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Reducing health inequalities

European Parliament resolution of 8 March 2011 on reducing health inequalities in the EU (2010/2089(INI))

The European Parliament,

– having regard to Articles 168 and 184 of the Treaty on the Functioning of the European Union,

– having regard to Article 2 of the Treaty on European Union,

– having regard to Article 35 of the Charter of Fundamental Rights of the European Union,

– having regard to Article 23 of the Charter of Fundamental Rights of the European Union, which deals with equality between men and women in all areas,

– having regard to the Commission Communication entitled 'Solidarity in health: reducing health inequalities in the EU' (COM(2009)0567),

– having regard to Decision No 1350/2007/EC of the European Parliament and of the Council of 23 October 2007 establishing a second programme of Community action in the field of health (2008-13)[1],

– having regard to Council Decision 2010/48/EC of 26 November 2009 concerning the conclusion, by the European Community, of the United Nations Convention on the Rights of Persons with Disabilities[2],

– having regard to the Social Protection Committee Opinion on 'Solidarity in health: reducing health inequalities in the EU',

– having regard to the Council Conclusions of 8 June 2010 on 'Equity and Health in All Policies: Solidarity in Health',

– having regard to the report on the second joint assessment by the Social Protection Committee and the Commission of the social impact of the economic crisis and of policy responses,

– having regard to the Council Conclusions on 'Common values and principles in European Union Health Systems'[3],

– having regard to the Council Resolution of 20 November 2008 on the health and well-being of young people,

– having regard to the Final Report of the Commission on Social Determinants of Health

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1 OJ L 301, 20.11.2007, p. 3.
2 OJ L 23, 27.1.2010, p. 35.
3 OJ C 146, 22.6.2006, p. 1.

(WHO, 2008),

– having regard to the opinion of the Committee of the Regions on 'Solidarity in health: reducing health inequalities in the EU'[1],

– having regard to its resolution of 1 February 2007 on Promoting Healthy Diets and Physical Activity: a European Dimension for the Prevention of Overweight, Obesity and Chronic Diseases[2]) and its resolution of 25 September 2008 on the White Paper on Nutrition, Overweight and Obesity-related Health Issues[3],

– having regard to its resolution of 9 October 2008 on the White Paper entitled 'Together for Health: A Strategic Approach for the EU 2008-2013'[4],

– having regard to Rule 48 of its Rules of Procedure,

– having regard to the report of the Committee on the Environment, Public Health and Food Safety and the opinions of the Committee on the Internal Market and Consumer Protection and of the Committee on Women's Rights and Gender Equality (A7-0032/2011),

A. whereas universality, access to high-quality care, equity and solidarity are common values and principles underpinning the health systems in the EU Member States,

B. whereas, while people live, on average, longer and healthier lives than previous generations, the EU is faced, in the context of an ageing population, with an important challenge, namely the wide disparities in physical and mental health which exist and are growing between and within EU Member States,

C. whereas the difference in life expectancy at birth between the lowest and highest socioeconomic groups is 10 years for men and six years for women,

D. whereas the gender dimension in terms of life expectancy is also a major issue to be addressed in the context of health inequalities,

E. whereas, apart from genetic determinants, health is influenced above all by people's lifestyles, by their access to healthcare services, including health information and education, disease prevention and treatment for short- and long-term illnesses; whereas lower socioeconomic groups are more susceptible to poor nutrition and to tobacco and alcohol dependency, all of which are major contributory factors in many diseases and conditions, including cardiovascular diseases and cancers,

F. whereas inequalities in health between people in higher and lower educational, occupational and income groups have been found in all Member States,

G. whereas there is evidence of a gender dimension in malnutrition rates which suggests that women suffer more from malnutrition and that this inequality is exacerbated further down the socioeconomic scale,

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1 OJ C 232, 27.8.2010, p. 1.
2 OJ C 250 E, 25.10.2007, p. 93.
3 OJ C 8 E, 14.1.2010, p. 97.
4 OJ C 9 E, 15.1.2010, p. 56.

