MEMO: Questions and Answers on Solidarity in health: Reducing health inequalities in the EU

What are health inequalities?
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 those differences in health which 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 can be addressed by public policy. Therefore, health inequalities here refer to those avoidable and unfair differences in health that are strongly influenced by the actions of governments, stakeholders, and communities and can be addressed by public policy.

How large are health inequalities between EU Member States?
In 2007, between Member States, there was an 8-year difference in life expectancy at birth for women and a 14-year gap for men. In several Member States the difference between national life expectancy and the EU average has increased in the last two decades. In some countries, contrary to the general EU trend, some mortality rates have grown during the last decade. There are also large differences of up to 20 years in the number of years lived in good health (Healthy Life Years). Large differences are also found in infant mortality – more than five times as many babies die before the age of one in some countries than in others. There are also large differences in premature deaths which are), treatable and preventable , and in subjective measures of health such as self-perceived general health, long-standing illness and activity limitations.

How large are health inequalities within EU Member States across population groups?
Major differences in health also exist between socio-economic groups within all EU countries. These start at a young age and persist and widen during life and may be passed on to the next generation. Differences in life expectancy at birth between the lowest and the highest socio-economic groups (e.g. between manual and professional occupations; people with primary level and post-secondary education; low and high income quintile) range from 4 to 10 years for men and 2 to 6 years for women. In some countries the gap has widened in the last decades. Infant mortality is higher in the lowest socio-economic groups. Moreover, people with lower education, income or occupation also spend more time in poorer health. They are more likely to report very bad health than their richest counterparts..

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 suffering from mental or chronic illnesses, elderly pensioners on minimum pensions, and single parents) suffer a particularly greater burden of mortality and disease. For example, the Roma can expect to live 10 years less than the majority population in some countries.

What is the cost of those health inequalities?

Indirect economic costs of the persistence of large scale inequalities in health are potentially considerable but difficult to estimate. One of the few studies that has attempted to do so estimated that the potential economic gain which would occur if it was possible to bring the health of the whole population up to the level of health experienced by those with higher education would be between 1.2% and 9% of the EU Gross Domestic Product (Mackenbach et al., 2007).

Why are health inequalities a policy concern for the EU?
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. High levels of health (i.e. reducing unnecessary ill health and premature death) for all sections of the population are important in the context of an ageing population to allow longer working lives and support higher productivity and employment levels. Avoidable ill-health also means large costs for health systems and puts unnecessary pressure on public budgets.

What are the current problems and barriers in taking action on inequalities in health?
These can be grouped in three areas:

a) *Lack of awareness and insufficient policy priority and commitment by Member States and other stakeholders.* While Member States have now subscribed to the principle of reducing health inequalities, the level of awareness and the extent to which action is being taken to achieve it varies substantially. Member States are implementing some actions but in general, comprehensive strategies are lacking. In addition, the policies which are implemented lack assessment/ evaluation which limits knowledge on policy effectiveness and can thus hinder policy development by other Member States.
b) *Absence of comparable and regular data, monitoring and reporting and lack of knowledge on the determinants and the effective policies to implement.* The data availability and reliability varies substantially by Member State thus contributing to policy makers' lack of awareness on the extent, causes and consequences of the problem. Data is not routinely collected in a comparable manner by age, gender, socio-economic status or geographic dimension. While some causes are well known, we need to have more information on the degree of causality and the relative weight of several determinants of health inequalities.
c) *Insufficient concerted EU approach to health inequalities (in other words lack of mainstreaming at the EU level).* Through its policy processes and support, the EU has gradually given the issue of health inequalities higher priority in the policy agenda and there are a large number of EU policies which potentially can and are impacting on health inequalities. However, it is currently difficult to establish and quantify what that impact is/ has been.

Why should there be EU action?
While the principal responsibility for health and social policy rests with Member States, not all Member States have the same available resources, tools or pools of expertise to address the different causes and routes of the current health inequalities. EU policies can have a role both through their indirect impact on health and by helping to overcome some of the current obstacles to action. The EU is better placed then individual Member States to ensure the necessary, reliable and comparable data to measure health inequalities. The EU also provides financial support to Member States under the Cohesion policy that can be used to invest in key determinants of health inequalities such as living conditions, training and employment

services, and more recently healthcare (promotion, prevention and treatment). The EU can also 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 should 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. Better and shared evidence, a good understanding of the rationale for action and technical and financial EU level support can provide the political commitment for action currently required.

What is the legal basis for action?

The legal basis for action that can contribute to the reduction of health inequalities in the EU is found in various articles of the EC Treaty. Article 152 indicates that the Community shall ensure that all Community policies and activities provide a high level of health protection. Articles 12 and 13 are the basis for EU action on anti-discrimination in e.g. employment and social protection. Article 125 and related articles indicate that Member States and the Community shall promote a skilled, trained and adaptable workforce and achieve a high level of employment. Articles 136 and 137 and related articles indicate that the Community and Member States shall have as their objective improving living and working conditions, ensuring proper social protection and combating exclusion. Articles 158 and 159 refer to the Community goal of strengthening economic and social cohesion by reducing disparities between the least favoured regions, including rural areas and supporting the achievement of those objectives through the Structural Funds. This legal basis for action is reinforced by a "political mandate" for action with several EU bodies, Member States and various stakeholders calling for further EU action.

What is the Commission proposing as EU actions?

The Commission is determined to support and complement Member States and other stakeholders in their efforts to tackle health inequalities. Actions are to take place in relation to three areas:

a) Raising awareness, promoting information, best-practice exchange and policy coordination and advocating the tackling of health inequalities as a policy priority
b) Improving data availability and the mechanisms to measure, monitor and report on health inequalities and improving the knowledge base on the causes of health inequalities and the effective policies to address them.
c) Develop the contribution of relevant EU policies towards reducing inequalities in health

Actions include:

- Produce headline indicators to monitor health inequalities, support further development and collection of data by age, sex, socio-economic status and geographic dimension and stimulate a reflection on target development in the Social Protection Committee.
- Provide funding under PROGRESS including for peer reviews and a call for proposals in 2010 to assist Member States in developing relevant strategies.
- Develop health inequality audit approaches through the Health Programme in joint action with Member States willing to participate.
- 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.

- Review the possibilities to assist Member States to make better use of EU structural funds to support activities to address factors contributing to health inequalities
- Develop actions and tools on professional training to address health inequalities using the health programme, ESF and other mechanisms.
- 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.
- Encourage Member States to further use the existing options under the EU rural development policy and CAP (school milk, food for most deprived persons, school fruit scheme) to support vulnerable groups and rural areas with high needs.