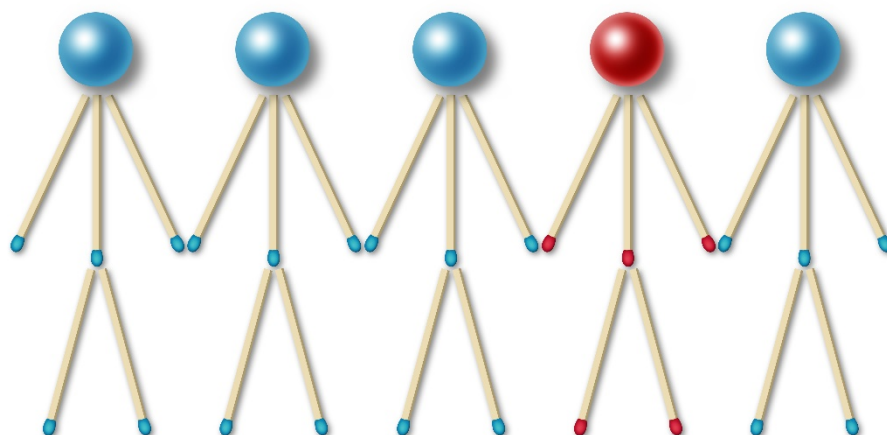

Addressing health inequalities in the European Union

Concepts, action,
state of play



IN-DEPTH ANALYSIS

EPRS | European Parliamentary Research Service

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This analysis looks at the concept of socially determined inequalities in health in the European Union (EU), giving examples of health inequalities across and within Member States. It presents the work of international agencies and EU institutions aimed at reducing health inequalities, and depicts stakeholders' views in the debate. The outlook indicates areas requiring further action.

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Executive summary

Addressing the persistent and considerable differences in health within the EU and among its Member States is viewed as one of the most important challenges in public health – by the EU institutions and by people themselves.

Health is determined by a wide range of personal, social, economic and environmental factors ('determinants'). According to the World Health Organization (WHO) – which has undertaken significant work on the topic, largely shadowed by the EU – the social determinants of health are 'the conditions in which people are born, grow, work, live, and age, and the systems put in place to deal with illness'. These are in turn shaped by wider forces: economics, social policies, and politics, including the distribution of money, power and resources at global, national and local levels. Examples from the EU show not only differences in life expectancy, both by sex and level of education, but also in mortality rates for cardiovascular diseases and cancer, health-related behaviours (including unhealthy diets and obesity), and other long-standing health problems. There are also notable differences in access to healthcare and unmet healthcare needs. The factors that give rise to, and exacerbate, disparities in health are complex and interlinked.

In terms of action at international level, the United Nations (UN) committed in 2015, with the sustainable development goals, to 'leave no one behind', striving among other things to achieve universal healthcare. The WHO's work on social determinants of health and health inequities¹ goes back to its 1948 constitution and was further developed by its Commission on Social Determinants of Health, in particular, which produced a landmark report with recommendations. The Organisation for Economic Co-operation and Development (OECD) has produced evidence and recommendations regarding inequalities in the areas of ageing; education and the labour market; risk factors to health; and access to and utilisation of healthcare. Moreover, the biennial publication *Health at a Glance: Europe* is part of the 'State of Health in the EU' cycle, in which the OECD and the European Commission jointly undertake comparative analyses, including on health inequalities.

At European level – while the main responsibility lies with the Member States – the EU institutions, bodies and agencies have contributed to reducing health inequalities through an array of policies, programmes, initiatives and instruments. These include, inter alia, Council conclusions; European Commission communications; the EU health programme and joint actions; financial support through EU funds, notably the Fund for European Aid to the Most Deprived (FEAD) and the European Social Fund (ESF); and health research to address mechanisms that reduce health inequalities through the Horizon 2020 programme for research and innovation. Addressing the social determinants of health and reducing health inequalities in its many dimensions has long been at the heart of the European Parliament's work, namely through resolutions and by financing pilot projects.

Moreover, stakeholders from academia, non-governmental organisations, the healthcare community and industry have expressed opinions on how best to tackle health inequalities from their point of view. Going forward, a demand for action arises on several fronts. Broadly speaking, there is a need for improved data, measurements, reporting, and comparisons; and for dedicated, collaborative research. Given the considerable societal and economic costs of health inequalities, there is also a need for a broader understanding and clear political will. Finally, there is a need for synergies, cross- and inter-sectoral policies, and multi-level cooperation.

¹ This paper uses the terms 'inequity' and 'inequality' interchangeably.

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Abbreviations

Country code	EU Member State
BE	Belgium
BG	Bulgaria
CZ	Czechia
DK	Denmark
DE	Germany
EE	Estonia
IE	Ireland
EL	Greece
ES	Spain
FR	France
HR	Croatia
IT	Italy
CY	Cyprus
LV	Latvia
LT	Lithuania
LU	Luxembourg
HU	Hungary
MT	Malta
NL	Netherlands
AT	Austria
PL	Poland
PT	Portugal
RO	Romania
SI	Slovenia
SK	Slovakia
FI	Finland
SE	Sweden
UK	United Kingdom ²

² Although the United Kingdom left the EU with effect from 1 February 2020, the data included in this paper concern a period in which the UK was a Member State.

1. Introduction

People in the European Union (EU) live, on average, longer and healthier lives than previous generations.³ However, while the average level of health has continued to improve, large differences in health persist both between and within EU Member States. Addressing such inequalities has long been viewed as one of the most important challenges in public health.⁴ Indeed, the European Commission counts health inequalities, including access to health and care, among the four main healthcare challenges Europe is facing.⁵ In a representative poll from February 2019,⁶ over a quarter (27 %) of those interviewed considered health inequalities to be the EU's foremost public health challenge over the next five years; the vast majority (69 %) felt that health inequalities needed to be addressed more than they have been so far.⁷ Could this poll – albeit small in scale – point to a wider demand from citizens to close the 'health gap'⁸ and 'leave no one behind'?⁹

2. Background: main terms, concepts, models and theories

Many factors have an influence on health. In addition to a person's individual genetics and lifestyle, health is determined by a wide range of personal, social, economic and environmental factors (or 'determinants'). The main **determinants of health** include:¹⁰ income and social status; employment and working conditions; education; childhood experiences; physical environments; social support networks; personal behaviours and coping skills; access to healthcare; biology and genetics; gender; and culture.¹¹ Within the broader determinants of health, the **social determinants of health** refer more specifically to the social and economic (or 'socioeconomic') factors that relate to a person's place in society, such as education, occupation or income. (Both terms – determinants and social determinants – are often used interchangeably, and are so in this analysis). The World Health Organization (WHO), which has undertaken significant work on the topic,¹² defines the social determinants of health as 'the conditions in which people are born, grow, work, live, and age, and the systems put in place to deal with illness'.¹³ According to the WHO, these are in turn shaped by wider forces: economics, social policies, and politics, including the distribution of money, power and resources at global, national and local levels.¹⁴

³ [Solidarity in health: Reducing health inequalities in the EU](#), COM(2009) 567 final. For further reading, see also M. Kiss et al., [Demographic outlook for the European Union](#), EPRS, European Parliament, February 2020.

⁴ [European strategies for tackling social inequities in health: Levelling up Part 2](#), WHO/Europe, 2007.

⁵ The other three challenges are: rising healthcare costs; the influence on health of environmental factors, including climate change; and the risk of losing the ability to protect the population against the threat of infectious disease ([Horizon 2020 – Work programme 2018-2020: Health, demographic change and wellbeing](#), European Commission).

⁶ Among more than 9 000 Europeans (aged 18 and over) in eight EU countries (HR, FI, FR, DE, IT, RO, ES, UK).

⁷ [More EU action in health: A demand from citizens to address their policy priorities in the 2019 to 2024 term](#), Incisive Health, May 2019.

⁸ [Closing the gap in a generation: Health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health](#), WHO/Europe, 2008 (more on this in [Section 4.1.1](#)).

⁹ [What does it mean to leave no one behind?](#), United Nations Development Programme (more in [Section 4.1](#)).

¹⁰ [Health Impact Assessment – The determinants of health](#), WHO.

¹¹ [Social determinants of health and health inequalities](#), Government of Canada.

¹² Notably in the framework of its [Commission on Social Determinants of Health](#) (see [Section 4.1.1](#)).

¹³ [Social determinants of health](#), WHO.

¹⁴ [About social determinants of health](#), WHO.

These factors, combined together, bring about **inequalities in health**. They can be defined in a descriptive way as differences in health status or in the distribution of health determinants between different population groups (for example, by age, gender, ethnicity or place).¹⁵ More commonly, however, the moral and ethical dimensions of the term are emphasised. As Eikemo et al. point out,¹⁶ in most European research and policy discourses, health inequalities denote differences in health by socioeconomic status: they are not 'natural' or 'inevitable', but socially produced and determined, and carry the connotation of being unfair and unjust.¹⁷ While the WHO and others sometimes distinguish between 'inequalities' and 'inequities' (that is, avoidable inequalities), both terms are used interchangeably in this analysis. For the WHO, reducing inequities in health can be thought of as 'increasing the freedom and power among people with the most limited possibilities of controlling and influencing their own life and society'.¹⁸

Quote: Empowerment for equity in health

'My argument is that tackling disempowerment is crucial for improving health and improving health equity. I think of disempowerment in three ways: material, psychosocial and political. The psychosocial dimension can be described as having control over your life.'

Source: M. Marmot, *The health gap. The challenge of an unequal world*, Bloomsbury Paperbacks, 2016.

Health inequalities can be observed along a **social gradient** in health.¹⁹ In general, the higher one's social position, the better one's health is likely to be: 'Life expectancy is shorter and most diseases are more common further down the social ladder in each society'.²⁰ The gradient is not confined to the most disadvantaged groups in society. 'Even comfortably off people somewhere in the middle tend to have poorer health than those above them'.²¹ Marmot, as quoted by the European Commission, has argued that, 'to reduce the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage'.²² This is known as **proportionate universalism** – universal solutions with an effort proportional to need.

Disadvantaged, vulnerable or marginalised groups are defined by the WHO as those who, 'due to factors usually considered outside their control, do not have the same opportunities as other, more fortunate groups in society'.²³ Examples might include unemployed people, refugees and others who are socially excluded. Disadvantage takes many forms; it starts before birth, and its effects on health accumulate throughout life.²⁴ Moreover, it may be absolute or relative. Marmot

¹⁵ Health inequality and inequity, [Health Impact Assessment: Glossary of terms used](#), WHO. For a discussion on the difference between 'inequality of outcomes' and 'inequality of opportunity', see A. Widuto, [Regional inequalities in the EU](#), EPRS, European Parliament, May 2019.

¹⁶ T.A. Eikemo et al., '[The First Pan-European Sociological Health Inequalities Survey of the General Population: The European Social Survey Rotating Module on the Social Determinants of Health](#)', *European Sociological Review*, Vol. 33, Issue 1, February 2017, pp. 137-153.

¹⁷ M. Whitehead, '[A typology of actions to tackle social inequalities in health](#)', *Journal of Epidemiology and Community Health*, Vol. 61, Issue 6, June 2007, pp. 473-478.

¹⁸ [European strategies for tackling social inequities in health: Levelling up Part 2](#), WHO/Europe, 2007.

¹⁹ [Social determinants](#), WHO/Europe.

²⁰ [Social determinants of health. The solid facts. Second edition](#), WHO/Europe, 2003.

²¹ M. Marmot and R.G. Wilkinson (eds.), *Social determinants of health. Second edition*, Oxford University Press, 2006.

²² [The Marmot Review](#), Institute of Health Equity, 2010, as quoted in [Reducing health inequalities in the European Union](#), European Commission, 2010.

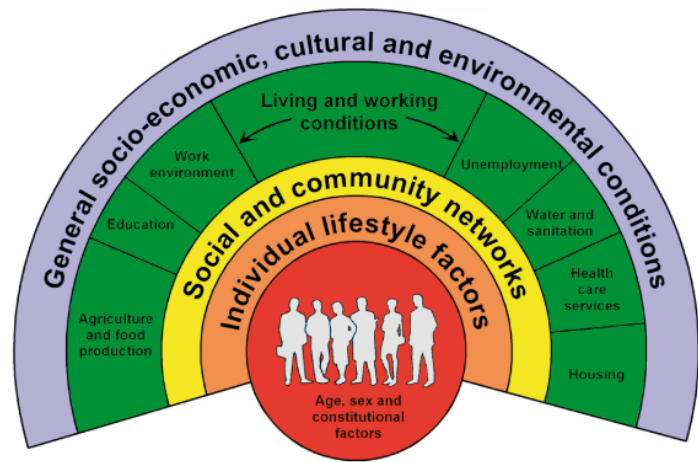
²³ Health inequality and inequity, [Health Impact Assessment: Glossary of terms used](#), WHO.

²⁴ [Social determinants of health. The solid facts. Second edition](#), WHO/Europe, 2003.

argues that relative disadvantage with respect to income translates into absolute disadvantage in empowerment and control over one's life.²⁵

One of the most widely used **models** that attempt to illustrate the **relationship between different determinants and health** is the Dahlgren-Whitehead 'rainbow' model, developed by Dahlgren and Whitehead in 1991 (see Figure 1).²⁶ It maps the relationship between people, their environment and health. People are placed at the centre. Surrounding them in concentric half-circles are the various layers of influences on health: individual lifestyle factors; community influences; living and working conditions; and the more general social conditions.²⁷

Figure 1 – Dahlgren and Whitehead model of the determinants of health



Source: Dahlgren and Whitehead, 1991

Source: T. A. Eikemo et al., [European Sociological Review](#).

Three main **theories** try to explain how social determinants interact with health and inequalities in health.²⁸ The **materialist explanation** focuses on income, and what it enables, in the relationship between socioeconomic status and health. **Psychosocial explanations** centre on how social inequality makes people feel, and the effects of the biological consequences of these feelings on health. According to the **cultural-behavioural** explanation, the link between socioeconomic status and health is a result of differences between socioeconomic groups in terms of their health-related behaviour, such as levels of smoking, alcohol and drug consumption, diet, physical activity, and health service usage.

In addition, the '**fundamental cause**' theory tries to explain the persistent association between social status and health. It posits that social factors are likely fundamental causes of disease. Because they embody access to an array of important resources (such as money, knowledge, prestige, power, and beneficial social connections), they affect multiple disease outcomes through multiple mechanisms, and consequently maintain an association with disease even when intervening mechanisms change.²⁹ In other words, such resources can be used regardless of the prevailing health risks or available protective steps at any point in history. 'This, according to the theory, is how socioeconomic status continues to shape health status even as the major threats and ways to avoid them change dramatically over time.'³⁰

²⁵ M. Marmot, '[The health gap. The challenge of an unequal world. Viewpoint](#)', *Lancet*, Vol. 386, Issue 10011, December 2015, pp. 2442-2444.

²⁶ T. A. Eikemo et al., '[The First Pan-European Sociological Health Inequalities Survey of the General Population: The European Social Survey Rotating Module on the Social Determinants of Health](#)', *European Sociological Review*, Vol. 33, Issue 1, February 2017, pp. 137-153

²⁷ For an in-depth discussion of the different layers, and the policy options available, see [European strategies for tackling social inequities in health: Levelling up Part 2](#), WHO/Europe, 2007.

