

**TACKLING HEALTH INEQUALITIES IN THE EU:
THE CONTRIBUTIONS OF VARIOUS EU-LEVEL ACTORS**

CLOSING THE GAP

Strategies for Action to tackle Health Inequalities



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Health Inequalities in the EU

Introduction

INGRID STEGEMAN

EuroHealthNet

Throughout Europe, a person's chance of living a long and healthy life is strongly associated with his or her socio-economic status. Health inequalities between socio-economic groups are a substantial and increasing problem, even in the relatively wealthy countries of the EU. This issue is central to EuroHealthNet's work. By networking and improving cooperation among relevant and publicly accountable national and regional public health and health promotion agencies in EU member states, we aim to contribute to a healthier Europe with greater equity in health within and between European countries.

Health Inequalities are commonly understood 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.'**¹

Much evidence has been collected of social variations in health and life expectancy in all EU countries². Studies also indicate that relative mortality differences between high and low socio-economic groups have increased within EU countries,³ with actual differences in life expectancy of four to six years in men and two to four years in women.⁴ Differences in healthy life years and self-perceived healthy life years are much higher, often in the area of 15 years.

The impact of health inequalities is perhaps most apparent when expressed in terms of chances of survival: e.g. in France, the probability of men who do manual work dying between 35 and 65 years of age is twice as high as that for men in senior executive positions. Fifteen year old boys living in the most affluent areas of Glasgow have a 90% chance of getting to the age of 65 whereas boys in the poorest part have just a 50% chance.⁵

It is only natural that some health differences exist within a population, since they can result from biological variation, or from health damaging behaviours that are freely chosen. The fact however that there is a health gradient, or a systematic correlation between health status and social class, indicates that these differences are more likely to result from exposure to unhealthy and stressful living and working conditions and inadequate access to basic social services. This means that health differences are not the result of individual choice, that they are avoidable and unjust.

While there is much evidence regarding the existence of health inequalities, less is known about how to reduce them. EuroHealthNet and the Bundeszentrale für gesundheitliche Aufklärung (BZgA) are currently coordinating a three year project on Closing the Gap – Strategies for Action to Tackle Health Inequalities (see box). The project brings together over twenty countries from across Europe to exchange information on what can be done to reduce health inequalities and, importantly, to stimulate action in this area. The emphasis on Action is important.

All project outcomes, including the national actions and good practice interventions that are being implemented in the participating countries can be consulted on the project Portal: www.health-inequalities.eu. One of the project's objectives is also to look at the impact of EU policies on health inequalities. As part of this task, we have asked a number of Brussels based organisations working in different fields to identify some current EU-level regulations and programmes which they feel influence levels of health inequalities in the EU. Their views are presented in the following pages.

Mention health inequalities and people immediately think 'health care' – and consign actions to health care services. They may also assume that this is mainly an issue to be dealt with at the national level, since, in EU jargon, health is primarily a national level competence.

As the first and second articles indicate, this is changing, since the establishment of a single market has also begun to affect health systems. These developments bring with them opportunities but also threats with respect to health inequalities. The social consequences of greater economic integration, including the impact on health equity, must be carefully considered.

While a person's access to quality health care is relevant to good health, it is not the only determinant. Equally, if not more important are the circumstances in which people live, their health-related behaviours and their ability to take in and act on the health-related messages that they receive.

A large number of policies and programmes developed at the European level also have significant effects on these factors. Action at the EU level is therefore of utmost importance to efforts to reduce health inequalities.

1 Whitehead M (1990) The concepts and principles of equity and health. Copenhagen. WHO Regional Office Europe, 1990.
2 Drever and Whitehead, 1997; Marmot and Wilkinson, 2005; Mackenback and Bakker, 2002; Marmot and Bobak, 2000 and Graham H (2004). Social determinants and their unequal distribution: clarifying policy understandings. *Milbank Quarterly*, 82, 101-24.
3 Marchenback et al. (2003) Widening socioeconomic inequalities in mortality in six Western European countries. *International Journal of Epidemiology*, 32, 830-7
4 Machenback JP (2005) Health Inequalities: European in Profile. London: UK Presidency of the EU.



The following contributions provide a sample of the range of factors that can have a positive or negative impact on the health of people in the EU, and of the range of actors that can contribute to progress in this area.

The issues addressed vary from the provision of health care, to what kinds of and how food is produced and marketed, which is critical to making healthy choices the easy choice. The rules established and goals developed at EU level regarding e.g. environmental problems, social exclusion, and obesity affect how these themes are prioritised and dealt with at the national, regional and local level, while EU funding programmes can spur important initiatives that can make important contributions to efforts to reduce health inequalities. A short glossary of concepts has been included at the back of the newsletters for readers who may not be familiar with some of the EU-related concepts mentioned.

The opinions expressed in the articles provide the important perspective of non-governmental organizations, which do not necessarily reflect those of the 'Closing the Gap' partners and coordinating bodies. The intention is, however, to generate debate, to establish common ground to build multi-sectoral partnerships, which are critical to any successful approach to tackle health inequalities in fast changing communities.

EuroHealthnet is a network of health promotion and public health agencies in Europe, that aims to contribute to a healthier Europe, with greater equity in health within and between European countries. We achieve this by coordinating the work of 31 national and regional agencies in Europe thereby constituting a valuable platform for information, advice, policy and advocacy on health issues at EU level.

For more information, see:

www.eurohealthnet.eu

All EU Member States claim to share common values such as justice, solidarity and equality. Reducing health inequalities is an important way to manifest these values, which can only be achieved through common visions and close cooperation across policy sectors and levels.

Closing the Gap – Strategies for Action to tackle Health Inequalities

'Closing the Gap' is a three year project (2004-2007) that is being coordinated by EuroHealthNet and the Bundeszentrale für gesundheitliche Aufklärung (BzgA) and is co-funded by the EC under the Public Health Action Programme. It is a partnership of 21 public health agencies and institutes from across Europe that are working together to develop a shared understanding of health inequalities and to determine what is and can effectively be done to reduce them. The project aims to stimulate all participating countries to take action in this area.

