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

Solidarity in health: Reducing health inequalities in the EU

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Key concepts

The term "health inequalities" taken literally means differences, variations or disparities in health status between individuals or groups.

The term *inequity* refers to differences in health which are not only unnecessary and avoidable but, in addition, are considered unfair and unjust.[1] Health inequities are systematic differences in health outcomes across different population groups (often defined by place of residence or on a socio-economic basis) which arise not from chance or from the decision of the individual but from avoidable differences in social, economic and environmental variables that are largely beyond individual control yet can be addressed by public policy.

In common usage and in many policy circles, the term health inequality is used as a synonym for health inequity. This is partly because health inequalities is a much more readily understandable term by the general public and partly because in terms of measurement "inequalities", i.e. measured differences in health outcomes, can be used as a proxy for health inequities. There are also practical reasons for the use of "inequalities" rather than "inequities": it is suggested by some academic researchers and other stakeholders that the term "health inequities" does not find a direct translation in all languages. In consideration of these points, this document uses the term health inequalities rather than health inequities. Clearly not all health inequalities are unfair and unjust, nor are all health inequalities amenable to public policy.

[1] Health21, the health for all policy for the European Region. World Health Organization Regional Office for Europe. Copenhagen 1999.

INTRODUCTION AND POLICY BACKGROUND

This impact assessment considers policy options for a possible EU initiative "Solidarity in Health: Reducing Health Inequalities in the EU", launching work in this field while building on existing measures and mechanisms. The Commission identified the need for policy action on health inequalities in the EU Health Strategy[2] and announced an EU initiative on health inequalities in the 2008 Renewed Social Agenda[3]. This document considers options for what such an initiative should be.

This report provides information on health inequalities in the EU and some of their causes, as well as on the current actions taken at Member State and EU levels. It outlines a rationale for action and proposes a number of options and related policy actions which are then appraised. The report commits only the Commission's services involved in its preparation and does not prejudge the final form of any decision to be taken by the Commission.

Principal responsibility for action to address health inequalities rests with Member States, but EU policies could also have a role both through their indirect impact on health and by helping to overcome some of the current obstacles to action as identified in this report. EU action appraised here therefore explores options to support and complement the efforts of Member States and stakeholders and to mobilise EU policies towards reducing health inequalities, in full respect of subsidiarity.

The aim of EU action on health inequalities should support improvements in the health of the whole population, but with particular emphasis on reducing avoidable and unfair gradients in health between social groups, protecting the health of vulnerable groups and contributing, where appropriate, to more rapid improvements in the health of populations for those regions of the EU that are lagging behind – i.e. a 'levelling-up' approach.

A legal basis for action is provided by the EC Treaty. The EU has a responsibility to ensure that all its policies and activities provide a high level of health protection. It also has a responsibility to strengthen economic and social cohesion. There is also a "political" background for action. In June 2006 the Council adopted conclusions on Common values and principles for health systems stating that they aim to reduce the gap in health, which is a concern of EU Member States"[4] and in November 2006 the Council adopted conclusions on health in all policies recognising the importance of health determinants and calling for inter-sectoral and broad societal action on those determinants[5]. Policy action on health inequalities was foreseen in the Commission White Paper "Together for Health, a strategic approach for the EU 2008-2013" of October 2007 (the EU Health Strategy)[6] which stressed the need to reduce health inequity between and within Member States involving exchange of best practice and health promotion. The European Parliament, the Council and the Committee of the Regions, in their opinions on the Health Strategy, have all underlined the need for EU action to help address inequalities in health. In June 2008 the European Council underlined the importance of closing the gap in health and in life expectancy between and within Member

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[2] "Together for Health, a strategic approach for the EU 2008-2013" http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf

[3] "Renewed Social Agenda: Opportunities, Access and Solidarity". COM(2008) 412 final at http://ec.europa.eu/social/main.jsp?catId=547&langId=en

[4] OJ C 146 of 22.06.2006, p.01.

[5] See http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/91975.pdf page 10

[6] "Together for Health, a strategic approach for the EU 2008-2013" http://ec.europa.eu/health/ph_overview/Documents/strategy_wp_en.pdf

States.[7] Finally, in July 2008 the Commission Communication on a Renewed Social Agenda[8], highlighted the principles of opportunity, access and solidarity and announced a Commission Communication dedicated to the issue of health inequalities for 2009.

In 2006 Member States agreed on the objective of addressing inequities in access to care and in health outcomes,[9] within the Open Method of Coordination for Social Protection and Social Inclusion (social OMC)[10]. Reducing health inequalities within and between Member States was also agreed in 2006 as an operational objective of the renewed EU Sustainable Development Strategy[11]. The persistence of health inequalities has been highlighted in the annual Joint Report on Social Protection and Social Inclusion (Joint Report SPSI)[12].

In the international arena, in addition to Member States' adoption of the 2008 Tallinn Charter[13], that establishes as health systems goals "improving the level and distribution of health, equity in finance and equity of access to care", the 2008 report of the WHO Commission on the Social Determinants of Health (WHO CSDH)[14] described the global burden of health inequalities and called for concerted action at all levels of government to address them.

This background demonstrates increasing attention to the large and persistent inequalities in health between and within Member States and growing concerns about the negative consequences for health, social cohesion and economic development if they are not effectively addressed. EU action in this field should be seen as part of the general EU commitment to increase the welfare and living standards of all as set out in the Treaties and reiterated in the Renewed Social Agenda, as well as in the international arena. The means to achieve this goal include existing economic, employment and social strategies, such as the strategy for growth and more and better jobs. However, the Council Conclusions and the consultation for this communication indicate an increasing recognition that further and dedicated EU action in support of Member States' efforts to tackle health inequalities is needed.

The possibility of EU action should also be considered in the context of the economic crisis that the EU is currently facing. It is not yet known to what extent the economic situation will impact on health inequalities, but unemployment is fast increasing and poverty is likely to increase as many households lose jobs. At the same time, some countries are beginning to cut social and health care budgets. This may worsen the observed health disparities between and within Member States and highlights the need for action to mitigate the negative health effects of the crisis. Moreover, in a context of rising strains between resources and needs, it is particularly important to protect the health of EU citizens and to improve the understanding of how economic, social, regional and other policies impact on the overall health of populations

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[7] See http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/ec/101346.pdf , page 13.

[8] "Renewed Social Agenda: Opportunities, Access and Solidarity". COM(2008) 412 final at http://ec.europa.eu/social/main.jsp?catId=547&langId=en

[9] http://ec.europa.eu/employment_social/spsi/common_objectives_en.htm

[10] See http://ec.europa.eu/social/main.jsp?catId=448&langId=en

[11] Review of the EU Sustainable Development Strategy. Council of the European Union. Document 10117/06. 9 June 2006 http://register.consilium.europa.eu/pdf/en/06/st10/st10117.en06.pdf

[12] http://ec.europa.eu/employment_social/spsi/joint_reports_en.htm

[13] http://www.euro.who.int/document/hsm/6_hsc08_edoc06.pdf

[14] "Closing the gap in a generation: health equity through action on the social determinants of health." Commission on Social Determinants of Health Final Report. World Health Organization, Geneva 2008. http://www.who.int/social_determinants/final_report/en/index.html

and on the various subgroups within them. The current economic crisis through posing a financial pressure on health systems can motivate countries to review their policy mix on health and health determinants in search for higher effectiveness and efficiency.

1. PROCEDURAL ISSUES AND CONSULTATION OF THIRD PARTIES

1.1. Organisation and timing

This work is jointly led by the Directorate-General for Employment Social Affairs and Equal Opportunities (DG EMPL) and the Directorate-General for Health and Consumers (DG SANCO).

Exploratory work on the impact assessment began in early 2008 when an initial roadmap for the Communication was drafted. This was finalised and agreed jointly by the two Directorates General DG EMPL and DG SANCO in July 2008. Following the inclusion of the Communication on health inequalities in the Commission's legislative and work plan for 2009 an invitation was sent to all Commission services to participate in the impact assessment inter-service steering group (IA ISSG). The first IA ISSG meeting took place in November 2008. Three further meetings of the group took place in February, March and April 2009. The following Directorates-General participated: AGRI, AIDCO also representing DEV, EAC, ECFIN, EMPL, EUROSTAT, INFSO, JLS, MARKT, REGIO, SANCO, SG, and RTD. These Commission Services made very useful and active contributions and discussed important aspects of the document notably the options and the actions within these as well as the need to relate this initiative to the economic crisis. The IA ISSG allowed the initiating DGs to take stock of what the other Commission services are doing and can do in relation to addressing health inequalities. The IA ISSG positively reviewed the draft impact assessment document circulated for the 1 April meeting and found it suitable for submission to the Impact Assessment Board (IAB) subject to taking account of the (small) comments then provided.

The IAB considered the document at its meeting of 13 May and provided its initial opinion on 25 May 2009. Following resubmission, the IAB issued a positive opinion on 15 July 2009 with a number of further suggestions for improvements. This version of the document consolidates all changes in response to the comments and observations of the IAB. The four points below set out the changes that have been introduced. Adjustments following the second opinion of the IAB appear in italics.

(1) The objectives for EU action were reformulated with the aim of ensuring an appropriate level of ambition for the policy context and to be appropriately linked with the problems identified and the actions proposed. A decision was taken to use the term 'health inequalities' throughout the whole document and an explanation of this decision is provided in the beginning of the document. To achieve greater explicitness on the competence of the EU and the scope of this initiative changes have been made throughout the whole document but especially in section 2 (problem definition), section 3 (the objectives) and section 6 (comparison of the options). More emphasis has been put on better data collection and strengthening the knowledge base which is included as a specific objective (section 3.2). Some information previously in section 2 was moved to the annex for the sake of conciseness.

(2) The problem definition was reworked to clarify the drivers of health inequalities. Additional evidence and clarification on issues relating to causation of health inequalities was to section 2.1.3 *(and further elaborated after the 2nd IAB opinion),* highlighting that evidence on causality, albeit growing, is limited and indeed improving the knowledge pool is one of the aims of this initiative. This helps distinguish to what extent causal links have been estimated

or only inferred from statistical correlation. More use is made of evidence on existing actions at Member States and EU level. An additional section (section 2.2) was included containing a list of effective Member States actions. Additional information was added to section 2.3 "Existing action and links to other relevant EU policies" on the current contribution of various EU policies. Attention is drawn to the fact that consistent and comprehensive evaluation of policy actions both at Member State and EU level is limited. *A table to illustrate the relationship between national and EU level actions was added to end of section 4.*

(3) Information on costs was reworked and expanded including in a new subsection 5.3. *Further points on costs have been provided, particularly in section 5.2 with the aim of clarifying that this is an initiative aimed only at encouraging Member States to take action without any obligatory compliance costs.* A separate section on subsidiarity and proportionality, section 2.6 was added and in addition, issues of subsidiarity and proportionally added under the analysis for each option (6.1, 6.2, 6.3). *To further improve the analysis of subsidiarity and proportionality extra detail and examples was added to section 2.6.*

(4) Additional information on the consultation carried out by the Committee of the Regions was added in section 1.2 *and the consultation section in the Annex adjusted to take account comments received following publication of a separate report on the consultation in July 2009.*

Beyond that the document was generally reworked to ensure consistency with the new sections and to improve readability.

1.2. Consultation and expertise

A targeted consultation of stakeholders working with DG EMPL and DG SANCO, inviting written contributions, was launched on 3 February 2009 with a closing date of 1 April, subsequently extended by a further two weeks. This was placed on the Commission's website providing an opportunity for other stakeholders to respond. Altogether 125 responses were received. Responses included national and regional authorities; EU level representations of regions and local governments; umbrella NGOs and networks in the domain of social policy; EU level organisations representing health insurers, healthcare providers and pharmaceutical industries; the social partners; EU Agencies; national/regional/local providers and insurers; national agencies and researchers active in the domain of social policy; political parties and international organisations. A number of forums and processes were consulted including the Social Protection Committee (SPC) in March 2009, the EU Expert Group on Social Determinants of Health and Health Inequalities (Expert Group SDH) in December 2008 and March 2009, and the EU Open Health Forum (December 2008). The Committee of the Regions (COR) undertook a consultation process on health inequalities and provided input during the development of this impact assessment. Prior to this, consultation on the issue of health inequalities took place as part of linked initiatives such as the Renewed Social Agenda (2008) (consultation ended February 2008, Social Agenda Forum of 5/6 May 2008), and the EU Health Strategy (2007) (consultation in early 2007). A list of consultations and a more elaborated summary on positions is given in the Annex.

The vast majority of respondents reported the existence of health inequalities within and between Member States, and perceived these as increasing even prior to the crisis. EU action was seen as providing added value. Several causes of health inequalities were mentioned such as employment and working conditions, poverty and environment. Respondents did not see the problem as just rooted in the character and extent of healthcare.

Regarding concrete actions better measurement, monitoring, reporting and exchange of best-practices were suggested by nearly all stakeholders. As the causes for health inequalities are so manifold, respondents indicated that they should be taken into account in all EU policies. A majority proposed a better targeting of EU funds and special focus on vulnerable groups. Targets/ milestones were suggested by a quarter of respondents. A small number of responses (notably national authorities) remarked that EU action should respect subsidiarity principles.

The responses were used to include some actions and confirm the inclusion of some of the initial ideas for action in section 4. They also influenced the way that actions were organised under the three options, how the options were appraised and how the final option was chosen.

The Committee of the Regions (COR) carried out an impact assessment consultation among the partners of the Subsidiarity Monitoring Network during February and March 2009 and received 13 responses. Health inequalities were also perceived as a problem. Factors mentioned as drivers included: (i) socio-economic conditions; (ii) lifestyle; (iii) geographical features of the territory; and (iv) cultural heritage. Action at Community level was considered necessary particularly in relation to improving comparability of information and assessment of the state-of-the-art processes at national and regional level. Other suggestions for action included: (i) promoting 'Health equality in all policies' (ii) developing an equality-focused health impact assessment; (iii) promoting universal coverage health systems across the EU; (iv) improving mechanisms for monitoring inequalities in health across Europe, (v) promoting research and exchange of best practice. In more specific terms and stressing the particularities of remote areas, like islands, EU support for health information technology was seen as an added value for these regions. The COR highlighted the EU's role for agenda setting.

2. PROBLEM DEFINITION

2.1. Background and context: nature and scale of health inequalities in the EU

This section summarises the nature and causes of health inequalities in the EU. Annex 2 contains a detailed presentation of the issues including graphs and references to data sources.

2.1.1. Inequalities in health outcomes between Member States

Substantial differences in population health between different EU Member States can be observed in a wide range of health indicators[15]. Individuals in many new Member States live shorter lives than their Western counterparts. In 2007 there was an 8-year gap between Member States in life expectancy for women and a 14-year gap for men (Figures A1-A5 in annex). In several Member States the gap between national life expectancy and the EU average has increased in the last two decades (Table A1 in annex). There are also large differences, of up to 20 years, in the number years lived in good health (Healthy Life Years) (Table A2)[16,17,18] and recent negative trends have been observed especially for women who already spend a higher proportion of their lives with limitations. Large differences are also

[15] See the Annual Monitoring Report from the European Observatory on Social Situation & Demography for detailed data analysis at http://ec.europa.eu/employment_social/spsi/reports_and_papers_en.htm.

[16] A word of caution is necessary as by construction this indicator is based on self-perceived limitations in activities and this measure may be prone to cross-country cultural differences.

[17] See also Jagger et al. (2008) that suggest that the gap between East and West in both life expectancy and years spent in good health is considerable.

[18] See http://ec.europa.eu/health/ph_information/indicators/lifeyears_en.htm for more detail.

found in infant mortality, in premature and treatable and preventable mortality, in subjective measures of health such as self-perceived general health, long-standing illness and activity limitations (Figures A6-A7, tables A3,A4). In some countries, contrary to the general EU trend, some mortality rates have grown during the last decade. See annex 2.1.1 for more detail.

2.1.2. Inequalities in health outcomes between social groups within Member States.

Major differences in health exist between social groups in all EU countries (for a review, see the report by Mackenbach for the 2005 UK Council Presidency Conference[19]). These start at a young age and persist and widen in older ages (Survey of Health Ageing and Retirement in Europe - SHARE[20]). Differences in life expectancy at birth between the lowest and the highest socio-economic groups (e.g. between manual and professional occupations; people with primary level and post-secondary education; low and high income quintile) range from 4 to 10 years for men and 2 to 6 years for women. In some countries the gap has widened in the last decades. Despite an overall decline, mortality and infant mortality are higher in the lowest socio-economic groups and relative inequalities have increased in several countries. See annex 2.1.1 for detail.

Rates of disease and disability also vary substantially by socio-economic group. People with lower education live shorter lives and spend more time in poorer health. For 'self-perceived general health' a clear income gradient can be observed in that those in the lowest (poorest) income quintiles more often report very bad health than those in the highest (richest) quintile (Table A3). In some countries the percentage reporting very bad health in the lowest quintiles has gone up since 2005.[21] SHARE data shows that individuals with lower education or income are more likely to experience limitations with arm or motor functions and have a higher prevalence of eyesight, hearing and chewing problems (Figure A8). Education-related inequalities in common chronic diseases and in height are also observed for European Countries (Dalstra et al., 2005; Cavelaar et al., 2000).

Vulnerable groups suffer a particularly greater burden of mortality and disease[22]. These include some migrant groups and ethnic minorities, people living in deprived urban and rural areas and in poverty, the long-term unemployed, those informally employed, seasonal/daily workers and subsistence farmers, those further from the labour market, jobless households, the homeless, the disabled, those suffering from mental or chronic illnesses, elderly pensioners on minimum pensions, and single parents. For example, the Roma can expect to live 10 years less than the majority population in some countries[23].

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[19] Mackenbach J. "Health inequalities: Europe in profile". COI for Department of Health, London 2006 http://ec.europa.eu/health/ph_determinants/socio_economics/documents/ev_060302_rd06_en.pdf

[20] See http://www.share-project.org/

[21] A word of caution is needed when looking at these conclusions, as current information covers a maximum of three years and hence the changes observed may not be a significant sign of a trend.

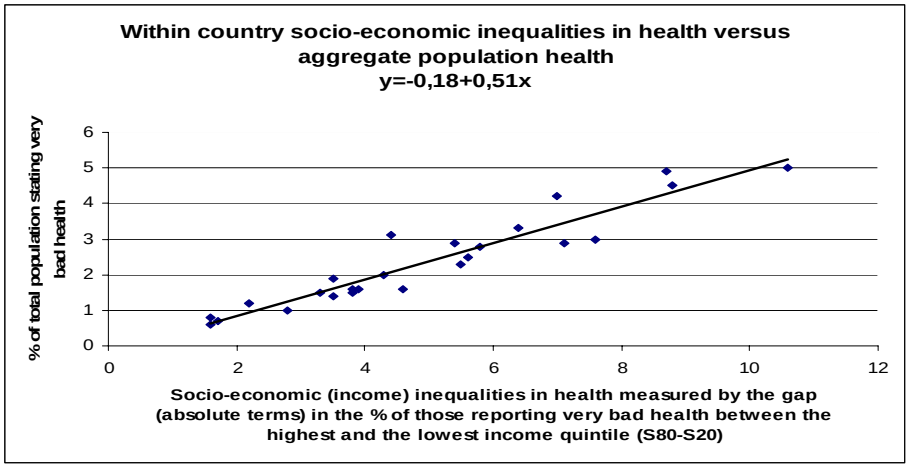
[22] As indicated in the Joint Report on Social Protection and Social Inclusion and social OMC and equal opportunities related studies/ networks at http://ec.europa.eu/employment_social/spsi/the_process_en.htm, the Handbook on Integration for policy-makers and practitioners at http://ec.europa.eu/justice_home/doc_centre/immigration/integration/doc/2007/handbook_2007_en.pdf, the Health and Migration in the EU work under the 2007 PT Presidency, and the work of the International Organisation of Migration.

[23] See the European Monitoring Centre on Racism and Xenophobia http://eumc.eu.int/

The June 2006 Council Conclusions on Women's Health[24] recognised a gender dimension in health. For example, although women live longer than men, they suffer a greater burden of unhealthy life years, and a higher incidence and prevalence of certain diseases.

Importantly, there appears to be a strong association between within country socio-economic inequalities in health and the overall population health i.e. the higher the socio-economic inequality in health, the poorer the overall population health (Figure 1). This adds to the analysis under the 2006 Finnish Presidency and the 2008 Joint Report on Social Protection and Social Inclusion that addressing health inequalities can contribute to important improvements in overall population health.

Figure 1:



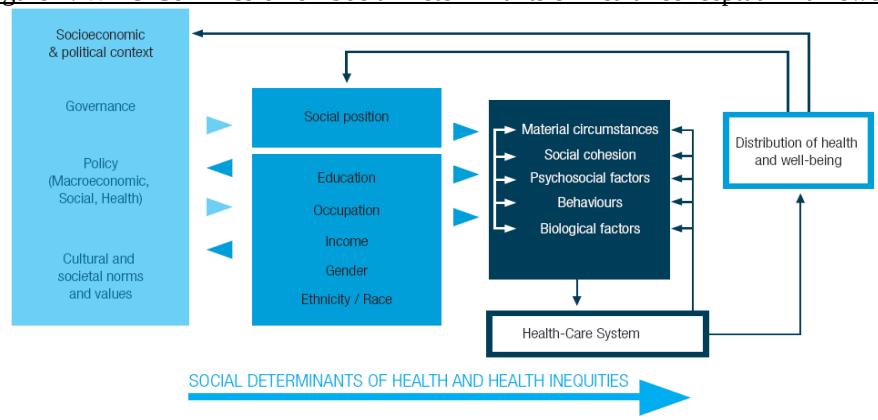
Source: EUROSTAT

2.1.3. Determinants (drivers or causes) of health inequalities

Determinants of health inequalities can be summarised in the recent framework used by the WHO CSDH (Figure 2, see Annex 2.1.2 for a detailed analysis). Note that, while there is a substantial amount of evidence on association (i.e. when we look at measures of health across population groups based on education, we find a systematic socio-economic gradient in health), there is limited but growing evidence (as longer data series and more sophisticated econometric techniques become available) which indicates a causal relationship between the set of factors in the figure and measures of health status both at the country level and within countries between socio-economic groups. This is why improving the data and knowledge base for action is one of the objectives of this initiative.

[24] See http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/89830.pdf

Figure 2: WHO Commission on Social Determinants of Health conceptual Framework.



Source: Amended from Solar & Irwin, 2007

Living conditions and health related behaviour: Living conditions affect health through direct and indirect physical and psychological mechanisms. There are sections of the EU population which do not have access to running water, adequate washing and toilet facilities, affordable energy, appropriate housing, heating, new clothes, or safe environment (e.g. EUROFOUND – 2008 European Quality of Life Survey[25]). Some studies (e.g. Trannoy and Tubeuf, 2008; Tubeuf et al., 2008) show suggest a negative effect of geographic environment (pollution) and neighbourhood/area (deprivation defined as high unemployment rates, single parent families, high share of individuals with lower education) on the health of individuals independently of each individual characteristics. Health is also determined by health-related behaviours (e.g. diet, physical activity, tobacco and alcohol use). Some studies (e.g. Stronegger et al., 1997; van Lenthe, F. J., C. TM Schrijvers, et al. 2004 based on GLOBE NL; Mackenbach, 2007) suggest that individual health behaviour can explain from 25% to 35% of differences in people's health. Other studies hypothesise that maternal smoking and poor diet during pregnancy cause impaired development in utero which increases the risk of cardiovascular disease, stroke, respiratory diseases and lung cancer in middle age (Baker, 1992). There are large variations between EU Member States and between socio-economic groups in the consumption of fruit and vegetables and the prevalence of smoking, alcohol consumption, obesity and physical activity (Figures A10-A12). Countries with high rates of smoking combined with low rates of exercise and unhealthy diet are also countries with the lowest life-expectancy in the EU (LV, LT, EE, BG, RO, PL, SK, HU, CZ). Studies also show that health related behaviour is itself and to a large extent influenced by socio-economic and cultural factors (SHARE; Stronegger et al., 1997; Lundberg, 1991). Note that the above academic studies showing causality are often restricted to specific countries, regions or even cities in a country and there is no EU coverage/ comparison on the causality of this sub-set of determinants.

Education, occupation and income/wealth are other important determinants of health (even after adjusting for risk factors - SHARE) shown to explain 40-50% of observed health differences (van Lenthe, F. J., C. TM Schrijvers, et al. 2004 based on GLOBE, NL). Living in poverty is associated with higher mortality and disease. Unemployment is associated with increased poor mental health and suicide (Kessler et al. 1987; Warr 1987; Blakely, 2003). A number of studies have suggested that job quality and working conditions affect health to a great extent (e.g. Debrand and Lengagne, 2008; Jusot et al., 2007): low physical pressure and stress, high decision ability and possibilities to develop new skills, a correct monetary reward

[25] See http://www.eurofound.europa.eu/pubdocs/2008/52/en/1/EF0852EN.pdf

and having prospects for personal progress lead to good health status whereas lack of support at work and the feeling of job insecurity increase the risk of depression and bad health. In addition, occupational health risks vary across sectors and not all workers are equally exposed (European Agency for Safety and Health at Work)[26]: e.g. workers with a fixed- duration or temporary employment relationship are statistically more likely to suffer from accidents at work and occupational diseases. In general, one can observe disparities in employment/ unemployment rates and differences in poverty and income inequality across and within Member States which might also help explain part of the differences in health between countries. Notwithstanding the range of studies in this area much of this evidence remains at the level of association and suggestion rather than providing clear explanations or mechanisms of causality. A growing number of academic studies are contributing to understanding of the causality between education or income and health because better data panels and econometric techniques are becoming available. In some cases it is now possible to use Census information and link it to mortality data, or through specialised surveys to follow cohorts of individuals, examine the relation between parents and their children or compare siblings (including twin studies) as techniques to improve understanding of the effect of socio-economic determinants of health. While such evidence is contributing to understanding of the factors involved there is a lack of studies evaluating initiatives and actions in this area which could inform policy.

Public policies including income distribution and access to health care: Public policies belong among the structural determinants of health inequalities as they influence the distribution of the above factors (e.g. education, income) and the degree of stratification in society. The extent of redistribution and social protection (pensions, sickness and health care, disability, family and child, unemployment, housing and social exclusion benefits), which vary significantly across Member States, may contribute to the observed health gaps. A number of research studies indicate that income inequality is one of the factors explaining differences in health between countries and individuals (Jen et al, 2009; Babones, 2008; Leigh and Jenks, 2007; Wilkinson and Picket, 2006; Cantarero et al., 2005; van Doorslaer and Koolman, 2004; Asafu-adjaye, 2004; Gravelle et al, 2002). Income distribution policies, which have been estimated to reduce the risk of poverty in the EU by 38% are therefore potentially very important (2008 OMC Monitoring Report[27]).

Healthcare influences the likelihood of overcoming disease and avoiding mortality thus its availability and quality between and within Member States can help explain some of the health disparities observed. Country differences in the availability, access and quality of care contribute to differences in treatable mortality[28] (Newey et al., 2003, 2008). EU Statistics on income and living conditions suggest an income gradient in unmet need for medical care: those in the lowest income quintiles more often report unmet need (Table A9). Evidence suggests that lower income families have further to travel to hospital or family doctor (Figures A24,A25) and that, after adjusting for different levels of need, the rich are significantly more likely to see a specialist and a dentist than the poor. (e.g. Jusot et al., 2008; Couffinhal et al., 2004; van Doorslaer and Masseria, 2004 for the OECD). Joint Reports on SPSI have

[26] See e.g. http://osha.europa.eu/en/topics/accident_prevention/risks

[27] See http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/omc_monitoring_en.pdf

[28] There are over 30 conditions considered treatable, some examples are: cancer of the colon, skin, cervix, testis and breast; diabetes mellitus; epilepsy; pneumonia; appendicitis; thyroid disease; measles. A similar picture can be found for preventable mortality.

identified the following as barriers to healthcare access: lack of health insurance[29], direct financial costs of care (Figures A26 andA27), geographical disparities in provision, waiting times, lack of information, discrimination, language barriers, health literacy and socio-cultural expectations in relation to life and care use. In general, inequitable access to care appears to be associated with higher health inequalities.

The current economic crisis can impact on health and increase health inequalities through a deterioration of social determinants of health, especially for those with lower qualifications and savings, and who are already vulnerable. The loss of job and thus income can lead to worse living conditions and life-styles, especially if social protection mechanisms are not present. Unemployment or job insecurity lead to increased levels of stress and greater risk of health damaging behaviours (e.g. harmful patterns of alcohol consumption) and contribute for example to depression, immune disturbances or accidents and have possible consequences on other family members. The negative impact on health can be long lasting. In addition, a deep economic crisis can impact on health and increase health inequalities through a deterioration of the access to quality health and social care by those in lower socio-economic groups. This is the case if access to care depends on being employed, having financial means, or Member States cutting the resources allocated to the health and social care sectors resulting in lower coverage or quality of care. The current economic crisis through posing a financial pressure on health systems can motivate countries to review their policy mix on health determinants in search for higher effectiveness and efficiency. Evidence (WHO World Report, 2008[30]) shows that countries with different levels of economic performance and social protection (notably health) expenditure can achieve similar health outcomes.

The analysis in 2.1.1 and 2.1.2 is in line with the 2006 Council Conclusions that "health determinants are unequally distributed among population groups resulting in health inequalities".

In summary the above description indicates that inequalities in health both between and within Member States across socio-economic population groups can be substantial. It suggests that the extent of within-country health inequalities may influence the overall health status of that country's population. The analysis provides a general outline of the various socio-economic determinants of health inequalities between countries and between social groups, including living and working conditions, health-related behaviour and social protection policies including healthcare. Robust evidence exists in a number of areas but more detailed and specific information is required on the effect (causality) and weights of several of those health determinants in order for Member States to choose and implement effective action in relation to particular population groups and determinants.

2.2. What Member States are doing and consider effective to address health inequalities

While about half of the EU Member States have activities which address inequalities in health only a small number have developed comprehensive inter-sectoral strategies and even fewer have fully assessed their impact. Hence, information based on comprehensive assessment and evaluation of the effectiveness of actions and strategies is limited. General examples of reductions in gaps in health between regions of Member States include those achieved by FI

[29] See 2008 OMC Monitoring Report where data and analysis of national strategy reports shows that in several EU Member States – NL, PL, SK, AT, BE, ES, LU, DE, FR, SI, LT and EE – non-negligible numbers of the population are not covered by public or primary private insurance

[30] See http://www.who.int/whr/2008/en/index.html

in the North Karelia project and by DE with a reduction in the mortality rates between new and old Länder since reunification. The UK has recently reported some encouraging signs of narrowing of health gaps between areas and social groups following a period were these inequalities widened.

Despite the limited knowledge[31], it is possible to establish a list of policy actions (see annex 2.2 for more detail) which have been judged by Member States to be effective in tackling health inequalities. Member States assessments suggest a number of broad conclusions.

First, that in addition to maintaining universal access to a number of key services such as education, social protection and healthcare, access also needs to be intensified and targeted at specific groups (e.g. to mothers and children, young parents, and those over 50) in disadvantaged areas, in vulnerable families and in lower socio-economic groups. This is particularly the case for health promotion and disease prevention programmes. Indeed, according to some evaluation studies untargeted health promotion information campaigns may increase health inequalities because of a tendency to be more effective in affluent groups.

Secondly, a number of Member States argue that regional and local action, supported by national and EU actions, is very important to achieve results. Building partnerships between the public and the voluntary/ third sector and businesses can also be effective in raising general awareness and developing action. For example, in DE the health insurance BKK and the Ministry of Work Health and Social Affairs concluded a partnership to improve the health of the unemployed (JobFit).

Thirdly, it is widely accepted that measurement and regular reporting of health inequalities indicators is an essential first step towards effective action. Such information allows for awareness-raising activities; enables policy makers to identify the extent of the gap and possible causes; and to inform the development of strategies to achieve faster decreases in disease prevalence and mortality for areas and groups with high needs. A good example of the impact of available information and reporting is that of NL where data analysis of the socio-economic gradient in health identified a 6 year gap for women and a 7 year gap for men. The publication of the report has motivated the development of a policy strategy for tackling health inequalities. Data collection, analysis and monitoring, it is argued, must then be accompanied by building scientific knowledge for action and which is gathered and disseminated through a coordination centre (e.g. the policy coordination centre for health inequalities in BE). Learning quickly from innovation elsewhere is also deemed crucial and several Member States suggest that initiatives linking cities and regions have been very effective in disseminating information (e.g. the Healthy Cities Network in DK). Taking stock of increasing body of evidence on the causes of health inequalities and how they can be influenced is therefore seen as a fundamental and effective step for devising policy action

Fourthly, several Member States (UK, BE, IE) state that health impact assessment/health inequalities test/ health inequalities audit applied to policies across the board is an effective way to generate inter-sectoral awareness.

More specific examples of policies considered effective by Member States or research review studies are mentioned below(see annex 2.5 for a longer list and more detailed explanation):

- Improve access to smoking cessation services for those in deprived areas and in lower socio-economic groups (UK, NL). To decrease infant mortality and increase life

[31] See http://ec.europa.eu/health/ph_determinants/socio_economics/keydo_socioeco_en.htm

expectancy in these groups it is effective to a) ensure smoking-cessation during pregnancy, b) stop parental smoking and c) reduce smoking in general for those groups. Studies have shown that the widespread provision of stop smoking services was effective in reducing the number of smokers living in more disadvantaged areas.

