Solidarity in health

The European Commission sets out new actions on health inequalities

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Summary: Following concerns about an increase in the level of health inequalities across the EU, the European Commission (EC) has recently adopted a Communication announcing what it will do to address this issue, which includes actions to help Member States and other actors. This article provides an overview of actions set out in the Communication.

Keywords: health inequalities, Europe, European Commission

Concerns over the extent and the consequences of health inequalities – both between and within Member States – have been expressed by EU institutions and many stakeholders, including through consultation on the recently published Communication Solidarity in Health: Reducing Health Inequalities in the EU.1 Previously, the European Council of June 2008 underlined the importance of closing the gap in health and in life expectancy between and within Member States. In 2007 the EU Health Strategy 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 which restated the fundamental social objectives of Europe through equal opportunities, access and solidarity and announced a Commission Communication on health inequalities.

The new Commission Communication sees 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. Moreover, reducing avoidable and unnecessary ill health and premature death is important in the context of an ageing population to allow longer working lives, higher productivity and higher employment levels. Avoidable poor health for those more vulnerable further enhances social exclusion and socioeconomic inequalities. Avoidable ill-health also means large costs for health systems and puts unnecessary pressure on public budgets. As identified in a study funded by the EC the economic costs associated with large inequalities in health may be considerable.2 Health inequalities thus represent a loss of human and economic potential across the EU. Reducing them can make a contribution to achieving Europe’s full potential for prosperity.

Since 2006, through both the Open Method of Coordination on social protection and social inclusion (social OMC) and the EU health strategy, the EC has been working together with Member States and other stakeholders on the commonly agreed objective to “address inequities in health outcomes” and “improving equity in health”. Through a number of funding programmes (for example, PROGRESS, Community Health Programme, Framework Programmes for Research) it has supported studies and networks which have highlighted the issue and promoted the exchange of good practice (for example, Closing the Gap; Determine; Roma-Health; Eurotime; European Network for Workplace Health Promotion). Work in collaboration with several EU presidencies has helped to create political support for action (for example, PT 2000, BE 2001, UK 2005, FI 2006, PT 2007).

The extent of health inequalities in the EU – what has been identified at EU level

Drawing on joint EC and Member States analysis, as well as a wide range of research, the Communication and its

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1 See amongst others the 2003 EC Social Situation Report, various joint (Commission – Council) reports on social protection and social inclusion, the 2006 Social Protection Committee in-depth review of National Strategy Reports on social protection and social inclusion, the 2007 peer review on access to care and health inequalities in EU, the 2008 EC Monitoring Report on social protection and social inclusion, the EC-funded Health Status & Living Conditions part of the Annual Monitoring Report from the European Observatory on Social Situation and Demography at http://ec.europa.eu/employment_social/spsi/reports_and_papers_en.htm, the EC-supported Survey of Health, Ageing and Retirement in Europe (SHARE) and related reports at http://www.share-project.org/ and the EU supported project “health inequalities, governing for health” including the 2006 paper Health Inequalities: Europe in Profile.

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accompanying impact assessment\(^3\) conclude that despite increased prosperity and overall improvements in health in the EU, health differences between and within EU Member States and EU regions persist and in some cases are increasing.\(^6\)

Eurostat figures for 2007 show that the gap in life expectancy at birth between EU countries for women is around eight years and over fourteen years for men.\(^4\) Infant mortality ranges from around three per 1,000 live births to more than ten per 1,000. There are also large differences (of up to twenty years) in the number of years lived in good health (Healthy Life Years), in premature deaths and in treatable and preventable mortality. In some countries (for example, BG, IV, ET, RO, SK) the gap in health in relation to the EU average and the best performers has widened in the last two decades. In general, people in Central and Eastern Europe live shorter lives and spend more years of their lives in ill health (with limitations) especially in the case of men. Infant mortality is also higher in Central and Eastern Europe. The largest differences between Member States are seen in mortality and morbidity of cardiovascular disease, injuries and violence, cancer, and alcohol-related diseases and their underlying risk factors: smoking, diet and alcohol consumption.

There are substantial differences in health between different social groups defined on the basis of income, occupation, educational level or ethnic group in all Member States. People with lower education, income or occupation tend to die at a younger age and to have a higher prevalence of most types of health problems. These differences start at a young age and persist and widen at older ages. For example, differences in life expectancy at birth between the lowest and highest socio-economic groups range from four to ten years for men and from two to six years for women. In some countries the gap has widened in recent decades.