Participating agencies have assessed how health inequalities are currently being addressed in their countries, and are developing Strategic Initiatives outlining further steps that can be taken to improve this situation.⁵ This information will be shared during National Seminars that will take place in each participating country in mid February 2007. In addition, project partners have identified over 90 good practice projects and programmes that are contributing to the reduction of health inequalities in their countries. 'Closing the Gap' also looks at how policies and programmes deriving from the EU can have a positive or negative impact on health inequalities in EU Member States. All project outcomes are available on the health inequalities Portal, and will be presented during a final conference, 'Action for Health Equity', that will take place in Brussels on 8 May 2007.

For more information: www.health-inequalities.eu

⁵ Mesrine, 1999 and Burns, 2005 in: Dahlgren, G and Whitehead M. Levelling up: a discussion paper on European strategies for tackling social inequities in health. WHO Collaborating Centre for Policy Research on Social Determinants in Health, 2006.

⁶ For an initial overview of the outcomes see: K. Judge, S.Platt, C.Costongs, K.Jurczak (2005) Health Inequalities: A Challenge for Europe. London: UK Presidency of the EU.

Fighting poverty in the EU

PATRIZIA BRANDELLERO

European Anti Poverty Network (EAPN)

The reality of 72 million people experiencing poverty and social exclusion in the EU, one of the wealthiest regions of the world, is one that raises serious questions about the way in which policies are designed across the board. This reality is closely associated with that of health inequalities, since the poorest also invariably have the poorest health, perpetuating their difficulties. What exactly is the EU doing to address this critical situation?

Particularly since 2000, the fight against poverty has acquired a different status on the agenda of the EU. At the time, the Heads of State and Government agreed in Lisbon that the levels of poverty in the EU were unacceptable and that steps had to be taken to 'make a decisive impact on the eradication of poverty'.

2010 is considered the target date by which we will be able to assess whether the different mechanisms in place since the Lisbon commitment was voiced and implemented are delivering in reducing poverty and social exclusion. With average levels still at 15% of the population living below the poverty line (calculated on the basis of 60% of the median income), and little evidence of any decrease in numbers of people enduring this reality on a daily basis, EAPN believes it is time to invest more energy in making these processes work better for people at the margins of society.

The Open Method of Coordination on social protection and social inclusion (OMC) is the key tool in delivering the EU's commitment to poverty eradication. Bringing together the three areas of social inclusion, health and long-term care and pensions, and based on a set of common EU objectives, it provides a framework for Member States to prepare and submit at EU level, Action Plans or Reports in these areas of concern. Having this structure in place is essential, not only in guaranteeing the regular, continuous production of strategies at national level to tackle these issues, but also in providing a valuable overview of the situation in the Member States, in facilitating mutual learning and in highlighting priority areas and shortcomings in policies.

One of the benefits of the OMC process is that it recognizes the importance of, and promotes a multi-dimensional approach. Addressing poverty is linked to the issue of health inequalities and pensions, etc., while investing in equitable health policies can have a positive impact on the alleviation of social exclusion. The value of the OMC also lies in its ability to mainstream the concerns it highlights into other policy areas. It is essential to see poverty and exclusion as multi-dimensional issues which cannot only be solved through social policy measures alone.

Economic and employment policies for example play a determining role when it comes to poverty and exclusion. Are the policies in place in these fields – currently presented by Member States at EU level in the form of National Reform Programmes within the so-called 'Lisbon Strategy' – producing or alleviating poverty? **Often the effects of trends such as the liberalisation of services, activation measures or terms such as 'flexicurity' of the labour market on people experiencing inequalities or exclusion are not taken on board when the policies are being shaped.** EAPN therefore believes in the need for all stakeholders to be involved in the definition of these strategies, particularly people experiencing poverty themselves.



Some examples of integrated approaches show how it is possible to balance economic, employment and social concerns. It is worth mentioning here the recent communication by the Commission on active inclusion of people most distanced from the labour market, which looks at issues of activation and accompanying measures towards integration in the labour market but also at issues of access to services and to minimum income. Other examples can be the broader debate on the EU Constitutional Treaty, which could include clauses on social inclusion and social protection, equality and discrimination, and the references to this in the Charter of Fundamental rights, which could become an integral part of such a Treaty.

It is important that all stakeholders working on issues of exclusion and inequality are actively involved at national as well as at EU level in all the debates that the EU is putting forward to shape a stronger social profile for its policies, and to ensuring that they benefit those people who are most excluded from society.



EUROPEAN ANTI POVERTY NETWORK

The European Anti-Poverty Network (EAPN) is an independent coalition of non-governmental organisations fighting poverty and social exclusion and mobilised into national networks in most of the Member States of the European Union. It brings together many European-level NGOs whose work focuses on issues of poverty and social exclusion, often specializing on specific concerns. Since 1990, EAPN has sought to promote a European Union agenda strongly anchored on the values of social justice, equality, inclusion and non-discrimination. It has supported and contributed to the development of processes to address poverty and social exclusion. For more information: www.eapn.org.

Environmental dangers often hit the deprived and most vulnerable the hardest

BY GÉNON JENSEN
AND DIANA G. SMITH

Health and Environment Alliance (HEAL)

The Health and Environment Alliance (HEAL) monitors developments within the European Union policy framework and carries out advocacy activities on environmental and sustainable development policy by bringing in health expertise and citizens' perspectives from the health community. In collaboration with our 50 member organisations, we tackle a wide range of issues such as air quality, chemicals and pesticides management, climate change, and accidents and injuries. **Health inequality is a key concern because environmental degradation has its most devastating effects on the poorest and the most vulnerable, who are often least well-informed and least able to fight back.**

HEAL aims to encourage changes in public policy that promote a cleaner and safer environment. This strategy tends to disproportionately benefit the relatively less well off, since it is marginalized groups that are likely to benefit most where public policy improves. For example, strong health standards on outdoor air are likely to favour poorer communities who are more likely to live near busy roads where air pollution is significantly higher and can contribute significantly to an increased incidence of asthma and other respiratory diseases. **A study in the UK revealed that lower income families are 100 times more likely to live in an area where there is a polluting factor than a wealthier family.¹**

Tighter health standards and other policy that gives greater priority to the safety of what we eat, the water we drink and the air we breathe could help reduce inequalities in Europe. Cleaner water and air and safer food could help prevent many cases of diarrhoeal and respiratory diseases, cancer, asthma, allergies, birth malformations and infertility, especially within disadvantaged communities where the burden of ill health is higher.

