



EUROPEAN COMMISSION
HEALTH & CONSUMERS DIRECTORATE-GENERAL
EMPLOYMENT, SOCIAL POLICY & EQUAL OPPORTUNITIES DIRECTORATE-GENERAL

REPORT ON THE CONSULTATION FOR THE COMMISSION COMMUNICATION ON HEALTH INEQUALITIES

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23 July 2009

CONSULTATION FOR THE HEALTH INEQUALITIES COMMUNICATION

This is a report of the responses received to the written consultation carried out by the Commission as preparation for a Commission Communication on Health Inequalities. The results will also be included in the impact assessment document which will be published alongside the Communication once it is adopted.

Consultation process.

A targeted written consultation of stakeholders was carried out as part of the preparation for a Commission Communication on Health Inequalities. The Health and Consumers Directorate-General (DG SANCO) and the Employment, Social policy and Equal Opportunities Directorate-General (DG EMPL) invited stakeholders and organizations working with them on issues related to health inequalities to respond to a consultation document which contained a number of questions (Annex 1). Altogether 148 requests for consultation were sent it. The consultation was launched on 3 February 2009 with a closing date of 1 April subsequently extended until 15 April. The consultation document was also placed on the Commission's web site giving an opportunity for others to reply¹.

Composition of respondents

125 answers were received of which 13 came from Member States or national governmental organizations within Member States. A number of regional health service organisations also gave their input. A significant share of answers (52) came from EU umbrella organisations, therefore summarising a broader range of national organisations. One third of the respondents came not directly from the health sector, like women councils or regional authorities.

Responses from EU Member States and national governmental organizations in Member States: Belgium, Cyprus, Czech Republic, Finland, France, Germany, Hungary, Ireland (national public health institute), Latvia, Lithuania, Malta, Sweden, United Kingdom, (Department of Health)

Responses from national governmental organizations in other countries:
Norway

European Bodies outside the Commission@
The Committee of the Regions,
the European Centre for Disease Prevention and Control,
CEN - European Committee for Standardization.

Responses from the regional level,
Assembly of European Regions AER
European Regional and local Health Authorities platform - EUREGHA
Bayrisches Staatsministerium für Umwelt und Gesundheit
Cornwall health service
Glasgow health service

¹ See <http://ec.europa.eu/social/main.jsp?langId=en&catId=89&newsId=462&furtherNews=yes> and http://ec.europa.eu/health/ph_determinants/socio_economics/cons_inequalities_en.htm

Kent & Medway health service
Limburg (NL)
Local Government Association - Wales and England
Scottish health service
Skane County Council
Västernorrland County Council
Västra Götaland health service
Verbindungsstelle der Bundesländer (AU)
Western Investing for Health (Northern Ireland)

From health service systems responses were received both from providers and insurers:

BKK (DE)
Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege
Bundesärztekammer und Kassenärztliche Bundesvereinigung
Caritas (DE)
Eurodiaconia
European Social Insurance Platform
HOPE European Hospital and Healthcare Federation
Mutualité Française
Mutuelle générale de l'Éducation nationale (FR)

European wide networks of health professionals of several disciplines replied as well:

Standing Committee of European Doctors
British Dental Association
British Medical Association
Council of Occupational Therapists for the European Countries
European Association of Intellectual Disability Medicine - MAMH
European Association of Service providers for Persons with Disabilities – EASPD
European Society of Intensive Care Medicine
European Union Geriatric Medicine Society - EUGMS
International Association of Gerontology and Geriatrics

European umbrella organisations (ENGOS):

AIDS action Europe
AVERROES Network (migrants' health)
Central and Eastern European Women's Network for sexual and reproductive Health and Rights -
ASTRA
Confederation of Family Organisations in the European Union
EuroCare - European Alcohol Policy Alliance
Eurochild
Eurocities
EuroHealthNet (Public Health)
European Child Safety Alliance
European Disability Forum - EDF
European Federation for Street Children
European Federation of Retired and Elderly People
European Forum for Primary Care
European health and Fitness Association
European Health Management Association
European Institute for Women's Health

European Men's Health Forum
European Network against racism
European Network for Smoking Prevention - ENSP
European Network of Occupational Therapy in Higher Education - ENOTHE
European Network of Regions Improving Citizens Health
European Older People's Platform - AGE
European Patients' Forum
European Social Network - ESN
European Volunteer Center - CEV
European Womens Lobby
European Youth Forum
FEANTSA the European Federation of National Organisations working with the Homeless
International Association for the Study of Obesity IASO
International Planned Parenthood Federation
National Heart Forum (UK) / European Heart Network
Smokefree Partnership
Social Platform

