Reducing health inequalities in the European Union

Social Europe

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Statements

John Dalli – Commissioner for Health and Consumer policy

I believe in a Europe where all citizens live in good health and have access to good health services regardless of who they are, where they live, how much they earn. This is the Europe we should strive for. Reducing health inequalities is a key priority.

Reducing health inequalities requires concerted action between public health and a range of other policies impacting on health including social protection, education and environment. The challenge is how to use different policy tools to build effective coalitions for action across government and across society.

I am committed to ensuring that our Communication on health inequalities "Solidarity in health" leads to concrete results, and to supporting Member States' efforts in bridging the health gap in every way I can.

Sharing best practice and lessons learnt and helping to channel EU funding opportunities to benefit health in deprived regions and amongst those worst off are some of the means we will put in practice. The Commission will also provide better monitoring of health inequalities and trends across Europe and expand research opportunities in this area. Finally, we will work together to ensure that EU policies contribute, where possible, towards tackling the problem. Work on developing areas such as e-health and health technology assessment are critical contributors to the sustainability of health systems and can be a key contribution to tackling inequalities.

In these times of economic crisis and budgetary pressures, I believe we must join forces to ensure that the health gaps in our societies do not widen further. I am confident that in years to come, we will look back with pride in the realisation that our efforts have made a difference in reducing health inequalities in Europe.

László Andor – Commissioner for Employment, Social Affairs and inclusion

Considerable progress has been made in the field of health, yet despite this, the level of inequalities between different social groups and between people living in different parts of the European Union remains unacceptably large. Health inequalities are not only unfair, they also have a huge economic and social cost.

Paying greater and more regular attention to the social determinants of health in working and living conditions can help us reduce the factors which lower life expectancy and impact negatively on people's lives, productivity levels and health care spending.

Boosting employment, raising the quality of work and ensuring a healthy and safe working environment for all are essential to improving health outcomes. We also need to tackle long-term unemployment and poverty so as to minimise their negative effects on overall health. In addition, we must strive to provide adequate and accessible social protection with effective safety nets to mitigate the impact of adverse economic and social circumstances on health.

Lastly, and most importantly, improved access to quality health care services can substantially contribute to better health and longer life in many regions of the European Union, thus contributing to economic, social and territorial cohesion.

Contents

1. Health inequalities in the EU

European Union (EU) citizens live, on average, longer and healthier lives than previous generations and health levels in the EU have improved continuously in recent decades. At the same time, there exist large and perhaps increasing inequalities in health both between and within EU Member States.

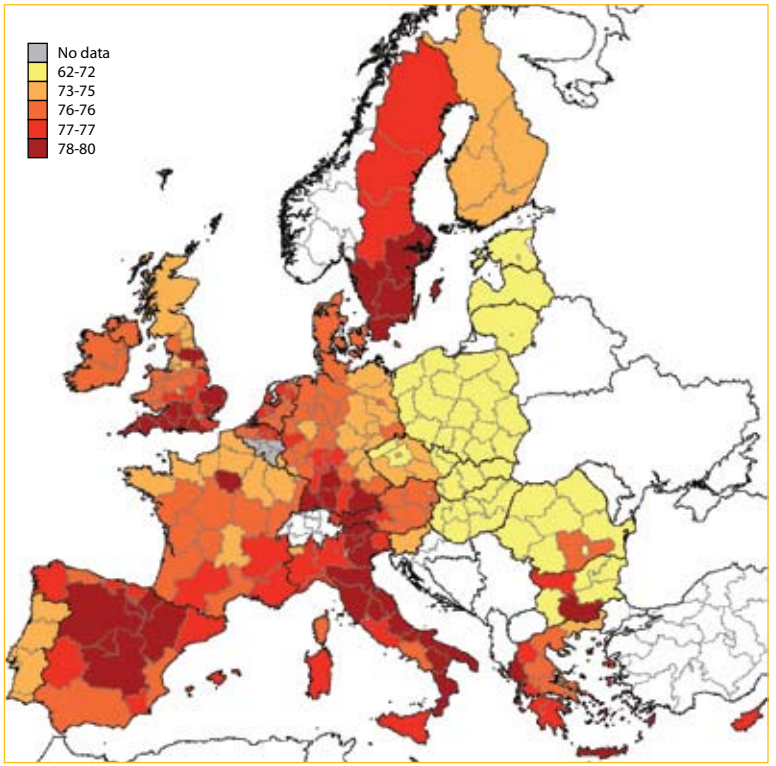
The European Commission regards these inequalities as a challenge to the EU's commitment to solidarity, social and economic cohesion, human rights and equal opportunities. The Commission is thus determined to support Member States and stakeholders at various levels of society in their efforts to tackle them.

