

Review of social determinants and the health divide in the WHO European Region: executive summary



Review of social determinants and the health divide in the WHO European Region: executive summary

Review chair

Michael Marmot

Report prepared by

UCL Institute of Health Equity

Abstract

The WHO European Region has seen remarkable health gains in populations that have experienced progressive improvements in the conditions in which people are born, grow, live and work. Inequities persist, however, both between and within countries. This review of inequities in health between and within countries across the 53 Member States of the Region was commissioned to support the development of the new European policy framework for health and well-being, Health 2020. Much more is understood now about the extent and social causes of these inequities. The European review builds on the global evidence and recommends policies to ensure that progress can be made in reducing health inequities and the health divide across all countries, including those with low incomes. Action is needed on the social determinants of health, across the life-course and in wider social and economic spheres to achieve greater health equity and protect future generations.

Keywords

Health inequities
Health management and planning
Health status disparities
Intergenerational relations
Socioeconomic factors
Social determinants of health

ISBN: 978 92 890 0032 1

Address requests about publications of the WHO Regional Office for Europe to:

Publications
WHO Regional Office for Europe
UN City
Marmorvej 51
DK-2100 Copenhagen Ø
Denmark

Alternatively, complete an online request form for documentation, health information, or for permission to quote or translate, on the Regional Office web site (<http://www.euro.who.int/pubrequest>).

© World Health Organization 2013,
updated reprint 2014

All rights reserved. The Regional Office for Europe of the World Health Organization welcomes requests for permission to reproduce or translate its publications, in part or in full.

The designations employed and the presentation of the material in this publication do not imply the expression of any opinion whatsoever on the part of the World Health Organization concerning the legal status of any country, territory, city or area or of its authorities, or concerning the delimitation of its frontiers or boundaries. Dotted lines on maps represent approximate border lines for which there may not yet be full agreement.

The mention of specific companies or of certain manufacturers' products does not imply that they are endorsed or recommended by the World Health Organization in preference to others of a similar nature that are not mentioned. Errors and omissions excepted, the names of proprietary products are distinguished by initial capital letters.

All reasonable precautions have been taken by the World Health Organization to verify the information contained in this publication. However, the published material is being distributed without warranty of any kind, either express or implied. The responsibility for the interpretation and use of the material lies with the reader. In no event shall the World Health Organization be liable for damages arising from its use. The views expressed by authors, editors, or expert groups do not necessarily represent the decisions or the stated policy of the World Health Organization.



Contents

iv	Foreword
vi	Note from the Chair
vii	Acknowledgements
	
1	Executive summary
	
3	Areas for action – emphasizing priorities
	
4	New approaches
	
5	Taking action – do something, do more, do better
	
5	Social determinants, human rights and freedoms
	
6	Action in a cold economic climate
	
6	Recommendations and action required
	
28	Conclusions
29	References

Foreword

Health and well-being are much needed assets for us all and for the societies in which we live in today's increasingly complex world. At first sight, overall population health indicators have certainly improved across the WHO European Region over the last decades. Yet when we look more closely, we can see that improvement in health status has not been experienced equally everywhere, or by all. There are widespread inequities in health between and within societies. They reflect different conditions in which people live and affect the magnitude and trends in health inequities in today's Europe. Health inequities offend against the human right to health and are unnecessary and unjust.

Given our European values and know-how, we can and must do better to promote health and reduce health inequities in our continent. It is for this reason that when I took up office as WHO Regional Director for Europe I started the process of developing Health 2020. My commitment was to producing a values- and evidence-based European policy framework supporting action across government and society for health and well-being.

The promotion of population health and well-being, the reduction of health inequities and the pursuit of people-centred health systems are key to a sustainable and equitable Europe. This vision is duly reflected in the key strategic objectives of Health 2020. I am delighted that Health 2020 was adopted at the sixty-second session of the Regional Committee held in Malta in September 2012.

Behind Health 2020 lies a simple yet vital idea: health and well-being matters to human, social and economic development and the future of Europe. Health is a fundamental resource for the lives of people, families and communities. Poor health wastes potential, causes despair and drains resources. By developing this new health policy framework for Europe, the European Region and its Member States wanted to bring a focus on health and improve its distribution in societies. To achieve this, we need to tackle the root causes of health inequities within and between countries. This has to be seen as a priority within our current European context, characterized in many countries by increased or persisting health inequities, a growing burden from noncommunicable diseases and shrinking public service expenditures due to the financial crisis. In this context, there is an urgent need to promote and protect health, particularly for the most vulnerable segments of the population. The WHO Regional Office for Europe has a key role to play in addressing these challenges as a proactive leader and a partner when joint actions are needed. This is the rationale of all the efforts that brought about Health 2020.

I commissioned a number of studies and scientific reviews to inform Health 2020's development. One of the most important is the European review of social determinants of health and the health divide, led by Professor Sir Michael Marmot and his team at the University College London Institute of Health Equity. The review was carried out by a consortium of over 80 policy researchers and institutions and in close cooperation with technical units and programmes in the Regional Office. I am delighted that the findings and recommendations of the review informed Health 2020 and are now published and made available throughout Europe and globally. I congratulate Sir Michael and all those who contributed to accomplishing this unique piece of work.

The review has collected new evidence on the magnitude and pathways related to health inequalities in the European Region and the most effective interventions and policy approaches to address them. We now know that what makes societies flourish and sustainable also makes people healthy. We understand more of the powerful impact of the social determinants on both health and disease. We better appreciate how the conditions of everyday life affect health at individual and population levels. We know that the opportunities to be healthy are far from being equally distributed in our countries. We have more accurate evidence that today's disease burden is rooted in our present-day societies, in the way our resources are distributed and utilized and in how we address gender and other social factors that shape current patterns of ill health and lifestyles. We know with much greater insight that our opportunities to live in healthy settings are closely linked to good upbringing and education, decent work, housing and income support throughout our life-course.

