, the Organisation for Economic Co-operation and Development, the Council of Europe and the EU should be strengthened in terms of monitoring inequalities and creating mechanisms for collecting evidence and supporting solutions for reducing health inequalities within and between countries.
- Links should be strengthened between existing institutions specialising in SDHI monitoring and a European network structure should be created for know-how development and exchange, which the EU could benefit from. In addition, the network should seek to strengthen the capacity of and alliances with institutions from countries that joined the EU after 2004.
- The efforts discussed during the Country Health Systems Action Plan (Bellagio, Italy 2008), the Bamako Ministerial Forum for Health Research (Mali, 2008), the 12th European Health Forum (Gastein, Austria, 2009) and other forums on health inequalities should be continued, as should research, featuring a review of EU-funded research projects that evaluate interventions addressing broader determinants of health and health equity.
- Efforts should be strengthened to increase the accessibility and usefulness of research for policy makers within the EU and in other European countries, including the strengthening of networks of other potential users, such as civil society organisations and centres of excellence outside the European region.
- Global norms and standards should be developed with WHO's new Scientific Resource Group on Equity Analysis and Research for monitoring health inequalities; and responses to queries by policy makers should be coordinated with the WHO Regional Office for Europe, balancing evidence-based options and data from monitoring systems.

## IV. INEQUALITIES IN CHILD HEALTH

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This section presents an overview of inequalities in child health, discusses the importance of a lifecourse perspective for addressing the social gradient in child health, and summarises initiatives to promote equity in child health. It also proposes interventions aimed at improving policies to reduce inequalities as well as next steps for moving forward in the monitoring of and action on inequalities in child health in Europe. Annex III, sub-annex B supplements this chapter by proposing indicators for monitoring inequalities in child health.

### What is known about inequalities in child health

The only way to reduce inequalities in child health and to achieve a new generation of adults with equitable health opportunities is to prioritise child health equity in government policies. Government priorities set the context for multisectoral and multi-stakeholder activities, which is consistent with the stewardship function of the government. There is an urgent need to implement interventions with a reasonable evidence of effectiveness that can reduce health inequality during the prenatal period, early child development, and adolescence.

Despite generally improved health resulting from scientific advances underlying medical care in the last half of the twentieth century, large differences in health remain between countries and across the various social groups of children. Infant mortality rates (under one year of age) in the EU27 decreased from an average of 28.6/1000 live births in 1965 to 4.7/1000 in 2006-2007, but there is a considerable variation between countries, with a 10-fold difference between countries with the highest and the lowest rates at the end of period. There are also significant differences between groups and areas within countries. For instance, in the United Kingdom, which has explicit targets to reduce infant mortality, the infant mortality rate among manual labour groups in 2004-2006 was 17% higher than the rate for the total population, and had increased from the 13 percent difference recorded a decade ago (Department of Health, 2007).

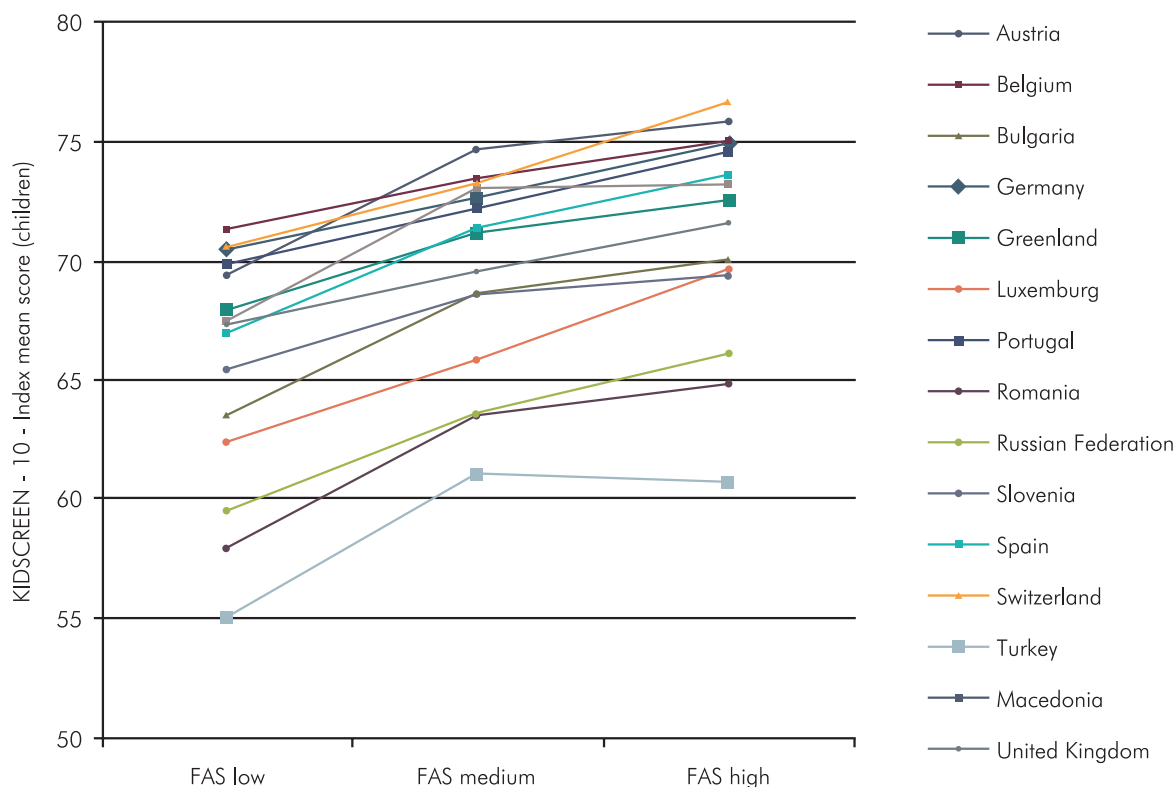
In 2005, nineteen million children lived under the poverty threshold in the 27 EU Member States; these children represented almost one in five of all children residing in these countries. In most countries, children are proportionally at a higher risk of poverty and social exclusion than the rest of the population (European Commission, 2008). There is considerable evidence as to the impact of social factors on the health of the poorest and most disadvantaged children. Children living in poverty, vulnerable children from migrant populations or ethnic minority groups, children from jobless families, and children from single-parent families have worse health outcomes, much higher infant and under-five mortality rates, and lower immunisation rates (European Commission, 2009). Young

persons from low socioeconomic status and from less affluent areas tend to die from injury to a greater extent than others in EU27, although most studies on injuries come from high-income countries in Northern Europe, limiting their generalization.

Only recently has interest focused on the concept of a social gradient in health; that is, the greater the social disadvantage, the worse the health (Starfield, 2008). Several studies have described gradients in infant mortality, under-five mortality, and mortality related to injuries in childhood and adolescence according to family social class, level of education and family income. Large differences in health and burden of disease attributable to environmental factors among children and adolescents were also found between European countries (Valent et al, 2004). Family socioeconomic position may be an independent variable, undoubtedly interacting with other factors (Bolte et al, 2005). Most conditions are associated with a social gradient in child health; few health outcome measures (e.g. myopia; allergies; atopy; some cancers) have not revealed a social gradient pattern.

The development of new multi-domain health status instruments has enabled a broad view of health and its relationship with social position. KIDSCREEN is a family of questionnaires developed in several European countries. The summary index of this instrument, which collects information on self-reported health and well-being, was recently administered in the Health Behaviour in School-Aged Children (HBSC) WHO collaborative cross-national study. Inequalities in health and well-being were analysed according to the wealth of the family. The study revealed inequalities observed for the KIDSCREEN summary score, with a gradient between the least wealthy and the wealthiest families in almost all 15 countries analyzed (Figure 2). This figure shows the gradient in children's reporting of their physical and emotional well-being, family and peer relationships, and satisfaction with school performance, according to the material resources of the family. These inequalities—found to a lesser extent in some countries—would also be associated with differences in other measures of health between countries, given that the KIDSCREEN was developed cross-culturally.

**Figure 2. Socioeconomic differences in self-reported KIDSCREEN-10 index scores according to the Family Affluence Scale (FAS) in 15 European countries**  
 Source: Adapted from Erhart M, et al.: *Int J Public Health*; 54 (suppl.2): 160-6. Notes: KIDSCREEN index scale scores: 0-100. 11, 13, and 15 year-old children from the Health Behaviour in School-Aged Children (HBSC) WHO Study 2005-6. All differences are statistically significant  $atp < .001$  except for Greenland.



Results from the international report on inequalities arising from the 2005-2006 HBSC survey clearly showed that children, especially girls, from progressively less affluent families were increasingly likely to report fair or poor health, multiple health complaints and less satisfaction with health.

The Child Health and Illness Profile (CHIP), developed in the United States, is based on a broader concept of health and provides separate domain and subdomain scores as well as profiles of individuals and, by aggregation, profiles of different groups of individuals. Studies using the CHIP have shown consistent social class gradients in the profiles of children and adolescents: a greater proportion of children of lower social position are included in the poor profile type, and progressively higher social position is associated with an increasing proportion of the good-excellent profile type. Approaches using instruments such as KIDSCREEN and CHIP, which analyse the burden of disease, contribute to a better understanding of the nature of the relationship between social position and morbidity than do specific disease-oriented models.

Despite national and regional efforts made to date, differences in the capacity to produce data on health inequalities among and within Member States of the EU27 make it difficult to compare, monitor, and evaluate national and international interventions.

## Lifecourse approach

Cohort studies have investigated the influence of maternal health and pre- and postnatal health on future adult health, and the relationship between social position and future health. In particular, British cohort studies have shown that poor maternal health and nutrition, which are more common in women in disadvantaged social positions, are associated with increasing rates of intrauterine growth retardation and low birth weight of offspring, as well as consequences later in life, such as an increased risk of coronary artery disease (Galobardes et al., 2008). This is a clear example of an intergenerational disadvantage creating a vicious cycle in which poor health, along with social position, leads to poor health in the next generation. Children suffering from an illness during childhood are much more likely to later suffer recurrences of that disease or other diseases. These cohort studies using a lifecourse approach have contributed a great deal to the knowledge of how social position can influence future health, and inversely, how health can influence social position (Kuh and Ben-Shlomo, 1997). Other cohort studies analysed health outcomes other than disease or mortality. For example, the cohort from New Zealand found a social gradient on physical health (dental health, body mass index) and tobacco dependence at 26 years old in children who grew up having a low socioeconomic status (Poulton et al., 2002).

Childhood is a vulnerable period in which genetic and family-related factors interact with exposure to environmental factors (e.g., housing and living conditions)

and other social influences, producing a complex combination of effects on health. Some factors can guard against future health problems (resilience), whereas others (e.g., unhealthy lifestyle habits) are a risk compromising future health (Starfield, 2008). Addressing resilience requires identifying individual and community contexts that increase the likelihood of better health, a very important consideration in childhood in the context of their lifecourse (for example, promoting family involvement, social problem-solving, and safe physical and social environments). More in-depth studies, targeting both individuals and populations, are needed to better understand the pathways through which each factor interacts with and influences the others, and under what circumstances and contexts within and across countries. .

Although social gradients in child health have been found in almost every population, the specific effects of deprivation on material needs, educational level, and psychosocial factors, and the interactions among these elements over the lifecourse, are still poorly understood and are not automatically transferable to all populations and all health outcomes.

## Initiatives promoting equity in child health and proposals of interventions

The UK Black report of 1980 was one of the early initiatives aimed at systematically examining social inequalities among the general population, including children. Considerable effort has also been made to develop models to explain and better address inequalities in child health. More recently, certain international agencies such as UNICEF (2007) and the World Health Organization (WHO, 2008), as well as some national governments, have published reports addressing this issue. Nevertheless, much more effort is needed to make equity in child health and action on social determinants of child health a common priority in government agendas.

The CSDH proposed closing the health gap in a generation by using a lifecourse model. This model shows how inequities in early child development are one of the main factors contributing to future health inequalities among adults (ECDKN, 2007). Poor academic achievement has negative consequences later in life that contribute to intergenerational disadvantage. The way a child interacts with the environment, as well as his/her physical, cognitive, emotional, and social development at an early age significantly influence her/his future health, education, and social participation. Investing in early child development can be a powerful "equalizer" if interventions have the largest effect on the most deprived children.

The CSDH highlighted the need for a continuum of care from pre-pregnancy through pregnancy, childbirth and the early days and years of life. Good nutrition is crucial and begins in utero with adequately nourished mothers. It is important to promote initiation of breastfeeding within the first hour, skin-to-skin contact immediately after birth, and



exclusive breastfeeding in the first 6 months of life, as well as to ensure the availability of and access to healthy diets for infants and young children improving food safety. The CSDH also pointed out the importance of promoting maternal and early childhood education and gender equity. Poor educational attainment is associated with an increased risk of unemployment, and unemployment is associated with poor adult health. Early gender socialisation, and cultural norms creating the distinction between 'masculine' and 'feminine' roles can have consequences along the lifecourse.

Both the individual and the population perspectives need to be considered when deciding on the most effective interventions to reduce social gradients in child health (Starfield, 2007). A specific influence on the health of a child may be individually very strong (high relative risk), but if it is not common in the corresponding population, it will not contribute to social gradients. On the contrary, a common influence in health among certain population groups may considerably contribute to social gradients even if there is only a small increased risk for disadvantaged children (population-attributable risk). For example, public health spending contributes heavily to reduce under-five mortality among socially disadvantaged children because mortality in this age group is more common among disadvantaged children than among socially advantaged children.

Many improvements in child health are influenced by policies in areas other than health. For example, the addition of vitamins to food products, fluoride in drinking water and food quality standards, educational and childcare standards, control of environmental emissions, among other policy measures, can improve child health (IOM, 2004). Traffic safety standards such as child car seats have prevented countless injury and death cases. Analysis of European data, such as the Nordic Experience: Welfare States and Public Health (NEWS) can provide detailed information on the impact and importance of certain determinants of health in order to enable effective action related to specific population groups (Lundberg et al., 2008).

Implementation of a comprehensive, coordinated, multidisciplinary approach to early child development by using one of the strategies with demonstrated effectiveness is a matter of social policy at the regional and the national level. Universal social policies have proven to be more conducive to better health for all than strategies addressing specific population subgroups. Nevertheless, as often happens, better-off children benefit first when new interventions are implemented (Victora et al., 2000). One of the main purposes of social policy should be to provide high-quality, adequate health care, particularly focused on increasing resilience and reducing health threats. A summary of the literature showed that well-organised primary health care reduces inequalities in health with an especially significant influence on infancy and childhood (Starfield et al., 2005). Moreover, since health systems

encompass both personal and population services as well as activities to influence the policies and actions of other sectors, coordinating actions with educational and social services is crucial to achieving the objective of reducing inequalities in child health

To decide what interventions would be most cost-effective in reducing child health inequalities, an in-depth analysis of the ways by which social influences affect health at local, national and international levels is needed.

## Policy implications and future directions

The first step to improvement is to recognize the problem. The positive outcomes achieved in most child health indicators over the previous decade may be reversed in the context of the global economic crisis that began in late 2008. If governments and society as a whole intervene at younger ages, implementing effective programmes to reduce health gaps and facilitating early child development, the necessary investment will pay for itself. Returns on human capital investment are greatest for children, because younger people have a longer time horizon to recover the fruits of the investment.

Future research on inequalities should start with children. Children have been subjected to fewer cumulative influences than adults, making it easier to determine which factors exert a significant influence on them. Giving greater visibility to inequalities requires a broadening of the type of data and information used for socioeconomic analysis, along with greater research efforts and monitoring. Studies analyzing health inequalities in childhood should determine the likely relative magnitude of various influences based on previous studies and test their impact on different social groups in the population. The evidence should be analyzed according to the relative likelihood of the risk leading to a problem, as well as in terms of the extent to which the risk has a large influence on populations. In light of this, the forthcoming study on child health to be carried out by the European Commission and published in 2010 is timely and important.

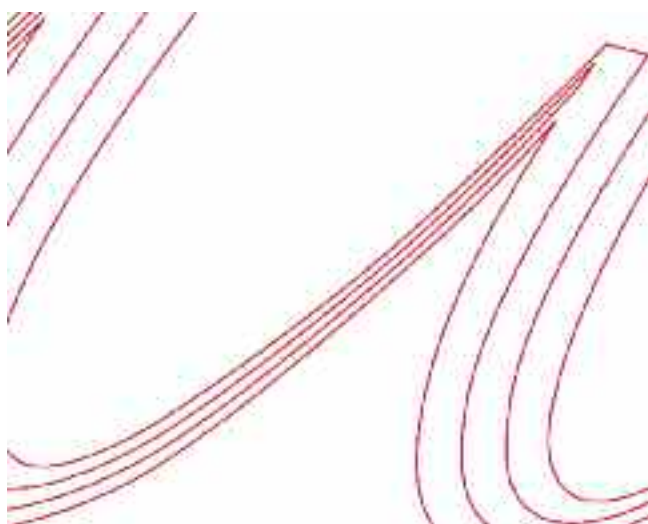
A policy of collecting information in order to stratify the population into major subpopulation groups should be promoted. Furthermore, a variety of competing hypotheses should be included, and testing for interactions and the main effects of influences should be carried out. More studies using a longitudinal design are needed to test both long-term and short-term influences. Current policy perspectives continue to focus largely on disease, illness and the health services relevant to their diagnoses rather than on factors that facilitate healthy development. Instead of narrowing the focus on specific diseases on a one-by-one basis, a broad conceptualization of morbidity and health profiles should be adopted, using new and innovative methods for characterizing the morbidity burden.

Mortality and child health indicators should be systematically collected according to gender and

socioeconomic strata (and other variables such as migrant status and ethnicity; see chapter VI) at the national and European level. This data would enable the monitoring and evaluation of interventions aimed at reducing health inequalities. The EC can help by promoting coordination mechanisms and by facilitating the exchange of information and participation in various information sources, such as the EU Statistics on Income and Living Conditions (EU-SILC), the European Health Interview Survey, the EU survey on disability, the Labour Force Survey (LFS), and other international data collection projects (e.g., PISA, HBSC, TIMMS, PIRLS, EUROMOD simulation). European initiatives, such as the European Strategy for Child and Adolescent Development and its assessment experiences, the indicators proposed by the Child Health Indicators of Life and Development (CHILD) project, and the EuroHealthNet initiative should also be taken into account. Annex III, sub-annex B contains authors' considerations on indicators for monitoring child health inequalities.

From a policy perspective, it is also important to ascertain to what extent policies aimed at families or adult family members, even when not explicitly targeting child well-being, in practice alter children's chances of healthy development. Specific policy measures to reduce inequalities related to social class, gender, education, income, ethnicity and migrant status would also be helpful in terms of reducing inequalities in children's health. For example, measures focused on protecting the first year of life by promoting work policies that help parents take care of their child (e.g., facilitating maternity and paternity leave) would be beneficial for children's development.

New and existing knowledge can provide useful information for policy makers, who must choose the best approach to reduce and ultimately eliminate the social gradients that compromise the health of children and the adults that they will become, and which in the long run influence society's chances of success in achieving a better life for all.



## Considerations for moving forward

The first step that the EU Member States should take is to give greater recognition to the existence of inequalities during childhood and to urgently implement or strengthen measures aimed at reducing child poverty, vulnerability and social exclusion within the EU27. Any proposed measure should take into account not only income redistribution, but also other social transfers and the political and social context in which the strategy will be implemented.