- Improve antenatal care, post natal care and parent support for those in less affluent areas / lower socio-economic groups (UK, PL) or migrants (NL) to reduce the gap in infant mortality. Specific actions include the multidisciplinary Sure Start child centres in the UK or the ONE centres in BE.
- Increase breastfeeding initiation and duration rates in deprived areas and lower socio-economic groups which are currently lower than those of more affluent areas /groups. A specific action is the baby-friendly hospital initiative in several Member States.
- Improve child immunisation rates and follow-up of children's health in lower socio-economic group. A specific action is the school U-programme (U1-U9) in DE.
- Fluoridation of water which reduces the socio-economic differences in tooth decay in children as shown when comparing different counties of UK.
- Providing meals, fruit and milk at schools (DK, UK, HU), which can reduce socio-economic differences in nutrition (i.e. improve child nutrition in deprived areas and lower socio-economic groups notably in terms of healthy foods).
- Provide affordable pre-school day care for lower socio-economic groups as this increases education and employment attainment, income level and thus health.
- Improving work organisation (FI, SE, DE). For example, improving work organisation in a bus company in DE lead to a significant reduction of sick leave and employees' turnover of bus drivers (e.g. Greiner & Syme 1994).
- Improve the physical environment through clean air legislation, green spaces and encouraging more walking and cycling (UK, NL). Improving housing quality (UK, EE) through improved building standards and affordable heating for lower socio-economic groups and measures to reduce accidents at home (smoke alarms, hand rails). A review of UK "area regeneration initiatives" shown that these lead to better education and employment rates, higher household income and housing quality and contributed to improving health.
- Seat belt and speed legislation (UK, BE),
- Income support (NL, SE)
- Using of Health Status Targets (UK, NL, CZ, FI, Basque Country in ES) has been effective in raising awareness and motivating policy action. An award system to recognise local authorities, local strategies, partnerships or actions to reduce health inequalities has been effective to motivate policy development.
- Health infrastructure investment e.g. through Structural Funds (HU, EL, PT, LV, SK)

In summary it can be seen that Member States are implementing some actions but in general comprehensive strategies are lacking. Also, policies implemented lack assessment/ evaluation which limits knowledge on policy effectiveness and can thus hinder policy development by other Member States. Finally, several areas can be identified where the EU can support and complement Member States such as awareness raising, data development, monitoring, research, dissemination of information and best-practice exchange, and legislative frameworks for environment, health and safety and equal opportunities. A collaborative approach is important to help optimise resources and tackle common challenges within the EU.

2.3. Existing EU action and links to other relevant EU policies.

From the above analysis of the determinants of health inequalities, one can see that while many are potentially amenable to policies which are of national competence, they can also be influenced to a certain extent, by EU economic, employment, environment, health, education, social and cohesion policies. For example, national health promotion and disease prevention strategies can be influenced by EU actions on health promotion, disease prevention and consumer protection. While healthcare delivery is the responsibility of Member States, EU action through the social OMC, the health strategy, the Structural Funds and anti-discrimination legislation can complement and support Member States actions in addressing inequalities in access to care. Financial support (e.g. Structural Funds, Health Programme) can be used to develop targeted health promotion and disease prevention interventions and to improve the geographic distribution of primary care, for example. Such examples can be found in areas other than healthcare.

Examples of existing EU policies that are relevant for action to contain and reduce health inequalities include the following (see annex 2.3 for more detail).

The Lisbon Strategy on growth and jobs can be expected to positively contribute to improve health outcomes as growth and more and better jobs improve overall living standards and thus health. Healthy life years has been agreed as one of the structural indicators, thus indicating this strategy has paid a growing attention to the health dimension.

Similarly, under the Employment Strategy the overarching Employment Guidelines and the associated common indicators provide a vehicle to motivate policy and allow monitoring of some important determinants of health and health inequalities. For example, reducing accidents at work, occupational diseases and work-related illnesses for all workers and in particular for workers suffering from the worse working conditions is an objective under Guideline 17. Guideline 18 puts emphasis on improving occupational health status with the aim of reducing sickness burdens, increasing labour productivity and prolonging working life. Guidelines 21 and 23 call for the implementation of flexicurity approaches and new skills for new jobs with the aim of helping the low skilled and those at the margins of the labour market to cope with a working life that is becoming more complex, diverse and irregular and therefore demanding. A set of common indicators related to quality of work/ working conditions, occupational health and health and safety in the work place, active ageing, and flexicurity has been agreed to monitor progress in these areas.

Following the adoption in 2006 of the common objective of addressing health inequalities under the social OMC, Member States have submitted the first National Strategies Reports on Social Protection and Social Inclusion (NSRs on SPSI) which included a chapter on healthcare and long-term care with some reporting on their policies to tackle health inequalities. A number of in-depth discussions in the SPC followed and the topic was part of the analysis of several joint reports. In 2008 a set of common indicators (including on health status and healthcare) was agreed to measure progress towards that objective. As a follow up, the first social OMC monitoring report was published which presented some analysis of health inequalities between and within Member States. The social OMC has regularly called for the need to have indicators broken down by socio-economic status. Some reviews (e.g. EuroHealthNet Closing the Gap and Determine) indicate that the social OMC has help stimulating debate and some action in Member States to tackle health inequalities. PROGRESS has funded a number of health related peer reviews and studies.

In a similar manner, following the 2006 adoption of the objective of addressing health inequalities between and within Member States and related indicators[32] the Sustainable Development Strategy report has highlighted differences in health between Member States. This report is to be discussed by the European Council.

The EU Health Strategy (2008-2013) promotes the tackling of health inequalities as a key value among other objectives and calls for attention to social determinants as part of the implementation of existing EU health activities, such as those on tobacco, obesity and alcohol, young people and mental health. The EU public health programme 2002-2008 provided funding for around ten collaborative projects addressing aspects of health inequalities. Health Inequalities is a priority of the current Health Programme 2008-2013. In 2005 the Commission established an EU Expert Group on Social Determinants of Health and Health Inequalities and this has been instrumental in improving understanding of the problem as well as promoting the sharing of information and good practice. The Health Information Strategy has also led to the development of a list of health indicators the European Community Health Indicators.

Under the Environment Strategy the EU supports a wide range of initiatives which are conducive to reducing the health impact of environmental factors. For example, a study (Health and Environment Alliance) shows that a 30% cut of greenhouse gases by 2020 would result in health savings of up to €25 billion per year.

The EU also provides significant financial support via the European Social Fund (ESF), the European Regional Development Fund (ERDF), the cohesion fund, the European Agricultural Guarantee Fund (EAGF), the European Agricultural Fund for Rural Development (EAFRD), and the Research Framework Programmes (currently FP7), which has allocated funding to some health related studies.

Under the Cohesion Policy funds are directed to less well-off regions in the EU and which can be used to invest in key determinants of health inequalities such as living conditions (water and sanitation), training and employment services, transport and technologies. Moreover, additional dedicated funding has been allocated to health infrastructure, capacity building and training of health staff through the Structural funds and health has become one of the top ten priority spending areas in 2007. The EU poorest regions can now use structural funding to invest in healthcare provision and support health promotion and disease prevention. Significant investments in health systems have been supported by the structural funds. The total allocated investment in the current programming period is € 5.2 bn. Countries such as HU, SK and LV have indicated in their responses that the structural funds have helped address inequalities in access to health care, notably geographic disparities in health provision, through investment in poorer/ deprived regions. In the past, countries such as PT and EL have also used the funds to the same effect.

The Common Agricultural Policy (CAP) has elements that may contribute to the reduction of health inequalities such as ensuring a fair standard of living for farmers, assuring the availability of supplies and reasonable prices for consumers. The CAP also supports the School Fruit and School Milk Scheme and the distribution of agricultural products to most deprived people. Rural development policy includes measures to improve the quality of life in rural areas through the provision of basic services for the economy and rural population (including social and health care services and infrastructure). Such investments have the

[32] Since 2006 – See Review of the EU Sustainable Development Strategy. Council of the European Union. Document 10117/06. 9 June 2006 http://register.consilium.europa.eu/pdf/en/06/st10/st10117.en06.pdf

potential to contribute to narrowing health inequalities which exist in some Member States (deprived) rural areas.

Internal market work has the potential to contribute to a reduction in health inequalities by stimulating economic growth, lowering prices, generating employment opportunities and thus improving standards of living. More specifically, "health-related" infringement procedures for example on the freedom of establishment and provision of services, restrictions to ownership of pharmacies and their location, restrictions to ownership of laboratories and their opening hours, which may lead to sales monopolies and constitute barriers to access, can contribute to lower prices of care and thus particularly benefit citizens from lower social-economic groups.

The EU also provides a substantial legislative framework in various areas. It has established Community labour law and Community legislation in the field of health and safety at work. The implementation in the Member States of Community Legislation on Health and Safety at Work, as well as all the actions foreseen in the Community Strategy on Health and Safety at Work 2007-2012 constitutes an important contribution to the reduction of health inequalities in the European Union. The improvements in the protection of worker's health and safety represents a significant contribution reducing health inequalities in Europe through reducing the negative impact of some of their determinants. The Impact Assessment to the Community Strategy 2007-2012 showed that occupational health strategy reduces work accidents, helps accident victims or chronically ill to retain their job or return to work, is a main platform for integrating migrant workers and can reduce stressful and monotonous working conditions that cause early deterioration of health, and hence, an early exit from working life.

In broader terms, EU regulations (e.g. tobacco advertising, and food labelling amongst others) and harmonisation of technical/ regulatory standards have raised public health related standards in many Member States and have potentially contributed to reducing health inequalities between and within Member States. The Commission has highlighted the importance of health to achieve the goals set out in the Lisbon Agenda (e.g. more employment, longer working lives) and considers health as a dimension in the framework of its impact assessments of new policy proposals.

In summary, through its policy processes and support, the EU has gradually given the issue of health inequalities higher priority in the policy agenda and there are a large number of EU policies which potentially can and are impacting on health inequalities. However, while these initiatives may have made a positive contribution to the issue, it has been difficult to establish and quantify the impact. Moreover, the description suggests a lack of mainstreaming health inequalities across all relevant EU policies. The next section therefore analyses some of the weaknesses in the current approach.

2.4. Problems and barriers in taking action on inequalities in health – and possible role of the EU.

There are a number of barriers and obstacles at EU and national level, to taking effective action to address health inequalities[33].

[33] The Joint Report on Social Inclusion and Social Protection, the work under the SPC and its Indicators Sub-Group, the work of the EU Expert Group on SDH, the report of the WHO CSDH.

2.4.1. Lack of awareness and insufficient policy priority and commitment by Member States

Analysis of the 2008-2010 National Strategy Reports on Social Protection and Social Inclusion (NSRs SPSI) shows that addressing health inequalities is regarded as the most important health policy challenge for 2 Member States (FI and UK) and a major goal for 6 Member States (LT, IE, AT, EE, SI and SK). For others (BE, HU, ES, DK and MT) reducing health inequalities receives some policy emphasis. Over half of all Member States do not refer to the issue at all in spite of the fact that addressing inequalities in health outcomes is a common objective under the social OMC and in spite of the 2008 Council conclusions. Table A16 shows that many Member States that show large health disparities have not allocated particular policy priority to their reduction.

Moreover, while Member States have affirmed their wish to adopt a "Health in All Policies approach" (2006 Council conclusions), only a minority have so far put this into place. While Member States have now subscribed to the principle of reducing health inequalities, the level of awareness and the extent to which action is being taken to achieve it varies substantially. A review carried out for the 2005 UK Presidency (Judge et al., 2005)[34] reported that while most EU countries express concerns with socio-economic dimensions of health only a smaller group had coordinated national policies to tackle health inequalities. The few which have implemented a range of dedicated policies are still far from having made a major breakthrough. This may relate to policy makers lacking awareness of the extent and the economic and social consequences associated with health inequalities. It may also reflect a lack of awareness of the effective policy options that can be implemented by national, regional and local administrations (as well as schools, workplaces, local health and community services, community organizations and other stakeholders). Evidence suggests that the right policy mix can achieve reductions in disparities and thus improve general health by optimising the health gain for the resources available (section 2.1.3). Thus, further work is needed to disseminate knowledge of existing good practice and that which will become available through best-practice exchange and information sharing mechanisms.

Moreover, there is a need to better involve other levels of government and other stakeholders that which have the potential to take action on various determinants and thus influence health outcomes as indicated in the consultation responses. The 2009 Joint Report on SPSI indicates that in general it is not clear how stakeholders are consulted on the NSRs SPSI and how the results from any consultations are taken into consideration. The EU could facilitate exchange of information and knowledge to assist stakeholders to take action that contributes to the reduction of health inequalities, as a number of consultation responses called for.

Finally, some Member States and respondents to consultations have argued that attention should be paid to a perceived lack of targets and benchmarks in the areas of inclusion and healthcare in order to strengthen policy prioritisation.

There is also a problem of policy priority and awareness of special groups. The analysis in section 2.1 indicated that the vulnerable groups may need special attention as they face the highest burden of disease and mortality and the highest risk: lack of basic requirements for health such as clean water, safe sanitation, proper heating, inadequate diet, lack of access to healthcare, housing or education, exclusion, stigmatisation and discrimination, inadequate

[34] "Health Inequalities: a Challenge for Europe", Judge K., Platt S., Costongs C. and Jurczak K., 2005, at http://www.eurohealthnet.eu/images/publications/pu_2.pdf;

income and low rates of employment. For these groups, the barriers to access to general services are more severe.[35] As the 2007 Council Conclusions on Health and Migration in the EU highlight there is a need for more data and knowledge of these groups' health (notably by gathering information by nationality or place of origin) and its determinants and a need to use a "Health in All Policies" approach.

2.4.2. Absence of comparable and regular data, monitoring and reporting. Lack of knowledge on the determinants and the effective policies to implement

While the measurement of health inequalities is a fundamental first step to take effective action, the availability of this information varies widely by Member State thus contributing to policy makers' lack of awareness on the extent, causes and consequences of the problem. Information regarding the differences in health outcomes and some determinants of health between and within countries is not routinely collected in a comparable manner across the EU Member States (year of data collection, age-group, socio-economic classification do not correspond across Member States as illustrated by the graphs/tables in the annex). To monitor and assess progress on health inequalities in the EU, Eurostat has in recent years, together with the European Statistical System, developed a system of statistics in this field. This system is firstly composed of household surveys, of which the EHIS (European Health Interview Survey) and the EU-SILC (Community Statistics on Income and Living Conditions) are key elements. To these households surveys are added the collection of administrative data (Health care data including expenditure and non-expenditure, causes of death, morbidity statistics). Some of the health and healthcare related data is currently provided to EUROSTAT on the basis of informal agreements and is not necessarily available for all Member State for the same years using fully comparable definitions (e.g. on staff and hospital beds). Many consultation responses remarked on the need for improvements in the accuracy and comparability of measures of health status; (mortality, life expectancy, premature mortality, avoidable mortality, mental illness), healthcare use; (visits to doctor, dentists, hospitals) and risk behaviour; (alcohol, tobacco, physical exercise) by geographical area and by social-economic group in order to enhance the existing indicators base.

Moreover, while the EU produces a variety of reports these do not necessarily take into account the health and health inequality dimensions or the social determinants of health. For example, the three-yearly Cohesion Report on the outcomes of the Structural Funds does not provide an assessment of the impact of the use of funds in reducing regional differences in health. Furthermore there is no dedicated and regular reporting on health inequalities across and between countries, though there is some limited reporting through the Joint Report on SPSI.

There is also a lack of evidence and knowledge on the causes of health inequalities. In relation to some factors there is a need to have more information on the degree of causality and the relative weight of different determinants of health inequalities. While some of the causes of health inequalities are well understood (e.g. lack of access to basic needs or services

[35] See various Joint Reports on Social Protection and Social Inclusion and other social OMC related studies, as well as "Challenges for health in the age of migration" at http://www.eu2007.min-saude.pt/PUE/en/conteudos/programa+da+saude/Publications/Relat%C3%B3rio+Sa%C3%BAde+e+Migra%C3%A7ao.htm, "Migration and the right to health", IOM, at http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/published_docs/serial_publications/IML12-MRH%20dec07.pdf and "Quality in and equality of access to healthcare services" at http://ec.europa.eu/employment_social/spsi/studies_en.htm#healthcare

- poor water, housing and environment conditions); other causes are much more difficult to determine - for example, how the different ways that jobs are organized can have such markedly different health impacts. More evidence is needed on the relation between unequal access to healthcare and the health status of the population and on the capacity of health systems to provide equal, timely and appropriate diagnosis and treatment. Further work is also needed to identify those factors which are causative from the wealth of information on association. Obtaining such information requires better availability of data and the development and use of more sophisticated (e.g. epidemiological) modelling to establish the independent effect and weight of the various determinants. It may also require a more regular use of health inequalities impact assessment and ex-post evaluation to elucidate the possible impacts of existing and planned policies on the health of particular groups.

Knowledge on the effectiveness of interventions and policies to tackle inequalities is also lacking. This is in part because only a small number of interventions that impact on health have been evaluated for their differential impacts on particular social groups or in particular areas. Hence, more research is needed to provide such knowledge. As this is an area where Member States can learn from each other when devising their own policy strategies, existing knowledge, and that which will be built, needs to be disseminated.

2.4.3. Insufficient concerted EU approach to health inequalities (lack of mainstreaming at the EU level)

Section 2.3 presented an overview of the EU policies/ tools that directly or indirectly have been underpinning efforts in Member States to address health inequalities. The issue is however, that while EU policies include current actions that may contribute directly or indirectly to contain or reduce health inequalities this policy outcome is very rarely an explicit goal. In other words, promoting the reduction of health inequalities has not been mainstreamed in an explicit manner in EU policies and activities tools and most of them do not take the dimension of health inequality into account. For example, few EU policies are evaluated after implementation (ex-post) in relation to their impact on health and health inequality. This reduces understanding of how effective EU policies are in reducing (or not) health inequalities. Analysis and reporting on the relation between such policies and health inequality is also limited.

The following illustrates some of the limitations and potentials of relevant EU policies to deliver a more effective contribution in this area.

In relation to the Lisbon Strategy and associated Employment Strategy, while there has been a growing attention to health and the economic benefits of good health (employment, productivity). The analysis on the impact of growth and jobs on health and health inequality or on the impact of working conditions on health and health inequality is more limited. In addition, while the healthy life years indicator can allow for assessing gender and between country disparities in health outcomes it does not allow for assessing socio-economic differences in health. The common employment indicators on quality of work and working conditions could also be further developed in this respect.

Under the current social OMC, full delivery on common objectives remains a challenge[36]. Despite the common objective of addressing health inequalities, the issue has not yet been taken up as a policy priority by all Member States. In addition to the improvement and greater use of the common indicators, more regular monitoring and improved evidence within

[36] See Com(2008)418 at http://ec.europa.eu/social/main.jsp?catId=550&langId=en for more detail.

the OMC, it has been argued that there is a need for a) developing quantitative targets to achieve more and faster progress in relation to the objectives and b) a better integration between social and other policies such as environment, health, economic and employment policy. The use of peer reviews and the involvement of regional and local administrations and stakeholders is still too limited (Joint Report SPSI). PROGRESS could be better used as the basis for local policy innovation.

While the Environment Strategy takes the impacts on health into account more attention could be paid in relation to environmentally related health inequalities as more vulnerable groups are often more exposed to environmental hazards (e.g. pollution). More attention could also be paid to the health protection of more vulnerable groups as well as children and young people as well as the potential for further improvements in coordination with international agencies (e.g. WHO).

Although it is difficult to establish the impact of EU public health initiatives on the reduction of health inequalities, it has been argued by a number of relevant projects co funded by the EU (Closing the GAP, DETERMINE) that some may have unintended negative consequences. Thus, stakeholders should there should be greater emphasis on health inequality audit or health inequalities "proofing" of EU policies. Regarding the Health Information Strategy, several ECHI indicators would equally benefit from a social-economic breakdown.

Large health inequalities between and within Member States present a challenge to the EU objectives of economic and social cohesion. Despite the potential for using the Structural Funds to address disparities in healthcare, the planned investment in healthcare infrastructure is only a relatively small amount of the total funds. Furthermore Member States do not always use these to their full potential. So far, funds allocated for health related infrastructure investment (ERDF) represent about 1.5% of the total Structural Funds investment (ca. €5 bn for the period 2007-13) and actual investments are likely to be lower based on proposed interventions. Possible reasons are 1) lack of knowledge of the opportunity to use funds in this area, 2) lack of coordination between national policy departments and 3) lack of technical capacity to propose / allocate investment in the field. Indeed, health is not a traditional area of support for Cohesion Policy and there may be need to increase capacity building in the area. The current or proposed investment in the operational programmes does not necessarily relate to the priorities identified in the Joint Report and NSRs on SPSI and is not necessarily allocated to areas where larger gains in health or larger reductions in health disparities could be attained. For example, many regions in the newer Member States do not have enough health facilities and trained staff in some areas and this is preventing them from responding to population needs. This suggests a need for more investment in health equality, notably in the poorest regions in the next programming period. Additionally, a) no structured data is available on ESF spending on health, which makes monitoring difficult and b) health and health inequality is not used as an outcome measure of the use of funds. All this is of more concern because some countries that have used the funds on health such as PT have attained positive outcomes.

A greater emphasis on addressing health and health inequality problems in the EU's Cohesion Policy – including better monitoring of health outcomes for all EU funds - could help overcome barriers to their effective use to reduce health inequalities. Several stakeholders suggested in their consultation responses improving the exchanges of knowledge and good practice between recipients of Structural Funds with the aim of maximising their added value for improving the overall health of the population and narrowing health inequalities.

Finally, while this paper focuses on health inequalities in the EU, the 2008 WHO CSDH report highlighted the enormous health inequalities which exist at global level and called for sustained, comprehensive, action globally, nationally and locally to tackle them. Health inequalities in third countries are a concern to the EU because the EU is an important contributor to development (through aid and development funds and the provision of technical capacity) and has an interest that health inequalities are addressed globally. The EU and its Member States are important partners in the global effort to attain the Millennium Development Goals and work together with other international organisations such as the WHO and the UN. Hence, it would be important to ensure that any evidence and best-practices that result from the actions in EU Member States are disseminated to other countries. It remains for the future to think how this policy priority can be linked to the policies addressing health inequalities in the EU's development and aid agenda.

In summary, lack of routinely available and comparable EU data and research knowledge poses an obstacle to rethink policy priorities, establish comparisons, derive best-practices, and reallocate resources where they are most needed. Better and shared evidence and a good understanding of the rationale for action can provide the political commitment and momentum which is currently lacking from a wide range of stakeholders.

2.5. Why are health inequalities between and within countries a problem and a policy concern to the EU?

Although the major responsibility for addressing health inequalities rests with Member States, the problem is nevertheless one of potential policy concern for the EU for a number of reasons.

Firstly, the pervasiveness and persistence of such inequalities in health suggests a possible discrepancy between the existing situation and some of the overarching goals of the European Union such as strengthening of economic and social cohesion, ensuring equal opportunities, promoting the reduction of inequalities and the promotion of equality between men and women and solidarity among Member States (Art. 2 of the EU Treaty and Art. 2 of EC Treaty). See annex 2.3 for more detail.

Secondly, high levels of poor health in sections of the EU population imply substantial opportunity costs for the Union and thus provide an economic reason for promoting action to address them. High levels of population health are important in the context of an ageing population to allow longer working lives and support higher productivity, competitiveness and employment levels (Community Strategic Guidelines on Cohesion)[37]. Reducing unnecessary losses due to ill health and premature death can thus make a contribution to meeting the Lisbon goals and achieving Europe's full potential for prosperity. Avoidable ill-health also leads to large costs for health systems and puts unnecessary pressure on public budgets.

2.6. Legal and political basis for action and subsidiarity

The above sections have identified 3 sets of problems which the EU could help addressing:

- Lack of awareness and insufficient policy priority and commitment by Member States
- Absence of comparable and regular data, monitoring and reporting and lack of knowledge on the determinants and the effective policies to implement

[37] See http://ec.europa.eu/employment_social/esf/docs/TP_files_update/tp_health_EN.pdf

- Insufficient concerted EU approach to health inequalities (lack of mainstreaming at the EU level)

There is a legal basis for action. Under Article 152 of the EC Treaty the Community should ensure that all its policies and activities provide a high level of health protection. Strengthening economic and social cohesion by reducing disparities between the least favoured regions, including rural areas is a goal expressed in Art. 158 of the EC Treaty. Art. 159 states that the formulation and implementation of Community policies and actions shall take into account those objectives and that the *Community shall also support the achievement of those objectives through the Structural Funds*. Art. 125 and related articles state that "Member States and the Community shall work towards developing a coordinated strategy for employment and particularly for promoting a skilled, trained and adaptable workforce" and that "*the Community shall encourage cooperation between Member States and support and complement their actions in relation to achieving a high level of employment*". Arts. 136 and 137 and related articles indicate that the Community and Member States, having in mind fundamental social rights, shall have as their objective the promotion of employment, improved living and working conditions, proper social protection, development of human resources and the combating of exclusion, and thus "*the Community shall support and complement the activities of Member States in various fields*" including working conditions and health and safety at work, social security and social protection, integration of people excluded from the labour market, equality between women and men in relation to employment and the combating of social exclusion. Finally, arts. 12 and 13 form the basis for EU directives on anti-discrimination e.g. in employment and social protection that are relevant to addressing health inequalities.

This legal basis for action is reinforced by a "political mandate" for action with several EU bodies calling for further EU action which has recently been expressed by the Commission in the 2008 Renewed Social Agenda (see introductory section).

Member States have the main responsibility for the policy changes needed to address most of the determinants of health inequalities and can make the biggest contribution. Most of the policy areas described above are areas where the EU has only competence to carry out actions to support, coordinate or supplement the actions of the Member States. EU action and a more pro-active role at EU level can be considered only where the objectives of the proposed action cannot be sufficiently achieved by the Member States acting individually and where for reasons of scale or the effects of the proposed action, they can be better achieved by the Community. For example Community research frameworks allow the building up of a richer pool of research knowledge than individual country level frameworks (knowledge could be restricted in less wealthy countries). Community frameworks can facilitate the exchange of information and best-practice across 27 Member States so that all countries but especially those countries in a disadvantageous position can benefit from learning from the experience of others and develop their own strategies. EU level action can facilitate and support Member States' cooperation. Community action can act as a catalyst in relation to the development of national strategies to address health inequalities and can help Member States improve the use of the various financing mechanisms currently at their disposal to better support and reinforce those actions. Moreover, in various areas the EU undertakes actions which can indirectly impact on the socio-economic determinants of health at national level. It would therefore be important to understand if the Community can be more effective in the way it supports and complements Member States' efforts in this field. These considerations explain why Community action may produce faster and larger results than individual action.

In this context, the necessity of EU action can be found in relation to two areas. A first area relates to the need for EU-wide harmonised data_collection and monitoring which is a fundamental step prior to putting forward any action. Lack of reliable socio-economic data on health status is a common challenge in a large number of Member States. The Community (through EUROSTAT) working together with Member States is better placed then individual Member States working alone to ensure EU wide availability, reliability and comparability of data that is needed.

Another area is Cohesion policy through which the EU provides financial support to Member States, especially less well-off regions, that can be used to invest in key determinants of health inequalities such as living conditions, training and employment services, and more recently healthcare (promotion, prevention and treatment) through training and infrastructure (in convergence regions). Enlargement has increased the economic and social disparities which exist between EU regions. European Regional Policy provides tools (including funding) to create potential (conditions and factors) in the least-developed Member States and regions so that they can achieve greater growth and competitiveness and real convergence. These conditions and factors conducive to convergence include more and better jobs and better health by improving accessibility and ensuring adequate quality of services. An EU level policy, which includes support to some measures in the health field and can lead to a leveling-up (in terms of health, employment and growth) of poorer regions, is seen as necessary to tackle the disparities which would otherwise remain substantial or even widen. By improving health services, employment and growth it can contribute to reducing health inequalities across EU areas.

Looking at the problems identified the EU can also provide added value (both in terms of scale and effects) by raising awareness and reinforcing a focus on health inequalities, improving its own monitoring mechanisms, enhancing research and knowledge gathering, providing greater visibility of relevant actions through improving the sharing of experiences and good practices and capacity building and improving the linkages between EU policies, areas where weaknesses have been identified. This has been suggested in the many consultations responses received and in various other research reviews. Moreover, given the complex nature of the problem and the wide divergence of experience and performance, this is an area where Member States can obtain clear benefits from mutual learning and exchange with other Member States as this can provide good ideas and avoid repeating the errors of others. Member States have expressed keen interest in cooperating in this area.

All the options examined in section 4 respect the principle of subsidiarity as they respect national competences. They are also proportional in that the options considered here do not force or even suggest any specific measure to be followed by Member States and in fact leave the choice, definition and implementation of policy strategies in the hands of the Member States to best fit their national setting, fully respecting their national arrangements. Actions considered here are appropriate to the level of EU objectives and responsibility and leave all the decision scope to Member States. For example, while the EU would encourage participation or reporting by Member States and other stakeholders these would be voluntary. Improving data collection by socio-economic status would be done together with Member States allowing for the best national alternative. In addition, actions proposed and appraised would be pursued within existing EU instruments (e.g. OMC, Health Strategy and existing financial tools) so that costs are minimised. Many actions are about using existing EU tools in a more effective way to support and reinforce Member States activities with a benefit to Member States.

3. OBJECTIVES

In broad terms the aims of EU action in relation to inequalities in health are to support and complement the actions of Member States in this field and to continue to ensure that EU policies and activities provide a high level of health protection as set out in the Treaty. As far as possible, the health protection provided by EU policies should extend to all citizens irrespective of where they live or their social background. In fulfilling these aims, EU action can make a contribution towards a reduction in health inequalities in the EU.

3.1. General Objectives

The general objective of this initiative is to support and complement the efforts of Member States and stakeholders and mobilise EU policies towards reducing health inequalities.

3.2. Specific Objectives

Specific objectives are to:

- Raise awareness, promote information, best-practice exchange and policy coordination and advocate the tackling of health inequalities as a policy priority; both at Community and Member States level and by other stakeholders.
- Improve data availability and the mechanisms to measure, monitor and report on inequalities in health across the EU and improve the knowledge base on the causes of health inequalities and the evidence base for action.
- Develop the contribution of relevant EU policies towards reducing inequalities in health, including better support of Member States and stakeholders' efforts to tackle health inequalities and a specific focus on vulnerable groups and third countries.

The objectives and their relation to the problems outlined in section 2.4 are summarised in the following table:

Problem	Specific Objective
Lack of awareness and insufficient policy priority and commitment	Raise awareness, promote information and best-practice exchange and advocate the tackling of health inequalities as a policy priority; both at Community and Member States level and by other stakeholders
Absence of comparable and regular data, monitoring and reporting. Lack of knowledge on the determinants and the effective policies to implement	Improve data availability and the mechanisms to measure, monitor and report on inequalities in health across the EU and improve the knowledge base on the causes of health inequalities and the evidence base for action
Insufficient concerted EU approach to health inequalities (lack of mainstreaming at the EU level)	Develop the contribution of relevant EU policies towards reducing inequalities in health, including better support of Member States and stakeholders' efforts to tackle health inequalities and a specific focus on vulnerable groups and third countries

4. POLICY OPTIONS

Three options are put forward for analysis towards achieving these objectives. Option I is the continuation of current activities ("business as usual"). Option II "Current plus" builds on existing work which can be taken forward in a short time frame without the need for further or fundamental changes to current Community instruments, and formulated in a Communication. Option III "Far Reaching" requires a longer time frame, involves deeper

changes in existing EU instruments, and includes a Council Recommendation in addition to the Communication.

4.1. Option I: Continue current activities, no new initiative:

Under Option I, work to support the reduction of health inequalities would continue under the social OMC and the Health Strategy, but there would be no new initiatives. Equity in health is a guiding principle of the Health Strategy and reducing inequalities in access to health care and health outcomes is a common objective under the social OMC. Hence, work would continue to take place, mainly in the form of exchange of experience to assist Member States to translate this objective into national strategies. Mechanisms would include National Strategy Reports and the Joint Report on Social Protection and Social Inclusion, peer reviews and Social Protection Committee (SPC) meetings, as well as meetings of the EU Expert Group on Social Determinants of Health and Health Inequalities and the Council Working Party on Public Health at Senior Level (Council WPPH). There would be continued support for initiatives in this area through PROGRESS and the Health Programme 2008-2013. Likewise, Cohesion Policy would continue to support a limited range of activities in the public health and healthcare areas, while the Common Agriculture Policy and the Agricultural and rural Development funds would continue to support some initiatives. In more detail, this option would include work in the following areas:

Raising awareness, promoting information and best-practice exchange, and promoting the tackling of health inequalities as a policy priority:

a) Addressing health inequalities would remain a common objective of the social OMC and the Sustainable Development Strategy.

b) The SPC under the social OMC, the EU Expert Group on SDH and the Council WPPH in relation to the Health Strategy would provide mechanisms for information and best practice exchange. Under these structures work would take place on topics related to social determinants of health inequalities such as: housing (exclusion, deprivation and homelessness), active inclusion (follow-up 2008 active inclusion recommendation) and measures to enhance employment of those further from the labour market; looking at social aspects of migration and ethnic minorities; the analysis of child wellbeing; review inequalities in access to health and social care services in general and for people suffering from specific diseases (e.g. Alzheimer's disease); analysis of access to quality primary care; quality of health and social services.

c) A greater use of social OMC peer reviews to address social determinants of health could be encouraged and a health inequalities dimension would be included in reviews of EU health strategies as appropriate.

d) Presumably, the Commission would organise a first reflection on targets in the area of health status as announced in the strengthening social OMC communication.