H. whereas gender and age inequalities in biomedical research and the under-representation of women in clinical trials undermine patient care,

I. whereas the comparative measurement of health inequalities is a fundamental first step towards effective action,

J. whereas rates of morbidity are usually higher among those in low educational, occupational and income groups and substantial inequalities can also be seen in the prevalence of most specific forms of disability and of most specific chronic non-communicable diseases, oral diseases and forms of mental illness,

K. whereas the incidence of tobacco use among women, particularly young women, is rapidly rising, with devastating consequences for their future health; and whereas, in the case of women, smoking is aggravated by multiple disadvantage,

L. whereas the Commission has noted that there is a social gradient in health status in all the EU Member States (Commission Communication of 20 October 2010 entitled 'Solidarity in Health: Reducing Health Inequalities in the EU'); and whereas the World Health Organisation defines this social gradient as being the link between socioeconomic inequalities and inequalities in the areas of health and access to healthcare,

M. whereas numerous projects and studies have confirmed that the onset of overweight and obesity in particular is characterised by early disparities linked to the socioeconomic environment and that the highest incidence rates of overweight and obesity are registered in lower socioeconomic groups; whereas this situation could lead to even greater health and socioeconomic inequalities owing to the increased risk of obesity-related diseases,

N. whereas despite the socioeconomic and environmental progress that has led to an overall improvement in people's health status over long periods, a number of factors, such as hygiene, living and working conditions, malnutrition, education, income, alcohol consumption and smoking, are still having a direct impact on health inequalities,

O. whereas climate change is expected to result in a number of potential health impacts through increased frequency of extreme weather events, such as heat waves and floods, through changing patterns of infectious disease, and via increased exposure to ultraviolet radiation; whereas not all EU countries are equally prepared to address these challenges,

P. whereas health inequalities are not only the result of a host of economic, environmental and lifestyle-related factors, but also of problems relating to access to healthcare,

Q. whereas health inequalities are also linked to problems in accessing healthcare, both for economic reasons (not so much for major treatment, which is dealt with correctly by the Member States, but rather for everyday treatment, such as dental and eye care) and as a result of poor distribution of medical resources in certain areas of the EU,

R. whereas the dearth of medical professionals in certain parts of the EU and the fact that they can easily move to other parts of the EU is a real problem, and whereas this situation is resulting in major inequalities in terms of access to healthcare and patient safety,

S. whereas people living in remote and island areas continue to have limited access to prompt and high-quality healthcare,

T. whereas patients living with chronic diseases or conditions form a specific group which suffers inequalities in access to diagnosis and care, social and other support services, and disadvantages including financial strain, poor access to employment, social discrimination and stigma,

U. whereas violence against women is a widespread phenomenon in all countries and among all social classes and has a dramatic effect on the physical and emotional health of women and children,

V. whereas infertility is a medical condition recognised by the World Health Organisation which has a particular impact on women's health, and whereas the UK National Awareness Survey has shown that over 94% of women suffering from infertility also suffer from forms of depression,

W. whereas there are wide disparities between Member States in terms of access to fertility treatment,

X. whereas, according to Eurostat, the EU's statistical office, unemployment across the 27 EU Member States reached 9.6% in September 2010, and whereas the Council of the European Union's Social Protection Committee, in its opinion of 20 May 2010, expressed concern that the present economic and financial crisis will adversely affect people's access to healthcare and Member States' health budgets,

Y. whereas the current economic and financial crisis may have a severe impact on the healthcare sector in several EU Member States, on both the supply and the demand sides,

Z. whereas the restrictions due to the current economic and financial crisis, combined with the consequences of the forthcoming demographic challenge that the Union will have to face, could seriously undermine the financial and organisational sustainability of Member States' healthcare systems, thus hindering equal access to care on their territories,

AA. whereas the combination of poverty and other forms of vulnerability, such as childhood or old age, disability or minority background, further increases the risks of health inequalities, and whereas, vice versa, ill health can lead to poverty and/or social exclusion,