Trade Unions

UEAPME (European Association of Craft, small and medium-seized enterprises)
Confédération Européenne des Syndicats Indépendants (CESI)
European Federation of Public Service Unions
European Trade Union Confederation ETUC

Among the stakeholders are naturally also representatives of the Industry / companies:

European Diagnostic Manufacturers Association
European Federation of Pharmaceutical Industries and Associations EFPIA
Alliance Boot
Eucomed - medical technology
European Association of Service providers for Persons with Disabilities - EASPD
Insurers of Europe - CEA
Novartis
Gilead Science

National Non Governmental Organizations

Actuarial Profession UK
Dental Health Foundation Ireland
Home Safety Scotland
La Confederacion Espanola de Agrupaciones de Familiares y Personas con Enfermedad Mental - FEALES
National Pensioners Convention UK
NIVEL & PHAROS - Centre of expertise on refugees and newcomers' health
Romanian Association Against AIDS
Zminijietna - Voice of the Left (MT)
IOGT-NTO (SE, Alcohol)
Connections - Integrated responses to drugs and infections across European criminal justice systems
ver. E.A.T.R.G.
National Roma Centrum Macedonia
Fundación Secretariado Gitano

Women's Health Council IR

Research institutes and individual scientists:

Association of Schools of Public Health in the European Region

Health Monitor Research HU

Health and Social Development Foundation, BG

Kosice Institute (SK)

Landesinstitut für Gesundheit und Arbeit NRW

Royal College of Nursing UK

And individually: Dr. Margaret Douglas, G. Costa, Prof. Stronegger, James Scanlan, Dr. Mc Hugh Mike, Gerardo Zamora-Monge and, Tor-Kristian Rønneberg.

Other responses included

International Organization for Migration

The European Office for Investment for Health and Development of the WHO (please note that this is not an official WHO communication)

the Women of the Green Party (SE)

Alternattiva Democratica party (MT).

1.1. Summary of responses

Nature and scale of the overall problem

The vast majority of respondents recognised health inequalities within and between member states as a serious problem. The current economic crisis is expected to aggravate the gap as on the one hand raising unemployment deteriorates the health status and on the other hand decreasing tax revenues might lead to cut-backs in health care expenditures. For example, groups concerned with mental illness expected an increase in such problems due to the economic crisis.

Some pointed out, that there is no common definition of the scope of the problem yet, it varies between unequal access to care to the social gradient in health status.

Several stakeholders noted the economic value of improving population health status. One health service organization proposed not to focus on increasing gross domestic product (GDP) to raise healthy life-expectancy, but the other way around arguing that one year increase in average life expectancy leads to 4% increase of GDP.

Inequalities between and within Member States

While life-expectancy is on the rise all over Europe, health inequalities tend to widen as well. The existence of differences in life-expectancy and healthy life-years was reported in nearly all responses and for all Member States.

The gap between Member States was reported to have increased and was expected to increase further. For example decrease mortality rates for coronary heart diseases in the old Member States, whereas they increase in the EU-10.

Differences in Socio-Economic Status (SES) widened in Eastern Europe, following the introduction of a market economy. While the gap remained stable in the 80s and 90s in Western Europe it increased in the 2000s. Some stakeholders stressed that in the new Member States gaps tend to be wider.

Injuries are also more prevalent among groups with low socio-economic status (SES): injury prevalence is five times higher among the lowest income quintile. People with multiple and chronic diseases, most prevalent among the very old (80+), most often lack access to the appropriate coordinated services.

It was noted that disparities within cities are deepening as some neighbourhoods accumulate multiple problems.

Determinants

Several social umbrella organisations stressed the close connection between socio-economic status and health status. A scientific study presented a hierarchy of causes, identifying physical and physical working conditions as the most influential, followed by childhood conditions and risk behaviour. All these factors were regarded as being more prevalent among lower socio-economic strata.

Several responses underlined the importance of the early ages for a healthy life. Life-styles are acquired in the early life years, policy therefore has to focus on children and young people, who can not determine their living environment, nutrition and housing themselves and are susceptible to outside influences.

Among respondents there was a difference of opinion on whether the higher risk behaviour can be solved by education and information campaigns alone or whether additional measures are required addressing socio-economic factors and living conditions more broadly.

Huge differences in access to and quality of treatment received, both between Member States and between different groups of patients within a country, were also remarked on as another determinant of health inequalities. The worst access to health care was reported for highly vulnerable groups including mentally disabled people, unaccompanied minor immigrants and trafficked women. The increasing liberalisation in the health care sector is a source of concern to social umbrella organisations as they report this is increasing health inequalities and it is feared that this might lead to a two tier system.

A minority of respondents did not regard the scientific evidence on the link between determinants and outcomes as sufficient. However, the majority appeared to take a different view summarised by one health ministry which concluded: "We already know enough to take action".