Improve data availability and the mechanisms to monitor and report on health inequalities and improve the knowledge base on the cases and the evidence base for action:

a) Healthy life years would remain a structural indicator in the Lisbon strategy

b) The social OMC common indicators on health status would be used to monitor progress in relation to health inequalities. Under the Indicators sub-Group of the SPC, some indicators

would be developed including on poverty and material deprivation, social aspects of migration and child wellbeing; on pension adequacy; on avoidable mortality, on access to and utilisation of health care and on health promotion and disease prevention (risk factors/ behaviours, screening), as much as possible by age, sex, socio-economic status and region/geographic dimension. This would be done in connection with other statistical work notably further developments of the European health information system (incl. European Community Health Indicators).

c) The agreed indicators of the sustainable development strategy would also be used to monitor progress between and within Member States

d) The Health Strategy and social OMC reporting mechanisms would continue to be used for reporting. Health inequalities concerns reported by Member States (in the NSRs and in the Expert Group on SDH) would be analysed in public health reports from the EU health information system, in the Joint Report SPSI, the Monitoring Report on progress towards the common objectives on the social OMC, the monitoring report on the EU Sustainable Development Strategy and perhaps in the Annual Social Situation and Demography Report. There would be no special monitoring of health outcomes for the use of EU Funds under this option.

e) PROGRESS and the Health Programme (2008-2013) would provide some financial support to policy development and innovation by Member States and other stakeholders in this area.

f) The 7th EU Research Framework Programme (FP7) funding for Research would only address health inequalities under existing, broader research sections without a specific focus.

Develop the contribution of EU policies:

a) Cohesion Policy would continue to support a range of activities in the public health and healthcare areas.

b) The CAP (market measures, agricultural and rural development funds) would continue to support some initiatives such as the school milk scheme, the school fruit scheme, food distribution for most deprived people, social care and health care infrastructure and services.

c) The Commission would continue to monitor the implementation of labour law and health and safety legislation. A report is to be drafted in 2009 on the implementation of Directive 91/383/EC, covering the period up to 2007 and attempt identify potential deficiencies in the Directive in order to give guidance for the future action of the Commission in this field.

d) The Roadmap on Gender Mainstreaming would continue to be pursued

d) Some support would be available for stakeholder actions through PROGRESS and the Health Programme.

e) The 2010 European Year Against Poverty is being organised to raise awareness and develop policy to tackle poverty, a main determinant of health inequalities.

f) Other EU actions on specific vulnerable groups (e.g. Roma, migrants, disabled) would continue from the perspective of integration and non-discrimination but not specifically focusing on health inequalities. For example, the European Fund for the Integration of Third Country Nationals would continue to be used and monitored.

4.2. Option II: Current plus

Under Option II, a Commission Communication would raise awareness on health inequalities, highlighting their economic, political and ethical magnitude. It would confirm the reduction

of health inequalities as a policy priority, increase dialogue with other relevant actors in the field and strive towards a better use of existing information and best-practice exchange mechanisms and existing financial support. It would support actions to build knowledge for effective action and strive to improve the existing measurement system on health inequalities between Member States and EU Regions and between social groups across the EU. Indeed, one of the problems identified as an important obstacle to action is the current limited data on the extent and consequences of health inequalities and the current limited knowledge on the effective policies to implement. Information and knowledge is a first step in policy development and this is why under Option II the Commission would propose a number of actions to improve and disseminate information and knowledge. These include actions to improve data and statistics available through improving data collection by socio-economic status and geographic dimension, which would allow the EU and its Member States to measure the extent of health inequalities and to monitor them over time. Improving data collection is to be done through EUROSTAT together with Member States implementing EU surveys and reviewing existing data collection mechanisms and investigating how to improve them. Other actions to improve information and knowledge include more regular monitoring and a more regular use of existing reporting mechanisms to assess the possible impact of policies and to monitor the evolution of health inequalities. Actions to improve knowledge also include using EU funds including Research funds, the Health Programme and PROGRESS to fund scientific research from which Member States could benefit to develop their strategies. It would encourage a first consideration by all relevant policy areas on what is their potential for future action in this field (as proposed by some national authorities in the consultation). It would announce a number of specific actions which would aim to strengthen existing activities, without requiring significant new policy development. It will however be the principle responsibility of Member States' to develop and implement concrete policies.

Activities would include the following:

Raising awareness, promoting information and best-practice exchange, and promoting the tackling of health inequalities as a policy priority:

a) A Communication would underscore Commission commitment to tackling health inequalities as a policy priority. This Communication could be seen as the Commission recognition at a high level that health inequalities are an important issue for policy. It would indicate that there is some evidence and knowledge on the extent, causes of and policies to address health inequalities but there are also important gaps in these domains that need to be filled. The Communication would also indicate that while the EU and Member States have increasingly acknowledged the problem and are pursuing some policies, more can be done at both levels and thus the Commission would start to explore what could be done at the EU level to better support Member States' efforts and ensure a more effective contribution of relevant EU policies towards a reduction on health inequalities in full respect of subsidiarity; and, in this context, the Communication would propose a set of initial actions in that direction.

b) The Commission would explore possibilities for including the reduction of health inequalities as an objective in the post 2010 Lisbon strategy.

c) Strengthen the synergy between Member States and EU work on health inequalities to ensure a more effective sharing of information and best-practice via, for example, the Commission proposing to revise the terms of reference of the existing EU Expert Group on SDH with the aim of ensuring that it was able to add the maximum additional value in relation to work in this area feeding into the work of the SPC and the Council WPPH.

d) Establish a mechanism for bringing social partners and other relevant stakeholders together at European level (e.g. a stakeholder platform) to promote commitment and the uptake and dissemination of good practice in reducing health inequalities at the local level – including through activities at the workplace, in schools and in local communities. Many open consultation responses highlighted the importance to establish a stakeholder platform similar to what happen in other EU initiatives (e.g. nutrition platform) and ensure that a wide range of stakeholders (not only NGOs and not only from the health field) participate. This stakeholder platform will include NGOs which, as stated in the open consultation, can provide an important channel to reach people in the context of their everyday lives..

e) The Commission would bring forward proposals with the aim of stimulating and focussing the reflection on targets on improvements in health status and narrowing of health inequalities to which it committed to in the strengthening social OMC communication, as wished for by many stakeholders in the open consultation.

Improve data availability and the mechanisms to monitor and report on health inequalities and improve the knowledge base on the cases and the evidence base for action: In addition to the work under the social OMC and European health information system as described in Option I this option the Commission would:

a) Develop a consistent methodology for measuring and monitoring differences in health between social groups, Member States regions at the level of the EU using data provided to EUROSTAT.

b) Undertake a feasibility study on the further development of indicators and collection of health data by age, sex, socio-economic status and geographic dimension (e.g. regions) at EU level (as suggested in some open consultation responses) through EUROSTAT work together with Member States;

c) Improve the availability and comparability of health data collected at national level by implementing and analysing EU-SILC and EHIS surveys and regulations on public health statistics. Improve data comparability and coherence with other international datasets (e.g. WHO, OECD) as requested in several responses to the open consultation.

d) Orient relevant EU research program elements towards closing knowledge gaps on the extent, causes, consequences of health inequalities and policies to address them such as Socio-economic Sciences and Humanities of the 7th EU Framework Programme for Research. Develop a consistent and rational EU public health research agenda in future framework programmes to embed health inequalities research. The need for more research and related financial support was also seen as one of main areas of added value of the EU by the responses to the open consultation.

e) Propose inclusion of research on the reduction of health inequalities in the work plans of relevant EU agencies (the European Foundation EU Framework Programme 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, the Fundamental Rights Agency).

f) Develop regular reporting, monitoring and analysis notably via publishing of a special Commission report on progress in addressing health inequalities by 2012 with further reports envisaged in three to five years. The report would be compiled by the Commission and consider data on health inequalities as well as the contribution of EU and National policies. The 2012 report would be an input into the revision of the EU Health Strategy and the further development of EU specific actions on health inequalities for the period beyond 2013,

including the new budget framework. Such a dedicated EU level report was deemed essential by responses to the open consultation (e.g. national authorities) to attain progress in this field.

Develop the contribution of EU policies:

In addition to elements relating to the Research Framework and the EU statistical and monitoring system described above this would require actions to:

a) Review how existing EU Structural Funds (at current levels) in area of health could be better used to address health inequalities by

- Developing the assessment of the impact of the structural funds on health inequality i.e. the Commission would initiate monitoring of the use of the structural funds for health purposes and analyse the impact of the use of funds on health inequalities in the Cohesion Reports
- Encouraging Member States to make a greater use of health status indicators in the assessment of their operational programmes,
- Improving Member States' capacity building in health (i.e. guidance on investment) through seminars on how to use the funds for care infrastructure (ERDF) and to provide staff training on social determinants of health and the social gradient in health (ESF),
- Improving links between policy priorities identified in the Joint Report on SPSI and the investment proposals in operational programmes, including creating an internal Working Group in DG EMPL connecting issue of health inequalities with the use of funds;
- Giving "RegioStarts" to good practices that help reduce health inequalities thus encouraging investments in those health care sector services which make a greater contribution towards reducing health inequalities.

b) Encourage Member States to exploit further the existing options under the EU rural development policy and apply in full the existing schemes under CAP (school milk, food for most deprived, school fruit scheme).

c) Organise a forum on health and restructuring in 2010,

d) Establish a mechanism for health inequality audit (assessing the contribution of existing policies towards reducing health inequalities) for example through work supported by the Health Programme to produce a methodology and provide technical support. Promote exchange of best-practice on using health inequality audits at Member State level

e) Undertake health inequality audits (ex-post) with the aim of strengthening the health equality focus of existing EU activities on health determinants including tobacco, alcohol and nutrition as well as other policy areas

f) Review possibilities for increasing contributions to health inequality reduction in other EU policies such as public health, education; antidiscrimination, gender; environment etc, notably through the use of indicators and reporting

Action to increase the protection of health for vulnerable groups would include:

a) Follow up on the 2007 Council Conclusions on Health and Migration in the EU by improving knowledge of migrants' and ethnic minorities health and its determinants through more EU funded research, better data collection, considering the establishment of a network of national experts on health and migration, disseminating best-practices;

b) Adding focus on reducing health inequalities to the 2010 Roma summit and the integrated platform for Roma inclusion and develop an initiative in collaboration with Member States, to raise awareness and improve the ability of actions to promote health and address inequalities to meet the particular needs of migrant and ethnic minority groups including Roma.

c) Improve synergies between policies and analyse and monitor access to basic goods and services which impact on health (shelter, water, sanitation, healthcare, and other factors)

d) Adding focus on reducing health inequalities in the 2010 European Year Against Poverty and in the proposal for an European Year on active ageing and intergenerational solidarity 2012,

e) Increase the focus on reducing health inequalities in EU activities on the health of children and young people.

In addition the Commission would take the following actions to promote the tackling of health inequalities at a global level:

a) Provide input to the development cooperation work on poverty and health and work on developing social protection in health care in developing countries,

b) Create a tool for assembling and disseminating relevant good practices on social determinants of health and health inequalities;

c) Provide support for joint work with WHO and other relevant international organizations to take forward recommendations of WHO Commission on Social Determinants of Health and

d) Pursue the EU global health agenda outlined in EU Health Strategy;

e) Make full use of the potential of this policy for sector policy dialogue on health inequalities in the context of the European Neighbourhood Policy.

4.3. Option III: Far reaching efforts to enhance EU policy priorities in relation to health inequalities.

In addition to the actions under option II a comprehensive policy approach would be put in place including actions which involve significant changes in polices at EU and national levels. Option III would include the actions in Option II and in addition proposes the following elements including a Council Recommendation:

Raising awareness, promoting information and best-practice exchange, and promoting the tackling of health inequalities as a policy priority:

a) A Council recommendation on health inequalities would set a common agenda for Member States to address health inequalities, while respecting national responsibilities for determining health policy and health services. This would be based on article 152 and has been requested by a number of consultation responses including national authorities.

b) The Commission would propose targets to reduce health inequalities across the EU. Conceivably they could relate to:

- No Member State having an estimated life expectancy at birth for either men or women that is more than X% less than the EU average (measured through ECHI mortality data) by 2020 and/or
- A reduction of X% in the gap in life expectancy between those EU Regions comprising 1/5th of population with lowest life expectancy and the EU as a whole by 2020 (baseline 2008) (measured through ECHI mortality data) and/ or

- A reduction of X% in the level of chronic illness and disability between those with the lowest fifth of incomes and the rest of the EU population by 2020 (measured through EU SILC)

Improve data availability and the mechanisms to monitor and report on health inequalities and improve the knowledge base on the cases and the evidence base for action: In addition to proposing changes to the work plans of relevant EU agencies (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), the Commission would propose changes to the terms of reference of one of them to transform it into an independent and dedicated research agency on health inequalities (as proposed in consultation).

Develop the contribution of EU policies, including better support of Member States and stakeholders' efforts and a specific focus on vulnerable groups and third countries:

a) A high level inter-institutional advisory committee would be proposed to review progress and provide advice to the Commission on the future development of policy. It would include members nominated by: Council, European Parliament, SPC, Committee of the Regions, Economic and Social Committee, EU Health Forum, European Social platform, WHO Regional Office for Europe with a secretariat provided by the Commission. This would meet once per year and provide comment on: the trend and implications of health inequalities and the extent to which health inequalities are taken into account in EU policies. A report would be presented to the Commission.

b) As programmes and policies are renewed for the period beyond 2013, the reduction of health inequalities would be made an explicit key priority and resources would be reallocated or added accordingly. These would include i) the Cohesion policy ii) the research framework programme, iii) health policy, iv) policies on employment, social protection and equal opportunities and v) development and aid policies. This is in line with the findings of the WHO CSDH and many requests in the consultation.

c) The Commission would review the extent to which additional community measures could contribute to ensuring that access to basic needs for health (health care, shelter, food, water education) can be better defined and assured for all groups, but particularly for those who are vulnerable (section 2.1) – including Roma, migrants and people with disabilities.

d) The Commission would propose a major international initiative to address global health inequalities. It would consider additional approaches to support countries neighbouring the EU to reduce health inequalities.

A table spreading through the next two pages provides an overview of the actions under each option and its relation with the objectives.

It can be further illustrated how the EU level actions proposed here relate to Member States actions using some examples

EU level action	Member State level actions / Stakeholders actions
Establish stakeholder platform to overcome current limited commitment by stakeholders: Commission provides the facilities for stakeholders to meet and, together with stakeholders, defines an agenda. The Commission organises the administrative running of the meetings of the platform (e.g. invitations,	Stakeholders' representatives define agenda with Commission and participate on a voluntary basis, providing evidence from their work / experiences / policies. Some travelling and accommodation costs involved. Stakeholders benefit from the information and knowledge generated and may use it to apply it in

secretariat) and provides a mechanism (web) to disseminate useful information that is built through the Platform.	their fields.
Target development to overcome current limited commitment by Member States: under the social OMC the Commission will submit discussion papers to the SPC to generate debate and reach some specific proposals. Funding under the health Programme and PROGRESS may be used to fund specific research on what could be good targets. Based on this and once a consensus is reached at the SPC the Commission proposes a number of targets under the social OMC.	Member States participate in the debate in the SPC and discuss advantages and disadvantages and make proposals for what the targets should be based on the best information available. Awareness is raised especially by those countries which currently put a lower policy priority on health inequalities.
Develop a consistent methodology for measuring and monitoring differences in health between social groups and regions at the EU level using data provided to EUROSTAT to overcome the fragmented knowledge and non-comparable methodologies that currently exist: using funding from the Health Programme commission studies that will provide suggestions for a methodology. The Commission will review such suggestions and will apply the methodology at EU level using EUROSTAT data.	Member States will provide the data as usual on the basis of agreed surveys and regulations. Member States can use and benefit from such methodological developments if they so wish at national level as well as from the general and public knowledge that results from using the methodology. They can thus generate national information where it was not previously available. This contributes for more informed decision making.
Develop collection of health data and health indicators by age, sex, socio-economic status (SES) and geographic dimension which is currently limited: a) continue working with Member States using existing exchange frameworks to improve the implementation and comparability of relevant EU level surveys, whose data the Commission services will analyse; b) EUROSTAT together with Member States using existing exchange frameworks, reviews current practices and the potential for improving mortality and life expectancy data collection by SES in Member States and makes suggestions. Funding may also be used to commission a study to explore the feasibility to improve mortality and life expectancy data collection by SES.	On a) Member States work with EUROSTAT to implement the EU surveys some of which are EU regulations; on b) Member States provide information on their practices and discuss with EUROSTAT the proposals to improve mortality and life expectancy data collection by SES and then choose if and how to best obtain mortality and life expectancy data by SES. Member States can use and benefit from the improved information that results. They can establish more accurately the extent of national health inequalities especially in those countries where this information is currently non-available. Again, this contributes for more informed decision making.
Dedicated report on health inequalities in 2012 with further reports envisaged thereafter to overcome the irregular, fragmented knowledge that currently exists: Commission services will write the report on the basis of existing reporting by Member States, available EUROSTAT data at EU level and any other relevant reporting available at EU level and national level which is public information.	Member States already produce the National Strategy Reports on social protection and social inclusion and will be encouraged to report on actions in the field although reporting on this topic will remain voluntary. Representatives to the Expert Group on social determinants of health and health inequalities may voluntarily produce reports on national actions in the field. Other expert networks (e.g. gender, social protection and social inclusion) may produce relevant information. There may be national research studies or studies by other organisations with relevance to this reporting. Member States and other stakeholders may if they wish provide the Commission services through existing exchange frameworks and on a voluntary basis a report dedicated to their actions to address health inequalities. Member States can use and benefit from the public knowledge that results.

Orient relevant EU research program elements towards closing current knowledge gaps on the extent, causes (causality), consequences of health inequalities and policies to address them: in the coming calls under the 7th EU Framework Programme for Research and for example under the Socio-economic Sciences and Humanities branch, space is made for research on health inequalities.	Member States can use and benefit from the public knowledge that results notably in devising national strategies in this area.
Establish a mechanism as far as possible for health inequality audit to improve ex-post assessment of the impact of relevant EU policies which is currently limited: use funding under the Health Programme to produce a methodology for health audit and to provide technical support. In a pilot manner apply the methodology developed to a small number of EU policies.	Promote exchange of best-practice on using health inequality audits at Member State level by using existing exchange frameworks and dedicated seminars. Participation and the choice to develop and use this audit would remain voluntary. Developing and using health equity audit at national level also provides evidence base for policy development to overcome the current limited knowledge on policy effectiveness at national level.
To address gaps in key services and determinants of health inequalities in those regions lagging behind a) Review how existing EU Structural and Cohesion funds investments (at current levels) could be better used to address health inequalities: see detailed information in the main text above. b) allocate additional funding to the health priority	Member States would be encouraged to use health inequalities related indicators in their assessment of the operational programmes but this would remain voluntary. Participation in the capacity building seminars would also be voluntary. Member States can benefit from the knowledge provided when developing their investment programmes. Any decisions on funding allocations would be approved by the Council.
To improve assessment of the impact of EU policies use existing reporting mechanisms and indicators of the Lisbon, Employment, Cohesion, Social and Health strategies to analyse the relationship between those policies and health inequalities.	To a large extent reporting and indicator development is done in collaboration with Member States. They can benefit from the knowledge created to develop national strategies.

Objective	**Option I –** *Business as usual*	**Option II –** *Current plus*	**Option III –** *Far reaching*
	Continue current activities, no new initiatives	Additionally to the actions under Option I, this Option includes:	Additionally to the actions under Option I and II, this Option includes:
Raise awareness, promote information and best-practice exchange; health inequalities as a policy priority	- health inequalities remain objective of social OMC and health strategy - encourage greater use of peer reviews - some first reflection on targets possible - use existing Health Strategy and social OMC structures for best-practice exchange (OMC, SPC, Expert group, Council WPPH)	- Commission Communication - explore possibility to strengthen link between growth, jobs and health in Lisbon strategy - strengthen the EU expert group on SDH to inform WPPH and SPC -establish a stakeholder platform - stimulate and focus work towards the development of targets	- Council recommendation - set clear targets

Improve data availability and the mechanisms to measure, monitor and report on inequalities in health across the EU and improve the knowledge base on the causes of health inequalities and the evidence base for action	- continue development of Health information system - under social OMC, continue to develop indicators on poverty, utilisation of health care, where possible by socio-economic status - continue to use the EU sustainable Development Strategy and Lisbon Strategy indicators - use the existing monitoring and reporting mechanisms of the social OMC, health strategy plus the social Situation and Demography Report - use existing funding notably under: FP7, PROGRESS and public health programme to develop additional knowledge and evidence base for action	- develop consistent methodology for measuring and monitoring health inequalities - explore the feasibility to improve data collection, and develop indicators by socio-economic status and regions; - ensure further comparability of data by implementing EU-SILC and EHIS and through the implementation regulations on public health statistics - ensure coherence with WHO and OECD datasets - review and orient FP7 to fill knowledge gaps - include special funding line on health inequalities in further FP - propose to change work plans of agencies - dedicated report on health inequalities in 2012 with further reports envisaged thereafter	- propose to change terms of reference of an agency to transform into dedicated HI agency (e.g. EUROFUND, ECDC, OSHA)

Develop the contribution of relevant EU policies towards reducing inequalities in health, including better support of Member States and stakeholders' efforts to tackle health inequalities and a specific focus on vulnerable groups and third countries	- continue financial support through the structural and cohesion funds - continue financial and in-kind support (school milk) via CAP and rural development - some support for stakeholders (PROGRESS, Health Programme) - continue to monitor implementation of labour law and health and safety legislation - 2010 European Year Against Poverty - Continue existing work on determinants (housing, labour market) and specific groups (disabled, Roma) without necessarily a health inequality focus	- ensure better use of Structural Funds by - Assessing the impact of Cohesion funds on health inequalities through for example the cohesion report - Improving Member States capacity building to use the funds through user seminars - new Working group in DG EMPL coordinating ESF and HI - RegioStarts to reward and promote investment - forum o health and restructuring - include a health inequalities audit in public health (tobacco, alcohol, nutrition) and other EU policies - review possibilities for more effective contribution of health, education, anti-discrimination, gender, environment, social, etc. policies, notably through the use of indicators and reporting *Vulnerable groups:* - work on Council Conclusions on health and migrants and the requests to the Commission - add health inequalities focus in the 2010 Roma summit - review existing policies to analyse and monitor access to goods and services, in a joint exercise involving relevant DGs - add health inequalities focus in 2010 European Year of Poverty and in the 2012 Year of Ageing - add health inequalities focus to the Health Strategy for children *Global dimension:*	- create an inter institutional advisory board - make health inequalities a priority in post 2013 programmes and policies including. additional dedicated funding (e.g. Cohesion, FP8, CAP, Health, employment) - review how additional EU policy can ensure access to basic goods and services - propose new international initiative health inequalities - support Neighbouring countries reducing health inequalities

- provide information (assemble and disseminate best-practice information) to third countries

- collaborate with other international organisations (e.g. WHO)

- add a health inequalities focus to the European Neighbourhood Policy

5. ANALYSIS OF IMPACTS

This is a non-legislative initiative with the aim of strengthening action to support and complement the efforts of Member States and other stakeholders on a broad policy objective – reducing inequalities in health. The options are cumulative representing different levels of Community institutional response (option III builds on option II which in turn builds on option I). The actions proposed in options I, II and III operate at two levels: they entail increasing degrees of effort to improve co-ordination and facilitation of the issues at EU level and, secondly, increasing degrees of effort to raise awareness among Member States and other stakeholders of the importance of considering health and social issues notably though not only at this time of financial insecurity for many.

The extent to which the activities addressed in this document make a contribution to assisting action at EU level and by Member States and other stakeholders to reduce inequalities in health is the main factor determining the impact of these proposals.

This initiative falls within the category of 'broad policy-defining documents' as described in the Impact Assessment Guidelines. In line with the guidance there, and taking into account the type of measures proposed, the appraisal is broad and qualitative rather than quantitative.

The impact on the actual health status in the EU or on the reduction in the economic burden as a result of actions at the EU level cannot be estimated with any precision and is not easily measured in quantitative terms. It is difficult to assess the direct impact of the actions listed in section 4 due to the multitude of contributing factors. Indeed, the main effect of the actions proposed is to support efforts by Member States and other actors, who will choose which policy strategies to implement. For example, some measures to reduce health inequalities require investment (e.g. strengthening health and social protection systems) or reallocation of resources, others require little funding (e.g. legislation on smoke free areas). The actions proposed here do not go as far as indicating to Member States and others the specific measures to be taken. Hence, the impact on health status or the economic impact depends on the level of involvement and implementation by Member States (in particular the ones with no current health inequalities focus and the ones with the biggest health gaps) and other actors and the particular mix of initiatives followed by them. In addition it is in general difficult to quantify the monetary value of health as this has a value in its own right over and above the additional economic output that a healthier population is able to generate. The analysis below is thus more an assessment of potential qualitative impacts of the various options, regarding social and economic outcomes as these are the main impacts expected. No direct environmental impacts are expected (and no option among those proposed would have a priori a negative impact on the environment) and they are therefore not considered in the appraisal.

5.1. Social Impacts

None of the options and the actions within them would be expected to have a negative social impact. The actions listed under the three options may be expected to have a number of social impacts as listed below. As said, option III builds on option II which in turn builds on option I so that as we move from Option I to Option II and then Option III we may expect that an strengthening of activities under each of the key objectives can provide a larger positive indirect (via encouraging the development of effective policies to tackle health inequalities at all levels of government) contribution to social aspects such as health and employment.

Options II and III vis-à-vis option I by proposing stronger awareness raising, associated with better data collection and greater monitoring, more knowledge and better and more effective support to Member States (not only financial but also in terms of enhanced policy exchange mechanisms including in the field of health and social inclusion), could lead to Member States: 1) ensuring social protection support to all including in the field of healthcare (access for all to insurance coverage for health promotion, disease prevention, care and rehabilitation); 2) improving the geographic location and availability of services (facilities and staff) in areas where they are lacking; 3) looking at the specific needs of vulnerable groups (including third country nationals) and developing targeted social policy action. Providing a focus on more equality-orientated use of the Structural Funds and Cohesion Funds proposed in options II and III vis-à-vis option I could further encourage Member States to look at those investments that could make a greater contribution to reducing health inequalities. This would be especially the case, if Member States' use of the Structural Funds and Cohesion Funds resulted in an investment towards those areas requiring higher labour inputs both high and low skilled – such as health and social care in the community and notably in deprived population areas. As a consequence, positive employment and health effects can expected such as higher employment of those less skilled, a more equal access to care across socio-economic groups and thus more vulnerable groups, the protection of care recipients or their relatives from the financial costs of care (and thus protecting their financial situation), and better health outcomes in deprived geographic areas / lower socio-economic groups. At EU-level this could also contribute to a greater health convergence between Member States - as the link between within country inequalities and overall country health suggests.

Option II and III vis-à-vis Option I may further enhance the contribution to mainstreaming gender equality issues by looking at gender differences in health and access to health care.

A mechanism for involving social partners as in Options II and III, building on previous and positive Commission's experience to involve stakeholders in other areas, such as obesity and alcohol, sends a positive signal about the importance of partnerships and social responsibility.

Options II and III can also bring an additional impetus to research and policy innovation when the potential of joint EU research will be used for health inequalities issues.

An important issue, both social and economic, is that the present economic crisis can translate into a deterioration of some of the determinants of health (employment, income, health behaviour) and thus an increase in health inequalities, while stricter financial constraints on national authorities' budgets can lead them to cut public budgets associated with health and social protection in general (as the first assessment of the recovery plans of EU Member States conducted by the SPC shows for some countries). Option II and III, through stronger awareness raising activities regarding the extent and economic consequences associated with the pervasiveness of health inequalities and the gains attained by addressing them could ensure that, at a time of prioritisation, Member States do not neglect this area for action and thereby risk incurring negative future economic and social consequences. Further deterioration of health of certain groups now, can imply less employment and productivity of these groups in the future. Furthermore, the economic crisis and the stricter financial constraints imply a need for greater efficiency and emphasis on effective measures that can be introduced to tackle health inequalities. Hence, the crisis makes the need for better information and its dissemination more pertinent and pressing, suggesting that actions under Options II and III would be preferred to those in Option I. Note that, under option I, we start with a baseline scenario of large and widening health inequalities between and within Member States which the current economic crisis could potentially further enhance. In this context, no new actions in the

light of the crisis notably in terms of awareness raising could represent a wasted opportunity with regards to possibilities for health and employment (which could be attained through a greater emphasis on developing community health and social care).

5.2. Economic impacts

The cumulative nature of the options also implies that Option III could create greater uptake of effective measures then Option II and consequently Option I and thus the economic impact of Option III could be greater than that of Option II, in its turn greater than that of Option I.

Indirect economic costs of the persistence of large scale inequalities in health are potentially considerable. Such losses cannot be estimated with any precision or reliability and even less for each option at stake. One of the few studies that has attempted to do so estimated that the potential economic gain which would occur if it was possible to bring the health of the whole population up to the level of health experienced by those with higher education would be between 1.2% and 9% of GDP (Mackenbach et al., 2007). Such a wide estimate highlights the difficulties in deriving monetary costs from changes in mortality and morbidity. Similar estimates are not available for the gap between Member States. However, to the extent that a country's aggregate population health is poorer the larger the within county socio-economic inequalities in health and the fact that death and disease rates of people of working age are over twice as high in some Member States than others clearly represents a loss of human capital and an obstacle the objective of reducing the gap in GDP between countries. The positive economic implications estimated, although not precise, indicate the possibility for investments in reducing health inequalities to have positive economic benefits.

Reinforced action on health inequalities is likely to have overall positive economic effects with the reduction of unnecessary and premature losses (productivity, labour market participation) for health reasons (death or disability) to the labour market. For example, Options II and III, by implying a greater EU focus on the mutual relationship between employment and health could lead to Member States focusing more strongly on health and safety at the workplace, resulting in a) fewer accidents and injuries in the workplace, b) longer working lives and greater labour participation of older workers, which have a positive economic impact (increased GDP).

As this initiative is about *encouraging* Member States to address health inequalities it does not impose any course of action. In this sense there are no *compliance* costs for Member States. Potential savings and costs will depend on the particular mix of initiatives and implementation chosen by Member States. Indeed, awareness raising, best practice exchange, policy analysis and greater knowledge for example, can have different economic impacts. For example, , where Member States decide to strengthen inter-sectoral policies to address health inequalities, there could be budgetary implications as a result of such activities in Options II and III. Member States could allocate additional national investment for the strengthening of health and social protection systems (e.g. more resources devoted to fight poverty or to close gaps in health care provision). Or there could be opportunity costs as a result of the reorientation of resources which could occur particularly in Member States that do not currently have a focus on health inequalities. It is also possible that in some countries there is no change in national budgets as the right priorities are deemed to have been set. And it is even possible that in some Member States, as a result of the activities proposed, there is a reallocation of resources/ reprioritisation and efficiency gains are achieved. Some measures may require more funding than others and it is difficult to prejudge which will be chosen by which Member State and thus the costs of those actions. At the EU level no actual changes in budget or priorities are foreseen

under these options and any future change would be subject to a specific impact (including cost) analysis.

Overall, if the underlying determinants of health and health inequalities continue to improve this would be likely to have a positive economic impact. In the longer term gains in health and reductions in loss of healthy life years may be either cost neutral or of overall economic benefit. The actions proposed here may prove essential in ensuring that to be the case. Indeed, as mentioned in section 5.1, the current economic crisis can have a negative economic impact. Severe economic downturns, such as those which occurred in some Eastern European countries in the early 1990s, were associated with marked deterioration in health and rising premature death rates, which some current Member States are only just emerging from. The economic crisis of FI and SE in the 1990s also had important health and employment consequences (e.g. a large increase in the long-term unemployment rates) which can still be observed. Hence, the crisis makes the need for action along the lines expressed in section 3 and 4 more pertinent and pressing, so that, in a time when Member States need to establish priorities, they do not overlook the possibility to achieve economic and health gains through the tackling of health inequalities. In this respect, additional action under Options II and III would be preferable to those in Option I.

5.3. Costs regarding data collection

Regarding the activities related to improving data availability and comparability notably in terms of obtaining data by socio-economic status it is also difficult to identify the costs involved. Following a very recent questionnaire by ESTAT to Member States on the possibility to obtain such data it was identified that: a) some countries can and provide mortality data by socio-economic status (education level, last occupation) so that for these there would not be additional costs; b) some countries indicated that by law such an information would be difficult to obtain which also implies no additional costs; c) for some countries there could be the possibility to easily link various instruments (e.g. census data and death certificates) at a minimum cost; d) for some, such linkages would require some more additional work and thus costs. In general, EUROSTAT in its work with Member States would aim for the most cost-effective way of obtaining the information. EUROSTAT is currently exploring and proposing a way to improve data collection and dissemination in general that can lead to lower economic and administrative costs. Certainly, any activity that would imply changes in data collection at EU level would be subject to its own impact assessment (including cost) analysis.

Some actions proposed are not expected to generate extra cost. Option II and III would develop a simple mechanism to provide input to third countries which would not involve any additional costs. Some other actions may have a cost. , By proposing a stronger mechanism to involve stakeholders, Options II and III may impose some insignificant costs on those who take part, but participation will not be mandatory. The additional high profile inter-institutional committee in Option III would involve some minor additional costs.