AB. whereas early years have lifelong effects on many aspects of health and well-being – from obesity, heart disease and mental health, to education, professional achievement, economic status and quality of life,

AC. whereas health inequalities have significant economic implications for the EU and for Member States; whereas losses linked to health inequalities have been estimated to cost around 1.4% of GDP,

AD. whereas in many EU countries equitable access to healthcare is not guaranteed, either in practice or in law, for undocumented migrants,

AE. whereas cases still arise in the Member States of members of various social groups (for example, people with disabilities) being faced with obstacles to equal admission to healthcare establishments, which limits their access to health services,

AF. whereas, with their ageing populations, the Member States are having to deal with

problems relating to dependency and an increasing need for geriatric care and treatment; whereas a change in the approach to organising healthcare is therefore needed; and whereas inequalities relating to access to healthcare for elderly people are on the increase,

1. Welcomes the key suggestions made by the Commission in its Communication entitled 'Solidarity in health: reducing health inequalities in the EU': (1) making a more equitable distribution of health part of our overall goals for social and economic development; (2) improving the data and knowledge bases (including measuring, monitoring, evaluation, and reporting); (3) building commitment across society for reducing health inequalities; (4) meeting the needs of vulnerable groups; and (5) developing the contribution of EU policies to the reduction of health inequalities;

2. Stresses the importance of healthcare services being provided in a manner consistent with fundamental rights; points to the need to maintain and improve universal access to healthcare systems and to affordable healthcare;

3. Points to the importance of improving access to disease prevention, health promotion and primary and specialised healthcare services, and reducing the inequalities between different social and age groups, and emphasises that these objectives could be achieved by optimising public spending on preventive and curative healthcare and targeted programmes for vulnerable groups;

4. Calls on the Commission and Member States to press ahead with their efforts to tackle socio-economic inequalities, which would ultimately make it possible to reduce some of the inequalities relating to healthcare; furthermore, on the basis of the universal values of human dignity, freedom, equality and solidarity, calls on the Commission and Member States to focus on the needs of vulnerable groups, including disadvantaged migrant groups and people belonging to ethnic minorities, children and adolescents, people with disabilities, with a special focus on mental illness, patients diagnosed with chronic diseases or conditions, older people, people living in poverty, and people affected by alcoholism and drug addiction;

5. Calls on the Member States to ensure that the most vulnerable groups, including undocumented migrants, are entitled to and are provided with equitable access to healthcare; calls on the Member States to assess the feasibility of supporting healthcare for irregular migrants by providing a definition based on common principles for basic elements of healthcare as defined in their national legislation;

6. Calls on the Member States to take account of the specific health protection needs of immigrant women, with particular reference to the guaranteed provision by health systems of appropriate language mediation services; those systems should develop training initiatives enabling doctors and other professionals to adopt an intercultural approach based on recognition of, and respect for, diversity and the sensitivities of people from different geographical regions; priority must also be given to measures and information campaigns to combat female genital mutilation, including severe penalties for those who practise it;

7. Calls on the EU and the Member States rapidly to find ways of combating ethnic discrimination, particularly in certain Member States where Council Directive 2000/43/EC has not been implemented and where women from ethnic minorities have little or no social protection or access to healthcare;

8. Calls on the Member States to promote access to high-quality legal advice and information in coordination with civil society organisations to help ordinary members of the public, including undocumented migrants, to learn more about their individual rights;

9. Emphasises that the economic and financial crisis and the austerity measures taken by Member States, in particular on the supply side, may lead to a reduction in the level of funding for public health and health promotion, disease prevention and long-term care services as a result of budget cuts and lower tax revenues, while the demand for health and long-term care services may increase as a result of a combination of factors that contribute to the deterioration of the health status of the general population;

10. Stresses that health inequalities in the EU represent a substantial burden to Member States and their healthcare systems and that the effective functioning of the internal market and strong and, if possible, coordinated public policies on prevention can contribute to improvements in this field;