My aim in promoting the review's findings is to generate new interest and commitment in tackling health inequities and their causes in the Region and to strengthen existing support and effective action. The review provides a "wake-up" call to action among political and professional leaders and an opportunity to actively facilitate the generation and sharing of effective practices and policy innovations among those working to improve health outcomes and narrow the health gap among and within our European Member States.

This review had an impact on the content of Health 2020 and its goal to be a powerful vehicle for collective action to seize new opportunities to enhance the health and well-being of our populations across the whole of the Region. The present often extreme health inequities across our Region must be tackled. In the end, the impact of Health 2020 will

depend on successful implementation in countries. Its success will be judged by tangible improvements in health and health equity in our populations. I am sure that, informed by the findings from this most important review, we can add significant value to our collective work for the benefit of all peoples of the Region. We must act on the new evidence provided by this review for better health outcomes for present and future generations. This is both our opportunity and our challenge.

Zsuzsanna Jakab

WHO Regional Director for Europe

Note from the Chair

Recognizing the importance of addressing health inequities globally, WHO set up the Commission on Social Determinants of Health (CSDH). Commonly, health is equated with health care and public health with disease control programmes. A different approach is needed to complement these two. The CSDH 2008 report, *Closing the gap in a generation*, concluded that health inequities were determined by the conditions in which people are born, grow, live, work and age, and the inequities in power, money and resources that give rise to these conditions of daily life. It said: "Social injustice is killing people on a grand scale".

The CSDH made recommendations for action based on its synthesis of evidence. In my note from the Chair, I said that all associated with the CSDH were united by three concerns: a passion for social justice, a respect for evidence, and a frustration that there appeared to be far too little action on the social determinants of health.

Things have changed. All connected with the European review share the CSDH's commitment to social justice and evidence. But there is now tangible, and very welcome, interest in applying understanding of social determinants of health to improving health and increasing health equity. Showing the lead in Europe, and wishing to translate her vision into practical action, Zsuzsanna Jakab, WHO Regional Director for Europe, set up this review of social determinants of health and the health divide. Building on the CSDH, our task was to synthesize the evidence and make recommendations that could be applied in the 53 countries that make up the diversity of the WHO European Region.

There are persisting and substantial health inequities across the Region. It includes countries with close to the best health and narrowest health gaps in the world. The evidence suggests that this welcome picture is related to a long and sustained period of improvement in the lives people are able to lead – socially cohesive societies, increasingly affluent, with developed welfare states and high-quality education and health services. All these have created the conditions for people to have the freedom to lead lives they have reason to value. Remarkable health gains have been the result.

However, not everyone has shared equally in this social, economic and health development. Although social and economic circumstances have improved in all countries, differences remain and health has suffered, particularly in those countries to the east of the Region. Even the more affluent countries have increasingly seen inequities in people's life conditions and declining social mobility and social cohesion. As a likely result of these changes, health inequities are not diminishing, and are increasing in many countries.

The review set up 13 task groups to review new evidence on what can be done in diverse countries across the Region to take action on the social determinants of health. The findings of the task groups, and the work of the review teams at the University College London Institute of Health Equity and WHO, was overseen by a group of senior advisors who brought their wisdom and experience to bear on translating the evidence into recommendations ready to be implemented.

The global financial crisis has brought conditions of great hardship to parts of the Region. There is therefore an even more pressing need for action on the social determinants of health to ensure that a commitment to health equity survives and is enhanced. A central argument of this review is that social policies can be judged by their likely impact on health equity. Our aim was to provide both the evidence and the recommendations to make such a judgement possible. What is now needed is the political and social commitment of governments, civil society, transnational bodies and academic institutions to translate into reality the vision of a more equitable Europe. We are optimistic.

Michael Marmot

Chair, European review of social determinants of health and the health divide



Acknowledgements

This review was carried out by a consortium chaired by Michael Marmot of the Institute of Health Equity, University College London and supported by a joint secretariat from the Institute and the WHO Regional Office for Europe. The review was informed and shaped by the work of 13 task groups and guided by a senior advisory board.

Senior advisors

Guillem Lopez Casanovas	Universitat Pompeu Fabra	Spain
Zsuzsa Ferge	Eotvos University	Hungary
Ilona Kickbusch	Graduate Institute Geneva	Switzerland
Johan Mackenbach	Erasmus University	The Netherlands
Tilek Meimanaliev	Central Asia AIDS Control Project	Kyrgyzstan
Amartya Sen	Harvard University	United States of America
Vladimir Starodubov	Ministry of Health and Social Development	Russian Federation
Tomris Turmen	University of Ankara	Turkey
Denny Vagero	Centre for Health Equity Studies	Sweden
Barbro Westerholm	Member of Parliament	Sweden
Margaret Whitehead	University of Liverpool	United Kingdom
Ex-officio representatives of WHO (Roberto Bertollini, Agis Tsouros and Erio Ziglio) and the European Commission (Michael Hübel and Charles Price)		

Task group chairs/co-chairs

Task groups provided evidence on tackling the major social determinants of health and related areas. The task groups and their chairs/co-chairs were as follows.