6. COMPARISON OF THE OPTIONS

This section examines, as relevant, the three options and related actions from the perspective of effectiveness – the contribution of the options to achieve the objectives; efficiency – taking into account the amount of resources and effort involved and feasibility – in relation to the time to achieve the objective and possible barriers to implementation. Progress towards achieving the general objectives is regarded as a proxy towards supporting and complementing the efforts of

Member States and other stakeholders in tackling health inequalities and thus the EU contribution towards a reduction of health inequalities in the EU, because it is not possible, with any degree of confidence to make an accurate assessment of the outcome in this area. We finalise each option appraisal by looking at subsidiarity and proportionality issues.

6.1. Option I – Baseline – Continue current activities, no new initiatives

Effectiveness

Option I is maintenance of the status quo and includes a number of activities which will help to achieve some of the objectives. Under option I, it seems likely that continuation of current activities can be expected to lead to some progress.

While the current EU policy framework supports a certain amount of awareness raising and mechanisms for exchange of good practice between Member States, under Option 1 (status quo) and despite current activities, we see that only a small minority of countries has set the reduction of health inequalities as a main policy priority and has implemented a comprehensive inter-sectoral approach to tackle health inequalities. The COR's response to the public consultation also highlighted that the current action was not sufficient to ensure that health inequalities would appear on all national policy agendas.

Similarly, while current activities support some development of information and knowledge in this area, weaknesses would remain in monitoring the level of health inequalities between and within Member States due to lack of comparable data (e.g. health related indicators are not fully comparable and routinely available across Member States) and in lacking an accepted methodology for calculating health inequalities. Without an agreed way of monitoring health inequalities and without recognised dedicated reporting, knowledge at the Community level about the rate of progress and the effective policies to implement would be weak.

Continuation of EU activities as currently set would not necessarily lead to a greater understanding of the contribution of EU policies to reducing health inequalities, neither would it necessarily lead to greater awareness in relation the protection of health of vulnerable groups such as Roma, nor would it provide an input to a global agenda on health inequalities.

Thus continuing with current level of activities is likely to lead to some but modest progress in relation to the objectives (i.e. some progress in raising awareness and encouraging further policy prioritisation by Member States, some data and knowledge developments).

Efficiency and Feasibility

This option does not imply any additional administrative costs, nor require re-orientation of funds from other policies. However, in political terms, it would not respond to the requests by Member States and other stakeholders for additional EU action in this field.

Subsidiarity and Proportionality.

There are no subsidiarity issues at stake with this option as Member States' prerogative for health and other policies remains untouched.

6.2. Option II – Current Plus

Effectiveness

The actions listed under option II represent an additional strengthening of activities under each of the key objectives. Overall they would lead to a greater and more rapid change in the direction of achieving the objectives.

For example, Option II (as well as Option III), through improving the work of the current EU Expert Group on SDH would provide additional input and value to the work of the SPC and the Council WPPH and thus strengthen the existing information sharing and best-practice exchange mechanisms without significant administrative or economic costs to the EU or national administrations. Mechanisms for involving social partners create additional momentum for action to achieve the objectives. Building on previous and positive Commission's work to involve stakeholders in other areas, such as obesity and alcohol, they can create a greater policy focus for example on effective policies to improve the health of specific and vulnerable groups such as migrants. Option II could also bring an additional impetus to research and policy innovation. Indeed, Option II (as well as Option III) compared to Option I could produce better information and knowledge to inform decision making by Member States and other stakeholders on policies to address health inequalities, something that has been supported by the majority of stakeholders.

Option II could lead to more appropriate ("equality proof") regional investments, making them responsive to the observed large and widening health inequalities and other challenges such as the current economic crisis or the future challenges of ageing societies.

Efficiency and Feasibility

Option II builds on existing work, does not require any significant shifts in policy, and there will be no changes in budgetary allocations. No new obligatory reporting would be required from Member States by this option, as information would primarily be drawn from existing reporting mechanisms.

In general this option is achievable within existing resources and highly feasible although there are some issues that need noting. Policy priority under Option II would imply more in-depth work on targets. Such work received substantial support in the consultation (some national authorities included). While support for this has been building, an acceleration may still involve the risk of generating resistance from some Member States. In addition, some actions to improve data availability and comparability could require the modification of current information systems in some Member States as explained in section 5.3 which could raise some resistance. This work would however be coordinated through the working groups with Member States convened by EUROSTAT as is done with all areas of statistics.

Subsidiarity and Proportionality

This option envisages an extension of some EU activities and therefore proper consideration of whether such an extension is consistent with the principles of subsidiarity and proportionality. This goes beyond the simple legal basis for action which has been set out in section 2.6, to consider whether the proposed actions meet in addition all the following criteria – necessity and added value of EU level action in addition to that of Member States and proportionality. The issues relating to the necessity and added value of EU action on health inequalities focus on 3 elements:

- harmonised EU-wide data collection and monitoring to allow for comparison of performances;

- added value of exchange of information and knowledge facilitated by the EU and use of EU Research Programmes.

- in addition to this, the EU has a role in determining and monitoring EU level policies such as labour market policies, cohesion policies and others which influence HI;

The section on the causes of health inequalities has outlined the multitude of influences starting with overall macroeconomic policies but also including a wide range of other policy areas such as social, health and regional policy and activities combating discrimination and ensuring equal rights. EU policies are important in all these areas in supporting and complementing the efforts of Member States and other stakeholders. A better understanding of how EU policies affect health inequalities, which would be obtained under Option II through health inequalities impact analysis, would have the potential to inform future EU policy development. EU wide data collection and monitoring will provide the possibility of comparison and learning between Member States which will be of benefit to policy makers in each country. By reason of their greater scale and opportunities for sharing expertise between countries the EU research programme can add additional value to national efforts in this area. Finally there is considerable experience from the OMC in social, educational and other policy areas of the added value of exchange of information and knowledge between Member States facilitated through EU mechanisms. These benefits of a supportive intervention of the EU were highlighted by the COR's response.

The actions in Option II are relatively modest and proportional to the objectives defined in this impact assessment. Option II represents a lighter implementation requirement for the EU and for Member States, in comparison with the activities listed under Option III.

6.3. Option III – Far reaching efforts to enhance EU policy priorities in relation to health inequalities

Effectiveness

As options are cumulative it is conceivable that Option III is evaluated as the package of measures likely to have the greatest impact on the objectives. The particular added value of Option III is in relation to political commitment and monitoring and evaluation. Under Option III, a Council recommendation, EU wide targets and high profile inter-institutional committee, as well as the additional focus on reducing health inequalities from key EU policies described under Option III, are likely to have the biggest effect in terms of raising awareness and establishing the tackling of health inequalities as a policy priority. Although not legally binding, a recommendation would be highly visible and would ensure ownership by Member States. Experience shows that the status of recommendations does facilitate the uptake and dissemination of measures and can become a reference document for all actors involved. It could then be a useful tool to strengthen monitoring and evaluation. A recommendation would also be a good opportunity to make clear how a package of measures on tackling health inequalities should be integrated into overall social and economic development measures as part of the Lisbon agenda. Some of the responses to the open consultation including by national authorities support the proposal for a Council Recommendation for these reasons.

Efficiency and Feasibility

Option III however is likely to take longer to achieve the objectives and carries additional "risks" – particularly in relation to possible lack of acceptance of measures proposed by the

Commission which have not previously had the opportunity for a developmental process with Member States and stakeholders.

In general, the possible drawback of the package of measures in Option III is that there are currently significant uncertainties regarding causations and effective measures. This means that, while such deep policy changes should be considered as realistic future actions, in the current context, there is a risk that we propose an incomplete and ineffective set of changes. There are therefore advantages in taking an intermediate set of steps as proposed in Option II to build up information, knowledge and experience before we suggest larger actions.

Moreover, some of the actions proposed in Option III such as a Council Recommendation and additional work in relation to community measures that can improve access to basic needs, would also require the support of other EU institutions and Member States and at this stage such level of support has not been determined. While it is true that the Council has requested further EU action to address health inequalities it is not clear that a Council Recommendation would be favoured by a majority of Member States in the current situation and given the existing lack of information and knowledge.

Proposing targets allows the Commission to test the strength of political interest and respond to the challenge created by the economic crisis to reorient Member States actions around health and social actions. Although the majority of consultation responses supported the idea of targets, they also feel that setting quantitative EU targets would not be possible at this moment due to data and knowledge limitations and large differences between Member States. Introducing targets without sufficient preparation may result in them being ignored, and waste the political potential of this action for the future.

Hence, the implementation of the package of measures outlined in Option III requires the support of other EU institutions and at this stage such support has not been sufficiently gauged. Option III may also involve some opportunity costs and risks associated with too ambitious actions on the basis of current knowledge and experience which could be reduced through the intermediate information/ knowledge and experience building exercise of Option II. Many stakeholders wished for parts of Option III, but agreed that not all are feasible right now. Concluding, while there is a general political consensus for additional EU action under the lines of Option II, going further, along the lines of Option III, may bring a split between those Member States who wish to go further and those who do not and thus there is a risk of creating political resistance which is counterproductive.

Subsidiarity and Proportionality

Option III represents a further extension of EU level activities beyond those in Option II. However the main points discussed under Option II are also valid. By introducing a Council Recommendation Option III would seek to create a common approach and impetus amongst all Member States to addressing inequalities in health. Such a non binding recommendation would continue to fully respect the responsibilities of Member States to determine their health policies and organize and deliver health services. However, it is questionable whether at the current state of knowledge the setting of targets for HI reduction at EU would still meet the objective of proportionality.

The following table summarises the impact of the three options on the specific objectives as defined in section 3.2. In the table "+" indicates some positive impact, ++ indicates significant positive impact, +++ major positive impact, impact "0" indicates no change and "-" some negative impact, -- significant negative impact, --- major negative impact.

Contribution towards Objectives	**Option I**	**Option II**	**Option III**
Raising awareness and promoting the tackling of health inequalities as a policy priority	+	++	+++
Enhance mechanisms to monitor and report on inequalities in health and improve the knowledge on the causes of health inequalities and the evidence for action	+	++	+++
Develop the contribution of relevant EU policies towards reducing inequalities in health	+	++	+++
Feasibility	**Option I**	**Option II**	**Option III**
Political risks / lack of acceptance / lack of Member States' support / counterproductive	No	No	Yes, some
Costs of achieving the objectives	**Option I**	**Option II**	**Option III**
Administrative cost development of information systems	0	-	--
Investments allocated to addressing health inequalities for national authorities	-	--	---

Preferred Option

All three options would help to achieve the specific objectives albeit to a different extent. Option III is expected to achieve most in terms of the specific objectives and positive social and economic impacts. However, it also has the potential for some additional administrative and opportunity costs, may suffer from knowledge uncertainty and may face some political barriers. Option I is likely to make a modest contribution. From the effectiveness and feasibility perspective, the costs involved and the ability to act quickly in relation to the current crisis, Option II is the one which is preferred. Therefore, while actions under Option III are realistic potential EU actions, the current situation suggests that we should follow an intermediate Option II. Option II can be seen as a stepping stone to further EU level work on health inequalities. This option fully respects the principle of subsidiarity. Note that actions have been grouped together under the different options according to the level of additional policy content and support from other institutions involved. To some extent however, there is a possibility for individual elements to be moved between Options II and III if so decided.

7. MONITORING AND EVALUATION

This document has identified a number of gaps in information and lack of comparable indicators across Member States on health inequalities[38]. It contains several proposals to improve information, monitoring and reporting on the progress in relation to impact on health inequalities and related outcomes such as social protection and social inclusion. These include the development of indicators based on current data and further progress on the development of EU wide indicators on related outcome measures.

[38] For an overview table linking the identified problems via the objectives with the evaluation see Annex A17.

The key elements for monitoring and evaluation are: impact on national policymaking, impact on EU policy and on policy outcomes. Impact on national policy will be monitored firstly through the existing OMC and health strategy mechanisms. That is through reporting, self monitoring and evaluation including through peer review. Monitoring and evaluation will be on the basis of measurement against the specific objectives. The precise mechanisms for monitoring and evaluation will thus depend on what measures are chosen in the eventual communication. The table below should therefore be regarded as indicative of the kind of approach that will be taken to monitoring and evaluation of activities on health inequalities in a future communication.

An additional mechanism for reporting and monitoring is identified in Option II – a report by the Commission on progress in tackling health inequalities. This Option foresees that in 2012, the Commission will publish a report on the implementation of this initiative and the progress it has had on addressing health inequalities with further reports envisaged (including an evaluation of the HI strategy). This report will give elements for the revision of the EU Health Strategy and the further development of specific actions on health inequalities for the period beyond 2013. Option II also provides for the development of a consistent methodology for measuring and monitoring differences in health between social groups, Member States regions at the level of the EU and support Member States to collect data on health inequalities and determinants of health. These data will be used for monitoring and evaluation.

Impact on EU policy could also be monitored through the newly configured EU Expert Group reporting to the SPC and the Council Working Party on Public Health at Senior Level. The Commission will provide expert support for regular analyses of EU policy developments for discussion with relevant groups through existing mechanisms. These include the Observatory on the Social Situation and the Observatory on Health Systems and Policies.

The Commission will also contribute to analysis which could form the basis for discussion at the EPSCO Council.

Objective	**Indicator**
Raise awareness, promote information and best-practice exchange and advocate the tackling of health inequalities as a policy priority	Number of Member States with comprehensive policy approach which can be analysed in the social OMC NSR 2011-2013 (currently two)
Improve data availability and the mechanisms to measure, monitor and report and improve the knowledge base	To be evaluated by the Eurostat Working group on mortality data, who is compiling the data
	To be evaluated by DG Research by number and quality of studies, and amount of distribution platforms (internet portal), publications (available in all languages)
Develop the contribution of relevant EU policies towards reducing	how many relevant EU policy strategies have an indicator of health status inequalities

inequalities in health	how many EU reports address the influence of certain strategies on health and health disparities	
	Additional assessment under Option II and III in dedicated Health Inequality report 2012	

Annexes to the Impact Assessment on "Solidarity in Health".

8. ANNEX 1 CONSULTATION AND EXPERTISE

8.1. Targeted written consultation

Consultation process.

A targeted written consultation of stakeholders was carried out as part of the preparation for a Commission Communication on Health Inequalities. The Health and Consumers Directorate-General (DG SANCO) and the Employment, Social policy and Equal Opportunities Directorate-General (DG EMPL) invited stakeholders and organizations working with them on issues related to health inequalities to respond to a consultation document which contained a number of questions (Annex 1). Altogether 148 requests for consultation were sent it. The consultation was launched on 3 February 2009 with a closing date of 1 April subsequently extended until 15 April. The consultation document was also placed on the Commission's web site giving an opportunity for others to reply[39].

Composition of respondents

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

Responses from EU Member States and national governmental organizations in Member States:

Belgium, Cyprus, Czech Republic, Finland, France, Germany, Hungary, Ireland (national public health institute), Latvia, Lithuania, Malta, Sweden, United Kingdom, (Department of Health)

Responses from national governmental organizations in other countries:

Norway

European Bodies outside the Commission@

Committee of the Regions,

European Centre for Disease Prevention and Control,

CEN - European Committee for Standardization.

Responses from the regional level,

Assembly of European Regions AER

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

European Regional and local Health Authorities platform - EUREGHA
Bayrisches Staatsministerium für Umwelt und Gesundheit
Cornwall health service
Glasgow health service
Kent & Medway health service
Limburg (NL)
Local Government Association - Wales and England
Scottish health service
Skane County Council
Västernorrland County Council
Västra Götaland health service
Verbindungsstelle der Bundesländer (AU)
Western Investing for Health (Northern Ireland)

From health service systems responses were received both from providers and insurers:
BKK (DE)
Bundesarbeitsgemeinschaft der Freien Wohlfahrtspflege
Bundesärztekammer und Kassenärztliche Bundesvereinigung
Caritas (DE)
Eurodiaconia
European Social Insurance Platform
HOPE European Hospital and Healthcare Federation
Mutualité Française
Mutuelle générale de l'Education nationale (FR)

European wide networks of health professionals of several disciplines replied as well:
Standing Committee of European Doctors
British Dental Association
British Medical Association
Council of Occupational Therapists for the European Countries
European Association of Intellectual Disability Medicine - MAMH
European Association of Service providers for Persons with Disabilities – EASPD
European Society of Intensive Care Medicine
European Union Geriatric Medicine Society - EUGMS

International Association of Gerontology and Geriatrics

European umbrella organisations (ENGOs):

AIDS action Europe

AVERROES Network (migrants' health)

Central and Eastern European Women's Network for sexual and reproductive Health and Rights - ASTRA

Confederation of Family Organisations in the European Union

EuroCare - European Alcohol Policy Alliance

Eurochild

Eurocities

EuroHealthNet (Public Health)

European Child Safety Alliance

European Disability Forum - EDF

European Federation for Street Children

European Federation of Retired and Elderly People

European Forum for Primary Care

European health and Fitness Association

European Health Management Association

European Institute for Women's Health

European Men's Health Forum

European Network against racism

European Network for Smoking Prevention - ENSP

European Network of Occupational Therapy in Higher Education - ENOTHE

European Network of Regions Improving Citizens Health

European Older People's Platform - AGE

European Patients' Forum

European Public Health Alliance

European Respiratory Society

European Social Network - ESN

European Volunteer Center - CEV

European Womens Lobby

European Youth Forum

FEANTSA the European Federation of National Organisations working with the Homeless

International Association for the Study of Obesity IASO

International Planed Parenthood Federation

National Heart Forum (UK) / European Heart Network

Smokefree Partnership

Social Platform

Trade Unions

UEAPME (European Association of Craft, small and medium-seized enterprises)

Confédération Européenne des Syndicats Indépendants (CESI)

European Federation of Public Service Unions

European Trade Union Confederation ETUC

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

European Diagnostic Manufacturers Association

European Federation of Pharmaceutical Industries and Associations EFPIA

Alliance Boot

Eucomed - medical technology

European Association of Service providers for Persons with Disabilities - EASPD

Insurers of Europe - CEA

Novartis

Gilead Science

National Non Governmental Organizations

Actuarial Profession UK

Dental Health Foundation Ireland

Home Safety Scotland

La Confederacion Espanola de Agrupaciones de Familiares y Personas con Enfermedad Mental - FEAFES

National Pensioners Convention UK

NIVEL & PHAROS - Centre of expertise on refugees and newcomers' health

Romanian Association Against AIDS

Zminijietna - Voice of the Left (MT)

IOGT-NTO (SE, Alcohol)

Connections - Integrated responses to drugs and infections across European criminal justice systems

ver. E.A.T.R.G.

National Roma Centrum Macedonia

Fundación Secretariado Gitano

Women's Health Council IR

Research institutes and individual scientists:

Association of Schools of Public Health in the European Region

Health Monitor Research HU

Health and Social Development Foundation, BG

Kosice Institute (SK)

Landesinstitut für Gesundheit und Arbeit NRW

Royal College of Nursing UK

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

Other responses included

International Organization for Migration

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

the Women of the Green Party (SE)

Alternattiva Democratica party (MT).

8.2. Summary of responses

Nature and scale of the overall problem

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

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

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

Inequalities between and within Member States

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

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

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

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

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

Determinants

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

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

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

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

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

The EU added value

The overwhelming majority of responses welcomed further action by the European Union. The appreciation of EU added value was linked to respondents views on the definition of health inequalities. Stakeholders, which focussed on health care access stressed Member States'

responsibility, whereas those which focussed on health outcomes welcomed further Community action. An organization representing insurers underlined that inequalities in health care access are subject to Member State regulations and best solved at the regional or even local level. EU added value was welcomed in the areas of data collection, agenda setting and funding.

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

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

Awareness

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

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

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

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

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

Measurement, Monitoring, Reporting

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

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

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

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

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

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

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

One response suggested a dedicated institution to monitor health inequalities.

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

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

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

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

Policy coordination at EU level

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

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

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

EU policies

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

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

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

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

Some documents explicitly asked for better interservice communication.

Resources

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

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

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

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

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

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

A regional organization proposed an exchange programme for health professionals.

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

Most vulnerable groups

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

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

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

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

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

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

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

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

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

Targets and Benchmarks

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

Targets were proposed for injuries and concrete groups of people.

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

Overall summary of targeted consultation

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

8.3. Consultation during the development of previous communications.

Considerable consultation took place on the broad elements of possible future Commission action on health inequalities prior to the commencement of the impact assessment exercise. Proposals for Commission action on health inequalities were included as part of the development of the EU Health Strategy (2007) and the Renewal of the Social Agenda (2008). These consultations are documented in the impact assessments accompanying these communications and included both written consultation and via key meetings which included the Social Protection Committee and the EU Expert Group on Social Determinants.

Renewed social agenda

A wide public consultation took place during 2007 on Europe's Social Reality which is relevant to this communication. The consultation was launched in February 2007.40 The initial results of this consultation resulted in the November 2007 Communication "Opportunities, Access and Solidarity: Towards a New Social Vision for 21st Century Europe" setting out a range of possible responses to the societal challenges at work in the EU. The consultation process involved 150 contributions from a wide range of sources such as public authorities, a national parliament committee, social partners, non-governmental organisations (NGOs), various interest groups, universities and research institutions, religious groups and churches as well as individual citizens. Improving health receives considerable attention in most of the contributions, thus confirming the crucial role attributed to this area of action in the consultation document. In a number of contributions, health was seen as a factor influencing virtually all domains of the social reality of individuals. A second consultation followed (ending in February 2008) and the Social Agenda Forum, was organised on 5/6 May 2008, with a view to provide a platform for stakeholders — representatives of EU institutions and the national authorities of Member States, notably representatives of national, regional and local authorities, social partners, NGOs, international organisations, networks in the domain of social policy, researchers active in the domain of social policy — to discuss the outcome of the social reality stocktaking exercise and the broad policy orientations for a renewed Social Agenda. Once again improving health and reducing health inequalities was part of the discussions held. The Commission closed the conference with the announcement of future action in the field of health inequalities including a Communication. The Commission then launched the Renewed Social Agenda in July 2008, part of which relates to ensuring longer and healthier lives and announces a Communication on health inequalities for 2009.

EU Health strategy

The consultation process in early 2007, which aimed to gain stakeholder input with regard to the EU Health Strategy (adopted in October 2007) involved national, regional and local authorities, NGOs, associations, companies, universities and individual citizens. The majority (54%) of the more than 150 respondents considered reducing health inequalities, both between and within Member States or regions, as a very important objective for the Health Strategy and said that EU activity should be enhanced in this area.

Committee of the Regions

40 See http://ec.europa.eu/citizens_agenda/social_reality_stocktaking/index_en.htm

The Committee of the Regions conducted a consultation of its members on the "Assessment of Territorial Impacts of EU Action to Reduce Health Inequalities". It has to be noted that just 13 regions replied, out of which five from Spain and none from the new Member States.

The drivers of inequalities identified in the survey complement the list given in this impact assessment (socio-economic factors and lifestyle) by geographical features (remoteness, fragmentation, islands and mountainous environments, presenting concrete barriers to the use of services) and cultural heritage (peoples perception of health systems and issues according to local traditions, organisation and ethnic group).

Desirable Community action includes: mainstreaming, equity-focused health impact assessment, promoting universal coverage, improve monitoring and standardisation of indicators, research, learning and training, exchange of information and best practices.

Additionally the actions outlined in the health inequalities impact assessment stakeholder consultation, the CoR calls for the funding of telemedicine. Assessment of the impact of Community funding is difficult, because finances are channelled through various national or regional structures.

Mainstreaming is deemed necessary especially in the policy fields of social policy (incl. social housing and poverty reduction), education, labour market (safe working conditions and reduction of job insecurity), urban planning and transport (reducing inequalities between rural and urban areas), environment (food safety) and immigration (special support to border regions).

8.4. Consultation with key groups convened by the European Commission

Social Protection Committee (SPC)

Specific consultation took place with the SPC during the impact assessment process on the possible objectives and action which are included in this document.

Prior to that, in early 2007 a peer review on health inequalities in the context of health care reform took place in Hungary within the programme of peer reviews organized through the SPC. It brought together representatives of 8 EU Member States, who shared their policy experiences with each other and with a small number of relevant non governmental organizations, academic researchers and Commission staff. The peer review showed that differences in health status and access to care can be substantial within each country depending on place of residence and socio-economic status. Member States exchanged views in terms on policies particularly in relation to the design of health services in order not to deter those more vulnerable from accessing necessary care and thus to avoid a negative impact on health from delayed treatment (e.g. cost-sharing, health insurance).

In the spring of 2007, the Commission presented a discussion paper on health inequalities in the EU to the Member State delegates to the SPC. This paper reviewed existing evidence of health status inequalities within Member States using published research papers, SHARE data and EU-SILC data. It reviewed existing policies or policy proposals by Member States as put forward in the National Strategy Reports (NSRs) on Social Protection and Social Inclusion 2006-2008. The paper was well received by Member States who considered this to be a priority area for health and social policy.

Several Joint Reports have also highlighted the issue of health inequalities as a crucial area for policy (Joint Report on Social Inclusion 2004, the JRSPSI 2006, the JRSISP 2007 and the JRSISP 2008). The JRSISP 2008 provided an entire chapter on health inequalities within

countries, across population groups. NSRs 2008-2011 and Joint Report 2009 in addition to above mentioned reports.

An indication of the policy interest in this area is that Member States have agreed to a regular monitoring of health status inequalities under the social OMC using a set of common indicators (life expectancy, healthy life years and self-perceived measures of general health and activity limitations). The Indicators sub-Group (ISG) of the SPC has in several occasions highlighted the need to improve data comparability in this area and the need to have data and indicator by sub-categories such as age, sex and socio-economic status. The ISG has also called for further improvements in the collection of mortality data by socio-economic status. The development of indicators of health status and access to care are an important part of its work.

On the SPC meeting of 18 March 2009 there was a dedicated agenda item whether and what additional EU level action was needed to address health inequalities between and within EU Member States. The outcomes of that discussion are as follows.

Member States strongly welcomed additional action by the Commission as they deemed this is a very important/pertinent topic, central to human development. They held a social determinants perspective of the issue i.e. health inequalities are the result of many factors (social determinants) that lead to unhealthy living conditions (e.g. life-styles, income, employment) in addition to access to quality healthcare (promotion, prevention and treatment). Thus health inequalities relate to policy areas other than healthcare such as education, income distribution, housing, and social protection for example. Thus, they support a "health in all policies /inter-sectoral" approach to addressing the issue and welcome the fact that additional actions are joint initiatives by DGs EMPL and SANCO and other Commission services. Moreover, they suggest that, from this perspective, it is necessary to look at both member States competences and work and at EU competences and work and mobilise resources at the two levels, where they can impact on those factors. Member States claimed that the issue does not pertain to vulnerable groups only but is in fact about a social gradient and thus action should address this social gradient. However, if these actions do not help improve e.g. access to services by those more vulnerable then special actions may be needed. Additional actions were proposed along the following lines:

- Conduct reviews of Member States actions to address health inequalities e.g. assess equal access to health services, quality and effectiveness of health systems in addressing health inequalities; Conduct studies based on an SPC questionnaire.
- Fund research studies on the quality and practical implication and consequences of actions.
- Conduct more extensive and intensive exchange through peer reviews but especially in-depth reviews on the basis of a questionnaire / consultation structure.
- Organise a high profile conference every 2 years to see what has been the progress in the area.
- Create a platform approach with stakeholder involvement.
- Support and follow experiments better through PROGRESS and public health action programme.
- Conduct analysis of specific types of diseases and mortality rates as it may be "easier" to identify good promotion and prevention strategies. Monitor evolution of specific diseases and in certain groups (e.g. children).
- Complement this with looking at specific groups and their access to care (e.g. disabled, elderly, profession, gender).

- Work on improving the common social OMC indicators already agreed to, notably in terms of comparability. Continue work to have life expectancy, mortality rates and healthy life years by age, sex and socio-economic status.
- Investigate whether more resources could be made available to healthcare through the Structural Funds and to reduce health inequalities
- Ensure the visibility of the issue i.e. of the existing inequalities in health, of the actions to improve it and look for political commitment (especially from other policy areas).

Finally, assess the impact of the crisis on healthcare and health in the SPC assessment and the crisis should not halt the work on health inequalities, quite the contrary

EU Expert Group on Social Determinants and Health Inequalities

The EU Expert Group on health inequalities and social determinants of health is an informal group convened by the Commission including representatives nominated from Ministries of health of Member States as well as officials from several Commission services, the WHO, OECD and the Council of Europe. The Commission's Communication on health inequalities was a main agenda item at meetings of the group in December 2008 and March 2009.

The group commented favourably on the review of the evidence and expressed strong support for the main ideas for further action. Participants saw the crisis as adding extra urgency to the initiative and offered a number of suggestions for how to tackle various methodological, procedural and political issues.

The group identified a range of ideas for how to progress EC work on health inequality reduction which will be further elaborated in written responses. Particularly useful were suggestions for how to approach methodological problems of measurement and monitoring and political dilemmas of priority setting and sequencing of actions. There was a wide-ranging discussion on the pros and cons of target setting. Several participants made clear that they would welcome support for countries who wished to set targets for themselves. However, they did not support the European Commission setting targets at country level. There was considerable discussion about targets for the European Commission e.g. on 'equity-proofing' EU policies, with more discussion necessary. Participants from a number of Member States expressed interest in the possibility of a joint action through the Health Programme to support implementation mechanisms for the forthcoming Communication.

Other points included:

- The health impact of the crisis adds new urgency to action aimed at containing and reducing health inequalities – there is a danger that these will increase.
- Reduction of health inequalities is neither just about health promotion nor primarily about poverty avoidance; it concerns health in all policies with a definite equity emphasis.
- At this stage more is known about policies to tackle gaps in health rather than the gradient in health inequalities. While better data might be useful to understand how the steepness of the gradient plays out across social groups in different MS, a

greater concentration should be given to identifying policies which help to level the gradient, as well as addressing the gap.

- Delivering benefits for the working and middle classes are important for securing broad political support for action on health inequalities.
- At the same there needs to be special attention to those groups particularly disadvantaged by socially determined poor health. In this work it would be important to draw on knowledge and experience from the EU's work on social inclusion.
- Delivery mechanisms in present health services can increase socially determined health inequalities sometimes in a very significant way. Addressing the health sector from a social determinants and equity perspective would both make a contribution to reducing HI s, and set the lead for action by other sectors. .
- Need to include elements on public health capacity building.
- Additional work at the EU level on health equity impact assessment of both existing and future policies would be welcome.
- Improved mechanisms for collaboration on health inequalities between the Social Protection Committee the EU Expert Group and the Council Working Party on Public Health would be a good idea.
- In addition to support from the structural funds more work should be done to see, among other policies how the Agriculture and Rural Development and internal market policies could assist, and consider the impact of EU policies on health inequalities globally, particularly in low income countries..

Open Health Forum

A session of the EU Open Health Forum held a plenary session in December 2008 on health inequalities chaired by the Director General of DG SANCO with around 400 participants. A background paper described the proposed communication and invited comment on a number of key questions. The rapporteur summarised the discussion as follows:

Making a difference in health inequalities at the local level will only be possible through the active involvement of a very wide range of stakeholders. EU action should be across all relevant policies and enable engagement at all levels with a wide range of civil society actors as well as governments. The EU should contribute to alleviating poverty and improving the living conditions – with an emphasis on the most vulnerable. Rural and urban deprivation should be addressed Ultimately all action must impact locally and involve local people, which will require measures to enable relevant networks and stakeholders to have an impact on people as part of their everyday lives – at work, at leisure, at home, in schools and universities in hospitals in care institutions and in communities. Equity orientated health policies on chronic disease prevention are needed with greater emphasis on tackling major health determinants such as tobacco, alcohol, obesity, physical activity and accidents. Action should aim to create the biggest impacts amongst areas, communities and groups with the greatest need.

The EU should be active in: proposing targets and benchmarks; suggesting what action is needed by which actors; monitoring progress towards targets; carrying out analyses and impact assessment of its policies to determine their impact on equity between social

groups and regions; facilitating exchange of good practice and engaging with governments and stakeholders; using its funding instruments to support action on inequalities in ways which are easier for disadvantaged people to benefit and creating a genuine health in all policies approach. It is particularly important to do this now in order to protect and make fundamental values of solidarity, social cohesion and human rights a reality at a time of economic difficulties

European Health Policy Forum

The European Health Policy Forum meeting in January 2009 discussed the possible actions which would be desirable in a future Communication on health inequalities and were invited to provide further input on several key questions.

Participants strongly welcomed the Commission initiative to bring forward a communication on health inequalities. Participants commented that more work should be done to encourage and support countries which had not yet carried out any analyses on the distribution of health by area and by social group to do so. There was qualified support for target setting at the EU level and the idea of health inequality impact assessment of existing and planned policies was strongly supported. More work was needed to involve disadvantaged and vulnerable groups in contributing to policy development which affects them. The EU work on health literacy could be a useful and relevant input to the development of the Communication. Further work by the EU to support regions to improve health and address health inequalities both directly through the structural funds and by encouraging exchange of good practice via networking and other arrangements, would be very welcome.

8.5. Consultation with EU institutions

The Committee of the Regions included a consultation on the Communication on health inequalities as part of its work for 2009. A targeted consultation took place through the subsidiarity platform.

In order to facilitate dialogue and provide input into the development of the Communication the European Economic and Social Committee established a study group and selected a rapporteur in anticipation of the Communication.