Contributing to the WHO process

HEAL and its sister organisation, the European Public Health Alliance, have played a leading role in building up the health sector's involvement in tackling environmental risk factors across the 53 countries in the World Health Organization (WHO) European Region. This has been possible because HEAL serves on a unique multi-sectoral steering body that is responsible for the WHO's Environment and Health process in the European Region. The European Health and Environment Committee involves governments, intergovernmental organisations, NGOs, trade unions and industry bodies in making progress on four regional goals which link environmental pollution with children's ill health. The goal is to create national action plans in each country to address priority concerns. It is commonly referred to as the Children's Health and Environmental Action Plan for Europe (CEHAPE).

Ministerial commitments taken within the CEHAPE process address health inequalities not only by focusing on the state of the physical environment but also stress that effective action should also emphasise primary prevention, equity, poverty reduction and health promotion.²



1 "Children's health and the environment: A review of evidence", World Health Organization Regional Office for Europe and European Environment Agency (page 192).
2 Children's Environmental and Health Action Plan for Europe is available at www.euro.who.int/childhealthenv/policy/20020724_2 (accessed 4.12.2006) HEAL has its own CEHAPE website at www.cehape.env-health.org
3 Brundtland starts new movement to address environmental crisis affecting children's health, WHO press release, www.who.int/mediacentre/news/releases/who66/en/
4 The European Child Safety Alliance website at www.childsafety.org
5 VOICE website at www.etsc.be/Voice.php



The Health and Environment Alliance (HEAL), formerly EPHA Environment Network (EEN), is an international non-governmental organisation that aims to improve health through public policy that promotes a cleaner and safer environment. HEAL brings together a diverse network of citizens', patients', women's, health professionals', academic and environmental organisations across Europe. We advocate greater protection of the environment as a means to improving the health and well being of European citizens. More information at www.env-health.org



Burden on children

Worldwide, the World Health Organization (WHO) estimates that 40% of the global burden of disease attributed to environmental risk factors falls on children under 5 years, who account for only 10% of the world population.³ On top of this inequality, huge differences exist between the health of children in Western Europe and those in poorer countries in Central and Eastern Europe. Many children in the wider European region die from diarrhoeal diseases associated with unsafe drinking water and respiratory infections associated with air pollution are the single largest cause of children mortality in children under five in Europe, according to WHO.

Child injuries represent another area in which great inequalities exist across the European Region. In low-income countries and countries in political and economic transition, children are 4.3 times more likely to die of injuries than children in high income countries. Although high-income countries in Europe are among the safest in the world, the most deprived areas within them suffer 3.5 times more road traffic accidents, six times as many falls and 18 times more house fires.⁴ HEAL is part of a platform called VOICE, which aims to raise awareness of the needs of vulnerable road users among EU policy makers.⁵

Disparities among young people

HEAL has prioritised working with young people from economically disadvantaged communities to increase their participation in environment and health policy making, and ensure that the political processes better reflect their realities and prioritise action. We produced an award winning video⁶ called, "It's Our World, Our Future Too" with young people from disadvantaged communities in four countries (UK, Russia, Belgium, Hungary). It enabled disadvantaged youth to express their concerns to top policy makers gathered for the WHO Fourth Ministerial Conference on Environment and Health in Hungary in 2004.⁷ HEAL chose to highlight the voices of young people from economically-deprived communities because of an underlying belief in the fundamental right to a healthy environment and environmental justice for all, especially those marginalized economically, socially, by age or by gender.

Environmental justice

When disadvantaged groups face environmental injustice, it adds to the burdens on their health. For example, internally displaced ethnic communities resettled on a toxic, mostly inactive mine in Kosovo suffer high infant mortality and neurological problems due to lead poisoning. HEAL is currently developing a joint project with the Centre for Environmental Policy and Law.⁸ It involves several case studies of environmental injustice in Central and Eastern European countries focusing on economically disadvantaged people and ethnic minorities. It will highlight links with public health and make policy recommendations for action at EU and international level.

EU leadership

The European Union has its own defined health and environment strategy and the European Commission supports a wide range of initiatives on reducing the health impact of environmental factors.

The criticism the Health & Environment Alliance has of the strategy is that it gives too little attention to the need for greater protection of vulnerable groups, such as children and young people. We would also like to see much tighter coordination and cooperation between the EU and WHO children's environment and health plans. But most importantly we seek a comprehensive communication strategy that takes into account the perspectives of health experts and the demands of citizens.

The Health & Environment Alliance video project brought youth concerns to policy makers. One of the key demands of the young people was that they wanted to be seen as part of the solution. Involving youth in environment and health advocacy is our strategy to reach out to disenfranchised communities. Policy change aimed at benefiting environmental health can succeed. It can also disproportionately benefit disadvantaged groups. However, to achieve its best, youth and health communities must be part of the process.

⁶ The video was part of the Health & Environment youth participatory project entitled "It's our world our future too: Youth participation project on environment and health". The video can be viewed at www.env-health.org/a/1419 In March 2006; the project received the prestigious Children's Environmental Health Recognition Award from the U.S. Environmental Protection Agency (EPA) Office of Children's Health Protection. HEAL has also published a *Practical Guide on using Video for projects on environmental education* as part of this project.