1.1. Health inequalities between and within Member States

Life expectancy at birth can give some idea of health levels amongst the population as a whole and in this, there are substantial differences between EU regions. In 2006, the difference between the Member States with the highest and lowest life expectancies was eight years for females and 14 years for males. For several countries, the gap between national life expectancy and the EU average has increased in the last two decades.

There are also differences of up to 20 years in the number of years lived in good health (Healthy Life Years), with people living in the Central and Eastern part of the EU, especially men, living on average fewer years in good health.

Life expectancy at birth men 2002-2004, NUTS 2



Source: Eurostat.

Substantial differences between Member States are also found in infant mortality, premature mortality, avoidable mortality and more subjective health measures such as self-perceived general health and long-standing illness or activity limitations experienced in the past six months.

High mortality and morbidity from cardiovascular disease, injuries and violence, cancer and alcohol-related diseases contribute to differences in life expectancy. Underlying risk factors for these conditions, such as poorer living and working conditions, smoking, diet and alcohol consumption, are more prominent in countries with shorter life expectancies.

1.2. Inequalities between social groups

Aside from differences between Member States, a social gradient in health status has been identified. People with lower education, a lower occupational class or lower income, as well as some ethnic minorities in many Member States tend to die younger and suffer from a higher prevalence of most types of health problem.

The impact on health of these variables starts at a young age and persists throughout life. Differences in life expectancy at birth between the lowest and highest socio-economic groups (e.g. between manual and professional occupations, people with primary and post-secondary education and the lowest and highest income quintiles) range from 4-10 years for men and from 2-7 years for women. In some Member States, the gap has even grown over the last few decades. In addition, infant mortality is higher in the lowest socio-economic groups and inequalities related to this factor have also increased in several countries.

1.3. Particularly poor health amongst vulnerable groups

Groups such as people in deprived areas and in poverty, the unemployed and informally employed, the homeless, the disabled, the mentally or chronically ill, the elderly on low pensions and single parents tend to experience higher levels of disease and premature death.

Inequalities between nationals and some migrant groups persist, both in terms of health status and access to health services. Migrants may experience greater vulnerability to communicable diseases, such as tuberculosis, HIV/AIDS or hepatitis, thereby impacting on overall levels of health. They may also face higher risks of non-communicable diseases (e.g. cardiovascular disease) and mental health problems. These can stem from a combination of socio-economic and environmental conditions in their countries of origin, the process of moving country and having to adjust to a new environment in their host countries[1].

In addition, there appears to be a link between health inequalities within a county and the overall health of the population, in that the higher the inequality, the poorer the health of the population as a whole. Reducing inequalities within Member States may well therefore help to reduce those between Member States.

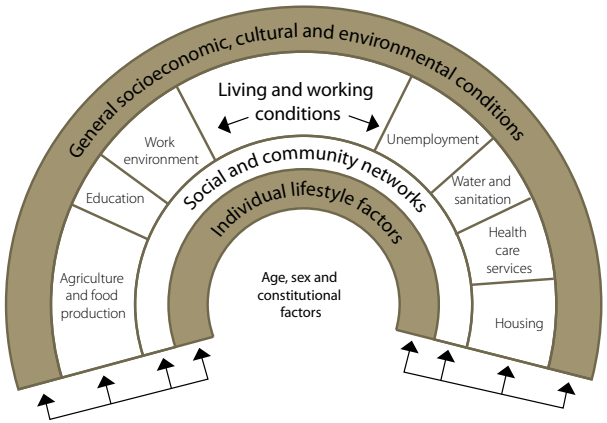
1 2007 Council Conclusions on Health and Migration in the EU.

2. Causes of health inequalities

2.1. General health determinants

Several models attempt to demonstrate the relationship between different determinants and health. The Dahlgren and Whitehead model, used by the World Health Organization illustrates the "rainbow-layered" view of the causes of inequalities. Health levels do not vary at random but are the result of systematic differences in the distribution of factors affecting them.

Dahlgren-Whitehead health determinants model



Source: Dahlgren/ Whitehead: WHO Europe 2007 "European strategies for tackling social inequities in health: levelling up Part 2" Referring to D&G / previous source 1993.

Living and working conditions affect health through direct and indirect physical and psychological mechanisms. The impact of some factors is felt over long periods. For instance, poor conditions in childhood can affect health later in life. Exposure to factors which influence health differs according to where people live and their job situation. As regards housing, sections of the EU population lack access to running water, adequate washing and toilet facilities, affordable energy, central heating and insulation and live in damp, over-crowded conditions. Physically demanding work may impact negatively on health, as can low levels of job control, effort reward imbalance and exposure to physical and mental risks in the workplace. On the other hand, sound management, good working conditions and the existence of strong social networks at work may have positive impacts on health.

