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Delegations will find attached Commission document COM(2009) 567 final.

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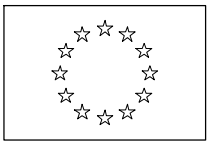

COMMISSION OF THE EUROPEAN COMMUNITIES

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COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS

SOLIDARITY IN HEALTH: REDUCING HEALTH INEQUALITIES IN THE EU

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COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS

SOLIDARITY IN HEALTH: REDUCING HEALTH INEQUALITIES IN THE EU

(Text with EEA relevance)

1. EQUAL OPPORTUNITIES AND SOLIDARITY IN HEALTH

European Union (EU) citizens live, on average, longer and healthier lives than previous generations. However, the EU is faced with an important challenge: the large gaps in health which exist between and within EU Member States. Moreover, there are indications that such gaps may be growing. Increased unemployment and uncertainty arising from the current economic crisis is further aggravating this situation. This communication launches the debate needed to define potential EU-level flanking measures to support actions by Member States and other actors to address this issue.

Concerns over the extent and the consequences of health inequalities – both between and within Member States - have been expressed by the EU institutions and many stakeholders, including through the consultation on this Communication. The European Council of June 2008 underlined the importance of closing the gap in health and in life expectancy between and within Member States[1]. In 2007 the EU Health Strategy[2] set out the Commission's intention to carry out further work to reduce inequities in health. This was reiterated in the 2008 Commission Communication on a Renewed Social Agenda[3] which restated the fundamental social objectives of Europe through equal opportunities, access and solidarity and announced a Commission Communication on health inequalities.

The Commission regards the extent of the health inequalities between people living in different parts of the EU and between socially advantaged and disadvantaged EU citizens as a challenge to the EU's commitments to solidarity, social and economic cohesion, human rights and equality of opportunity. Therefore, the Commission is determined to support and complement Member States and other stakeholders in their efforts to tackle them.

2. INEQUALITIES IN HEALTH IN THE EU

While the average level of health in the EU has continued to improve over the last decades, differences in health between people living in different parts of the EU and between the most advantaged and most disadvantaged sections of the population remain substantial and in some instances have increased. Between EU Member States there is a 5-fold difference in deaths of babies under one year of age, a 14 year gap in life expectancy at birth for men and an 8 year gap for women. Large disparities in health are also found between regions, rural and urban areas and neighbourhoods.

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1 http://tinyurl.com/n2xl6b
2 COM(2007) 630.
3 COM(2008) 412.

Throughout the EU a social gradient in health status exists where people with lower education, a lower occupational class or lower income tend to die at a younger age and to have a higher prevalence of most types of health problems[4]. Workers doing predominantly manual or routine repetitive tasks have worse health than those doing non manual, less repetitive tasks. Differences in life expectancy at birth between lowest and highest socio-economic groups reach 10 years for men and 6 years for women. There is also an important gender dimension, women in general live longer than men but may spend a longer proportion of their lives in ill health.

Vulnerable and socially excluded groups such as people from some migrant or ethnic minority backgrounds, the disabled or the homeless experience particularly poor average levels of health[5]. For example Roma have an estimated life expectancy 10 years less than the general population[6]. Reasons for poor health in such groups may include poor housing, poor nutrition and health related behaviours as well as discrimination, stigmatisation and barriers to accessing health and other services[7].

Health inequalities are due to differences between population groups in a wide range of factors which affect health. These include: living conditions; health related behaviours; education, occupation and income; health care, disease prevention and health promotion services as well as public policies influencing the quantity, quality and distribution of these factors. Health inequalities start at birth and persist into older age. Inequalities experienced in earlier life in access to education, employment and health care as well as those based on gender and race can have a critical bearing on the health status of people throughout their lives. The combination of poverty with other vulnerabilities such as childhood or old age, disability or minority background further increases health risks.

Differences in health, are linked to a number of socio-economic factors [8]. Economic conditions can effect many aspects of living conditions which can impact on health. Some areas of the EU still lack basic amenities such as adequate water and sanitation. Cultural factors which affect lifestyle and health behaviour also differ markedly between regions and population groups. Many regions, in particular in some of the newer Member States, are struggling to provide much needed health services to their populations. Barriers to access to health care can include lack of insurance, high costs of care, lack of information about services provided, language and cultural barriers. Some research has suggested that poorer social groups use health care less for equivalent levels of medical need than more affluent groups.