Interventions on early child development and health should be based on reasonable evidence of effectiveness in respect of guaranteeing prenatal and childhood care, enabling the early detection and treatment of physical, emotional, and cognitive deficits, and preventing social exclusion in the populations of children at highest risk.

The European Commission has a role to play in assisting child health policy coordination within the EU27. Better coordination could facilitate action to promote early child development and resilience to health threats through the available services (education, health, and social services), as well as action to reduce differences between and within regions.

Universal access to health services and high-quality primary care for all children in all regions has proved effective in reducing child health inequalities. It is one policy strategy that has proved its worth in improving health and health equity and, as such, should be used as a model for other social sectors. A broad conceptualization of morbidity and health profiles should also be adopted, using new and innovative methods for characterizing the morbidity burden, instead of focusing solely on specific diseases.

The interventions and experience of countries and regions with experience in reducing child health inequalities should be taken into account, using the established criteria related to efficiency and maximizing equity. Promoting strategies to reduce differences in maternal education levels, as well as providing universal access to education for preschoolers (3-5 years old) and 0-3 year olds would help to reduce health gaps in current and future generations.

Social gradients in child health within and between countries, in respect of both mortality rates and the incidence of several childhood conditions and injuries, are widespread. Some of the reasons for these differences are very clear. Nonetheless, the scarcity of data and the varying capacity of the EU27 Member States to produce data on health inequalities make it difficult to draw comparisons, while also limiting the strength of the evidence and the generalization of the results. It is important to promote studies that will increase the capacity to understand how interacting influences operate in different national and sub-national contexts.

## V. EMPLOYMENT CONDITIONS AND HEALTH INEQUALITIES

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Adverse employment and work conditions make a significant contribution to the explanation of health inequalities in the EU. Therefore, concerted efforts are needed to monitor and reduce health-endangering work. This chapter provides a short review of scientific evidence, showing the social distribution of health-adverse work and employment and highlighting the importance of these conditions in explaining health inequalities. It illustrates how these conditions can be monitored at different levels, most importantly at national and international/European level. It also highlights the need to improve and supplement existing monitoring activities by illustrating innovative examples from several EU Member States.

### Introduction

Employment and working conditions contribute to the development of social inequalities in adult health in all EU Member States and beyond to a significant extent. They are of critical importance for population health and health inequalities in at least four interrelated ways:

- Firstly, labour market and economic policies determine employment rates and conditions (e.g. precarious, insecure or informal work). These have a major impact on a range of life chances associated with paid work as a main social role in adult life.
- Secondly, wages and salaries provide the main component of income. Low and insecure income affects health via material deprivation, unhealthy behaviours and stressful experience.
- Thirdly, adverse working conditions in terms of physical, biological and chemical hazards, risk of injuries, long or irregular working hours, shift work and physically demanding work increase workers' risk of ill health.
- Fourthly, as the organisation of work and employment has changed significantly during the last century, psychological and socio-emotional job demands and challenges have become more common. Increased work pressure, often in combination with reduced job security, contributes to a high prevalence of adverse psychosocial work environments. These demands and threats have been shown to have a direct effect on the mental and physical health of workers in the long run.

These four types of health-adverse employment and working conditions (1. unemployment and precarious work; 2. low wage jobs; 3. jobs involving physical, biological or chemical hazards or increased risk of injury; 4. jobs in an adverse psychosocial work environment) are unequally distributed across the workforce, leaving those in lower socioeconomic positions at higher risk. It is therefore important to monitor these conditions and to document their effects on workers' health as a basis for targeted policy and workplace-related measures of intervention and prevention.

### Social inequalities of work and employment

## and their contribution to the health gradient

The education and skill level of people is of critical importance for their employment opportunities and their occupational standing. In all countries with available data, the unemployment rate is strongly patterned according to the level of educational attainment and skill training, leaving those with lower skills at higher risk. This trend is aggravated by the continued globalisation of the labour market and by its growing segmentation into well-trained jobs on the one side (high-technology industries; professional services) and low-paid unskilled jobs on the other side. However, the recent economic and financial crisis has affected parts of the more highly trained workforce in Western countries as well. Long-term unemployment (for longer than one year) is associated with a substantial increase in fatal or non-fatal cardiovascular or cerebrovascular events, in all-cause mortality, depression and suicide (as the most serious outcome of depression). Moreover, several limiting physical and mental disorders and health-adverse behaviours are more prevalent among the unemployed in comparison with employed people, even after adjusting for health selection and other important confounders (Kasl & Jones 2000, Schnall et al. 2009).

Job instability, often due to downsizing, restructuring, merging and outsourcing, is highly prevalent in occupational groups with a lower socioeconomic status, in those working under temporary or fixed-term contracts, and in migrant workers. The same holds true for several forms of non-standard work arrangements and precarious jobs, such as contingent, home-based or informal work. In addition to low job security, these employment conditions are characterised by low wages, greater hazards in the workplace and exposure to a variety of physical and psychosocial stressors. As a result, an increased risk of ill health was observed in the respective occupational groups, in particular musculoskeletal problems, poorer mental health and long-term sickness absence. In addition, several groups of less privileged workers are deprived of appropriate social protection and access to healthcare services, thus aggravating their work-related burden of disease. Some studies also report elevated mortality risks among employees with involuntary temporary work or among those 'surviving' massive downsizing. However, generally speaking, scientific evidence of these latter associations is less consistent than in the case of unemployment (Ferrie et al. 2008).

Today, every sixth worker in Europe is exposed to toxic substances in the workplace and a high prevalence of noise has been reported. Physical, biological and chemical stressors at work make a significant contribution to the prevalence of work-related diseases and injuries. Construction workers, agricultural workers, transport workers, miners and unskilled or semi-skilled blue-collar workers in the industrial sector experience these conditions more often than white-collar employees. Restricted posture at work, repetitive movements and heavy lifting are more

prevalent among lower status workers, reducing their likelihood of working to retirement age and increasing their chances of receiving a disability pension. Physical, biological, ergonomic and chemical hazards at work are often combined with an adverse psychosocial work environment, thus multiplying respective health risks. Similarly, long work hours and shift work may endanger workers' health. Jobs with an overtime schedule have a higher injury rate while those who work more than 11 hours a day experience twice as many coronary events as those working less hours. Night shifts are particularly relevant as a potential source of work accidents, cardiovascular and gastrointestinal problems and eventually cancer (Siegrist et al. 2009).

Monotonous jobs or repetitive work where high quantitative demands are combined with a low degree of control and decision latitude ('job strain') are more often confined to people with a low skill level, affecting both manual blue-collar workers and lower level service occupations. For instance, in a British study, the proportion of those reporting low control at work ranged from 6 percent among managers and professionals to 47 percent among semi-skilled or unskilled workers. A similar social gradient is observed with regard to a severe lack of social support from colleagues or supervisors at work. High demand in combination with low control and low social support was identified as a major psychosocial stressor at work that leads to significantly elevated relative risks of incident physical and mental disorders, in particular coronary heart disease and depression. Moreover, long-term sickness absence and disability pensions occur more often under these conditions. Similar results are observed if workers experience an imbalance between high effort spent at work and low rewards received in return, where rewards include money, promotion prospects, job security, and esteem. Overall, in a ten-year observation period, almost twice as many cardiovascular events and depressive disorders occur in workers exposed to an adverse psychosocial work environment in terms of these two models ('job strain' and 'effort-reward imbalance'), compared with less stressed workers. In addition, psychosocial stress at work was found to be associated with an increased risk of metabolic syndrome and type 2 diabetes, alcohol dependence, musculoskeletal pain, and reduced physical and mental functioning (Cartwright & Cooper 2009, Schnall et al. 2009, Kivimäki et al. 2006, Siegrist et al. 2009).

There is robust evidence indicating that at least the crucial components of the two models, i.e. low control and low reward at work, follow a social gradient, leaving those with the poorest qualifications at the highest risk of exposure. These members of the workforce are therefore the most vulnerable to the adverse health effects associated with stressful work. In fact, a significant proportion of the social gradient of adult health can be explained by an adverse psychosocial work environment, above and beyond the effects that are attributable to material stressors at work. It was also demonstrated that the magnitude of the effect on health produced by psychosocial stress at work is larger

among lower status workers than among higher status ones, probably due to the former's lack of appropriate coping resources (Marmot et al. 2006, Siegrist 2009).

In summary, all four conditions of poor quality of work and employment in modern societies mentioned above were found to contribute to a higher burden of disease, a higher rate of premature retirement from work, often due to disability, and a higher probability of early death. The lower the workers' socioeconomic position, as defined by their level of education or level of material living circumstances, the higher the risk of work-related morbidity and mortality. Importantly, there is a social gradient across the whole of society. The further one moves down the occupational ladder, the worse one's health becomes. This trend is aggravated by additional social inequalities related to gender, ethnicity, and regional deprivation. Therefore, in a society that is concerned with health inequalities, the extent of these problems needs to be monitored, along with their determinants and consequences. The resulting evidence can then be used to design and adjust policies and programmes to maximise health benefit for all.

### **The role of monitoring adverse work and employment conditions in reducing health inequalities**

Ideally, routine monitoring systems for work-related health should be in place locally, nationally and internationally. Furthermore, these systems should be complemented by additional, scientifically driven representative data. At European Union level, this aim is still a long way from being fulfilled since large differences exist at the stage of the national development of monitoring systems. Some of these differences are due to legal requirements regarding data protection, to the different responsibilities assigned to organisations within the health and work sectors, and to varying levels of political awareness and commitment. Moreover, it is often difficult to link occupation-related data to health-related data, e.g. based on morbidity or mortality registers, or based on data from sickness funds, pension insurance institutions or occupational health and safety offices. International, national and local surveys that monitor occupational conditions, with or without explicit links to health information, constitute a promising approach, providing that valid and conceptually sound measures are used. A short summary is provided here on current monitoring activities at national and EU levels, and some future directions of the respective actions are listed.

At the European level, work and employment conditions with relevance to health inequalities are monitored by a variety of initiatives. Most prominent among these are the first four European Working Conditions Surveys and additional reports from the European Foundation for the Improvement of Living and Working Conditions and the European Agency for Safety and Health at Work, including the European Risk Observatory Reports. The European Working Conditions Survey has a chapter on the impact of

work on health. The fifth survey is underway and its findings will be presented at the end of 2010. However, despite the fact that these and other related reports (e.g. decentralised Eurostat surveys, such as EU-LFS or EU-SILC, or harmonised and centralised surveys, such as the European Social Survey ESS) demonstrate links between social inequalities and work, they provide limited evidence on links between work and health (Parent-Thirion et al. 2007).

More promising in this regard is the Survey of Health, Ageing and Retirement in Europe (SHARE), a longitudinal panel study of representative samples of men and women aged 50 plus in the majority of European countries. Detailed occupational trajectories and current work and employment conditions are monitored in combination with a set of subjective and objective health indicators. For instance, based on SHARE data, the results of multivariate statistical analyses demonstrated that a low socioeconomic position, as measured by educational attainment, significantly increased the risk of exhibiting clinically relevant depressive symptoms during follow-up in the European countries under study. However, after introducing the two measures of an adverse psychosocial work environment, i.e. effort-reward imbalance and low control at work, this significant effect disappeared while both work-related indicators remained clearly related to this health outcome. A further classification of European countries according to the type of welfare state regime showed that the effect of work stress on mental health was relatively strongest in the liberal welfare regime, while the weakest effect was observed in social-democratic Nordic welfare states, with an intermediate effect in conservative regimes (Börsch-Supan et al. 2008).

There is clearly rich potential in exploring the extent and the determinants of work-related health inequalities across Europe, linking them to regional and institutional policy-related variations, setting benchmarks for future development, and strengthening the evidence base of targeted interventions. A very recent initiative undertaken by the EU Committee of Senior Labour Inspectors aiming at developing an integrated set of measures concerning psychosocial stress in the workplace holds particular promise in this regard. These developments are supported by initiatives taken by various Member States. Three such initiatives are briefly mentioned as examples of good practice.

In England (UK), a new National Statistics Socio-Economic Classification (NS-SEC) was introduced in 2001 to monitor social inequalities in current work and employment conditions in a reliable way. Its five key dimensions are pay structure, the quality and period of a work contract, promotion prospects and the degree of flexibility in working time. NS-SEC data is linked to administrative data on health including mortality, thus offering rich information on work-related health inequalities and their development over time (Rose & Pevalin 2003). Additional efforts have been undertaken by the Health and Safety Executive (HSE) where a standardised measurement of psychosocial stress at work

has been implemented as a web-based tool, providing options for comparing work stress levels between branches or companies and enabling them to monitor progress following worksite health promotion activities. Furthermore, in England one of the world's leading research projects on the role of work in explaining health inequalities, the Whitehall II study of British civil servants, was set up and remains active.

A different approach has been developed in Denmark where the Danish Work Environment Act, which came into force in 1995, opened new options for monitoring occupational risks. This act puts the main burden of responsibility for employees' health in the workplace on employers but provides substantial support in the form of a broad network of labour inspectors. Meanwhile, elaborated guidance tools have been developed, comprising 24 sector-specific standardised assessment devices for monitoring health-adverse working conditions. Based on these assessments, tailored counselling activities are provided by trained labour inspectors. Denmark is also one of the few countries within the EU that maintains an internationally visible National Research Centre for the Working Environment with close links between basic science and applied research.

More recently, France has become a highly committed Member State with regard to occupational health following an initiative by the Ministry of Labour to develop a unified measurement tool for assessing health-adverse working conditions. To this end, an expert committee, set up in 2008, is expected to complete its mission in 2010. Its work is based on a comprehensive review of the international state of the art, including ongoing surveys and epidemiological investigations in France, as well as on a series of meetings with prominent scientists and on close cooperation with social partners. An innovative approach that bridges research in a major attempt to reduce work-related health inequalities is currently being developed by the 'CONSTANCES' project. This project is planned as an epidemiological population-based open laboratory encompassing a population of some 200,000 persons covered by the National Health Insurance Fund who will be offered a comprehensive health examination and consultation irrespective of whether they are employed in the formal or informal labour market or whether they are unemployed.

These national examples are not unique, but they do illustrate the range of innovative approaches adopted in order to monitor work-related health inequalities and to develop actions to reduce them. It is hoped that these approaches will be instrumental in advancing and fulfilling the aims declared by various European institutions and organisations (including the Community Strategy 2007-2012, the Health Strategy 2008-2013, the Renewed Lisbon Strategy 2008-2010, the Employment Guidelines, the

European Pact for Mental Health and Wellbeing) and emphasised by the most recent resolution of the World Health Assembly.

## Considerations for moving forward

- *Efforts towards monitoring health-endangering employment and work conditions need to be strengthened at the national and European levels, taking account of available evidence from scientific and administrative sources.*

This can be achieved by implementing routine administrative monitoring systems for work-related health in all member states, complemented by scientifically driven standardized surveys mirroring worker's experiences of adverse work and, where available, health. National and European agencies and organizations in charge of occupational health and safety need to be strengthened to advance and implement respective knowledge.

- *Actions aiming at extending fair employment and 'good' working conditions are required to reduce health inequalities in adult populations.*

To this aim, provision of fair employment and improvement of 'good' work should become a central goal of government policies, in line with principles of a sustainable economy. Furthermore, labor standards and labor market regulations should be used to tackle harmful work and employment conditions. Specific aims include the enhancement of job security and of participation at work, the promotion of control and reward at work, and the strengthening of work-life balance.

- *These actions should include appropriate measures of social protection and access to health care for all employed people, as well as measures of reintegrating sick, disabled and unemployed people.*

Importantly, surveillance and monitoring of health-endangering work needs to be combined with adequate provision of, and access to, occupational health care services, and with regulations that adequately cover the workers' need for protection. Sick, disabled, and unemployed people should be reintegrated by applying early intervention and rehabilitation models and by endorsing initiatives for reintegrating newly and longer-term unemployed into work.

## VI. SOCIAL EXCLUSION AND STRUCTURAL HEALTH INEQUALITIES

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This chapter focuses on monitoring social exclusion and structural health inequality. It sets forth a proposal of indicators to monitor the protection of sick, poor, migrant, ethnic, gender, age and local disadvantaged minorities in the European Union. It proposes an integrated battery of indicators that enables the identification of the impact of social exclusion on health inequalities as well as its interaction with other (structural and contextual) social determinants of health in the EU 27. To this end, it builds on previous work carried out by WHO and EU institutions and researchers. Key dimensions of structural inequality such as early life disadvantage and employment, reviewed in previous sections of this report, are also briefly covered here. The chapter's first section identifies the role of social exclusion as a cause and mechanism of structural health inequalities. The second section analyses research evidence in the EU. The third section reviews EU agreements and priorities for action, and proposes a summary battery of indicators based on them. The fourth section presents the conclusions. Annex III sub-annexes C-E set forth a proposed battery of indicators and offer further details on the concepts, as well as include information on other EU indicators regarding structural inequality.

### Social exclusion and the structural roots of health inequalities

Research in the EU and elsewhere confirms the structural roots of health inequalities (HIs). The structural nature of HIs in practice means that they affect all groups of society; and they affect most those in lower positions of the social structure (upon whom a multiplicity of socially patterned health risks accumulate across their lifetime) often trapping them in poverty and ill health. Being poor, unemployed or underemployed, socially excluded and stigmatised usually go hand in hand. Socioeconomic disadvantage and social exclusion are distinct but closely related causes of HIs. Both are independently associated with various risk factors, including discrimination, high stress levels, unhealthy life behaviours, and violence. Social exclusion is also directly associated with chronic diseases and mental disorders, as well as with premature mortality, controlled by socioeconomic status (SES). People living in poverty who are socially excluded are more likely to lack access to accurate information and good quality health care, as well as to other basic political and social power resources. Sickness and weak social protection can further exacerbate the risk of poverty and social exclusion. Ethnic minorities and migrants, the unemployed or underemployed, the poor, women, children, the sick and the aged are especially prone to fall into this poverty trap and vicious circle of powerlessness (European Commission 2010; European Foundation for Living and Working Conditions 2010, 2007; Council of Europe 2008-2001; International Centre for Migration and Policy Development 2003).

