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**NOTE**

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from :            Presidency  
to:                Council  
Subject :        Health inequalities and patient safety  
                    - *Information note from the Presidency*

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In view of the Council meeting (Employment, Social policy, Health and Consumer affairs) on 8-9 December 2005, Delegations will find attached the note from the Presidency on the above subject.

**PRESIDENCY INFORMATION NOTE**  
**on Health inequalities and Patient safety**

The UK Presidency of the Council of the European Union placed particular emphasis on the importance to European citizens of tackling health inequalities to reduce the health gap, and in improving patient safety, as two key health issues where working across Europe would be valuable and could make a difference. In doing so, it built on the helpful work of previous Presidencies.

**On health inequalities:**

1. The Presidency programme highlighted that health inequalities exist in all Member States, and that many European citizens do not benefit from the health improvements their countries have achieved in the last decades. The Presidency focussed attention on the importance of tackling the social and economic determinants, such as poverty, education and social welfare from early life, through a cross-government approach, as well as specific health determinants such as tobacco, nutrition and alcohol. It noted the contribution that tackling health inequalities will make to economic growth, social cohesion and sustainable development across Europe.
2. The Presidency commissioned two new reports which set out patterns and trends in health inequalities, and policies to address them, across Member States. These show that almost all important health problems, and major causes of premature death such as cardiovascular disease, and cancer, are more common among people with lower levels of education, income and occupational status. The health gap in life expectancy is typically five years or more. Strategies to reduce the health gap within Member States are at different stages. The Presidency noted that EU level support to assist Member States in developing effective strategies, building on this work, would add value.
3. The Presidency Summit *‘Tackling Health Inequalities: Governing for Health’*, held in London in October 2005 brought together decision makers from all EU Member States, with representatives of the Commission, WHO and other International agencies such as OECD, highlighted in particular the need for:

- cross-sector action at national, regional and local levels, and for pan-European cooperation and action;
- support for Member States and policy development through improved good-quality information, exchange of information on effective strategies and policies, and research and evidence;
- specific actions on illicit sales of tobacco, and marketing of food and alcohol.

A summary of the Summit Proposals for Action is attached at Annex A. The Presidency hopes that the information highlighted by the Summit and new reports will help to inform the work of the Commission and Member States in developing future policy and action on health inequalities.

4. The Presidency welcomed the Commission's intentions to establish a new European 'Expert Working Group on Social Determinants of Health Inequalities'. This Group, which will bring together policy experts from Member States across the EU, will play an essential role in progressing work to reduce the health gap, and should be useful to future Presidencies. The Presidency also welcomed the links that the Commission has established to tackle health determinants, with other directorate-generals, and with international agencies such as WHO and OECD, which will also be important for future sustainable policy and action.

#### **On patient safety:**

5. Patient safety has been a headline health priority theme of our Presidency and the 2005 Luxembourg Presidency. The focus of patient safety activity during the Presidency has been to identify priorities for action at a European level. We have built upon the groundswell of support generated by the 2005 Luxembourg Declaration, emerging patient safety recommendations from the Council of Europe and the broader international programme of work being led by the WHO through the World Alliance for Patient Safety. Our vision has been simple - to demonstrate that by concrete, practical action we can achieve visibly safer care for patients across Europe.

6. The Presidency held a highly successful Patient Safety Summit on 28-30 November 2005. The Summit highlighted European and world action on patient safety bringing together hundreds of international and European politicians, experts, patients, clinicians and many other stakeholders. Further information on discussions at the Summit and on patient safety activities during the UK Presidency is attached in Annex B.
  
7. There is considerable scope for European collaboration in designing and implementing systems to improve patient safety. The Presidency welcomes the decision of the Commission's High Level Group on Health Services and Medical Care in 2004 to establish a sub-group with a programme of work on patient safety. Working with European Commission Services, Member States, the WHO and with other key bodies including civil society and industry, the Presidency has been helping ensure the development of a coherent package of work on patient safety at the European level.
  
8. The Presidency hopes that the proposals put forward by this group will help to inform the work of the Commission and Member States in taking forward and supporting ongoing programmes of action in this area, from 2006 onwards.