As health inequalities are not simply a matter of chance but are strongly influenced by the actions of individuals, governments, stakeholders, and communities, they are not inevitable. Action to reduce health inequalities means tackling those factors which impact unequally on the health of the population in a way which is avoidable and can be dealt with through public policy.

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4 Health inequalities: Europe in profile. Mackenbach J., 2006.

5 SEC(2006) 410.

6 SEC(2008) 2172.

7 Breaking the barriers: Romani women and access to public health care. EU European Monitoring Centre on Racism and Xenophobia 2003.

8 Monitoring progress towards the objectives of the European Strategy for Social Protection and Social Inclusion, 2008.

3. CURRENT EU FLANKING POLICIES

In 2006 the Council agreed conclusions on common values and principles in EU health systems stressing the overarching goal of reducing health inequalities[9]. Improving the access to health care and to disease prevention and promotion systems could certainly mitigate some of the health inequalities as pointed out in the EU Health Strategy. The contribution towards reducing health inequalities should be ensured in implementing initiatives such as the Council recommendation on cancer screening, the Communication on telemedicine[10] the Communication on patient safety[11] or the Proposal for a Directive on the application of patients' rights in cross-border healthcare.

Addressing health inequalities is a key action of the EU Health Strategy (2008-2013) which identifies equity in health as a fundamental value and has led to an orientation towards addressing health inequalities in areas such as mental health, tobacco, youth, cancer, and HIV/AIDS. The EU public health programme has supported the identification and development of activities to address health inequalities including a European directory of good practices[12]. First steps have been taken to improve data collection and the networking of Member states and key stakeholders.

Through the Open Method of Coordination for Social Protection and Social Inclusion (social OMC)[13] EU Member States have agreed to the objective of addressing inequalities in health outcomes. This is supported by a set of common indicators based on Eurostat work on public health statistics. The EU level analysis of Member States' National Strategies Reports on Social Protection and Social Inclusion has helped stimulate debate and action in Member States. At EU level an expert group has worked since 2005 to review evidence and exchange information on policies and practice[14]. EU health programmes have supported a number of initiatives on health inequalities. The Research Framework Programmes (currently FP7) provide important support for research in this field, and a variety of action programmes including the Health Programme and the EU's employment and social solidarity programme PROGRESS[15], finance studies, examples of good practice and policy innovations.

Other EU policies can also contribute to reducing health inequalities. Reducing health inequalities is also an objective for the public health challenges identified in the EU Sustainable Development Strategy[16]. The goal of a more equal distribution of health is underpinned by the EU's overarching objectives to create economic growth with social solidarity, the Lisbon strategy. EU legislation in the areas of labour law and occupational health and safety contributes to reducing accidents at work and occupational diseases. EU environment policy and the market policies under the Common Agricultural Policy support a range of initiatives which can contribute to improving health. The EU provides financial support via the Cohesion policy and the European Agricultural Fund for Rural Development which can be used to reduce disparities between regions through investment in determinants of health inequalities, such as living conditions, training and employment services, transport,

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9 OJ C 146, 22.6.2006, p. 1.
10 COM(2008) 689.
11 COM(2008) 836.
12 European Directory of Good Practices to reduce health inequalities. http://tinyurl.com/ybrpdy2
13 COM(2005) 706.
14 http://tinyurl.com/dmycvx
15 OJ L 354, 31.12.2008, p. 70.
16 Council of the European Union. Doc 10117/06. 9 June 2006.

technologies, health and social care infrastructure. Further consideration of the contribution of existing EU policies is contained in the impact assessment accompanying this Communication.

4. TAKING ACTION ON HEALTH INEQUALITIES: A COLLABORATIVE APPROACH

The need for further action arises because of increasing evidence on the size and pervasiveness of health inequalities across the EU and concerns about the negative consequences for health, social cohesion and economic development if health inequalities are not effectively tackled. Existing actions appear to have had only limited impact and there is a risk that these gaps could widen as a result of recent economic difficulties. Moreover better levels of health across all population groups are critical in the context of an ageing EU population to contribute to the sustainability of social protection systems.