11. Stresses that countering socio-economic factors such as obesity, smoking, etc., the accessibility of healthcare systems (jeopardised by the non-reimbursement of the cost of care and of medicines, inadequate prevention and the fragmentation of medical demography) and effective diagnosis should be considered key aspects of measures to combat health inequality and that, in addition, the accessibility and affordability of pharmaceutical treatments should also be regarded as a key aspect of individual people's health; therefore calls on Member States to ensure that the Transparency Directive (89/105/EEC) is being properly implemented and that the conclusions from the 2008 Commission Communication on the Pharmaceutical Sector Inquiry are being appropriately addressed;

12. Stresses that healthcare is not and should not be regarded as a general good or service;

13. Calls on the Council and the Member States to evaluate and implement new measures to improve the effectiveness of their health expenditure, in particular by investing in preventive healthcare so as to reduce future longer-term costs and social burdens, and to restructure healthcare systems in order to provide equitable access to high-quality healthcare (in particular basic medical care) without discrimination throughout the EU, and encourages the Commission to study the use of existing European funds in order to further promote investment in health infrastructure, research and training and to promote and step up disease prevention;

14. Calls on the Commission and the Member States to ensure that equitable access to healthcare and treatment options for older patients are included in their health policies and programmes and to make adequate access to healthcare and treatments for older people a priority for '2012 European Year for Active Ageing and Intergenerational Solidarity'; calls on the Member States to promote initiatives in order to tackle social isolation in elderly patients as it has a significant impact on patients' longer-term health; stresses the need for the European Union and its Member States to anticipate, through an appropriate long-term strategy, the social and economic impact of the ageing of the European population, in order to guarantee the financial and organisational sustainability of healthcare systems, as well as equal and continued delivery of care for patients;

15. Calls on the Member States to improve their capacity to monitor closely, at national, regional and local levels, the health and social impact of the crisis;

16. Calls on the Commission to foster the pooling of experience in connection with health education, healthy lifestyle promotion, prevention, early diagnosis and appropriate treatments, in particular in relation to drinking, smoking, diet and obesity and drugs; calls on Member States to promote physical activity, good nutrition and 'Healthy Schools' programmes targeted at children, in particular in more disadvantaged areas, and to improve levels of personal, social and health education, with view to promoting healthier behaviour and encouraging positive lifestyle-related behaviour;

17. Encourages all the Member States to invest in social, educational, environmental and health infrastructure in line with the principle of 'health in all policies',while coordinating measures concerning the qualification, training and mobility of health professionals, thus guaranteeing the capacity and sustainability of the health infrastructure and workforce at both EU and national level;

18. Emphasises that health inequalities in the Union will not be overcome without a common and overall strategy for the European health workforce, including coordinated policies for resource management, education and training, minimum quality and safety standards, and registration of professionals;

19. Calls on the Member States to ensure that information on health, healthy lifestyles, healthcare, prevention opportunities, early diagnosis of diseases and suitable treatments is available in a form and in languages that everyone can understand, using new information and communication technologies, with particular reference to online health services;

20. Calls on the Member States to promote the introduction of telemedicine technologies, which can significantly reduce geographical disparities in access to certain types of healthcare, with particular reference to specialist care, in particular in border regions;

21. Calls on the Member States to promote public policies aimed at ensuring healthy life conditions for all infants, children and adolescents, including pre-conception care, maternal care and measures to support parents and, more particularly, pregnant and breast-feeding women, in order to ensure a healthy start to life for all newborns and avoid further health inequalities, thereby recognising the importance of investing in early child development and life course approaches;

22. Calls on the Member States to ensure that all pregnant women and children, irrespective of their status, are entitled to and actually receive social protection as defined in their national legislation;

23. Recalls the EU's obligation, under the UN Convention on the Rights of Persons with Disabilities, to guarantee the right of persons with disabilities to the highest attainable standard of health without discrimination on the grounds of disability; insists that the inclusion of disability in all relevant health measurement indicators is a key step towards meeting this obligation;