Task group	Chair/co-chair	Affiliation	Country
Early years, education and family	Alan Dyson	University of Manchester	United Kingdom
	Naomi Eisenstadt	University of Oxford	United Kingdom
Employment and working conditions	Johannes Siegrist	University of Dusseldorf	Germany
Social exclusion, disadvantage and vulnerability	Jennie Popay	University of Lancaster	United Kingdom
GDP, taxation, income and welfare	Olle Lundberg	Centre for Health Equity Studies	Sweden
Sustainability and community	Anna Coote	New Economics Foundation	United Kingdom
Ill health prevention and treatment	Gauden Galea	Division of Noncommunicable Diseases and Life-course, WHO Regional Office for Europe	
	Witold Zatonski	Cancer Centre & Institute of Oncology	Poland
Gender issues	Maria Kopp	Semmelweis University	Hungary
Older people	Emily Grundy	London School of Economics	United Kingdom
Economics	Marc Suhrcke	University of East Anglia	United Kingdom
	Richard Cookson	University of York	United Kingdom
Governance and delivery mechanisms	Harry Burns	Chief Medical Officer for Scotland	United Kingdom
	Erio Ziglio	European Office for Investment for Health and Development, WHO Regional Office for Europe	
Global influences	Ronald Labonte	University of Ottawa	Canada
Equity, equality and human rights	Karien Stronks	Academic Medical Centre, University of Amsterdam	The Netherlands
Measurement and targets	Martin Bobak	University College London	United Kingdom
	Claudia Stein	Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe	

UCL secretariat

The writing of the report was led by Michael Marmot and coordinated by Peter Goldblatt.

Jessica Allen, Ruth Bell, Ellen Bloomer, Angela Donkin, Ilaria Geddes and Mike Grady contributed to writing and reviewing material for the report.

Ruth Bell and Peter Goldblatt coordinated production and analysis of tables and charts, assisted by David Bann, Sadie Boniface, Michael Holmes, Akanksha Katyal and Anne Scott.

The team was supported by Matilda Allen, Luke Beswick, Ria Galeote and Alex Godoy.

WHO secretariat

The WHO secretariat was led by Agis Tsouros, with Johanna Hanefeld, Piroska Ostlin, Asa Nihlen, Chris Brown, Isabel Yordi, Theadora Koller, Sarah Simpson, Erio Ziglio and Richard Alderslade.

Additional input and comments on the report were provided by Vivian Barnekow, Roberto Bertolini, Matthias Braubach, Joao Breda, Pierpaolo De Colombani, Gauden Galea, Manfred Huber, Marijan Ivanuša, Matthew Jowett, Hans Kluge, Gunta Lazadane, Enrique Loyola, Marco Martuzzi, Leen Meulenbergs, Lars Moller, Arun Nanda, Jose Maria Moreno, Dinesh Sethi, Santino Severino, Claudia Stein and Brenda van der Bergh.

In addition, many WHO staff provided invaluable support: Connie Petersen, Antonella Biasiotto, Simone Tetz, Maria Ruano, Pamela Charlton, Mary Stewart Burgher, Anita Strandsbjerg.

Editors: Alex Mathieson and David Breuer.

Design: John McGill and Lucienne Roberts.

Members of the task groups

Szilvia Adam, Semmelweis University, Hungary; Joan Benach, Universitat Pompeu Fabra, Spain; Jovanka Bislimovska, WHO collaborating centre, the former Yugoslav Republic of Macedonia; Chris Brown, WHO Regional Office for Europe; Tatjana Buzeti, Centre for Health and Development Murska Sobota and Ministry of Health, Slovenia; Candace Currie, University of St Andrews, United Kingdom; Espen Dahl, Oslo and Akershus University College of Applied Sciences, Norway; Dorly Deeg, VU University, the Netherlands; Paul Dourgnon, Institut de Recherche et Documentation en Economie de la Sante, France; Johan Fritzell, Centre for Health Equity Studies, Sweden; Dominic Harrison, Blackburn with Darwen Borough Council, United Kingdom; Aart Hendriks, Universiteit Leiden, the Netherlands; James Higgins, Youth Forum, United

Kingdom; Manfred Huber, WHO Regional Office for Europe; Martijn Huisman, VU University, the Netherlands; Umar Ikram, Academic Medical Centre, University of Amsterdam, the Netherlands; Bjarne Bruun Jensen, Steno Health Promotion Centre, Denmark; Darya Khaltourina, Russian Academy of Sciences, Russian Federation; Rohko Kim, WHO Regional Office for Europe; Katalin Kovacs, Demographic Research Institute, Hungary; Anton Kunst, University of Amsterdam, the Netherlands; Roderick Lawrence, Universite de Geneve, Switzerland; Marco Martuzzi, WHO Regional Office for Europe; Martin McKee, London School of Hygiene and Tropical Medicine, United Kingdom; Edward Melhuish, Birckbeck, University of London, United Kingdom; Michael Murphy, London School of Economics, United Kingdom; Michal Myck, Centre for Economic Analysis, Poland; Joakim Palme, Uppsala University, Sweden; Hynek Pikhart, University College London, United Kingdom; George Ploubidis, London School of Hygiene and Tropical Medicine, United Kingdom; Jorma Rantanen, University of Jyväskylä, Finland; Sanna Read, London School of Hygiene and Tropical Medicine, United Kingdom; Arne Ruckert, University of Ottawa, Canada; Gyongyver Salavecz, Semmelweis University, Hungary; Sarah Simpson, WHO Regional Office for Europe; Nicolas Sirven, Institut de Recherche et Documentation en Economie de la Sante, France; Ola Sjöberg, Stockholm University, Sweden; Selma Sogoric, University of Zagreb, Croatia; Sylvie Stachenko, WHO Regional Office for Europe; Tamara Steger, Central European University, Hungary; Urszula Sulkowska, Maria Skłodowska-Curie Memorial Cancer Centre, Poland; Gerdt Sundstrom, University of Jonkoping, Sweden; Julia Szalai, Central European University, Hungary; Andras Szekely, Semmelweis University, Hungary; Jukka Takala, Tampere University of Technology, Finland; Brigit Toebe, University of Groningen, the Netherlands; Cleon Tsimbos, University of Piraeus, Greece; Cretien van Campen, Netherlands Institute of Social Research; Sridhar Venkatapuram, London School of Hygiene and Tropical Medicine, United Kingdom.

The eastern network who assisted the review

Yulia Abrosimova, St Petersburg State University, Russian Federation; Baktygul Akkazieva, WHO Country Focal Point for National Health Accounts, Kyrgyzstan; Jane Falkingham, University of Southampton, United Kingdom; Amiran Gamkrelidze, WHO Regional Office for Europe; Assomidin Latipov, CAAP project, Tajikistan; Martin McKee, London School of Hygiene and Tropical Medicine, United Kingdom.