These headline indicators are reflected in similar patterns for a very wide range of objective and subjective measures of physical and mental health. For example, for ‘self-perceived general health’ a clear income gradient can be observed in that those in the lowest (poorest) income quintiles more often report very bad health than those in the highest (richest) quintiles.\(^5\) Data from the Survey of Health, Ageing and Retirement in Europe (SHARE) shows that individuals with lower education or lower income are more likely to experience limitations with mobility, arm or motor functions and have a higher prevalence of eyesight, hearing and chewing problems.

Vulnerable groups (some 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 living with mental or chronic illnesses, older pensioners on minimum pensions and single parents) suffer a particularly great burden of mortality and disease. For example, the Roma can expect to live ten years less than the majority population in some countries. Migrants may also face higher risks of non-communicable diseases (cardiovascular disease) and mental health problems due to a combination of the socioeconomic and environmental conditions in the origin, transit and host countries.\(^6\)

There is also a gender dimension to health.\(^7\) While women live longer than men, they also spent a higher proportion of their lives in ill-health. Moreover, there are diseases that affect men more than women and vice-versa, a fact that is not necessarily taken into account in health services delivery.

Importantly, there appears to be a strong association between within-country socio-economic inequalities in health and the overall population health i.e. the higher the socioeconomic inequality in health, the poorer the overall population health. Addressing health inequalities within Member States could thus contribute to reducing differences in health outcomes between Member States.\(^3\)

**The determinants of health inequalities in the EU – what is known at EU level**

The Commission recognises that the reasons behind these gaps in health are complex and involve a wide range of factors. These relate to inequalities in the wider social determinants of health including:

- living conditions (housing, environment);
- health-related behaviour (smoking, alcohol consumption, exercise) which are themselves influenced by socio-economic and cultural factors;\(^8\)
- employment and working conditions (exposure to physical, chemical, and biological agents at work occupational health, health and safety at work, type of contract);
- income (or its absence and thus financial distress);
- education; and
- access to social protection including access to quality health care including health promotion and disease prevention interventions.\(^5\)

The 2008 European Quality of Life Survey from the European Foundation for the Improvement of Living and Working Conditions\(^15\), for example, has identified sections of the EU population which do not have access to running water, adequate washing and toilet facilities, affordable energy, appropriate housing, heating, new clothes, or a safe environment.

The European Agency for Safety and Health at Work has indicated that health risks vary significantly across sectors and not all workers are equally exposed to occupational hazards: for example, young workers are usually less informed about occupational risks, which makes them overexposed, and workers with a fixed-duration or temporary employment relationship are more exposed to the risk of accidents at work and occupational diseases. The EC Impact Assessment to the Community Strategy on Health and Safety at Work 2007–2012 showed that occupational health strategy reduces work accidents and helps accident victims or the chronically ill to retain their job or return to work. It is a key 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.

The 2008 EC Monitoring Report on social protection and social inclusion indicates that income distribution policies (for example, social transfers) may reduce the risk of poverty in the EU by 38% on average, but the extent of redistribution and social protection vary significantly across Member States.\(^5\)

Differences in access to quality care between and within EU Member States also contribute to differences in mortality. There are large differences between EU Member States in terms of unmet need for health care and there is a clear income gradient in unmet need for medical care for all EU Member States: those in the lowest income quintiles more often report an
unmet need due to waiting, the direct financial costs of care and the distance to care. Several Joint Reports on Social Protection and Social Inclusion have identified barriers to access (lack of health insurance coverage, direct financial costs of care, geographical disparities in service availability, waiting times, lack of information, discrimination and language barriers, health literacy and socio-cultural expectations in relation to life and care services) while the First European Communicable Disease Epidemiological Report by the European Centre for Disease Prevention and Control concluded that every year three million patients experience health care associated infections; 50,000 will die from them. This may be particularly acute in some regions of new Member States which lack high quality health facilities with up-to-date equipment and well trained staff. In general, inequitable access to care appears to be associated with higher health inequalities [5].

Looking at this set of determinants a possible consequence of the current financial crisis is that health gaps may further increase in the groups most hit by the recession such as the unemployed and those facing financial distress.

**Background to action**

Differences in the determinants of health and health inequalities are thus strongly influenced by the actions of governments, stakeholders, and communities and can be addressed by public policy, which itself can be influenced by EU policy.

Through its work, notably under the social OMC and the EU expert group on social determinants of health and health inequalities, the EC has identified three broad areas which pose obstacles to taking effective action to address health inequalities. These are areas where the EU can support and complement Member States actions and include:

- Lack of awareness and insufficient policy priority and commitment by Member States and other stakeholders and insufficient exchange of good practice.