## **PRESIDENCY HEALTH INEQUALITIES SUMMIT PROPOSALS FOR ACTION**

1. The Presidency Summit, *'Tackling Health Inequalities: Governing for Health'*, brought together over 570 decision-makers from 36 countries including Member States of the EU and beyond, with representatives of the European Commission, WHO and other international agencies such as OECD. Plenary sessions focussed on the social and economic determinants of health, such as early years, poverty and social factors, and investment and governance. These were complemented by workshops focussing on issues such as policy and practice, research, information, regional and local action, consumer engagement, tobacco, nutrition and alcohol, plus fringe meetings on ethnicity, the contribution of the local health sector, and health impact assessment. Participation in the workshops and policy development groups at the Summit was almost 400.
2. To inform the Summit and the health inequalities work, the Presidency commissioned two new expert reports. *Health Inequalities: Europe in Profile*, produced by Professor Johan Mackenbach, sets out prevalence and patterns of health inequalities within Member States, drawing from information from across the EU. *Health Inequalities: A Challenge for Europe*, produced by a team led by Professor Ken Judge, sets out policies and practice within Member States to address these health inequalities.
3. This report provides a summary of key Proposals for Action derived from the Summit plenaries and actions agreed during the Summit workshops, and represents discussions at the Summit. The Presidency also held a seminar on mental health inequalities, involving representatives from 30 Member States, as well as the Commission and WHO, and key points from that seminar are included.

### ***Health inequalities strategies – policy and practice in Member States***

4. Member States should do more to develop cross-government and cross-sector policies to reduce health inequalities, and provide leadership. Actions need to tackle social and economic determinants of health, as well as the avoidable health risks for individuals, and to engage different sectors who may have an impact on health inequalities. This might include tackling low income and poverty, education, unhealthy living conditions, working conditions and unemployment, and health care access, as well as lifestyle factors.
5. There is a need to intensify efforts to collect evidence of effective strategies, policies and practice to tackle health inequalities. It is important that information collected on effective action is shared and disseminated between Member States.
6. There is a need to develop work in a systematic and sustainable manner. Within Member States, government engagement and leadership is needed at local, regional and national level.
7. The Commission might have a role in facilitating and increasing the opportunities for Member States to share information on effective policies, strategies and best practice on what works, to learn from existing networks and centres of excellence, and in supporting European countries to establish effective programmes and policies, particularly through the new Expert Working Group. The public health programme and the proposed ‘Programme of Community action in the field of Health and Consumer protection 2007-2013’ will be important in supporting work.

### ***Regions and cities***

8. Regional and local action and leadership, as well as national and international action, is needed to help reduce the health gap. A large number of networks and projects, both within cities and regions and between them, have addressed public health issues and inequalities, *inter alia* WHO Healthy Cities, WHO Regions for Health and Megapoles.
9. Regions and cities across the EU should collaborate to reduce health inequalities under existing EU Programmes, such as the Structural Funds, Public Health and Research programmes. Such collaboration might include a ‘network of networks’ to map and consolidate existing good practice. Issues that need to be addressed include

- information gaps, including the availability of comparable information on health inequalities at regional and local levels;
- training and capacity building;
- sharing of evidence, best practice and effective implementation of evidence-based policy;
- communication between Member States on regional and local initiatives; and
- collaboration between the health sector and local government and economic development bodies to address issues such as employment and social inclusion.

### ***Patterns and trends – improving information on health inequalities***

10. Good quality health information will assist Member States to identify health inequalities, and to develop and implement appropriate policies and monitor progress. However, information on health inequalities and their determinants across the EU is of variable availability and quality.
11. The European Commission and Member States should improve the collection and analysis of information and make information on health inequalities an integral part of the evolving EU health information and knowledge system, including information on the social and economic determinants and their trends. There is also an important need to make linkages between social and economic and health data and policies.
12. In addition, the European Commission should produce a five-yearly report on trends in health inequalities, including analysis of best practice, and regional and international comparisons.