⁷ The Declaration signed at the Fourth Ministerial Conference on Environment and Health, May 2004, Budapest is available at www.euro.who.int/document/e83335.pdf

⁸ The project is entitled "Case Studies of Environmental Injustice in Central and Eastern Europe". CEPL – Hungary at www.cepl.ceu.hu/

Putting health higher on the European agenda

BY WILLY PALM

European Observatory on Health Systems and Policies

Health in Europe presents a quite divergent picture. Inequalities not only exist between countries but also within them. Even in the European Union, important gaps can be observed in terms of mortality and morbidity. Even though social and economic determinants are important factors to explain these differences and to remediate them, the vital role that the health system can play in reducing these inequalities should not be forgotten. Irrespective of differences in terms of organisation and financing modes, which to a large extent are historically and culturally linked, health systems differ in terms of financial capacity and performance levels.

Faced with an ever increasing health bill, essentially due to demographic change and medical progress, health policy makers are being forced to consider fundamental reforms to maintain health systems' sustainability. This also includes the option of more private sector involvement as well as increased private funding. Considering the impact of health systems on Member States' public budgets, especially in the context of the Stability and Growth Pact, EU institutions have on various occasions raised concerns about their future development. However, it is increasingly acknowledged that efficient health systems actually not only contribute to Europe's citizens' health, but also to its wealth. This idea that health expenditure should not only be considered as a short term cost, but as well as a long term investment, fostering in its turn economic growth and sustainable development, was conveyed by former EU Health Commissioner Byrne in 2004. Today, the economic dimension of health, helping to achieve the goals set out in the Lisbon agenda, together with a multi-sectoral approach towards health, looking at impacts on health in all policy areas, are driving the health policy agenda at EU level.



The increasing pressures on health systems as well as the common public health threats have urged the need to cooperate at an international level. The integration of Article 152 in the Treaty establishing the European Community marked an increased role for the EU level in the field of public health, although this primarily involved supporting and coordinating actions undertaken by the Member States. While the subsidiarity principle is often understood as the exclusive competence of Member States in organising and delivering health care, it can also indicate that certain problems may be more effectively addressed at the supranational rather than at the national level.

To illustrate this, the increasing shortage of health professionals and the professional mobility arising from it would perhaps require Community action or a concerted response. Since 2001, Member States are testing a "soft law" approach to improve the alignment of their national policies in health and long-term care by setting common objectives for modernising their health systems and exchanging best practice, through the so-called open method of coordination. In addition, the high level group on medical care and health services, established as an outcome of the 2003 high level reflection process on patient mobility and EU healthcare developments, tries to set out a framework for cross-border cooperation in healthcare in various fields (reference centres, purchasing, information, accessibility and quality of care, patient safety).

Yet, it is not so much a clear choice for greater coordination at the EU level that has led Member States to seek greater cooperation in the area of health care, as the common fear that EU economic integration is undermining national steering capacities in this area. The European Commission as well as the European Court of Justice intervened on many occasions to extend and apply fundamental Treaty provisions of free movement and fair competition to the health sector. Since health systems increasingly operate in an open market and reforms have introduced market mechanisms as a way to stimulate cost-effectiveness, they have also become more exposed to individual complaints and legal infringements.

REFERENCES:

■ Marc Shurcke, Martin McKee, Regina Sauto Arce, Svetla Tsoleva, Jørgen Mortensen, *The contribution of health to the economy in the European Union*, 2005;

■ Timo Ståhl, Matthias Wismar, Eeva Ollila, Eero Lahtinen & Kimmo Leppo (eds.), *Health in All Policies: Prospects and potentials*, 2006;

■ Markus Wörz, Thoms Foubister and Reinhardt Busse, *Access to health care in the EU Member States*;

Following the Court judgments with respect to the reimbursement of non-authorised healthcare treatment in another Member State, attempts have been undertaken to clarify the impact of EU rules on health care and to better reconcile national health policy objectives with Community obligations.

The recent exclusion of health care from the Services Directive showed that an adapted approach is preferred in which health services can be delivered in a European market only if clear rules are set in terms of cover, quality and safety, as well as patient rights. This will be the purpose of a Commission initiative that is currently under preparation. In some cases, action by the ECJ has forced Member States to reconsider their health system's responsiveness, providing individual patients with more leverage to challenge internal deficiencies.

These developments and the application of internal market rules are generally not considered to be the primary objectives or mechanisms to address health inequalities. They are, nevertheless, putting health higher on the European agenda and raising awareness that health care is a service of general interest, which requires or justifies specific safeguards to ensure overall accessibility, quality and sustainability.

The European Observatory on Health Systems and Policies is a partnership between the WHO Regional Office for Europe, the Governments of Belgium, Finland, Greece, Norway, Spain and Sweden, the Veneto Region of Italy, the European Investment Bank, the Open Society Institute, the World Bank, CRP-Santé Luxembourg, the London School of Economics and Political Science (LSE) and the London School of Hygiene & Tropical Medicine (LSHTM). It supports and promotes evidence-based health policy-making through comprehensive and rigorous analysis of the dynamics of health care systems in Europe. The Observatory's fundamental mission is to help bridge the gap that often is observed between health systems research and health policy making. Although not pursuing any specific political agenda, the Observatory aims to improve health outcomes and reduce inequalities in health by empowering European policy makers committed to these goals and to the common values and principles underpinning all health systems.

For more information:

www.euro.who.int/observatory

Health Inequalities and the Community Pharmacist

JOHN CHAVE

Pharmaceutical Group of the European Union (PGEU)

It is 32 years since the groundbreaking LaLonde report¹ identified definitively the problem of health inequalities in advanced industrialized countries – 32 years in which societies in the West have grown massively wealthier, and citizens on the whole much healthier. Life expectancy has improved, and some diseases are in retreat. But the problem of health inequality persists. We see this in the fact that some groups experience lower life expectancy (to name one form of inequality) than others, or in other words, that while society as a whole has become healthier some groups have not shared as much in the improvements. We also see it in the fact that some health inequalities have worsened *in absolute terms*.