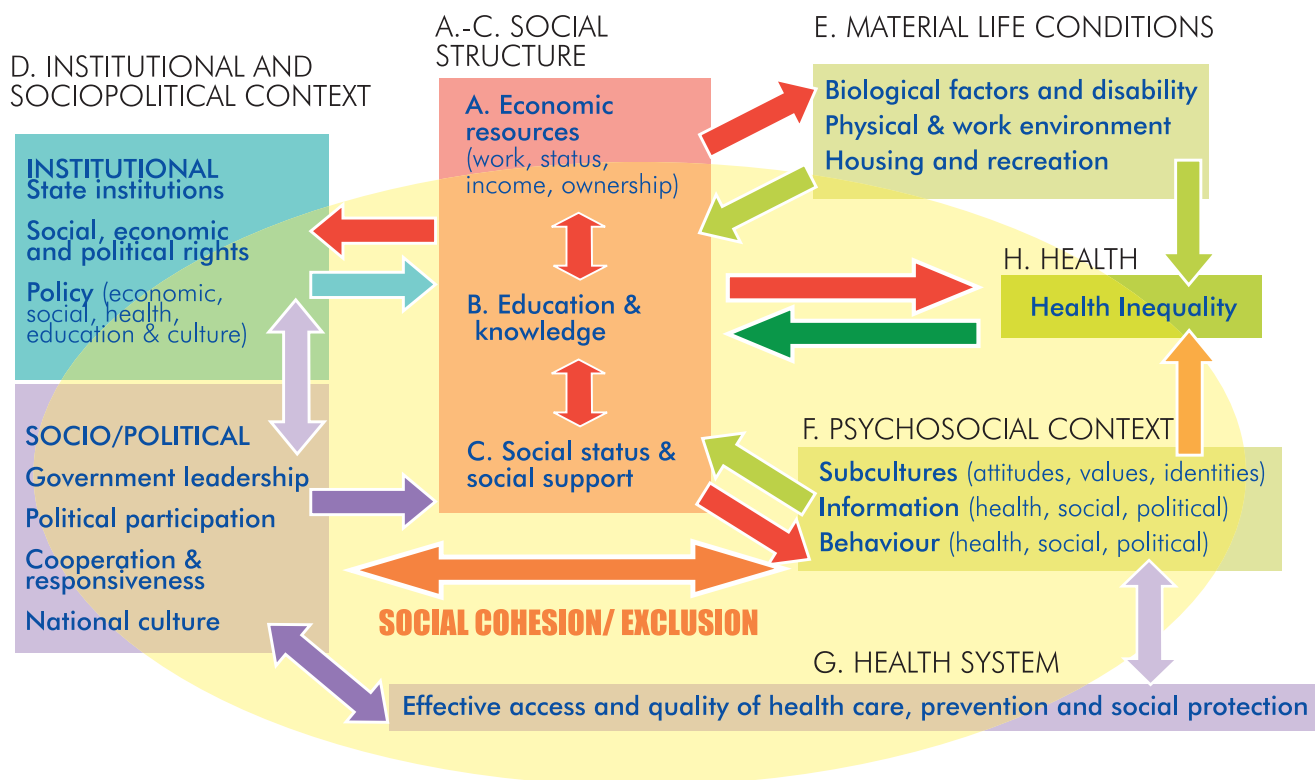
<sup>1</sup>The authors are grateful to Ana Zoni, Javiera Alvarez, Maria Sastre y Maria-José Peiró for bibliographic and logistic assistance, and to Theadora Koller, 9 anonymous reviewers and the coordination team at the Spanish Ministry of Health and Social Protection for their comments.

Socioeconomic disadvantage and social exclusion are often used as synonymous terms. Socioeconomic status (SES) is defined within the literature on HIs by three interrelated dimensions: income (and wealth), employment (and occupation) and education. Social exclusion encompasses a broader set of social, cultural and political factors. Also, being disadvantaged in terms of SES is an end state, whereas social exclusion is a complex multidimensional process, and its impact on HIs involves all other SDH as causal mechanisms.

The Social Exclusion Knowledge Network (SEKN) of the Commission on Social Determinants of Health carried out an in-depth study of the relationship between social exclusion and health inequalities. Its work included the

development of a framework/model for analysis that portrayed how the four main dimensions of social exclusion (social, political, cultural and economic) converge in the area of social stratification. The model depicts how social stratification, in turn, leads to differential exposure and vulnerability to ill health and results in health inequalities (SEKN, 2007). While the model developed by the SEKN is of value, for the purposes of grouping the indicators discussed in this chapter, the below figure is used. This figure is similar to the conceptual framework used by the Commission on Social Determinants of Health for its overarching analysis on the social determinants of health.

**Figure 3. Social determinants of health and social exclusion**  
Source: Author's elaboration, amended from CSDH (2008).



### Social exclusion, SDH and structural HIs

In 1946, a documentary made by British Encyclopaedia, based on classic sociological theory, summarised in four scales and eleven minutes the main social determinants of democracy (see the figure in Annex III, sub-annex E). According to the professor leading the production of the documentary, democracy depends on the equal distribution of *social power resources* (such as (A) work, income and ownership; (B) information, education and knowledge; and

(C) respect and social support) and also that of (D) *sociopolitical/institutional power resources* (such as political rights, public investment and political participation). There is agreement in modern social theory that the social determinants of health inequalities are the same as the root causes of despotism: unequal distribution of power resources across social groups and local communities. One of the most influential modern accounts of classic sociological theory on social power resources is Bourdieu (1990, 1977). Other authors who have applied this



framework to health and welfare are Caroline Hughes Tuhoy, Walter Korpi, Alexander Hicks and Joya Mishra.

Figure 3 mirrors sociological theory quite closely. There is considerable agreement on grouping (A), (B) and (C) together under the term *social structure*, or referring to (A) and (B) as *social class* or *socioeconomic status*, and to (C) as *social support* and *social capital*. Meanwhile, (D) is known as the *sociopolitical and institutional context*. Mediating between structural factors and health are (E) *material life conditions*, and (F) *attitudes and behaviours*. (G), the *health care system*, also mediates. The only difference between the general framework used by the Commission on Social Determinants of Health and Figure 3 is that (C) is usually grouped within (F) under “*social environment*” or “*psychosocial factors*” in the simplified version of the model.

### **Social exclusion as a cause of structural inequality**

The reason to highlight social status and support lays in its key role as a primary structural cause of social exclusion processes and of HIs. There is overwhelming evidence that social status and support are closely correlated to SES (Brunner 2009; CSDH 2008; Marmot and Wilkinson 1999; Wilkinson and Marmot 2003; León and Walt 2001), and social capital to income inequality (Babones 2009; Wilkinson and Pickett 2009; Rico et al. 2005; Kawachi et al. 1999, 1998, 1997), which underlines its structural nature (see also the chapter on Employment in this report). Social status and respect in turn are key causes of social and institutional discrimination, which leads to unemployment, barriers of access to health and social services as well as verbal or physical violence, and from there to ill health and disability. The social exclusion continuum ends up generating structural low SES and adverse material living conditions, which lead to further social exclusion. Low SES itself can trigger the social exclusion process. Other social stratifiers also trigger overlapping, accumulating social exclusion processes, especially if based on easily recognisable features, such as race (*racism*), sex (*sexism*) or age (*ageism*), as well as some mental illnesses and disabilities (European Commission 2009c, Sean and Östlin/WGEKN 2007, Wilkinson and Marmot 2003; Karlsen and Nazroo, 2002a, 2002b).

The conceptual model in Figure 3 guides the proposed battery of indicators and the remaining content of the paper. Its main message is that structural factors (A-D), both directly and through E-G cause inequalities in (H) health status, risks, disability, chronic illness, mental health and premature mortality. An additional message is that social exclusion (C) can be triggered not only by low SES but also by the unequal distribution of social respect according to certain arbitrary social identifiers (such as race or sex) linked to stigma and discrimination, which decrease chances of social mobility and cause structural health inequalities.

## **Research on social exclusion and health inequalities in the EU**

### **Social determinants and health status**

In the EU, on average 10% and 20% of the population in Western and Eastern Europe Member States respectively is poor (that is, earning less than 60% of the median income). Children and the elderly are at higher risk of poverty than adults, except in some Eastern European and Nordic countries. Material deprivation reaches 20% in some Western European countries and rises to 30%-60% in Eastern Europe (European Commission 2010, 2007c; Brook 2009; Dennis and Guio, 2005). Social capital, measured as the % of the population that believes that most people can be trusted, oscillates between 20%-30% in Eastern and Southern Europe, and 60%-70% in the Nordic region (European Commission, 2007a). During the last decade, poverty did not increase much, but the income inequality gap widened in almost all countries, and violence (a good sum indicator of social cohesion) increased (Nielsen et al. 2005; Dominguez et al. 2004).

The gap in life expectancy according to SES and ethnic minority status in the EU amounts to 10 years, and infant mortality differences according to SES are five-fold (European Commission 2008c, 2009a, 2009b, 2009c; Department of Health of the UK Government 2008; Rodríguez and Urbanos 2008). Low SES multiplies by 3-4 the risk of depression and ill health, and doubles the risk of suffering chronic disease or disability (Mackenbach 2006). There is a six-fold difference between the risk of death of the socially isolated versus well-integrated people in Sweden (Wilkinson and Marmot 2003). Living alone increases the risk of depression and addictions, and low SES multiplies by 3 the risk of suffering schizophrenia (Beecham et al. 2000). Between 30% and 50% of the homeless suffer from serious mental health problems in the UK (Department of Health of the UK Government, 2008). Health inequalities according to SES are generally greater for women and the young (Mackenbach 2006). Some health conditions such as diabetes, hypertension, lung, heart and liver disease, stomach cancer, schizophrenia and depression are clearly related to lower family SES. Low weight babies are 7 times more prone than high weight babies to develop diabetes (Wilkinson and Marmot 2003).

Health attitudes and behaviours explain less than 50% of HIs. As such, structural and environmental social inequalities must account for more than half of all HIs (Mackenbach 2006). Attitudes and behaviours are heavily influenced by structural inequality and, increasingly, by the health system. Motivation to engage in healthy behaviours among groups of low SES in Denmark is about half of that of groups of high SES (European Commission 2007b). More than 30% of obesity (44% among women) is attributable to low SES (European Commission 2007b). According to the CSDH, the risk of smoking or developing a drug addiction in some countries is almost 10 times higher for low than for high SES (Wilkinson and Marmot

2003). For all these reasons, addictions and other risk behaviours are considered by many a result of mental ill health rather than a cause of HIs (Beecham et al. 2000). This perspective has been adopted in some of the priorities reflected in the proposed battery of indicators.

### Migrants and ethnic minorities

There are 44.1 million migrants estimated in the EU 27, a number which represents close to 9% of the total population, with 5.6 million new migrants arriving in the EU between 2005 and 2010 (UNPD, 2009). Migration can be a win-win opportunity for Member States and for migrants, health playing a major role in migrants' integration and contribution to societies. Migrants and ethnic minorities do not need to be socioeconomically disadvantaged to suffer social exclusion (Davey-Smith 2000; Cooper 2002; Krieger et al. 1993). In the UK, the experience of discrimination doubles the likelihood of ill health, independently of SES (Karlsen and Nazroo 2002a-b). Partly as a result of discrimination and other specific challenges, however, both migrants and ethnic minorities (even those who have been established in the host countries for centuries, such as the Roma in the EU or the African American population in the US) experience lower SES and higher homelessness, school drop-out, financial and employment exclusion rates (Portuguese EU Presidency 2008; Krieger et al 1993). In the EU, the risk of poverty for migrants is between 2 and 4 times higher (Elkes, 2008). The most affected groups are Roma (see Box 1 below, which gives a detailed account of this group, in keeping with the priority given to it by the Spanish EU Presidency 2010), undocumented migrants, asylum seekers and refugees. They tend to live in poor quality and overcrowded housing, as well as in socially and ethnically segregated areas lacking access to healthy goods and services, which can further hinder social inclusion within the host community (Gushulak et al 2010; Barnett et al. 2009; Ingleby 2009; European Commission 2008a, European Foundation for Working and Living Conditions 2007). However, paradoxically, segregation also increases social support and capital, promotes political mobilisation, and can exert a protective effect upon migrants' health (Veling et al. 2008).

Migration can also exacerbate the impact of SDH: migrants face specific added health challenges related to countries of origin, the migration journey, weak social networks, discrimination, and culture and language barriers (Barnett et al 2009; Council of Europe 2001; Portuguese EU Presidency 2007). Indeed, in spite of suffering high structural inequality, the health status of some migrants is often above average, a phenomenon known worldwide as the "healthy migrant effect", which in some cases tends to subside after several years in the host country. It reflects selection processes acting both before and after migration: prompting failed migration or the early return home of sick migrants. It is therefore critical to monitor the health status of migrants in host communities as well as returning migrants and prospective migrants in their country of origin, in order to be able to monitor ethnic-related structural HIs (Llacer et al., 2007; Markides et al 2005; Khlal and Darmon 2003; Razum et al. 1998; Krieger et al. 1993). Pioneering research on this issue in Spain by Rodriguez-Alvarez et al. (2009), for instance, shows that Moroccan migrants living in the Basque country have better health-related quality of life but worse mental health than the Moroccan population.

The unsuccessful social inclusion of young people with a migrant background or from ethnic minorities is recognised in the EU (IOM 2009a). Studies indicate that they are at greater risk than their peers of becoming overweight, getting involved in accidents or experiencing problems of psychological adjustment; they also have lower vaccination and health care utilisation rates (Ravens-Sieberer et al 2007; Moreno et al. 2007). There are large and persistent gaps in the employment of immigrants even for second generation young people from ethnic minorities (OECD 2008; Elkes 2008). Many are hired in low-skilled jobs, including so-called 3D jobs (dirty, dangerous and degrading). There is an urgent need for specific attention to the issues of health and safety at work for migrant workers. Migrant women, who often work in the informal and home-based sectors, may face double isolation (European Commission Communication 2007a, 2007b).

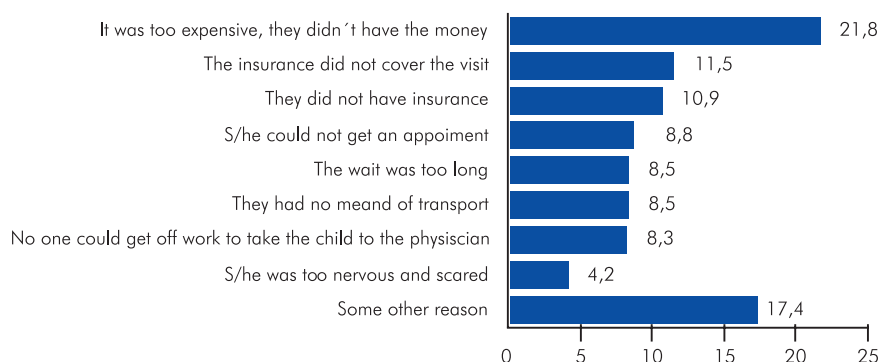
#### Box 1: The Roma population in the EU: Social exclusion and health inequality

The Roma are, among Europe's minorities, one of the largest (close to 12 million throughout the EU) present in the entire continent and are greatly affected by persistent social exclusion and wide-ranging poverty. Research demonstrates that a relatively high percentage of Roma community members suffer serious health problems. Both Roma men and women age faster and die younger than the general population. Roma may also be at a high risk of non-communicable diseases, such as diabetes, hypertension and heart conditions. 30% live in substandard housing. Repeated involuntary displacement has also been linked to breakdowns in mental health and child coping mechanisms (Schaaf, 2008). Men in particular are habitual smokers and start smoking at an increasingly early age. The consumption of vegetables and fruits tends to be low, partly due to poverty and high prices, whereas animal fat and sugar tend to be more prevalent in the Roma diet (Spanish Ministry of Health and Social Policy 2006).

A significant part of the Roma population in the EU has only limited access to health care, education, housing, and employment services: 10% declare unmet health care needs (not visiting the doctor when sick); 28% of children are not properly vaccinated; 40% of adult Roma women have never been to visit a gynaecologist other than to give birth; 44% of the adult Roma population have not completed primary school, and only a quarter (24%) have secondary education (Fundación Secretariado Gitano 2009). Roma are also disproportionately involved in informal sector employment. As a result they only have limited access to social security benefits (Schaaf, 2008).

**Figure 4. Reasons for not visiting a doctor in spite of feeling sick among the Roma Population**  
 Source: EDIS S.S., European Survey on Health and the Roma Community 2009

**Graph 3.3. Percentage of the Roma population that failed to receive needed medical assistance due to lack of assistance**



Since 2009, thanks to the concerted effort of the organisations representing the Roma, the Spanish and Portuguese governments and EU institutions, there is a EU survey (EDIS) on their health and protection needs. An early, pioneering community health promotion programme in Navarre, Spain (Jarauta 2010), is reviewed in the section on Health Care below. To promote the equal integration of the Roma, the EU Commission has launched the Integrated Platform for Roma Inclusion, and on April 2010, during the Spanish EU Presidency, the second European Roma Forum will be held.

### Gender across the class & ethnic divides

The impact of SES on women's health is often considered to be smaller in Europe than it is on men. In fact, European women live longer, and the gap in years of life expectancy by SES is on average 8 years in women and 14 years in men. However, across the EU, women overall also tend to be at higher risk of poverty, especially in old age, and the relative risk of death by SES varies more widely among women than among men. Reproducing the pattern of the healthy migrant effect, women often have lower self-assessed health status in spite of having lower death rates. The impact of SES on unequal health risks for women is higher for obesity, diabetes and depression, and lower for smoking, lung cancer and suicide. Female migrants and women from ethnic minorities are especially vulnerable to the most extreme forms of social exclusion: work and housing discrimination, violence and abuse (Llacer et al. 2007; Thapa and Hauff 2005). Another similarity between women and migrants is that their life conditions depend on their own structural position, as well as on the position of their husbands and family, and may have changed considerably as a result of marriage or migration. Both should be surveyed in research (Council of Europe 2008; Llacer et al. 2007; Borrell et al. 2004; Sean, Östlin and WGEKN 2007; Mackenbach 2006). Older migrant women are thus particularly vulnerable due to multiple risk factors for social exclusion such as poverty, social isolation and poor health, and due to their relative invisibility in statistics and research results (Cangiano et al. 2009; AGE 2008).

### Health care and social protection

Poverty and social exclusion can present strong barriers to receiving quality health care. Even if universal insurance is ensured in most EU countries, some groups risk falling through the safety net, and not all health services may be accessible or diversity appropriate. There is little data on these issues at the EU level, even if most Member States have some data on it. Socially excluded groups, and undocumented migrants in particular, frequently lack health coverage. Women may be dependent on their husbands for coverage. Waiting lists are often long, and prevention and specialist outpatient care are unequally distributed. Co-payments are often high, and maybe unaffordable to chronic patients. In many countries, dental care, psychological counselling and mental health care are not fully covered. Migrants and disadvantaged groups tend to use less preventive care and outpatient specialists and more emergency services. They are often undertreated and face longer waiting lists, as well as discrimination by health and social care personnel.

There is considerable evidence of the critical role that universal public health and social care has played to reduce structural health inequalities as well as child and adult poverty in the EU (European Commission 2008b; Mackenbach 2006; Marmot and Wilkinson 2003; Light 1993). As explored in the UN Report on the World Social Situation 2010, the concept of social protection, implying universalism, has given way in recent decades to that of social safety nets, implying targeting. Universalism emphasises the basic right of each citizen to social services.

Targeting focuses on eligibility and often involves means-testing (UN 2010). The CSDH Social Exclusion Knowledge Network (SEKN) reviewed global evidence on targeting and conditionality, finding that they can be stigmatising and disempowering, reproducing exclusionary processes and potentially exacerbating inequalities. They can also have high transaction costs, problems with uptake and be subject to leakage. The SEKN recommended that targeted policies and action only be implemented within a framework guaranteeing human rights and universal access to essential services and socially acceptable living standards (CSDH, 2008).