- Gaps in information and knowledge. There is an absence of comparable and regular data, monitoring and reporting. Lack of knowledge on the determinants of health inequalities and the effective policies to implement and difficulties in creating an inter-sectoral policy approach.

- An insufficiently concerted EU approach to health inequalities (lack of mainstreaming at the EU level).

Principal responsibility for action to address health inequalities rests with Member States, but EU policies can also have a role both through their direct (e.g. health and safety at work, consumer protection, public health policies) or indirect (e.g. economic, regional, equal opportunities policies) impacts on health and by helping to overcome some of the current obstacles to the actions just identified.

For example, EU-wide data collection and monitoring is an economical way of improving the knowledge base for national policymaking and allows countries to learn from each other. Financial support to Member States under the European Cohesion policy can be used to invest in key determinants of health inequalities, such as living conditions, training and employment services, and more recently health care (promotion, prevention and treatment). The EC can raise awareness on the scope, consequences and determinants of health inequalities and reinforce the policy focus to address them. It can enhance the research and knowledge base through various tools (research programmes and EU agencies), provide the means for Member States and relevant stakeholders to share experiences and good practices and improve Member States’ capacity building. Finally, it can strive to improve the linkages between EU policies (e.g. economic, social, health and environmental policies) so that these ensure a high level of health protection of all citizens.

**EU action on health inequalities**

Broadly the actions proposed by the Commission in its Communication include:

- Enhancing collaboration with national authorities, regions and other bodies to identify what works best and how to put this into practice.

- Better assessing the impact of EU policies on health inequalities to ensure that they help reduce them where possible.

- Ensuring more regular statistics and reporting on the size of inequalities in the EU and improving existing knowledge on successful strategies to reduce them.

- Improving information on EU funding to help national authorities and other bodies to use EU funds to address inequalities by improving, for example, primary care facilities, water and sanitation and housing renewal.

More specific EC actions include:

- Developing headline indicators to monitor health inequalities, supporting further development and collection of data by age, sex, socio-economic status and geographic dimension and stimulating a reflection on target development in the Social Protection Committee.

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

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

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

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

- Reviewing the possibilities to assist Member States to make better use of EU structural funds to support activities to address factors contributing to health inequalities.

- Developing actions and tools on professional training to address health inequalities using the health programme, European Social Fund (ESF) and other mechanisms.

- Launching 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.

- Encouraging Member States to further use the existing options under the EU Rural Development Policy and Common Agricultural Policy (school milk, food for deprived individuals, school fruit scheme) to support vulnerable groups and rural areas with high needs.

The aim is to support and complement the efforts of Member States and stakeholders.
and to mobilise EU policies towards reducing health inequalities. As far as possible, the health protection provided by EU policies should extend to all citizens irrespective of where they live or their social background. EU actions should support improvements in the health of the whole population, but with an emphasis on reducing avoidable and unfair gradients in health between social groups and EU regions – i.e. a ‘levelling-up’ approach. In fulfilling these aims EU actions can make a contribution towards a reduction in health inequalities in the EU. A first report on progress will be produced in 2012.

REFERENCES

Health inequality
Why is it important and can we actually measure it?

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Summary: Health inequalities are present in most European countries and evidence of widening inequalities is shown in a number of national and international studies. However, the measurement and monitoring of health inequalities over time and across countries is not straightforward since the choice of measure will influence the results. Numerous measurement tools have been developed for measuring health. Results can be affected by not only the choice of indicator but also by the social group for analysis. The focus of the paper is mainly on the relationship between relative and absolute inequalities discussing the role of the statistical artefact.

Keywords: health inequality, absolute versus relative inequality, statistical artefact

"Health is a universal human aspiration and a basic human need. The development of society, rich or poor, can be judged by the quality of its population’s health, how fairly health is distributed across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.1 Health inequalities can be defined as ‘the systematic and avoidable differences in health outcomes between social groups such that poorer and/or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent’2. Evidence of socioeconomic inequalities in health can be found as early as the 19th century. In recent decades there have been a large number of national and international studies on health inequalities, given the increasing evidence of widening inequalities in Europe.3 However, the measurement and monitoring of inequalities in health over time and across countries is not straightforward since the choice of the measure will influence the results. No consensus has been reached on the best and most meaningful measure. Numerous measurement tools have been developed for measuring health. These can be differentiated into macro- and micro-level health indicators. Population summary measures such as life expectancy and infant mortality are extremely useful for estimating changes in overall population health and the global burden of disease across countries or within a country over time, but may