²⁸ T. A. Eikemo et al., [op. cit.](#)

²⁹ B. G. Link and J. Phelan, '[Social conditions as fundamental causes of disease](#)', *Journal of Health and Social Behavior*, 1995, Extra Issue, pp. 80-94.

³⁰ [Key concepts: Fundamental causes of health disparities](#), Association of Health Care Journalists, Center for Excellence in Health Care Journalism.

3. Health inequalities in the European Union

In the EU, a significant health differential exists between different social groups and between people living in different parts of the EU.³¹ The examples below illustrate the scope of health inequalities, including of access to healthcare and unmet needs.

3.1. Scope of health inequalities – examples

Data on **life expectancy at birth** for both men and women show substantial differences between EU Member States. Typically, Member States in eastern Europe have a much lower life expectancy compared to the rest of the EU. Considering the 2008-2017 averages, there was a difference of almost 9 years between the Member States with the lowest and highest life expectancy – 73.9 years in Latvia compared to 82.7 years in Spain (Eurostat data).³² The **difference in average life expectancy at birth between men** (76.2 years) **and women** (82.3 years) across the EU-28 was 6.1 years. Latvia had the greatest difference in life expectancy of 11 years between men (68.4 years) and women (79.4 years), while the Netherlands had the smallest difference (3.7 years) between men (79.4 years) and women (83.1 years). As the European Core Health Indicators (ECHI)³³ show, sizable differences exist **between** some countries in terms of the **life expectancy at birth by education level** for both men and women. From 2007 to 2016, the average life expectancy at birth ranged between 67.1 years for people with a low education level in Estonia and 84.6 years for the highly educated in Italy.³⁴ Large inequalities in life expectancy at birth between people with high and low education levels can be seen **within** some countries, such as gaps of up to 10 years and more in Estonia, Bulgaria and Slovakia (ECHI, 2016). Average **healthy life expectancy at birth**³⁵ from 2007 to 2017 varied between 53.7 years in Latvia and 71.6 years in Sweden, meaning that, depending on their country of birth, Europeans could expect to have almost 20 more (or less) years of healthy life.³⁶ The EU-28 average over ten years (2008-2017) of another commonly used indicator as a measure of population health, **infant mortality rate**, ranged from 2.2 per 1 000 in Finland and Slovenia to 8.7 in Romania, indicating a fourfold variation across countries.³⁷

European Commission report on health inequalities in Europe: Three key findings

A 2013 comparison of social determinants and health inequalities in the EU and the European Economic Area (EEA) yielded three main findings: first, average life expectancy is lower in the countries of central and eastern Europe than, for instance, in Sweden, Italy, and Norway; second, the social gradient in health is steeper in the east than in the west; and third, the country differences in life expectancy are much greater for people with little education than for people with tertiary education.

Source: [Report on health inequalities in the EU. Final report of a consortium](#), European Commission, 2013 (more on this in [Section 5.1.2.](#)).

³¹ [Social determinants – Overview](#), European Commission.

³² Life expectancy at birth by sex, [table SDG_03_10](#), Eurostat.

³³ See [Section 5.1.4.](#) for more information on ECHI.

³⁴ European Core Health Indicators (ECHI), [ECHI data tool](#), European Commission.

³⁵ For a discussion of healthy life years and the measuring health (objective data versus self-assessed-measures), see also D. Eatock et al., [Demographic outlook for the European Union](#), EPRS, European Parliament, 2017, and in particular, the 'Focus on health' section.

³⁶ A 2018 [study](#) with data from England, Finland, France and Sweden found that there are inequalities in healthy life expectancy between ages 50 and 75 according to occupational position. The authors conclude that reducing socioeconomic inequalities would make an important contribution to extending healthy life expectancy.

³⁷ [Infant mortality rates](#), Eurostat.

Standardised mortality rates³⁸ for cardiovascular diseases³⁹, which are the leading cause of death in the EU, in 2016 ranged from approximately 200 deaths per 100 000 inhabitants (males and females) in France, to around 1 100 per 100 000 in Bulgaria.⁴⁰ The European Cardiovascular Disease Statistics 2017, published by the European Heart Network,⁴¹ further illustrate the large differences in death rates from ischaemic heart disease and stroke across Europe (data from latest available year). For instance, there is a 13-fold difference in **female death rates from heart disease** in France and Lithuania (32 deaths versus 429 per 100 000 women); a 9-fold difference in **male death rates from heart disease** in France and Lithuania (77 deaths versus 700 per 100 000 men); and a 6-fold difference in **male and female death rates from stroke** in France and Bulgaria. As the report explains, death rates from both ischaemic heart disease and stroke are generally higher in central and eastern Europe than in northern, southern and western Europe, but mortality from cardiovascular diseases is now falling in most European countries, including those in central and eastern Europe. While it is hard to identify the exact causes of these big differences between countries, lifestyle and access to medicines may play a role.⁴²

Wide variations across the EU also exist in **cancer mortality**.⁴³ In 2016, the highest standardised death rates for cancer were recorded in Hungary and Croatia, each with rates of more than 330 per 100 000 inhabitants, while the lowest rate was recorded in Cyprus (194 per 100 000).⁴⁴ Of note in this context are the gaps in the **availability of cancer screening technology** (advances in screening are credited with cancer survival gains in recent decades).⁴⁵ In 2016, the average number of computer tomography (**CT**) scanners available across the EU was 2.2 units per 100 000 inhabitants, while the rate for magnetic resonance imaging (**MRI**) machines was 1.4 per 100 000. Hungary had the lowest rate of availability of either technology (0.9 and 0.4 units per 100 000 inhabitants, respectively).

There are also wide variations between European countries, and between socioeconomic groups within countries, in **health-related (or 'lifestyle') behaviours**. Marked differences can be seen with regard to: nutrition and diet-related determinants (including breastfeeding, breakfast habits, family dinners, fruit and vegetable consumption, soft drink consumption); physical activity levels; tobacco and alcohol consumption; and in outcomes from these factors, such as obesity and poor health.⁴⁶ This analysis will limit its scope to examples of diet-related determinants and obesity. **Unhealthy diets** (with too much fat and sugar and too few vegetables and fruit) are, together with lack of physical activity, important determinants of poor health and premature death across Europe. Conversely, healthy diets (rich in fruit and vegetables) may protect against major diseases.⁴⁷ Data from 2014 show that the (self-reported) daily consumption of fruit and vegetables differs widely across the EU, from less than 50 % of the population aged 15 and over eating at least one portion of

³⁸ The [standardised death rate](#) is the death rate adjusted to a standard age distribution. It is calculated as a weighted average of the age-specific death rates of a given population; the weights are the age distribution of that population.

³⁹ That is, diseases that affect the circulatory system (the heart, blood vessels and arteries), such as ischaemic heart disease (heart attacks) and cerebrovascular diseases (strokes).

⁴⁰ [Cardiovascular diseases statistics](#), Eurostat.

⁴¹ [European Cardiovascular Disease Statistics 2017](#), European Heart Network.

⁴² S. Wheaton, [Politico Pro Morning Health Care](#), 14 February 2019.

⁴³ The European Commission's [forthcoming action plan to beat cancer](#) aims to reduce the cancer burden and address cancer-related inequalities between and within Member States. See also N. Scholz, [Europe's Beating Cancer plan: Launch of the EU-wide debate](#), EPRS, European Parliament, January 2020.

⁴⁴ [Cancer statistics](#), Eurostat.

⁴⁵ K. Jennings, [Politico Pro Morning Health Care](#), 30 January 2019.

⁴⁶ [Health Inequalities: dietary and physical activity-related determinants](#), EU Science Hub/Health Promotion and Disease Prevention Knowledge Gateway, European Commission.

⁴⁷ [European strategies for tackling social inequities in health: Levelling up Part 2](#), WHO/Europe, 2007.

fruit and vegetables on a daily basis in Bulgaria and Romania, to more than 75 % in Italy, the United Kingdom, Portugal and Belgium.⁴⁸ Daily fruit and vegetable consumption is higher in groups with higher education levels in northern and central European countries, but not necessarily in southern ones.⁴⁹ The share of the EU population eating at least five portions of fruit and vegetables rises with increasing income.

Many socioeconomic variables are associated with **obesity**,⁵⁰ including socioeconomic status, education level and ethnicity, as well as a gender gap. Moreover, the link between obesity and socioeconomic disadvantage appears to be perpetuated in a vicious cycle. Obesity significantly increases the risk of chronic diseases, such as cardiovascular disease, type-2 diabetes, hypertension, coronary heart diseases and certain cancers. Eurostat data from 2014 show that, across the EU, substantial inequalities exist with regard to the proportion of adults who are overweight or obese. The proportion of overweight adults (15 years and over, both sexes, including obese people) varied between 44 % in Italy and 60 % in Malta, while that of obese adults ranged from 9 % in Romania to 25 % in Malta.⁵¹ As regards education level and weight, women with lower education were more likely to be overweight or obese; as the education levels of women rose, the proportion considered as being overweight or obese fell. There was no clear-cut pattern linking educational attainment levels and obesity in men.⁵² Obesity among children of parents with lower education status is also found in many European countries. Measured overweight (including obesity) among children at various ages in the EU is about 23 % for boys and 21 % for girls (2010 or latest year available, evidence from 22 countries).⁵³

Socioeconomic differences can also be observed in medical conditions other than obesity. For instance, people in the highest income group (the fifth quintile)⁵⁴ have a much lower rate of **long-standing, chronic illness or health problems** compared to those with the lowest incomes (the first and second quintiles); the EU-28 average for people aged 16 years and over in 2018 was, respectively, an estimated 30 % versus 44 % and 41 %.⁵⁵ Moreover, there appears to be an inverse association between the level of education and the number of people reporting a chronic illness or health problem; that is, the higher the education level, the fewer the reported long-standing health concerns.⁵⁶ A study exploring socioeconomic inequalities among European adults aged 50 or older with chronic diseases between 2004 and 2015 showed that such inequalities existed, and that they disadvantaged poor people.⁵⁷

⁴⁸ [Fruit and vegetable consumption statistics](#), Eurostat, 2018.

⁴⁹ [Health Inequalities: dietary and physical activity-related determinants](#), European Commission.

⁵⁰ A person with a [body mass index \(BMI\)](#) of equal to or more than 25 is considered overweight; a person with a BMI of equal to or more than 30 is considered obese.

⁵¹ [Body mass index \(BMI\) by sex, age and educational attainment level](#), Eurostat.

⁵² [Obesity in the EU: gender differences](#), Eurostat.

⁵³ [Health Inequalities: dietary and physical activity-related determinants](#), European Commission.

⁵⁴ 'Quintiles' denote how income is distributed among the population: the first quintile contains the bottom fifth of the population on the income scale (or the 20 % of people with the lowest income), the second quintile represents the second fifth (from 20 % to 40 %), and so on; the fifth quintile represents the 20 % of those with the highest income.

⁵⁵ [People having a long-standing illness or health problem, by sex, age and income quintile](#), Eurostat.

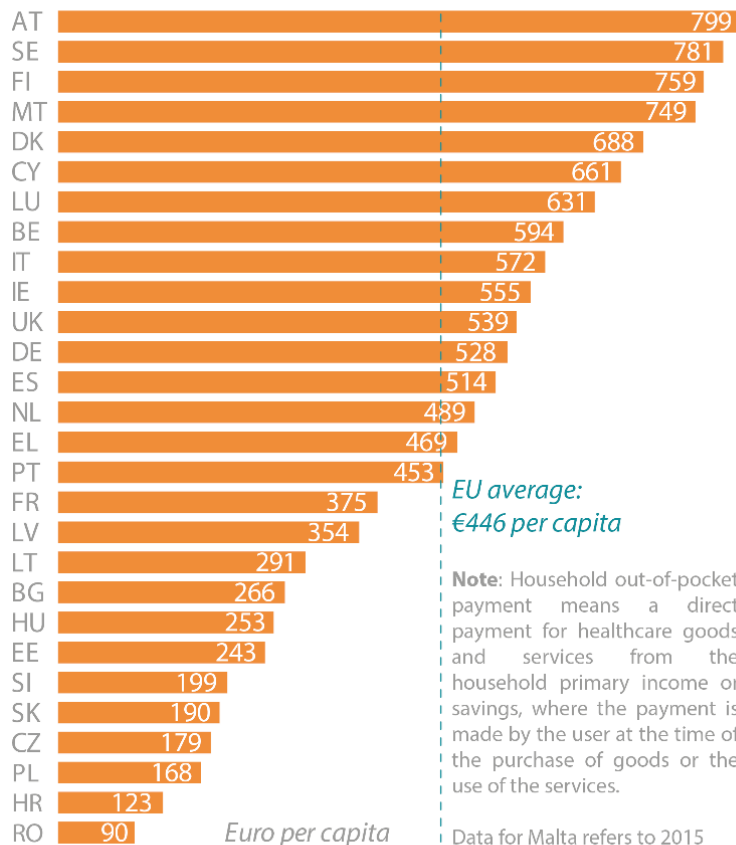
⁵⁶ [Health Inequalities: dietary and physical activity-related determinants](#), European Commission.

⁵⁷ F. Bono and D. Matranga, '[Socioeconomic inequality in non-communicable diseases in Europe between 2004 and 2015: evidence from the SHARE survey](#)', *European Journal of Public Health*, Vol. 29, Issue 1, February 2019, pp. 105-110.

Wide variations in **access to healthcare** can also be observed within and across Member States. According to a study by the European Commission,⁵⁸ ensuring that EU citizens have good and equitable access to healthcare is important for several reasons. Firstly, healthcare is a significant determinant of wellbeing that contributes to health improvements and prolonged life, as well as

Figure 2 – Household out-of-pocket expenditure on healthcare (Euro per capita, 2016)

Household out-of-pocket expenditure on healthcare (Euro per capita, 2016)



Data source: Eurostat

EPRS | European Parliamentary Research Service
EUI | European University Institute

Source: G. Sabbati, [Living in the EU: Education and Health](#), EPRS, European Parliament, April 2019, based on data from Eurostat.

the prevention of suffering and ill health. Secondly, a healthy population is linked to better economic growth, labour market participation and productivity. Thirdly, persistent avoidable and preventable inequalities in healthcare within and between Member States conflict with the rights stated in the Charter of Fundamental Rights – the EU and its Member States are legally bound to reduce health inequalities.⁵⁹

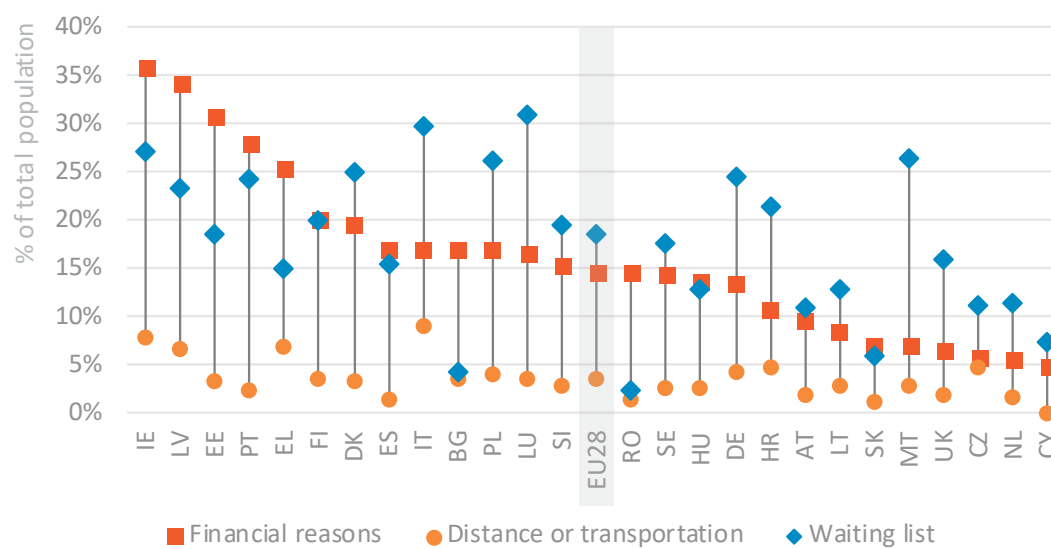
Access has three dimensions: coverage, affordability and availability of care. Barriers to access include, for instance, lack of health insurance coverage; high levels of private ('out-of-pocket')

⁵⁸ [Towards a fairer and more effective measurement of access to healthcare across the EU](#), ICF/European Commission, November 2018.