As such, targeted measures can, however, play a role in ensuring the right to health of socially excluded groups who may fall through the cracks of universal services, as well as to implement local intervention strategies directly targeted to address social determinants of health. As stated by Prof. Marmot in his recent review of the CSDH's recommendations for the British Government (Marmot 2009: 11) "Health follows social gradients and this implies the need for a combination of targeted and universal policies; [even if] reduction of health inequalities will not be achieved only by focusing on people at the bottom of the social gradient". In particular targeted local-level (hence not based on means-testing) pro-equity interventions that coordinate policy and social action for socially excluded groups and communities present advantages over universal approaches in the specific field of health promotion (Mackenbach et al. 2003; White et al. 2009), and have been successful when based on sufficient and well-allocated public (and sometimes private) investment. In Europe, an emblematic early example is the Health Promotion among Ethnic Minorities programme in Navarre, which Spain launched in 1987, focused on the Roma, which has contributed to higher levels of primary health care coverage, strengthened the reproductive health of women and improved child health (Jarauta et al. 2010). Other interventions in different European countries and from other regions (such as Latin America) show similarly good results of targeted, participatory community care (Judge et al. 2006; King et al. 2009; Meresman 2009; OPS 2009, 2008a, 2006; Borrell and Artacoz 2008). Few of them are well evaluated (Judge et al 2006). A recent pilot community intervention project designed as a clinical trial and carried out in London achieved a 50% increase in the % of adults on a healthy diet, a 70% increase in the % of adults doing regular exercise, and a 30% decrease in mental health problems (Wall et al. 2009).

Research also shows that dedicated civil society organisations (CSOs), particularly if embedded in the community, can play an important role in reaching and helping build delivery networks for severely excluded populations, such as neighbourhoods with high rates of crime or drug addiction (Pereira and Angel 2009; Sampson et al. 1997). The European Commission (2001), for instance, recommends reinforcing rights to universal services and positive discrimination for migrants, as well as relying on the support of NGOs for the specific case of

refugees. The CSDH underlines the importance of involving CSOs in interventions, while underscoring the essential responsibility of the public sector for leadership in ensuring universal coverage, focusing on the primary health care level (CSDH, 2008; recommendation 9.1; WHO 2008).

### Migrants and ethnic minorities

Legal residence status, language and cultural differences, stigmatisation and geographical and financial barriers may present prominent obstacles to migrants and ethnic minorities, particularly in seeking access to income support as well as health and welfare services. The legal status of migrants has a significant impact on their ability to live healthy lives and their access to basic human rights such as health care. Health systems, services and policy often fail to respond to the particular needs of migrants and ethnic minorities (International Organisation of Migration 2009 c; European Commission 2008b; Council of Europe 2001, 2006 and 2007; Wolf et al. 2008; World Health Assembly 2008). Stigma and discrimination may also deter the at-risk groups from seeking support from health services, especially in the case of mental health as well as HIV and TB (OSI 2007). Lack of adequate information and knowledge about available services can prevent or delay utilisation, and the lack of sensitivity and preparedness (cultural and SDH competency) of health staff can hamper it further (European Commission, 2008a-b). The nature of mobility itself can also make it difficult to identify health care providers and to complete long-term treatment. As a result of a lack of availability, accessibility and acceptability of services, research indicates that migrants and ethnic minorities may show low health seeking behaviour (Committee of Experts on Mobility, migration and access to health care 2009; European Foundation for the Improvement of Living and Working Conditions 2007; International Centre for Migration Policy Development 2003). The few studies on the quality of care that they receive, for example in diabetes, show worse control of glycaemia, more complications such as blindness and knee amputations, and lower levels of satisfaction than the general population (Committee of Experts on Health Services in a Multicultural Society 2006).

### Gender across the class & ethnic divides

Rising concerns about maternal and child health outcomes in migrants are noted in many studies throughout Europe. The recognition and management of reproductive and sexual health issues requires cultural competence among health care providers, health promotion and prevention initiatives developed in collaboration with target population groups, and the use and institutionalisation of community facilitators/intercultural mediators as additional recommendations. Cultural and ethnic reproductive and sexual health practices and norms among certain migrant groups and ethnic minorities, on issues such as teen pregnancies, female genital mutilation, abortion and the use of contraception, may intensify gender HIs and challenge or clash with those in the host and prevalent communities (IOM 2009b, Committee of Experts on

Mobility, migration and access to health care 2009; Council of Europe 2008). Some researchers and official reports recommend that the % of health professionals and experts who are women, of low SES and from ethnic minorities should be monitored, equating this % with the % of patients belonging to these population groups, as one of the best strategies to reduce access and cultural barriers, as well as discrimination and underutilisation.

## Monitoring social exclusion and structural health inequality: proposed indicators and EU agreements

The proposed indicators are outlined in a summary version in Table 2 below, and in an extended version in Annex III, sub-annex C. On the basis of the battery of indicators compiled by the CSDH (see Annex III, sub-annex D), they also incorporate a review of recent research by academics and international organisations on integrating poverty, health system performance and quality indexes (Fung et al 2008; Smith et al. 2008; García et al. 2007; Kamanou 2007; Pireus 2007; Schoen et al 2007; García-Altés et al., 2006; McLoughlin et al 2001; Marshall et al. 2003; MacIntyre et al., 2001). In addition, the indicators are adapted to EU research facts, health needs and policy goals. The facts are summarised in the next paragraph, while the EU agreements are summed up in the paragraphs below and in Table 2.

Research on social exclusion, SDH and HIs shows a complex causal pattern, which we have grouped into 8 main causes of HIs (4 of which are mainly structural) (see Figure 3). The position of a given person in the (A-C) *social structure and the (D) sociopolitical and institutional context* varies according to family origin and adult employment, along with gender and age, disability and mental health status, ethnic identity, country of origin, and place of residence. Together with (E) *the local physical environment*, it directly determines *life conditions*, and influences (F) *attitudes and behaviours*. Structural position also determines the chances of (G) *access to good quality health care and social protection*, as well as those of successful political mobilisation in favour of pro-equity policies. The social structure influences (H) health and disability through all these channels as well as directly.

Social exclusion and structural health inequalities are key priorities in the EU government institutions (see Table 2). A majority of citizens in the EU think that poverty and ill health respond to structural reasons and ultimately to social injustice, and not to the lack of effort of individuals (European Commission 2010). A recent comparative study with the US shows that, conversely, two thirds of US citizens believe that the main cause of poverty is laziness (Alesina and Glaeser 2004). The first chapter of this report summarises the numerous initiatives and agreements of EU institutions in the field. Two early turning points are the commitment of the European Councils of 2000 in Lisbon and of 2001 in Laeken to fight inequality and social



exclusion, and to monitor it at country level through the 18 summary indicators (including health), collected by the newly created EU Statistics on Income and Living Conditions (EU-SILC), which built on the European Household Panel (see Overview on Part I of this report; and also Brook 2009, Dennis and Guio 2008, and the Social situation reports of the DG Employment, Social Affairs and Equal Opportunities).

The EU-SILC panel data, which has been routinely produced by Eurostat and most Member States since the early 2000s, covers points A, B, D and E well, and part of points C, F, G and H (Table 2.). There are special task forces in Eurostat working on aspects not yet covered, such as ethnicity, disability, social capital, access to local services and intergenerational transmission of poverty. Migration, mental health, perceived discrimination and stress, and political mobilisation should be also included in the future. Recently, some countries like Estonia have pioneered the introduction of disaggregation of structural inequality indicators in the EU-SILC survey by ethnic and local community. It is of critical importance that the current sample size of the survey is extended to allow for disaggregation by minority excluded groups, and that postcodes and local and regional boundaries are recorded. Of critical importance to excluded minorities is recording detailed information on family (parents, husband) background, country of birth and ethnic status

Table 2. Indicators and key EU agreements on structural HI

AGREEMENTS AND COMMITMENTS AT THE EU LEVEL	
Key Agreements	Pending Issues
<ul style="list-style-type: none"> <li>• Health is a basic human right and a key source of wealth and development;</li> <li>• Health equity occupies a key role in the EU agenda of making compatible social cohesion and good governance with growth and jobs;</li> <li>• Structural inequalities in power resources are the main social determinant of health inequalities (HIs) and premature mortality;</li> <li>• Structural HIs are avoidable by concerted policy and social action;</li> <li>• Health and social protection systems must be proactive to reach the most needy; include culturally sensitive information in relevant languages; promote strategies aimed at mutual understanding and respect; and make suitably trained local professionals and services accessible and affordable to all.</li> </ul>	<ul style="list-style-type: none"> <li>• Recent European surveys on structural HIs made relative less emphasis on the interactions between SES and migration, disability, gender, old age, the social and physical environment, and specially disadvantaged ethnic and local communities.</li> <li>• The few EU reports on pro-equity health policies and governance institutions in Europe underline the leading role in health inequality research and policy of the United Kingdom, Ireland, the Netherlands, and the Nordic countries, which can help fill the gaps still not covered at the EU level.</li> <li>• There is also little discussion yet in the EU of key issues of governance such as who should lead concerted action against health determinants; the priority of different SHD indicators, or the role of the health system in promoting pro-equity policies or impact assessment in the rest of policy sectors.</li> </ul>
PROPOSED INDICATORS TO MONITOR STRUCTURAL HIs	
Individual Data	Local & Country Area Data
<ul style="list-style-type: none"> <li>A. Risk &amp; intensity of poverty, family SES and social mobility, % who owns a house &amp; car;</li> <li>B. Results in math and literacy or years of educ.;</li> <li>C. % lives alone or feels socially discriminated;</li> <li>D. % feels institutionally discriminated, % long-term unemployed, salary gap, % politically active;</li> <li>E. % poor housing or low access to healthy food;</li> <li>F. % stress, little social or recreation activities;</li> <li>G. % unmet health needs, % without a GP;</li> <li>H. % disability &amp; mental ill health (inc. addictions).</li> </ul>	<ul style="list-style-type: none"> <li>A. Income inequality (S80/S20) within and across local areas, % areas with &gt;20% population poor;</li> <li>B. % Illiterate or doesn't know the language well;</li> <li>C. Trust, % lone young mothers, elderly &amp; migrants;</li> <li>D. Legislation, plans &amp; funds to fight discrimination and structural HI, number of demonstrations;</li> <li>E. Pollution, work accidents, green areas, water;</li> <li>F. Violence, imprisonments, homelessness;</li> <li>G. % areas understaffed in health &amp; education;</li> <li>H. Inequality in life expectancy and infant mortality.</li> </ul>

NOTE: All indicators should be disaggregated by SES, gender, age, sick, migrant, ethnic, refugee, and homeless status. Sources: European Commission (2010-2007); Council of Europe (2008-2001); WHO Europe (2008). See Annex III, sub-annex D for more details on other EU HI and SDH indexes.



## Considerations for moving forward

In summary, there are some good prospects for the reduction of structural HIs and social exclusion in Europe at the start of 2010. Research, evidence and political commitments in the European Union on the social determinants of HIs have made considerable progress in recent years. There is now considerable knowledge, consensus and committed resources around a set of priorities and facts: health equity is a basic human right, a driver of wealth, and a key priority within the EU Agenda; social determinants of health cause HI and are avoidable through concerted policy and social action, which should focus both on vulnerable social groups and on reducing inequalities across all social groups and local communities through progressive taxation and universal policies.

There is a need for better data on the state of the health and specific needs of migrant, Roma and other ethnic minority groups, and on the accessibility, availability and quality of health care for them at the EU level. There is little data on the social inclusion of disabled, mentally ill and chronic patients, as well as other highly vulnerable groups such as refugees and the homeless. A basic challenge is the lack of consensus on how to group persons in terms of migrant status, and ethnic, religious or cultural background. Some EU countries have legal or ethical restrictions on the collection and storage of data related to ethnic or legal status, while the same applies to SES but not race in the US (Krieger et al., 1993). The US is the world pioneer, while the Netherlands and UK have the longest tradition in the EU (Committee of Experts on Health Services in a Multicultural Society 2006). During the last EU Presidencies, Portugal and Spain have been pushing the issue of migration forward.

This chapter has three main conclusions:

- Both evidence and agreements in the EU underline the fact that different structural dimensions are strongly interlinked/synergistic, so that persons with less socioeconomic resources also have less sociopolitical and institutional resources, and simultaneously suffer from

adverse material life conditions, discrimination and other aspects of social exclusion that trap them in multidimensional poverty. *The social groups most affected by structural inequalities, who should be given special protection, are refugees, Roma and other ethnic minorities, migrants, homeless, lone mothers, the sick, the poor and the aged, as well as children and the un- and underemployed, as covered in previous sections.*

- As has been pointed out, in spite of universal health care and generous pensions throughout the European Union, research evidence on the persistent nature of HIs points to its deep structural roots (Mackenbach 2006), *but it also points to gaps in social protection and health coverage, and barriers of access to vulnerable minorities. Positive discrimination policies and progressive public financing are required to make effective the rights to welfare of the social groups that fall through the cracks of universal services.*

- *We have a lot of information on the structural roots of HI in the EU (consistent with its causal and policy priority), but little on the specific resources and health needs of the social groups most vulnerable to structural health inequalities, and even less on effective policies to tackle them.* Three urgent needs in the field of health information are: (1) *the expanded sample size of existing surveys (such as EU-SILC) to a minimum of 20000, to enable disaggregation according to vulnerable minority groups and local areas;* and (2) *the inclusion of specific questions on all SDH (including family SES and ethnic background) within health surveys, mortality registers or patient records as well as the inclusion of questions on discrimination, violence, access to health care, and health problems more prevalent among disadvantaged minorities, such as risk pregnancies, nutritional deficiencies, mental ill health or lack of preventive care;* and (3) *the generation of new local and regional databases recording availability in poor and excluded areas of educational and cultural centres, clean air, green spaces, affordable healthy food and housing, and health and social services.* In Figure 3 and Sub-Annex C we propose a basic and extended battery of structural (individual and local) HIs indicators grouped around 7 SDH dimensions or equity stratifiers.

## VII. GLOBAL HEALTH INEQUALITIES AND SOCIAL DETERMINANTS OF HEALTH: OPPORTUNITIES FOR THE EU TO CONTRIBUTE TO MONITORING AND ACTION

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<sup>1</sup>The term "third countries" in this chapter refers to countries that are not EU or European Economic Area (EEA) members, and are recipients of "traditional" development aid. Discussion of EU cooperation for health equity through the transatlantic agenda and with the BRICs and other developed countries is outside of the scope of this chapter.

<sup>2</sup>Policy areas such as trade and research are important for confronting global health inequalities, but due to space constraints they are not addressed in this chapter. Readers are encouraged to consult the work of the CSDH Globalization Knowledge Network (Labonté R et al, 2008) and the Issues Paper on the role of the EU in Global Health (European Commission, 2009e) for more information on how trade and research influence global health equity.

<sup>3</sup>The EU Strategy for Action on the Crisis in Human Resources for Health in Developing Countries and the Programme for Action to tackle the shortage of health workers in developing countries (2007 – 2013) details the EU's commitments to guiding the international recruitment of health personnel by ethical considerations and cross-country solidarity, ensured through a code of practice.

<sup>4</sup>The health components of the progress reports available on the EC ENP web site were reviewed. As of mid-November 2009, progress reports were available for Armenia, Azerbaijan, Egypt, Georgia, Israel, Jordan, Lebanon, Moldova, Morocco, the occupied Palestinian territory, Tunisia, and Ukraine (European Commission, 2009d).

This chapter contributes to the ongoing discussion on opportunities for the EU to help address social determinants of health and reduce health inequalities in third countries through its development cooperation. The chapter covers potential entry points for action in relation to the European Consensus on Development; EU support of progress towards the MDGs; the EU's implementation of the Accra Agenda for Action; and the European Neighborhood Policy (ENP). Annex II supplements this chapter by providing an overview of EC communication on "The EU Role in Global Health".

### Introduction

Differences, within and between countries, in income levels, opportunities and health status are greater today than at any time in recent history (Chan M, 2009; CSDH, 2008). Ensuring the right of all people worldwide to the attainment of the highest possible level of health is of benefit to all countries. Likewise, the development of all nations, within and beyond the health sector, is a prerequisite to ensuring global health security (Committee for Development Policy, 2009).

EU action to improve health in third countries<sup>1</sup> and address social determinants of health through policy coherence is underpinned by Article 168 of the Treaty on the Functioning of the European Union. This article specifies that the *Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health, and that a high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities* (European Union, 2008).

Communications on "the EU role in global health" and "Solidarity in health: Reducing health inequalities in the EU" (European Commission, 2009e and 2009c) reinforce the EU's commitment to reduce health inequalities, including through its role in global health. The forthcoming Communication on "the EU role in global health" is particularly salient to this chapter. It defines the global health concept, framework and challenges; provides an analysis of the EU added-value as a major actor in global health; sets the priority areas for action; and proposes the core strategic elements to enhance the EU role in global health. The main priority areas are global health governance, global health coherence, global health knowledge, and the EU contribution to the universal coverage of health services (see Annex II for details).

The EU (referring to the European Union and its Member



States) is the world's largest donor. In 2008, it accounted for 60% (49 billion EUR) of official development assistance globally. The primary and overarching objective of EU development policy is the eradication of poverty in the context of sustainable development, including the achievement of the Millennium Development Goals (MDGs) (European Commission, 2008a). The European Commission manages more than a fifth of EU development aid, with assistance provided to more than 160 countries, territories or organisations worldwide (European Commission, 2008a).

The Treaty of Lisbon gives higher profile to human rights, equality and solidarity as key principles under which the EU acts (European Union, 2009). In keeping with this and as ensuring solidarity for the right to health is fundamental in order to reduce global health inequalities, the analysis in this chapter is underpinned by Article 12 on the right to health in the United Nations International Covenant on Economic, Social and Cultural Rights (Kickbusch I, Lister G, 2009; OHCHR, 1966). The right to health embraces socioeconomic factors that promote conditions in which people can lead a healthy life, extending to underlying determinants of health (ECOSOC, 2000). Resource limitation may require the progressive realisation of this right. As in the case of other rights, the international community has a responsibility to support the progressive realisation of the right to health, including through development assistance<sup>2</sup>. This chapter also draws from the work of the CSDH and the World Health Assembly resolutions on *Reducing health inequalities through action on the social determinants of health and Primary health care, including health system strengthening* (World Health Assembly, 2009a, 2009b).

## Health as a cross-cutting issue in the European Consensus on Development

This section explores how global health (and health equity) could be incorporated to a greater extent in the implementation of the European Consensus on Development. The European Consensus on Development provides the basis for EU action in the field of development. It sets forth nine "areas for Community action": 1) trade and regional integration; 2) the environment and the sustainable management of natural resources; 3) infrastructure, communications and transport; 4) water and energy; 5) rural development, territorial planning, agriculture and food security; 6) governance, democracy, human rights and support for economic and institutional reforms; 7) conflict prevention and fragile states; 8) human development; and 9) social cohesion and employment.

In addition to its action areas, the European Consensus on Development has four cross-cutting issues: a) good governance, human rights, the rights of children and indigenous peoples; b) gender equality; c) environmental sustainability; and d) HIV/AIDS (European Union, 2006). The rationale for having cross-cutting issues is that these "touch on general principles applicable to all initiatives and demand a multisectoral response". The EU promotes the integration of cross-cutting issues into all areas of donor programmes (DG Development and Relations with African, Caribbean and Pacific States, 2008).

The existing cross-cutting themes address some key determinants of health. However, in keeping with Article 168 of the Treaty on the Functioning of the European Union, the EU might wish to consider the adoption of health (and health equity) as a cross-cutting issue. This would follow up the Council Conclusions on Health in All Policies advanced by the Finnish EU Presidency (2006) and the Oslo Ministerial Declaration, the latter of which calls for making the "impact on health" a point of departure and a defining lens to examine key elements of foreign policy and development strategies (Ministers of Foreign Affairs, 2007). Table 3 on the next page illustrates the cross-cutting nature of health and health equity in the 9 areas for Community Action of the European Consensus for Development.