Committee of the Regions

The Subsidiarity Platform of the Committee of the Regions conducted a consultation on the "Assessment of Territorial Impacts of EU Action to Reduce Health Inequalities". Thirteen regions participated, five of which were from Spain and none from the new Member States.

The drivers of inequalities identified included socio-economic and life-style factors; geographical features such as remoteness, fragmentation, islands and mountainous environments which present concrete barriers to the use of services; and cultural heritage (people's perception of health systems and issues according to local traditions, organisation and ethnicity)..

Desirable Community action included: mainstreaming, equity-focused health impact assessment, promoting universal coverage, improve monitoring and standardisation of indicators, research, learning and training, exchange of information and best practices.

Additionally the actions outlined in the health inequalities impact assessment stakeholder consultation, the CoR called for the funding of telemedicine. Assessment of the impact of Community funding is difficult, because finances are channelled through various national or regional structures.

Mainstreaming is deemed necessary especially in the policy fields of social policy (incl. social housing and poverty reduction), education, labour market (safe working conditions and reduction of job insecurity), urban planning and transport (reducing inequalities between rural and urban areas), environment (food safety) and immigration (special support to border regions).

The Committee of the Regions (COR) carried out an impact assessment consultation among the partners of the Subsidiarity Monitoring Network during February and March 2009 and received 13 responses. Health inequalities were perceived as a problem. Factors mentioned as drivers included: (i) socio-economic conditions; (ii) lifestyle; (iii) geographical features of the territory; and (iv) cultural heritage. Action at Community level was considered necessary particularly in relation to improving comparability of information and assessment of the state-of-the-art processes at national and regional level. Other suggestions for action included: (i) promoting 'Health equality in all policies' (ii) developing an equality-focused health impact assessment; (iii) promoting universal coverage health systems across the EU; (iv) improving mechanisms for monitoring inequalities in health across Europe, (v) promoting research and exchange of best practice. In more specific terms and stressing the particularities of remote areas, like islands, EU support for health information technology was seen as an added value for these regions. More broadly, the COR highlighted the EU's role for agenda setting.

8.6. Expertise

Expert input to the development of the Communication came from a number of projects funded by the Second Programme of Community Action in the Field of Health 2008-2013 and before by the Public Health Programme (2003-2008) and by DG EMPL PROGRESS and the previous Social Inclusion Action Programme.

EuroHealthNet and the German Federal Centre for Health Education (BZgA) coordinated a project entitled "Closing the Gap: Strategies for Action to tackle Health Inequalities in Europe" (June 2004- June 2007), co-funded by the European Commission, under the EU Public Health Programme. A final Closing the Gap Conference, 'Action For Health Equity' took place in Brussels on 8 May, 2007 and was followed by a publication 'Taking Action on Health Equity'[41] which presents an overview of what each of the countries that participated in the project are currently doing to tackle health inequalities, and further actions that they plan to take. It also includes a series of key conclusions and recommendations for priority actions in this area. Four areas in which action was most needed: a) Awareness Raising and Advocacy; b) Health in All Policies and Health Impact Assessment (HIA); c) Support to the Regional and Local Level and d) Evidence and Evaluation

EuroHealthNet and the Czech National Institute of Public Health are coordinating a three year initiative (2007-2010) that focuses on mobilising all relevant collective forces within the EU to generate action on improving health by addressing the socio-economic determinants of health.

[41] See http://www.eurohealthnet.eu/images/publications/taking%20action%20on%20health%20equity.pdf

DETERMINE is co-funded by the European Commission Public Health Action Programme. Building on the work of the WHO Commission on Social Determinants of Health the objective is to generate greater understanding and to change conceptions and approaches amongst policy makers and practitioners, so that improving health and health equity is considered in all policy sectors. See also the European Portal for Action on Health Equity[42]. Previously EuroHealhtNet and NHS Health Scotland (PHASE II) and the Netherlands Institute for Health Promotion and Disease Prevention (Phase I) conducted a project entitled "Tackling Health Inequalities and Social Exclusion in Europe", funded by the European Commission Action Programme to Combat Social Exclusion. The associated report[43] highlights the exchange of good practices between health professionals addressing social exclusion across Europe, that is, the wide range of ways in which the health field can contribute to reducing social exclusion and poverty. This work has highlighted that areas for development include the need for monitoring and evaluation, evidence based policies, policy coordination and the establishment of targets.

A study commissioned by the European Commission Public Health Programme regarded the "Economic implications of socio-economic inequalities in health in the European Union" and was conducted by the Erasmus MC, Department of Public Health, The Netherlands. The study argues that health inequalities are one of the main challenges for public health and have a large negative economic impact: the estimates suggest that the economic impact of socioeconomic inequalities in health is likely to be substantial: about €1,000 billion, or 9.5% of GDP. The study concludes that there is a great potential for improving average population health by reducing the health disadvantage of lower socioeconomic groups. This requires an active engagement of many policy sectors, not only of the public health and health care systems, but also of education, social security, working life, city planning, etc.

Previously, "The health status of the European Union - narrowing the health gap, 2003" came as an outcome from a project of the health monitoring programme (1997-2002)

Finally, the project "EUROTHINE - Tackling Health Inequalities in Europe: an integrated approach" was conducted by the EMC (Erasmus MC) Universitair Medisch Centrum Rotterdam - University Medical Centre Rotterdam[44]

[42] At http://www.health-inequalities.eu/

[43] See http://www.eurohealthnet.eu/images/publications/pu_1.pdf. Other related documents include "Promoting social inclusion and tackling health inequalities in Europe, an overview of good practices from the health field" and "The role of the health care sector in tackling poverty and social exclusion in Europe" at http://www.eurohealthnet.eu/images/publications/pu_3.pdf and http://www.eurohealthnet.eu/images/publications/pu_4.pdf

[44] See http://ec.europa.eu/health/ph_projects/2003/action1/action1_2003_16_en.htm#3

9. ANNEX 2: HEALTH INEQUALITIES IN THE EU

This section provides additional detail on the nature and scale of the problem of health inequalities in the EU.

9.1. Background and context: Nature and scale of health inequalities in the EU

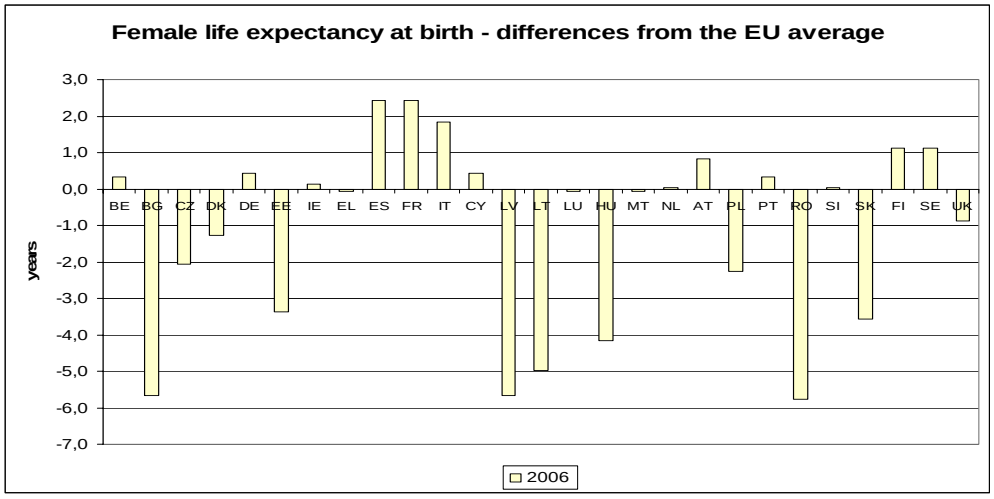
9.1.1. Inequalities in health outcomes between Member States

Substantial differences in life expectancy at birth can be observed across the EU Member States, with individuals in many new Member States living shorter lives than their Western counterparts (Figure A1-A5). An 8-year gap for women (between ES, FR and IT, and BG, on one hand, and LV and RO on the other) and a 14-year gap for men (between CY and SE, on one hand, and LT and LV on the other) can be seen. In BG, LV, LT, RO, SK, DK, EL and LU the gap between national life expectancy and the EU average has actually increased in the last two decades (Table A1). Moreover, while the gender gap in New Member States is still large (e.g. 11 years in LV and LT).

Figure A1: Life expectancy at birth, 2006

Source: Eurostat, UK 2005, IT 2004.

Figure A2:

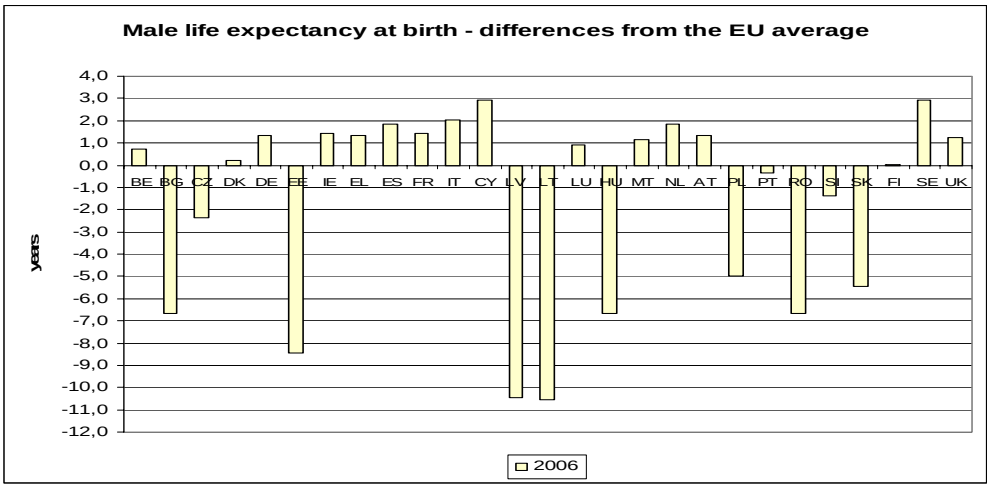


Source: Eurostat, UK 2005, IT 2004

Figure A3:

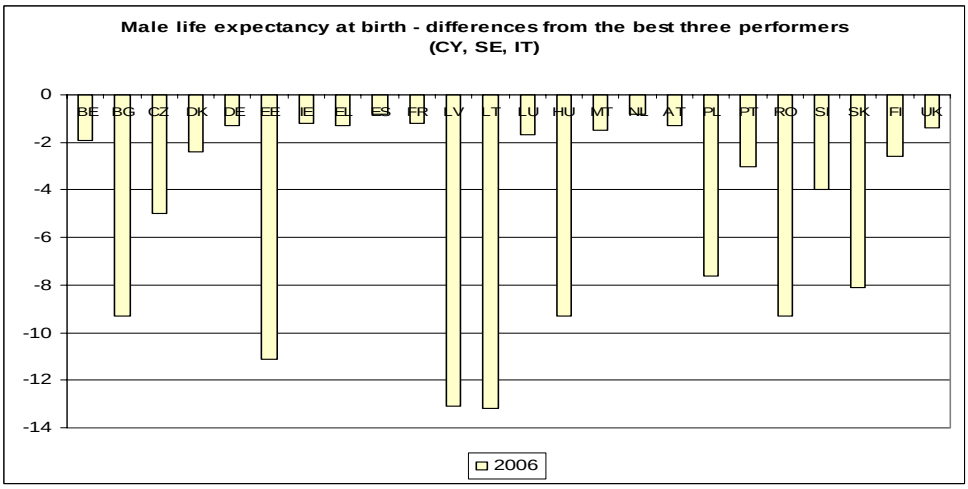
Source: Eurostat, UK 2005, IT 2004

Figure A4:



Source: Eurostat, UK 2005, IT 2004

Figure A5:



Source: Eurostat, UK 2005, IT 2004

Table A1: Differences in female national life expectancy and the EU average, 1986, 1996 and 2006

	Life expectancy 1986	difference to EU average	Life expectancy 1996	difference to EU average	Life expectancy 2006	difference to EU average
AT	77,8	-0,2	80,2	0,9	82,8	0,8
BE	78,2	0,2	80,7	1,4	82,3	0,3
BG	74,8	-3,2	74,5	-4,8	76,3	-5,7
CY					82,4	0,4
CZ	74,7	-3,3	77,5	-1,8	79,9	-2,1
DE	77,7	-0,3	80,1	0,8	82,4	0,4
DK	77,7	-0,3	78,3	-1,0	80,7	-1,3
EE			75,6	-3,7	78,6	-3,4
ES	79,9	1,9	82	2,7	84,4	2,4
FI	78,9	0,9	80,7	1,4	83,1	1,1
FR	79,8	1,8			84,4	2,4
GR	78,8	0,8	80,2	0,9	81,9	-0,1
HU	73,3	-4,7	75	-4,3	77,8	-4,2
IE	76,4	-1,6	78,7	-0,6	82,1	0,1
IT	79,1	1,1	81,8	2,5	83,8	1,8
LT	76,4	-1,6	75,9	-3,4	77	-5,0
LU	78,7	0,7	80,2	0,9	81,9	-0,1
LV	75	-3,0	76,8	-2,5	76,3	-5,7
MT			79,6	0,3	81,9	-0,1
NL	79,7	1,7	80,5	1,2	82	0,0
PL			76,6	-2,7	79,7	-2,3
PT	76,8	-1,2	79	-0,3	82,3	0,3
RO	72,8	-5,2	72,8	-6,5	76,2	-5,8
SE	80,2	2,2	81,7	2,4	83,1	1,1
SI	76,4	-1,6	79	-0,3	82	0,0
SK	75,1	-2,9	77	-2,3	78,4	-3,6

UK		79,5	0,2	81,1	-0,9
EU averag	78,0	79,3		82,0	

Source: Eurostat, UK 2005, IT 2004

There are also large differences (of up to 20 years) in the number years lived in good health (Healthy Life Years) (Table A2)[45,46,47] Recent negative trends have been observed: Since 2006 the number of Healthy Life Years has decreased in many countries (FI, AT, ES, IT, IE, BE and all EU12 countries), especially for women who already spend a higher proportion of their lives with limitations. Data in Table A2 suggests that, in general, people in Central and Eastern Europe live fewer years of their lives in good health (without limitations) especially in the case of men; the difference between the best and lowest performing states in the EU can reach 20 years![48] While men in EE live only 71% of their lives in good health, in DK men can expect to live 90% of their lives in good health (EUROSTAT 2006)[49].

Table A2: Life expectancy and healthy life years, 2005

[45] A word of caution is necessary as by construction this indicator is based on self-perceived limitations in activities and this measure may be prone to cross-country cultural differences.

[46] See also Jagger et al. (2008) that also suggests that the gap between East and West in both life expectancy and years spent in good health is considerable.

[47] See http://ec.europa.eu/health/ph_information/indicators/lifeyears_en.htm for more detail.

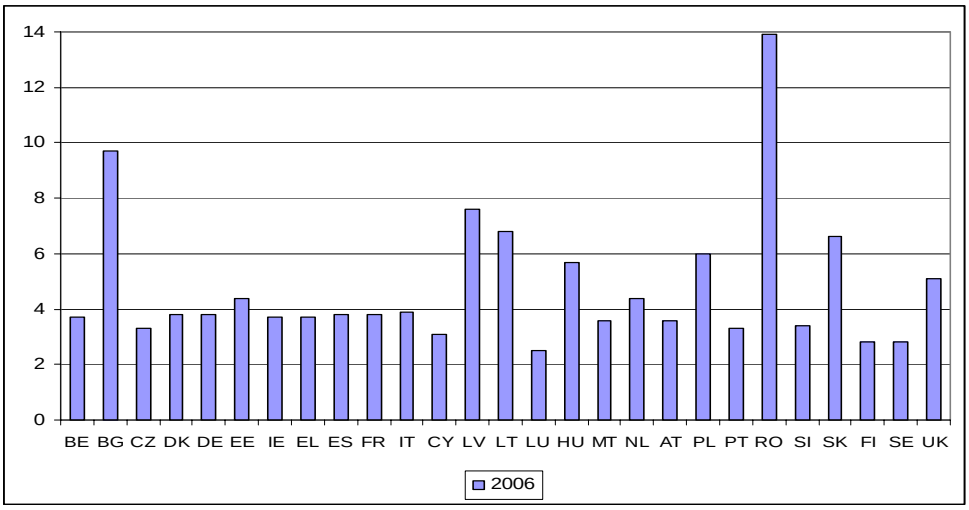
[49] See http://ec.europa.eu/health/ph_information/indicators/lifeyears_en.htm for more detail.

Member State	Healthy life years at birth	Life expectancy at birth Men	Percentage of life expectancy without disability	Healthy life years at birth females	Life expectancy at birth Women	Percentage of life expectancy without disability
BE	61.7	76.2	81.0%	61.9	81.9	75.6%
BG						
CZ	57.9	72.9	79.4%	59.9	79.2	75.6%
DK	68.4	76.0	90.0%	68.2	80.5	84.7%
DE	55.0	76.7	71.7%	55.1	82.0	67.1%
EE	48.0	67.3	71.3%	64.1	78.2	66.7%
IE	62.9	77.3	81.4%	64.1	81.7	78.4%
EL	65.7	76.8	85.5%	52.2	81.6	82.3%
ES	63.2	77.0	82.1%	67.2	83.7	75.4%
FR	62.0	76.7	80.8%	64.3	83.7	76.8%
IT	65.8	78.2	77.4%	67.0	84	80.2%
CY	59.5	76.8	77.5%	57.9	81.1	71.4%
LV	50.6	65.4	77.4%	53.1	76.5	69.4%
LT	51.2	65.3	78.4%	54.3	77.3	70.2%
LU	62.2	76.7	81.1%	62.1	82.3	75.5%
HU	52.0	68.7	75.7%	53.9	77.2	69.8%
MT	68.5	77.3	88.6%	70.1	81.4	86.1%
NL	65.0	77.2	84.2%	63.1	81.7	77.2%
AT	57.8	76.7	75.4%	59.6	82.3	72.4%
PL	61.0	70.8	86.2%	66.6	79.3	84.0%
PT	58.4	74.9	78.0%	56.7	81.3	69.7%
RO						
SI	56.3	73.9	76.1%	59.9	80.9	74.0%
SK	54.9	70.2	78.3%	56.4	78.1	72.2%
FI	51.7	75.6	68.4%	52.4	82.5	63.5%
SE	64.2	78.5	81.8%	63.1	82.9	76.1%
UK	63.2	77.1	82.0%	65.0	81.1	80.1%

Source: Eurostat based on EU-SILC 2005, IT figures for life expectancy at birth in 2005 are estimates based on EHEMU.

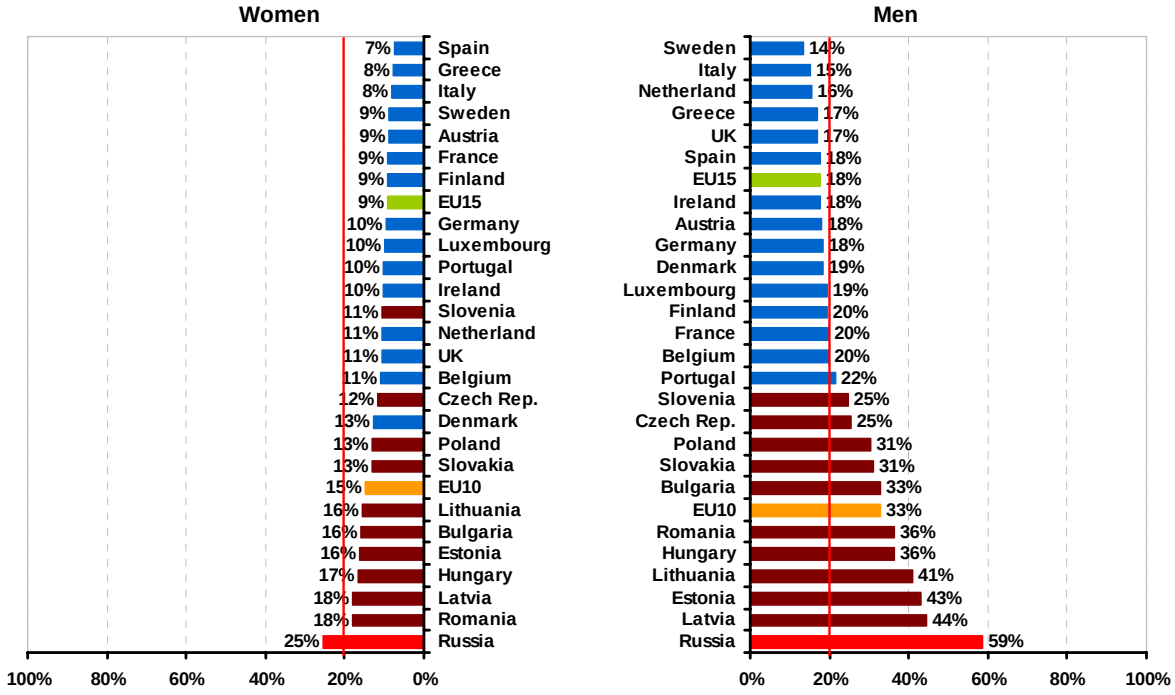
Substantial differences are found in infant mortality, which is higher in Central and Eastern Europe, in premature mortality, in avoidable mortality and in more subjective measures of health such as self-perceived general health, long-standing illness or activity limitations in the past 6 months (Figures A6-A7).

Figure A6: infant mortality



Source: Eurostat, BE 2005, UK 2005, IT 2004.

Figure A7: Premature mortality - risk (probability) of dying before the age of 65, 2002



Detailed analysis of the health gap (see Annual Report of the European Observatory on Social Situation and Demography[50]) between EU-15 (+ MT & CY), and the remaining new Member States shows that differences between Member States are explained by high mortality and morbidity in terms of cardiovascular disease, injuries and violence, cancer, and alcohol-related diseases and their underlying risk factors: smoking, diet and alcohol consumption. In some countries, contrary to the general EU trend, some mortality rates have grown during the last decade. For example (EUROSTAT, 2006), death rates due to ischemic heart diseases for women are 12 times higher in LT than in FR (263.2 vs 22.5 deaths per 100,000 inhabitants), death rates due to pneumonia varies 9 fold for men (5.3 in EL vs 46.4 deaths per 100.000 inhabitants in SK), and death rates from cerebrovascular diseases for women are 6 times higher in RO than in FR (184.9 vs 25.9 deaths per 100.000 inhabitants). Death rates from liver cirrhosis for men are 10 times higher in HU or RO than in NL or EL (65 and 52 vs 4.4 and 5.3 per 100,000 inhabitants). Fatal injuries amongst men in the Baltic States (LT, LV, EE) are about 7 fold higher than in the NL and the UK (219, 210 and 206 deaths vs 31 and 33 deaths per 100,000 inhabitants). There are also differences in disease incidence: e.g. the incidence rate of lung cancer for men varies 4.5 fold between EU countries (GLOBOCAN 2002, IARC - International Agency on Research on Cancer). In addition, mortality rates have increased in the poorest Member States since 1996 (EUROSTAT): e.g. the mortality rate due to pneumonia has risen in LT by 52%, in LV by 34%, and in PL by 13%, when many other Member States have actually reduced such mortality rates by up to 50%. Moreover, LV, LT, HU, SK and PL have reduced mortality due to ischaemic heart disease and respiratory diseases by only 5% since 1996 (Inequalities in health outcomes between socio-economic groups within Member States.

[50] See http://ec.europa.eu/employment_social/spsi/reports_and_papers_en.htm

The literature showing socio-economic differences in health in the EU is extensive[51]. These start at a young age and persist and widen in older ages (SHARE). An analysis (Mackenbach, 2006)[52] produced for the UK Presidency[53] shows differences in life expectancy at birth and at higher ages between the lowest and the highest socio-economic groups (e.g. between manual and professional occupations; people with primary level and post-secondary education; low and high income quintile) ranging from 4 to 10 years for men and from 2 to 7 years for women. In some countries the gap has widened in the last decades.

Also, despite an overall decline, mortality and infant mortality are higher in the lowest socio-economic groups and relative inequalities have increased in several countries. The risk of dying in the lowest socio-economic groups was found to be 25 to 50 to even 150% more than in higher groups and relative inequalities in mortality have increased in several countries. Inequalities in mortality from cardio-vascular diseases account for about half of the excess mortality in lower socio-economic groups, who also register lower cancer survival. Also, despite an overall decline, infant mortality continues to be higher in lower social-economic groups. In some countries this gap has increased.

Rates of disease and disability also vary substantially by socio-economic group. People with lower education live shorter lives and spend more time in poorer health. For 'self-perceived general health' a clear income gradient can be observed in that those in the lowest (poorest) income quintiles more often report very bad health than those in the highest (richest) quintiles (Table A3). In some countries (DK, LT, and SK) the percentage reporting very bad health in the lowest quintile has gone up since 2005.[54] Similar conclusions can be drawn when looking at self-perceived activity limitations (Table A4). SHARE data shows that individuals with lower education or lower income are more likely to experience limitations with mobility, arm or motor functions and have a higher prevalence of eyesight, hearing and chewing problems. Several studies (Dastra et al., 2005; Huisman, Kunst et al., 2003; Huisman, Kunst et al., 2004) found socio-economic inequalities for a range of common chronic diseases such as diabetes, arthritis, chronic respiratory and heart diseases (figure A8).

[51] See the Health Status & Living Conditions part of the Monitoring Reports from the European Observatory on Social Situation and Demography reports for a review of the literature at http://ec.europa.eu/employment_social/spsi/reports_and_papers_en.htm

[52] See "Health inequalities: Europe in Profile" by Mackenbach (2006) at http://ec.europa.eu/health/ph_determinants/socio_economics/keydo_socioeco_en.htm. Previous important studies include van Doorslaer, Wagstaff et al. (1997), Cavelaars, Kunst et al. (1998), Mackenbach, Cavelaars et al. (2000); Mackenbach, Bos et al. (2003), Avendano, Kunst et al. (2005).

[53] See http://www.dh.gov.uk/en/Healthcare/International/EuropeanUnion/EUPresidency2005/DH_4119613

[54] A word of caution is needed when looking at these conclusions, as current information covers a maximum of three years and hence the changes observed may not be a significant sign of a trend.

Table A3: Self-perceived general health (very bad health), by income quintile

Very bad health	1st quintile Q0-Q20		2nd quintile Q20-Q40		3rd quintile Q40-Q60		4th quintile Q60-Q80		5th quintile Q80-Q100	
	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006
Belgium	4.7	3.4	2.5	2.4	1.6	1.2	0.7	0.9	0.5	0.4
Bulgaria										
Czech Republic	4.4	4.7	3.2	3.4	3.1	2.5	1.3	1.2	0.9	0.9
Denmark	1.7	3.5	3.7	3.7	1.2	1.4	0.6	1.0	0.3	0.8
Germany	3.0	3.0	1.8	1.8	1.3	1.1	1.1	1.4	0.6	0.9
Estonia	4.9	5.3	6.5	5.4	3.2	2.6	1.1	0.7	0.8	0.5
Ireland	1.5	1.7	1.3	1.5	1.1	0.4	0.3	0.3	0.1	
Greece	4.1	4.0	4.0	3.6	2.3	3.3	2.0	2.4	0.8	1.4
Spain	4.3	4.4	3.6	3.3	2.6	2.0	1.6	1.3	0.8	1.1
France	3.2	2.9	1.5	1.6	0.9	1.0	1.1	1.1	0.8	0.6
Italy	2.3	2.4	2.2	2.6	1.8	2.1	1.5	1.5	1.2	1.1
Cyprus	6.8	4.1	2.9	1.9	1.7	1.3	0.8	0.6	0.8	0.5
Latvia	9.1	7.8	10.6	8.4	4.3	3.2	2.7	3.1	2.0	1.0
Lithuania	4.3	5.5	5.0	5.6	3.3	3.3	1.7	1.7	1.0	0.9
Luxembourg	2.5	3.2	2.3	2.0	0.8	0.9	0.7	0.9	0.5	0.6
Hungary	5.2	5.6	6.0	6.6	6.7	5.0	3.9	3.1	2.0	1.4
Malta	1.5	1.5	0.7	0.8	0.6	0.6	0.3	0.3	0.1	0.1
Netherlands	1.8	1.3	1.2	1.4	0.7	0.8	0.3	0.4	0.7	0.3
Austria	2.2	1.9	1.5	1.8	2.1	1.2	1.6	1.2	0.9	1.4
Poland	3.5	2.8	5.1	4.7	4.8	4.0	3.8	2.9	1.8	1.6
Portugal	10.8	9.2	9.0	7.8	5.5	4.5	3.1	2.6	1.7	1.4
Romania										
Slovenia	6.5	6.7	3.5	4.1	2.6	2.2	1.9	1.6	1.6	0.9
Slovakia	6.3	7.1	8.4	7.9	6.9	5.8	3.7	3.4	1.7	1.6
Finland	5.5	5.6	4.0	4.1	1.6	1.9	1.8	1.4	1.4	1.5
Sweden	3.1	2.2	2.8	1.1	0.8	0.8	1.2	0.7	0.4	0.6
United Kingdom	2.2	2.0	2.3	2.1	1.5	1.2	0.7	0.8	0.2	0.2

Source: Eurostat based on EU-SILC 2006 data

Table A4: Self-perceived limitations in activities people usually do as a result of health problems and lasting for at least the last 6 months (severely hampered in activities), by income quintile

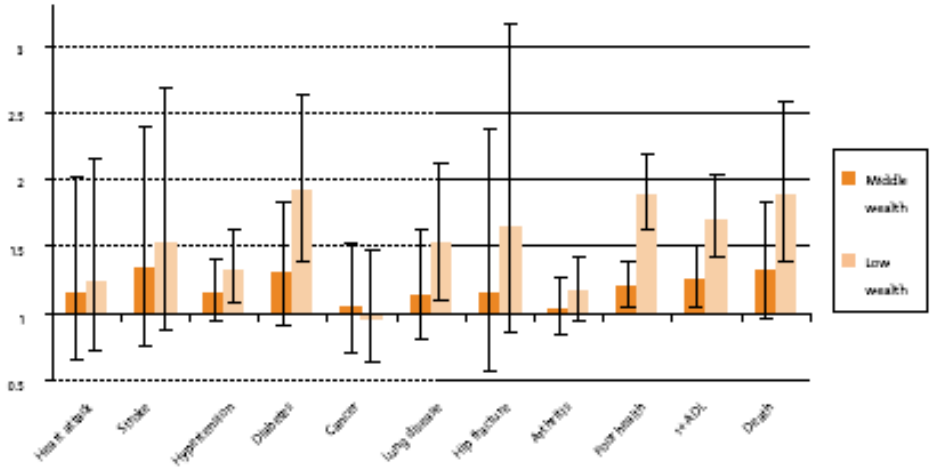
Severely hampered	1st quintile Q0-Q20		2nd quintile Q20-Q40		3rd quintile Q40-Q60		4th quintile Q60-Q80		5th quintile Q80-Q100	
	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006
Belgium	15.8	15.7	13.0	10.8	8.1	6.7	4.8	4.8	3.6	2.0
Bulgaria										
Czech Republic	11.8	10.9	9.1	9.3	8.4	6.3	4.6	4.7	3.4	3.6
Denmark										
Germany	13.8	13.5	9.5	10.0	6.9	7.4	6.4	6.8	5.0	5.1
Estonia	22.1	18.4	21.4	17.5	12.5	7.0	6.8	4.3	4.4	2.1
Ireland	14.9	12.5	9.1	9.6	5.6	5.3	2.9	3.2	2.1	2.0
Greece	9.2	8.3	9.3	7.7	6.0	6.9	4.6	5.0	2.6	3.1
Spain	13.0	13.0	10.9	10.4	9.4	8.2	6.9	6.9	5.5	5.5
France	9.7	9.8	8.3	8.3	5.8	5.8	5.3	4.3	4.7	4.1
Italy	8.2	9.0	7.8	8.7	6.6	7.8	5.6	5.9	3.7	4.4
Cyprus	24.4	20.5	11.3	9.1	8.9	6.8	5.9	4.8	4.3	2.7
Latvia	15.5	14.0	16.9	16.9	10.5	9.2	8.4	8.1	5.7	4.3
Lithuania	16.0	15.7	17.2	16.6	13.5	11.0	7.6	6.2	4.1	3.4
Luxembourg	8.5	9.3	8.4	8.3	6.0	7.8	4.7	6.2	4.6	4.0
Hungary	18.4	18.2	19.5	18.8	17.7	16.2	13.1	10.6	7.1	5.5
Malta	5.7	7.1	5.5	4.6	4.9	5.0	3.8	2.8	2.2	1.7
Netherlands	12.4	13.0	11.3	11.2	7.6	8.0	4.8	6.2	3.8	3.6
Austria	15.4	14.5	10.0	9.7	11.5	9.1	7.0	7.8	8.3	7.0
Poland	1.6	5.3	2.7	7.8	3.2	8.3	2.7	6.7	1.5	4.1
Portugal	21.3	20.9	16.9	16.6	11.8	9.3	7.5	6.3	5.5	6.2
Romania										
Slovenia	14.9	14.1	10.0	10.4	10.7	7.4	7.8	6.5	5.8	4.7
Slovakia	12.1	14.8	16.0	16.6	12.9	12.5	7.5	8.4	4.4	5.0
Finland	17.4	19.8	18.5	14.1	10.1	10.9	8.4	8.1	7.7	7.8
Sweden	18.2	11.2	16.7	12.6	10.2	7.4	7.9	6.3	5.9	4.8
United Kingdom	12.2	13.3	14.1	13.6	10.3	8.5	5.0	5.0	2.7	3.2

Source: Eurostat based on EU-SILC 2006 data

Note: DK does not report severe and moderate limitations separately.