The EU added value

The overwhelming majority of responses welcomed further action by the European Union. The appreciation of EU added value was linked to respondents views on the definition of health inequalities. Stakeholders, which focussed on health care access stressed Member States' responsibility, whereas those which focussed on health outcomes welcomed further Community action. An organization representing insurers underlined that inequalities in health care access are subject to Member State regulations and best solved at the regional or even local level. EU added value was welcomed in the areas of data collection, agenda setting and funding.

Responses from the national level took quite diverging positions on the desired involvement of the EU in principle. Whereas some saw a need for the EU to take a lead, others were of the view that actions tackling health inequalities should be the sole responsibility of Member States. Despite this general divergence, consensus existed in relation to a range of concrete actions. All

national level responses were of the view that better indicators and exchange of best practices can add value to the national policies to tackle health inequalities.

The role of the EU in providing leadership in relation to the economic crisis was also identified as an added value. The possible contribution of the following EU policies was mentioned also in relation to improving working conditions, pharmaceuticals, food safety, housing, education, environment and employment.

Awareness

The suggestion of a Commission communication was welcomed by nearly all stakeholders. Especially among NGOs this would be seen as raising the issues salience and thereby assisting their work in Member States. Whereas all national responses agreed that health inequalities are to be tackled there was recognition that concrete actions face obstacles. A renewed European discourse is expected to help to overcome these.

One health ministry and the professional association from the same country saw a Council recommendation as best way to ensure a high commitment to the health inequity problem.

A patients group proposed establishing an Ombudsman monitoring health inequality. Another respondent asked for a white paper on Health Inequality.

A very small number of responses preferred to see the actions of the Commission limited to information campaigns.

Umbrella NGOs concerned with womens' health and mental illness expected added value from a Commission communication which would raise issue salience.

Measurement, Monitoring, Reporting

Providing comparable data on health inequalities and its determinants along with exchange of best practices was identified in nearly all responses as a necessary action on behalf of the Commission.

Many recommendations were made for improvement of the current indicators. Several health ministries proposed improving reporting by socio-economic status, gender and geographic area. Respondents commented that many of the proposed indicators are already included in the Open Method of Coordination (OMC) health indicators, but coherent data are not available yet. The need to raise data on the determinants to better suit policy responses was underlined repeatedly. One national response raised concerns about comparability of subjective indicators (unmet need) as these are influenced by cultural expectations rather than real provision.

Two European umbrella Non Governmental Organizations proposed a further reporting by private or public funded care / insurance.

A health inequalities index was proposed a few times, but also explicitly rejected by others.

Some responses proposed more research on indicators and special workshops for stakeholders including on how to use existing datasets.

A number of non-governmental organizations suggested expanding the concept of Socio-Economic Status measured by income, education and occupation by measures of sexual orientation, ethnicity and neighbourhood.

Many suggestions concerning indicators were quite detailed and were forwarded to the relevant statistical units.

One response suggested a dedicated institution to monitor health inequalities.

There were diverging views among national level responses regarding on how to pursue further reporting and monitoring. Whereas one called for much more reporting on determinants, following the model of the Townsend Score of Social deprivation, others stressed the need to carefully design further reports, to avoid duplication of work, in particular with the WHO and not to overload national bureaucracy with reporting burdens.

One health ministry proposed the production of a special reporting section on health inequality once every three years and have a five-year report on trends and best practices. Another health ministry proposed annual reports on indicators. A third health ministry suggested inclusion of ministries of social affairs, interior affairs and education into the OMC process. Inclusion of the European and national parliaments was also suggested.

One forum of regional authorities did not regard the OMC and reports as an adequate measure, as national situations are too diverse.

Comments from the national level of some new Member States asked for special support to be able to provide data and reporting. While a number of older ones underlined the need not to overburden Member States with reporting obligations and therefore include health inequalities into other reporting exercises like the public health .

Policy coordination at EU level

A stakeholder platform following the example of the nutrition forum, to coordinate actions on health inequalities was proposed several times. Interregional collaboration among social NGOs would require more support from the EU.

The Open Method of Coordination (OMC) was seen a key forum for reports and exchange of best practices. Nearly all NGOs called for a better incorporation of stakeholders into the OMC. Next to the OMC; the Open Health Forum and the Social Platform were mentioned as Forums for the exchange of best practices on stakeholder level.

One Member State called for coordination of Health Strategy and social OMC to reduce double work. Furthermore it stressed the need to work in existing forums without creating new reporting obligations for Member States.

EU policies

Most contributions noted that although the EU does not have competence in health care, many of its policies affect the determinants of Health Inequalities. In addition to the demand for better measurements, was therefore the call for taking health inequalities into account in all policies. Additional Health Impact assessment was proposed by some. Health Inequality Impact Assessment at EU level was regarded as an important activity by some.