Current cross-cutting issues are integrated into donor programmes through tools including strategic assessments, programming guides and topic-specific country profiles. Tools and resources can be created (and/or existing ones adapted) to help apply a Health-in-All-Policies approach (sensitive to health equity) to EC development programming. These could provide guidance to EU development staff for addressing social determinants of health and health inequalities in each phase of elaborating Country Strategy Papers and National Indicative Programmes, and for dialoguing with/supporting third countries in order to integrate these issues in national development policy. In addition, the EC or an EU Member State could create a dedicated training programme on applying a Health in All Policies approach for EU development staff or incorporate a module/course into existing programmes. Training measures could draw expertise from across all EU countries, civil society groups, academia and other development partners.

Since mainstreaming cross-cutting issues is a complex process, it could be beneficial to review the challenges and enabling factors encountered in mainstreaming other cross-cutting issues. The uptake and application of tools such as

Strategic Environmental Assessments, Country Environmental and Gender Profiles, and the *Toolkit on Mainstreaming Gender Equality in EC Development Cooperation* could be reviewed (European Commission,

2008b). At Member State level, an example resource for review would be the gender and social exclusion analysis tool (DFID, 2009).

**Table 3. Areas for Community action as they relate to select\* recommendations and findings for health equity from the Commission on Social Determinants of Health (CSDH)**

European Consensus for Development 9 areas for Community action	Examples of relevant CSDH recommendations and findings for health equity
Trade & regional integration	<ul style="list-style-type: none"> <li>- Ensure policy coherence so that different government departments' policies complement rather than contradict each other in relation to the production of health and health equity (for example, trade policy that actively encourages the unfettered production, trade, and consumption of foods high in fats and sugars is contradictory to health policy, which recommends relatively little consumption of high fat, high-sugar foods and increased consumption of fruit and vegetables).</li> </ul>
Environment & the sustainable management of natural resources	<ul style="list-style-type: none"> <li>- International agencies and national governments, building on the Intergovernmental Panel on Climate Change recommendations, consider the health equity impact of agriculture, transport, fuel, buildings, industry, and waste strategies concerned with adaptation to and mitigation of climate change.</li> </ul>
Infrastructure, communications & transport	<ul style="list-style-type: none"> <li>- Local government and civil society plan and design urban areas to promote physical activity through investment in active transport.</li> </ul>
Water & energy	<ul style="list-style-type: none"> <li>- National governments, in collaboration with relevant multilateral agencies, strengthen public sector leadership in the provision of essential health-related goods/services (such as water and sanitation).</li> </ul>
Rural development territorial planning, agriculture & food security	<ul style="list-style-type: none"> <li>- National and local government develop and implement policies and programmes that focus on: issues of rural land tenure and rights; year-round rural job opportunities; agricultural development and fairness in international trade arrangements; rural infrastructure including health, education, roads, and services; and policies that protect the health of rural-to-urban migrants.</li> </ul>
Governance, democracy, human rights & support for economic & institutional reforms	<ul style="list-style-type: none"> <li>- The monitoring of social determinants and health equity indicators be institutionalized and equity-oriented health impact assessment of all government policies, including finance, is used.</li> <li>- Public resources be equitably allocated and monitored between regions and social groups, for example, using an equity gauge.</li> <li>- Governments ensure that all children are registered at birth without financial cost to the household. This should be part of improvement of civil registration for births and deaths.</li> </ul>
Conflict prevention & fragile states	<ul style="list-style-type: none"> <li>- Support the creation of a minimum health equity surveillance system by building routine health statistics where they do not exist; even in areas of conflict/emergency, cluster sample health and living conditions surveys can be feasible, albeit difficult.</li> </ul>
Human development	<ul style="list-style-type: none"> <li>- National governments, with civil society and donors, build health-care services on the principle of universal coverage of quality services, focusing on Primary Health Care.</li> <li>- Governments build universal coverage of a comprehensive package of quality early child development programmes and services for children, mothers, and other caregivers, regardless of ability to pay.</li> <li>- The health sector expands its policy and programmes in health promotion, disease prevention, and health care to include a social determinants of health approach.</li> <li>- National governments establish a national health equity surveillance system, with routine collection of data on social determinants of health and health inequality.</li> </ul>
Social cohesion & employment	<ul style="list-style-type: none"> <li>- Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, build universal social protection systems and increase their generosity towards a level that is sufficient for healthy living. Targeting is used only as back up for those who slip through the net of universal systems.</li> <li>- National governments develop and implement economic and social policies that provide secure work and a living wage that takes into account the real and current cost of living for health.</li> </ul>

\*This is a non-exhaustive list. See the source CSDH (2008) for all recommendations and a review of the evidence base.

## Strengthening national capacity for equity-oriented progress towards the MDGs

The United Nations Millennium Declaration, adopted in 2000 by 189 nations, is a corrective strategy that aims to introduce greater equity in the world by tackling multidimensional poverty and promoting sustainable development (Chan M, 2009). The MDGs comprise three health-specific objectives (on child health, maternal health, and combating HIV/AIDS, malaria, and other diseases) and seek improvements on key social determinants of health (poverty and hunger, education, gender equality, and environmental sustainability) (WHO, 2009). Slow progress in achieving the health-specific MDGs is increasingly acknowledged as a result of lack of attention to inequalities, within and beyond the health sector. The food price and financial crises further threaten progress towards all of the MDGs (United Nations, 2009).

The MDGs are of central importance in EU development cooperation, as evidenced by the EU Agenda for Action (Council of the European Union, 2008). This section explores how social determinants of health and health equity could be increasingly addressed through EU support to MDG progress. Specific attention is given to:

- Health system strengthening, including for health equity surveillance;
- Social protection as a means of safeguarding health, health equity, and progress towards the MDGs.

### **Health system strengthening, including for health equity surveillance**

Strengthening health systems that ensure progress towards the MDGs and deliver equitable health outcomes requires attention to all system functions, since action on one function alone will not produce the desired results. Coherent, simultaneous and synergistic efforts to reinforce equity-oriented health financing, health workforce, procurement and distribution of medicines and vaccines, infrastructure, information systems, service delivery and political will in leadership and governance are required (ECOSOC, 2009). Particular emphasis should be placed on strong primary health care.

A primary health care approach requires the equitable coordination of all levels of the health system. Local health services, which provide the first point of contact with the health system, are especially important. They have a responsibility to provide care on-site care where possible and navigate people to other services as necessary. The strength of local health services strongly influences inequalities in health and health system access. In keeping with the principles of the Alma Ata Declaration, health care needs to be brought as close as possible to where people live and work (WHO, 1978). The fundamental principles of primary health care are universal coverage, putting people at the centre of care, integrating health into broader public policy, and providing inclusive leadership for health. Data in the World Health Report 2008 indicates that many health

systems globally are not delivering on fair access to care and are failing in their capacity to meet the needs and expectations of people, especially impoverished and marginalized populations (WHO, 2008). A focus on strengthening health systems through a primary health care approach is an important aspect of EU support to third countries.

The EU is increasingly orienting its focus towards health system strengthening, as reflected by actions to address the human resource crisis of health providers<sup>3</sup>; reduce the risk of catastrophic health expenditures through improved health care financing; tackle HIV/AIDS, malaria and TB with intensified support to health systems; and provide the “continuum of care” required for MDGs 4 and 5 (Presidency of the European Council, European Commission, 2008c; Council of the European Union, 2009b; Office of the Prime Minister of Norway, 2009). EU support of the Taskforce on Innovative Financing for Health Systems, and its welcoming of a draft code of practice on the international recruitment of health personnel (being developed by WHO) are related examples of actions supporting a systems approach.

However, there is general consensus among development partners that increased and simultaneous attention to all health system building blocks and functions is needed. This encompasses (but is not limited to) greater augmented action to improve national health information systems, including their capacity to monitor social determinants of health and health inequalities (World Health Assembly, 2009c; Committee for Development Policy, 2009). This is not to suggest an earmarked approach, but rather to support attention to health information systems, including their ability to monitor health equity, as a fundamental aspect of comprehensive health system strengthening.

Information systems are at the core of guiding development processes, since what is measured affects what is done. If our measurements are flawed, decisions may be distorted (Stiglitz J, Sen A, Fitoussi JP, 2009). Major gaps in health information hamper the monitoring of progress towards the MDGs and other goals. The heads of the H8 (the agencies most active in health, comprising WHO, the Bill and Melinda Gates Foundation, GAVI, GFATM, UNAIDS, UNFPA, UNICEF, and the World Bank) recently called for international partners to go beyond the current focus on indicator development and reporting requirements, and step up efforts to strengthen country systems including data generation to address major information gaps (Chan et al, 2010).

Few developing countries are able to produce data of sufficient quality to enable the regular tracking of progress made in scaling up and strengthening health systems (IHP+, 2009d), especially with regards to how health systems address health inequalities. In most developing countries, the limited availability and poor quality of health data and statistics highlights the urgent need for investment and expansion of health information activities. This can only

be achieved through a joint effort by countries and international partners (IHP+, 2009c). Building the capacity of health information systems to gauge equity can be considered within the context of the six country goals suggested by the H8 for improving MDG data availability, quality and use. These goals are: to strengthen health surveys, to improve birth and death registration, to strengthen the census platform, to strengthen health-facility reporting systems; to improve monitoring of health-system resources; and to strengthen country capacity in data generation, validation, analysis, dissemination, and use (IHP+, 2009c). The MDG data collection process has been criticized for not permitting the monitoring of in-country inequalities to a greater extent. Efforts are increasingly being made to disaggregate national averages by gender, rural and urban living, and socioeconomic status. Continued efforts towards this end are essential.

The CSDH recommends, for all countries, that health information systems should have the capacity to routinely collect, collate and disseminate information on health, health inequalities, and health determinants in a coherent fashion. Going beyond the presentation of national averages, health equity surveillance systems stratify data according to gender, social and regional groups. They also include measures of inequality in health and determinants between these groups. These include indicators to enable monitoring and evaluation of the progressive realisation of the right to the conditions for health (CSDH, 2008). In many countries, data on different social and environmental determinants of health is currently dispersed across a range of information systems; a surveillance system that monitors health equity brings together in one place data on a broad range of social determinants of health (CSDH, 2008).

An increased EU effort to fortify national health information systems in third countries, in the context of comprehensive health system strengthening, could build on existing initiatives. For instance, the EU Programme for Action to Confront HIV/AIDS, Malaria, and TB through External Action (2007-2010) calls for support to countries in collecting and monitoring sex and age-disaggregated data through national health information systems (European Commission, 2007a). By extending this to entail the disaggregation of data by socioeconomic status, geographical location, and other measures, the EU could support the country in order to assess better whether interventions are reaching the populations in greatest need.

Since the EU contributes significantly to the work of Global Health Initiatives (GHIs), it could promote the idea of GHIs carrying out additional work to strengthen national information systems. A review commissioned by the CSDH (Hanefeld, et al, 2007) provides evidence that the inability of national systems to collect data that is disaggregated according to stratifying factors has resulted in a failure to monitor the impact of GHIs according to equity criteria. Building up the capacity of national systems to monitor health equity, rather than creating parallel monitoring and evaluation systems for specific diseases only, complies with the guidance in the EU Code of Conduct on the Division of

Labour in Development Policy (European Commission, 2007b).

Lower and middle-income countries can face a range of challenges in the establishment of surveillance systems that can monitor health inequality. These include the under-registration of births and deaths. Increased support by the EU towards improving national health information systems would need to take these into account. Where routine data do not exist, survey data, including from cluster sample health and living conditions surveys, is essential for health equity surveillance systems (CSDH, 2008). Civil society organizations and academia are important partners in implementing surveillance systems since, for instance, they can conduct community-based monitoring to assess service availability. In synergy with the above, improved platforms and processes are required in order for data on health inequalities to be shared and used in policy and practice.

### **Social protection to safeguard health, health equity, and MDG progress**

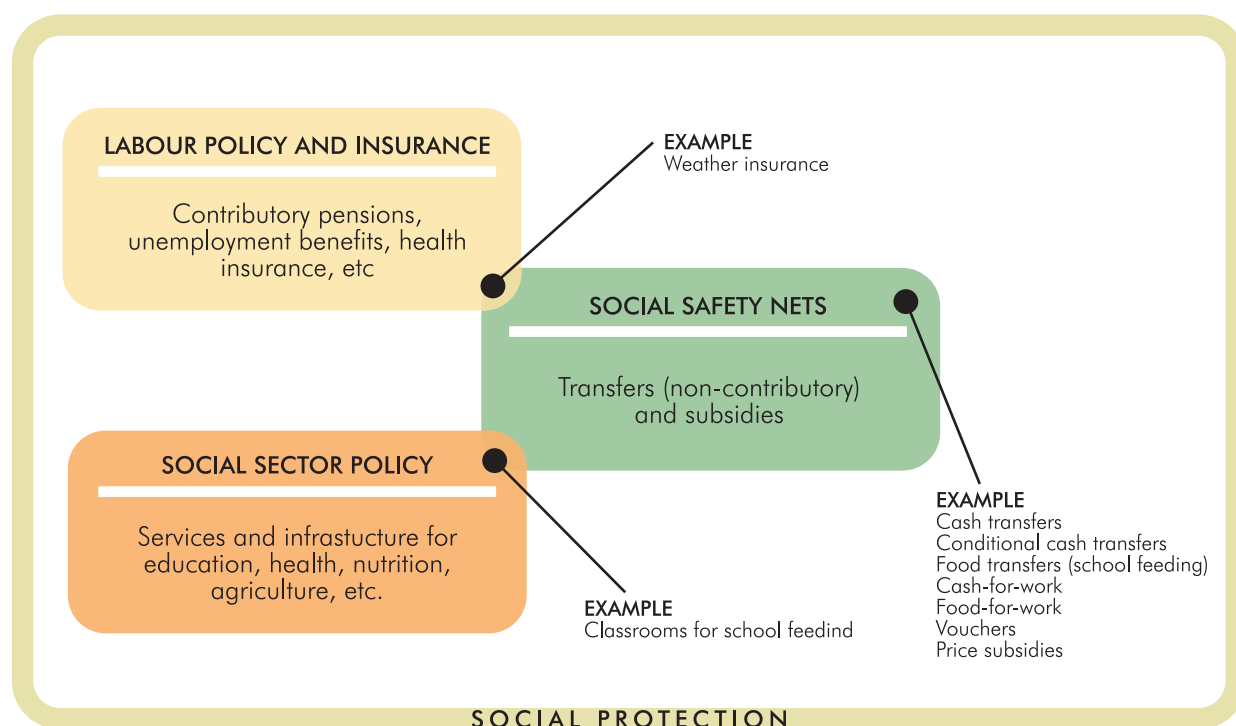
Extending social protection to all people across their lifecourse contributes to health and health equity (CSDH, 2008). Social protection that promotes the availability of and access to goods and services essential to health and well-being also helps towards the achievement of the MDGs, as emphasised by the WHO Executive Board in its January 2010 resolution on *Monitoring the achievement of the health-related MDGs* (Executive Board, 2010).

Social protection has been defined by the International Labour Organisation (ILO) as *the set of public measures that a society provides for its members to protect them against economic and social distress that would be caused by the absence or a substantial reduction of income from work as a result of various contingencies (sickness, maternity, employment injury, unemployment, invalidity, old age, and death of the breadwinner); the provision of health care; and the provision of benefits for families with children* (ILO, 2003). Building on this definition, the more recently elaborated social protection floor concept promotes nationally defined strategies (comprising a basic set of rights and transfers) that protect a minimum level of access to essential services and income security. The social protection floor approach includes:

- Services: ensuring the availability and continuity of, and geographical and financial access to, essential services, such as water and sanitation, food and adequate nutrition, health, education, housing, life and asset saving information and other social services.
- Transfers: Realising access by ensuring a basic set of essential social transfers, in cash and in kind, to provide a minimum income and livelihood security for poor and vulnerable populations and to facilitate access to essential services. It includes social transfers (but also information, entitlements and policies) to children, people in active age groups with insufficient income and older persons (Social Protection Floor workgroup, 2009).

Figure 5 provides an overview of the components of social protection systems.

Figure 5. Components of social protection systems  
Source: FAO (2009: 43).



Increased levels of social protection and strengthened public services are crucial to achieve the MDGs and to address the vulnerability of poorer populations in the context of the financial and food price crises (European Commission, 2009a). The EU has committed to supporting actions by third countries to cope with crises through the creation and strengthening of social protection systems (European Commission, 2009a; Council of the European Union, 2009a). This will help facilitate the redistributive potential of public policies, as improved access to public services and assets (especially in the health and education sectors) and income transfers change the structure of opportunities (European Commission, 2009a).

Four out of five people worldwide lack the backup of basic social security coverage (CSDH, 2008). In the past, social protection has been criticized as costing too much and reducing opportunities for public investment in other priority areas. These criticisms have largely been invalidated by the experience of countries successful in economic, political and social terms that show that economic development and social protection are mutually reinforcing (ILO, 2003). Effective access to social protection is an investment in people, social justice and social cohesion, with a high rate of return, not only in economic terms (ILO, 2003).

In its support to social protection systems in third countries, the EU may consider that both the degree of universality and the level of generosity are important aspects of a health equity promoting social protection system (CSDH, 2008).

The CSDH calls for the establishment and strengthening of universal comprehensive social protection policies that support a level of income sufficient for healthy living for all. It recommends that social protection systems be extended to include those groups that may be normally be excluded (e.g., those in precarious work) and that they use targeting only as a backup for those who slip through the net (CSDH, 2008).

Resource constraints can constitute barriers to the advancement of social protection systems. However, there are important arguments for creating systems that from the outset have as their goals the progressive attainment of universality and enhanced generosity over the long term. It is increasingly recognised that most targeted social protection programmes across the world lack mechanisms to deal with the "new poor", who are pushed into poverty by aggregate shocks (European Commission, 2009a). The CSDH provides evidence that universal approaches tend to be more efficient than approaches that target the poor. In most lower-income countries, leakage to the rich costs less than means testing (CSDH, 2008). In lower-income countries, even a small amount of money on a regular basis can make an important difference in terms of well-being (CSDH, 2008).

While limited institutional capacity remains an important barrier, it is feasible for lower-income countries to start building social protection programmes through scaling up pilot projects (CSDH, 2008). In the absence of universal

systems, means-tested or targeted cash transfers can have a significant positive impact on living conditions and health, although it remains advisable to move towards a universal approach in long-term development plans (CSDH, 2008). Ensuring a social protection floor for the entire world population represents a considerable challenge, but calculations by UN agencies show that a basic floor of social transfers is globally affordable at virtually any stage of economic development, even if the funding is not yet available everywhere (Social Protection Floor workgroup, 2009).

The EU can play an important role in supporting the establishment and strengthening of social protection measures in third countries. The EU MDG contracts, which provide for more long-term and predictable budget support, could be useful tools for this. Continued coordination and coherence between the EU and other development partners working on social protection is required. An example of existing cooperation is the Providing for Health (P4H) initiative, which aims to support countries with the development of social health protection systems by increasing financial protection against out-of-pocket

payments. The EU might wish to explore further collaboration with the new Social Protection Floor (SPF) Initiative. The SPF Initiative was adopted by the United Nations System Chief Executive Board in 2009 as one of its nine key priorities to cope with the current global crisis.