⁵⁹ [Charter of Fundamental Rights of the European Union](#), 2012/C 326/02.

healthcare expenditure; geographical disparities in the availability of healthcare services (including infrastructure, equipment, and number of health professionals); waiting times; and cultural obstacles. As shown in Figure 2 above, out-of-pocket expenditure on healthcare (that is, expenditure borne directly by a patient)⁶⁰ varies widely across the EU. Household out-of-pocket expenditure can create a financial barrier to access, thus resulting in unmet needs for healthcare. According to Eurostat,⁶¹ more than a quarter of the EU population (aged 15 and over) declared they had an **unmet healthcare need** in 2014,⁶² due to three main reasons: financial costs; travelling distance to care facilities (including transportation problems); or long waiting times (see Figure 3).

Figure 3 – Self-reported unmet needs for healthcare (2014)



Graph by G. Sabbati, EPRS, based on data by Eurostat, [Share of persons aged 15 and over reporting unmet needs for healthcare, by specific reason, 2014 or nearest year](#).

In 2016, more than 4 % of the EU-28 population aged 16 and over and had an **unmet need for a medical examination or treatment**. The most common reason was that it was too expensive. Close to 6 % of those aged 16 and over had an **unmet need for dental examination or treatment**; overall, by far the most common main reason for this was cost. Moreover, about 5 % of the population aged 15 and over in need of prescribed medicines could not afford them in 2014, whereby the share of people with **unmet needs for prescribed medicines** was highest among those with lower education. People in the lowest income quintiles more often report unmet needs due to the above three reasons. According to a 2017 Eurostat breakdown of the **financial burden of healthcare on households' budgets**,⁶³ 55 % of people in the EU reported that the amount their household had to pay for **medical care** (excluding dental care and medicines) did not represent a financial burden. Some 34 % stated that costs for medical care were somewhat of a financial burden, while 11 % perceived such costs as a heavy burden on the household budget. The perceived financial burden of medical care was greatest for those living in two-person households that included at least one person aged 65 years or more. Cyprus had the largest share of persons reporting that medical costs posed a high financial burden (39 %). The share of those declaring that paying for medical care caused no financial burden was largest in Denmark, Slovenia and Sweden

⁶⁰ It comprises cost-sharing, self-medication and other expenditures ([Glossary of Statistical Terms](#), OECD).

⁶¹ [Unmet health care needs statistics](#), Eurostat.

⁶² That is, felt they needed healthcare but did not receive it for a number of reasons.

⁶³ [The burden of healthcare on households' budgets](#), Eurostat.

(all 86 %). Of those surveyed, 49 % declared that **paying for medicines** posed no financial burden to the household. A further 39 % reported that these costs represented some financial burden, and 13 % found paying for medicines a heavy financial burden on the household. In the EU, 48 % reported no financial burden relating to costs for **dental examinations or treatment**.

3.2. Possible drivers and explanations

The factors that give rise to, and exacerbate, disparities in health are complex and interlinked. Because of the social gradient in health within countries, it is often **people in vulnerable situations**⁶⁴ that are most affected by health inequalities (see the definitions of disadvantaged, vulnerable and marginalised social groups in [Section 2](#)). Vulnerable groups typically include people with lower household income, lower education level and lower occupational class (that is, lower socioeconomic status);⁶⁵ the unemployed (especially long-term unemployment); people living in poverty or at risk of poverty; people with a migrant background; and people with an ethnic minority background, such as the Roma communities.⁶⁶ According to Dahlgren and Whitehead, the assumption that the lifestyles of different socioeconomic groups are freely chosen is flawed, as the social and economic environments in which people live are of critical importance for shaping their lifestyles.⁶⁷ Furthermore, as the WHO argues, it is not simply that poor material circumstances are harmful to health: the **social meaning** of being disadvantaged, poor, unemployed, socially excluded or otherwise stigmatised also plays a role.⁶⁸

Quote: The right to healthcare

'Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.'

Source: Article 35 of the EU Charter of Fundamental Rights, [Charterpedia](#), European Union Agency for Fundamental Rights (FRA).

There appears to be a **link between health inequalities within a country and the overall health of the population**: the higher the inequality, the poorer the health of the population as a whole. According to Marmot, tackling the social gradient in health implies reducing inequality and improving society as a whole.⁶⁹ As the Commission points out in its report, reducing inequalities within Member States may well help to reduce those between Member States.⁷⁰

Age and gender differences can aggravate health inequalities. A recent study found that the more disadvantaged the socioeconomic circumstances during childhood, the higher the risk of disability in older age, especially for women, who – unlike men – could not compensate their disability risk through adult socioeconomic attainments. According to the authors, these findings underline that childhood is a sensitive period to which public health policies should pay attention.⁷¹

⁶⁴ For further reading, see A. Zimmermann, [Social Vulnerability as an Analytical Perspective](#), Population Europe, 2017.

⁶⁵ [Defined as](#) the social standing or class of a person or group, often measured as a combination of income, education or occupation.

⁶⁶ [Health Inequalities: dietary and physical activity-related determinants](#), European Commission.

⁶⁷ [European strategies for tackling social inequities in health: Levelling up Part 2](#), WHO/Europe, 2007.

⁶⁸ [Social determinants of health. The solid facts. Second edition](#), WHO/Europe, 2003.

⁶⁹ M. Marmot, '[The health gap. The challenge of an unequal world. Viewpoint](#)', *Lancet*, Vol. 386, Issue 10011, December 2015, pp. 2442-2444.

⁷⁰ [Reducing health inequalities in the European Union](#), European Commission, 2010.

⁷¹ A. Landös et al., '[Childhood socioeconomic circumstances and disability trajectories in older men and women: a European cohort study](#)', *European Journal of Public Health*, Vol. 29, Issue 1, February 2019, pp. 50-58.

Unequal distribution of income, or income inequality, is deemed to be one of several factors underlying differences in health between countries and people.⁷² Income inequality is one of the indicators for the Social Scoreboard, which supports the European Pillar of Social Rights.⁷³ Data from 2016 show that income is unequally distributed in the EU: the 20 % richest households earned over 5 times more than the poorest 20 %.⁷⁴ This ratio varied substantially across Member States.⁷⁵

Poverty is also considered to be an important determinant of health.⁷⁶ In 2017, 112.8 million people in the EU (or 22.4 % of the population) lived in households at **risk of poverty or social exclusion** (mainly women, children, young people, people living in single-parent households, lower educated people and migrants).⁷⁷ A further 6.6 % of the population were **severely materially deprived**.⁷⁸ Experts have pointed to income as a key factor explaining inequalities in access to healthcare. Data from the Commission's 2018 report on inequalities in access to healthcare show that the lower the income is, the more (self-reported) unmet needs there are for medical examination due to cost. According to the report, the most striking example is Greece, where people in the lowest income quintile report 34.3 % of unmet needs due to cost, compared to only 0.4 % of those in the highest quintile. Only a few countries report barely any difference between income groups.⁷⁹

In terms of **social protection**, it is estimated that social transfers help reduce the share of people at risk of poverty by 8.6 percentage points (2016 data).⁸⁰ It has been argued that social policies as a method of public redistribution are a possible instrument to reduce income inequalities, which in turn would lead to a reduction in health inequalities.⁸¹ According to a recent review, the evidence of the effects of social protection policy interventions on health inequalities remains sparse, of low quality, limited generalisability, and relatively inconclusive, and there is a need for further evaluation.⁸²

Environmental harm as a health determinant

A report from the European Environment Agency (EEA) draws attention to the close links between social and environmental problems across Europe. The report shows that poorer social groups, as well as the elderly and children, remain disproportionately affected by environmental health hazards, such as air and noise pollution and extreme temperatures, especially in Europe's eastern and southern regions. Solutions could include road traffic management, promoting walking and cycling, nature-based solutions (e.g. tree planting) and good-quality housing. The report also makes a case for enhancing the coherence between different EU policy areas (health, poverty, climate change and air pollution), and – at the local level – a multi-pronged approach, from welfare to urban design.

Source: [More action needed to protect Europe's most vulnerable citizens from air pollution, noise and extreme temperatures](#), European Environment Agency, 4 February 2019; [EEA Report No 22/2018](#).

⁷² [Reducing health inequalities in the European Union](#), European Commission, 2010

⁷³ [Social Scoreboard indicators](#), Eurostat (more on the European Pillar of Social Rights in [Section 5.1.2](#)).

⁷⁴ [Social Scoreboard 2018 country reports](#), European Commission.

⁷⁵ [Income inequality in the EU](#), Eurostat, 26 April 2018.

⁷⁶ [Reducing health inequalities in the European Union](#), European Commission, 2010.

⁷⁷ [Health Inequalities: dietary and physical activity-related determinants](#), European Commission.

⁷⁸ [People at risk of poverty or social exclusion](#), Eurostat.

⁷⁹ [Inequalities in access to healthcare – A study of national policies](#), European Commission, 2018.

⁸⁰ [Social Scoreboard 2018 country reports](#), European Commission.

⁸¹ R. Jutz, 'The role of income inequality and social policies on income-related health inequalities in Europe', *International Journal for Equity in Health*, Vol. 14, Issue 1, December 2015.

⁸² F. Hillier-Brown et. al, 'The effects of social protection policies on health inequalities: Evidence from systematic reviews', *Scandinavian Journal of Public Health*, Vol. 47, Issue 6, August 2019, pp. 655-665.

4. International agencies' work on social determinants of health and health inequalities

This section presents the angle from which supranational agencies approach the issue. It will highlight some key findings from their work, as well as associated policy recommendations.

4.1. United Nations

In September 2015, the United Nations (UN) adopted the 2030 Agenda for Sustainable Development. With the adoption of the 2013 Agenda, the international community pledged to 'leave no one behind', and committed to achieving 17 sustainable development goals (SDGs)⁸³ aimed at helping humanity undergo a transformative shift.⁸⁴ As experts have stressed, health and wellbeing and the SDGs are interrelated in a bidirectional way: many SDGs are important determinants of health, and their achievement will lead to improvements in health and wellbeing; in turn, health is an important contributory factor to achieving other SDGs.⁸⁵

Goals 3 and 10 specifically focus health and equality.⁸⁶ Goal 10 also states that, to reduce inequality, 'policies should be universal in principle, paying attention to the needs of disadvantaged and marginalised populations'. This mirrors the UN's continued efforts to achieve universal health coverage,⁸⁷ which is also a priority objective of the World Health Organization (WHO).⁸⁸ Universal health coverage aims to ensure: that those who need services get them, not merely those who can pay for them (equity); that the quality of health services is good enough to improve the health of those receiving services (quality); and that the cost of using care does not put people at risk of financial hardship (financial risk protection).⁸⁹

4.1.1. World Health Organization

This section gives a brief overview of the WHO's milestones at global level. It will then focus on the work of the WHO Regional Office for Europe (WHO/Europe),⁹⁰ which covers the countries of the WHO European region,⁹¹ and specifically, on some recent analyses and recommendations.

The foundations of WHO's work on social determinants of health and health inequities are its constitution⁹² and the 1978 Declaration of Alma-Ata,⁹³ which affirm health as a basic human right.

⁸³ [Sustainable Development Goals](#), UN.

⁸⁴ M. Latek, [Understanding Sustainable Development Goals](#), EPRS, European Parliament, 2017.

⁸⁵ See, for instance, [Key policies for addressing the social determinants of health and health inequities](#) (Health Evidence Network synthesis report 52), WHO/Europe, 2017.

⁸⁶ See [Goal 3](#): Ensure healthy lives and promote wellbeing for all at all ages; and [Goal 10](#): Reduce inequality within and among countries, UN.

⁸⁷ Universal health coverage is also referred to as universal coverage, universal healthcare or universal care.

⁸⁸ [A History of Universal Health Coverage in the UN](#), UHC2030.

⁸⁹ [Universal health coverage](#), WHO. See also the September 2019 UN [political declaration](#) on universal healthcare.

⁹⁰ [WHO/Europe](#) is centred around two main areas of work: providing services to member states to increase their capacity to tackle health inequities; and monitoring, reviewing and systematising the policy implications of research findings.

⁹¹ The WHO European region comprises 53 [countries](#), spanning a geographical region from the Atlantic to the Pacific.

⁹² [Constitution of the World Health Organization](#), WHO. The constitution entered into force in 1948.

⁹³ [Declaration of Alma Ata](#), WHO.

The 1986 Ottawa Charter⁹⁴ stressed the importance of intersectoral action and community participation in policies to address social determinants of health and health inequities.⁹⁵

In 2005, as a response to growing concerns about inequities in Europe and globally, the WHO established a Commission on Social Determinants of Health.⁹⁶ The purpose of the commission, which was chaired by the noted researcher on epidemiology and health inequalities, Professor Sir Michael Marmot,⁹⁷ was to synthesise the evidence on what can be done to promote health equity and to foster a global movement to achieve it. The commission produced a report, 'Closing the gap in a generation',⁹⁸ which asked that governments, civil society, WHO and other global organisations come together to take action to improve the lives of the world's citizens within a generation. It contained three main overarching recommendations (see Figure 4).⁹⁹

Figure 4 – Main WHO Commission on Social Determinants of Health recommendations

Improve the conditions of daily life – the circumstances in which people are born, grow up, live, work and age.

Tackle the inequitable distribution of power, money and resources – the structural drivers of those conditions of daily life – globally, nationally and locally.

Measure the problem, evaluate action, expand the knowledge base, develop a workforce trained in the social determinants of health, and raise public awareness about the social determinants of health.

Data source: [Policy goals and recommendations](#), Commission on Social Determinants of Health, WHO/Europe, 2008.

The WHO's Rio Political Declaration on Social Determinants of Health of October 2011¹⁰⁰ expresses a global political commitment to develop and support policies, strategies, programmes and action plans that address social determinants of health and health inequities. Among other things, it pledges to further reorient the health sector towards reducing health inequities, including moving towards universal health coverage that is accessible, affordable and good-quality for all; strengthen coordinated global action; and monitor progress and increase accountability. A May 2012 resolution commits WHO member states to implement the pledges made in the declaration.¹⁰¹

⁹⁴ [The Ottawa Charter for Health Promotion](#), WHO.

⁹⁵ [Social determinants - Policy](#), WHO/Europe.