Source: SHARE 2005

Figure A8: Odds ratios of having a chronic disease between 2004 and 2006 comparing low and middle with high wealth



Source: SHARE 2007. NB: The odds are adjusted for age, gender, country, and the time-interval between waves

Some vulnerable groups suffer a greater burden of mortality and disease[55]. These include some migrant and ethnic minority populations, people living in deprived urban and rural areas and in poverty, the unemployed, especially long-term unemployed, those informally employed, seasonal/daily workers and subsistence farmers, those further from the labour market, jobless households, the homeless, the disabled, those suffering from mental or chronic illnesses, elderly pensioners on minimum pensions, and single parents. In rural areas of RO and BG infant mortality is 3 times higher than in the capital. Inequalities between nationals and migrants persist in Europe, in terms of health status and in access to health services (promotion, prevention, treatment and care).[56,57] Note for example that migrants may experience greater health risk than the majority population due to greater vulnerability to communicable diseases (TB, HIV/AIDS, hepatitis). They may also face higher risks of non-communicable diseases (cardiovascular disease) and mental health problems due to a combination of the socio-economic and environmental conditions in the origin, transit and host countries (2007 Council Conclusions on Health and Migration in the EU).

[55] As indicated in the Joint Report on Social Protection and Social Inclusion and social OMC and equal opportunities related studies/ networks, the Handbook on Integration for policy-makers and practitioners, the Health and Migration in the EU work under the 2007 PT Presidency, and the work of the International Organisation of Migration.

[56] See "Challenges for health in the age of migration" at http://www.eu2007.min-saude.pt/PUE/en/conteudos/programa+da+saude/Publications/Relat%C3%B3rio+Sa%C3%BAde+e+Migra%C3%A7ao.htm

[57] See also "Migration and the right to health", IOM, at http://www.iom.int/jahia/webdav/site/myjahiasite/shared/shared/mainsite/published_docs/serial_publications/IML12-MRH%20dec07.pdf and "Quality in and equality of access to healthcare services" at http://ec.europa.eu/employment_social/spsi/studies_en.htm#healthcare

The June 2006 Council Conclusions on Women's Health[58] recognise the importance of the gender dimension in health. Health inequalities are also a global issue (WHO CSDH, 2008).

Importantly, there appears to be a strong association between within country socio-economic inequalities in health and the overall population health i.e. the higher the socio-economic inequality in health, the poorer the overall population health. Addressing health inequalities within Member States could thus contribute to reducing differences in health outcomes between Member States. The importance of addressing health inequalities as part of overall socio-economic development was highlighted in Council Conclusions under the 2006 Finnish Presidency[59] and in the 2008 Joint Report on Social Protection and Social Inclusion.

9.1.2. Determinants (drivers or causes) of health inequalities

Several models (varying in complexity and details) synthesize the relation between various determinants (including socio-economic factors) and health (Figure A9). They illustrate the "layered" view of the causation of health inequalities (Mackenbach, 2002): health is not randomly distributed but the result of systematic differences in the distribution of those factors, in a variety of areas, which improve or harm health.

According to these models, while biological factors/ genetic predispositions may explain why one person is more likely to get ill than another in the same circumstances, living and working conditions, as well as exclusion and marginalisation, affect health through direct and indirect physical and psychological mechanisms. Some factors operate over long periods: e.g. poor conditions in childhood can affect health later in life. Depending on where people live and what their situation is, people differ in their exposure to positive and negative factors which influence health.

Indeed, individuals face differences in the quality of their physical and social environments (at home – central heating, insulation, dampness, crowding, at school, in the workplace – exposure to chemicals, accidents and physically hard work; social networks) and are more likely to be in poor health when they live in poor housing/social environments (WHO World Report 2003, WHO CSDH). In relation to housing, for example, people are significantly more likely to be in poor health when they live in housing characterised by poor conditions such as: insufficient protection against noise, vibrations, dampness, droughts, mould, and cold in winter; overcrowding; lack of light or no view of the outside environment; impediments to socialisation (e.g. absence of parks and gardens); vandalism; and other factors which occur more often with low socioeconomic status, such as fear of losing the dwelling, having bad image of the neighbours. In terms of living conditions, the exposure to noise in EU countries for example ranges from 3% up to 18% with possibly big regional/local differences (Table A5). There are sections of the EU population which do not have access to running water, adequate washing and toilet facilities, affordable energy, appropriate housing, heating, new clothes, or safe environment (e.g. EUROFUND – 2008 European Quality of Life Survey[60]). Some studies (e.g. Trannoy and Tubeuf, 2008; Tubeuf et al., 2008) show a geographic environment (pollution) and a neighbourhood/area (deprivation defined as high unemployment rates, single parent families, high share of individuals with lower education) effect (negative) on the health of individuals independently of each individual characteristics.

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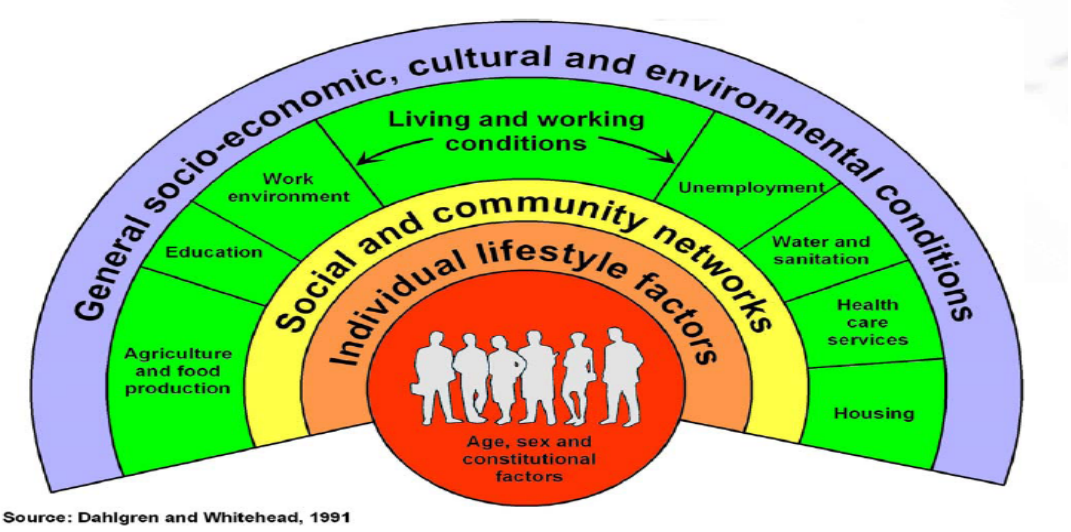
[58] See http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/89830.pdf

[59] Council Conclusions on Health in All Policies (HIAP). http://ec.europa.eu/health/ph_projects/2005/action1/docs/2005_1_18_frep_a8_en.pdf

[60] See http://www.eurofound.europa.eu/pubdocs/2008/52/en/1/EF0852EN.pdf

Figure A9: Determinants of health and health inequalities



Source: Dahlgren and Whitehead, 1991

Health is also determined by health-related behaviours (quality of nutrition, level of physical activity, tobacco and alcohol use, sexual behaviour), themselves influenced by socio-economic and cultural factors and can explain part of the differences between social groups and between countries and areas (SHARE, 2007). Some studies (e.g. Stronegger et al., 1997; van Lenthe, F. J., C. TM Schrijvers, et al. 2004 based on GLOBE, NL; Mackenbach, 2007) show that individual health behaviour can explain from 25% to 35% of differences in people's health. Other studies suggest that maternal smoking and poor diet during pregnancy cause impaired development in utero which increases the risk of cardiovascular disease, stroke, respiratory diseases and lung cancer in middle age (Baker, 1992). There are large variations between European countries and socio-economic groups in nutrition (e.g. consumption of fruit and vegetables) and the prevalence of smoking, alcohol consumption, obesity and physical activity (Cavelaars et al., 1998; Mackenbach, 2006). For example, the prevalence of daily smokers for men varies 3 fold between EU countries and smoking rates are very high in Central and Eastern Europe. Countries with high rates of smoking combined with low rates of exercise and unhealthy diet are also countries with the lowest life-expectancy in the EU (LV, LT, EE, BG, RO, PL, SK, HU, CZ). Studies also show that health related behaviour is itself and to a large extent determined by socio-economic and cultural factors (SHARE; Stronegger et al., 1997; Lundberg, 1991). Note that the above studies are often restricted to specific countries, regions or even cities in a country and there is no EU coverage/ comparison on the causality of this sub-set of determinants.

Psychosocial factors such as negative life events and a combination of high effort and demands with a low reward and low control also contribute to one's health.

Past social positions influence individuals' health status in that for example family socio-economic status (income, interest in education) can determine a child's education attainment, occupation, income and health. Some studies (e.g. Trannoy and Tubeuf, 2008; Jusot et al, 2007) show that a high family /parents socio-economic status impacts on an individual's health reducing one's risk of stroke and of stomach cancer in adulthood life. Maternal socio-economic deprivation is significantly associated with low birth weight and thus the person's health throughout his life (MRC Scotland).

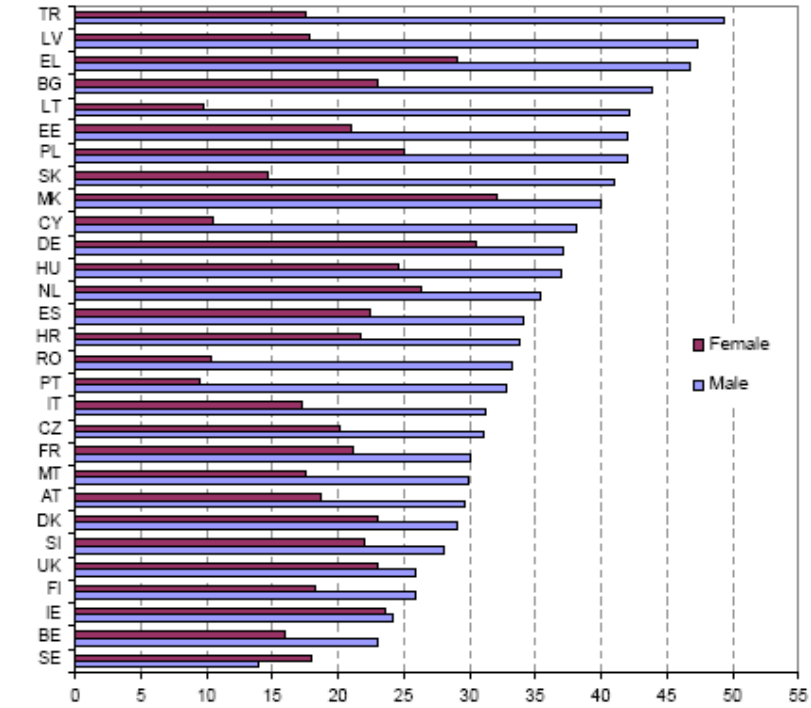
Table A5: Differences in life-styles and living and working conditions between EU Member States

QA24 Could you please tell me if any of the following apply to you? (MULTIPLE ANSWERS POSSIBLE)

	You smoke	You are overweight	You never do any exercise, or do so very rarely	You do not eat very healthy food	You tend to drink a bit too much alcohol	You live in a noisy environment	You live or work in an environment that is heavily polluted	You suffer from stress at work	You suffer from stress in your personal relations	None of the above (SPONT.)	DK
EU27	**30%**	**20%**	**24%**	**14%**	**7%**	**8%**	**6%**	**17%**	**10%**	**32%**	**1%**
BE	27%	25%	29%	10%	8%	10%	7%	22%	11%	24%	1%
BG	37%	13%	38%	42%	7%	13%	8%	11%	7%	24%	2%
CZ	32%	21%	40%	37%	4%	7%	6%	15%	7%	23%	0%
DK	31%	26%	23%	12%	10%	9%	5%	19%	8%	28%	0%
DE	28%	21%	14%	10%	7%	7%	4%	19%	9%	37%	1%
EE	34%	27%	34%	26%	6%	11%	11%	19%	17%	16%	7%
EL	44%	16%	37%	21%	10%	18%	10%	22%	20%	22%	-
ES	31%	15%	28%	7%	6%	8%	5%	12%	6%	37%	1%
FR	33%	20%	23%	10%	7%	9%	9%	18%	10%	30%	0%
IE	30%	14%	15%	13%	14%	3%	3%	11%	14%	40%	1%
IT	25%	17%	24%	8%	3%	5%	2%	10%	7%	40%	2%
CY	29%	17%	37%	28%	5%	14%	6%	26%	33%	19%	-
LV	41%	26%	31%	32%	12%	16%	15%	27%	13%	14%	0%
LT	31%	26%	51%	45%	11%	13%	14%	23%	12%	12%	1%
LU	23%	25%	33%	8%	6%	13%	7%	26%	8%	27%	1%
HU	34%	21%	25%	22%	6%	9%	8%	13%	9%	26%	-
MT	22%	34%	33%	10%	7%	10%	13%	13%	7%	28%	0%
NL	24%	26%	28%	7%	7%	5%	8%	16%	7%	31%	0%
AT	39%	24%	19%	23%	15%	8%	5%	24%	8%	27%	1%
PL	33%	22%	25%	20%	5%	9%	7%	20%	18%	25%	2%
PT	21%	17%	25%	9%	3%	4%	4%	14%	6%	45%	1%
RO	29%	11%	33%	25%	6%	8%	7%	14%	8%	32%	5%
SI	28%	23%	16%	16%	5%	10%	6%	22%	12%	31%	0%
SK	28%	23%	41%	33%	7%	12%	8%	24%	13%	21%	0%
FI	23%	27%	15%	18%	10%	3%	1%	19%	7%	33%	0%
SE	19%	29%	29%	16%	6%	4%	5%	34%	13%	24%	1%
UK	30%	28%	18%	11%	15%	7%	6%	15%	11%	28%	0%

Source: Eurobarometer 283

Figure A10: regular daily smokers in the population (%), age +15, WHO European Region



Source: WHO Health for All 2007.

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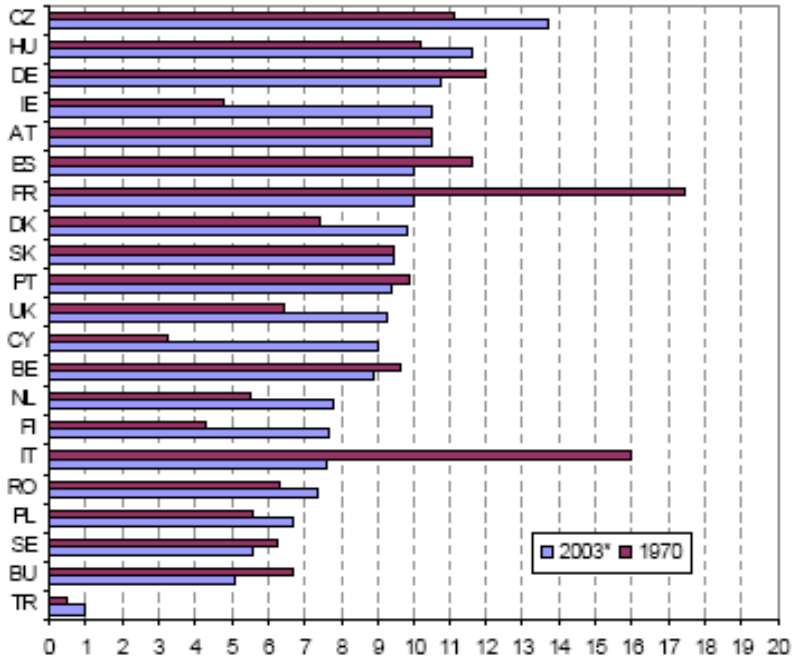
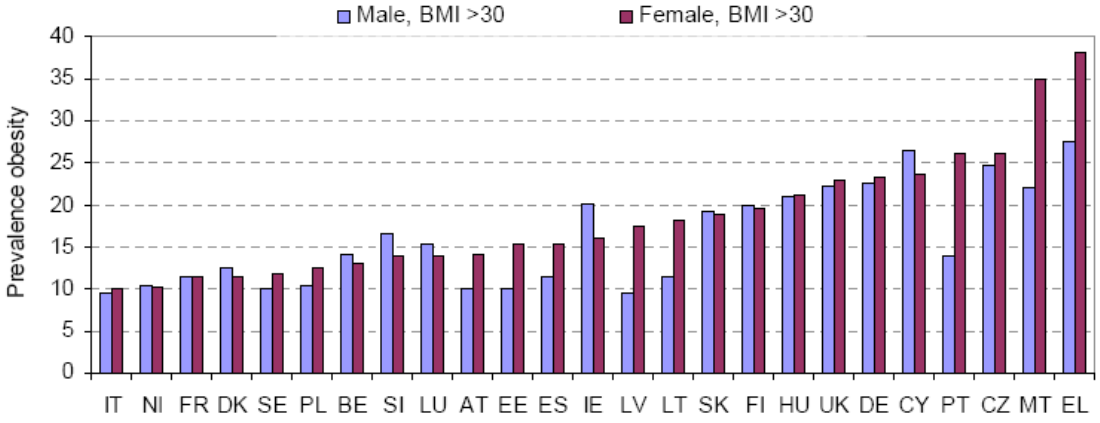
Figure A11: pure alcohol consumption, litres per capita, WHO European Region



European Observatory of the Social Situation and Demography

Figure A12: obesity rates in european countries



***Source**: International Obesity Task Force 2005.*

European Observatory of the Social Situation and Demography

Table A6: Differences in life-styles and living and working conditions by age, gender and socio-economic status

QA24 Could you please tell me if any of the following apply to you? (MULTIPLE ANSWERS POSSIBLE)

	You smoke	You are overweight	You never do any exercise, or do so very rarely	You do not eat very healthy food	You tend to drink a bit too much alcohol	You live in a noisy environment	You live or work in an environment that is heavily polluted	You suffer from stress at work	You suffer from stress in your personal relations	None of the above (SPONT.)	DK
EU27	**30%**	**20%**	**24%**	**14%**	**7%**	**8%**	**6%**	**17%**	**10%**	**32%**	**1%**
Sex											
Male	**35%**	19%	22%	**16%**	**12%**	8%	7%	**19%**	7%	29%	1%
Female	24%	**22%**	**25%**	12%	3%	7%	5%	15%	**13%**	**34%**	1%
Age											
15-24	34%	9%	17%	**22%**	10%	10%	6%	11%	11%	37%	1%
25-39	**39%**	15%	23%	16%	8%	9%	7%	**25%**	11%	26%	1%
40-54	34%	**25%**	**26%**	14%	9%	8%	8%	**26%**	12%	25%	1%
55 +	17%	**26%**	**26%**	8%	4%	6%	3%	5%	7%	**39%**	1%
Education (End of)											
15	25%	23%	27%	10%	6%	6%	4%	8%	9%	36%	1%
16-19	**36%**	22%	25%	16%	8%	8%	7%	18%	10%	28%	1%
20+	28%	20%	23%	12%	8%	8%	6%	**28%**	10%	29%	1%
Still Studying	25%	8%	15%	**20%**	9%	**11%**	5%	8%	11%	43%	1%
Respondent occupation scale											
Self- employed	37%	18%	22%	13%	10%	8%	8%	28%	10%	27%	1%
Managers	21%	19%	20%	12%	10%	6%	5%	**39%**	8%	30%	1%
Other white collars	33%	21%	27%	17%	8%	7%	7%	29%	9%	26%	1%
Manual workers	42%	19%	23%	17%	9%	9%	10%	27%	9%	24%	1%
House persons	23%	20%	28%	9%	2%	7%	3%	2%	14%	36%	2%
Unemployed	**53%**	24%	26%	19%	**12%**	12%	6%	5%	**19%**	22%	1%
Retired	18%	**27%**	26%	8%	5%	5%	3%	1%	8%	**41%**	1%
Students	25%	8%	15%	20%	9%	11%	5%	8%	11%	43%	1%

Source: Eurobarometer 283

Table A7:. Socio-economic inequalities in daily smoking in Sweden

	Number of daily smokers , 1,000		*Relative difference*		*Absolute difference*	
	1988-89	1998-99	1988-89	1998-99	1988-89	1998-99
Blue-collar	314	223	1.6	1.7	115	91
White-collar	199	132				

Men							
	Poorly educated	327	265	1.6	3.4	118	186
	Highly educated	209	79				
	Blue-collar	328	263	1.8	1.7	144	110
	White-collar	184	153				
Women							
	Poorly educated	310	277	2.1	3.0	163	185
	Highly educated	147	92				

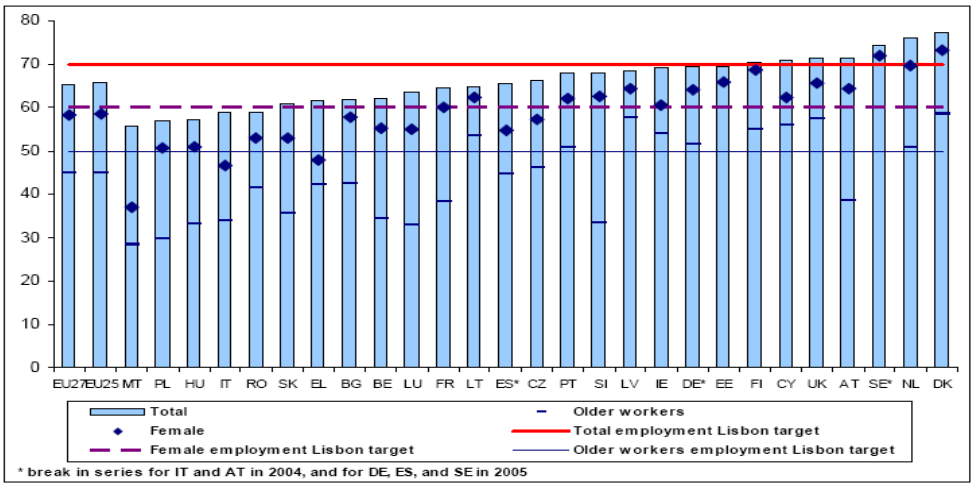
Source: Boström & Rosén, 2003.

Unemployment is associated with increased chance of poor mental health, social exclusion (Kessler et al. 1987; Warr 1987) and suicide (Blakely, 2003). Job quality and working conditions also affect health to a great extent. A good working environment plays a crucial role in terms of ensuring people's health: e.g. differences in exposure to physical, chemical, and biological agents at work lead to differences in health status. A number of studies have suggested that job quality and working conditions affect health to a great extent (e.g. Debrand and Lengagne, 2008; Jusot et al., 2007): low physical pressure and stress, high decision ability and possibilities to develop new skills, a correct monetary reward and having prospects for personal progress contribute to good health status whereas lack of support at work and the feeling of job insecurity increase the risk of ill health, including depression. Occupational health risks vary significantly across sectors and not all workers are equally exposed to occupational hazards (European Agency for Safety and Health at Work)[61]: e.g. young workers are usually less informed about occupational risks, which makes them overexposed, and workers with a fixed-duration or temporary employment relationship are more exposed to the risk of accidents at work and occupational diseases. The Whitehall-Study (1984) of UK 17.500 civil servants shows a clear gradient between the lowest and the highest professional level of civil servants. The link between type of work and health is related not only to income, but also to type of contract, method of work organization and occupational health and safety.

We can indeed observe geographic disparities in employment, unemployment (Figures A13 and A1) and long-term unemployment rates, in working conditions, in continuous life long-training and adult education, in health and safety and health at the workplace practices (e.g. Employment Report[62]), which might also help explain part of the differences in health between countries. GDP per capita and poverty rates vary across the EU, and substantial income inequality persists (Table A8 and Figures A15-A16). In 2006 the total income received by the 20% of the population with the highest income was 4.8 times higher than that received by the 20% with the lowest income.

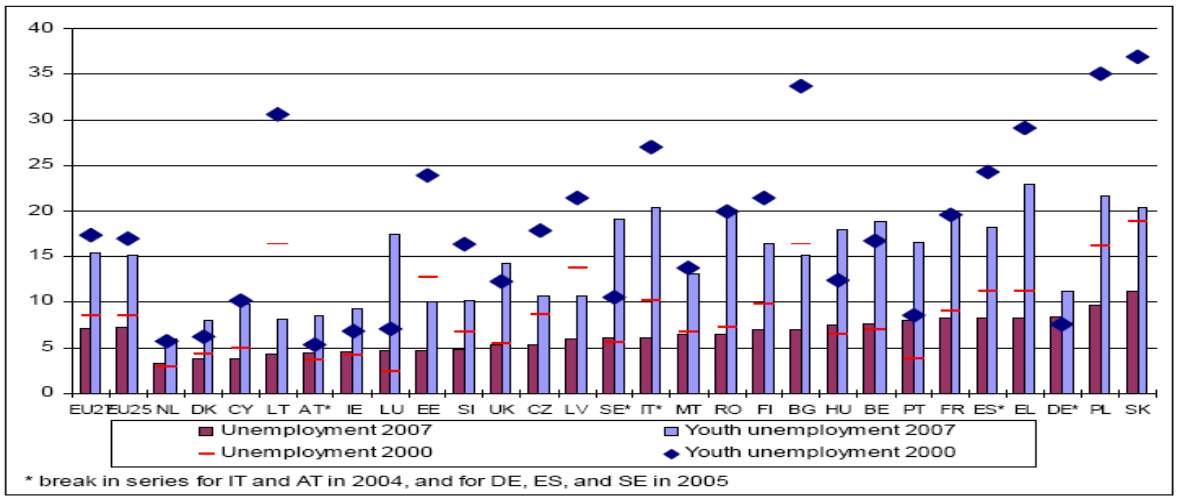
[61] See e.g. http://osha.europa.eu/en/topics/accident_prevention/risks
[62] See http://ec.europa.eu/employment_social/employment_analysis/employ_en.htm

Figure A13: employment rates in the EU; total, women and older workers; 2007.



Source: Eurostat — Labour Force Survey

Figure A14: Unemployment and youth unemployment; 2000 and 2007.



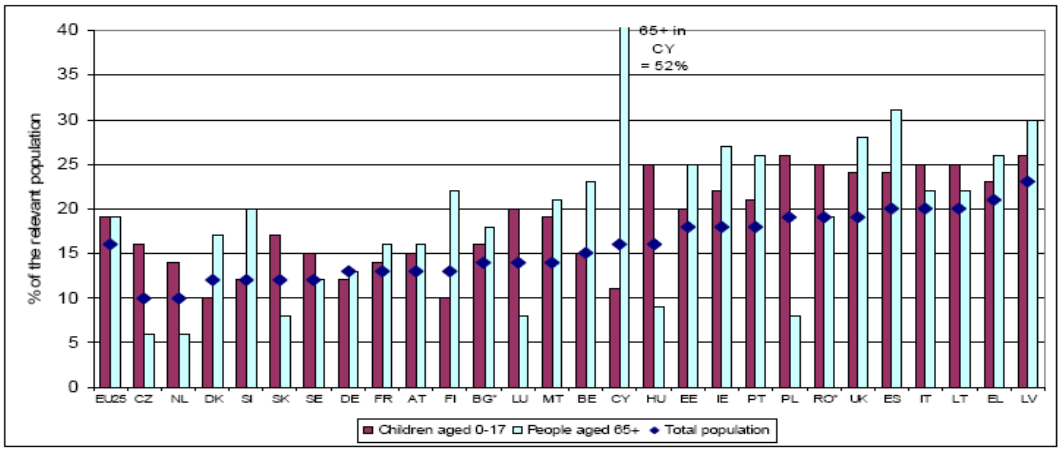
Source: Eurostat — Labour Force Survey

Table A8: GDP PPS per inhabitant

	200
be Belgium	297
bg Bulgaria	950
cz Czech Republic	202
dk Denmark	303
de Germany	281
ee Estonia	176
ie Ireland	371
gr Greece	241
es Spain	265
fr France	276
it Italy	252
cy Cyprus	232
lv Latvia	144
lt Lithuania	152
lu Luxembourg	689
hu Hungary	158
mt Malta	192
nl Netherlands	329
at Austria	316
pl Poland	133
pt Portugal	186
ro Romania	101
si Slovenia	226
sk Slovakia	170
fi Finland	290
se Sweden	313
uk United Kingdom	291

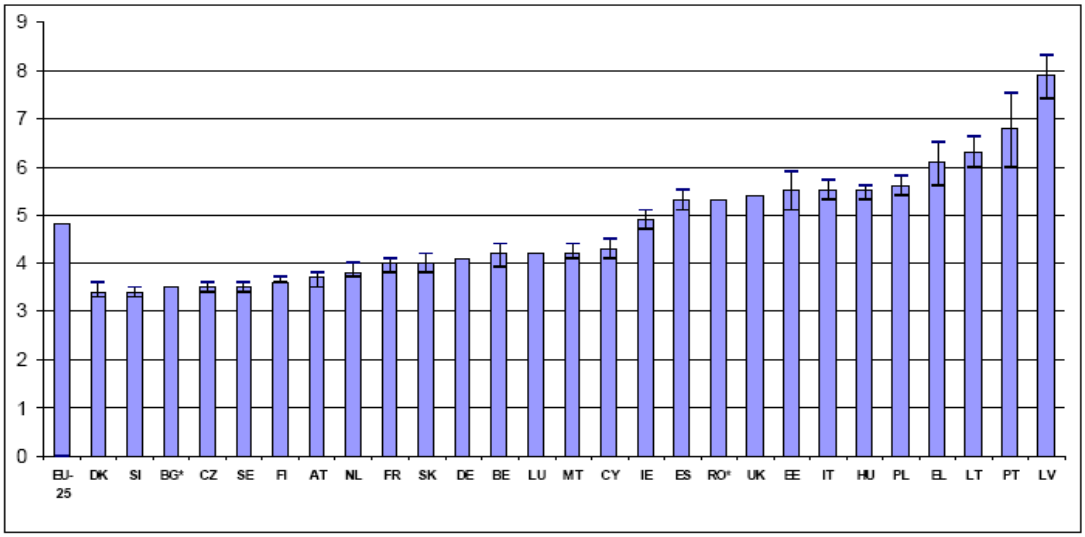
Source: EUROSTAT

Figure A15: At-risk-of-poverty rate for the total population and for children (0-17) and elderly people (65+), in %, 2006



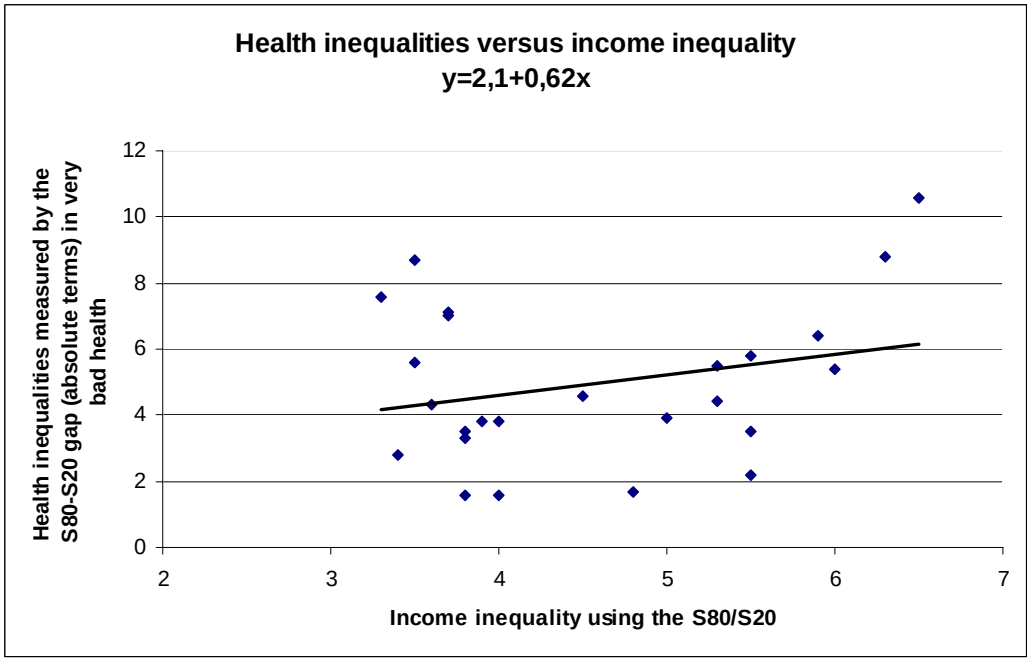
Source: EU-SILC (2006); income year 2005; except for UK (income year 2006) and for IE (moving income reference period 2005-06); BG and RO: National Household Budget Survey 2006

Figure A16: Income inequality: S80/S20 income quintile ratio, confidence intervals7 at 95% — 2006



Source: EU-SILC (2006); income year 2005; except for UK (income year 2006) and for IE (moving income reference period 2005-06); BG and RO: National Household Budget Survey 2006; BG, DE, LU, RO, UK confidence intervals not available. EU-25 average excludes BG and RO

Figure A17:



Source: EUROSTAT

In the background are some important structural drivers such as the political context, biases, norms and values within society, and economic, social, education, environmental and health policy, as these can contribute to the degree of social stratification in society (the magnitude of inequity along various dimensions). Differences in average health status between Member States can relate to differences in the economy of different areas, which in turns affects health through its impact on the quality of jobs, levels of income and quality of living conditions and services. Economic growth and income distribution policies for example appear to have a positive impact on health.