Other contributors to the task groups

Baktygul Akkazieva, WHO Regional Office for Europe; Vivian Barnekow, WHO Regional Office for Europe; Mel Bartley, University College London, United Kingdom; Sanjay Basu, University of California at San Francisco, United States of America; Jenni Blomgren, Kela (social insurance institution), Finland; Carme Borrell, Public Health Agency of Barcelona, Spain; Tammy Boyce, Imperial College London, United Kingdom; Jonathan Bradshaw, University of York, United Kingdom; Harvey Brenner, University of North Texas Health Science Center, United States of America; Kristie Carter, University of Otago, New Zealand; Audrey Chapman, University of Connecticut, United States of America; Michelle Collins, Lancaster University, United Kingdom; Pierpaolo de Colombani, WHO Regional Office for Europe; Marc Mari Dell' Olmo, Public Health Agency of Barcelona, Spain; Elia Diez, Public Health Agency of Barcelona, Spain; Mariel Droomers, National Institute for Public Health and the Environment, the Netherlands; Terje Andreas Eikemo, Norwegian University of Science and Technology, Norway; Eric Emerson, Lancaster University, United Kingdom; Sarah Escorel, Lancaster University, United Kingdom; Ingemar Farm, European Disability Forum, Belgium; Tommy Ferrarini, Institute for Social Research, Sweden; Amiran Gamkrelidze, Centre of Allergy and Immunology, Georgia; Yevgeniy Goryakin, London School of Hygiene and Tropical Medicine, United Kingdom; Merce Gotsens, CIBER Epidemiology and Public Health, Spain; Emma Halliday, Lancaster University, United Kingdom; Rachel Hammonds, Institute of Tropical Medicine, Belgium; Mario Hernandez, National University of Colombia, Bogotá, Colombia; Jennie Bacchus Hertzman, Centre for Health Equity Studies, Sweden; Heikki Hiilamo, Tampere University, Finland; Paul Hunt, University of Essex, United Kingdom; Wiking Husberg, International Labour Organization, Russian Federation; David Ingleby, University of Amsterdam, the Netherlands; Kinga Janik-Koncewicz, Maria Skłodowska-Curie Memorial Cancer Centre & Institute of Oncology, Poland; Heidi Johnston, International Centre for Diarrhoeal Disease Research, Bangladesh; Lisa Jones, University of Manchester, United Kingdom; Elena Jørgensen, WHO Regional Office for Europe; Matthew Jowett, WHO Regional Office for Europe; Florence Jusot, Université Paris Dauphine, France; Olli Kangas, University of Southern Denmark, Denmark; Rokho Kim, WHO Regional Office for Europe; Meri Koivusalo, National Institute for Health and Welfare, Finland; Gunta Lazdane, WHO Regional Office for Europe; Stavroula Leka, Nottingham University, United Kingdom; Vivian Lin,

La Trobe University, Australia; Marta Mańczuk, Maria Skłodowska-Curie Memorial Cancer Centre & Institute of Oncology, Poland; Jane Mathieson, Lancaster University, United Kingdom; Mari Matveinen, WHO Regional Office for Europe; Stefano Mazzuco, Padua University, Italy; Martin McKee, London School of Hygiene and Tropical Medicine, United Kingdom; Silvia Meggiolaro, University of Padova, Italy; Antony Morgan, National Institute for Health and Clinical Excellence, United Kingdom; Joana Morrison, CIBER Epidemiology and Public Health, Spain; Irma Munoz-Baell, University of Alicante, Spain; Carles Muntaner, University of Toronto, Canada; Gulgun Murzalieva, Health Policy Analysis Centre, Kyrgyzstan; Kenneth Nelson, Swedish Institute for Social Research, Stockholm University, Sweden; Aasa Nihlen, WHO Regional Office for Europe; Gorik Ooms, Institute of Tropical Medicine, Belgium; Zeynep Or, Institut de Recherche et Documentation en Economie de la Sante, France; Pirooska Ostlin, WHO Regional Office for Europe; Corinne Packer, University of Ottawa, Canada; Laia Palencia, CIBER Epidemiology and Public Health, Spain; Frank Pega, University of Otago, New Zealand; Jitka Pikhartova, University College London, United Kingdom; Mariona Pons-Vigues, Public Health Agency of Barcelona, Spain; Sue Povall, University of Liverpool, United Kingdom; Susan Ramsay, London School of Hygiene and Tropical Medicine, United Kingdom; Boika Rechel, University of East Anglia, United Kingdom; Jan Reinhardt, Swiss Paraplegic Research, Switzerland; Marilyn Rice, Consultant, United States of America; Laetitia Rispel, University of the Witwatersrand, South Africa; Bayard Roberts, London School of Hygiene and Tropical Medicine, United Kingdom; Lorenzo Rocco, University of Padova, Italy; Ellen Roskam, University of Massachusetts, United States of America; Vivien Runnels, University of Ottawa, Canada; Philip de Winter Shaw, University of Edinburgh, United Kingdom; Katja Siling, London School of Hygiene and Tropical Medicine, United Kingdom; Maria Skarphensdottir, WHO Regional Office for Europe; Jeppe Sorensen, Disabled People's Organization, Denmark; David Stuckler, University of Cambridge, United Kingdom; Maria Stuttford, University of Warwick, United Kingdom; Catriona Towriss, London School of Hygiene and Tropical Medicine, United Kingdom; Wim Van Damme, Institute of Tropical Medicine, Belgium; Suzanne Van De Vathorst, Erasmus University, the Netherlands; Kjetil Van Der Wel, University of Oslo, Norway; Brandon Vick, Fordham University, United States of America; Isabel Yordi Aguirre, WHO Regional Office for Europe; Mateusz Zatoński, Consultant, Poland.