⁹⁶ [The Commission on Social Determinants of Health - what, why and how?](#), WHO.

⁹⁷ [Sir Michael Marmot](#), WHO.

⁹⁸ M. Marmot et al., 'Closing the gap in a generation: health equity through action on the social determinants of health', *Lancet*, Vol. 372, Issue 9650, 8 November 2008, pp. 1661-1669.

⁹⁹ [Policy goals and recommendations of the Commission on Social Determinants of Health](#), WHO/Europe, 2008.

¹⁰⁰ [Rio Political Declaration on Social Determinants of Health](#), WHO, October 2011.

¹⁰¹ [Resolution \(WHA65.8\)](#), WHO, May 2012.

Within the WHO European region, health inequalities are a major public health priority, given the large differences in health and life expectancy that exist between countries. The Tallinn Charter of 2008¹⁰² affirms the central role of health systems in addressing health inequities. The charter points out that while the characteristics of health systems may vary due to historical, economic and cultural factors, they share common functions related to service delivery, resource generation, financing and stewardship.¹⁰³

In 2012, WHO/Europe adopted the 'Health 2020' policy framework. It aims at supporting action across government and society to: significantly improve the health and wellbeing of populations; reduce health inequalities; strengthen public health; and ensure people-centred health systems that are universal, equitable, sustainable and of high quality.¹⁰⁴ To support the development of Health 2020, WHO/Europe commissioned a comprehensive review of inequities in health between and within countries across the WHO European region.¹⁰⁵ The review gathers evidence on the most effective interventions and policy approaches to address these inequities, and makes detailed recommendations for action. Its conclusions in a nutshell were:

Quote: The moral and economic arguments for action on social determinants of health

'The review makes the moral case for action on social determinants of health – social injustice kills and causes unnecessary suffering. There is also a strong economic argument. The cost of health inequities to health services, lost productivity and lost government revenue is such that no society can afford inaction.'

Source: [Review of social determinants and the health divide in the WHO European Region: final report](#), WHO/Europe, 2014.

- In all countries in the WHO European region, reduction of health inequities should become one of the main criteria used to assess the effectiveness of the health system and the government as a whole.
- All countries should establish clear strategies to redress the current patterns and magnitude of health inequities by taking action on the social determinants of health, and should undertake regular reviews of these strategies.
- Steps towards realisation of the ambitions should be taken, covering the life course; wider societal influences; the broader context; and the systems needed for delivery.¹⁰⁶

According to a WHO/Europe 2017 report on engagement and participation for health equity,¹⁰⁷ communities and individuals need to be involved, alongside local and national authorities, as important partners in addressing the determinants of inequities. In a 2017 report on key policies addressing the social determinants of health and health inequities,¹⁰⁸ WHO/Europe identifies specific policy options that focus on: early childhood education and care; child poverty; investment strategies for an inclusive economy; active labour market programmes; working conditions; social cash transfers; affordable housing; and planning and regulatory mechanisms to improve air quality and mitigate climate change. The policy options are based on evidence that actions within four main

¹⁰² [The Tallinn Charter: Health systems for health and wealth](#), WHO/Europe.

¹⁰³ [Social determinants – Policy](#), WHO/Europe.

¹⁰⁴ [About Health 2020](#), WHO/Europe.

¹⁰⁵ [Review of social determinants and the health divide in the WHO European Region: final report](#), WHO/Europe, 2014.

¹⁰⁶ M. Marmot et al., '[WHO European review of social determinants of health and the health divide](#)', *Lancet*, Vol. 380, Issue 9846, 15 September 2012, pp. 1011-1029.

¹⁰⁷ [Engagement and participation for health equity](#), WHO/Europe, 2017.

¹⁰⁸ [Key policies for addressing the social determinants of health and health inequities](#) (Health Evidence Network synthesis report 52), WHO/Europe, 2017.

themes – early child development, fair employment and decent work, social protection, and the living environment – are likely to have the greatest impact.

WHO/Europe's 2017 report on investment for health and wellbeing¹⁰⁹ pleads for urgent action to address growing health, inequality, economic and environmental challenges. Quantifying both the costs and the solutions, it argues that health inequalities cost €980 billion for one year in the EU, while early years interventions can save over €1.7 trillion spent on social problems in 20 years.¹¹⁰ The report identifies pathways through which investment for health and wellbeing enables sustainable development, and suggests policies for priority investment to support the SDGs, building on the Health 2020 framework.

In 2018, WHO/Europe introduced the Health Equity Status Report Initiative 2018,¹¹¹ a set of tools to promote and support policy action for health equity and wellbeing in Europe. The initiative's deliverables include: an interactive health equity atlas; policy guidance on reducing inequalities in health in early years, youth, working years and later life; and tools to support improved governance, investment and accountability for health equity.

The WHO/Europe 2019 report¹¹² on financial protection in the WHO European region looks at whether people can afford to pay for healthcare. It focuses on out-of-pocket payments for health, which can create unmet needs for healthcare services and financial hardship, and assesses 'impoverishing' and 'catastrophic' health spending. The report shows that financial hardship varies widely between and within the 19 countries included in the study. Catastrophic health spending is heavily concentrated among the poorest quintile of the population. Among households with catastrophic spending, out-of-pocket payments are mainly due to outpatient medicines (that is, medicines delivered outside of hospital settings). According to the report, the first step to strengthening financial protection is to identify gaps in health coverage, followed by addressing them through a redesign of coverage policy. In contexts where public resources are severely limited, it is vital to ensure those most disadvantaged benefit first. The report summarises actions that strengthen coverage policy, and highlights those that weaken it.

'Healthy, prosperous lives for all'

The June 2019 WHO/Europe high-level conference on health equity in Ljubljana highlighted the five essential conditions needed to live a healthy life:

- good-quality and accessible health services;
- income security and an appropriate, fair level of social protection;
- decent living conditions;
- good social and human capital; and
- decent work and employment conditions.

In the Ljubljana statement adopted at the conference, participants reaffirm their commitments to taking gender-responsive and rights-based approaches to improving the health and wellbeing of all, and encourage the WHO to launch a European Region health equity solutions platform for policy-makers to exchange best practices and share innovations in sustainable solutions that accelerate equity in health and wellbeing.

Moreover, the September 2019 WHO/Europe Health Equity Status report deals with the factors fundamental to creating more equitable societies: policy coherence, accountability, social participation and empowerment. The report provides evidence of the indicators driving health inequities in WHO member states and provides solutions to reducing these inequities.

Source: [About the High-level Conference on Health Equity; Ljubljana statement on health equity](#); and [Healthy prosperous lives for all: the European Health Equity Status Report \(2019\)](#), WHO/Europe.

¹⁰⁹ M. Dyakova et al., [Investment for health and well-being: a review of the social return on investment from public health policies to support implementing the Sustainable Development Goals by building on Health 2020](#) (Health Evidence Network synthesis report 51), WHO/Europe, 2017.

¹¹⁰ [Investment for health and well-being](#), WHO/Europe, 2017.

¹¹¹ [Health Equity Status Report Initiative 2018](#), WHO/Europe.

¹¹² [Can people afford to pay for health care? New evidence on financial protection in Europe \(2019\)](#), WHO/Europe.

4.2. Organisation for Economic Co-operation and Development

The Organisation for Economic Co-operation and Development (OECD) provides a forum in which the governments of its member countries¹¹³ can work together to seek solutions to common problems. It collects and analyses data, and drawing on facts and real-life experience, recommends policies designed to improve people's economic and social wellbeing.¹¹⁴ The two-year Health at a Glance: OECD indicators series highlights how countries differ in terms of the health status and health-seeking behaviour of their citizens; access to and quality of healthcare; and the resources available for health.¹¹⁵ As the OECD points out, there are large inequalities in health status and life expectancy between and within OECD countries; these are due to many factors.¹¹⁶ The OECD's work on social determinants of health and health inequalities can be grouped into four areas: inequalities in ageing; inequalities in education and the labour market; inequalities in risk factors to health; and inequalities in access to and utilisation of healthcare.

Inequalities in ageing. A 2017 OECD report¹¹⁷ on preventing ageing unequally shows how inequalities in education, health, employment and income reinforce each other. Compounding over the course of a lifetime, they result in large disparities in lifetime earnings across different groups. The report suggests that a whole-of-government approach is likely to be more effective than separate inequality-reducing policies. Specific recommendations include, among others:

- Preventing inequality before it cumulates over time – place early-life interventions at the top of the policy agenda;¹¹⁸ promote a good start in working life;¹¹⁹ and break the links between socioeconomic disadvantages and health status;
- Mitigating entrenched inequalities – promote healthy ageing by developing a multi-sectoral active ageing strategy and providing equal access to healthcare; combat long-term unemployment; provide equal opportunities for workers to upgrade their skills; and remove barriers to retaining and hiring older workers.¹²⁰
- Coping with inequality at older ages – limit the impact of socioeconomic differences in life expectancy on pension benefits;¹²¹ target adequate levels of retirement income; increase pension coverage; move towards a unified pension framework for all workers; and reduce inequalities in long-term care by making home care affordable for all.

Inequalities in education and the labour market. As the OECD explains, good health enhances people's opportunities to participate in the labour market. People in poor health are less likely to work and more likely to be unemployed than those in better health. Conversely, people with higher levels of education and higher income tend to be in better health and live longer than those with lower education and income. According to the OECD, more emphasis on public health and disease

¹¹³ The OECD's 36 [member countries](#) span the globe, from the Americas to Europe and Asia-Pacific.

¹¹⁴ [About the OECD](#), OECD.

¹¹⁵ See the latest edition, [Health at a Glance 2019](#), OECD.

¹¹⁶ [Health Inequalities](#), OECD.

¹¹⁷ [Preventing Ageing Unequally](#), OECD, 2017. The report is accompanied by country-specific notes, including on FR, DE, IT, ES and UK.

¹¹⁸ For further reading, see N. Milotay, [Early childhood education and care in family-friendly policies](#), EPRS, European Parliament, 2016.

¹¹⁹ For further reading, see M. Lecerf, [NEETs: who are they? Being young and not in employment, education or training today](#), EPRS, European Parliament, 2017.

¹²⁰ For further reading, see N. Scholz and M. Kiss, [EU policies – Delivering for citizens: Health and social security](#), EPRS, European Parliament, November 2018.

¹²¹ See also D. Eatock et al., [Demographic outlook for the European Union](#), EPRS, European Parliament, 2017.

prevention, especially among disadvantaged groups, and better access to health services can contribute to improving their health status and life expectancy, and it can increase their employment rates and social inclusion.¹²² An OECD report from 2015¹²³ on inclusive growth¹²⁴ examines how factors such as health, education and employment prospects matter for people's wellbeing and, at the same time, are heavily determined by their socioeconomic status. The report posits that 'investing in the education and skills of people at the bottom of the distribution will pay long-term dividends for the economy and enhance individual wellbeing'.¹²⁵ Moreover, a 2015 paper¹²⁶ examines the labour market impacts of lifestyle risk factors and chronic diseases, such as diabetes, cardiovascular diseases, cancer, musculoskeletal diseases, and mental health conditions. According to the paper, the evidence suggests overall that chronic diseases and associated risk factors have potentially large detrimental labour market impacts, in terms of employment, wages, labour productivity and early retirement. The paper supports the use of chronic disease prevention strategies targeting people at higher risk.

Inequalities in risk factors to health. Lifestyle behaviours, such as unhealthy eating habits; low levels of physical activity; obesity; tobacco and alcohol consumption are important risk factors for many chronic diseases, and there is a social gradient in health. As the OECD points out, people in lower socioeconomic groups are more likely to smoke, be obese,¹²⁷ and exposed to other behavioural risk factors.¹²⁸ The OECD argues that greater efforts targeting modifiable, behaviour-related risk factors among disadvantaged groups can play an important role in promoting healthier lifestyles and reducing health inequalities.¹²⁹

Inequalities in access and utilisation of healthcare. The OECD states that most of its European member countries have achieved universal (or near-universal) coverage for a core set of health services, although inequalities in accessing healthcare continue to exist.¹³⁰ Access to care can be limited by a number of reasons, mostly financial (the cost of care may not be affordable), geographical (the distance to the closest healthcare facility may be too great), and those related to waiting times (too long for treatment).¹³¹ While most health expenditure in the EU is financed through government and compulsory insurance, the share of private out-of-pocket spending varies widely across countries.¹³² The OECD notes the importance of ensuring 'proper health insurance coverage for essential health services for all the population, as well as proper geographic distribution of health services across different regions in each country, to ensure effective access to

¹²² [Health Inequalities](#), OECD.

¹²³ [All on Board: Making Inclusive Growth Happen](#), OECD, 2015.

¹²⁴ Defined as 'economic growth that creates opportunity for all segments of the population and distributes the dividends of increased prosperity, both in monetary and non-monetary terms, fairly across society' (ibid, p. 85).

¹²⁵ Ibid. foreword, pp. 3-4.

¹²⁶ M. Devaux and F. Sassi, [The Labour Market Impacts of Obesity, Smoking, Alcohol Use and Related Chronic Diseases](#), OECD Health Working Papers No. 86, 2015.

¹²⁷ [OECD Obesity Update 2017](#).

¹²⁸ The relationships between socioeconomic dimensions and alcohol consumption are complex. According to the 2015 OECD report on [Tackling Harmful Alcohol Use](#), people with more education and higher socioeconomic status are more likely to drink alcohol, while less educated men of lower socioeconomic status, as well as better educated women of higher socioeconomic status, are more likely to indulge in risky drinking. Despite this, evidence suggests that people in lower socioeconomic groups and ethnic minorities are more prone to alcohol-related harms.

¹²⁹ [Health Inequalities](#), OECD.

¹³⁰ [Health at a Glance: Europe 2018](#), OECD/EU.

¹³¹ These may also include personal reasons (such as the fear of not being understood by the doctor or not having the time to seek care), see [Health at a Glance 2017](#), OECD, Chapter 5. Access to care.

¹³² [What are the key health disadvantages across high-income countries?](#), presentation by M. Devaux/OECD, 2016.

care'.¹³³ Moreover, it argues that policies must prioritise financial protection for disadvantaged groups.

In its May 2019 report on 'the European Project, its achievements and challenges',¹³⁴ the OECD identifies – and proposes solutions for – two main issues in the area of health. Firstly, since inequalities in access to healthcare and in outcomes across socioeconomic groups require policies at national level that address such gaps by supporting the most vulnerable people, the EU can promote measurement of health outcomes that matter most for people, which can serve as a tool to improve national policy design and implementation. Secondly, lowering exposure to risk factors would promote further gains and convergence in life expectancy, so the EU can continue to support national efforts to reduce exposure to risk factors for chronic non-communicable diseases.

One of the key messages of a September 2019 report on social inequalities in health and health systems¹³⁵ is that tackling health-related inequalities can make societies more inclusive. The report proposes policy options ranging from moving towards patient-centred primary care delivery, to extending healthcare coverage, to improving health literacy and public health interventions. According to the report, policies related to the labour market, education, environment, housing and social policies can also contribute to tackling inequalities in health.