### ***Health inequalities research***

13. Research and evidence are important to underpin strategies on health inequalities and, while there is a growing evidence base, there is a need for investment, by Member States, and EU research funding bodies (including European Commission Directorate-General Research and others), to develop the evidence base, particularly on effective interventions to tackle health inequalities.
14. There is also a need for the development of mechanisms to share and disseminate research outcomes and information on effective action to reduce the health gap, between Member States.

15. In particular, there is a need for:

- *Research on the effectiveness and impact of interventions on health inequalities, including critical success factors and economic assessments.*
- *Research on reducing the health gradient, as well as the health gap to assess the impact of different strategies (e.g. to reduce the social and health gradient – which may have the biggest impact on population health; to improve the health of the poorest; and to narrow the health gap), including any unintended consequences.*
- *Research on the impact of macro social and economic policies on health inequalities, including international comparisons, to help provide information on optimal conditions for interventions and policies to work in practice.*

16. There are already a number of initiatives and projects funded by the European Commission on health inequalities, and social determinants, and it is important that further action builds on their findings and work. The health theme of the proposed 7<sup>th</sup> Research Framework programme, which aims to improve the health of European citizens, and the socio-economic sciences theme, and the public health programme, provide valuable opportunities.

### ***Tobacco***

17. Smoking is a leading cause of health inequalities. Illicit trade makes cheap tobacco easily available to young people and to people on low incomes. This leads to continuing high smoking rates among these groups, with a significant impact on health and health inequalities.

18. Illicit trade in tobacco is undermining effective tobacco control programmes across the EU, which are reducing smoking prevalence. It has a negative effect on health inequalities.

19. Illicit trade in tobacco is a serious problem around the world as well as the EU, which needs international cooperation and solutions. The WHO Framework Convention on Tobacco Control (FCTC) sets a context for joint action to combat illicit trade. It is important that all Member States ratify this as soon as possible. An illicit trade protocol should be a priority, which could set out specific action needed. The EU could usefully highlight concerns about illicit trade and, with the agreement of relevant EU working groups and the Commission, call for a protocol on illicit trade in tobacco, at the first Conference of the Parties of the FCTC.

20. While much important work has already been done, there is a need for further collaborative action by the various agencies committed to ending the problem, including for example, Member States Ministries dealing with customs and public health, as well as the WHO, the European Commission and non-government organisations.

### ***Nutrition***

21. Poor nutrition in childhood is an important cause of health inequalities - with later life impacts on diseases such as heart disease and cancer. Furthermore, rising childhood obesity levels is a problem across the EU. The forthcoming Commission Green Paper, *Promoting healthy diets and physical activity: towards a European strategy for the prevention of overweight, obesity and chronic diseases*, and the EU Platform for Action on Diet, Physical Activity and Health provide important opportunities for strategic and effective pan-European action and to support Member States in developing comprehensive strategies to address obesity and nutrition. The Employment, Social policy, Health and Consumer affairs Council conclusions of 3 June 2005 on obesity, nutrition and physical activity<sup>1</sup> recognise the importance of addressing inequalities.

22. There is growing concern about the level and content of food advertising to children. Food advertising has been shown to have an effect on children, and particularly on their food preferences and their purchasing behaviour. Advertised foods differ strongly from recommended diets.

23. Children should not be targeted by advertising which exploits their credulity and lack of media literacy. There is a need for tighter control on advertising and promotion of foods that are considered less healthy (foods high in fat, sugar and salt). Monitoring activity should be carried out by an independent body, possibly at national level.

24. In order to foster a harmonized approach across the European Union, the European Commission, Member States, industry and consumer organisations should work together on the issue of food advertising to children, through for example the *TV without Frontiers Directive* for broadcast advertising and other mechanisms for non-broadcast. The recent establishment of a Round Table on Advertising by the Commission is an important element of such an approach.