Health-related behaviours such as diet, physical activity levels, tobacco and alcohol use and sexual behaviour are influenced by socio-economic and cultural factors. This can partially explain health differences between social groups and between countries and areas. Most studies estimate that individual behaviour can account for 25-35% of differences in people's health. There are large variations between European countries and socio-economic groups in terms of healthy nutrition, prevalence of smoking, alcohol consumption and physical activity and outcomes from these factors such as obesity and poor health.

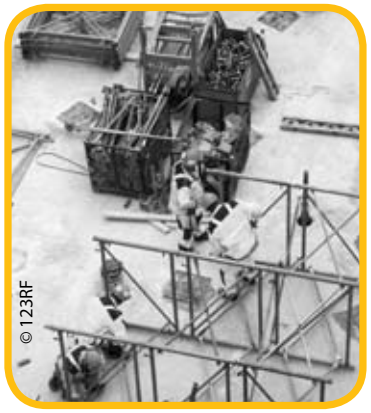
Psycho-social factors such as negative life events, feelings of exclusion and marginalisation, lack of control over events in one's life and doing a demanding job for scant financial reward can all contribute to deteriorating health.

Past social positions may also influence individuals' health status. For example, family socio-economic status (including income and interest in education) can play a large role in determining a child's educational attainment, employment prospects, income and health. Some studies show that high parental socio-economic status reduces the risk of strokes and stomach cancer in adulthood. Maternal socio-economic deprivation is strongly associated with low birth weight which impacts on a person's health throughout his or her life. Furthermore, as already seen, poor living conditions in childhood can have an impact at a later stage.

Differences in life-styles and living and working conditions by age, gender and socio-economic status
QA24 Could you please tell me if any of the following apply to you. (Multiple Answers possible)

	You smoke	You are overweight	You never do any exercice, or do so very rarely	You do not eat very healthy food	You tend to drink a bit too much alcohol	You live in a noisy environment	You live or work in an environment that is heavily polluted	You suffer from stress at work	You suffer from stress in your personal relations	None of the above (SPONT.)	Don't know
EU-27	30%	20%	24%	14%	7%	8%	6%	17%	10%	32%	1%
Sex											
Male	35%	19%	22%	16%	12%	8%	7%	19%	7%	29%	1%
Female	24%	22%	25%	12%	3%	7%	5%	15%	13%	34%	1%
Age											
15-24	34%	9%	17%	22%	10%	10%	6%	11%	11%	37%	1%
25-39	39%	15%	23%	16%	8%	9%	7%	25%	11%	26%	1%
40-54	34%	25%	26%	14%	9%	8%	8%	26%	12%	25%	1%
55+	17%	26%	26%	8%	4%	6%	3%	5%	7%	39%	1%
Education (End of)											
15	25%	23%	27%	10%	6%	6%	4%	8%	9%	36%	1%
16-19	36%	22%	25%	16%	8%	8%	7%	18%	10%	28%	1%
20+	28%	20%	23%	12%	8%	8%	6%	28%	10%	29%	1%
Still studying	25%	8%	15%	20%	9%	11%	5%	8%	11%	43%	1%
Respondent occupation scale											
Self-employed	37%	18%	22%	13%	10%	8%	8%	28%	10%	27%	1%
Managers	21%	19%	20%	12%	10%	6%	5%	39%	8%	30%	1%
Other white collars	33%	21%	27%	17%	8%	7%	7%	29%	9%	26%	1%
Manual workers	42%	19%	23%	17%	9%	9%	10%	27%	9%	24%	1%
House persons	23%	20%	28%	9%	2%	7%	3%	2%	14%	36%	2%
Unemployed	53%	24%	26%	19%	12%	12%	6%	5%	19%	22%	1%
Retired	18%	27%	26%	8%	5%	5%	3%	1%	8%	41%	1%
Students	25%	8%	15%	20%	9%	11%	5%	8%	11%	43%	1%

Source: Eurobarometer 283



2.2. Employment issues

Employment issues have a role to play in determining the state of peoples' health and unemployment is associated with an increased risk of poor mental health, social exclusion and suicide. As mentioned above, job quality and working conditions also have a significant effect on health.

A good working environment such as one that limits exposure to *physical risks or chemical and biological agents* brings health benefits. A number of studies suggest that job quality and working conditions affect health to a considerable extent. For instance, *low physical pressure and stress*, a *high degree of control* over one's professional life, opportunities to develop new skills, a *high salary* and *prospects for progress* all contribute to good health. On the other hand, lack of support at work and a feeling of job insecurity increase the risk of ill health, including depression.