While the principal responsibility for health policy rests with Member States, not all of them have the same available resources, tools or pools of expertise to address the different causes to health inequalities. The European Commission can contribute by ensuring that relevant EU policies and actions take into account the objective of addressing the factors which create or contribute to health inequalities across the EU population.

The EU should use to that extent in the most efficient way the mechanisms and tools available. For instance it can play an important role in raising awareness, promoting and assisting the exchange of information and knowledge between the concerned Member States, identifying and spreading good practices and in facilitating the design of tailored made policies for the specific issues prevailing in Member States and/or special social groups. It shall also monitor and evaluate the progress in the application of such policies.

5. KEY ISSUES TO ADDRESS

Experience to date suggests a number of important challenges which must be addressed to strengthen existing action to reduce health inequalities.

An equitable distribution of health as part of overall social and economic development

In broad terms the level of health is associated with wealth. Richer countries and regions have on average better health as measured by various indices. But this relationship does not hold consistently. More economic resources provide greater potential for maintaining and improving health but only if deployed in a way which enables this to occur. It is clear that not all groups have benefited to the same extent from economic progress. What is important is to create a pattern of overall economic and social development which leads to greater economic growth, as well as greater solidarity, cohesion and health. The EU structural funds have a vital role to play in this regard.

Achieving the objectives of economic growth and greater social cohesion is the aim of the Lisbon agenda. The healthy life years indicator is the current measure to monitor progress on the Lisbon agenda in relation to the health dimension. Consideration could be given to whether a sound monitoring of health inequalities indicators would be a useful tool to monitor its social dimension.

Improving the data and knowledge base and mechanisms for measuring, monitoring evaluation and reporting

Measurement of health inequalities is a fundamental first step to effective action. Although robust evidence exists in a number of areas, more detailed information is required on the effect and importance of various health determinants to implement effective action in relation to particular population groups and determinants.

Knowledge on the effectiveness of policies to tackle inequalities also needs improving. Despite a body of research on the effectiveness of public health interventions and of the effect of other policies and actions on health, only a small number have been specifically evaluated for their differential health impacts on social groups or areas. The assessment of the impact of policies outside the public health sector is even more limited.

Lack of routinely available and comparable EU data and research knowledge poses an obstacle to assessing the current situation, rethinking policy priorities, establishing comparisons, deriving best-practices, and reallocating resources where they are most needed. Existing and future data available at the EU level notably through the full implementation of EU surveys such as the EU Survey on Income and Living Conditions (EU-SILC), European Health Interview Survey and the EU survey on disability and the implementation regulations on all fields of public health statistics should be used to create measures of health inequalities which will enable comparison over time and across the EU. Coherence with other international datasets should also be ensured.

Causes of Health inequalities vary between Member States and between specific population groups. Member States should aim to establish, in close collaboration with the Commission, a common set of indicators to monitor health inequalities and a methodology to audit the health situation in Member States aimed to identify and prioritizing areas of improvement and best practices. The Commission could support Member States to achieve their objectives by providing analysis and support on the basis of available information. This could prove to be a useful tool for Member States when designing, prioritizing and implementing more efficient and effective policies adjusted to their specific situation, and to better use the existing EU tools to support their actions.

Funding pilot and twinning projects and peer review programs could help Member States to implement such policies. Peer reviews should encompass scrutiny of existing policies, programs or institutional arrangements that have been identified as good practices.

EU level Actions:

Support the further development and collection of data and health inequalities indicators by age, sex, socio-economic status and geographic dimension.

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

Orient EU research towards closing knowledge gaps on health inequalities – including activities under the themes of Health and Socio-economic Sciences and Humanities of the 7th EU Framework Programme for Research.

Emphasise research and dissemination of good practices relevant to addressing health inequalities by EU Agencies, including: the European Foundation for the Improvement of Living and Working Conditions, the European Centre for Disease Prevention and Control and the European Agency for Health and Safety at Work.