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<sup>1</sup> <http://register.consilium.eu.int/pdf/en/05/st09/st09803.en05.pdf>

## ***Alcohol***

25. Alcohol is an important cause of health inequalities in Member States. While there are variations in drinking patterns across Europe, trends towards increase consumption by young people, binge drinking and associated harms are issues of concern across the EU.
26. The levels and patterns of alcohol consumption among young people that can lead to mental, physical and social problems, are a major and growing concern for many Member States. These trends appear to be due to a combination of factors, including increased spending power by young people, the influences of ‘youth culture’ and the influence of alcohol marketing.
27. The influence of alcohol marketing is a particular concern. There is a need for the European Commission, Member States, the industry and consumer groups to take action, through an effective balance of regulation and industry self-regulation, to minimise the impact of alcohol marketing on young people, for example through the *TV without Frontiers Directive*. Alcohol marketing should be monitored by an independent body, possibly at national level.
28. This should be part of a comprehensive strategy, at both EU and national level, to reduce alcohol-related harm, which should be developed with the involvement of young people. The forthcoming Commission Communication on the EU Alcohol strategy provides an important vehicle.

## ***Engaging consumers***

29. Member States should take action to ensure that socially excluded citizens and groups can fully participate in strategies to tackle health inequalities, through consumer involvement and information. This might include:
- supporting behaviour change using a social marketing approach and adopting marketing techniques used by the commercial sector to promote health information;
  - provision for citizen engagement in making personal decisions about health and health care, including self-care;
  - support of programmes to improve health literacy amongst disadvantaged groups, and a new definition of health literacy across Europe.

### *Non-government organisations and public health associations*

30. European and national non-government organisations and Public Health Associations play an important and critical role in tackling health inequalities through their practice, advocacy and awareness campaigns.
31. There is a need to strengthen national and European networks between non-government organisations and Public Health Associations, and ensure that these are effectively linked with civil society stakeholders as well as government at all levels, to contribute towards the reduction of health inequalities and engagement of citizens. It is important that such organisations are adequately resourced.
32. NGOs and Public Health Associations need to be assertive, confident and vocal in taking a leadership and challenging role in collaborative partnerships which work towards reducing health inequalities.

### *Mental health*

33. Good mental health has positive effects on prosperity, solidarity and social justice. These effects, however, are not evenly distributed. The European Commission's Green Paper "Improving the mental health of the population. Towards a strategy on mental health for the European Union" recognises the significant inequalities that exist in mental health within Member States.
34. At the Presidency seminar on mental health inequalities, common issues of concern which were identified included:
  - the mental health of migrant populations;
  - the need for a stronger evidence base for remedial action;
  - the need for cooperation between Member States to share learning on these issues.
35. It is important that that European networks on tackling mental health inequalities are developed and strengthened and that the Commission, Member States and the WHO collaborate on mental health, in particular in taking forward the WHO European Ministerial declaration on mental health signed in Helsinki in January 2005.

### *European cooperation and the role of international agencies*

36. The European Commission, and international agencies such as WHO and OECD, have key roles in taking forward international action and supporting Member States.
37. The new European ‘Expert Working Group on Social Determinants of Health Inequalities’ will be important vehicle for future action and support for Member States. The intention to involve other Commission Directorate-Generals, and international agencies such as the WHO, in the work of the new Group will be important to enhance cooperation.
38. The new WHO *Commission on Social Determinants of Health*, which will emphasise learning from practice, through the knowledge networks, also provides an important opportunity and resource.
39. Shared membership of key international groups on health inequalities and social determinants may facilitate sharing of practice and avoid duplication.

**PATIENT SAFETY ACTION DURING THE PRESIDENCY**

1. The UK used its Presidency to help lead an international initiative, championing patient safety and putting it at the centre of all health care being delivered across Europe and internationally.
2. Patient safety activity during the Presidency aimed to:
  - establish patient safety as a key priority on the European health agenda, both at EU level and in individual Member States and agreeing priorities for action;
  - initiate concrete mechanisms and practical programmes of activity at EU level to take forward action on agreed priorities;
  - promote greater alignment of European patient safety initiatives with international developments to add value to the efforts of Member States to facilitate real and lasting improvements in the safety of patient care across the EU.
3. The *Patient Safety Summit* on 28-30 November 2005 brought together over 500 politicians, experts, patients, clinicians and many other stakeholders from 47 countries including EU Member States and beyond, representatives of the European Commission, WHO and other international agencies such as OECD.
4. The Summit discussions focused on a number of key questions for all policy makers, stakeholders and those involved in delivering health care, including:
  - *the global patient safety agenda* - what are the international priorities for action? How can we best link action at country level and collaboration across Europe with work underway internationally?
  - *patient safety from the perspective of patients* - how do we empower patients to play an active role as agents of their own safety and that of their families?