This ought not to be acceptable to any of us. Without reasonable health equality there can be no reasonable equality of opportunity and without the fair chance of a decent life for all, our society is wasting its principal resource – its people. Health inequality should be on all our agendas, regardless of our position on the political spectrum.

Where do Community Pharmacists fit in to the debate? Let's go back to the LaLonde report and the principle of the 'health field'. **LaLonde identified four factors that influence individual health – environment, biology, lifestyle and health care organization. Improvements in these areas can reduce health inequality in both relative and absolute terms.**

Now from the point of view of the Community Pharmacist, life style and health care organization are of particular relevance. We would argue that governments have a duty to ensure that access to essential health services is maximized for all sectors of the population, and that individuals are as well informed as possible about the consequences of lifestyle choices for their health. **Community Pharmacists can and do play a central role in ensuring equality of access and active health promotion.** It is interesting to note, for example, that community pharmacies have been identified as central in ensuring accessibility to information to patients in the Pharmaceutical Forum Conclusions of 29 September 2006².

Consider some facts:

- Community Pharmacists are the health professionals people see most;
- In most European Societies, the Community Pharmacists is a pillar of the local community – you will frequently find a community pharmacy where there are few other economic units, for example in depressed or rural communities, precisely the areas where health inequalities arise;
- **Community Pharmacists are not mere retailers, but highly qualified health professionals who provide a wide range of health advice and health intervention. They are one of the best conduits whereby governments can speak to the citizen about health through health promotion campaigns. So Community Pharmacists are on the frontline in influencing people's lifestyles.**

Any government – or the European Commission for that matter – that is serious about reducing health inequality cannot afford to ignore the Community Pharmacist.

But these are times of change for pharmacy, both negatively and positively. Positively, because some governments are realizing that in many ways community pharmacy is an under used resource for public health, particularly considering the facts I set out above. Negatively, because in some quarters community pharmacy is perceived as just another form of retail distribution, performing little, if any, service to society.



¹ Marc Lalonde. *A New Perspective on the Health of Canadians (Lalonde Report)*. 1973-1974
http://www.hc-sc.gc.ca/hcs-sss/alt_formats/hpb-dgps/pdf/pubs/1974-lalonde/lalonde_e.pdf

² <http://europa.eu/rapid/pressReleasesAction.do?reference=MEMO/06/358&format=HTML&aged=0&language=EN&guiLanguage=en>



Arguably, one manifestation of the latter view is apparent in the fact that the European Commission has initiated infringement proceedings against Spain and Austria with respect to their systems of pharmacy regulation. In particular, the Commission argues that the systems of geographical partition and limited ownership in place in these countries are inconsistent with the internal market. For example, Spain establishes new pharmacies to where there is a need for a pharmacy, as determined by geographical and demographic criteria. The result is that 99% of Spaniards have easy access to a pharmacy. There is no discrimination involved (any EU citizen can open a pharmacy in Spain). But Spain wants to avoid the situation common in more liberal countries where pharmacies tend to be clustered in the most profitable areas. In other words, it is Spain's solution to a problem identified 32 years ago by the LaLond report, which noted the problem of unequal concentrations of health resources.

Now whatever the merits of the free market model of pharmacy we see in countries such as Ireland and the Netherlands, can it really be right that a single model of pharmacy is the right solution for the 25 (soon 27) countries of the Union? That the internal market is the solution to all problems related to health organization that we face? I doubt it, and my doubts are borne out by the fact that some countries that have deregulated their systems are now considering re-regulating (Poland and Latvia to name two).

The Commission is trying to achieve by judicial means what it failed to do by democratic means in the Services Directive – to impose the internal market on health. If the Commission succeeds in its actions, there will need to be fundamental reforms of the pharmacy systems in the majority of EU states. Never before has the Commission initiated such a widespread reform on an essential health or social security service.

So, in conclusion, if we really want to tackle the problem of health inequalities we need to make sure that we maximize our potential for doing so, and that means strengthening, not weakening, the role of health professionals such as pharmacists, and strengthening, not weakening, the measures available to governments to ensure access for all. I question whether current EU policy with respect to the pharmacy sector is consistent with this.

The Pharmaceutical Group of the European Union (PGEU) represents the community pharmacists of 29 European Countries. The Members of the PGEU are the professional bodies and pharmacists' associations in EU Members States, EU candidate countries and EEA Member States. PGEU's objective is to promote the role of the pharmacists as key players in healthcare systems throughout Europe and to ensure that the views of the pharmacy profession are taken into account in the EU decision making process. For more information: www.pgeu.org

Reducing Cardiovascular diseases – a main contributor to inequalities in health

MARLEEN KESTENS

European Heart Network

Mortality and determinants

Each year, cardiovascular disease (CVD) causes over 4.35 million deaths in Europe and over 1.9 million deaths in the European Union. It is the main cause of death in Europe.

Cardiovascular mortality, incidence and case fatality are falling in most Northern, Southern and Western European countries but either not falling as fast or rising in Central and Eastern European countries.¹ Inequalities in mortality CVD do not only occur between countries, but also within countries, and account for almost half of the excess mortality in lower socio-economic groups in most countries. Socioeconomic inequalities in this area are therefore a major public health problem in most industrialized countries.

Underlying causes for CVD are well known: tobacco use, high blood pressure, high blood cholesterol, lack of physical activity, obesity. The European Heart Network (EHN) works in all these areas with a keen accent on *why* some people engage more and more often in 'unhealthy' behaviour and *what* might assist in addressing the 'causes behind the causes'.



Causes and the remedies

Child obesity

Rising levels of obesity in Europe are set to lead to an increase in cardiovascular diseases. Whereas diets are generally improving in Northern and Western European countries, they are deteriorating in Southern, Central and Eastern European countries², with rates of overweight children (7 – 11 years) in Italy for example being as high as 36%.³ This rising trend in childhood obesity has caused alarm amongst EU policy makers, mainly because the health effects of this increase are beginning to be felt.