Health at a Glance: Europe 2018 – Highlights from the joint OECD/EU publication

The biennial publication *Health at a Glance: Europe* is part of the 'State of Health in the EU' cycle, in which the OECD and the European Commission jointly undertake comparative analyses of the health status of EU citizens and the performance of EU health systems. With regard to health inequalities, key findings include:

- **Life expectancy** exceeds 81 years in most EU Member States, but the difference between the country with the highest life expectancy and that with the lowest is still over eight years. There are **large gaps in life expectancy by education level and socioeconomic status**: at age 30, people with a low level of education can, on average, expect to live six years less than the most educated (eight years for men, four years for women). There are also large gaps **in self-reported health by income level**: 60 % of people with the lowest income report being in good health, compared to 80 % of those with the highest income.
- **Obesity** among adults is rising across the EU. In most Member States, at least one in six adults are obese. There are still **wide disparities by socioeconomic status**: 20 % of adults with a lower level of education are obese, compared to 12 % of those with a higher education level.
- Over 75 % of **health spending** across the EU is publicly financed. **Out-of-pocket payments** account for 18 % on average, but represent a much bigger share in some countries. This can cause financial problems for poor households and for those having to pay for long-term treatment.
- The share of EU citizens that report **unmet needs for healthcare** is generally low and has declined over the past ten years. However, low-income households are still five times more likely than high-income households to report unmet needs for medical care, and even more so for dental care.
- The **quality of acute care for life-threatening conditions** has improved in most EU Member States over the past decade. Disparities nevertheless persist, not only between countries but also between hospitals within each country.

Source: [Health at a Glance: Europe 2018](#), OECD/EU (in particular, Part II Chapter 7 Accessibility: Affordability, availability and use of services), and [chartset](#).

¹³³ [Health Inequalities](#), OECD.

¹³⁴ [The European Union: A People Centred Agenda. An International Perspective](#), OECD, 2019.

¹³⁵ [Health for Everyone? Social Inequalities in Health and Health Systems](#), OECD; 2019.

5. European Union action to reduce health inequalities

While Member States have the main responsibility for health policy and the provision of healthcare, there are areas where addressing common challenges at EU level achieves added value.¹³⁶ The EU institutions, bodies and agencies contribute to reducing health inequalities through an array of policies, programmes, initiatives and instruments that affect the socioeconomic determinants of health. This section highlights some of their main contributions from the last ten years.

5.1. EU institutions

5.1.1. Council

Many EU presidencies have addressed issues linked to the social determinants of health and health inequalities, some have done so in their conclusions. The June 2010 Council conclusions on **Equity and Health in All Policies: Solidarity in health**¹³⁷ express concern that vulnerable and socially excluded groups experience particularly poor average levels of health. According to the conclusions, reasons for poor health in such groups may include less favourable levels of income, education, housing and economic wellbeing than the mainstream population, as well as social discrimination, stigmatisation and uneven access to health services. The conclusions note:

- In all EU Member States, social conditions are linked to the existence of avoidable social inequalities in health.
- There is a social gradient in health status, 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.
- Health inequalities occur even in countries where access to healthcare has been universal, free and without charge for decades. This shows that healthcare services will always need complementary action by other sectors to ensure equity in health.
- Health inequalities have an important gender dimension.
- Further information on the social determinants of health is needed to guide policies towards equity in health.¹³⁸

In its conclusions, the Council considers it appropriate to incorporate the equity in health approach into all relevant EU policies gradually, taking the social determinants of health into account, and to advance in the development of new tools for information exchange to make this possible. The Council urges Member States to recognise the impact of the social determinants of health in shaping health status, and the implications of this impact for their health and social systems; to implement policies aimed at ensuring a good start in life for all children; and to consider policies to ensure that citizens can make full use of their rights of universal access to healthcare, including health promotion and disease prevention services.

The December 2012 Council conclusions on **Healthy ageing across the lifecycle**¹³⁹ recognise that economic, social and environmental conditions, as well as lifestyles, are among the determinants of health, and that addressing them through intersectoral action remains one of the important challenges for achieving active and healthy ageing for all. Council invites the Member States to make

¹³⁶ For further reading, see N. Lomba, [The benefit of EU action in health policy: The record to date](#), EPRS, European Parliament, 2019.

¹³⁷ [Council conclusions on Equity and Health in All Policies: Solidarity in health](#), 8 June 2010.

¹³⁸ Ibid.

¹³⁹ [Council conclusions on Healthy ageing across the lifecycle](#), 7 December 2012.

healthy ageing across the lifecycle a priority for the coming years, with a social and equity approach; and to enhance coordination and collaboration between all stakeholders, taking the health in all policies principle into account. It invites the Commission to support future initiatives addressing health determinants and risk factors, as well as promoting healthy ageing throughout the lifecycle at EU, regional, national and local level, while respecting the competences of the Member States.

The June 2016 Council conclusions on **Combating poverty and social exclusion: An integrated approach**¹⁴⁰ call on the Commission and the Member States to develop an integrated approach that should combine adequate income support and access to quality services and inclusive labour markets. This approach is characterised by interventions throughout the lifecycle and requires cooperation among all stakeholders. A booklet¹⁴¹ annexed to the conclusions contains examples of innovative best practices from across the Member States. They illustrate the value of an integrated approach for vulnerable groups such as children, migrants, people with disabilities, elderly people, young people, the unemployed, people with a migrant background and homeless people.

The December 2016 Council conclusions on **Accelerating the process of Roma integration**¹⁴² strongly affirm the continued need for integrated measures to improve the situation of marginalised and disadvantaged groups in Europe, including the Roma. The Council urges the Member States to ensure equal access for the Roma to universal primary and specialised healthcare services; and to widen access to healthcare by increasing healthcare awareness and improving access to vaccination and preventive healthcare in Roma communities.

The June 2017 Council conclusions **to contribute towards halting the rise in childhood overweight and obesity**¹⁴³ consider the large numbers of cases of childhood obesity in many Member States to be a major health challenge, which contributes to widening health inequalities, with children as the vulnerable group most severely affected. The Council invites the Member States to include, in their action plans, cross-sectoral policies and lifelong action to reduce socioeconomic inequalities, and in particular, to address vulnerable children and adolescents in socially disadvantaged communities, for instance by offering improved access to healthy diets and physical activity. In the June 2017 conclusions on **Encouraging Member States-driven voluntary cooperation between health systems**,¹⁴⁴ the Council encourages the European Reference Networks¹⁴⁵ to attain their intended objectives of providing better access for patients requiring highly specialised healthcare, to break barriers to access and reduce inequities between European citizens.

The December 2017 Council conclusions on **Cross-border aspects in alcohol policy – tackling harmful use of alcohol**¹⁴⁶ emphasise that harmful use of alcohol also contributes significantly to health inequalities, between and within the Member States. In this context, the conclusions refer back to the Council's 2009 conclusion that health inequalities based on social determinants are strongly linked to, among other factors, alcohol consumption both as a cause and a consequence. According to the December 2017 conclusions on **Health in the digital society – making progress**

¹⁴⁰ [Council conclusions on Combating poverty and social exclusion: an integrated approach](#), 16 June 2016.

¹⁴¹ [Integrated approaches to combating poverty and social exclusion](#), 2016.

¹⁴² [Council conclusions on Accelerating the process of Roma integration](#), 8 December 2016.

¹⁴³ [Council conclusions to contribute towards halting the rise in childhood overweight and obesity](#), 16 June 2017.

¹⁴⁴ [Council conclusions on Encouraging Member States-driven voluntary cooperation between health systems](#), 16 June 2017.

¹⁴⁵ For further reading, see N. Scholz, [Understanding European Reference Networks: Cooperation on rare diseases across Europe](#), EPRS, European Parliament, 2017.

¹⁴⁶ [Council conclusions on Cross-border aspects in alcohol policy – tackling harmful use of alcohol](#), 8 December 2017.

in data-driven in the field of health,¹⁴⁷ digital solutions should contribute both to more efficient use of healthcare resources and more integrated healthcare. The conclusions emphasise that the design and implementation of digital tools in healthcare also need to take account of the differences in digital and health literacy, to avoid creating further health inequalities.

The June 2018 Council conclusions on **Integrated early childhood development policies as a tool for reducing poverty and promoting social inclusion**¹⁴⁸ underline that participation in early childhood education and care is crucial for preventing and tackling inequality through early intervention. Children from minority groups and low-income families are often much less likely to be enrolled in early childhood education and care, and it is essential to guarantee equal access to quality universal services to these children from disadvantaged backgrounds. According to the June 2018 conclusions on **Healthy Nutrition for Children: The Healthy Future of Europe**,¹⁴⁹ obesity in children is a health challenge that should also be considered in the broader context of the socioeconomic determinants of health and social inequalities; the social and economic environment has a key role in shaping choice. The Council recognises that the reduction of health inequalities cannot be based on individual choice alone, but also requires all relevant public policies to support healthy environments. It invites the Member States, among other things, to continue to implement targeted policies, paying particular attention to reaching and involving children with a lower socioeconomic background and children in vulnerable situations.

The July 2019 Council conclusions on the **economy of wellbeing** consider that access for all to health services, long-term care, health promotion and disease prevention, provided by a sustainable health system, are essential elements of wellbeing that also address health inequalities and thus contribute to the economy and society.¹⁵⁰

Social Protection Committee

The Social Protection Committee (SPC) is an advisory policy committee for Employment and Social Affairs Ministers in the Employment and Social Affairs Council (EPSCO). The SPC produces reports on its own initiative or at the request of the Council or the Commission.¹⁵¹ The SPC's 2018 annual report has a special focus on health.¹⁵² It uses an analytical tool, based on a set of indicators, to monitor policies in healthcare from a social protection perspective.¹⁵³ Some findings (2015 data) from three of the six areas covered – outcome, quality and access – are described below.

'Outcome' area: for 18 Member States,¹⁵⁴ healthy life years and/or life expectancy (at birth or at age 65) remain a key health challenge. Their overall score is lower or significantly lower than the EU average, despite positive developments in some countries. Infant mortality is a major challenge for four Member States.¹⁵⁵ Amenable and preventable mortality¹⁵⁶ proves to be a challenge for eight

¹⁴⁷ [Council conclusions on Health in the Digital Society – making progress in data-driven innovation in the field of health](#), 21 December 2017.

¹⁴⁸ [Integrated early childhood development policies as a tool for reducing poverty and promoting social inclusion](#), 21 June 2018.

¹⁴⁹ [Council conclusions on Healthy nutrition for children: The healthy future of Europe](#), 22 June 2018.

¹⁵⁰ [Council conclusions on The Economy of Wellbeing](#), 15 July 2019.

¹⁵¹ [Social Protection Committee](#), European Commission.

¹⁵² [Social Protection Committee annual report](#), November 2018. (For the 'Special focus on health', see pp. 52-59.)

¹⁵³ The Joint Assessment Framework in the area of health (JAF Health) currently includes 93 indicators divided into six areas: outcome; access; quality; non-healthcare determinants; resources; and socioeconomic.

¹⁵⁴ AT, BG, CZ, DK, EE, EL, FI, HR, HU, LT, LU, LV, NL, PL, PT, RO, SI, SK.

¹⁵⁵ SK, MT, BG, RO.

¹⁵⁶ A death can be considered as 'amenable' if all or most deaths from that cause could be avoided through optimal quality healthcare. It is 'preventable' if, in the light of understanding of the determinants of health at the time of death,

Member States.¹⁵⁷ 'Potential year of life lost'¹⁵⁸ scored below the EU average for eight Member States.¹⁵⁹

'Quality' area: 18 Member States face a key challenge in cancer screening and vaccination coverage for both children and adults. This concerns particularly child vaccination coverage, where nine Member States¹⁶⁰ perform worse than the average on one or more vaccines.

'Access' area: included in this area are health insurance coverage, number of doctor consultations, and self-reported unmet medical care needs. As the report explains, the variety of ways of organising a healthcare system can lead to results that differ in terms of accessibility and its key aspects of coverage; availability and affordability. The different healthcare systems in the EU can be classified into three types: universal, insurance-based and others (including atypical systems without comprehensive healthcare organisation). As far as financing healthcare expenditure is concerned, EU Member States can be divided into three groups: tax based, that is, mostly financed from government revenues (approximately one third of Member States); mostly financed by insurance contributions (around half of Member States); and mostly relying on out-of-pocket payments (three Member States). According to the report, in most of the Member States in which an access challenge was identified, this concerns the availability of human resources (that is, healthcare professionals) and the geographical distribution of healthcare.¹⁶¹ Seven Member States face challenges referring to healthcare coverage, and six with challenges regarding the affordability of care. Three Member States face challenges for all three aspects (see Table 1).

Table 1 – Challenges in access to healthcare identified by the Social Protection Committee¹⁶²

Member State	Coverage	Availability (human resources, geographical distribution)	Affordability
CZ, FR, HR, LU, SI, DK, ES			
EE, HU, PL, SK			
IT, LV, LT			
EL, BG, RO			

Source: Social Protection Committee [annual report](#) 2018, p. 56.

all or most deaths from that cause could be avoided by public health interventions in the broadest sense ([Eurostat Statistics Explained](#)).

¹⁵⁷ BG, EE, HR, HU, LT, LV, RO, SK.

¹⁵⁸ 'Potential years of life lost' is a summary measure of premature mortality. It provides an explicit way of weighting deaths occurring at younger ages, which may be preventable ([OECD Glossary of Statistical Terms](#)).

¹⁵⁹ BG, EE, LV, LT, HU, PL, RO, SK.

¹⁶⁰ BG, CY, DK, EE, FR, IT, LT, MT, RO.

¹⁶¹ It is argued that shortages of healthcare professionals in rural areas and islands reduce accessibility to healthcare services and thereby increase the population's unmet needs due to distance.

¹⁶² The table presents the results from the Joint Assessment Framework (JAF) Health [country analyses](#).

5.1.2. European Commission

Strategies, Commission staff working documents and communications

Adopted in 2007, the **EU health strategy 'Together for Health'**¹⁶³ sets out an overarching framework to give direction to Community activities in health. The strategy is based on a number of fundamental principles, and expressly states that values relating to improving health must include reducing inequities in health.¹⁶⁴

The 2009 Commission communication on **Solidarity in health: reducing health inequalities in the EU**¹⁶⁵ acknowledges that tackling health inequalities is a long-term process, and pleads for a collaborative approach in taking action. According to the communication, the EU can play an important role in raising awareness; promoting and assisting the exchange of information and knowledge between Member States; identifying and spreading good practices; facilitating the design of tailor-made policies for the specific issues prevailing in countries and/or special social groups; and monitoring and evaluating the progress in the application of such policies. The communication broaches the following key issues:

- an equitable distribution of health as part of overall economic and social development;
- improving the data and knowledge base and mechanisms for measuring, monitoring evaluation and reporting;
- building commitment across society;
- meeting the needs of vulnerable groups; and
- developing the contribution of EU policies, such as EU cohesion policy.

The **Europe 2020 strategy**,¹⁶⁶ adopted in 2010, acknowledges the need to combat poverty and social exclusion and reduce health inequalities as a prerequisite for growth. As one of the means to deliver on the strategy's target to lift 20 million people out of poverty and social exclusion by 2020, the Commission launched a European platform against poverty and social exclusion.¹⁶⁷

The Commission's 2013 staff working document on **Investing in Health**¹⁶⁸ argues that investing in reducing health inequalities breaks the vicious circle of poor health contributing to, and resulting from, poverty and exclusion. According to the document, a multisectoral approach focused on achieving greater gains in less advantaged groups is needed to close gaps. Key measures put forward in the paper include: to prioritise less advantaged groups in policies to improve the quality

Quote: Health inequalities can be dealt with through public policy

'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.'