Task group report reviewers

Angela Anning, University of Leeds, United Kingdom; Mauricio Avendano, London School of Economics, United Kingdom; Fran Baum, Flinders University, Australia; Tarani Chandola, University of Manchester, United Kingdom; Finn Diderichsen, University of Copenhagen, Denmark; Arjan Gjonca, London School of Economics, United Kingdom; Myer Glickman, Office for National Statistics, United Kingdom; Sofia Gruskin, University of Southern California, United States of America; Johanna Hanefeld, WHO Regional Office for Europe; Cristina Hernandez Quevedo, London School of Economics, United Kingdom; Ken Judge, University of Bath, United Kingdom; Tord Kjellstrom, Australian National University, Australia; Hans Kluge, WHO Regional Office for Europe; Daniel La Parra Casado, Universidad de Alicante, Spain; Cecily Maller, RMIT University, Australia; Chris Naylor, The King's Fund, United Kingdom; Kristina Orth-Gomer, Karolinska Institute, Sweden; Peter Paulus, Leuphana University, Luneburg, Germany; Hynek Pikhart, University College London, United Kingdom; Kumanan Rasthanan, UNICEF, United States of America; Jan Rigby, Nui Maynooth, Ireland; Elena Ronda, University of Alicante, Spain; Reiner Rugulies, National Research Centre for the Working Environment, Denmark; Tom Shakespeare, WHO Regional Office for Europe; Richard Smith, London School of Hygiene and Tropical Medicine, United Kingdom; Devi Sridhar, Oxford University, United Kingdom; Juan Eduardo Tello, WHO Regional Office for Europe; Marcel Verwij, Utrecht University, the Netherlands; Helen Weatherly, University of York, United Kingdom; Margaret Whitehead, University of Liverpool, United Kingdom; Gareth Williams, Cardiff University, United Kingdom.

Further support

The production of this report has been made possible with the financial support of the Ministry of Health, Welfare and Sport of the Government of the Netherlands, the Health Department of the Government of Norway, the Ministry of Foreign Affairs of the Government of Spain and the Department of Health, United Kingdom (England), which provided financial support to the review process and the production of the related task group reports. Support was provided by the Ministry of Health of Italy and the Veneto Region through their support of the WHO European Office for Investment for Health and Development in Venice and the Tuscany Region of Italy. Support for meetings of senior advisors was provided by the Ministry of Health and Social Policy of Spain, Malmö Kommun and Research Council in Sweden, Universitatea de Stat de Medicina si Farmacie in the Republic of Moldova, Health Action Partnership International and the British Medical Association in the United Kingdom.

Executive summary

This study of inequities in health between and within countries across the 53 Member States of the WHO European Region was commissioned to support the development of the new European policy framework for health and well-being, Health 2020 (1). Much more is understood now about the extent, and social causes, of these inequities, particularly since the publication in 2008 of the report of the Commission on Social Determinants of Health (2). This European study builds on the global evidence.

There are good reasons for the specific European focus of this review. Health inequities across the Region are known to be high, and the Region's great diversity creates opportunities to offer policy analysis and recommendations specific to low-, middle- and high-income countries. The results of the review are clear: with the right choice of policies, progress can be made across all countries, including those with low incomes.

The review comes at an important moment in European history. The Region includes countries with close to the best health and narrowest health inequities in the world. The evidence suggests that this welcome picture is related to a long and sustained period of improvement in the lives people are able to lead – socially cohesive societies, increasingly affluent, with developed welfare states and high-quality education and health services. All these have created the conditions for people to have the freedom to lead lives they have reason to value. Remarkable health gains have been the result.

However, not all countries have shared fully in this social, economic and health development. Although social and economic circumstances have improved in all countries, differences remain and health has suffered. Even more-affluent countries in the Region have increasingly seen inequities in people's life

conditions and declining social mobility and social cohesion. As a likely result of these changes, health inequities are not diminishing and are increasing in many countries. The economic crisis since 2008, more profound and extended than most people predicted, has exacerbated this trend and exposed stark social and economic inequities within and between countries.

Human rights approaches support giving priority to improving health and reducing inequities. Achieving these goals requires definitive action on the social determinants of health as a major policy challenge. These inequities in health are widespread, persistent, unnecessary and unjust, and tackling them should be a high priority at all levels of governance in the Region. Necessary action is needed across the life-course and in wider social and economic spheres to protect present and future generations.

This review provides guidance on what is possible and what works, to be considered within the specific circumstances and settings of individual countries. Its recommendations are practical and focused. One response to addressing health inequities open to all is to ensure universal coverage of health care. Another is to focus on behaviour – smoking, diet and alcohol – that cause much of these health inequities but are also socially determined. The review endorses both these responses. But the review recommendations extend further – to the causes of the causes: the conditions in which people are born, grow, live, work and age and inequities in power, money and resources that give rise to them.

Fig. ES.1 shows life expectancy in countries, which is one measure of differences in health across the Region. The range between the highest and lowest figures for countries is 17 years for men and 12 years for women. Most countries in the lowest quintile are in the eastern part of the Region.