24. Calls on the EU and the Member States to include the health status of women and the question of ageing (older women) as factors in gender mainstreaming and to use gender budgeting in their health policies, programmes and research, from the development and design stage through to impact assessment; calls on the EU-funded framework research programmes and public funding agencies to include a gender impact assessment in their policies and to provide for the compilation and analysis of gender- and age-specific data

with a view to identifying key differences between women and men in relation to health, in order to support policy change, and to introduce and collate epidemiological tools to analyse the causes of the life-expectancy gap between men and women;

25. Considers that the EU and the Member States should guarantee women easy access to methods of contraception and the right to safe abortion;

26. Calls on the Commission to provide the Member States with examples of good and best practices to encourage more uniform access to fertility treatment;

27. Urges the EU and the Member States to focus on women's human rights, in particular by preventing, banning and prosecuting those guilty of the forced sterilisation of women and female genital mutilation;

28. Calls on the EU and the Member States to recognise male violence against women as a public health issue, whatever form it takes;

29. Calls on the EU and the Member States to take the necessary measures, in relation to access to assisted reproductive technologies (ART), to eliminate discrimination against women on the grounds of marital status, sexual orientation or ethnic or cultural origins;

30. Calls on the Member States to follow the World Health Organisation in recognising obesity as a chronic disease and thus to provide access to obesity-prevention programmes and guarantee access to treatment with proven evidence of a positive medical outcome for persons suffering from obesity who require medical treatment, also with a view to preventing the onset of further diseases;

31. Calls on the EU and the Member States to mainstream gender into tobacco control, as recommended by the WHO Framework Convention on Tobacco Control, and to introduce anti-smoking campaigns targeting young girls and women;

32. Calls on the Member States to encourage and support medical and pharmaceutical research into illnesses that primarily affect women, with reference to all phases of their lives and not only their reproductive years;

33. Calls on the Member States to solve problems of inequality in access to healthcare that affect people's everyday lives, for example in the areas of dentistry and ophthalmology;

34. Suggests that the EU and the Member States introduce coherent policies and supportive measures aimed at women who do not work or who hold jobs in sectors where they are not covered by personal health insurance and seek ways of providing such women with insurance;

35. Urges the Commission, in the context of its collaboration with the competent authorities of the Member States, to promote best practices on pricing and reimbursement of the cost of medicines, including workable models for pharmaceutical price differentiation so as to optimise affordability and reduce inequalities in access to medicines;

36. Recalls that the adoption of a European patent, with appropriate language arrangements and a unified dispute-settlement system, is crucial for the revitalisation of the European economy;

37. Notes that the work already done in the Committee on the Internal Market and Consumer Protection with regard to product safety and advertising, among other subjects, has helped to address certain aspects of health inequality in the EU, and, in that connection, stresses the importance of closely monitoring the information which pharmaceuticals firms provide to patients, particularly the most vulnerable and least well-informed groups, and the need for an effective and independent system of pharmacovigilance;

38. Calls on the Member States to adapt their health systems to the needs of the most disadvantaged by developing methods for setting the fees charged by healthcare professionals which guarantee access to care for all patients;

39. Urges the Commission to do its utmost to encourage Member States to offer reimbursements to patients and to do everything necessary to reduce inequalities in access to medication for the treatment of those conditions or illnesses, such as post-menopausal osteoporosis and Alzheimer's Disease, which are not reimbursable in certain Member States, and to do so as a matter of urgency;

40. Emphasises that, in addition to national governments, in many countries regional authorities play an important role in public health, health promotion, disease prevention and the provision of health services and thus need to be actively involved; points out that regional and local governments and other stakeholders also have a vital contribution to make, including within workplaces and schools; in particular as regards health education, the promotion of healthy lifestyles, effective disease prevention and early screening and diagnosis of diseases;