In 2004, EHN started a 32-month project on 'Children, obesity and associated avoidable chronic diseases' with part-funding from the European Commission. A main focus of the project was to examine the nature and extent of food marketing to children in Europe. It has been established scientifically that children enjoy and engage with food promotion and that food promotion has an effect on children's preferences, purchase behaviour and consumption and that this effect is independent of other factors and operates at both a brand and category level. Moreover, children's food promotion is dominated by television advertising and the great majority of this promotes unhealthy foods, i.e. foods high in sugar, fat and salt.^{4, 5}

In order to provide protection from excessive marketing to all children, whatever their socioeconomic background, EHN and other health NGOs are calling upon European decision makers to limit advertising of unhealthy food and drinks to children by prohibiting television advertising of unhealthy foods between 6am and 9pm.^{6, 7}

Food provision – fruit and vegetables

Availability of healthy food to all social classes is an issue of concern. Diets of the lower socioeconomic groups are often dominated by cheap energy from foods such as meat products, full cream milk, fats, sugars, preserves, potatoes, and cereals, with little intake of vegetables, fruit, and whole wheat bread. **There is scope for enormous health gains if a diet rich in vegetables, fruit, unrefined cereal, fish, and small quantities of quality vegetable oils could be more accessible to disadvantaged people.**⁸

¹ European Cardiovascular Disease Statistics, 2005

² International obesity Task Force, 2004 (www.iotf.org)

³ *Review of research on the effects of food promotion to children* September 2003, the UK Food Standards Agency

⁴ The marketing of unhealthy food to children in Europe, EHN 2005

⁵ EHN position paper on the Revision of the Television Without Frontiers Directive, July 2006; <http://www.ehnheart.org/files/EHN%20response%20TVWF-165200A.pdf>



In 2005, EHN published a report on *Fruit and vegetable policy in the European Union: its effect on the burden of cardiovascular disease*. The report estimates that if all EU Member States were able to increase fruit and vegetable intake to the minimum recommended levels of 400 g per person per day, this could prevent over 50 000 deaths each year from heart disease (CHD) and stroke. It further estimated that if people across the EU started to consume the same amounts of fruit and vegetables as are eaten by countries that currently consume the highest amounts, such as Spain or Italy, i.e. 600 g per person per day, it could prevent over 135 000 deaths each year.

The report states that dietary habits are deeply embedded in the cultural, economic and political structure and there should be greater emphasis on promoting policies that target the determinants of fruit and vegetables consumption rather than simply focusing on health education. It recommends that policy should aim to remove obstacles and to enhance people's ability to eat healthy diets, including action on the EU Common Agricultural Policy (CAP). Such policies would address, in particular, lower income classes.

Tobacco

Smoking is a major risk factor for CVD. The prevalence of smoking behaviour is higher in the lower socio-economic groups, and there are important differences between countries.⁹

Together with a range of health organisations, EHN is actively working for comprehensive tobacco policy measures to be put in place throughout Europe.¹⁰ Smoke free policies protect smokers and non-smokers alike – and are particularly beneficial for disadvantaged groups that are unable to speak up for themselves.

Mechanisms

Apart from publishing research, EHN participates in a number of Commission-led fora. These include the Member State *Nutrition and Physical Activity Network*, in which EHN has observer status; the *EU Healthy Policy Forum*, of which EHN has been an active member since the Forum's inception in 2001; and the *European Platform for action on diet, physical activity and health* of which EHN was a founding member.¹¹ The Platform was established by Commissioner Kyprianou in March 2005 and aims to coordinate efforts to tackle diet-related diseases with a particular focus on obesity. The Platform involves stakeholders from different sectors: health NGOs, consumer organisations, food manufacturers, retailing, catering and advertising industries.

The European Heart Network (EHN) is a Brussels-based alliance of heart foundations and likeminded non-governmental organisations in 26 countries which work on the prevention and reduction of cardiovascular diseases in Europe. EHN plays a leading role in the prevention and reduction of cardiovascular disease through advocacy, networking and education, so that it is no longer a major cause of premature death and disability throughout Europe. For more information www.ehnheart.org



⁶ Suggestions from 5 health NGOs on the Revision of the Television Without Frontiers Directive; October 2006;

⁷ <http://www.ehnheart.org/files/NGO%20position-091635A.pdf>

⁸ Socioeconomic determinants of health: The contribution of nutrition to inequalities in health; full article to be read on <http://bmj.bmjournals.com/cgi/content/full/314/7093/1545>

⁹ Health Inequalities: Europe in Profile, Prof. Dr Johan P. Mackenback, UK presidency of the EU, 2005;

¹⁰ "Lifting the Smoke Screen – 10 reasons for a smokefree Europe", Cancer Research UK, European Heart Network, European Respiratory Society, Institut National du Cancer (France); 2006 <http://www.ehnheart.org/files/lift%20smokescreen-102852A.pdf>

¹¹ See: http://ec.europa.eu/health/index_en.htm for more information

Common Agricultural Policy and Health Inequalities

ROBERT DELIS

North West of England Regional Health Brussels Office (NWHBO) and Heart of Mersey (HoM)



Approximately 80 per cent of legislation impacting upon the National Health Service in England is actually created at EU level.

Recognising the influence of EU decision making on local realities, the North West Region of England therefore decided to establish a presence in Brussels, specialising in health issues. The work of the office focuses on two main areas: public health issues, and EU policies affecting the National Health Service (NHS). The public health issues covered include the wider determinants of health, e.g. environmental issues, emergency planning, housing, urban planning and rural development. EU policies affecting the NHS include employment legislation, legislation affecting clinical services such as blood and tissue regulations and corporate issues such as building regulations, waste regulations and procurement.

In October 2006, the North West of England Regional Health Brussels Office (NWHBO) together with Heart of Mersey (HoM), a coronary heart disease prevention charity concentrating in part on Agriculture and Health issues established a new 'CAP Project Officer' position with the purpose of facilitating a healthy reform of the Common Agriculture Policy (CAP) in 2008.