Source: [Solidarity in health: Reducing health inequalities in the EU](#), COM(2009) 567 final.

¹⁶³ [White paper – Together for Health: A Strategic Approach for the EU 2008-2013](#), COM(2007) 630 final.

¹⁶⁴ *Ibid.*, p. 4.

¹⁶⁵ [Solidarity in health: Reducing health inequalities in the EU](#), COM(2009) 567 final.

¹⁶⁶ [Europe 2020 – A strategy for smart, sustainable and inclusive growth](#), COM(2010) 2020 final.

¹⁶⁷ [The European Platform against Poverty and Social Exclusion: A European framework for social and territorial cohesion](#), COM(2010) 758 final.

¹⁶⁸ [Investing in Health](#), SWD(2013) 043 final (document accompanying the communication [Towards Social Investment for Growth and Cohesion – including implementing the European Social Fund 2014-2020](#)).

of and access to health systems; address the underlying risk factors in health behaviours; and ensure adequate incomes and living and working conditions.

European Pillar of Social Rights

The European Commission, the European Parliament and the Council of the European Union jointly launched the European Pillar of Social Rights (or 'social pillar') in 2017. The social pillar aims to uphold 20 principles and rights, structured around three categories:

- equal opportunities and access to the labour market (Chapter I);
- fair working conditions (Chapter II);
- social protection and inclusion (Chapter III).

More specifically, Chapter III focuses on support for children; social protection for workers and the self-employed; unemployment benefits; minimum income; old-age pensions; the inclusion of people with disabilities; housing assistance for those in need; and access to essential services. Principles 16 and 18 focus explicitly on the right to access affordable, good-quality **healthcare** and long-time care. This underlines the EU's commitment to the UN's sustainable development goals, which call, inter alia, for universal health coverage for all, and strengthened inclusion and equity.

Source: [The European Pillar of Social Rights in 20 principles](#), European Commission; N. Milotay, [Social protection in the EU: State of play, challenges and options](#), EPRS, European Parliament, 2018.

A 2013 staff working document, **Report on health inequalities in the European Union**,¹⁶⁹ follows up on the 2009 Commission communication. It gives an overview of the size of health inequalities in the EU and describes the main actions the Commission has taken to implement its communication. The document concludes that, despite some progress, much more remains to be done to reduce poverty, close economic gaps, promote social inclusion and increase cohesion. Action is also needed on health-related behaviours. Particular attention should be paid to children and young people. The staff working document draws on the extensive analysis carried out by a consortium (led by Marmot).¹⁷⁰ The consortium's report demonstrates marked differences in the social determinants of health across EU Member States, and in inequalities in health between social groups based on these determinants. At a national level, the report finds that countries with lower levels of social protection also tend to have higher rates of (self-reported) bad or very bad health. The report mentions three primary dimensions to health inequalities that the EU is well placed to address: socioeconomic status; geographic inequalities; and health and its social determinants for groups subject to exclusion. According to the report, these aspects merit careful consideration in all policies that have an impact on health and its social determinants. Its suggestions include:

- The health sector needs to mainstream tackling health inequalities in its core policies.
- Further research and development of knowledge on effective policies and interventions is necessary, whereby monitoring, evaluation, implementation research and impact analysis of policy are crucial next steps.
- Further leadership and action at the Commission level should be considered to (re)stimulate action and build capacity to tackle health inequalities.
- The WHO European region review recommendations should be supported and taken forward by policy-makers at local, national and EU levels.

¹⁶⁹ [Report on Health Inequalities in the European Union](#), SWD(2013) 0328 final.

¹⁷⁰ [Report on health inequalities in the EU. Final report of a consortium](#), European Commission, 2013.

In its 2014 communication on **effective, accessible and resilient health systems**,¹⁷¹ the Commission mentions the common challenges that European health systems faced over the previous decade, including shortages and uneven distribution of health professionals; and health inequalities and inequities in access to healthcare. According to the communication, there is no detailed EU-wide methodology to monitor access to healthcare and promote best practice, and that developing this would be an important step in reducing health inequalities.

A comprehensive report¹⁷² from 2018 explores **inequalities in access to healthcare** in 35 European countries. It shows that, despite a general positive trend, important inequalities persist, both between and within countries. Vulnerable groups, in particular, face multiple barriers to access and therefore do not obtain the care they need. The main challenges, as identified in the report, include:

- inadequacy of the public resources invested in the health system;
- fragmented population coverage;
- gaps in the range of benefits covered;
- prohibitive user charges, in particular for medicines;
- lack of protection of vulnerable groups from user charges;
- lack of transparency on how waiting list priorities are set;
- inadequate availability of services, in particular in rural areas;
- problems with attracting and retaining healthcare professionals;
- difficulties in reaching particularly vulnerable groups (including the lowest income quintiles, women, ethnic minorities and migrants).

The report makes a series of recommendations to the 35 countries on: financing health systems; health coverage; user charges; availability of services; voluntary health insurance, initiatives targeting vulnerable groups (such as homeless people, drug addicts, ethnic minorities, Roma, asylum seekers and refugees). Recommendations at EU level include, inter alia the need to: develop a roadmap for the implementation of Principle 16¹⁷³ of the social pillar; use EU funding to improve access to healthcare; and strengthen the monitoring and reporting on inequalities in access to healthcare in the European

Health status of the Roma population

A 2014 study on behalf of the European Commission assesses the health situation of the Roma in 2008-2013, covering 31 countries (the EU-28 and EEA Member States). Despite some limitations in data availability and variation between countries, the study finds that the Roma in Europe generally:

- Suffer greater exposure to the wider – socioeconomic and environmental – determinants of ill health (including poor housing, lower education and higher unemployment);
- live less healthy lifestyles (a healthy diet and physical activities to stay healthy are less common, while smoking is more common among the Roma);
- have poorer access to (and lower uptake of) primary care and preventative health services;
- suffer higher rates of both infectious (including measles and hepatitis A) and chronic diseases (such as asthma, diabetes, cardiovascular disease and hypertension); and
- experience considerably lower life expectancy compared to non-Roma (up to 20 years less).

Roma women are in general more disadvantaged and in worse health than Roma men and non-Roma alike. Maternal health risks and pregnancy and childbirth complications are more common among Roma women. Roma women are also at higher risk of domestic violence and the mental health effects associated with it.

Source: [Roma health report](#), European Commission, 2014.

¹⁷¹ [On effective accessible and resilient health systems](#), COM(2014) 215 final.

¹⁷² [Inequalities in access to healthcare – A study of national policies](#), European Commission, 2018. [National reports](#) are also available.

¹⁷³ That is, the right to timely access to affordable, preventive and curative healthcare of good quality.

Semester process,¹⁷⁴ with the use of country reports and country-specific recommendations for those countries that are lagging behind.

Health programme, joint actions

The EU health programme,¹⁷⁵ managed by the European Commission's executive agency, Chafea, is a funding instrument designed to implement the EU health strategy.¹⁷⁶ It co-funds projects and joint actions. Both the first (2003-2007) and the second health programmes (2008-2013) promoted a number of strategic priorities to reduce health inequalities.¹⁷⁷ The current (third) programme for EU action in the field of health (2014-2020) has a budget of €449.4 million.¹⁷⁸ Its general objectives are to complement, support and add value to the policies of the Member States to improve the health of EU citizens and reduce health inequalities by promoting health, encouraging innovation in health, increasing the sustainability of health systems and protecting EU citizens from serious cross-border health threats.¹⁷⁹ The health programme's annual work plan 2019,¹⁸⁰ with a budgetary envelope of almost €64 million, focuses on four priority areas: country-specific and cross-country knowledge; cross-border health threats, preparedness and response, including antimicrobial resistance and vaccination; structural support for health systems and links to the digital single market; and promotion of health and prevention of non-communicable diseases. The dimension of health inequalities is addressed as a cross-cutting issue.

Under the second health programme, a **joint action on health inequalities ('Equity Action')** took place between 2011 and 2014. Its general objectives were to help to reduce health inequalities by: developing knowledge for action on health inequalities; supporting the engagement of Member States, regions and other stakeholders in tackling socioeconomic and geographic health inequalities; sharing learning between Member States and other actors; and supporting the development of effective action to address health inequalities at the European policy level.¹⁸¹ An output of the joint action is the European portal for action on health inequalities, developed by EuroHealthNet (more on this in [Section 6](#).)

Under the current health programme, a three-year **joint action on health inequalities ('Health Equity in Europe')** was launched in June 2018.¹⁸² It brings together 25 EU Member States plus Norway, Serbia, and Bosnia and Herzegovina, and has an estimated budget of €3.1 million (including the EU contribution of up to €2.5 million). The joint action aims to contribute to achieving greater equality in health outcomes for all social groups in the participating countries. A specific focus will be on migrants, since poor health and lack of access to health services can be an obstacle to integration.¹⁸³

¹⁷⁴ For further reading, see [The European Semester: why and how](#), European Commission.

¹⁷⁵ [What is the Health Programme?](#), Chafea/European Commission.

¹⁷⁶ [EU Health Programme](#), European Commission.

¹⁷⁷ [Action on health inequalities in the European Union](#), European Commission, 2014. This brochure presents the mapping of actions funded under the second health programme.

¹⁷⁸ For further reading, see also M. Parry and N. Scholz, [How the EU budget is spent: Health Programme](#), EPRS, European Parliament, 2015.

¹⁷⁹ [Regulation \(EU\) No 282/2014 on the establishment of a third Programme for the Union's action in the field of health \(2014-2020\)](#).

¹⁸⁰ [Work plan for 2019](#), European Commission.

¹⁸¹ [Joint Action on Health Inequalities \(Equity Action\)](#), Chafea/European Commission.

¹⁸² [Luxembourg: Joint Action on Health Inequalities kicks off, 21-22 June 2018](#), European Commission.

¹⁸³ [Joint Action Health Equity Europe \(JAHEE\)](#), Chafea/European Commission.

EU funds

The EU also supports action on health inequalities financially through various EU funds.

The **Fund for European Aid to the Most Deprived (FEAD)**¹⁸⁴ enables the EU to support policies and measures pursued by the Member States to alleviate the worst forms of poverty. It provides food support; material assistance; accompanying measures, such as advice and guidance; and social inclusion activities. The EU contribution to the FEAD is more than €3.8 billion for 2014-2020. In addition, Member States are to co-finance at least 15 % of the costs of their national operational programmes (around €674 million), bringing the total resources channelled through the fund to approximately €4.5 billion.¹⁸⁵ According to the FEAD mid-term evaluation, support has reached more than 12 million people per year, in particular families with children at risk of poverty, older people with limited income, the homeless, people with disabilities, and people who are often not reached by public services, such as migrants.¹⁸⁶ A June 2019 report on the implementation of the FEAD shows that 97 % of those receiving the support think that it made a difference.¹⁸⁷

The **European Social Fund (ESF)**¹⁸⁸ is the EU's main instrument to combat poverty and social exclusion. It provides funding to co-finance actions aimed at helping people access the labour market, and at improving the situation of the most vulnerable. For the 2014-2020 period, €80 billion is earmarked for investment.¹⁸⁹ Two of the priorities of the ESF activities to promote social inclusion are: 'fighting marginalisation' among groups of people that regularly encounter discrimination and prejudice, such as immigrant communities, itinerant travellers, and the Roma; and 'inclusive approaches' for groups that face discrimination in finding work, and in the workplace, including women, older workers, minorities, and immigrants.¹⁹⁰ In May 2018, the European Commission adopted a proposal for an **ESF+**, with a provisional budget of €101.2 billion in current prices for 2021-2027.¹⁹¹ The ESF+ will concentrate investment in three main areas: education, employment and social inclusion, which includes addressing health inequalities. It will be the main financial instrument to strengthen Europe's social dimension, and will incorporate the FEAD and other components, such as the EU health programme.¹⁹²

Horizon 2020

Health research can help address mechanisms that reduce health inequalities.¹⁹³ The EU's framework programme for research and innovation, Horizon 2020, offers possibilities for doing so.¹⁹⁴ Examples of current Horizon 2020 projects in the area of social determinants and health inequalities include: PIDS – Population level interventions to improve diet and reduce social inequality (EU contribution: around €1.4 million);¹⁹⁵ LIFEINEQ – Lifespan inequalities: Why the age-at-death distribution varies between countries and socioeconomic groups (EU contribution: around €1.5

¹⁸⁴ [Fund for European Aid to the Most Deprived \(FEAD\)](#), European Commission.

¹⁸⁵ M. Lecerf, [European Fund for the Most Deprived](#), EPRS, European Parliament, April 2019.

¹⁸⁶ [Publication of the FEAD mid-term evaluation](#), European Commission.

¹⁸⁷ [New FEAD report demonstrates support makes a difference to daily lives of people](#), European Commission, 7 June 2019.

¹⁸⁸ [European Social Fund](#), European Commission.

¹⁸⁹ [ESF budget by country: 2014-2020](#), European Social Fund.

¹⁹⁰ See project examples of [fighting marginalisation](#) and [inclusive approaches](#), European Social Fund.

¹⁹¹ See M. Lecerf, [European Social Fund Plus \(ESF+\) 2021-2027](#), EPRS, European Parliament, March 2019.

¹⁹² [A new, stronger European Social Fund Plus](#), European Social Fund.

¹⁹³ [Building the future of health research. Proposal for a European Council for Health Research](#), Scientific Panel for Health (SPH), May 2018.

¹⁹⁴ [Horizon 2020](#), European Commission.

¹⁹⁵ [PIDS](#), CORDIS database, European Commission.

million);¹⁹⁶ and FAMSIZEMATTERS – Family size matters: How low fertility affects the (re)production of social inequalities (EU contribution: €1.9 million).¹⁹⁷

In June 2018, the Commission presented its proposal for the next EU research and innovation programme, Horizon Europe,¹⁹⁸ which would have a revamped structure with a mission-oriented approach. Activities would be organised in five clusters. The health cluster would include two areas of intervention with relevance for tackling health inequalities. The first area, 'health throughout the life course', would allow reduced health inequalities and improved health outcomes to the benefit of active and healthy ageing. The second area of intervention would be 'environmental and social health determinants'. Through improved understanding of health drivers and risk factors determined by the social, cultural, economic and physical environment in people's everyday life, it would, inter alia, contribute to promoting healthy lifestyles and consumption behaviours, and to developing an equitable, inclusive and trusted society.¹⁹⁹ Parliament and Council have reached a partial agreement on the Horizon Europe proposal; it was endorsed by Parliament in April 2019.²⁰⁰

Expert Group on Social Determinants of Health Inequalities

The Expert Group on Social Determinants and Health Inequalities was set up with a three-fold mission to provide a forum for the exchange of information and good practice between Member States; act as an interface between policies, projects and activities at the EU and national levels; and give guidance on the need for further action and joint work and research in this area.²⁰¹ According to the Commission website, its last meeting took place in March 2017.²⁰² Agenda items included, among other things, an update on recent developments related to health inequalities; promoting healthy urban development and housing conditions for reducing health inequalities; and the preparation of the current joint action on health inequalities (discussed further up in this section).

5.1.3. European Parliament

Addressing the social determinants of health and reducing health inequalities in its many dimensions has long formed an integral part of Parliament's work. It has done so by various means.