Occupational health risks vary significantly across sectors. Young workers are usually less informed about, and therefore more exposed to, occupational risks. Workers with a fixed-duration or temporary employment relationship are at greater risk from accidents at work and occupational diseases.

2.3. Wealth and health: a complex relationship

Economic performance as measured by Gross Domestic Product (GDP) per capita, and poverty rates vary across the EU and substantial income inequality persists. In 2006, the total income of the richest 20% of the population was 4.8 times higher than that of the poorest 20%. Several studies suggest that income inequality is one of several factors behind differences in health between countries and individuals. Such inequality is in large part due to the degree of social stratification produced by structural drivers such as the political context, societal norms and values, and economic, social, education, environmental and health policy.

However, the overall relationship between economic growth and health is complex. Evidence suggests that, on its own, economic growth may not deliver a reduction in health inequalities. To limit health inequalities, economic growth needs to be accompanied by complimentary policy measures and greater attention to distribution of benefits. Moreover, translation of GDP per capita into healthy citizens and health equity depends, to a large extent, on the right policy mix for reducing disparities and improving general health by optimising the relationship between health gain and available resources. It should also be noted that, owing to factors such as diet, certain EU Member States and regions tend to have more favourable health indicators than some of their more economically successful counterparts.

2.4. Social protection and transfers: contributing to health status?

Variations in the size and extent of social security systems can be observed across the EU, including in relation to health care budgets and protection of people outside the labour market. Given that poverty is considered an important health determinant, the extent of redistribution and social protection may be linked to health inequality, as it has been estimated that income redistribution policies reduce the risk of poverty by 38%.

2.5. Focus: health care expenditure and budgets

The size of health budgets can determine the capacity of health systems to meet the needs of the population. There is a tendency for Member States reporting lower life expectancy and high levels of unmet need for medical care to also report low health expenditure per capita and as a percentage of GDP.

Availability (including infrastructure, equipment and number of health professionals), access to and quality of healthcare are key factors in determining inequalities as they influence the likelihood of overcoming morbidity and avoiding premature mortality. Health systems suffer from lack of resources (both financial and human) and their uneven geographical and social distribution. These issues affect the way and the speed with which diseases are diagnosed and treated and therefore impact on overall population health.

Quality of healthcare plays a key role in ensuring high levels of public health. For example, 3 million EU patients suffer from healthcare-associated infections every year and 50 000 die from them. Differences in access to quality care translate into very large differences in treatable mortality.

Socio-economic differences in access to care can also be observed. There is a clear income gap in terms of unmet need for medical care. Those in the lowest income quintiles more often report an unmet need due to waiting, direct financial costs or the distance to care facilities. Evidence suggests that, on average, lower income families have further to travel to hospital or to their family doctor. Moreover, those with low incomes have less chance of being admitted to hospital or seen by a specialist. Several Joint Reports on Social Protection and Social Inclusion have identified barriers to access including lack of health insurance coverage,

direct financial costs of care, geographical disparities in service availability, waiting times and cultural obstacles.

At the same time, high levels of private health care expenditure as a proportion of household income may deter lower socio-economic groups from accessing health care when they need it, thereby contributing to increased health inequality in some countries.

2.6. The current economic and financial crisis: what is the impact?

Difficult macroeconomic conditions can have a strong negative effect on health. They often lead to increased levels of stress and risky behaviour such as drinking and smoking. This can of itself negatively impact on health and also lead to factors such as depression, disturbed immune system and accidents. These effects can have further health and education consequences within families, particularly for children. A long economic crisis can give rise to long-lasting negative impacts on health. Symptoms of burnout conditions may appear years rather than weeks or months after redundancy.

Increased restrictions on access to quality health and social care, especially for those in lower socio-economic groups, is another effect of an economic downturn. If access to care comes to depend on having financial means or if Member States cut resources allocated to health and social care as a response to the crisis, the result will be lower coverage or quality of care.

Financial pressure on health systems can lead countries to review their policy mix on health determinants in search of greater effectiveness and efficiency. This again, can increase inequality of access to care.

3. Action on health inequalities in EU Member States

All EU Member States have committed themselves to reducing inequalities in access to health care and health outcomes as an objective of the Open Method of Coordination. Reports from Member States which are analysed as part of the annual joint reports on Social Protection and Social Inclusion document the actions they are taking. In addition, there are a number of sources of information on Member State-level policy initiatives which have proved effective in tackling health inequalities. These include the report produced for the 2005 UK Presidency, "Health Inequalities: a Challenge for Europe", the Eurohealthnet coordinated project "Closing the Gap: Strategies for Action to tackle health inequalities" and the ongoing Eurohealthnet coordinated project "Determine" and its related web site (*www. health-inequalities.eu*).