41. Calls on the Member States to support a ‘local care approach’ and to provide integrated healthcare, accessible at local or regional level, enabling patients to be better supported in their own local and social environment;

42. Encourage all the Member States to re-evaluate their policies on matters which have a significant impact on health inequalities, such as tobacco, alcohol, food, pharmaceuticals and public health and healthcare delivery;

43. 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, particularly in respect of access to state-of-the-art equipment;

44. Asks the Commission to study the effects of decisions based on national and regional assessments of the effectiveness of medicines and medical devices on the internal market, including in terms of patient access, innovation in new products and medical practices, which are some of the main elements affecting health equality;

45. Considers that the implementation of Directive 2011/24/EU on Patients' Rights in Cross-Border Healthcare should be followed by impact assessments in order to measure as accurately as possible its effectiveness in combating health inequalities and to ensure that it maintains an adequate level of public protection and safeguards patient safety, particularly in terms of the geographical allocation of medical resources, both human and material;

46. Notes that high-quality and efficient cross-border healthcare calls for increased transparency of information for the public, patients, regulators and healthcare providers on a wide range of issues, including patients' rights, access to redress and the regulation of healthcare

professionals;

47. Deplores the fact that the directive on cross-border healthcare was not accompanied by a legislative proposal on the mobility of healthcare professionals, taking into account the risk of a 'brain drain' within the EU, which would dangerously increase the geographical inequalities in certain Member States, and calls on the Commission to remedy this failure, possibly in the context of the future revision of the directive on professional qualifications (2005/36/EC);

48. Urges the Member States to implement fully the existing Professional Qualifications Directive (2005/36/EC); with regard to the complexity of medical qualifications, encourages the Commission, in its evaluation and review of the directive, to address some of the regulatory gaps that have the potential to leave patients vulnerable to harm and compromise their right to safe treatment; invites the Commission, further, to consider whether to make registration with the IMI System mandatory for competent authorities and improve the extent to which competent authorities can proactively share disciplinary information about healthcare professionals by creating an appropriate alert mechanism;

49. Urges the Commission, in its forthcoming legislative proposal on professional qualifications, to move towards a strengthened mechanism for the recognition of qualifications in the Member States;

50. Points out that increased innovation often leads to greater accessibility of treatment, which is particularly relevant for isolated or rural communities;

51. Calls on the Commission to foster, in conjunction with the Member States, the development of telemedicine services as a means of reducing geographical disparities in healthcare provision at both regional and local levels;

52. Calls on the Council and the Commission to give greater recognition within the Europe 2020 strategy to the fact that physical and mental health and well-being are key to fighting exclusion, to include comparative indicators stratified by socio-economic status and the state of public health in the procedures for monitoring the Europe 2020 strategy, and to take account of age-based discrimination, in particular in relation to clinical trials for treatments better suited to the needs of elderly people;

53. Considers that the EU and the Member States must support civil-society and women's organisations that promote women's human rights, including their sexual and reproductive rights, the right to a healthy lifestyle and the right to work, with a view to ensuring that women have a voice on European and national health policy issues;

54. Encourages all the Member States to foster and build capacity and international exchanges and cooperation between all relevant multi-sectoral stakeholders in developing and implementing policies that reduce health inequalities;

55. Calls on the Member States to support and implement a joined-up approach to policy-making at local, regional and national level, thereby striving towards a Health in All Policies Approach (HiAP);

56. Calls on the Commission and the Member States to develop a common set of indicators to monitor health inequalities by age, sex, socio-economic status and geographic location and

the risks resulting from alcoholism and drug addiction, and to establish a methodology for auditing the health situation in Member States with the aim of identifying and prioritising areas in need of improvement and best practices;

57. 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 not only of income but also of medical assistance, sickness prevention and health promotion services;

58. Stresses that health risks to members of disadvantaged (poorer) social categories are what is behind the problem of health inequalities, bearing in mind that these risks are being aggravated by a combination of poverty and other vulnerabilities;