- *research*: "knowledge is the enemy of unsafe care" - where are our gaps in knowledge and what are the priorities for research effort which really make a difference to the safety of front line health care?
  - *learning from other "high-risk" industries*: how can we learn from the best of experience in industries such as aviation, oil and transport to systematically reduce risks in health care?
  - *today's students, tomorrow's safe practitioners*: where should we be investing in education and training to create a generation of 'error wise' health care practitioners?
5. The Summit made the compelling case for patient safety as health priority and reaffirmed the consensus for collaborative action at the European level to improve the safety of care for all European patients. Patient safety is an increasingly high-profile issue at the European level and internationally. As people move freely across borders, they expect the care that they receive in any country to be safe and of good quality. Research suggests errors are as likely in fee-for-service or insurance based systems as in state-funded systems.
6. Key issues emerging from the Summit included:
- *Leadership* - much more remains to be done to ensure the commitment of health policy makers to action on patient safety.
  - *Cultural change* - systematic attempts to improve safety and transformations cultures, attitudes, leadership and working practices are only just beginning in most countries.
  - *Reporting and learning* - effective and timely analysis and learning from experience are still largely ad hoc. Adverse event reporting systems are embryonic and hampered by under reporting of events by health care workers.
  - *Systems focus* - understanding of the epidemiology of adverse events, frequency, causes, determinants and impact on patient outcomes, and of effective methods for preventing them is limited.

- *Scale up* - although there are examples of successful initiatives for reducing the incidence of adverse events, few have been expanded to the level of an entire health care organization or system.

### ***Health care professionals crossing borders***

7. As part of the work relevant to patient safety, the Presidency also welcomed the Agreement of the Consensus Conference held in Edinburgh, Scotland, on 13-14 October 2005, on the Exchange of Information on Healthcare Professionals for Competent Authorities. This agreement has been developed by competent authorities across Europe and other stakeholders to ensure a common, coherent and effective approach to fulfil obligations resulting from the Directives on the Mutual Recognition of Professional Qualifications.

### ***European-level programmes to achieve safer patient care - EU Member State's proposals***

8. Building on the momentum generated by the Summit and by working throughout 2005 with European Commission Services, Member States, the WHO and with other key bodies including civil society and industry, the UK Presidency has spearheaded the development of a coherent package of ongoing work on patient safety at the European level. A major emphasis has been on action areas which facilitate and help countries to establish effective patient safety programmes, rather than imposing new structures.
9. Following a 2004 paper from the UK, the Presidency welcomed the European Commission's involvement in establishing the working group on patient safety in 2005. This group has brought together 24 of the Member States, together with representatives of the civil society, to identify patient safety areas where European level collaboration and coordination of activities could bring added value.
10. High level discussion between the EU Member States in 2005 has prioritised a concrete programme of action and effective, practical tools aimed at:
  - supporting Member States in establishing and developing national level patient safety programmes and patient safety reporting and learning systems;

- bringing together design expertise from a range of industries and disciplines to embed the best thinking in "systems design" in patient safety;
- initiating research on key aspects of patient safety, not least on the economic impact of patient safety problems and the financial costs and benefits of implementing safety improvements - this is one key area where data and knowledge is currently insufficient;
- encouraging the development of a skills and knowledge framework for patient safety education, along with tools to support innovation and implementation;
- enabling the main players to align their work in this area and, wherever possible, to collaborate to ensure highest level of patient safety and quality of care at the European level.

11. Member States' proposals for this programme were put to the Council of EU Ministers of Employment, Social Policy, Health and Consumer Affairs meeting on 8-9 December 2005, as part of a report from the High Level Group on Health Services and Medical Care.

12. The Presidency welcomes the work of the patient safety working group and hopes that these proposals will help to inform the work of the Commission and Member States in taking forward and supporting ongoing programmes of action in this area, from 2006 onwards.

13. From the EU perspective, the proposals set out a very impressive, substantive work programme for the next few years, which has the potential to facilitate real and lasting improvements on the safety of patient care across Europe.

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