Differences in levels of income (GDP per capita) across Member States (Table A8) may explain part of the difference in health between countries. Across the EU on average higher levels of GDP per capita are associated with higher average levels of population health (Figures A18-A19), through improvements in social determinants such as levels of income and the quality of jobs, living conditions, and public services. High economic growth in Member States with lower health levels by narrowing differences in GDP per capita would thus help reduce health inequities. However the relationship between economic growth and health is complex. Evidence suggests that on its own economic growth may not deliver a reduction in health inequities. To ensure that this will happen, it needs to be accompanied by other policy measures and attention to the distribution of benefits. Indeed, while many EU countries registered high economic growth in recent years, this has not necessarily translated into 1) a reduction of poverty rates, which have actually increased in some Member States (Figure A20) and 2) a reduction in the health gap within Member States (e.g. Table A1 shows that for BG, LT, LV, RO and SK the gap in has actually increased). Moreover, health is not just a function of GDP levels; how economic resources are used to improve living conditions, promote solidarity and deliver services is also important. The level of health inequalities is therefore linked to but is not a simple function of the level of GDP. The translation of GDP per capita into health and health equity depends to a large extent on policy. The right policy mix can

achieve reductions in disparities and thus improve general health by optimising the health gain for the resources available. Globally there are examples of countries with high GDP and high health inequalities (USA) or lower health inequalities (Canada).

Figure A18: Life expectancy versus real GDP per capita PPP$

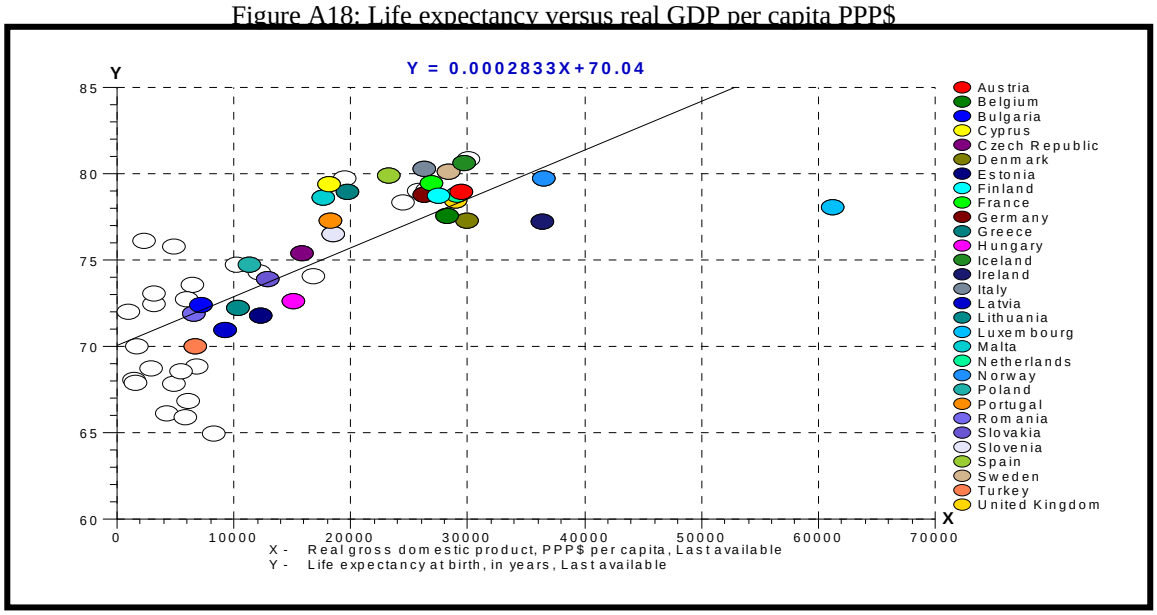
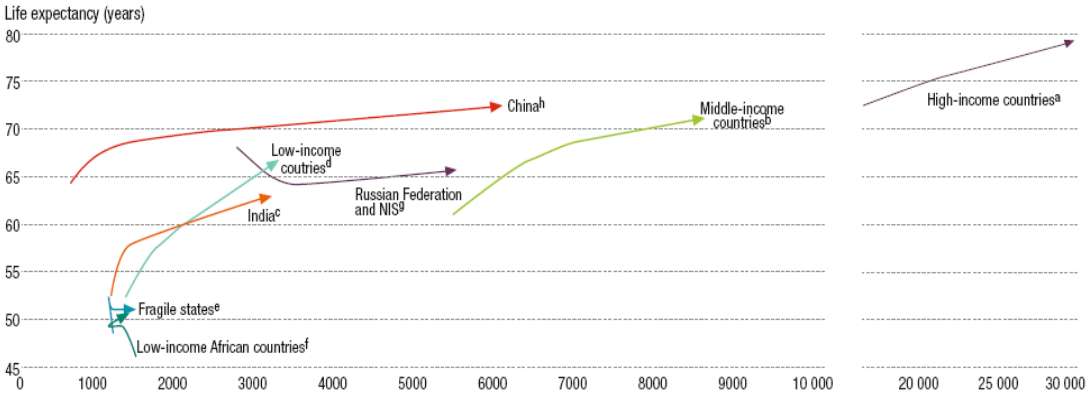


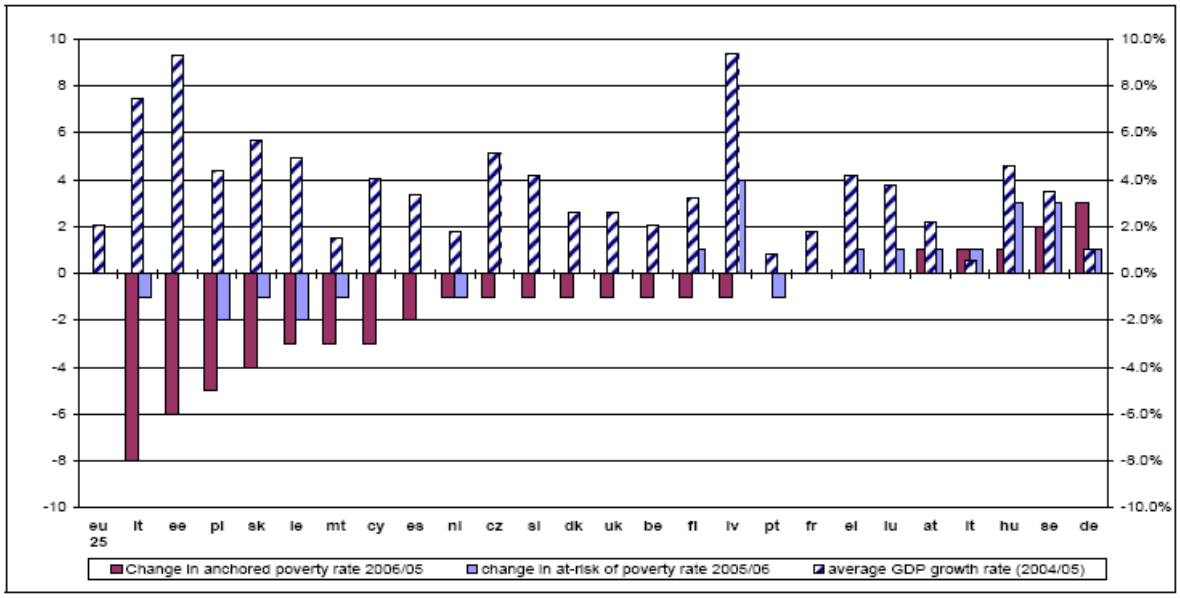
Figure A19: Trends in GDP per capita and life expectancy at birth in 133 countries grouped by the 1975 GDP, 1975-2005



[a] 27 countries, 766 million (M) inhabitants in 1975, 953 M in 2005.
[b] 43 countries, 587 M inhabitants in 1975, 986 M in 2005 .
[c] India, 621 M inhabitants in 1975, 1 103 M in 2005.
[d] 17 Low-income countries, non-African, fragile states excluded, 471 M inhabitants in 1975, 872 M in 2005.
[e] 20 Fragile states, 169 M inhabitants in 1975, 374 M in 2005.
[f] 13 Low-income African countries, fragile states excluded, 71 M inhabitants in 1975, 872 M in 2005.
[g] Russian Federation and 10 Newly Independent States (NIS), 186 M inhabitants in 1985, 204 M in 2005.
[h] China, 928 M inhabitants in 1975, 1 316 M in 2005.
* No data for 1975 for the Newly Independant States. No historical data for the remaining countries.
Sources: Life expectancy, 1975, 1985: UN World Population Prospects 2006; 1995, 2005: WHO, 9 November 2008 (draft); China: 3rd, 4th and 5th National Population censuses, 1981, 1990 and 2000. GPD: 2007[57].

Source: WHO World Report 2008

Figure A20: Impact of economic growth on poverty: change in anchored poverty rate (income years 2005/04), change in at-risk-of-poverty rate (income years 2005/04) — percentage points; and average GDP growth (2004-05) — %

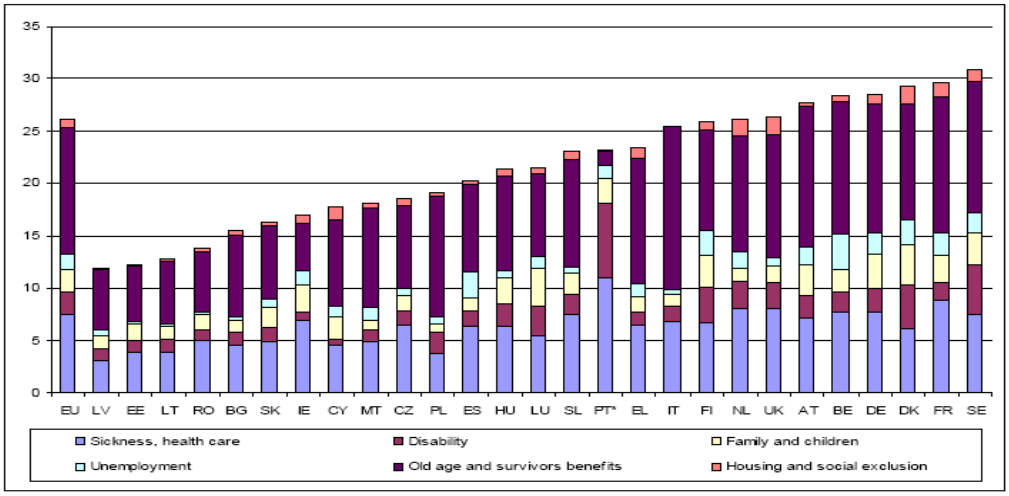


Source: Eurostat — EU-SILC (2006); income year 2005; except for UK (income year 2006) and for IE (moving income reference period 2005-06); BG and RO: National Household Budget Survey 2006; GDP: National Accounts

Variations across the EU can also be observed in relation to the size/ extent of social protection systems (Figure A21) including health care and long term care budgets and the protection of those outside of the labour market (pensions, sickness, disability, family and child, unemployment, housing and social inclusion benefits). The extent of redistribution and social protection, which vary significantly across Member States, may contribute to the observed health gaps (Figures A21-23). Income distribution policies (e.g. social transfers) are estimated to reduce the risk of poverty in the EU by 38% (Figure A21, 2008 OMC Monitoring Report[63]). Several research studies suggest that income inequality is one of a number of factors explaining differences in health between countries and individuals (Jen et al, 2009; Babones, 2008; Leigh and Jenks, 2007; Wilkinson and Picket, 2006; Cantarero et al., 2005; van Doorslaer and Koolman, 2004; Asafu-adjaye, 2004; Gravelle et al, 2002).

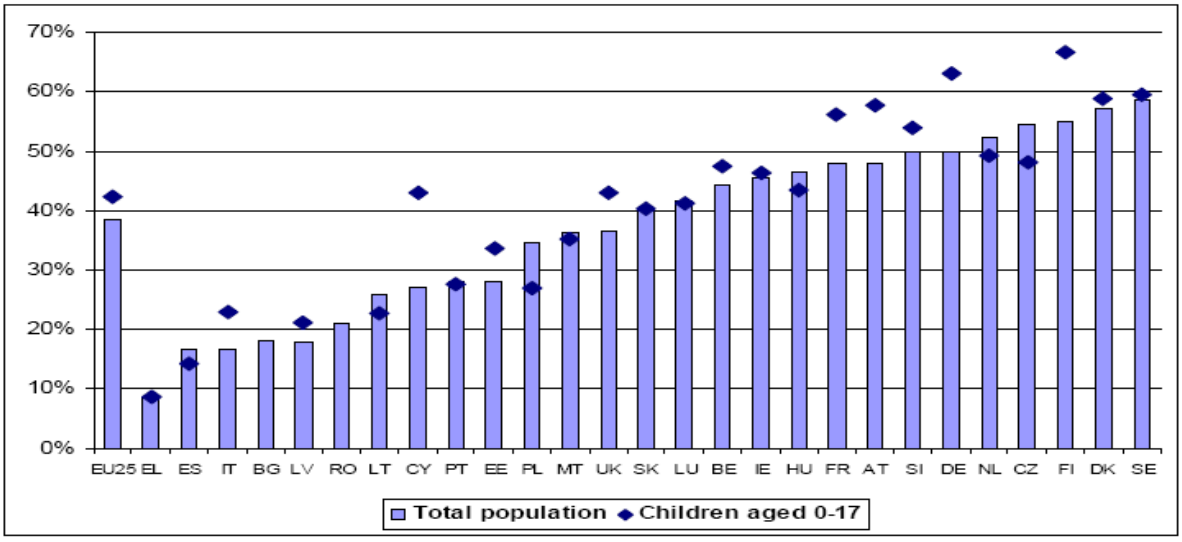
[63] See http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/omc_monitoring_en.pdf

Figure A21: social protection benefits, by function, in % of GDP — 2005



Source: Eurostat — ESSPROS; *Portugal: 2004 data

Figure A22: Impact of social transfers (excluding pensions) on the at-risk-of-poverty rate for the total population and for children, 2006 — %



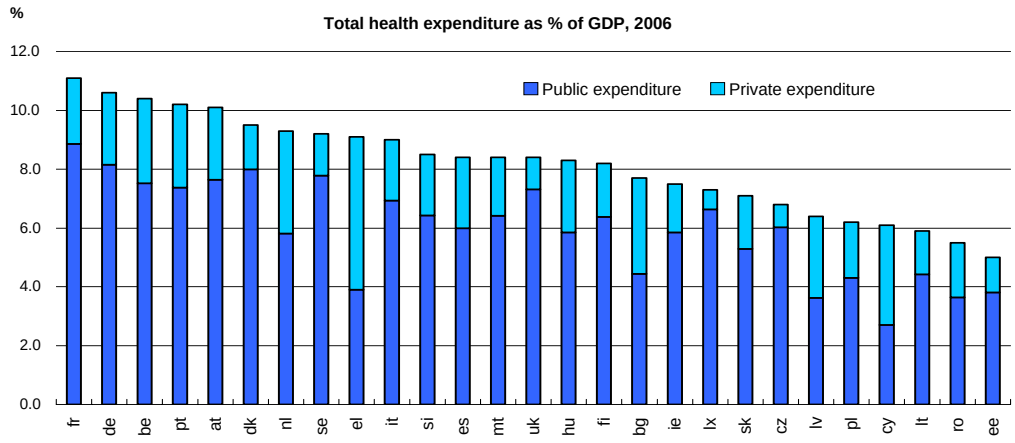
Source: EU-SILC (2006); income year 2005; except for UK (income year 2006) and for IE (moving income reference period 2005-06);

Healthcare influences the likelihood of overcoming disease and avoiding mortality thus its availability and quality between and within Member States can help explain some of the health disparities observed. The size of health budgets can determine the health system capacity to meet the care needs of the population: there is a tendency for those Member States reporting lower life expectancy[64] to also report the lowest total health expenditure per capita and as a percentage of GDP (Figure A23) and the highest proportions of unmet need for medical care (Table A9). Also, private expenditure, which can deter access to care by lower socio-

[64] BG, LV, RO, LT, HU, EE, SK, and PL

economic groups, may be a factor contributing to health inequalities in some countries (2008 OMC monitoring report).

Figure A23: total health expenditure as % of GDP, 2006 or most recent year



Source: OECD Health Data 2008 and WHO, HFA-DB

Table A9: Self-reported unmet need for medical care in the last year, 2006

Member State	Self-reported unmet need for medical care			Number of doctors' consultations per capita OECD and national data
	2004	2005	2006	2005
BE	1.3	0.8	0.5	7.5
CZ		1.2	0.7	13.2
DK	0.3	0.3	0.2	7.5
EE	7.2	6.6	7.3	6.9
IE	1.9	2.0	1.9	n.a.
EL	4.1	4.6	5.8	n.a.
ES	3.0	1.2	0.6	9.5
FR	1.8	1.7	1.5	6.6
IT	5.3	5.0	4.7	7.0
CY		3.3	3.2	2
LV		19.3	15.0	5.2
LT		7.2	8.2	6.8
LU	0.5	0.4	0.4	6.1
HU		3.9	2.4	12.6
MT		1.6	1.8	1.9
NL		0.5	0.4	5.4
AT	0.6	0.5	0.5	6.7
PL		9.9	9.3	6.3
PT	4.5	4.7	5.0	3.9
SI		0.3	0.2	7.2
SK		3.2	2.8	11.3
FI	2.9	3.0	2.5	4.3
SE	2.5	2.6	2.9	2.8
UK		2.3	1.9	5.1
EU*		3.4	3.1	

Source: Eurostat based on EU-SILC 2006 data

Availability (infrastructure, equipment and health professionals), access and quality of healthcare are keys factors determining health and health inequalities as they influence the likelihood of overcoming morbidity and avoiding mortality. Health systems inadequacies

include under-resourcing (financial and human[65]) and uneven geographical coverage. Quality distribution of resources and facilities including poor coverage in some regions and for some disadvantaged social groups such as Roma (e.g. Joint Reports on Social Inclusion and Social Protection). They affect the way diseases are diagnosed and treated and thus population health. The size of national health budgets can determine the capacity of a given health system to meet the needs of the population. The quality of healthcare plays a key role: e.g. every year 3 million patients suffer from healthcare associated infections and 50.000 die from them[66]. Differences in access to quality care translate into very large differences in treatable mortality i.e. conditions that respond to healthcare intervention (Newey, Nolte, McKee, & Mossialos, 2003, 2008). This is particularly acute in some regions of new Member States which lack high quality health facilities with up to date equipment and well trained staff.

Moreover, socio-economic differences in access to care can be observed (e.g. Alter et al, 1999, 2006). There is a clear income gradient in unmet need for medical care: those in the lowest income quintiles more often report an unmet need due to waiting, the direct financial cost of care and the distance to care (Table A10). Evidence suggests that lower income families have further to travel to hospital or family doctor (Figures A24 and A25) and those with low incomes have a lower chance of being admitted to hospital or be seen by a specialist. Several Joint Reports on Social Protection and Social Inclusion have identified barriers to access: lack of health insurance coverage[67], direct financial costs of care, geographical disparities in service availability, waiting times, lack of information, discrimination and language barriers, health literacy and socio-cultural expectations in relation to life and care services.

For example, in most countries, doctors and facilities tend to be concentrated in the capital and richer regions (2009 Joint Report on Social Protection and Social Inclusion). The current healthcare staff shortages, which may increase as a result of ageing, can undermine the quality of healthcare systems[68]. Finally, health staff may not be trained on issues of equity, social exclusion and discrimination or mental health problems.

Access to healthcare is also affected by gender. A gender-sensitive focus is critical when trying to reduce health inequalities as many are caused by social factors, such as education, employment and family life, where, again, gender has a significant impact.

In general, inequitable access to care appears to be associated with higher health inequalities (Figure A26).

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[65] When looking at resources, a 2-fold difference in the number of practicing physicians per 100,000 population fold can be found between EU countries.

[66] See: The First European Communicable Disease Epidemiological Report, http://www.ecdc.eu.int/pdf/Epi_report_2007.pdf, p. 319.

[67] See 2008 OMC Monitoring Report where data and analysis of national strategy reports shows that in several EU Member States – NL, PL, SK, AT, BE, ES, LU, DE, FR, SI, LT and EE – non-negligible numbers of the population are not covered by public or primary private insurance

[68] See: Green Paper on the European Workforce for Health, 2008, http://ec.europa.eu/health/ph_systems/docs/workforce_gp_en.pdf, p. 6.

Table A10: Self-reported unmet need for medical care in the last year, by income quintile

Member State	1st quintile Q0-Q20		2nd quintile Q20-Q40		3rd quintile Q40-Q60		4th quintile Q60-Q80		5th quintile Q80-Q100	
	2005	2006	2005	2006	2005	2006	2005	2006	2005	2006
BE	2.5	1.8	0.9	0.4	0.2	0.2	0.2		0.1	0.1
CZ	1.9	1.4	1.2	0.7	1.1	0.5	1.2	0.5	0.8	0.2
DK	0.5	0.2	0.3	0.3	0.5	0.2	0.3	0.2	0.1	0.2
EE	12.2	14.4	7.4	7.0	5.7	5.9	4.0	6.3	3.7	3.1
IE	2.5	2.7	2.9	2.1	2.9	2.4	1.1	1.9	0.7	0.7
EL	8.8	7.9	6.1	7.8	4.6	7.3	2.9	4.1	0.9	2.0
ES	2.0	0.9	1.4	0.9	1.1	0.5	0.7	0.4	0.7	0.2
FR	4.0	4.3	1.9	1.4	1.5	1.2	0.4	0.3	0.5	0.6
IT	10.1	9.2	5.6	5.1	4.5	4.0	2.8	3.1	1.9	2.1
CY	6.3	6.6	5.5	4.7	2.8	2.6	1.4	1.5	0.4	0.5
LV	31.5	28.9	25.1	20.5	19.3	10.2	13.5	9.8	7.2	5.9
LT	11.0	13.6	8.2	10.5	7.1	7.9	4.7	5.2	5.0	3.9
LU	0.8	0.8	0.2	0.1	0.4	0.2	0.2	0.2	0.3	0.4
HU	6.8	3.9	4.7	3.2	2.7	2.4	2.8	1.7	2.6	0.8
MT	2.2	3.4	1.8	1.9	2.0	1.6	1.5	1.2	0.7	0.8
NL	1.0	0.9	0.7	0.3	0.7	0.3	0.1	0.3	0.0	0.3
AT	1.0	1.0	0.2	0.5	0.4	0.2	0.5	0.3	0.2	0.3
PL	14.2	13.3	11.3	11.0	9.6	8.9	8.4	7.2	6.3	6.4
PT	10.2	9.6	5.5	6.8	4.4	4.9	2.7	2.7	0.8	1.1
SI	0.5	0.3	0.4	0.2	0.3	0.1	0.1	0.1	0.3	0.2
SK	5.7	6.4	4.5	3.4	2.9	2.2	1.9	1.5	1.3	0.8
FI	5.7	4.7	3.7	3.3	2.4	2.1	1.9	1.7	1.3	0.9
SE	3.0	4.1	4.0	3.9	2.3	3.3	2.5	2.0	1.4	1.1
UK	2.4	2.6	2.1	1.7	2.8	1.5	2.2	2.4	2.2	1.5

Source: Eurostat based on EU-SILC 2006 data

Figure A24: distance to hospital, income quintile

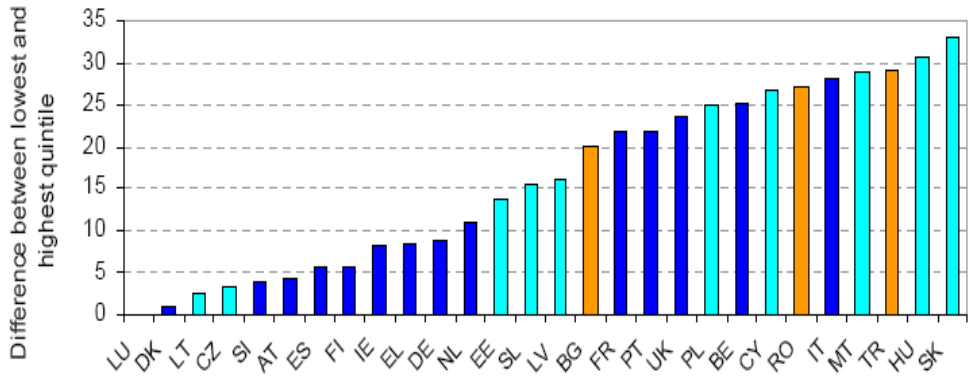


Figure A25: distance to general practitioner/family doctor, income quintile

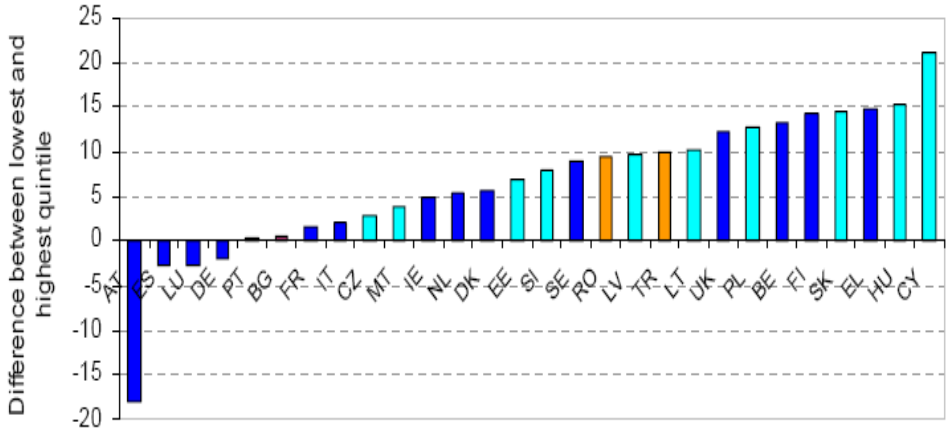
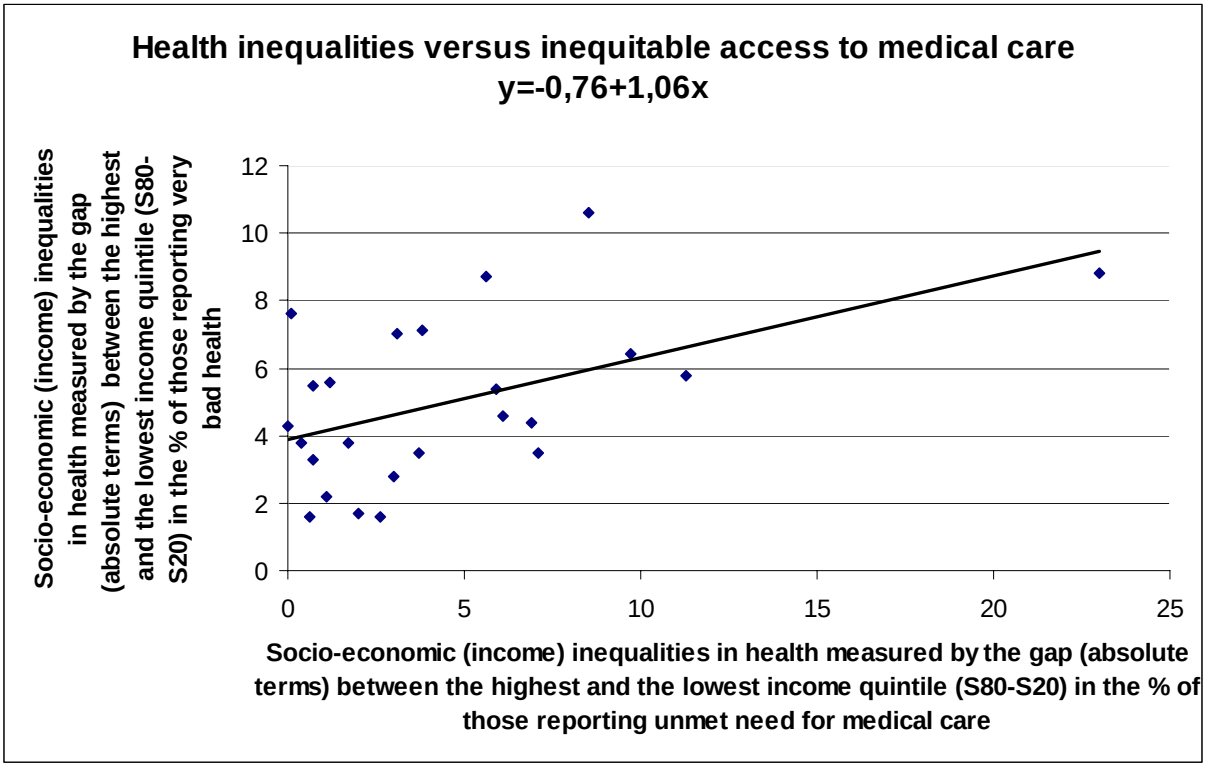
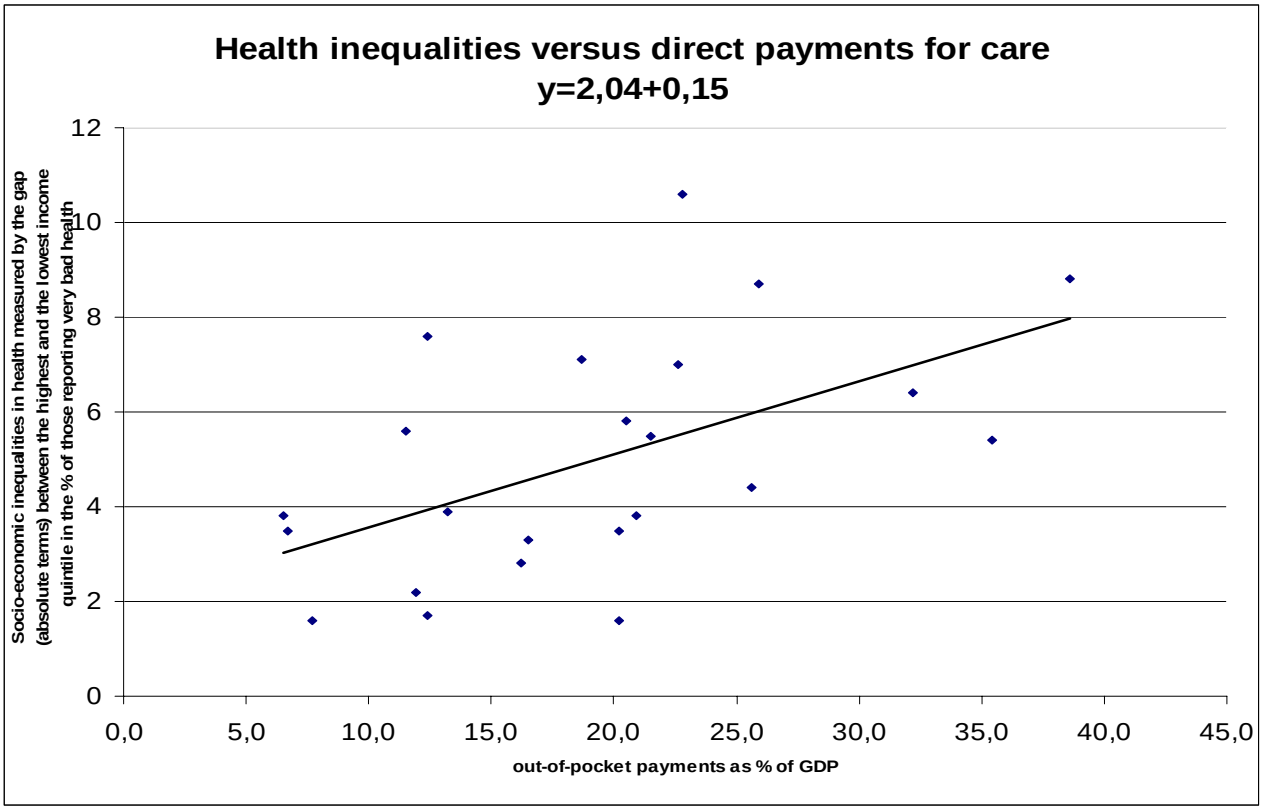


Figure A26:



Source: Eurostat based on EU-SILC 2006 data

Figure A27



Source: Eurostat based on EU-SILC 2006 data

Finally, the current economic crisis can impact on health and increase health inequalities through a deterioration of social determinants of health, especially for those who are already in lower socio-economic groups with lower qualifications and savings. The loss of job and thus income can lead to deterioration in living conditions, including a poorer diet, especially if a safety net (social protection mechanisms including unemployment benefits) is not present. Unemployment or job insecurity lead to increased levels of stress and risk behaviour (e.g. drinking, smoking) which harm health: depression and disturbed immune system, accidents, which possible health and education consequences on the rest of the family (e.g. children). Depending on the length of the crisis, the negative impact on health can be long lasting: e.g. burnout conditions appear years rather than weeks or months after unemployment started. In addition, a deep economic crisis can impact on health and increase health inequalities through a deterioration of the access to quality health and social care especially by those in lower socio-economic groups. This is the case if access to care depends on being employed, having financial means or on Member States cutting the resources allocated to the health and social care sectors resulting in lower coverage or quality of care. The current economic crisis through posing a financial pressure on health systems can motivate countries to review their policy mix on health determinants in search for higher effectiveness and efficiency.