59. Calls on the Commission to ensure that the tasks of reducing health inequalities and improving access to physical and mental health services are fully addressed and integrated into its current initiatives, such as the Partnership on Healthy and Active Ageing and the EU Platform against Poverty and Social Exclusion, and into future initiatives on early childhood development and youth policies focusing on education, training and employment;

60. Calls for better coordination between the EU agencies which have a major role to play in combating health inequalities, in particular between the European Foundation for the Improvement of Living and Working Conditions, the European Centre for Disease Prevention and Control and the European Agency for Health and Safety at Work;

61. Calls on the Commission to assist Member States in making better use of the Open Method of Coordination in order to support projects to address factors underlying health inequalities;

62. Calls on the Commission to develop ways to engage and involve all the relevant stakeholders at European level in promoting the uptake and dissemination of good practice in the public health sphere;

63. Draws attention to the particular importance, among the various health determinants, of a varied, high-quality diet, and, in that connection, urges the Commission to make greater use of the effective programmes established under the CAP (free distribution of milk and fruit in schools and of food to the most deprived groups);

64. Calls on the Member States to create a network of specific social, health and counselling services, with dedicated telephone helplines, for women, couples and families, with the aim of preventing domestic violence and providing qualified professional help and support for those needing it, in cooperation with the other bodies in the field;

65. Calls on the Commission to assist Member States in making better use of EU cohesion policy and structural funds in order to support projects that contribute to addressing the social determinants of health and reducing health inequalities; calls, further, on the Commission to help Member States make better use of the PROGRESS programme;

66. Urges the Member States to stop the current cuts in public spending on health services which play a pivotal role in providing a high level of health protection for women and men;

67. Calls on the Commission to mainstream an approach based on the economic and

environmental determinants of health and on ‘equity and health in all policies’ when developing all internal and external EU policies, especially with a view to achieving the Millennium Development Goals, and in particular good maternal health;

68. Urge all the Member States to recognise the importance of health for society and to look beyond a GDP-based approach when measuring societal, community and individual development;

69. Calls on the Council to promote efforts to tackle health inequalities as a policy priority in all Member States, taking into account the social determinants of health and lifestyle-related risk factors, such as alcohol, tobacco and nutrition, by means of actions in policy areas such as consumer policy, employment, housing, social policy, the environment, agriculture and food, education, living and working conditions and research, in keeping with the ‘health in all policies’ principle;

70. Calls on the Commission to support actions financed under the current and future Public Health Action Plans to address the social determinants of health;

71. Calls on the Commission to draw up guidelines to improve the mechanisms to monitor inequalities in health across the EU (between and within Member States) by enhancing data collection by compiling more systematic and comparable information that complements existing data on health inequalities and by means of regular monitoring and analysis;

72. Asks the Commission to consider drafting a proposal for a Council recommendation, or any other appropriate Community initiative, aimed at encouraging and supporting the development by Member States of integrated national or regional strategies to reduce health inequalities;

73. Calls on the Commission to assess, in its progress reports, the effectiveness of measures to reduce health inequalities and improvements in health resulting from policies relating to the social, economic and environmental determinants of health;

74. Calls on the Commission to apply the HiAP approach to EU-level policy-making and carry out effective impact assessments that take health equity outcomes into account;

75. Argues that open, competitive and properly functioning markets can stimulate innovation, investment and research in the healthcare sector, and recognises that this must be accompanied by strong financial support for public research in order to further develop sustainable and effective healthcare models and to promote the development of new technologies and their applications in this field (e.g. telemedicine), and by a common health technology assessment methodology, all of which should benefit every individual, including those from lower socioeconomic backgrounds, whilst taking into account the ageing of the population;

76. Calls on the Commission and the Member States to support public information and awareness-raising programmes and step up dialogue with civil society, the social partners and NGOs regarding health and medical services;

77. Regards it as essential to increase the number of women involved in the development of healthcare policies, programme planning and the provision of healthcare services;

78. Instructs its President to forward this resolution to the Council and the Commission.