This gathers information from Member States on strategies to tackle health inequalities. The largest amount of evidence comes from the UK, where comprehensive strategies to tackle health inequalities have been developed over more than a decade and where several evaluations have taken place.

The available evidence indicates that many Member States share the conclusions mentioned below. For some of them, a case study has been selected for illustration purposes.

1. Proportionate Universalism: "To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage" ("Fair Society, Healthy Lives – Strategic Review of Health Inequalities in England post 2010" Published by The Marmot Review February 2010)[2]. This is particularly the case for health promotion and disease prevention programmes for disadvantaged areas, vulnerable families and lower socio-economic groups (e.g. mothers, children, young parents and those over 50).

CASE STUDY 1 UK – Sure Start Local Programmes*: Putting "proportionate universalism" into practice

Based on a holistic approach of health inequalities Sure Start Local Programmes bring together childcare, early education, health and family-support services for families with children under 5 years old. It is one of the contributions of the British government to the reduction of health inequalities, from the perspective of child poverty and social exclusion. These programmes are implemented on a local basis, in Sure Start Local Centres, located in underprivileged areas.

The Sure Start approach brings together service providers from the statutory sector like health, social services and early education, as well as voluntary, private and community organisations and parents themselves, to provide integrated services for young children and their families based on what local children need and parents want.

Key results: the Impact Study of the National Evaluation of the Sure Start focused on over 9000 3-year-old children and their families. Benefits were identified in the following fields: immunisation, accidental injuries and social development. As far as parents were concerned, it showed beneficial parenting effects and an increased use of services designed to support child and family development.

* http://www.dcsf.gov.uk/everychildmatters/earlyyears/surestart/whatsurestartdoes/

2 http://www.marmot-review.org.uk/

2. Member States feel that regional and local action, supported by national and EU action, is very important to achieve results. Local authorities must identify individuals at risk of lower health status in their communities. To reach these individuals, regional-level actors can build neighbourhood and community infrastructure.


© Getty Images

CASE STUDY 2 Hungary – Opre Roma: Raising awareness for planning healthy and sustainable houses amongst a Roma community living in Debrecen*.

The main aims of this initiative were to raise awareness in the community towards environmental, energy and health-behavioural issues, to build up community plans for sustainable, energy-saving and health-conductive social housing, but also to build-up plans for social housing that can be performed immediately.

Community members were fully involved in the development of these plans and received appropriate training in household management and energy saving fields. More generally linkage between health and housing and environment was a key skill acquired by people involved in the project.

Key results: housing conditions were identified as a key determinant of health status, and thus playing a role in health inequalities. Improvement of housing conditions, and building of new houses taking the Roma cultural background fully into account was one of the key achievements of this project.

* http://www.health-inequalities.eu/?uid=e52af77626a071aba322dfded1c78d99&id=Seite3486

© Getty Images

3. Building partnerships with the non-profit sector, business and the employment market can also be an effective means of raising awareness and prompting action to help those at higher risk from health problems.

CASE STUDY 3 Germany "Job Fit Regional": Linking health and employment promotion*

The main objective was to use employment providers as an institutional framework for the implementation of health promotion. Specific training sessions were performed by training institutions that are normally in charge of supporting job seekers. Statutory health insurance institutions are also key partners of this project, as they also perform group-focused actions.

Jobless people were approached and managed through a specific methodology** to assess individual health competence very precisely (especially a comprehensive motivational health talk) and to build up a health promotion plan. Various programs, especially prevention courses, stress management, and group-focused training sessions are financially supported by statutory health insurances. Training sessions were also specifically designed for the staff of the qualifying and employment providers.

Thanks to this program, occupation and qualification institutions for the unemployed and statutory health insurance institutions work in close connection, to improve health of jobless people in their own setting.

Key results: The project was very well accepted by institutions. Improvement in health behaviour (especially physical activity and nutrition) and reduction of psychosocial stress has been identified and workability improved thanks to this program.

* http://www.gib.nrw.de

** http://www.gib.nrw.de/service/downloads/BKK_JobFit_guidelines_RZweb_Einzelseiten.pdf

4. Measurement and regular reporting of health inequality indicators is an essential first step towards effective action, especially in deprived areas. Gathering information through regular monitoring of health indicators can support awareness-raising and allow policy makers to identify the extent of inequalities and where they lie (types of diseases and causes of mortality).