## The Accra Agenda for Action and health equity

The EU and its Member States provide more than a half of global aid to developing countries. Since the Monterrey Consensus in 2002 and in view of achieving the MDGs, the EU has agreed to increase volumes of overseas development assistance (ODA). This means that the EU will be spending around €30 billion more per year on development assistance from 2010 (DG Development and Relations with African, Caribbean and Pacific States, 2009). The EU is committed to increasing aid effectiveness, in line with the Paris Declaration and Accra Agenda for Action. The table below, from the EC report "Aid Effectiveness after Accra" highlights current challenges and progress in relation to improved donor/aid coordination by the EU.

**Table 4. Areas for Community action as they relate to select\* recommendations and findings for health equity from the Commission on Social Determinants of Health (CSDH)**

Source: European Commission (2009b:4). \*These are the EU targets. The Accra global targets for both indicators are now 50%. Targets for each individual partner country depend on performance. \*\*This is the EU target; the Paris target is 40%.

**Table 4: Monitoring the Paris Declaration: EU status on some of the key targets**

Paris Indicators	EU (Member States and EC)	EC	2010 Target
Aid flows are recorded in countries' budgets	44%	57%	85%
Technical assistance is aligned and coordinated	53%	43%	100% (Paris target is 50%)
Donors use country systems for public financial management	47%	35%	50-80%*
Donors use country procurement systems	54%	34%	50-80%*
Donors reduce stock of project implementation units (PIUs) by two-thirds	780 (per MS: 56)	203	Indicative EU: 118 Indicative EC: 68
Aid is more predictable	43%	53%	71%
Aid is untied	94%	NA	Indicative: 100%
Donors use coordinated mechanisms for aid delivery (through programme-based approaches)	46%	44%	66%
Donors coordinate their missions	33%	33%	66%**
Donors coordinate their (country) studies & analytical work	62%	72%	66%

Aid delivery influences social determinants of health and health inequalities in third countries. The CSDH recommends that donors take social determinants of health and health inequalities into account in their efforts to improve aid effectiveness. What follows is an exploration of select entry points through which the EU could address health inequalities in its implementation of the Accra Agenda for Action. The areas explored are policy dialogue with third countries, support to the use of impact assessment methodologies by third countries, and integrating expertise and tools into multi-donor approaches, including those promoted by the International Health Partnership (IHP+) and related initiatives. With regards to the reinforcement and use of the systems of third countries for the delivery of aid (a key aspect of the Accra Agenda for Action), the previous section addressing national health information systems and social protection systems is relevant.

The Accra Agenda for Action calls for developing countries and donors to broaden country-level dialogue and ensure that their respective development policies and programmes are harmonised and consistent with international commitments, including those on human rights (OECD, 2008). In support of General Comment 14 on Article 12 on the right to health, the EU could incorporate more systematically social determinants of health and health inequalities into country-level dialogue. This could involve drawing from the global evidence base collected by the CSDH, reviewing and incorporating into dialogue national data on socially determined health inequalities, and sharing the experiences of countries that are advancing efforts to reduce health inequalities. Incorporating these issues into country-level dialogue could be aided by tools and resources, including those discussed in this chapter's section on the European Consensus on Development.

Strengthening country capacity to lead and manage development is a central objective in the Accra Agenda for Action. Managing the impact of development processes on health (and health equity) requires know-how to analyse, monitor and respond to intended and unintended consequences of planned strategies and interventions. For this reason, building the capacity of third country governments and civil society organisations to conduct impact assessments is highly relevant. The EU could provide technical guidance to partner countries on methodologies that assess the health equity impact of policies and programmes in all sectors, not just the health sector. Knowledge could be shared on equity-oriented Health Impact Assessment (HIA) methodologies (see the previous chapter), and on means to integrate health and health equity considerations better into Social or Environmental Impact Assessment methodologies.

While the CSDH advocates that equity-oriented health impact assessment must happen as a matter of course, it acknowledges that the institutionalisation of equity-oriented health impact assessment is at a very early stage. It faces considerable challenges with regards to required technical skills and institutional capacity in many countries, especially

those with low and middle incomes. As such, a long-term commitment is required; one that aims to integrate measures into existing activities and build institutional capacity steadily without overburdening institutions in the short term. The example of environmental impact assessment provides some basis for optimism. In the space of a generation, environmental impact assessment has become a widely acknowledged criterion in policy-making processes across the board (CSDH, 2008).

The Accra Agenda for Action aims to improve the capacity to deliver results. Health sector interventions that are unable to serve those in greatest need, and actions in other sectors that contribute to increased ill health and health inequality, are far from the results desired. The donor community can do more collectively to integrate and fund approaches and tools that take into account the social determinants of health and health equity in all phases of support provided to developing countries. The EU could take the lead in work with other donors to *integrate appropriate expertise and measures for health equity* into activities that aim to improve alignment with national development strategies, donor coordination and predictable funding flows. Such activities include joint missions, Joint Assistance Strategies, SWAPs, and common country assessments. It could support the initiative for measures to be applied in multi-donor input to Poverty Reduction Strategies and other national development strategies. EU development staff training (mentioned previously), the inclusion and maintenance of a list of experts in health equity in existing rosters, and cooperation with WHO and other relevant international agencies, associations and civil society organisations could help support these efforts.

A specific opportunity for the EU to work together with development partners for greater attention to health equity is through involvement in IHP+. EU and EEA Member States that are partners in IHP+ include Finland, France, Germany, Italy, Norway, Portugal, Spain, Sweden, the Netherlands and the UK. IHP+ aims to improve the way international agencies, donors and developing countries work together, including by the mobilising of donor countries and other development partners around a single country-led national health strategy, guided by the principles of the Paris Declaration on Aid Effectiveness and the Accra Agenda for Action (IHP+, 2009a). One of the initiatives of IHP+ is a tool and guidelines for the Joint Assessment of National Strategies and Plans (IHP+, 2009b). The joint assessment tool provides details of the attributes of robust national strategies across five broad categories, covering both national strategy processes and content. These categories are:

1. The situation analysis, and the coherence of strategies and plans with this analysis ('programming');
2. The process through which national plans and strategies have been developed;
3. Financing and auditing arrangements;
4. Implementation and management arrangements;
5. Results, monitoring, and review mechanisms.

Equity considerations are addressed across the five categories used in the joint assessment tool. For instance, in reviewing the situation analysis, characteristics to be assessed include but are not limited to the:

- comprehensiveness and participatory-nature of the analysis of health determinants and health outcome trends based on the prevailing epidemiological, political, socioeconomic and organizational context prevailing in the country;
- use of social, environmental and gender impact assessments; and
- use of disaggregated data (e.g., according to age, gender, socioeconomic group, ethnic group and geographic location) to describe progress towards achieving overall health sector policy objectives in line with the policy dimensions of Resolution WHA 62.12 on primary health care (IHP+, 2009b).

The findings of the joint assessments can be used as the basis for strengthening a national health strategy or plan, and for decisions on technical and financial support. Through its involvement in IHP+ and support of the Joint Assessment of National Health Strategies and Plans, the EU contributes further to addressing global health inequalities.

## The European Neighbourhood Policy and health equity

The ENP aims to deepen the political relationship with, and the economic integration of, the following EU neighbours: Algeria, Armenia, Azerbaijan, Belarus, Egypt, Georgia, Israel, Jordan, Lebanon, Libya, Moldova, Morocco, the occupied Palestinian territory, Syria, Tunisia and Ukraine. The EU recognises its interest in promoting global health in the ENP context, both at regional and country level, including through action on the social determinants of health (Madelin, 2007). ENP countries are invited to participate in EU instruments and networks on health, such as the Public Health Programme, the Community Health Programme and the Network of Competent Authorities on Health Information (European Commission, 2007d).

Bilateral Action Plans have been adopted with twelve ENP countries. All of these Plans include a health component, and health has been identified as an area where cooperation is increasing (European Commission, 2007c). The 2008 country progress reports on implementation of the ENP<sup>4</sup> reflect issues that include:

- ongoing *health sector reforms*, which address issues including expansion of social health protection and the reduction of geographical disparities in coverage;
- interest in strengthening *health information systems*, with almost all countries participating in the EU Network of Competent Authorities in Health Information and Knowledge;
- prominent attention to *communicable diseases*, with some countries involved in the EU HIV/AIDS Think Tank and the “EpiSouth” Network for EU, Mediterranean and Balkan Countries on Communicable Diseases, and two countries requesting increased collaboration with the European Centre for Disease Control (ECDC).

The ENP presents multiple entry points to increase action on health inequalities and social determinants of health. These comprise those discussed previously in this chapter (e.g, EU support for improving health information systems, strengthening social protection systems, integrating a focus on health inequalities and social determinants of health into policy dialogue and multi-donor cooperation; and building third country capacity to use impact assessment methodologies).

The ENP also offers specific opportunities for increased action, such as the participation of representatives from ENP countries in EU *networks and expert groups* (Madelin R, 2007). The EU could explore how ENP representatives could have Observer or participant status in the EU Expert Group on Social Determinants and Health Inequalities, as well as in European networks and EC-funded projects that focus on health inequalities and social determinants of health.

Furthermore, a core function of the ENP is to support *reform processes*, including those concerning the health sector. Reforms represent opportunities to integrate equity measures into health systems, in each of the functions. The EU can work increasingly with ENP countries towards this end, supporting simultaneous action for universal coverage of quality services, solidarity for social health protection, stewardship for cross-sectoral action for health, equity-oriented monitoring and evaluation, and know-how for addressing health equity and social determinants of health among health sector staff and at cross-government levels. Country-to-country exchange between EU Member States and ENP authorities and civil society could be part of this process.

## Considerations for moving forward

The EU has an essential role in addressing global inequities in income levels, opportunities and health status. The need for scaled up concerted action in this area has been evidenced by the current financial and food crises, climate change, the 2009 pandemic (H1N1) and the growing burden of noncommunicable diseases worldwide. This chapter has explored select opportunities for the EU to increase its contribution to action on and the monitoring of social determinants of health and health inequalities in third countries. It has highlighted entry points in relation to the European Consensus on Development; EU support of progress towards the MDGs; the EU’s implementation of the Accra Agenda for Action; and the European Neighborhood Policy. Emerging considerations for further analysis, particularly by policy makers, technical staff and other stakeholders working on development cooperation, are listed below.

### Short term

*Support implementation and follow-up to the communication “the EU role in global health”.*



The communication “the EU role in global health”, described in Annex II, sets forth priority areas including global health governance, global health coherence, global health knowledge, and the EU contribution to universal coverage of health services. Ensuring equity in health is a cross-cutting concern in all of these areas. The focus of the communication on improving policy coherence for development is particularly relevant to action on the social determinants of health globally.

*Increase attention to national health information systems as part of the EU’s comprehensive approach to health system strengthening.*

Greater attention to health information systems is an important part of strengthening health systems, as advocated by IHP+ and the H8. In its support to the MDGs and other development goals, the EU could give increased emphasis to reinforcing national health information systems, including their ability to monitor health inequalities and social determinants of health. Improving national health information systems also benefits action on health challenges not currently addressed by the MDGs, such as the growing non-communicable disease burden.

In its contribution to international fora addressing progress towards the MDGs, the EU can advocate the need to reinforce health information systems as an integral part of health system strengthening and to go beyond national averages to evidence health inequalities.

*Support comprehensive social protection systems in third countries.*

The EU is committed to increasing its support for social protection in developing countries, particularly in light of increased vulnerability due to the food price and financial crises. Both the degree of universality and the level of generosity are important aspects of a health equity promoting social protection system. Therefore, in responding to the current crisis, it will be important that the EU promotes realisation of social protection systems that from the outset have as goals the progressive attainment of universality and enhanced generosity over the long term.

The proposed longer-term EU MDG contracts and potential cooperation with the new Social Protection Floor Initiative could present opportunities for the EU to strengthen further its support of social protection.

### Longer term

Make health a cross-cutting issue in the European Consensus on Development.

The EU may consider whether it would be beneficial to make the Health in All Policies approach (sensitive to health equity) a cross-cutting issue in the European Consensus on Development. Cross-cutting issues are integrated into donor programmes through tools including strategic

assessments, programming guides and topic-specific country profiles. Acknowledging the difficulties in mainstreaming cross-cutting issues, efforts could build on lessons learned in the rolling out of other cross-cutting issues (e.g., gender, environment). A training programme for EU development staff could be created or a module/course could be incorporated into existing programmes. Training activities could draw expertise for addressing health inequalities and social determinants of health from across EU Member States, civil society organisations, academia and other development partners.

Scale up action on social determinants of health and health inequalities in efforts to improve aid effectiveness.

There are opportunities for the EU to increasingly account for social determinants of health and health inequalities in its efforts to improve aid effectiveness. This can be done through measures including but not limited to:

- Policy dialogue with third countries. In incorporating these issues into dialogue, the EU can draw from the global evidence base collected by the CSDH, existing national data on socially determined health inequalities, and relevant experiences in other countries.
- Strengthening the capacity of third countries (at government and civil society organisation levels) to lead and manage development through their use of impact assessment methodologies, particularly equity-oriented Health Impact Assessments and integration of health and health equity concerns into Social and Environment Impact Assessments.
- Integrating expertise and tools for addressing health equity and social determinants of health into joint donor missions, Joint Assistance Strategies, Sector-Wide Approaches (SWAps), and common country assessments ((including through partnership with IHP+ and partaking in IHP+ Joint Assessment of National Health Strategies and Plans).

These efforts could be supported by the inclusion of experts in social determinants of health and health equity in existing rosters; and by cooperation with relevant international agencies, associations and civil society organisations.

*Improve access to EU resources for improving health equity to ENP countries.*

The EU may consider how ENP countries could be represented in EU expert groups, networks, and EC-funded projects that address health equity and social determinants of health. It could also define mechanisms to integrate equity principles and a social determinants of health approach to EU support to health sector reform in ENP countries. This may involve facilitating country-to-country exchange between EU and ENP Member State authorities and civil society.

COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS  
SOLIDARITY IN HEALTH: REDUCING HEALTH INEQUALITIES IN THE EU  
(Text with EEA relevance)

<sup>1</sup><http://tinyurl.com/n2xl6b>.

<sup>2</sup>COM(2007) 630.

<sup>3</sup>COM(2008) 412.

<sup>4</sup>Health inequalities: Europe in profile. Mackenbach J., 2006.

<sup>5</sup>SEC(2006) 410.

<sup>6</sup>SEC(2008) 2172.

<sup>7</sup>Breaking the barriers: Romani women and access to public health care. EU European Monitoring Centre on Racism and Xenophobia 2003.

<sup>8</sup>Monitoring progress towards the objectives of the European Strategy for Social Protection and Social Inclusion, 2008.

<sup>9</sup>OJ C 146, 22.6.2006, p. 1.

<sup>10</sup>COM(2008) 689.

<sup>11</sup>COM(2008) 836.

<sup>12</sup>European Directory of Good Practices to reduce health inequalities. <http://tinyurl.com/ybrpdy2>

<sup>13</sup>COM(2005) 706.

<sup>14</sup><http://tinyurl.com/dmycvx>

<sup>15</sup>OJ L 354, 31.12.2008, p. 70.

<sup>16</sup>Council of the European Union. Doc 10117/06. 9 June 2006.

<sup>17</sup>COM(2008) 418.

<sup>18</sup>Council Conclusions on inclusion of the Roma. <http://tinyurl.com/kne9s5>

<sup>19</sup>Council Resolution of 20 November 2008 on the health and well-being of young people.

<sup>20</sup>SEC(2006) 410.

<sup>21</sup>Commission on Social Determinants of Health Final Report. WHO 2008.

<sup>22</sup>Current mandate at <http://tinyurl.com/l947z8>

## EQUAL OPPORTUNITIES AND SOLIDARITY IN HEALTH

European Union (EU) citizens live, on average, longer and healthier lives than previous generations. However, the EU is faced with an important challenge: the large gaps in health which exist between and within EU Member States. Moreover, there are indications that such gaps may be growing. Increased unemployment and uncertainty arising from the current economic crisis is further aggravating this situation. This communication launches the debate needed to define potential EU-level flanking measures to support actions by Member States and other actors to address this issue.

Concerns over the extent and the consequences of health inequalities – both between and within Member States – have been expressed by the EU institutions and many stakeholders, including through the consultation on this Communication. The European Council of June 2008 underlined the importance of closing the gap in health and in life expectancy between and within Member States<sup>1</sup>. In 2007 the EU Health Strategy<sup>2</sup> set out the Commission's intention to carry out further work to reduce inequities in health. This was reiterated in the 2008 Commission Communication on a Renewed Social Agenda<sup>3</sup> which restated the fundamental social objectives of Europe through equal opportunities, access and solidarity and announced a Commission Communication on health inequalities.

The Commission regards the extent of the health inequalities between people living in different parts of the EU and between socially advantaged and disadvantaged EU citizens as a challenge to the EU's commitments to solidarity, social and economic cohesion, human rights and equality of opportunity. Therefore, the Commission is determined to support and complement Member States and other stakeholders in their efforts to tackle them.

## INEQUALITIES IN HEALTH IN THE EU

While the average level of health in the EU has continued to improve over the last decades, differences in health between people living in different parts of the EU and between the most advantaged and most disadvantaged sections of the population remain substantial and in some instances have increased. Between EU Member States there is a 5-fold difference in deaths of babies under one year of age, a 14 year gap in life expectancy at birth for men and an 8 year gap for women. Large disparities in health are also found between regions, rural and urban areas and neighbourhoods.

Throughout the EU a social gradient in health status exists where people with lower education, a lower occupational class or lower income tend to die at a younger age and to

have a higher prevalence of most types of health problems<sup>4</sup>. Workers doing predominantly manual or routine repetitive tasks have worse health than those doing non manual, less repetitive tasks. Differences in life expectancy at birth between lowest and highest socio-economic groups reach 10 years for men and 6 years for women. There is also an important gender dimension, women in general live longer than men but may spend a longer proportion of their lives in ill health.

Vulnerable and socially excluded groups such as people from some migrant or ethnic minority backgrounds, the disabled or the homeless experience particularly poor average levels of health<sup>5</sup>. For example Roma have an estimated life expectancy 10 years less than the general population<sup>6</sup>. Reasons for poor health in such groups may include poor housing, poor nutrition and health related behaviours as well as discrimination, stigmatisation and barriers to accessing health and other services<sup>7</sup>.

Health inequalities are due to differences between population groups in a wide range of factors which affect health. These include: living conditions; health related behaviours; education, occupation and income; health care, disease prevention and health promotion services as well as public policies influencing the quantity, quality and distribution of these factors. Health inequalities start at birth and persist into older age. Inequalities experienced in earlier life in access to education, employment and health care as well as those based on gender and race can have a critical bearing on the health status of people throughout their lives. The combination of poverty with other vulnerabilities such as childhood or old age, disability or minority background further increases health risks.

Differences in health, are linked to a number of socio-economic factors<sup>8</sup>. Economic conditions can effect many aspects of living conditions which can impact on health. Some areas of the EU still lack basic amenities such as adequate water and sanitation. Cultural factors which affect lifestyle and health behaviour also differ markedly between regions and population groups. Many regions, in particular in some of the newer Member States, are struggling to provide much needed health services to their populations. Barriers to access to health care can include lack of insurance, high costs of care, lack of information about services provided, language and cultural barriers. Some research has suggested that poorer social groups use health care less for equivalent levels of medical need than more affluent groups.

As health inequalities are not simply a matter of chance but are strongly influenced by the actions of individuals, governments, stakeholders, and communities, they are not inevitable. Action to reduce health inequalities means tackling those factors which impact unequally on the health of the population in a way which is avoidable and can be dealt with through public policy.