Building commitment across society

Reducing health inequalities means having an impact on the health of people in their everyday lives, at work, at school, and at leisure in the community. In addition to national governments, regional authorities in many countries have an important role in public health and health services and thus need to be actively involved. The health sector has a leading role to play, both in ensuring equitable access to health care and in supporting knowledge and training both to health professionals and to other sectors. Local governments, workplaces, and other stakeholders also have a vital contribution to make.

Thus, improving the exchange of information and knowledge and improving the coordination of policies between different levels of government and across a number of sectors (health care, employment, social protection, environment, education, youth and regional development) can create more effective action and achieve a larger and consistent impact. There is also a need to create more effective partnerships with stakeholders that can help to promote action on various social determinants and thus improve health outcomes.

This is an area where Member States can learn from each other when devising their own policy strategies. The EU can help through strengthening policy coordination mechanisms and facilitating the exchange of information and good practice between Member States and stakeholders. Initiatives like the EU Health Policy Forum, the Partnership against Cancer, the Alcohol Forum or the EU Platform on Diet Physical Activity and Health are important instruments to address the health inequalities policy agenda.

The Commission has indicated[17] its intention, within the Social OMC, to make more use of peer reviews and PROGRESS funding as well as to consider targets on health status to sustain commitment and the achievement of common objectives.

The Commission will also take up the interest shown by the Committee of the Regions in the consultation on this communication and will aim to build a focus on health inequalities into regional cooperation arrangements on health.

EU level Actions:

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

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

Develop actions and tools on professional training to address health inequalities using the health programme, ESF and other mechanisms.

[17] COM(2008) 418.

Stimulate reflection on target development in the Social Protection Committee through discussion papers.

Meeting the needs of vulnerable groups

Addressing health inequalities effectively requires policies which include both actions to address the gradient in health across the whole of society as well as actions which are specifically targeted to vulnerable groups. Particular attention needs to be given to the needs of people in poverty, disadvantaged migrant and ethnic minority groups, people with disabilities, elderly people or children living in poverty. For some groups, the issue of health inequality including reduced access to adequate health care, can be qualified as one which involves their fundamental rights.

The European Charter of Fundamental Rights specifies the right to: social and housing assistance to ensure a decent existence for all those who lack sufficient resources; access to preventive health care and the right to benefit from medical treatment; and to working conditions which respect health. The United Nations Charter on the Rights of the Child specifies several key rights relating to children's basic needs which in turn affect their health while the UN Convention on the Rights of Persons with Disabilities specifies the rights of access for persons with disabilities to health services. Health inequalities are included as one of four priorities of the Commission's youth health initiative launched in 2009.

Demographic change and the ageing of our societies will create new health challenges.

The Council has identified the need for additional action on the health needs of migrants, and Roma[18] and young people with fewer opportunities[19]. The Commission is starting a pilot project on Roma inclusion, including health and integrated interventions in the educational, social, and economic areas and cross border cooperation

Further use of the Cohesion Policy and associated structural funds to promote interventions in favour of the health of vulnerable groups such as Roma should be developed.

EU level Actions:

Launch initiatives in collaboration with Member States to raise awareness and promote actions to improve access and appropriateness of health services, health promotion and preventive care for migrants and ethnic minorities and other vulnerable groups, through the identification and exchange of good practice supported by the health and other programmes.

Ensure that the reduction of health inequalities is fully addressed in future initiatives on healthy ageing.

A Report on the use of Community instruments and policies for Roma inclusion including a section on health inequalities will be prepared for the 2010 Roma summit.

Examine how the Fundamental Rights Agency could, within the limits of its mandate, collect information on the extent to which vulnerable groups may suffer from health inequalities in the EU, particularly in terms of access to adequate health care, social and housing assistance.

[18] Council Conclusions on inclusion of the Roma. http://tinyurl.com/kne9s5

[19] Council Resolution of 20 November 2008 on the health and well-being of young people.

Carry out activities on health inequalities as part of the European Year for Combating Poverty and Social Exclusion 2010.

Developing the contribution of EU policies

As mentioned in Section 3 a number of EU policies which can contribute directly or indirectly to tackling health inequalities, and there are a number of tools available at community level that could be use. There is further scope for improving the contribution of EU policies through better understanding of their impact on health and via greater policy integration. This would lead to a better prioritisation and more efficient use of the existing tools.