5. Applying health impact assessments and health equity tests and audits to policies across the board is an effective way to generate inter-sectoral awareness of health inequalities and their social determinants.

Member States or research review studies have deemed numerous specific policy actions to be effective in tackling healthcare inequalities.

In the Netherlands and the UK efforts were made to improve access to information on the risks of smoking as well as to smoking cessation services for those in deprived areas and in lower socio-economic groups.

These areas consistently show higher rates of smoking than more affluent groups.

Improving ante-natal (screening and immunisation) and post-natal care, including neo-natal screening and parent support, such as provision of information on nutrition, parental smoking and sleeping positions, is a key element in raising overall health levels. Both the UK and Poland have launched programmes so that those in less affluent areas and/or socio-economic groups can receive proper ante-natal and post-natal care in order to reduce the gap in neo-natal and infant mortality. A similar programme aimed at migrants is underway in the Netherlands. Such programmes work with family doctors and hospitals and include home visits to vulnerable mothers from early pregnancy until the child reaches two years of age.

4. EU-level action

4.1. Commission Communication on Health Inequalities

On 20 October 2009 the Commission adopted the Communication "Solidarity in health: reducing health inequalities in the EU"[3]. Work on the Communication was led jointly by the Commissioners for health and for social policy. The Communication builds on existing work described below and identifies areas where further action is needed.

Key actions set out in the Communication include:

- Integrating equitable distribution of health within overall economic and social development. Consideration could be given to whether sound monitoring of health inequality indicators would also help to monitor the social dimension of the future Lisbon Strategy (Europe 2020);
- Improving ways of working with Member States, stakeholders and regions;
- Enhancing EU support for research into health inequalities;
- Audits of policies to ascertain their impact in reducing health inequalities;
- Encouraging Member States to make better use of possibilities under EU Cohesion Policy, structural funds and the CAP rural development policy for addressing determinants of health inequalities;

3 COM(2009)567. http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=619&furtherNews=yes
http://ec.europa.eu/health/social_determinants/policy/commission_communication/index_en.htm

- Activities targeting certain vulnerable groups such as ethnic minorities, migrants and Roma;
- Exploring possibilities for synergies between the Commission's development aid and work on health inequalities;
- Improving measurement and monitoring of health inequalities, with the first report expected to be published in 2012.

4.2. European Employment Strategy

The importance of employment for health is highlighted in a number of EU guidelines:

Employment Guideline 17 focuses on improving quality and productivity at work and modernising social protection systems. Health and safety at work is one of the main factors in ensuring good working conditions. It is also a crucial element in attracting more people into the labour market, in particular in the light of Europe's ageing population. It thus has a concrete contribution to make towards reducing health inequalities.

Employment Guideline 18 promotes a lifecycle approach and calls for support for active ageing including appropriate working conditions and improved occupational health status so as to prolong citizens' working lives. It also calls for the promotion of modern social protection systems including in the area of healthcare. The guideline also emphasises that improved occupational health status will reduce sickness burdens, thereby increasing labour productivity.

Employment Guideline 21 promotes and disseminates innovative and adaptable forms of work organisation to improve quality and productivity, as well as health and safety at work. It encourages implementation of integrated flexicurity approaches with the aim of helping workers, including those in low-skilled jobs and at the margins of the labour market to cope with a more complex, diverse and irregular, and therefore demanding working life.

Employment Guideline 23 emphasises the need to focus on new skills for new jobs in order to promote access for all to the job market and ensure innovation and quality at work.

4.3. Cooperation with Member States

The EU supports Member State actions to address common challenges by facilitating dialogue, exchange of best practices and policy coordination with and between Member States and with stakeholder organisations. Mechanisms for such cooperation include the Open Method of Coordination, the Social Protection Committee and the EU Expert Group on Social Determinants and Health Inequalities. In 2010 the Council adopted conclusions on Equity and Health [4] which encourage Member States to further develop their policies and actions to reduce health inequalities and to participate actively in sharing good practice.

4.4. EU Health Strategy

Greater health equity is a key element of the EU Health Strategy and an important dimension of policies and initiatives in areas such as tobacco, obesity, alcohol, young people and mental health. Close cooperation is maintained with related work of the World Health Organization, the Organisation for Economic Co-operation and Development, the Council of Europe and research developments in this area.

4 Council conclusions on Equity and Health in All Policies: Solidarity in Health. 3019th Employment, Social Policy, Health and Consumer Affairs Council meeting, Brussels, 8 June 2010 http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lsa/114994.pdf

4.5. EU funds

Financial support for action on health inequalities is being provided through a number of EU programmes and instruments.