The relationship between agriculture and health is not always recognised as being of importance to European policy and decision-makers. However, given that the WHO estimates that 80 per cent of cardiovascular disease, 90 per cent of type 2 diabetes and 30 per cent of all cancers could be prevented by a healthy diet, adequate amounts of physical activity and smoking cessation, it is important to look at the nature of food production, which affects consumption patterns, and at the composition of our food. Therefore one of the main priorities of the CAP Project Officer is to highlight these links and to demonstrate that food, nutrition and health are crucial issues of concern for European policy-makers and politicians.

The legal responsibility of the European Community to protect the health of its citizens is enshrined in Article 152 of the Treaty of Amsterdam. The current CAP fails to do this, by providing large subsidies for unhealthy agricultural products such as sugar, wine and beef, whilst destroying healthier alternatives such as fruit and vegetables. It is now widely recognised that the health community should seek to change this policy, which is currently detrimental to the health of European citizens.

The CAP uses a significant proportion of the EU budget and supports only certain agricultural products, mainly beef, milk and dairy products and sugar. These products are heavily subsidised, which has led to over production of cheap beef, dairy fat and products with high sugar content. In addition, CAP subsidises production of tobacco and wine, spending 1 billion Euros on tobacco production and 1.5 billion Euros for wine production. In health terms, this encourages the over consumption of unhealthy products, which in turn contributes to increased rates of heart disease, cancer, obesity and diabetes in the European Union, as well as an increasing prevalence of overweight and obesity in Europe, a trend which needs to be reversed sooner rather than later.

By contrast, consumption of fruit and vegetables, which should be an integral part of any staple diet, is lower than it could be, since high prices for these products in the EU are maintained through the destruction of surplus produce. Since consumers are often influenced by price, they tend to choose cheap, unhealthy commodities with high energy and saturated fat content instead of healthy but more expensive products such as fruit and vegetables. Since those who are less well off are most price sensitive, this policy and process can be seen to contribute to growing European health inequalities.





Under the Finnish presidency of the EU, the issue of 'health in all policies,' has been championed. Given this current emphasis, and the fact that CAP is under review, this gives the public health community a unique opportunity to influence policy by underlining the health impacts of CAP. **The public health community should aim to lobby for a comprehensive 'health impact assessment' of CAP and should demonstrate the cost-of-illnesses related to the policy. This will show how much money is being spent on health care and treatment as a consequence of current CAP policy. Research is already underway on this issue within the North West of England.**

We believe that health should be taken into consideration when formulating any European policy, especially CAP, given its high impact on the health of European citizens. CAP should also promote fair living standards for the agricultural community, availability of food at reasonable prices, market stability, and increased production of healthy food products, all with the aim of creating a healthier European community. A reformed CAP that insists on health-fostering products and healthier consumption habits by providing products of higher nutritional value at cheaper prices would reduce health inequalities and incidences of illnesses, whilst increasing quality of life for European citizens. These goals should encourage the mobilisation of the public health community in CAP reform activities such as the reform of the Common Market Organisations for the wine and fruit and vegetable sectors, the reduction of milk quotas and tobacco subsidies. These activities will culminate in a health check for CAP in 2008, when it is likely that this process will result in further practical and political simplification measures, such as further decoupling of aid from production. **The public health community must not miss this unique opportunity to shape the future of CAP, ensuring a healthier policy, healthier European citizens and reducing health inequalities in Europe.**

'Working together for a healthier CAP'

The North West of England Regional Health Brussels Office (NWHBO) opened on 1 May 2004 in order to facilitate lobbying on EU policies that impact on the NHS and to assist in developing European partnerships and projects. The overall purpose of the office is to increase the capacity of the North West region to derive economic, social and environmental benefits from European agencies and institutions.

Heart of Mersey is a coronary heart disease prevention charity. Further information at www.heartofmersey.org.uk

How do you get involved?
Please sign up for our regular 'Agriculture & Health' Newsletter by emailing r.delis@nwhbo.org or calling [+32 2 229 53 77](tel:+3222295377)



Tackling health inequalities through a Regional Approach

MARIE LOUISE POULSEN-HANSEN

European Regional and Local Health Authorities Platform (EUREGHA)

Health inequalities and the close relation between social deprivation and poor health are threatening the creation of a first-class health system in Europe today. The uncomfortable truth for EU health policy-makers is that the poorer you are, the shorter your life expectancy. Indeed, glance around any of today's classrooms and it is possible to identify those students that are likely to have health problems in later life.

The World Health Organisation predicts that smoking, alcohol, lack of exercise, and a poor diet will cause 70 per cent of all illness and premature death by 2020. In all the regions of Europe, rates of premature mortality are higher among those with lower levels of education, occupational class, or income. This leads to substantial inequalities in life expectancy at birth.

Whilst new initiatives, programmes and action plans are being developed at European and national level, it is vital that the key roles that local and regional organisations play in tackling health inequalities are not overlooked.

Since health care in most EU Member States is provided at a regional and local level, the authorities at these levels have a great deal of expertise, experience and know-how, which needs to be taken seriously at European level.

Resources have been a constraint in the past for many Member States. In the EU, 123 million people – representing over a quarter of the total EU population – live in regions with a per capita GDP below 75 per cent of the EU average.



European REGIONal and local Health Authorities

The EU Structural Funds can be used to stimulate the development of new resources in these areas. And for the first time in structural funding, health has become one of the top ten priority spending areas. Reducing the burden of illness in Europe is important to the Lisbon Agenda, since it will minimise the economic loss and increase the quality of life of its citizens. **The EU's poorest regions can now use structural funding to invest in the development and improvement of health provisions which contribute to regional development and the quality of life in the regions.**

Structural funds can also be used to prevent health risks by education and awareness raising and other health information campaigns. We believe that tackling health inequality needs to be at the heart of these campaigns.

By investing in health, we help reduce the burden of illness, increase the economic gain by enhanced productivity and support the Lisbon Agenda.