The information provided above supports the Council Conclusions of November 2006[69] that "health determinants are unequally distributed among population groups resulting in health inequalities" and "that policies can have positive or negative impacts on health determinants reflected in the observed health outcomes and the health status of the population". It shows that health inequalities are associated with socio-economic inequalities (e.g. uneven distribution of resources and opportunities which translate into income, education, occupation and environmental differences between and within countries). The above description provides a general outline of the causes of inequalities in health between countries and between social groups. More detailed and specific information is nevertheless still required to be able to establish the effect (causality) and weights of several of those health determinants so that Member States can choose and implement effective action in relation to a particular population group or in relation to a particular determinant.

9.2. What Member States are doing and consider effective to address health inequalities

While about half of the EU Member States have activities which address inequalities in health only a small number have developed comprehensive inter-sectoral strategies and even fewer have fully assessed their impact. Hence, information based on comprehensive assessment and evaluation of the effectiveness of actions and strategies is limited. General examples of reductions in gaps in health between regions of Member States include those achieved by FI in the North Karelia project and by DE with a reduction in the mortality rates between new and old Länder since reunification. The UK has recently reported some encouraging signs of narrowing of health gaps between areas and social groups following a period were these inequalities widened.

Despite the limited knowledge, it is possible to establish a list of policy actions which have been judged by Member States as effective to tackle health inequalities. There are a number o f sources of information on effective policy initiatives including the report produced for the 2005 UK Presidency on the topic and entitled "Health Inequalities: a Challenge for Europe"[70], the Eurohealthnet coordinated project "Closing the Gap: Strategies for Action to tackle health inequalities", the ongoing Eurohealthnet coordinated project "Determine" and its related web site (www.health-inequalities.eu), which gathers Member States information on strategies to tackle health inequalities. The largest amount of evidence comes from the UK where comprehensive strategies to tackle health inequalities have been developed over more than a decade and where several evaluations have taken place [71].

Reviewing available evidence indicates that many Member States reach a number of general conclusions. Firstly, that in addition to maintaining universal access to a number of key services such as education, social protection and healthcare, access also needs to be intensified and targeted at specific groups (e.g. to mothers and children, young parents, and those over 50) in disadvantaged areas, in vulnerable families and in lower socio-economic groups. For

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[69] Council Conclusions on Health in All Policies (HIAP). http://ec.europa.eu/health/ph_projects/2005/action1/docs/2005_1_18_frep_a8_en.pdf

[70] See http://ec.europa.eu/health/ph_determinants/socio_economics/documents/ev_060302_rd05_en.pdf

[71] See for example "Tackling Health Inequalities: 10 years on", Department of Health, London 2009. http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_098936

example, health policy actions do not need to be new but redesigned i.e. we need to change the way we deliver health promotion, disease prevention and treatment services. This is particularly the case for health promotion and disease prevention programmes.

Secondly, Member States argue that regional and local action, supported by national and EU actions, is very important to achieve results and local authorities must actively search for the individuals at risk of lower health status in their communities. One effective way to reach those individual is to build neighbourhood and community infrastructures (e.g. communities for health programme in the UK). Building partnerships with the voluntary / third sector and with business can also be effective in raising general awareness and action (e.g. in the UK a social enterprise partner foundation delivers a programme in some disadvantaged areas and in DE the health insurance BKK and the Ministry of Work Health and Social Affairs concluded a partnership to improve the health of the unemployed - JobFit).

Thirdly it is widely accepted that measurement and regular reporting of health inequalities indicators is an essential first step towards effective action. Building information through the development of regular monitoring of health indicators (e.g. the UK has even developed a quite complex composite indicator, the health poverty index), allows for awareness-raising activities (e.g. conferences, seminars, pre and post graduate lectures in CZ, DE, IE, PL) and allows policy makers to identify the extent of the gap and where it lays (types of diseases and causes of mortality). They can then devise strategy to achieve faster decreases in these diseases and mortality in the deprived areas / lower socio-economic groups vis-à-vis the more affluent groups. A good example of the impact of available information and reporting is that of NL where a detailed data analysis of the socio-economic gradient in health identified a 6 year gap for women and a 7 year gap for men. The publication of the report has motivated the development of a policy strategy for tackling health inequalities. Similar conclusions come from EE, ES and BE following the publication of their first report on socio-economic inequalities in health. Data collection, analysis and monitoring must then be accompanied by building scientific knowledge for action (notably through partnerships between national administration and universities), which is gathered and disseminated through a coordination centre (e.g. the policy coordination centre for health equity in BE, the national support team for health inequalities in the UK, the National Institute of Public Health in DK, the National Institute for Health Development in EE, the National Institute for Health Education and Prevention in FR, the internet platform www.gesundheitliche-chancengleichheit in DE, the Institute of Public Health in IE comprising the Population Health Observatory and the All-Ireland Health Library, the Working Group on Health inequalities in the Trentino Region in IT, Inter-sectoral Coordination Commission of Public Health in LV, Health Inequalities Monitor in NL, the National Institute of Public Health in SE,). This entity can advise local authorities on what are effective actions. Learning quickly from innovation elsewhere is also deemed crucial and several Member States suggest that initiatives linking cities and regions have been very effective in disseminating information (e.g. the city wide initiative in the UK, the Local Government Denmark, the Healthy Cities Network in DK, the National Health Board in DK, the city links initiative in NL). Taking stock of increasing body of evidence on the causes of health inequalities and how they can be influenced is therefore seen as a fundamental and effective step for devising policy action

Fourthly, several Member States (UK, BE, IE) that health impact assessment/health equity test/ health equity audit applied to policies across the board is an effective way to generate inter-sectoral awareness of health inequalities and the social determinants of health and health inequalities.

More specific examples of policies considered effective by Member States or research review studies are as follows:

- Improve access to information on the risk of smoking and access to smoking cessation services for those in deprived areas and in lower socio-economic groups which consistently show higher rates of smoking than more affluent groups (UK, NL). To decrease infant mortality and increase life expectancy in these groups it is effective to a) ensure smoking-cessation during pregnancy (which has been shown to be the most significant of very few know modifiable risk factors in the prevention of low birth weight and as a consequence individuals' health throughout their lives – Kramer 2000), b) stop parental smoking (which research has shown is strongly associated with Sudden Infant Death Sindrome) and c) reduce smoking in general for those groups. Smoking was considered by the UK DoH as the single biggest preventable cause of socio-economic gradient in infant mortality and life expectancy through lower birthweight and higher mortality from Cardiovascular disease, stroke and respiratory disease. Studies have showed that NHS stop smoking services were very effective in reducing the number of smokers living in more disadvantaged areas when the access to those services was improved.
- Banning smoking in work places and in public places is effective in reducing smoking rates and passive smoking for all.
- Evidence from the UK, BE, FI, SE and NL also indicate that the use of taxes can make unhealthy items more expensive and reduces consumption while and subsidies for healthy food can increase consumption of these, and can contribute to reducing health inequalities because increasinge the price of tobacco and alcohol for example reduces consumption by lower income groups as these are more price sensitive.
- Improving access to food supplementation (vitamin and folate) for pregnant women in lower socio-economic groups
- Improve antenatal care (screening and immunisation) and post natal care including neonatal screening and parent support (information on nutrition, parental smoking, sleeping positions etc) for those in less affluent areas and in lower socio-economic groups (UK, PL) or migrants (NL) to reduce the gap in neo-natal and infant mortality. This has been done through working with family doctors and hospitals and the Sure Start child centres in the UK (multidisciplinary professionals providing services for families and children of up to 5 years in deprived areas), home visits from early pregnancy till 2 years for vulnerable mothers (young, single, deprived areas) in the UK; through the ONE centres in BE, for example.
- Increase breastfeeding initiation and duration rates in deprived areas and lower socio-economic groups which are currently lower than those of more affluent areas /groups notably through food vouchers for pregnant women in disadvantaged areas/ groups. Breastfeeding reduces the likelihood of gastro and respiratory infections and obesity and mother's likelihood of developing breast and ovarian cancer, all with the exception of breast cancer higher in lower socio-economic groups. See instruments of previous point.
- Improve child immunisation take-up and better follow-up of children's health in deprived areas and lower socio-economic group. An example is the school U-programme (U1-U9) in DE in addition to the instruments of previous point.
- Increase the up-taking of screening and reducing the delays to see a GP and a GP referral in deprived areas
- Managing high blood pressure and reducing cholesterol levels through medical advise and medicines and advise on diet exercise and smoking for those in deprived areas

- Increase flu vaccination of those 65+
- Reduce teenage pregnancy and STDs through comprehensive contraceptive advice.
- Ensure timely access to effective emergency services in more deprived areas.
- Address cultural barriers to care by a) adjusting medical curricula to look the topic of health inequalities (CZ, NL, PL) by b) using intercultural mediators in the primary and secondary care sector (BE, BG, RO, IT, FI, NL) and by using c) community health trainers (UK); d) medical services including emergency services working with faith/ religious representatives (UK). For example, in the UK the ambulance service is holding a summit with various faith and religious services to foster better understanding and better relationships and reduce discrimination
- Address care supply gaps in some geographic areas by reinforcing primary care services which should work together with community social services and other stakeholders (BE, NL, UK, HU). Investment in ICT in the field of healthcare has been effective to address healthcare gaps in the specific case of outermost regions such as the Canaries in ES, bringing professionals and users closer together.
- Making promotion and prevention interventions part of the basis packages of health insurance (e.g. exercising by prescription, smoking cessation services) in NL. Cervix Mass screening Programme in HU which was accompanied by social marketing to ensure a boost of screening in lower socio-economic groups.
- Fluoridation of water which reduces the socio-economic differences in tooth decay in children as shown by comparing different counties in the UK; Providing meals, fruit and milk at schools (DK, UK, HU), which can reduce socio-economic differences in nutrition (i.e. improve child nutrition in deprived areas and lower socio-economic groups notably in terms of healthy foods).
- Provide affordable pre-school day care for lower socio-economic groups as this increases education and employment attainment, income level and thus health
- Ensure good physical education programmes in schools (UK, NL).
- Decrease school drop-outs (IE, NO, FI, UK, NL) notably through the Sure Start scheme in the UK
- Improving work organisation (FI, SE, DE). For example, improving work organisation in a bus company in DE lead to a significant reduction of sick leave and employee turnover of bus drivers (e.g. Greiner & Syme 1994).
- Improve the physical environment through clean air legislation, green spaces and encouraging more walking more cycling (UK, NL). Improving housing quality (UK, EE) to tackle cold and dampness through improved house building standards and through affordable heating for lower socio-economic groups and measures to reduce accidents at home (smoke alarms, hand rails). A review of UK "area regeneration initiatives" showed that these lead to better education and employment rates, higher household income and housing quality and contributed to improving health.
- Child resistant containers
- Improving transport links
- Seat belt and speed legislation (UK, BE),
- Income support (NL, SE)
- Using targets (UK, NL, CZ, FI, Basque Country in ES) has been effective in raising awareness and motivating policy action.
- Partnerships with voluntary sector and community groups including faith / religious leaders

- Partnerships with companies and having public sector giving example for health at work strategies (UK, BE, IE, DE). In DE the health insurance BKK and the Ministry of Work Health and Social Affairs concluded a partnership to improve the health of the unemployed (JobFit). A public health advocacy tool to help develop meaningful partnerships (IE) and training individuals who can raise awareness and advocate from within and beyond their sector (IE).
- An award system to recognise local authorities, local strategies, partnerships or actions to reduce health inequalities has been effective to motivate policy development.

From the above list, several areas can be identified where EU and national action are complementary. The EU can support and complement Member States in the areas of awareness raising and advocacy, data development and monitoring. It supports research (Research and specific action programmes) and the dissemination of information and best-practice exchange (e.g. OMC mechanisms). It provides financial support (e.g. Structural Funds) which can be used for example to develop targeted health promotion and disease prevention interventions and to improve the geographic distribution of primary care. More generally, the EU is striving for better environment (cleaner air), health and safety at work and equal opportunities. The need for a collaborative approach is important as it can help optimizing resources and contribute to tackling common challenges within the EU.

9.3. Existing EU action and links to other relevant EU policies

EU strategies: growth, employment, social and health strategies

The Lisbon Strategy on growth and jobs can be expected to deliver some positive outcomes on health as growth and more and better jobs improve overall living standards and thus health. Healthy life years has been agreed as one of the structural indicators.

The current European Employment Strategy (EES) entails a number of policy areas that directly or indirectly addresses health inequalities. One of the key objectives in the overarching Employment Guideline 17 is to improve quality and productivity at work and to modernise social protection systems. Health and safety at work is one of the main dimensions of quality at work. It also represents a crucial element in attracting more people into the labour market, in particular in the light of ageing. Moreover, reducing accidents at work, occupational diseases and work-related illnesses for all workers and in particular for workers suffering from the worse working conditions is an important tool to address health inequalities. Employment Guideline 18 on promoting a lifecycle approach calls for support for active ageing including appropriate working conditions and improved occupational health status. It also calls for promoting modern social protection systems including healthcare. The employment guidelines put emphasis on improving the occupational health status with the aim of reducing sickness burdens, increasing labour productivity and prolonging working life. Employment Guideline 21 calls for the promotion and dissemination of innovative and adaptable forms of work organisation to improve quality and productivity at work including health and safety. The employment guidelines also calls for the implementation of integrated flexicurity approaches with the aim of helping workers including low skilled and those at the margins of the labour market to cope with a working life that is becoming more complex, diverse and irregular and therefore demanding. Finally Employment Guideline 23 emphasises the need to focus on new skills for new jobs in order to promote access for all and ensure innovation and quality at work.

The EU can support Member States actions to address common challenges through the OMC (employment OMC, social OMC) by facilitating dialogue and the exchange of best-practice and policy coordination with/between Member States and with stakeholder organizations, by supporting the development of innovative good practice through its funding programmes (e.g. PROGRESS). Addressing health inequalities is a common objective under the social OMC. Work under the employment and social OMC, supported by the ESF, has looked at how one can address long-term unemployment and bring those further from the labour market into work, looking at disadvantaged groups and the gender dimension. Under the social OMC and the Council Working Party on Public Health meeting at senior level, supported by the ongoing development of indicators (social OMC common indicators, ECHI) the EU has promoted the monitoring of health and coordination of health policies through information sharing and exchange of good practice. The 2008 social OMC Communication[72] proposed that the implementation of the objectives in the field of healthcare be supported by targets on access to healthcare and on health status.

Under the EU Health Strategy, inclusion of equity in health as a key value of the and attention to social determinants as part of the implementation of existing EU health activities, such as those on tobacco, obesity and alcohol, young people and mental health. : As some countries have begun to introduce policies intended to reduce health inequalities, sharing of good practice on national and regional policies to address health inequalities such as for example through the EU Expert Group on Social Determinants and Health Inequalities can provide a good basis for policy improvements. Work on social determinants of health has started to map out health equity related policies, linking up with international organisations such as WHO and the OECD, the Council of Europe and research developments in this area. Commission services (REGIO, SANCO, EMPL) are working together to map out the use of cohesion funds in the field of health.

Common Basic Principles for immigrant integration policy in the EU have been agreed to by the Commission (COM(2005) 389) of which access to services, such as healthcare, is seen as a fundamental elements. The Handbooks on Integration for practitioners and policymakers provide best-practice examples from a number of projects in this area.

EU Funds:

The EU's Cohesion Policy is financially supporting Member States to address regional imbalances. Recently, health has been defined as one of the areas of support by the European Regional Development Fund (ERDF) and European Social Fund (ESF) Structural Funds according to the Community Strategic Guidelines for Cohesion 2007-2013.[73] Health promotion, disease prevention, transfer of knowledge, training and availability of highly skilled staff and infrastructure in cohesion regions are some of the topical areas qualifying for support. The Guidelines note that there are "major differences in health status and healthcare between EU regions"... thus "it is important for cohesion… to contribute to healthcare

[72] "A Renewed commitment to social Europe: Reinforcing the Open Method of Coordination for Social Protection and Social Inclusion". COM(2008) 418/4 at http://ec.europa.eu/social/main.jsp?catId=550&langId=en

[73] http://ec.europa.eu/regional_policy/sources/docoffic/2007/osc/l_29120061021en00110032.pdf

facilities… Community based health improvement and preventive actions have an important role to play in reducing inequalities".".[74]

While the Common Agricultural Policy (CAP) is not a social policy in itself it has elements that may contribute to the reduction of health inequalities such as ensuring a fair standard of living for farmers, assuring the availability of supplies and reasonable prices of consumers. The CAP supports the School Milk Scheme and the distribution of agricultural products to most deprived people. More recently, there was work and discussion on how the CAP could contribute to a more healthy diet by putting more emphasis on fruit and vegetables. To contribute more effectively to the children's healthy diet, a School Fruit Scheme was agreed by the Council in 2008, and which is operational as of the school year 2009-2010.

In addition, the EU rural development policy supports investments and development of social and health care services, technologies and infrastructure in rural areas as well as training and information actions on health and social subjects.

The EU Public Health Programme has been funding action networks, local initiatives, expert reviews, conferences, and policy innovations in the field of public health. PROGRESS funds activities in the area of anti-discrimination (e.g. anti-discrimination training activities)

The European Fund for the Integration of Third Country Nationals supports Member States efforts to facilitate the integration of migrants into European societies. 7% of the total budget of €825M is for Community Actions supporting projects addressing different aspects of integration, including access to healthcare. The remaining 93% is for the Member States to implement an Annual Programme agreed with the Commission.

The EU Framework Programmes for Research also offer possibilities to tackle health inequalities in particular under the 3rd pillar of the Health Theme of the specific Programme "Co-operation" of the 7th EU Framework Programme. This new activity aims at developing new research methods and generating the necessary scientific basis to underpin informed policy decisions and more effective and efficient evidence-based strategies in such areas as health promotion and the wider determinants of health including lifestyle and socio-economic and environmental factors[75].

Legislation:

The EU has established Community labour law and Community legislation in the field of health and safety at work and monitors its implementation, including some funding of research in the area of occupational safety and health in order to improve working conditions. The implementation in the Member States of the Community Legislation on Health and Safety at Work, as well as all the actions foreseen in the Community Strategy on Health and Safety at Work 2007-2012 is seen to constitute an important contribution to the reduction of health inequalities in the European Union. The active working population is currently 48,3% percent of the total population of the EU. Therefore the improvement of the prevention and the

[74] See Annex: Table showing the allocated share of Structural Funds investment in health infrastructure per MS.

[75] COUNCIL DECISION (2006/971/EC) of 19 December 2006 concerning the Specific Programme "Cooperation" implementing the Seventh Framework Programme of the European Community for research, technological development and demonstration activities (2007 to 2013), OJ L400/127)

protection of the worker's health and safety represents a very significant contribution to the overall public health in Europe, and to the reduction of some of the main elements having an impact on health inequalities among countries and citizens of the EU. Directive 91/383/EC aims to ensure that fixed-term workers and temporary agency workers are afforded, as regards safety and health at work, the same level of protection as that of other workers in the user undertaking and/or establishment. A report will be drafted in 2009 on the implementation of Directive 91/383/EC. The report which will cover the period up to 2007 will try to find potential deficiencies in the Directive in order to give guidance for the future action of the Commission in this field. The Impact Assessment to the Community Strategy on health and safety at work 2007-2012 showed that occupational health strategy reduces work accidents, helps accident victims or chronically ill to retain their job or return to work, is a main platforms for integrating migrant workers and can reduce stressful and monotonous working conditions that cause early deterioration of health, and hence, an early exit from working life.

Since 2000, in addition to laws covering the equal treatment of men and women, EU anti-discrimination legislation has been in place to ensure minimum levels of equal treatment and protection for everyone living and working in Europe. These laws are designed to ensure equal treatment irrespective of racial or ethnic origin, religion and belief, disability, sexual orientation, and age in many aspects of daily life - from the workplace, to issues covering education, healthcare and access to goods and services. In 2008 the Commission set up a governmental expert group in the field of non-discrimination and the promotion of equality which examines the impact of national and EU-level non-discrimination measures, validates good practice through peer learning and evaluates the effectiveness of non-discrimination policies.

Internal Market

Work on "health-related" infringement procedures for example on the freedom of establishment and provision of services, restrictions to ownership of pharmacies and their location, restrictions to ownership of laboratories and their opening hours, which may lead to sales monopolies and constitute barriers to access, may contribute to lower prices of care and thus particularly benefit citizens from lower social-economic groups.

More broadly, at the EU level all Commission initiatives now undergo an assessment of its likely economic, social and environmental impacts, including in particular the impacts on different social and economic groups and on existing inequalities.

Education and Youth

Physical and mental health and healthy lifestyle are promoted as part of Social and civic competences in the Recommendation on key competences[76], which invites Member States to develop the provision of key competences for all as part of their lifelong learning strategies. The Commission has also proposed a new EU Strategy for Youth[77], which underlines the vulnerability of youth and identifies actions to improve their health, particularly for those at risk of social exclusion.

[76] Recommendation of the European Parliament and of the Council of 18 December 2006 on key competences for lifelong learning (2006/962/EC).

[77] COM (2009)200 – 27/04/09 - An EU Strategy for Youth -Investing and Empowering –

9.4. Additional information on why health inequalities between and within countries are a problem and a policy concern to the EU? The legal and political basis for action and subsidiarity

This section explains in more detail the articles cited in section 2.5 of the main text and adds some more information on other articles that also provide a legal basis for action.

Article 2 of the EU Treaty states that the EU shall "promote economic and social progress and a high level of employment, a balanced and sustainable development …through the strengthening of economic and social cohesion …". In the EC Treaty Article 2 states that "the Community shall have as its task …to promote throughout the Community a harmonious, balanced and sustainable development, a high level of employment and social protection, equality between men and women,… the raising of the standard of living and quality of life, and economic and social cohesion and solidarity among Member States". Art. 3 of the EC Treaty refers that "the activities of the Community shall include: (…) a policy in the social sphere (…), the strengthening of economic and social cohesion, (…) the promotion of research (…), a contribution to the attainment of a high level of health protection, contribution to education and training (…), a policy in development cooperation (…). Arts. 2 and 3 thus refer to a number of objectives and policies which relate to the reduction of health inequalities in the EU. In addition, art. 16 of the EC Treaty indicates that "(…) given the place occupied by services of general economic interest in the shared values of the Union as well as their role in promoting social and territorial cohesion, the Community and the Member States, each within their respective powers and within the scope of application of this Treaty, shall take care that such services operate on the basis of principles and conditions which enable them to fulfil their missions". These services can play an important role in addressing health inequalities.

In addition, Art. 35 of the Charter of Fundamental Rights of the EU states that "everyone has the right of access to preventive health care and the right to benefit from medical treatment under conditions established by national laws and practices"[78]. The 2006 Council Conclusions on Common Values and Principles Underpinning EU Health Systems[79] highlight the overarching values of universality, access to good quality care, equity and solidarity of healthcare systems as a central part of Europe's high levels of social protection and a major contribution to social cohesion and social justice. In addition, the 2008 Tallinn Charter, adopted by EU Member States establishes as health systems goals "improving the level and distribution of health, equity in finance and equity of access to care".

In additions to the articles in the main text a legal basis for action can be found in other specific policies areas of the EC Treaty. Art. 33 on the common agricultural policy puts forward the goal of ensuring "a fair standard of living for the agricultural community" and "that supplies reach consumers at reasonable prices" and that "account shall be taken of (…) structural and natural disparities between the various agricultural regions". Art. 98 indicates that Member States shall conduct their economic policies so as to achieve the goals expressed in art. 2. Art. 149 of the EC Treaty says "the Community shall contribute to the development of quality education by encouraging cooperation between Member States and (…) by supporting and supplementing action (…)." Art. 159 also states that the Commission shall submit a report on the progress made towards achieving economic and social cohesion which

[78] OJ C364, 18/12/2000
[79] OJ C 146 of 22.06.2006, p.01.

shall be accompanied by appropriate proposals if necessary. Finally, arts. 163 to 166 expressed the goal of strengthening research capacity in the Community and establish a framework programme to support this goal.

Moreover, health inequalities imply substantial opportunity costs for the Union. Good health is seen as a "tool and part of the solution to the key challenges of population ageing and labour shortages"(e.g. European Commission publications on the European Social Fund).[80] The Community strategic guidelines on cohesion for example adopted by the Council in October 2006 underline that investment in health promotion and disease prevention will help to maintain active participation in society (…), thus maintaining their economic contribution and reducing dependency levels. This has a direct effect on productivity and competitiveness". Health is recognised as an important element in meeting the Lisbon goals and achieving Europe's full potential for prosperity, solidarity and security because improving health reduces early retirement, contributes to longer working lives and induces higher productivity, competitiveness and employment levels (idem). Avoidable ill-health also leads to large costs for the healthcare system and puts unnecessary pressure on public budgets. (European Commission publications on the European Social Fund, Community Strategic Guidelines on Cohesion).[81] This is confirmed by a study (Mackenbach et al., 2008)[82] carried out for the Commission that estimates the potential economic impact if death and disease rates of those with lower educational attainment were the same as those with higher educational attainment. The consequent increase in the number of workers the number of days worked, productivity of work and income levels and the reduction in premature death before retirement and chronic disease could lead to a minimum gain of 1.4% of GDP with an estimate for the overall value of gain of around 9.5% of GDP or one trillion Euros per year.

Table A17: Overview table, linking Problems, general and operational objectives to monitoring and evaluation mechanisms

Problem	General Objective	Monitoring and evaluation mechanisms / Indicator
Lack of awareness and insufficient policy priority and commitment by Member States	Raise awareness, promote information and best-practice exchange and advocate the tackling of health inequalities as a policy priority; both at Community and Member States level and by other stakeholders	Number of MS with comprehensive policy approach which can be analysed in the social OMC NSR 2011-2013 (currently two)
		To be evaluated by the Eurostat Working group on mortality
Absence of comparable and regular data, monitoring and reporting. Lack of knowledge on the determinants and the effective policies to implement	Improve data availability and the mechanisms to measure, monitor and report on inequalities in health across the EU and improve the knowledge base on the causes of health inequalities and the evidence base for action	To be evaluated by DG Research by number and quality of studies, and amount of distribution platforms (internet portal), publications (available in all languages)
Insufficient concerted EU approach to health inequalities (lack of mainstreaming at the EU level)	Develop the contribution of relevant EU policies towards reducing inequalities in health, including better support of Member States and stakeholders' efforts to tackle health inequalities and a specific	how many relevant EU policy strategies have an indicator of health status inequalities how many EU reports address the impact of certain strategies on health

[80] See http://ec.europa.eu/employment_social/esf/docs/TP_files_update/tp_health_EN.pdf
[81] See http://ec.europa.eu/employment_social/esf/docs/TP_files_update/tp_health_EN.pdf
[82] See http://ec.europa.eu/health/ph_determinants/socio_economics/documents/socioeco_inequalities_en.pdf

	focus on vulnerable groups and third countries	and health disparities
		Additional evaluation under Option II and III in dedicated Health Inequality report 2012

10. BIBLIOGRAPHY

Avendaño, M., Kunst, A. E., van Lenthe, F. ., Bos, V., Costa, G., Valkonen, T., Cardano, M., Harding, S., Borgan, J-K, Glickman, M., Reid, A., and Mackenbach, J. P., 2005. Trends in socioeconomic disparities in stroke mortality in six European countries between 1981-1985 and 1991-1995. Am J Epidemiol 161 (1):52-61.

Braveman P, Gruskin S., 2003. Defining equity in health. J Epidemiol Community Health. 2003;57:254–258.

Breeze, E., A. E. Fletcher, et al., 2001. Do socioeconomic disadvantages persist into old age? Self-reported morbidity in a 29-year follow-up of the Whitehall Study. Am J Public Health 91 (2):277-83

Jagger, C., Gillies, C., Moscone, F., Cambois, E., Van Oyen, H., Nusselder, W. Robine, J., 2008. Inequalities in healthy life years in the 25 countries of the European Union in 2005: a cross-national meta-regression analysis. The Lancet, Volume 372, Issue 9656, Pages 2124 - 2131

Cavelaars, A. E., Kunst, A. E. et al., 1998. Morbidity differences by occupational class among men in seven European countries: an application of the Erikson-Goldthorpe social class scheme. Int J Epidemiol 27 (2):222-30.

Cavelaars, A.E., Kunst, A.E., Geurts, J.J.M. et al., 2000. Persistent variations in average height between countries and between socio-economic groups: an overview of 10 European countries. Ann Hum Biol, 27(4): 407-421

Dalstra, J.A., Kunst, A.E., Borrell, C., Breeze, E., Cambois, E., Costa G, Geurts, J.J., Lahelma, E., Van Oyen, H., Rasmussen, N.K., Regidor, E., Spadea, T., Mackenbach, J.P., (2005) Socio-economic differences in the prevalence of common chronic diseases: an overview of eight European countries. International journal of epidemiology 34 (2): 316-326

Eurohealthnet, 2007 Closing the Gap – Strategies for Action to tackle Health Inequalities. Taking Action on Health Equity

Huisman, M., A. E. Kunst, et al., 2003. Socioeconomic inequalities in morbidity among the elderly; a European overview. Soc Sci Med 57 (5):861-73.

Huisman, M., A. E. Kunst, et al., 2004. Socioeconomic inequalities in mortality among elderly people in 11 European populations. J Epidemiol Community Health 58 (6):468-75.

Kunst AE, Bos V, Lahelma E et al. Trends in socio-economic inequalities in self-assessed health in 10 European countries. Int.J. Epidemiol 2005; 34 295-305.

Kutzin, J. (2008). Health financing policy: a guide for decision-makers. Geneva, World Health Organization.

Lundberg, O., 1991. Causal explanations for class inequalities in health – an empirical analysis. Social Science & Medicine 32.

Mackenbach, J. P., Meerding, W. J., Kunst, A. E., 2006 Economic implications of socio-economic inequalities in health in the European Union, Erasmus MC, Department of Public Health, Netherlands for the European Commission

Mackenbach, J. P., 2006 Health Inequalities: Europe in Profile, 2006, An independent, expert report commissioned by the UK Presidency of the EU

Mackenbach, J. P., V. Bos, et al., 2003. Widening socioeconomic inequalities in mortality in six Western European countries. Int J Epidemiol 32 (5):830-37.

Mackenbach, J. P., A. E. Cavelaars, et al., 2000. Socioeconomic inequalities in cardiovascular disease mortality; an international study. Eur Heart J 21 (14):1141-51.

Newey, C., E. Nolte, et al. 2003. Avoidable mortality in the enlarged European Union. Paris, Institut des Sciences de la Santé.

SHARE - Survey of Health, Ageing and Retirement in Europe Börsch-Supan, A., A. Brugiavini, H. Jürges, J. Mackenbach, J. Siegrist, and G. Weber (eds.), 2005. Health, Ageing and Retirement in Europe – First Results from the Survey of Health, Ageing and Retirement in Europe. Mannheim: Mannheim Research Institute for the Economics of Aging (MEA).

Stronegger, W.J., Freidl W., et al., 1997. Health behavious and risk behaviour: socioeconomic differences in an Austrian county. Social Science & Medicine 44 (3):423-426.

Trannoy, A., S Tubeuf, et al. 2008. Inequality of Opportunities in Health in France: A first pass. York, Health, Econometrics and Data Group Working Paper 08/24.

van Doorslaer, E., A. Wagstaff, et al., 1997. Income-related inequalities in health: some international comparisons. J Health Econ 16 (1):93-112.

van Oort, F. V., F. J. van Lenthe, et al., 2005. Material, psychosocial, and behavioural factors in the explanation of educational inequalities in mortality in The Netherlands. J Epidemiol Community Health 59 (3):214-20.

van Lenthe, F. J., C. TM Schrijvers, et al. 2004. Investigating explanations of socio-economic inequalities in health. The Dutch GLOBE study. European Journal of Public Health 14:63-70.

Whitehead M, 1990 The concepts and principles of equity and health. Copenhagen. WHO Regional Office Europe, 1990

WHO Commission on social determinants of health, 2008, Closing the gap in a generation.

11. LIST OF ABBREVIATIONS

AGRI	Agriculture and Rural development
AIDCO	EuropeAid - Cooperation Office
CAP	Common Agriculture Policy
Council WPPH	Council Working Party on Public Health at Senior Le
DEV	Development
DG	Directorate General
EAC	Education and Culture
EAFRD	European Agricultural Fund for Rural Development
EAGF	European Agricultural Guarantee Fund
ECFIN	Economic and Financial Affairs
ECHI	European Community Health Indicators
EHIS	European Health Interview System
EMPL	Employment Social Affairs and Equal Opportunities
EPSCO	Employment, Social Policy, Health and Consun Affairs Council
ERDF	European Regional Development Fund
ESF	European Social Fund
EUROFUND	European Foundation for the Improvement of Livi and Working Conditions
EUROSTAT	European Statistical Office
EU-SILC	European Union survey on income and living conditic
Expert Group SDH	EU Expert Group on Social Determinants of Health
FP7	Research Framework Programme 7
GDP	Gross domestic product
HI	Health Inequalities
IA ISSG	impact assessment inter-service steering group

IAB	Impact Assessment Board
INFSO	Information Society and Media
JLS	Justice, Freedom and Security
Joint Report SPSI	Joint Reports on Social Protection and Social Inclusio
MARKT	Internal Market and Services
MS	Member States
NGO	Non-governmental organisation
NSR	National Strategy Report
PROGRESS	EU's employment and social solidarity programme
REGIO	Regional Policy
RTD	Research
SANCO	Health and Consumers
SG	Secretariat General
SHARE	Survey of Health Ageing and Retirement in Europe
social OMC	Open Method of Coordination for Social Protection a Social Inclusion
SPC	Social Protection Committee
WHO CSDH	WHO Commission on the Social Determinants Health