Cohesion Policy provides financial support to Member States in addressing regional imbalances. Recently, health has been defined as one of the areas for support through the European Regional Development Fund (ERDF) and European Social Fund (ESF) in accordance with the Community Strategic Guidelines for Cohesion 2007-2013.[5] Health promotion, disease prevention, transfer of knowledge, training and availability of highly skilled staff and infrastructure in convergence regions are some of the topical areas qualifying for support. The Guidelines note that there are "major differences in health status and healthcare between EU regions"... thus "it is important for cohesion… to contribute to healthcare facilities… Community based health improvement and preventive actions have an important role to play in reducing inequalities".

The **Common Agricultural Policy (CAP)** is not a social policy in and of itself, but it has elements that may contribute to the reduction of health inequalities such as ensuring a fair standard of living for farmers, availability of food supplies and reasonable consumer prices. The CAP supports the School Milk Scheme and the distribution of agricultural products to deprived groups. More recently, possible contributions on the part of the CAP to promoting a healthier diet by greater emphasis on eating fruit and vegetables were explored. In addition, the EU rural development policy supports investment in and development of social and health care services, technology and infrastructure in rural areas as well as training and information actions on health and social subjects.

5 http://ec.europa.eu/regional_policy/sources/docoffic/2007/osc/l_29120061021en00110032.pdf

The EU Health Programme funds action networks, local initiatives, expert reviews, conferences and policy innovations in the field of public health.

Within the framework of PROGRESS (*The EU Programme for Employment and Social solidarity 2007-2013*), a specific call for proposals has been launched in March 2010, to take forward the actions outlined in the Commission Communication, specifically by providing support to national or regional authorities in PROGRESS participating countries to strengthen policies to address health inequalities.

The European Fund for the Integration of Third Country Nationals supports Member State efforts to facilitate integration of migrants into European societies. Of the total budget of €825 million, 7% is aimed at supporting projects addressing aspects of integration, including access to healthcare. The remaining 93% is for Member States to implement an Annual Programme agreed with the Commission.

The EU Framework Programmes for Research also offers possibilities for tackling health inequalities, in particular under the third pillar of the Health Theme of the Cooperation Programme of the Seventh EU Framework Programme. This aims at developing research methods and generating the scientific basis to underpin policy decisions and more effective evidence-based strategies in such areas as health promotion and wider determinants of health including lifestyle and socio-economic and environmental factors[6].

4.6. Legislation

The EU has established legislation in the field of health and safety at work in order to improve working conditions. It monitors implementation of the legislation and also funds research in the area.

The active working population currently accounts for 48.3% of the total EU population. Therefore protection of workers' health and safety has a very significant contribution to make to overall public health and reduction of some of the main elements causing health inequalities between EU Member States and citizens. Directive 91/383/EC aims to ensure that fixed-term and agency workers are afforded, as regards safety and health at work, the same level of protection

6 COUNCIL DECISION (2006/971/EC) of 19 December 2006 concerning the Specific Programme "Cooperation" implementing the Seventh Framework Programme of the European Community for research, technological development and demonstration activities (2007 to 2013), OJ L 400/127)

as other workers. A report was drafted in 2009 on the implementation of the Directive up to 2007. The report attempts to pinpoint potential deficiencies in the Directive in order to guide future Commission action.

The Impact Assessment to the Community Strategy for Safety and Health at Work 2007-2012 showed that occupational health strategies reduce work accidents and help accident victims and the chronically ill to retain their jobs or return to work. They also provide a platform for integrating migrant workers and can reduce stressful and monotonous working conditions that cause early deterioration of health, and hence, an early exit from working life.

Since 2000, in addition to laws covering equal treatment of men and women, EU anti-discrimination legislation has been in place to ensure minimum levels of equal treatment and protection for everyone living and working in Europe irrespective of racial or ethnic origin, religion and belief, disability, sexual orientation and age. This legislation covers many aspects of daily life - from the workplace to education, healthcare and access to goods and services. In 2008 the Commission set up a Governmental Expert Group on anti-discrimination and promotion of equality which examines the impact of national and EU-level anti-discrimination measures and validates good practice through peer learning.

4.7. Internal market

Work on health-related infringement procedures can help reduce barriers to access to healthcare and lower prices for it, thus greatly benefiting citizens from disadvantaged socio-economic groups. Examples of this include legislation addressing freedom of establishment and provision of services, restrictions on ownership and location of pharmacies and on ownership of laboratories and their opening hours.