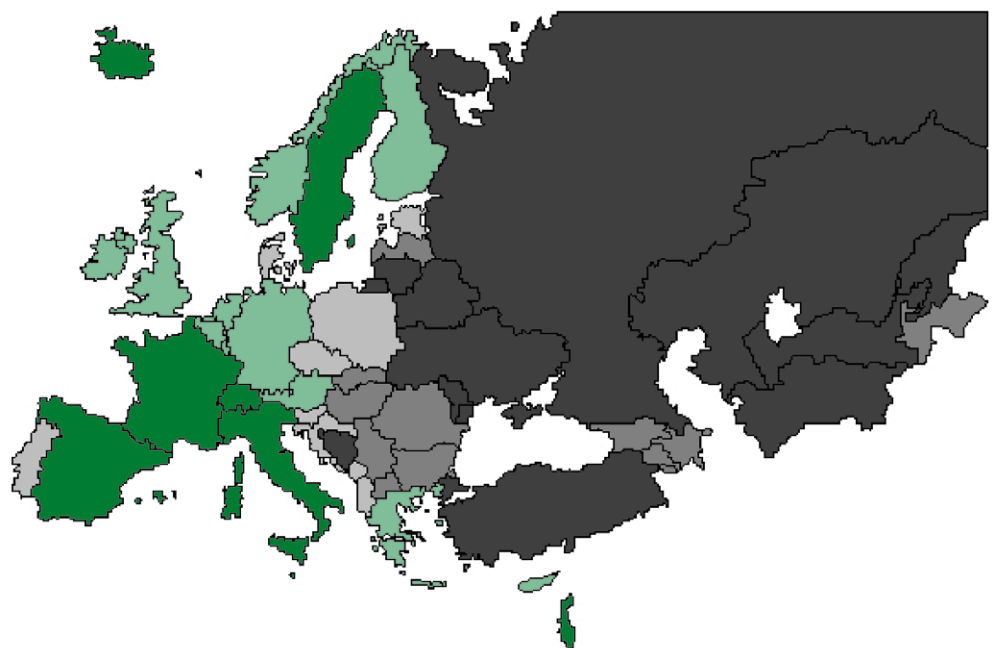
Fig. ES.1

Life expectancy in countries in the European Region, 2010 (or latest available)

Life expectancy – quintiles:

- Highest
- Second
- Third
- Fourth
- Lowest

Source: WHO Regional Office for Europe (3).



Further, health inequities are not confined to poor health for people in poor countries and good health for everyone else. Fig. ES.2 shows how health inequities persist even in some of the most affluent countries.

To address these health inequities within and between countries, the WHO Regional Office for Europe commissioned this review of social determinants of health and the health divide. The conclusions and recommendations of this review have informed development of Health 2020 (1).

Health inequalities that are avoidable are unjust: action is required across society

Systematic differences in health between social groups that are avoidable by reasonable means are unfair. This review therefore uses the term “health inequities” to describe these avoidable inequalities.

The analysis shows that action is required across the whole of government, on the social determinants of health, to achieve advances in health equity. Health ministers clearly have a role in ensuring universal access to high-quality health services. However, they also have a leadership role in advancing the case that health is an outcome

Fig. ES.2

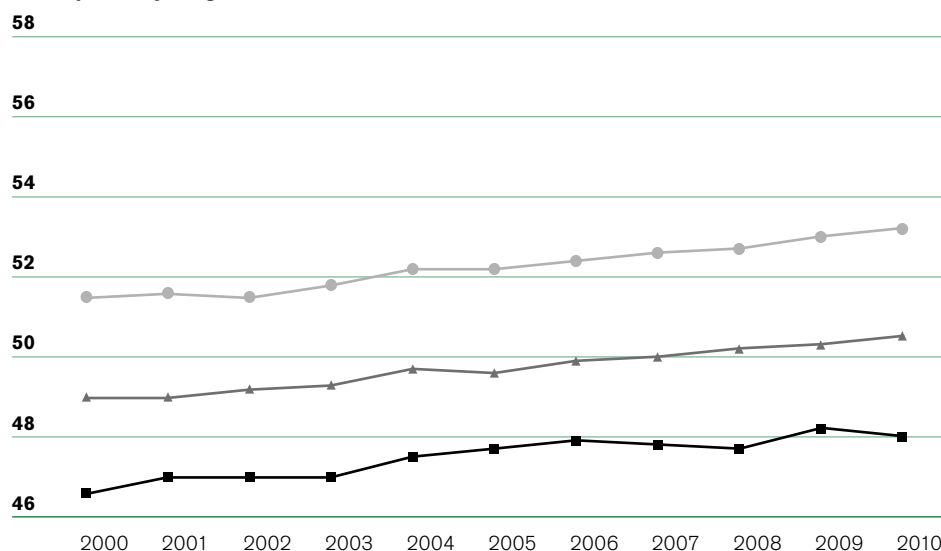
Life expectancy trends in Sweden 2000–2010 by education level, men and women

Source: Statistics Sweden (4).

Men

- Post-secondary
- ▲ Upper-secondary
- Compulsory

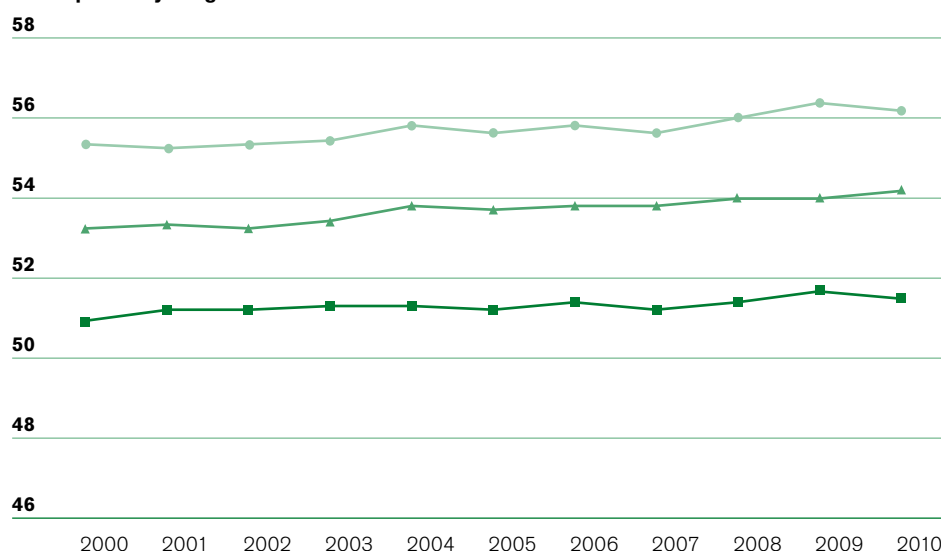
Life expectancy at age 30



Women

- Post-secondary
- ▲ Upper-secondary
- Compulsory

Life expectancy at age 30



of policies pursued in other arenas. So close is the link between social policies and health equity that the magnitude of health inequity shows how well society is meeting the needs of its citizens. Health is not simply a marker of good practice but is also highly valued by individuals and society.