However, increasing health budgets alone will only go part of the way to helping. The development of local and regional initiatives such as effective local health action plans, which directly target the most vulnerable groups, can also have a significant impact. Although these plans are generally tailored towards specific problem areas, all regions and municipalities can benefit from the experiences of others.

EUREGHA wants, in this respect, to improve the flow of information between countries by stimulating the exchange of best practice and experiences between different Member States and providing information about EU legislation or EU initiatives related to health care issues. The EU can play an important role in facilitating these exchanges between regions and countries.

We can all agree that socioeconomic inequality should not automatically lead to shorter lives and fewer years in good health for those who are less well off. It is vital that local, regional and European agencies work together and exchange knowledge and best practice to combat the vast health inequalities which persist in all Member States.

EUREGHA (European Regional and Local Health Authorities Platform) is an administrative regional and local network on health care issues, which aims to provide a forum where regional and local authorities and organisations and the European Commission can exchange information on health care issues to their mutual advantage. For more information contact Asger Andreasen at: asa@arf.be



Glossary of Key EU related terms

Article 152 in the Treaty establishing the European Community

This article, which was first included in the Maastricht Treaty, and later expanded in the Amsterdam Treaty, indicates that health protection is clearly regarded as an area for Community action, and stipulates its precise role. In essence, while Community action on health excludes any harmonisation of the laws, it can complement national policies, focus on major research activities, support and encourage co-operation between the Member States relating to diseases and major health scourges, the causes of danger to human health and the general objective of improving health. The article states that “a high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities”, indicating that health should be taken into consideration in the wide range of other policy areas in which the Community legislates. For the full text see: http://europa.eu.int/eur-lex/lex/en/treaties/dat/12002E/pdf/12002E_EN.pdf

Lisbon Strategy or Agenda

The European Council in Lisbon of March 2000 European governments committed themselves to work towards a new strategic goal for the next decade: “to become the most competitive and dynamic knowledge-based economy capable of sustainable economic growth with more and better jobs and greater social cohesion”. The objectives of Lisbon constitute a ‘virtuous’ policy triangle, where economic policy, employment policy and social inclusion interact in a mutually supportive manner.’ Following the mid-term review of the Strategy, it was decided that the emphasis would be on ‘Growth and Jobs’. For more information: http://ec.europa.eu/growthandjobs/index_en.htm

National Reform Programmes

EU Member States are required to draw up National Reform Programmes (NRP), which set out their three-year strategies for growth and jobs. The NRP must address the checklist of 23 objectives that make up the new Integrated Guidelines, which provide the basic economic, social and environmental targets that all Member States should aim to achieve. (These combine the previous Broad Economic Policy Guidelines (BEPG) and the Employment Guidelines.)

Stability and Growth Pact

The Stability and Growth Pact (SGP) is a political agreement laying out the rules for the budgetary discipline of the Member States that was concluded by the European Council at the Dublin Summit in December 1996. It is designed to contribute to the overall climate of stability and financial prudence underpinning the success of Economic and Monetary Union (EMU).

Open Method of Coordination

The Open Method of Coordination is a form of 'soft' law, or a mechanism by which the EC can achieve policy coordination amongst Member States (MS) without imposing legal obligations. Through the OMC, MS decide what goals they aim to achieve in a policy area and develop a list of common objectives, action plans and, where appropriate, quantitative and qualitative indicators and benchmarks as a means of comparing good practice. The European Commission coordinates this process and compares the outcomes. This process of periodic monitoring, evaluation and peer review aims to stimulate excellence, achieve greater convergence on EU goals and strengthen the learning process of those involved.

The EC is currently coordinating three OMC processes that fall under its Social Protection Strategy; in the areas of *Social Inclusion*, *Pensions* and *Health and Long Term Care*.

Relevant information that emerges from the Social Protection OMC processes will be passed on to the National Reform Programmes, thereby forming part of the Lisbon Strategy.

http://ec.europa.eu/employment_social/social_protection/index_en.htm

Services Directive

The Services Directive (previously also known as the Bolkestein Directive) aims to facilitate the provision of cross-border services by removing obstacles to the free movement of services in the internal market. Initial drafts met a great deal of public resistance, particularly in France, due to a number of controversial issues, such as the 'Country of Origin' principle, and the incorporation of 'Services of General Interest', including Health Services. These have been excluded, and a revised version of the Directive has been agreed by the Council and Parliament in a second reading.

Services make up around two-thirds of economic activities in the EU, but currently only some 20% of cross-border business. It is believed that the Directive could boost cross-border provision of services, leading to as many as 600,000 new jobs in Europe. For more information: http://ec.europa.eu/internal_market/services/services-dir/index_en.htm

Health Services Consultation

While health services remains a Member State competency, it has become clear through various European Court of Justice cases that this principle can clash with the EC Internal Market competencies. During the process of developing a Services Directive it was decided that while health and social services are closely inter-related, they should be treated as separate matters.

In September 2006, the EC launched a Communication and Consultation on Community action on health services. The document focuses on cross-border care, although it also addresses a number of issues in the field of health services.

This initiative builds and draws on many of the outcomes of the **2003 High Level Reflection Process on Patient Mobility**.

For more information:
http://ec.europa.eu/health/ph_overview/operation/mobility/patient_mobility_en.htm

CLOSING THE GAP

Strategies for Action to tackle Health Inequalities



BZgA
 Ostmerheimer Str. 220
 D-51109 Köln
 Germany
 Tel: +49 (0)221 8992-0
 Fax: +49 (0)221 8992-359
 www.bzga.de

Helene Reemann
 Simone Weyers
 Dr. Monika Meyer-Nürnberg
 Dr. Frank Lehmann



EuroHealthNet
 6 Rue Philippe le Bon
 B-1000, Brussels
 Belgium
 Tel: +32 (0)2 235 0320
 Fax: +32 (0)2 235 0339
 www.eurohealthnet.eu

Caroline Costongs
 Ingrid Stegeman
 Sara Bensaude de Castro Freire
 Clive Needle



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