More broadly, all Commission initiatives now undergo an assessment of their likely economic, social and environmental impacts, in particular on different social and economic groups and on existing inequalities.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4.8. Education and youth

Physical and mental health and a healthy lifestyle are promoted as social and civic competences in the Recommendation on key competences[7], which invites Member States to develop such competences for all as part of their lifelong learning strategies. The Commission has also proposed a new EU Strategy for Youth[8] which underlines the vulnerability of youth and identifies actions to improve the health of young people, particularly those at risk of social exclusion.

This booklet has aimed to provide a broad overview of health inequalities in the EU and some of the EU policies which contribute to their reduction.

For further information please see the links and references below, or contact the European Commission (Europe Direct Freephone number **00 800 6 7 8 9 10 11**).

7 Recommendation of the European Parliament and of the Council of 18 December 2006 on key competences for lifelong learning (2006/962/EC).

8 COM(2009)200 – 27/04/09 - An EU Strategy for Youth - Investing and Empowering.

Useful links and references

European Commission:

Communication on Health inequalities

http://ec.europa.eu/social/main.jsp?catId=89&langId=en&newsId=619&furtherNews=yes

http://ec.europa.eu/health/social_determinants/policy/commission_communication/index_en.htm

DG for Health and Consumers / Social determinants of health

http://ec.europa.eu/health/social_determinants/policy/index_en.htm

DG for Employment, Social Affairs and Equal opportunities

http://ec.europa.eu/social/home.jsp?langId=en

DG for Regional Policy

http://ec.europa.eu/dgs/regional_policy/index_en.htm

Council of the European Union

http://www.consilium.europa.eu/showPage.aspx?id=&lang=en

Council conclusions on Equity and Health in All Policies: Solidarity in Health.

http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lsa/114994.pdf

Eurostat:

http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/

WHO-OMS

http://www.who.int/en/

WHO Commission on social determinants on health

http://www.who.int/social_determinants/thecommission/finalreport/about_csdh/en/index.html

Other websites mentioned in this document (information / non exhaustive list)

http://www.health-inequalities.eu

http://www.marmot-review.org.uk/

http://www.dcsf.gov.uk/everychildmatters/earlyyears/surestart/whatsurestartdoes/

http://www.gib.nrw.de

Quick bibliography

Eurohealthnet, 2007, *Closing the Gap - Strategies for Action to tackle Health Inequalities. Taking Action on Health Equity*

Mackenbach, J. P., Meerding, W. J., Kunst, A. E., 2006, *Economic implications of socio-economic inequalities in health in the European Union*, Erasmus MC, Department of Public Health, Netherlands for the European Commission

http://ec.europa.eu/health/ph_determinants/socio_economics/documents/socioeco_inequalities_en.pdf

Mackenbach, J. P., 2006, *Health Inequalities: Europe in Profile*, 2006, An independent, expert report commissioned by the UK Presidency of the EU

http://ec.europa.eu/health/ph_determinants/socio_economics/documents/ev_060302_rd06_en.pdf

SHARE - Survey of Health, Ageing and Retirement in Europe: Börsch-Supan, A., A. Brugiavini, H. Jürges, J. Mackenbach, J. Siegrist, and G. Weber (eds.), 2005, *Health, Ageing and Retirement in Europe - First Results from the Survey of Health, Ageing and Retirement in Europe*. Mannheim: Mannheim Research Institute for the Economics of Aging (MEA).

http://www.share-project.org/t3/share/index.php?id=books&no_cache=1

Whitehead M, 1990, *The concepts and principles of equity and health*. Copenhagen. WHO Regional Office Europe, 1990

WHO Commission on social determinants of health, 2008, *Closing the gap in a generation*.

http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

For further information and references, please see the Background document for press pack, related to the EC Communication 2009-567 on health inequalities:

http://ec.europa.eu/health/archive/ph_determinants/socio_economics/documents/com2009_background_en.pdf

European Commission

Reducing health inequalities in the European Union

Luxembourg: Publications Office of the European Union

2010 — 23 pp. — 25 × 17.6 cm

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doi:10.2767/96086

This brochure called "*Reducing Health Inequalities in the European Union*" provides updated information on health inequalities between and within the Member States of the European Union.

It reviews several health inequality items (especially life expectancy) and explores the role of health determinants with a specific focus on the "Social Gradient", i e the social dimension existing in virtually all factors affecting health status.

Specific explanations are provided on the role of European and national policies in this specific field (including funding opportunities) and on their potential contribution to the reduction of health inequalities.

Finally, three case studies are spotlighted which describe the benefits achieved in such fields as child health, health of job seekers, and health status of ethnic minorities.

This publication is available in printed format in all EU official languages.

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- via one of the sales agents of the Publications Office of the European Union (http://publications.europa.eu/others/agents/index_en.htm).

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