While there is general agreement on the principle of reducing health inequalities, the level of awareness and the extent to which action is being taken varies substantially. Over half of the EU Member States do not place policy emphasis on reducing health inequalities and there is a lack of comprehensive inter-sectoral strategies[20]. In addition, policies implemented lack evaluation and dissemination which limits knowledge of policy effectiveness. The EU has a role to improve the coordination of polices and promote the sharing of best practices.

Different Commission policies should continue to support Member States to create more equitable access to high quality health care and prevention and promotion systems. The EU could play a role promoting better cooperation between health systems as envisaged in the Proposal for a Directive on the application of patients' rights in cross-border healthcare. It could also contribute to better understand and propose solutions for the challenges facing by the health systems regarding the capacity of the European health work force; and can also contribute to asses how to use efficiently the new technologies in the health sector.

EU Cohesion policy is important in achieving the Lisbon objectives of economic and social cohesion and can be a powerful tool to address health inequalities. The current Community Strategic Guidelines set out the possible use of the funds for health related actions. Member States have allocated around € 5 billion (1.5% of the total available) from the funds in the category Health Infrastructure for the period 2007-2013. An increased use of the funding opportunities offered by the Cohesion Policy to address health inequalities would require improvements in: knowledge of the opportunity to use funds in this area; coordination between national policy departments; and technical capacity to develop investments in this field. An effort should be made to increase the health focus for the next programming period and achieve a better alignment of the strategic documents under EU Cohesion Policy with the priorities identified in the Social OMC.

The national implementation of Community Legislation on Health and Safety at Work and the Community Strategy on Health and Safety at Work 2007-2012 provide an opportunity to reduce health inequalities in the EU by protecting worker's health and reducing the negative impact of some of its determinants. Further attention should be placed on health inequalities within the context of promoting equal opportunity between men and women.

Currently few EU policy actions are evaluated after implementation in relation to their impact on health inequality. Building on existing work more development is needed of mechanisms to evaluate the health impact of existing policies (ex post) on different population groups to produce information for further policy development Such mechanisms cannot be "one size fits

[20] SEC(2006) 410.

all" and would draw on good practice developed in Member States. In addition, the EU can make use of existing reports including the Cohesion Report, the Employment Report and the Lisbon Report to analyse the relationship between these policies and health outcomes across EU areas and population groups.

The EU is also committed to supporting other countries in health and related fields. The WHO Commission on the Social Determinants of Health[21] recently described the massive health differences between countries and social groups worldwide and called for concerted action at all levels of government to address them. EU activities may affect health in third countries in a variety of ways including trade, development assistance, work with international organizations, and exchange of knowledge. EU experience on tackling health inequalities may also have relevance outside the EU. Possible synergies between the Commission's development aid and the work within the EU on inequalities in health should therefore be explored. The EU should also liaise with relevant international organisations on work in this area.

EU level Actions:

Provide further support to existing mechanisms for policy coordination and exchange of good practice on health inequalities between Member States such as the EU expert group on Social Determinants of Health and Health Inequalities[22], linking both to the Social Protection Committee and the Council Working Party on Public Health and the Social Protection Committee.

Review the possibilities to assist Member States to make better use of EU Cohesion policy and structural funds to support activities to address factors contributing to health inequalities.

Encourage Member States to further use the existing options under the CAP rural development policy and market policy (school milk, food for most deprived persons, school fruit scheme) to support vulnerable groups and rural areas with high needs.

Hold policy dialogues with Member States and stakeholders on equity and other key fundamental values in health, as set out in the EU Health Strategy.

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

Run a forum on health and restructuring to examine appropriate measures to reduce health inequalities.

Commission initiative on the EU role in global health

6. NEXT STEPS

Tackling health inequalities is a long term process. The actions in this Communication are intended to lay the framework for sustained action in this area. On the basis of this Communication and the future discussions in the Council the Commission intends to work

[21] Commission on Social Determinants of Health Final Report. WHO 2008.

[22] Current mandate at http://tinyurl.com/l947z8

actively in partnership with Member States and stakeholders in the coming period. A first progress report on the situation will be produced in 2012.