## CURRENT EU FLANKING POLICIES

In 2006 the Council agreed conclusions on common values and principles in EU health systems stressing the overarching goal of reducing health inequalities<sup>9</sup>. Improving the access to health care and to disease prevention and promotion systems could certainly mitigate some of the health inequalities as pointed out in the EU Health Strategy. The contribution towards reducing health inequalities should be ensured in implementing initiatives such as the Council recommendation on cancer screening, the Communication on telemedicine<sup>10</sup> the Communication on patient safety<sup>11</sup> or the Proposal for a Directive on the application of patients' rights in cross-border healthcare. Addressing health inequalities is a key action of the EU Health Strategy (2008-2013) which identifies equity in health as a fundamental value and has led to an orientation towards addressing health inequalities in areas such as mental health, tobacco, youth, cancer, and HIV/AIDS. The EU public health programme has supported the identification and development of activities to address health inequalities including a European directory of good practices<sup>12</sup>. First steps have been taken to improve data collection and the networking of Member states and key stakeholders.

Through the Open Method of Coordination for Social Protection and Social Inclusion (social OMC)<sup>13</sup> EU Member States have agreed to the objective of addressing inequalities in health outcomes. This is supported by a set of common indicators based on Eurostat work on public health statistics. The EU level analysis of Member States' National Strategies Reports on Social Protection and Social Inclusion has helped stimulate debate and action in Member States. At EU level an expert group has worked since 2005 to review evidence and exchange information on policies and practice<sup>14</sup>. EU health programmes have supported a number of initiatives on health inequalities. The Research Framework Programmes (currently FP7) provide important support for research in this field, and a variety of action programmes including the Health Programme and the EU's employment and social solidarity programme PROGRESS<sup>15</sup>, finance studies, examples of good practice and policy innovations.

Other EU policies can also contribute to reducing health inequalities. Reducing health inequalities is also an objective for the public health challenges identified in the EU Sustainable Development Strategy<sup>16</sup>. The goal of a more equal distribution of health is underpinned by the EU's overarching objectives to create economic growth with social solidarity, the Lisbon strategy. EU legislation in the areas of labour law and occupational health and safety contributes to reducing accidents at work and occupational diseases. EU environment policy and the market policies under the Common Agricultural Policy support a range of initiatives which can contribute to improving health. The EU provides financial support via the Cohesion policy and the

European Agricultural Fund for Rural Development which can be used to reduce disparities between regions through investment in determinants of health inequalities, such as living conditions, training and employment services, transport, technologies, health and social care infrastructure. Further consideration of the contribution of existing EU policies is contained in the impact assessment accompanying this Communication.

## **TAKING ACTION ON HEALTH INEQUALITIES: A COLLABORATIVE APPROACH**

The need for further action arises because of increasing evidence on the size and pervasiveness of health inequalities across the EU and concerns about the negative consequences for health, social cohesion and economic development if health inequalities are not effectively tackled. Existing actions appear to have had only limited impact and there is a risk that these gaps could widen as a result of recent economic difficulties. Moreover better levels of health across all population groups are critical in the context of an ageing EU population to contribute to the sustainability of social protection systems.

While the principal responsibility for health policy rests with Member States, not all of them have the same available resources, tools or pools of expertise to address the different causes to health inequalities. The European Commission can contribute by ensuring that relevant EU policies and actions take into account the objective of addressing the factors which create or contribute to health inequalities across the EU population.

The EU should use to that extent in the most efficient way the mechanisms and tools available. For instance it can play an important role in raising awareness, promoting and assisting the exchange of information and knowledge between the concerned Member States, identifying and spreading good practices and in facilitating the design of tailored made policies for the specific issues prevailing in Member States and/or special social groups. It shall also monitor and evaluate the progress in the application of such policies.

## **KEY ISSUES TO ADDRESS**

Experience to date suggests a number of important challenges which must be addressed to strengthen existing action to reduce health inequalities.

### ***An equitable distribution of health as part of overall social and economic development***

In broad terms the level of health is associated with wealth. Richer countries and regions have on average better health as measured by various indices. But this relationship does not hold consistently. More economic resources provide greater potential for maintaining and improving health but

only if deployed in a way which enables this to occur. It is clear that not all groups have benefited to the same extent from economic progress. What is important is to create a pattern of overall economic and social development which leads to greater economic growth, as well as greater solidarity, cohesion and health. The EU structural funds have a vital role to play in this regard.

### ***Improving the data and knowledge base and mechanisms for measuring, monitoring evaluation and reporting***

Measurement of health inequalities is a fundamental first step to effective action. Although robust evidence exists in a number of areas, more detailed information is required on the effect and importance of various health determinants to implement effective action in relation to particular population groups and determinants.

Knowledge on the effectiveness of policies to tackle inequalities also needs improving. Despite a body of research on the effectiveness of public health interventions and of the effect of other policies and actions on health, only a small number have been specifically evaluated for their differential health impacts on social groups or areas. The assessment of the impact of policies outside the public health sector is even more limited.

Lack of routinely available and comparable EU data and research knowledge poses an obstacle to assessing the current situation, rethinking policy priorities, establishing comparisons, deriving best-practices, and reallocating resources where they are most needed. Existing and future data available at the EU level notably through the full implementation of EU surveys such as the EU Survey on Income and Living Conditions (EU-SILC), European Health Interview Survey and the EU survey on disability and the implementation regulations on all fields of public health statistics should be used to create measures of health inequalities which will enable comparison over time and across the EU. Coherence with other international datasets should also be ensured.

Causes of Health inequalities vary between Member States and between specific population groups. Member States should aim to establish, in close collaboration with the Commission, a common set of indicators to monitor health inequalities and a methodology to audit the health situation in Member States aimed to identify and prioritizing areas of improvement and best practices. The Commission could support Member States to achieve their objectives by providing analysis and support on the basis of available information. This could prove to be a useful tool for Member States when designing, prioritizing and implementing more efficient and effective policies adjusted to their specific situation, and to better use the existing EU tools to support their actions.

Funding pilot and twinning projects and peer review programs could help Member States to implement such

policies. Peer reviews should encompass scrutiny of existing policies, programs or institutional arrangements that have been identified as good practices.

#### ***EU level Actions:***

Support the further development and collection of data and health inequalities indicators by age, sex, socio-economic status and geographic dimension.

Develop health inequality audit approaches through the Health Programme in joint action with Member States willing to participate.

Orient EU research towards closing knowledge gaps on health inequalities – including activities under the themes of Health and Socio-economic Sciences and Humanities of the 7th EU Framework Programme for Research.

Emphasise research and dissemination of good practices relevant to addressing health inequalities by EU Agencies, including: the European Foundation for the Improvement of Living and Working Conditions, the European Centre for Disease Prevention and Control and the European Agency for Health and Safety at Work.

#### ***Building commitment across society***

Reducing health inequalities means having an impact on the health of people in their everyday lives, at work, at school, and at leisure in the community. In addition to national governments, regional authorities in many countries have an important role in public health and health services and thus need to be actively involved. The health sector has a leading role to play, both in ensuring equitable access to health care and in supporting knowledge and training both to health professionals and to other sectors. Local governments, workplaces, and other stakeholders also have a vital contribution to make.

Thus, improving the exchange of information and knowledge and improving the coordination of policies between different levels of government and across a number of sectors (health care, employment, social protection, environment, education, youth and regional development) can create more effective action and achieve a larger and consistent impact. There is also a need to create more effective partnerships with stakeholders that can help to promote action on various social determinants and thus improve health outcomes.

This is an area where Member States can learn from each other when devising their own policy strategies. The EU can help through strengthening policy coordination mechanisms and facilitating the exchange of information and good practice between Member States and stakeholders. Initiatives like the EU Health Policy Forum, the Partnership against Cancer, the Alcohol Forum or the EU Platform on Diet Physical Activity and Health are important instruments to address the health inequalities policy agenda.

The Commission has indicated<sup>17</sup> its intention, within the Social OMC, to make more use of peer reviews and PROGRESS funding as well as to consider targets on health status to sustain commitment and the achievement of common objectives.

The Commission will also take up the interest shown by the Committee of the Regions in the consultation on this communication and will aim to build a focus on health inequalities into regional cooperation arrangements on health.

#### ***EU level Actions:***

Develop ways to engage relevant stakeholders at European level to promote the uptake and dissemination of good practice.

Include health inequalities as one of the priority areas within the ongoing cooperation arrangements on health between the European regions and the Commission.

Develop actions and tools on professional training to address health inequalities using the health programme, ESF and other mechanisms.

Stimulate reflection on target development in the Social Protection Committee through discussion papers.

#### ***Meeting the needs of vulnerable groups***

Addressing health inequalities effectively requires policies which include both actions to address the gradient in health across the whole of society as well as actions which are specifically targeted to vulnerable groups. Particular attention needs to be given to the needs of people in poverty, disadvantaged migrant and ethnic minority groups, people with disabilities, elderly people or children living in poverty. For some groups, the issue of health inequality including reduced access to adequate health care, can be qualified as one which involves their fundamental rights. The European Charter of Fundamental Rights specifies the right to: social and housing assistance to ensure a decent existence for all those who lack sufficient resources; access to preventive health care and the right to benefit from medical treatment; and to working conditions which respect health. The United Nations Charter on the Rights of the Child specifies several key rights relating to children's basic needs which in turn affect their health while the UN Convention on the Rights of Persons with Disabilities specifies the rights of access for persons with disabilities to health services. Health inequalities are included as one of four priorities of the Commission's youth health initiative launched in 2009.

Demographic change and the ageing of our societies will create new health challenges.

The Council has identified the need for additional action on the health needs of migrants, and Roma<sup>18</sup> and young

people with fewer opportunities<sup>19</sup>. The Commission is starting a pilot project on Roma inclusion, including health and integrated interventions in the educational, social, and economic areas and cross border cooperation.

Further use of the Cohesion Policy and associated structural funds to promote interventions in favour of the health of vulnerable groups such as Roma should be developed.

#### ***EU level Actions:***

Launch initiatives in collaboration with Member States to raise awareness and promote actions to improve access and appropriateness of health services, health promotion and preventive care for migrants and ethnic minorities and other vulnerable groups, through the identification and exchange of good practice supported by the health and other programmes.

Ensure that the reduction of health inequalities is fully addressed in future initiatives on healthy ageing.

A Report on the use of Community instruments and policies for Roma inclusion including a section on health inequalities will be prepared for the 2010 Roma summit.

Examine how the Fundamental Rights Agency could, within the limits of its mandate, collect information on the extent to which vulnerable groups may suffer from health inequalities in the EU, particularly in terms of access to adequate health care, social and housing assistance.

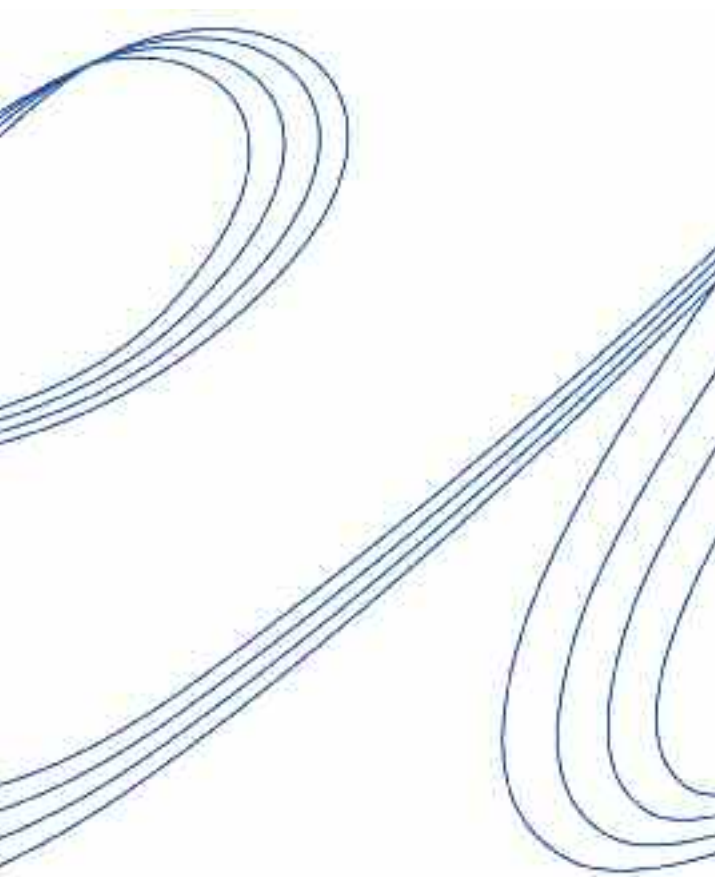
Carry out activities on health inequalities as part of the European Year for Combating Poverty and Social Exclusion 2010.

#### ***Developing the contribution of EU policies***

As mentioned in Section 3 a number of EU policies which can contribute directly or indirectly to tackling health inequalities, and there are a number of tools available at community level that could be use. There is further scope for improving the contribution of EU policies through better understanding of their impact on health and via greater policy integration. This would lead to a better prioritisation and more efficient use of the existing tools.

While there is general agreement on the principle of reducing health inequalities, the level of awareness and the extent to which action is being taken varies substantially. Over half of the EU Member States do not place policy emphasis on reducing health inequalities and there is a lack of comprehensive inter-sectoral strategies<sup>20</sup>. In addition, policies implemented lack evaluation and dissemination which limits knowledge of policy effectiveness. The EU has a role to improve the coordination of polices and promote the sharing of best practices.

Different Commission policies should continue to support Member States to create more equitable access to high



quality health care and prevention and promotion systems. The EU could play a role promoting better cooperation between health systems as envisaged in the Proposal for a Directive on the application of patients' rights in cross-border healthcare. It could also contribute to better understand and propose solutions for the challenges facing by the health systems regarding the capacity of the European health work force; and can also contribute to assess how to use efficiently the new technologies in the health sector.

EU Cohesion policy is important in achieving the Lisbon objectives of economic and social cohesion and can be a powerful tool to address health inequalities. The current Community Strategic Guidelines set out the possible use of the funds for health related actions. Member States have allocated around € 5 billion (1.5% of the total available) from the funds in the category Health Infrastructure for the period 2007-2013. An increased use of the funding opportunities offered by the Cohesion Policy to address health inequalities would require improvements in: knowledge of the opportunity to use funds in this area; coordination between national policy departments; and technical capacity to develop investments in this field. An effort should be made to increase the health focus for the next programming period and achieve a better alignment of the strategic documents under EU Cohesion Policy with the priorities identified in the Social OMC.

The national implementation of Community Legislation on Health and Safety at Work and the Community Strategy on Health and Safety at Work 2007-2012 provide an opportunity to reduce health inequalities in the EU by protecting worker's health and reducing the negative impact of some of its determinants. Further attention should be placed on health inequalities within the context of promoting equal opportunity between men and women.

Currently few EU policy actions are evaluated after implementation in relation to their impact on health inequality. Building on existing work more development is needed of mechanisms to evaluate the health impact of existing policies (ex post) on different population groups to produce information for further policy development. Such mechanisms cannot be "one size fits all" and would draw on good practice developed in Member States. In addition, the EU can make use of existing reports including the Cohesion Report, the Employment Report and the Lisbon Report to analyse the relationship between these policies and health outcomes across EU areas and population groups.

The EU is also committed to supporting other countries in health and related fields. The WHO Commission on the Social Determinants of Health<sup>21</sup> recently described the massive health differences between countries and social groups worldwide and called for concerted action at all levels of government to address them. EU activities may affect health in third countries in a variety of ways including trade, development assistance, work with international

organizations, and exchange of knowledge. EU experience on tackling health inequalities may also have relevance outside the EU. Possible synergies between the Commission's development aid and the work within the EU on inequalities in health should therefore be explored. The EU should also liaise with relevant international organisations on work in this area.

#### **EU level Actions:**

Provide further support to existing mechanisms for policy coordination and exchange of good practice on health inequalities between Member States such as the EU expert group on Social Determinants of Health and Health Inequalities<sup>22</sup>, linking both to the Social Protection Committee and the Council Working Party on Public Health and the Social Protection Committee.

Review the possibilities to assist Member States to make better use of EU Cohesion policy and structural funds to support activities to address factors contributing to health inequalities.

Encourage Member States to further use the existing options under the CAP rural development policy and market policy (school milk, food for most deprived persons, school fruit scheme) to support vulnerable groups and rural areas with high needs.

Hold policy dialogues with Member States and stakeholders on equity and other key fundamental values in health, as set out in the EU Health Strategy.

Provide funding under PROGRESS including for peer reviews and a call for proposals in 2010 to assist Member States in developing relevant strategies.

Run a forum on health and restructuring to examine appropriate measures to reduce health inequalities.  
Commission initiative on the EU role in global health

## **NEXTSTEPS**

Tackling health inequalities is a long term process. The actions in this Communication are intended to lay the framework for sustained action in this area. On the basis of this Communication and the future discussions in the Council the Commission intends to work actively in partnership with Member States and stakeholders in the coming period. A first progress report on the situation will be produced in 2012.

## ANNEX II. Overview of EC communication on "The EU Role in Global Health"

Juan Garay, Human and Social Development Unit, DG Development, European Commission

Globalisation has influenced growing inequalities between and within countries, in terms of both risks to health and access to health services. The Commission Communication on "The EU role in Global Health" aims to enhance the EU vision, voice and action to address these challenges. At the time of writing (26th February 2010), the final content of the Communication is still being considered. However, in its current state, the forthcoming Communication defines the global health concept, framework and challenges; provides an analysis of the EU added-value as a major actor in global health; sets the priority areas for action; and proposes the core strategic elements to enhance the EU role in global health. The main priority areas are global health governance, global health coherence, global health knowledge, and the EU contribution to universal coverage of health services. What follows is an exploration of key issues comprised in these main priority areas.

**Strengthening global health governance:** While global health policies are agreed in the World Health Assembly, the reality is that decisions on strategies, priorities and processes are largely fragmented, with over 140 global health initiatives. While this multiplicity of initiatives results in increased funding, it does not address problems in an equitable way (across countries, within countries, across groups, and across burden of disease). Addressing these inequalities requires stronger leadership at national and global level. The EU, in the context of the Lisbon Treaty, can have a stronger joint vision, voice and action in global health and should promote an inclusive framework under the UN leadership.

**Increasing EU coherence in global health:** The EU policy coherence for development approach focuses on five priority issues which are all relevant to global health. EU policies on trade and financing influence partner countries' capacities to advance in providing health services and particularly on access to medicines. EU migration policies also have direct repercussions on the capacities of partner countries to retain health professionals. The EU foreign and security policy needs to respond to global health threats. Food security is closely linked with nutrition, the main attributable risk of ill health. Climate change and related EU actions will also have a direct effect on global health. The policy will propose specific ways to maximise the synergies with these policies in coherence with the agreed EU principles in advancing global health. All of these factors play a critical role in global health equity.

**Reinforcing the link with global health knowledge:** Acknowledging that market forces can drive the research and development of health knowledge, it is important to ensure health equity by giving due attention to the priority health needs of populations experiencing poverty. At the



same time, global health knowledge can be often disconnected from health policy decisions at national and global levels. As health becomes more global, certain health developments or objectives are of global benefit and should be seen as global public goods for health. These deserve global investments beyond research and development funding. The EU, within the objectives of the Lisbon agenda, will maximise the opportunity to advance global health knowledge and give it greater equity and impact. In the Framework of the MDG Review, the lack of progress on health MDGs is, in part, linked with the low efficiency of addressing health MDGs in silos. There is a need to produce knowledge to interlink strategies and find synergies that impact on all three health MDGs, especially MDG 5 (which is the most off-track), and strengthen health systems.