One women's NGO recommended including a section on health inequalities into the gender mainstreaming process.

EU policies on working conditions, labour market, education and growth were regarded as important for their positive impact on health and health inequalities. Some respondents identified the Lisbon Strategy as important also in relation to health inequalities, as unemployment is a major determinant of bad health. Some stakeholders identified the proposed directive on patient mobility as a source for increasing health inequalities within Member States.

The increasing introduction of supplementary private health insurances was regarded as negatively affecting vulnerable groups, next to the economically disadvantaged, also old women, disabled and people with low health literacy. Also social assistance schemes may offer free health care for this groups, the shame associated with means-testing could prevent some of them from looking for care.

Some documents explicitly asked for better interservice communication.

Resources

The majority of respondents regarded the Structural Funds as a valuable support to tackle health inequalities at the local level and spread best practices. However more information was needed on behalf of the local stakeholders to be able to fully implement these funds. Structural funds should also support regional cross-boarder health care. The regional funds were widely seen as useful to support innovative projects at the local level. Also it was criticized, that this could lead to further disparities between regions, which are able to recruit funds and the ones, who are not. It was therefore called for a more simple application procedure.

The proposals how the EU funds could support training for medical professionals were manifold: specialized care for the very old vulnerable people, disabled, chronicle ill or in general patients with lower socio-economic status, were also mentioned.

The support of the funds would also be needed to increase capacities for data generation, reporting, health impact assessments and participation in EU level forums.

Poor housing as a cause of bad health status should also be included in the funding programme, as suggested by a few stakeholders.

The funding for research (FP7) was mentioned many times. More evidence about the causal relationships between determinants and health outcomes is needed. Some also called for scientific evaluation of programmes tackling health inequalities and for special research focussing on the particularities of Eastern Europe.

The areas mentioned for investment in health care were: primary care networks, risk groups and complex treatments.

A regional organization proposed an exchange programme for health professionals.

Some national responses provided positive examples of how the ERDF and ESF funding has been employed to improve health infrastructure, ensure access for all and improve health promotion. A few noted, that investment should always be a combination of EU and MS funding and will contribute to an increased workforce. A minority were firmly against expansion of the budget line following 2014 and recalled , that funding for health projects can just be increased by reshuffling budget lines.

Most vulnerable groups

Plenty of responses regarding the special needs of different vulnerable groups were received including on those mentally disabled, trafficked women, HIV infected, homeless, street children, elderly, Roma, migrants, prisoners.

Equal access to health care was regarded as a core element to tackle health inequalities. However, several stakeholders noted that such a right is not sufficient for the most vulnerable groups. Targeted approaches taking their special needs and cultures into account are called for. Health mediators have been proven a successful approach for Roma and migrants.

Health literacy is a central concept in their concerns. Reform policies are too often targeted at the educated middle-class, leaving the ones most in need of care aside.

Also for data generation, an approach to identify these most vulnerable groups without stigmatising them is called for by NGOs active in this field. They also stressed the need for inclusion of vulnerable groups in the policy formulation.

The special needs of women, who suffer from unsafe abortions and teenage pregnancies, have been brought to our attention by several women NGOs.

It was suggested to break down data on migrant health by country of origin to develop tailor made programmes. A group which also deserves special attention is the Roma minority. NGOs representing Roma called for special EU support to tackle the huge gap in health status between Roma and the majority population. Health inequalities should become a topic of the next Roma summit.

Many advocacy groups of disabled people responded to the consultation. Their main point was that also suffering from their specific impairment, disabled people can still enjoy good health, when treated in the right way.

In general, several NGOs working with vulnerable groups, asked for a better exchange of best practices and experiences at EU level.

On the current crisis, some responses noted that experiences from the former crises, were relevant.

Targets and Milestones

The majority, were supportive of the idea of setting targets and milestones at EU level. Some remained sceptical about the feasibility of implementation. Two respondents were against the idea of setting targets and milestones. Data limitations were the most mentioned obstacle. Furthermore a small majority regarded the differences in health status between the Member States as too big to come up with real targets. One national responses called for guidelines of recommendatory nature and also supported the idea of common targets.

Targets were proposed for injuries and concrete groups of people.

Milestones were seen a little bit more positive, as they would allow social NGOs to pressure the national governments. Targets should also be set at a national level.

Overall summary of targeted consultation

Overall the vast majority of respondents supported further action by the EU to address health inequalities. Many respondents also expressed willingness to participate actively as partners in future initiatives. In addition there was positive support for all the key areas of action which were specifically mentioned in the consultation document, though there were a number of reservations as reported above.