Resolutions

In its 2011 **resolution on reducing health inequalities**,²⁰³ Parliament stresses that health inequalities are rooted in social inequalities in terms of living conditions and models of social behaviour linked to gender, race, educational standards, employment and the unequal distribution of income and medical assistance, sickness prevention and health promotion services. It underlines the importance of improving access to such services and reducing the inequalities between different social and age groups. Parliament asks the Commission to assist Member States in making better use of EU cohesion policy and structural funds to support projects that target inequalities in health, and to draw up guidelines to improve the monitoring of health inequalities both between

¹⁹⁶ [LIFEINEQ](#), CORDIS database, European Commission.

¹⁹⁷ [FAMSIZEMATTERS](#), CORDIS database, European Commission.

¹⁹⁸ [Proposal for a regulation establishing Horizon Europe – the Framework Programme for Research and Innovation, laying down its rules for participation and dissemination](#), COM(2018) 435 final.

¹⁹⁹ [European Parliament legislative resolution](#) of 17 April 2019 on the proposal for a decision of the European Parliament and of the Council on establishing the specific programme implementing Horizon Europe – the Framework Programme for Research and Innovation.

²⁰⁰ For more information, see C. Karakas, [Establishing and implementing Horizon Europe](#), EPRS, European Parliament, April 2019.

²⁰¹ [Expert Group on Social Determinants and Health Inequalities \(E02674\)](#), Register of Commission Expert Groups.

²⁰² [EU Expert Group on Social Determinants and Health Inequalities](#), European Commission.

²⁰³ [Resolution on reducing health inequalities in the EU](#), European Parliament, 8 March 2011.

and within Member States. Moreover, Parliament calls on the Commission, the Member States and/or the Council to ensure that the most vulnerable groups have equitable access to healthcare without discrimination; to develop a common set of indicators to monitor health inequalities by age, sex, socioeconomic status and geographic location; and to solve problems of inequality in access to healthcare that affect people's everyday lives, for example, in dentistry and ophthalmology. Moreover, Parliament encourages the Member States to develop partnerships in border regions in order to share the cost of infrastructure and personnel and reduce inequalities with regard to health.

In its 2017 **resolution on combating inequalities as a lever to boost job creation and growth**,²⁰⁴ Parliament recognises that multiple inequalities in access to work and within work create a risk for individuals' health and wellbeing. It acknowledges that societies with greater income inequalities have, among other things, higher rates of poor health and higher obesity rates; that more equal societies incur less welfare expenditure for the state; and that inequalities throughout the life-cycle are reflected in inequalities in old age, such as lower healthy life expectancy, old-age poverty, and a gender pension gap of almost 40 %. Parliament encourages the Member States to improve their welfare systems on a basis of high-level social safeguards, taking the new social risks and vulnerable groups that have appeared as a result of the (financial, economic and then social) crises into account. It calls on the Commission to encourage reform of Member States' taxation policies, to ensure adequate public budgets for health, housing, social, employment, and education services.

In its 2018 **resolution on vaccine hesitancy**,²⁰⁵ Parliament is concerned that the wide variation in vaccination coverage exacerbates health inequalities between Member States and undermines efforts to reduce and eliminate preventable diseases. It is also concerned about the high prices and wide variations in the price of some vaccines, which risk further aggravating health inequalities. Parliament calls on the Commission, among other things, to facilitate a more harmonised vaccination schedule across the EU, to ensure even coverage across Europe, and to reduce health inequalities.

In its October 2019 **resolution on employment and social policies of the euro area**,²⁰⁶ Parliament emphasises the importance of healthcare services in combating poverty and social exclusion, and calls on the Member States to invest in prevention as a health policy priority.

Pilot projects

In the area of health inequalities, Parliament has funded several pilot projects implemented by the Commission to test the feasibility and usefulness of an action. They are considered important tools for developing evidence-based strategies to address a problem, identify good practices, and provide policy guidance for possible future initiatives.²⁰⁷ Three are outlined briefly below.

VulnerABLE (2015-2017) explored ways to improve the health of people living in vulnerable and isolated situations across Europe. Due to their circumstances, these groups may be at a greater risk of poor health, and may also face barriers in accessing healthcare services. The project focused, in particular, on: children and families from disadvantaged backgrounds; people living in rural/isolated areas; those with physical, mental and learning disabilities or poor mental health; the long-term unemployed; the inactive; those from lower income brackets ('in-work poor'); older people; victims

²⁰⁴ [Resolution on combating inequalities as a lever to boost job creation and growth](#), European Parliament, 16 November 2017.

²⁰⁵ [Resolution on vaccine hesitancy and the drop in vaccination rates in Europe](#), European Parliament, 19 April 2018.

²⁰⁶ [Resolution on employment and social policies of the euro area](#), European Parliament, 10 October 2019.

²⁰⁷ [Pilot projects funded by the European Parliament](#), European Commission.

of domestic violence; people with unstable housing situations (the homeless); and prisoners.²⁰⁸ The project recommended specific actions per target group.²⁰⁹ The main findings include:

- Although population health indicators have been improving, widespread inequalities in health and access to healthcare remain, within and between Member States.
- Unlike life expectancy, healthy life years have remained fairly stable for both sexes.
- The prevalence of ill health also varies across Member States.
- Despite EU support for equal access to healthcare, people continue to report having unmet healthcare needs.²¹⁰

Health4LGBTI, implemented between 2016 and 2018, set out to better understand how best to reduce specific health inequalities experienced by lesbian, gay, bisexual, trans and intersex (LGBTI) people. It focused on overlapping inequalities stemming from discrimination and unfair treatment on other grounds (such as age, status or income).²¹¹ The project explored the particular health challenges faced by LGBTI people and analysed the barriers experienced by health professionals when providing care. The aim was to raise awareness and provide health professionals with the tools, skills and knowledge needed to overcome the hurdles. According to the findings, the inequalities identified are avoidable and may be reduced through health services, and appropriate, mandatory training for health professionals across all Member States' health systems is an important step forward.²¹² Project outputs include a training course for healthcare professionals.²¹³

The **Health Equity Pilot Project (HEPP)** was implemented between 2016 and 2018, with funding of almost €1.5 million from the European Parliament. The aim of the project was to provide further solutions to reducing health inequalities in the EU by supporting knowledge sharing and policy development. The project focused on lifestyle-related determinants, such as alcohol consumption, diet and physical activity.²¹⁴ The project outputs included 28 individual country fiches²¹⁵ with profiles of socioeconomic inequalities in the three areas, and two policy briefs.²¹⁶ These outline the problem and propose concrete solutions along the following general lines:

- High-level policies:
 - Address health inequalities and their causes as part of a shared responsibility across government organisations and sectors;
 - Strengthen cross-government platforms to develop a consensus on the scope and action needed.
- Practical action:

²⁰⁸ [VulnerABLE: Improving the health of those in isolated and vulnerable situations](#), European Commission.

²⁰⁹ Ibid., [Policy Guidance](#), Findings per target group, pp. 26-36.

²¹⁰ Ibid., [Scientific Report](#) Section 4.2 – synopsis of findings, pp. 164-186.

²¹¹ [Health4LGBTI: Reducing health inequalities experienced by LGBTI people](#), European Commission.

²¹² Ibid., [State-of-the-Art Synthesis Report](#), 4.3. Conclusions, pp. 57-59.

²¹³ Ibid., [Trainers' Manual](#) and other resource materials.

²¹⁴ [HEPP – Maintaining a focus on health inequalities](#), European Commission.

²¹⁵ Ibid., [HEPP – EU Countries fiches](#).

²¹⁶ Ibid., policy briefs on interventions to reduce socio-economic inequalities in [health-harming alcohol consumption](#) and [diet and physical activity](#), 2018.

- Behavioural interventions;
- Environmental, legislative and fiscal measures;
- To ensure the equitable impact of interventions;
- Implement known good practice, for instance, by convening cross-government meeting on behaviours and learning from case studies.²¹⁷

More specifically, the brief on **alcohol consumption** broaches the problem of the 'alcohol harm paradox'. In many EU countries, people in lower socioeconomic groups are at higher risk of alcohol-related morbidity and mortality (that is, suffer greater health-related harm from alcohol consumption) than people in higher socioeconomic groups.²¹⁸ This occurs notwithstanding the fact that, in general, people in lower socioeconomic groups report consuming equivalent or even less alcohol than those in higher socioeconomic groups. According to the policy brief on **diet and physical activity**, the problem is that in many EU countries, people in lower socioeconomic groups eat less healthy diets than those in higher socioeconomic groups, and are less likely to engage in non-work related physical activity. This contributes to their poorer general wellbeing and early mortality rate.²¹⁹ Those aspects of diet and physical activity that lead to health inequalities mainly result from the social and economic conditions that people experience throughout their lives. The brief argues that, addressing the causes of health inequalities is not only a question of fairness and social justice, but will also contribute to the economic and social development of society, as well as its cohesion. It will also increase the age to which more people are able to remain economically active.

5.1.4. European-level data and indicators

Eurostat, the European Commission statistical office, is the main source of EU health data.²²⁰ Eurostat's health statistics consist of administrative data, such as cause of death statistics, and self-reported data derived from health or social surveys, such as the European health interview survey (EHIS) or the EU statistics on income and living conditions (EU-SILC) framework.²²¹ Eurostat data cover the following main topics: health status and health determinants; healthcare; disability; causes of death; and health and safety at work. More specifically, the data on health status and health determinants focus on various aspects of population health (healthy life years, self-perceived health and wellbeing, absence from work due to health problems, etc.), as well as health behaviours (including, for instance, body mass index, physical activity, consumption of fruits and vegetables, tobacco consumption, alcohol consumption, and social environment). The data enable an analysis of public health issues as well as demographic and socioeconomic patterns and disparities in health, and provide a tool for monitoring the effects of health policies.²²² They also serve in calculating health indicators,²²³ such as the European Core Health Indicators (ECHI),²²⁴ which can be useful for determining policy priorities. The ECHI cover five chapters: demographic and socioeconomic

²¹⁷ Ibid., HEPP – [Policy Brief on interventions to reduce socio-economic inequalities in health-harming alcohol consumption](#), 2018, and HEPP – [Policy Brief on interventions to reduce socio-economic inequalities in diet and physical activity](#), 2018.

²¹⁸ For example, they have a greater risk of liver cirrhosis, cancers, neuropsychiatric conditions and injuries. Harmful alcohol use can also impact negatively on other parties, through injuries, neglect and [foetal alcohol spectrum disorders](#).

²¹⁹ Due to the fact that they are, for instance, at greater risk of obesity, diabetes, cardiovascular disease, cancer and stroke.

²²⁰ [Health – Overview](#), Eurostat.

²²¹ [Glossary: EU-SILC](#) and [Glossary: EHIS](#), Eurostat.

²²² [Information on data: Health status and health determinants](#), Eurostat.

²²³ According to the Commission, [indicators](#) are quantitative or qualitative measures that help analyse and compare performance across population groups or geographic areas.

²²⁴ [European Core Health Indicators \(ECHI\)](#), European Commission. See, in particular, the interactive [ECHI data tool](#).

factors; health status; determinants of health; health services; and health promotion. Other sources of EU health data are the 'Special Eurobarometer' surveys on European's attitudes towards specific health-related topics,²²⁵ and the European Commission's Joint Research Centre's²²⁶ European Cancer Information System (ECIS).

5.2. Consultative committees

The two EU consultative committees have conducted work and delivered opinions on issues related to combating health inequalities.

5.2.1. European Committee of the Regions

Within the European Committee of the Regions (CoR), the Interregional Group on Health and Well-being,²²⁷ set up in 2010, serves as a platform for the exchange of views on policy issues related to healthcare and public health among local and regional authorities in the Member States and beyond. The European Regional and Local Health Authorities (EUREGHA, see text box) provides the secretariat to the group. The CoR's March 2017 opinion on the integration, cooperation and performance of health systems²²⁸ focuses on some of the challenges that the health systems in the EU are facing. These include large disparities in health and access to healthcare, often due to socioeconomic and geographical factors, that continue to exist between and within Member States and regions. In its opinion, the CoR agrees on the need to improve European health systems, and calls for greater integration between them to bridge the health gap and to improve health outcomes by guaranteeing equal access to quality healthcare everywhere in the EU.

Local and regional authorities in health equity

The European Regional and Local Health Authorities (EUREGHA) network brings health authorities together as a means to improve health policy. In its 2015 'Health for all' position paper, EUREGHA underlines the key role of local and regional authorities in creating and implementing policies to tackle health inequalities. It stresses the need for a whole-of-government approach to health equity, and the mandatory inclusion of all levels of governance. In its recent position paper on the future of health in Europe beyond 2020, 'Health in all regions', EUREGHA affirms the need to strengthen the multilevel government approach in health by creating new strategic partnerships with civil society, academia and the industry. EUREGHA considers that such partnerships should join forces to tackle health inequalities, since reducing such inequalities requires coordination among European, national and regional policy-makers. According to EUREGHA, sub-national authorities have a vital supportive role to play in achieving the UN Sustainable Development Goals.

Source: EUREGHA's [2015](#) and [2018](#) position papers.

5.2.2. European Economic and Social Committee

The European Economic and Social Committee (EESC) has a long-standing focus on the Roma people, and in particular, Roma women. An October 2018 hearing organised by the EESC focused on the situation of the Roma in relation to health and their access to healthcare. The stock-taking included: discrimination in access to healthcare; differences in life expectancy between Roma and non-Roma people; and poverty and its effects on health. Participants assessed, in particular, the situation of women and children, and raised issues such as: forced sterilisations;²²⁹ pregnancy, infant

²²⁵ [Eurobarometers Public Health](#), European Commission.

²²⁶ [ECIS – European Cancer Information System](#), European Commission.

²²⁷ [CoR Interregional Group on Health and Well-being](#), EUREGHA.

²²⁸ [Integration, cooperation and performance of health systems](#), CoR, 2016.

²²⁹ See also L. Orton et al., '[Roma populations and health inequalities: a new perspective](#)', *International Journal of Human Rights in Healthcare*, Vol. 12, No. 5, November 2019, pp. 319-327.

and maternal mortality; and the vaccination of children.²³⁰ In its December 2018 exploratory opinion,²³¹ the EESC stresses that Roma women are the most vulnerable minority group in the EU, and that ameliorating their situation is a key duty and obligation for European democracies. The EESC makes recommendations in specific areas, namely: education as a neutraliser of segregation; ensuring healthcare; opening up the labour market to fight social exclusion; and greater legal protection.²³²

5.3. EU agencies

Decentralised EU agencies have a major role to play in combating health inequalities. The contribution of two of the agencies is outlined below.

5.3.1. European Centre for Disease Prevention and Control

The European Centre for Disease Prevention and Control (ECDC)²³³ aims at strengthening Europe's defences against infectious diseases. As part of the EU's efforts to reduce inequalities in health, the ECDC addresses inequalities in health in relation to infectious diseases, given that socioeconomic factors play a role in the distribution of these diseases.²³⁴ The ECDC works with the Member States to specifically target vulnerable and underserved populations. One priority group are migrants, who may be confronted with numerous challenges that impact on their health,²³⁵ including stigma and discrimination, as well as a perceived lack of access to information and services. The ECDC has issued migrant screening and vaccination guidance, and handbooks and assessment tools to improve preparedness and surveillance in migrant reception centres.²³⁶ Another priority group for the ECDC are the Roma, who are more likely to be exposed to agents that cause infectious diseases; more vulnerable to becoming ill if exposed; and, once sick, are less likely to have access to healthcare. Other areas of ECDC study include vulnerabilities, such as unemployment, homelessness or injected drugs use, and examining the extent to which they are linked to the transmission of infectious diseases.