**Advancing towards universal and equitable access to health services:** The gaps between and within countries in access to health services and in life expectancy are growing. In the EU, the recent Communication “Solidarity in health: Reducing health inequalities in the EU” proposed a number of strategies to contribute to greater health equity. In its external action, the EU will maximise its support to countries to mobilise domestic resources for health; link commitments to ODA levels and additional innovative financing with health challenges; apply the EU division of labour; give greater attention to countries in critical need (often in fragile contexts); increase alignment and predictability behind comprehensive national health plans; and increase health sector dialogue (including in relation to other key sectors and MDGs with an impact on determinants of health such as gender equality, water and sanitation, and nutrition).

In order to advance in the four main priority areas outlined above, the forthcoming communication on the “EU role in global health” outlines a series of actions for the EU, including those listed below.

The EU should prioritise and increase its support to strengthen the capacities of countries in fragile contexts and/or those most off-track in efforts to reach the health MDGs. Support should be provided to design and implement national policies, strategies and programmes to accelerate their progress towards the achievement of health MDGs. This approach should be consistently pursued by the EU through bilateral channels and participation in global initiatives and international fora.

The EU should concentrate its support on strengthening health systems to ensure that their main components – health workforce, access to medicines, infrastructure and logistics and decentralised management, including health information systems – are sufficiently effective to deliver basic equitable and quality health care for all. This will

complement the EU existing action in the area of health workforce. This approach is particularly essential to progress towards MDG 5. The International Health Partnership (IHP+) should be the preferred framework to provide the EU support.

The EU should promote this approach also in global financing initiatives such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunisation (GAVI) and through its participation in the governance of IFIs. In this respect the EU considers that rather than creating a new health fund, preference should be given to adapting the existing global funds to the challenges of global health.

In complying with its overall ODA commitments, the EU should increase the share of direct or indirect support (through general budget support or global initiatives) for the implementation of national health strategies through country systems with a predictability of at least 3 years, which is essential in order to enable the design and implementation of national health strategies in countries with the lowest public funding capacities. To this end, Member States should be encouraged to join the Commission in MDG contracts, which offer predictability and increased national resources. This would be in line with the overall EU commitment to channel 50% of government-to-government assistance through country systems, including by increasing the percentage of assistance provided through budget support or sector-wide approaches. The EU should also actively explore with global partners the opportunities for additional innovative financing to advance on global health challenges.

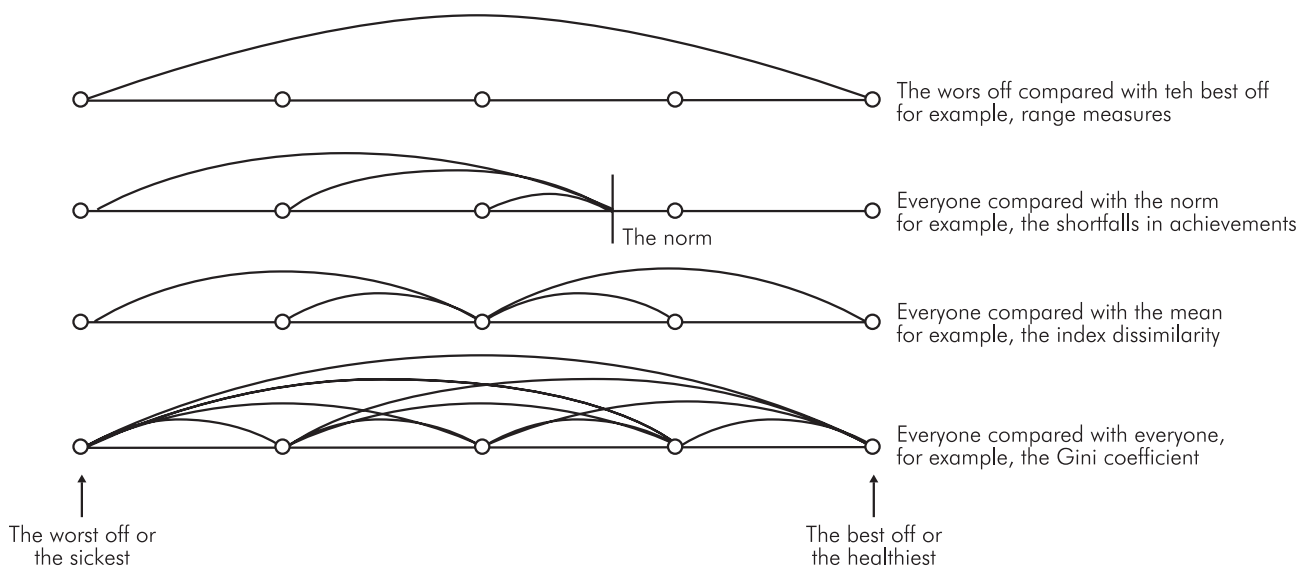
The EU should support the capacities of third countries to formulate effective policies to mobilise domestic revenues, scale up fair financing of health systems, and develop or strengthen social protection mechanisms in health. Replacement of user fees with fair financing mechanisms as well as delivery on existing commitments such as the allocation of 15 percent of national budgets to health in Africa and other ACP countries, should be considered as part of this process. The EU will support the WHO to assess, analyse and provide regular estimates of national public funding gaps for the delivery of basic health care.

The EU should address the multi-sectoral nature of health and its close links to gender, nutrition, water, sanitation and education in policy dialogue related both to health and other relevant policy areas. With regions or countries heavily affected by maternal and child malnutrition, the EU should support the formulation and implementation of government nutrition policies interlinking health and food security interventions. All the above mentioned policy areas will need a strong link with social protection and inclusion policies.

## Sub-annex A.

*Referred to in the chapter Overview: Monitoring of social determinants of health and the reduction of health inequalities in the EU*

Figure 6. Who to compare with whom: identifying the appropriate measurement approach  
Source: Yukiko, 2005.



Health inequalities can be measured through relative and absolute measures: both are needed over time for comprehensive analysis and as inputs to policy making, since they illustrate different aspects of inequalities especially when making comparisons over time or across countries. Relative measures can be used to make comparisons across indicators regardless of the unit of measurement (Keppel et al. 2005; Wilkinson 1997). Identifying who should be compared with whom is not always obvious. Across the European region and for policy purposes, it might be more appropriate to compare women in one country with women in another country, rather than women vs. men.

Depending upon who is being compared with whom, the figure presents four different approaches to comparing different groups, often using the same data sources, with each approach implying a different set of measurement techniques.

Identifying the best metrics or set of measures is also challenging (Keppel et al. 2005; Harper & Lynch 2006). Measures of inter-group differentials can be between two groups (rate ratios; rate differences; low to high ratio; shortfalls) and between more than two groups (slope indices of inequality; concentration indices; indices of dissimilarity). Where stratified data is available for more than two groups

(i.e. low, middle and high income groups), differences between more than two groups offer an approach to monitoring inequalities across the social gradient, which is better than comparing only the lowest and highest group.

Additionally, there are different approaches and measurement techniques for comparing indicators across countries. For example, Wagstaff (2001) and Shkolnikov (2009) have suggested using a health inequalities measure based on absolute mortality rates, which is equal to the population-weighted average of mortality differences across all pairs of group-specific mortality rates (Average Inter-group Difference) and facilitates the comparison of health inequalities between countries or across time periods.

## Sub-annex B.

*Referred to in the chapter "Inequalities in child health".*

Proposed indicators for monitoring inequalities in child health

### Children poverty and social exclusion

- Percentage of children at risk of poverty (60% of median disposable income of the country);
- Percentage of children living in jobless households;
- Percentage of children in single-parent households;
- Percentage of early school leavers.

### Early child development

- Percentage of children in pre-primary school and stratified by population subgroups of interest: maternal education level, family occupational social class, family income, migrant background and ethnic background;
- Maternal education level by population subgroups of interest: occupational social class, family income, migrant background and ethnic background.

### Mortality rates, health status, and health services indicators

- Indicators of child mortality (infant mortality, neonatal and post-neonatal mortality, under-5 mortality), stratified by population subgroups of interest: maternal education level, family occupational social class, family income, migrant background and ethnic background;
- Percentage of children with self-reported or parent-reported unmet health care needs;
- Percentage of exclusive breast-feeding at 1, 3 and 6 months, by maternal education and socioeconomic status;

- Measles immunisation coverage at 1 year in the total population and by socioeconomic status and minority groups;
- Percentage of children with a primary care professional, by socioeconomic status;
- Child-perceived health and health profiles, health behaviours, and risk factors, stratified by population subgroups of interest: maternal education level, family occupational social class, family income, migrant background and ethnic background.

## Sub-annex C.

*Referred to in the chapter "Social exclusion and structural health inequalities".*

The indicators below are suggestions for use in monitoring and reporting on the status of the health of the poor and socially excluded, including migrant and ethnic minority communities in Europe. Most indicators start by "differences in", which means "differences by SES, ethnic and migrant status, age and gender group, and place of residence".

### A. Social determinants and health

#### UNMET HEALTH NEEDS: KEY HEALTH OUTCOME

1. Gap in years of healthy life expectancy and infant mortality between:

- a) The poorest 20% and the richest 20% of individuals and/or local communities
  - Or between the less and better educated,
  - Or between the unemployed and the employed
  - Or between manual and non-manual occupations
- b) By country of origin, ethnic group, immigration status
- c) By men and women, in different categories of a) and b) above
- d) By place and country of residence

2. Differences in unmet needs of health care: no medical visit in spite of being sick

3. Differences in reasons for unmet needs (see EU-SILC)

#### SOCIAL DETERMINANTS OF HEALTH: SOCIAL POWER RESOURCES

4. Socioeconomic status. Differences between subgroups a)-d) above in prevalence of poverty and extreme poverty, ownership of house and car, % illiteracy, average education years, unemployment, informal jobs, average hours



devoted to paid job and housework, access to public benefits (maternity, old age, child care, education, sickness, disability, unemployment, poverty) pensions income support and grants programmes.

5. Physical, life and work environments. Differences in quality of water, pollution, sanitation, work hazards, traffic accidents, % decent affordable housing, density of cultural, social and welfare services and green areas in the place of residence (d) and at work.

6. Social capital and the psychosocial and sociopolitical environment: Differences in income inequality, ethnic density, social support, lone and teen parents, trust, social capital, respect, discrimination, violence, political participation (e.g. voting and demonstrating), redistributive and participatory policies in the place and country of residence (d).

#### SOCIAL AND POLITICAL RIGHTS: INSTITUTIONAL POWER RESOURCES

7. % of countries where legislation exists to protect children, migrants, ethnic and other minority groups from poverty and institutional and interpersonal discrimination; and where specific multisectoral positive discrimination public policy provisions and agencies are effective in combating violence and social isolation, in reducing financial insecurity and political apathy, and in providing these groups with adequate information, education, work, housing and transport, as well as information on rights, food and access barriers to health and social care (available in the relevant languages), service providers and localities, along with accessible and affordable healthy food and recreation services

#### FROM LIFESTYLES AND RISK BEHAVIOURS TO SOCIAL INEQUALITY-RELATED HEALTH RISKS

8. Differences in % adults < 75 years who are undernourished, work more than 12 hours a day (paid job + housekeeping), drink, practice unsafe sex; who are smokers, physically inactive or overweight; or suffer from depression, metabolic syndrome, stress, violence or discrimination

#### HEALTH SYSTEM: HEALTH CARE AND POLICY

9. Differences in the % women over 50 that have never had a mammography and Pap smear, and in the % of children adequately vaccinated

10. Differences between subgroups A., B., C. and D. above in % of cancer patients waiting for diagnosis or treatment for more than 1 month, or diagnosed in the emergency room, or in phases III-IV

11. Differences in % of patient waiting times of > 3 months for treatment for depression, diabetes, or knee and hip replacement

12. Differences in % of patients who are registered with a GP and can visit (or contact by phone or email) a GP within 24 hours

13. % Public expenditure in primary care (excluding pharmacy and specialised outpatient care) as a percentage of total health care

14. % Patients and/or migrants, Roma and other ethnic minorities who pay directly for a hospital emergency visit or admission, and who spend more than 10% and 50% of



their income on health care

15. % Total dental, mental and long-term care expenses covered by the public sector

16. Are resources being allocated according to need (i.e. according to adverse social determinants of health, included those related to mobility and ethnicity; or, in other words, to those with less power resources)? Are there economic or other effective incentives to attract health and other public professionals to remote or disadvantaged areas and social and vulnerable groups?

17. Are there training programmes on social determinants of health for policy makers, health professionals and health advocacy groups? Are there training programmes on cultural competence? Institutionalisation of cultural mediators? Of interpreters?

18. % of expenditure in health research and information and special prevention and promotion strategies devoted to reducing the social determinants of HIs and vulnerable groups

19. Existence of multisectoral government initiatives led by the health sector or by the President or Prime Minister's office, and devoted to fighting poverty and social exclusion across vulnerable social groups and local areas, such as: public institutions (Agencies, Funds, special incentives or providers, local trusts), national research/training/action/evaluation plans or strategies, priority intervention local areas

20. Existence of community health and development initiatives based on the employment of vocational

community representatives of migrant, Roma and ethnic minorities communities and other socioeconomically disadvantaged groups who promote community participation and organise local health education and promotion activities, information campaigns, and research programmes for their peers

21. Existence of a regulation requiring the compulsory health and HIs impact assessment of all policies prior to their approval

#### HEALTH OUTCOMES & UNMET NEEDS (2)

22. Differences in % children of < 15 years, who smoke, drink or suffer from excess weight

23. % of population with a disability or chronic disease (diabetes, asthma, depression, serious lung, heart or cancer conditions), and % of the disabled or chronically ill that are under-treated or self-financed, % who went bankrupt as a result

24. Differences in 5 years survival rates for selected diseases and patients (cancer, heart and lung); or differences of avoidable mortality

25. Differences in % of adults with a bad or very bad self-reported health status who have not visited a doctor in the last year

#### **Sub-annex D.**

*Referred to in the chapter "Social exclusion and structural health inequalities".*

The Annex lists some of the indexes of structural health inequality and social determinants of health that exist in the EU and that have been especially influential, together with the original list of indicators of the WHO Commission on Social Determinants of Health (2008) – see Figure 7 – to select the indicators proposed in the current report. The DG for Employment, Social Affairs and Equal Opportunities of the EU Commission has elaborated an interesting summary battery of indicators to monitor social inclusion and structural inequality in Europe which is made up of the

following priority items, based of the EU-SILC survey (see Social Situation Reports). Other interesting deprivation indexes are the Jarman index (the oldest in the EU, with considerable cross-country research on the association with health), the 10 items scale of structural HIs developed by Williamson or Pickett (the latest one), and the Local Basket of HI Indicators in the UK (the most comprehensive) (Fitzpatrick and Jacobson 2003; Brook 2009). Table 5 summarises the battery of indicators proposed by each of these sources.

Figure. EU indicators to monitor structural HI and SDH

DG Employment/EU-SILC	Williamson & Pickett 2009
<ul style="list-style-type: none"> <li>Poverty (% at risk of poverty – with less than 60% of the median income; % at persistent risk of poverty, intensity of poverty; in-work poverty).</li> <li>Income inequality (S20/S80).</li> <li>Long-term unemployment &amp; regional differences.</li> <li>Population living in jobless households.</li> <li>Employment gap of migrants &amp; older workers.</li> <li>Material deprivation and financial debts.</li> <li>Housing conditions and ownership.</li> <li>Health life expectancy.</li> <li>Child well-being.</li> <li>Early school leavers.</li> <li>Social expenditures and pension adequacy.</li> <li>Health expenditure.</li> <li>Self-declared unmet need of health care.</li> </ul>	<ul style="list-style-type: none"> <li>Life expectancy</li> <li>Infant mortality</li> <li>Math and literacy results</li> <li>Homicide</li> <li>Imprisonment</li> <li>Teenage births</li> <li>Trust</li> <li>Obesity</li> <li>Mental illness (inc. addictions)</li> <li>Social mobility</li> </ul>
Jarman index	UK Local Basket
<ul style="list-style-type: none"> <li>% Population over 65 years</li> <li>% Population under 5 years</li> <li>% Elderly living alone</li> <li>% Single parent families</li> <li>% Population in unskilled employment</li> <li>% Population unemployed</li> <li>% households which lack basic amenities and level of overcrowding</li> <li>% who changed address in the last 5 years</li> <li>% who belong to ethnic minority groups</li> </ul>	<ul style="list-style-type: none"> <li>Employment, poverty and deprivation</li> <li>Housing and homelessness</li> <li>Education</li> <li>Crime</li> <li>Pollution and physical environment</li> <li>Community development</li> <li>Diet, smoking and physical activity</li> <li>Access to local health and other services</li> <li>Accidents and injury</li> <li>Mental health</li> <li>Maternal and child health</li> <li>Older people</li> <li>Tackling the major killers</li> </ul>

Note: the UK Local Basket lists 60 indicators along the dimensions listed above

## BOX 16.3: TOWARDS A COMPREHENSIVE NATIONAL HEALTH EQUITY SURVEILLANCE FRAMEWORK

### HEALTH INEQUITIES

- Include information on:
  - health outcomes stratified by:
    - sex
    - at least two socioeconomic stratifiers (education, income/wealth, occupational class);
    - ethnic group/race/indigeneity;
    - other contextually relevant social stratifiers;
    - place of residence (rural/urban and province or other relevant geographical unit);
  - the distribution of the population across the sub-groups
  - a summary measure of relative health inequity: measures include the rate ratio, the relative index of inequality, the relative version of the population attributable risk, and the concentration index;

### HEALTH OUTCOMES

- mortality (all cause, cause specific, age specific);
- ECD;
- mental health;
- morbidity and disability;
- self - assessed physical and mental health;
- cause-specific outcomes

### DETERMINANTS, WHERE APPLICABLE INCLUDING STRATIFIED DATA

- Daily living conditions
  - health behaviours:
    - smoking
    - alcohol
    - physical activity;
    - diet and nutrition;

- physical and social environment:
  - water and sanitation;
  - housing conditions;
  - infrastructure, transport, and urban design;
  - social capital;

- working conditions:
  - material working hazards;
  - stress

- health care:
  - coverage;
  - health-care system infrastructure;

- social protection:
  - coverage;
  - generosity;

### ● Structural drivers of health inequity:

- gender:
  - norms and values;
  - economic participation;
  - sexual and reproductive health;

- social inequities:
  - social exclusion;
  - income and wealth distribution;
  - education

- sociopolitical context:
  - civil rights;
  - employment conditions;
  - governance and public spending priorities;
  - macroeconomic conditions.

### CONSEQUENCES OF ILL-HEALTH

- economic consequences
- social consequences

## Sub-annex E.

Referred to in the chapter "Social exclusion and structural health inequalities".

Figure 8. Democracy and unequal power resources

Source: Despotism (1946). Encyclopaedia Britannica Films.

[http://video.google.es/videoplay?docid=-461990723502527420&ei=uXY7S-\\_DCpDJ-Aatk\\_SfCg&q=despotism&hl=en#](http://video.google.es/videoplay?docid=-461990723502527420&ei=uXY7S-_DCpDJ-Aatk_SfCg&q=despotism&hl=en#)



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