The review makes the moral case for action on social determinants of health – social injustice kills and causes unnecessary suffering. There is also a strong economic argument. The cost of health inequities to health services, lost productivity and lost government revenue is such that no society can afford inaction. Tackling inequities in the social determinants of health also brings other improvements in societal well-being, such as greater social cohesion, greater efforts for climate change mitigation and better education.

Areas for action – emphasizing priorities

Reviewing the experience of countries in the European Region clearly shows that they should have two clear aims: improving average health and reducing health inequities by striving to bring the health of less-advantaged people up to the level of the most-advantaged. Improving the levels and equitable distribution of the social determinants should achieve both aims. Similarly, reducing health gaps between countries requires striving to bring the level of the least healthy countries up to that of the best. To achieve this, two types of strategy are needed: within each country, action on the social determinants of health to improve average health and reduce health inequities; and action at transnational level to address the causes of inequities between countries.

The review commissioned 13 task groups that reviewed European and world literature on social determinants of health and strategies to promote health equity within and between countries. Based on the evidence assembled, the review grouped its recommendations into four themes – life-course stages, the wider society, the macro-level broader context and systems (Fig. ES.3). Action is needed on all four themes.

Within each of these themes, the highest priorities for action are as follows.

A The life-course

The highest priority is for countries to ensure a good start to life for every child. This requires, as a minimum, adequate social and health protection for women, mothers-to-be and young families and making significant progress towards a universal, high-quality, affordable early years, education and child care system.

Emphasis on a good start in life does not of course mean that actions at later stages of the life-course – working ages and older ages – are not important.

They are crucial both to reinforce the improvement in skills and individual empowerment provided by a good start but also to achieve greater health equity among the existing adult populations of each country. In particular, it is essential to reduce stress at work, reduce long-term unemployment through active labour-market programmes and address the causes of social isolation.

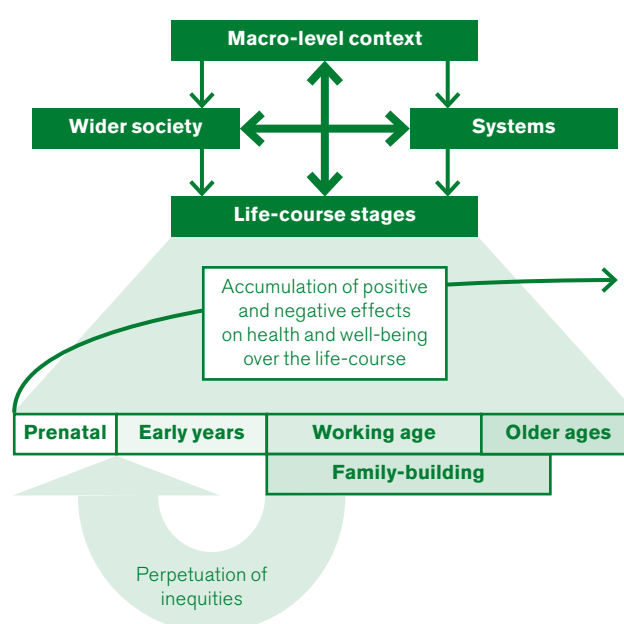
B Wider society

The most effective actions to achieve greater health equity at societal level are those that create or reassert societal cohesion and mutual responsibility. In particular, the most tangible and practical action is to ensure an adequate level and distribution of social protection, according to need. In many countries, this requires improving the level of provision. In all countries, it necessitates making better use of existing provision – such as making progress to increase the proportion of people who have the minimum standard of living needed to participate in society and maintaining health.

Supporting action to create cohesion and resilience at local level is essential through a whole-of-society approach that encourages the development, at local level, of partnerships with those affected by inequity and exclusionary processes – working with civil society and a range of civic partners. Central to this approach is empowerment – putting in place effective mechanisms that give those affected a real say in decisions that affect their lives and by recognizing their fundamental human rights, including the right to health.

Fig. ES.3

Broad themes



C Macro-level context

Wider influences, both within countries and transnationally, shape the lives, human rights and health of people in the European Region. In the short to medium term, the priority is to address the health effects of the current economic crisis. Recognition of the health and social consequences of economic austerity packages must be a priority in further shaping economic and fiscal policy in European countries. The views of ministers responsible for health and social affairs must be heard in the negotiations about such austerity packages. In particular, at the transnational level, WHO, the United Nations Children's Fund and the International Labour Organization should also be given a voice.

Equity between generations – intergenerational equity – is a fundamental driver of environmental policy. So must it be for societal policies for health. It is critical that approaches to environmental, social and economic policy and practice be integrated.

D Systems

Improvements in health and its social determinants will not be achieved without significantly refocusing delivery systems to whole-of-government and whole-of-society approaches. The starting point is the health system – what it does itself and how it influences others to achieve better health and greater equity. This requires achieving greater coherence of action across all sectors (policies, investments and services) and stakeholders (public, private and voluntary) at all levels of government (transnational, national, regional and local). Universal access to health care is a priority – where this is established, it is to be protected and must progressively be extended to all countries in the Region.

Action on disease prevention must include reducing the immediate causes of inequity within and between countries – alcohol consumption, smoking and obesity. Effective strategies go beyond providing information and include taxation and regulation. Evidence suggests that addressing the “causes of the causes” is the right way to proceed on these – ensuring that people have the skills and control over their lives to be able to change behaviour.