5.3.2. European Foundation for the Improvement of Living and Working Conditions

The European Foundation for the Improvement of Living and Working Conditions (Eurofound) provides knowledge to assist in developing better social, employment and work-related policies.²³⁷ One of its core areas is working conditions and sustainable work. Eurofound's expertise covers a wide range of aspects, such as work-life balance, workplace health, training and skills, and job satisfaction. The links between work and health are explored in collaboration with the European Agency for Safety and Health at Work (EU-OSHA).²³⁸ Eurofound's contribution to addressing the social determinants of health include the European Working Conditions Survey (EWCS), currently in its sixth edition (2015), which depicts the European work landscape across countries, occupations, sectors and age groups; and the European Quality of Life Survey (EQLS), which covers such topics as

²³⁰ [The situation of Roma people in relation to health and their access to healthcare is still dire, EESC hearing reveals](#), EESC, 2018.

²³¹ [The situation of Roma women \(Exploratory opinion from the European Parliament\)](#), EESC, 2018.

²³² [Addressing the situation of Roma women is a key duty for European democracies, says the EESC](#), EESC, 2019.

²³³ [Health inequality](#), ECDC.

²³⁴ [About ECDC](#), ECDC.

²³⁵ For further reading, see N. Scholz, [The public health dimension of the migrant crisis](#), EPRS, European Parliament, 2016.

²³⁶ [Public health area: migrant health](#), ECDC.

²³⁷ [What we do](#), Eurofound.

²³⁸ [What we do](#), EU-OSHA.

subjective wellbeing, health and access to healthcare.²³⁹ Eurofound's ongoing work concerns gender equality at work; and the working conditions of workers of foreign background.

6. Stakeholders' views in the health inequalities debate

This section aims to provide a flavour of the debate by shining a light on selected stakeholders from academia, non-governmental organisations, the healthcare community and industry. It is not intended to be an exhaustive account of all views.

The **European Federation of Academies of Sciences and Humanities (ALLEA) and the Federation of European Academies of Medicine (FEAM)** held an interdisciplinary symposium on health inequalities in May 2018 in Amsterdam. According to the symposium report,²⁴⁰ effective policy-making requires a proper understanding of what drives inequalities. There is, however, uncertainty and controversy about the extent to which the relationship between socioeconomic position and health reflects causation (socioeconomic position influences health), reverse causation (health influences socioeconomic position) or confounding (by factors that affect both socioeconomic position and health). The symposium found that the topic calls for further multidisciplinary discussion if common policy recommendations are to be developed for regulators. Participants agreed that it is vital to use the best available evidence to inform public policy now; at the same time, they expressed their commitment to perform robust research to fill knowledge gaps.

The **European Federation of Pharmaceutical Industries and Associations (EFPIA)** recognises that health outcomes for such common diseases as cancer, heart failure and diabetes vary considerably between and within EU countries. According to EFPIA, standardised and comparable outcomes data to analyse sufficiently what interventions bring in terms of benefits to patients are lacking. Measuring outcomes, and sharing best practices and implementing them, would help reduce health inequalities and ultimately enable more efficient and effective healthcare systems.²⁴¹ The EFPIA calls for more integrated health services, and for the EU to drive the evolution towards patient-centred and outcomes-focused healthcare by assessing and benchmarking EU health systems through patient-relevant outcomes data.²⁴²

The **European Observatory on Health Systems and Policy**, hosted by WHO/Europe, is a partnership between research centres, governments and international organisations, including the European Commission. It analyses health systems and policy trends in support of evidence-based policy-making, and issues a wide range of publications.²⁴³ A 2014 report²⁴⁴ argues that the EU has made some progress in addressing key social determinants such as working conditions, but that the impact of wider social inequalities on health remains. According to the report, this is due to a 'clear preference by national governments to address social issues domestically rather than at European level'. With regard to addressing the behavioural determinants of health, the observatory considers that it was most strongly focused on smoking, while for diet and exercise, as well as alcohol, 'European action has been limited to providing information and leaving choices to individuals'. In

²³⁹ [Health and well-being at work](#), Eurofound.

²⁴⁰ [Health Inequalities – An interdisciplinary exploration of socioeconomic position, health and causality](#), ALLEA/FEAM, 2018.

²⁴¹ [Value Based Health Care \(VBH\) Outcomes Workshop: A Health Systems Approach](#), EPFIA, November 2018.

²⁴² [Measure what matters – why the EU should support the standardisation of health outcomes measurements](#), EPFA, October 2018.

²⁴³ [About us](#), European Observatory on Health Systems and Policies.

²⁴⁴ S. L. Greer et al., [Everything you always wanted to know about European Union health policies but were afraid to ask](#), Observatory Studies Series 34, European Observatory on Health Systems and Policy, 2014.

an article in the Eurohealth quarterly,²⁴⁵ dedicated to reducing inequalities in health and healthcare, Mackenbach asserts that, despite some progress, health inequalities remain unacceptably wide. He argues that, while evidence on the effectiveness of policies and interventions to reduce health inequalities is accumulating, 'the political will to implement these policies, and to allocate the resources necessary to achieve population-level effects is often lacking'.

EuroHealthNet, a not-for-profit partnership of public bodies working from local to regional, national, and international levels across Europe for improving health, equity and wellbeing, hosts the **European portal for action on health inequalities**.²⁴⁶ The portal was developed on behalf of the EU-funded joint action on health inequalities, 'Equity Action', as a comprehensive source of knowledge-sharing, and comprises three searchable databases:²⁴⁷ one with examples of projects implemented at EU, national, regional or local level; a publications database; and a database with examples of policy responses (that is, any strategy, policy, framework or other kind of programme or action led by a governmental authority). For EuroHealthNet, action to reduce health inequalities means taking a holistic approach, going beyond the health sector, and tackling those factors that can be dealt with through public policy, for instance, through the European Semester, the European Pillar of Social Rights and EU funding mechanisms.²⁴⁸

The **European Patients' Forum (EPF)**, an umbrella organisation that works with patients' groups in public health and health advocacy across Europe,²⁴⁹ considers it crucial to raise awareness of the barriers patients face in accessing healthcare. According to the EPF, great disparities in healthcare between and within Member States, including the high reliance on out-of-pocket payments, are still major concerns for patients across Europe.

The **European Public Health Alliance (EPHA)** argues that the concept of universal healthcare coverage 'holds the potential to remove some of the most common barriers to accessing care, and to lay a foundation for tackling more complex inequalities within the health system'. According to the EPHA, universal healthcare coverage affects vulnerable and marginalised groups and particular geographical regions disproportionately. It thereby reflects the broader health and socioeconomic inequalities that exist between and within Member States, which makes it both an important indicator and a valuable lever to fight inequality.²⁵⁰ In its recommendations, the EPHA asks the EU to place universal healthcare coverage at the centre of its Sustainable Development Goals strategy; to adopt consistent, coherent and relevant indicators; to integrate monitoring into the European Semester; and to mobilise EU funding for the pursuit of universal healthcare coverage. It asks the Commission to, among other things, include prioritising a coordinated approach to addressing the social determinants of health in all policies.²⁵¹ Commenting on the EU framework for national Roma integration strategies up to 2020, the EPHA considers that, despite its shortcomings, the framework has the potential to change the lives of Roma, and that one way to do this would be for the national strategies to be binding on Member States.²⁵²

²⁴⁵ [Eurohealth incorporating Euro Observer](#), Vol. 21, No.1, 2015.

²⁴⁶ [European portal for action on health inequalities](#), EuroHealthNet.

²⁴⁷ [Project database](#), [publications database](#) and [policy database](#), EuroHealthNet.

²⁴⁸ [The European Semester 2018 from a health equity perspective](#), EuroHealthNet, 2018.

²⁴⁹ [World Health Day: European patients' organisations speak out on Universal Health Coverage](#), European Patient Forum, 7 April 2019.

²⁵⁰ [Universal Health Coverage and the Pillar of Social Rights: Prioritising Inequality in EU Policy Frameworks](#), European Public Health Alliance, October 2017.

²⁵¹ S. Marschang, [Ensuring that 'Nobody gets left outside'](#), European Public Health Alliance, 2 December 2019.

²⁵² M. Tudor, [As the NRIS reaches its half-way point, what next for the EU Roma framework?](#), European Public Health Alliance, 31 January 2019.

Health First Europe, a not-for-profit alliance of patients, healthcare workers, academics, healthcare experts and the medical technology industry, argues that investment towards reducing health inequalities contributes to social cohesion, and breaks the vicious spiral of poor health contributing to, and resulting from, poverty and exclusion.²⁵³ According to Health First Europe, the EU institutions' focus in the coming years should be on delivering patient-centred, high quality care to all citizens.

The **Standing Committee of European Doctors (CPME)** believes that inequalities in access to healthcare and healthy choices are not only socially unjust, but morally wrong.²⁵⁴ Apart from raising awareness for the social determinants of health and calling for action to tackle the social gradient, the CPME also addresses the situation of the most vulnerable groups, in particular undocumented migrants. The CPME cooperates with Médecins du Monde²⁵⁵ and is a co-signatory of the European Declaration of Health Professionals Towards Non-Discriminatory Access to Healthcare.²⁵⁶

7. Outlook

As points of reference for the future, several topics emerge. By way of example, findings from the HEPP pilot project (see [Section 5.1.3.](#)) suggest that there is an urgent need for **improved data** to describe the socioeconomic distribution of diet, physical activity across Europe, and an ongoing need for evidence of the effectiveness of interventions to tackle health behaviours.²⁵⁷ Researchers argue that **measurement and regular reporting** of health inequality indicators is an essential first step towards action,²⁵⁸ and have pointed to the need for **more comparative data** and more systematic **cross-national comparisons**.²⁵⁹ The EU Health Coalition, a multi-stakeholder initiative looking at the future of European healthcare, has made recommendations in this sense. For instance, it has asked the EU institutions, together with patient organisations and other healthcare stakeholders, to help implement **standardised measurements of health outcomes** and healthy life years; to strengthen the **collaboration of public and private sectors in health research**; and to establish a European health data institute to produce a range of health data to inform the work of policy-makers, researchers, industry and healthcare providers.²⁶⁰ The **joint action on health information (InfAct)**,²⁶¹ launched in March 2018, may well be a milestone on this path. It builds towards a sustainable infrastructure on EU health information by improving the availability of comparable, robust and policy-relevant health data and information.²⁶²

The role of **dedicated research in enabling health equality** in Europe has also been highlighted. For instance, a May 2019 workshop, hosted by the European Commission, explored the future of health research in a connected and participative society, where citizens and patients are mobilised

²⁵³ [Road Map 2020: For quality care in Europe](#), Health First Europe.

²⁵⁴ [Health Inequalities](#) and [Statement on health inequalities](#), CPME, 2011.

²⁵⁵ For further reading, see also [Left behind: The state of universal healthcare coverage in Europe](#), 2019 Observatory Report, Médecins du Monde, 2019.

²⁵⁶ [Position paper on Access to health care for undocumented migrants](#), CPME, 2008.

²⁵⁷ [HEPP – Scientific report](#), Conclusions, pp. 19-20.

²⁵⁸ [Reducing health inequalities in the European Union](#), European Commission, 2010.

²⁵⁹ T. A. Eikemo et al., 'The First Pan-European Sociological Health Inequalities Survey of the General Population: The European Social Survey Rotating Module on the Social Determinants of Health', *European Sociological Review*, Vol. 33, Issue 1, February 2017, pp. 137-153.

²⁶⁰ [EU Health Coalition: A shared vision for health](#), EU Health Coalition.

²⁶¹ [InfAct– Joint Action on Health Information](#).

²⁶² [Indicators and Data](#), European Commission.

and involved, research projects are co-designed with all stakeholders, and impact is better communicated.²⁶³ Moreover, the Commission's contribution to the future of Europe stresses the need to support high quality, affordable and accessible healthcare through the **digital transformation of health systems**.²⁶⁴ The Commission proposes to support this transformation with innovative solutions involving digital tools for **people-centre care**.²⁶⁵ This form of healthcare implies a stronger orientation towards the needs of people and their involvement in treatment and decision-making, and is expected to result in less inequality.

Tackling inequalities in health is thought to require a **broader understanding** of the social determinants of health inequalities, so developing **knowledge** on effective policies and interventions is necessary. This understanding needs to encompass the insight that high levels of inequalities are **undermining societal and economic progress**, and that only **clear political will and commitment** will tackle them effectively.²⁶⁶ In this context, an April 2019 European Parliament study on mapping the cost of non-Europe²⁶⁷ draws attention to the **considerable economic costs of health inequalities**, both between and within Member States. The potential efficiency gain for the European economy from EU action to reduce health inequalities could be up to €72 billion per year (based on the estimated annual monetary value related to health discrepancies, due to education inequalities, across the EU Member States).

Furthermore, creating healthy societies and overcoming inequalities in health is commonly held to require **synergies** between different stakeholders and policies at EU and Member States level. The Commission's Expert Panel on effective ways of investing in health²⁶⁸ argues, for instance, that reducing inequalities requires **acknowledgement of the importance of cross-sectoral policies** in particular groups, which need concerted solutions. According to the Expert Panel, explicit consideration of health in all policies could also help. The intersectoral initiative, All Policies for a Healthy Europe (AP4HE),²⁶⁹ which is focused on addressing the economic, social, environmental, commercial and political determinants of health and wellbeing, argues that EU action on health and wellbeing should be guided by strong equity principles. AP4HE, as well as the EU Health Coalition, is asking that the EU institutions make greater efforts to support **cross- and inter-sectoral action on health**, stressing that mechanisms that facilitate **multi-level-cooperation**, such as multi-stakeholder partnerships with regions and cities, would contribute to further tackling the health inequalities that persist in Europe.

²⁶³ [Enabling health equality in Europe – the role of health research](#), European Commission, 6 May 2019.

²⁶⁴ [Europe in May 2019. Preparing for a more united, stronger and more democratic Union in an increasingly uncertain world](#), European Commission, 9 May 2019.

²⁶⁵ [Horizon 2020 – Work programme 2018-2020: Health, demographic change and wellbeing](#), European Commission.

²⁶⁶ [Report on health inequalities in the EU. Final report of a consortium](#), European Commission, 2013.

²⁶⁷ [Europe's two trillion euro dividend: Mapping the Cost of Non-Europe, 2019-24](#), EPRS, European Parliament, April 2019.

²⁶⁸ [Expert Panel's reflection on priorities for the future of healthcare in the EU](#), EXPH, April 2019.

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Tackling socially determined inequalities in health, both between and within European Union (EU) Member States, is still a major challenge. This analysis describes the main concepts and gives examples for health inequalities across the EU. It then presents an overview of the work accomplished at international and EU levels. It shows, in particular, how the EU institutions, bodies and agencies have contributed to reducing health inequalities, notwithstanding that Member States have the main responsibility for health policy. The analysis then goes on to depict stakeholder views, before closing with an outlook on avenues for further action.

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