But nothing will happen without monitoring and adequate review. It is recommended that all 53 countries in the Region establish clear strategies to redress the current patterns and magnitude of health inequities by taking action on the social determinants of health. Countries should undertake regular reviews of these strategies. These should be reported to WHO and discussed at regular regional meetings.

New approaches

This European review draws on the findings and recommendations of the Commission on Social Determinants of Health (2): health inequities arise from the conditions in which people are born, grow, live, work and age and inequities in power, money and resources that give rise to these conditions of daily life. The explicit purpose of the review was to assemble new evidence and to develop new ideas that could be applied to the remarkable diversity of countries that make up the European Region; different in national income, social development, history, politics and culture.

Box ES.1 summarizes distinct approaches of the review to understanding and promoting health equity across Europe.

Several new themes emerged from the review.

- Human rights are central to our approach to action on the social determinants of health; human rights embody fundamental freedoms and the societal action necessary to secure them.
- In addition to addressing harmful influences, it is important to build on the resilience of individuals and communities; empowerment is central.
- The life-course emerges as the right way to plan action on social determinants of health; although the review emphasizes early childhood, action is needed at every stage of life, and it makes strong recommendations for working and older ages.
- Protecting future generations from the perpetuation of social and economic inequities affecting previous generations is important.
- Intergenerational equity features strongly, in addition to intragenerational equity.
- Strong emphasis is needed on joint action on social determinants of health, social cohesion and sustainable development; all imply a strong commitment to social justice.
- Proportionate universalism should be used as a priority-setting strategy in taking action to address health inequity.

The Region does not need to be so divided in health, depressed by gloomy economic prospects and failing in its environmental ambitions. Instead, the review suggests, it could move towards health equity, sustainable prosperity and social cohesion across the whole Region. This requires that the 53 Member States work together and take mutual responsibility to achieve this change.

Box ES.1

Key issues in understanding and promoting health equity

- **Social determinants of health** – we must address the conditions in which people are born, grow, live, work and age, which are key determinants of health equity. These conditions of daily life are, in turn, influenced by structural drivers: economic arrangements, distribution of power, gender equity, policy frameworks and the values of society.
- Taking a **life-course approach** to health equity. There is an accumulation of advantage and disadvantage across the life-course. This approach begins with the important early stages of life – pregnancy and early child development – and continues with school, the transition to working life, employment and working conditions and circumstances affecting older people.
- There is a **social gradient in health** – that is to say, health is progressively better the higher the socioeconomic position of people and communities. It is important to design policies that act across the whole gradient and to address the people at the bottom of the social gradient and the people who are most vulnerable. To achieve both these objectives, policies are needed that are universal but are implemented at a level and intensity of action that is proportionate to need – proportionate universalism.
- In relation to the most excluded people, it is important to address the **processes of exclusion** rather than focusing simply on addressing particular characteristics of excluded groups. This approach has much potential when addressing the social and health problems of Roma and irregular migrants as well as those who suffer from less extreme forms of exclusion and dip in and out of vulnerable contexts.
- The need to build on assets – the **resilience, capabilities and strength of individuals and communities** – and address the hazards and risks to which they are subject.
- The importance of **gender equity** – all the **social determinants of health** may affect the genders differently. In addition to biological sex differences, there are fundamental social differences in how women and men are treated and the assets and resilience they have. These gender relations affect health in all societies to varying degrees and should shape actions taken to reduce inequities.
- Much focus has been, and will continue to be, on **equity within generations**. The perspectives of sustainable development and the importance of social inequity affecting future generations means that **intergenerational equity** must be emphasized, and the impact of action and policies for inequities on future generations must be assessed and risks mitigated.

Taking action – do something, do more, do better

This was a key message emerging from the work of the task groups set up to review what would work in the variety of countries of the Region: do something, do more, do better.

In other words, if countries have very little in place in terms of policies on social determinants of health, some action matters. Where there are some existing policies, this review shows how these can be improved to deal with large and persistent health inequities. In the richest countries in Europe, there is scope to do better on these inequities.

The review, drawing on the research evidence brought together by the task groups, provides recommendations that apply across the diversity of countries in the Region but gives many specific examples of how these can be applied in different country contexts. Empowerment, a basic tenet of the review, means not imposing solutions from outside, but that countries, regions and cities use the scientifically based recommendations in this report to develop policies and programmes specific to each of the 53 Member States and, indeed, to cities and districts within those countries.

Social determinants, human rights and freedoms

There is vibrant debate on what is sometimes portrayed as a tension between action on social determinants and individual freedoms. This review calls for social action – but individual freedoms and responsibilities feature strongly in the approach taken, drawing on Amartya Sen's insights on freedoms to enable people to lead a life they have reason to value (5). The wider influences of society on the social determinants of individual health are of fundamental importance in enabling people to achieve the capabilities that lead to good health.

An individual's resources and capabilities for health are influenced by social and economic arrangements, by collective resources provided by the communities of which they are part and by welfare state institutions. Human rights approaches can support these resources. The right to health entails rights to equity in the social determinants of health. In other words, as Sridhar Venkatapuram (6) has argued, the right to health should be understood as a moral claim on the "capability to be healthy", which is determined largely by the social determinants of health.

Action in a cold economic climate

The review argues the moral case for action. In many areas the moral and the economic case for action come together – investment in early child development and education may meet the demands both of efficiency and justice. As a companion study for Health 2020 notes, prevention is a “good buy” (7). Further, action on social determinants of health leads to other benefits to society, which may in turn have more immediate economic benefits. For example, a more socially cohesive, educated population is likely to have lower rates of crime and civil disorder, a more highly skilled workforce and enable people to lead lives they have reason to value, as well as having better health and greater health equity.

Current economic difficulties in countries are a reason for action and not inaction on social determinants of health. The economic crisis affecting Europe provides the stark background and the urgent challenge to this work. It is often argued that coping with these severe economic difficulties requires reducing investment in health and its social determinants. Yet the evidence laid out in this review is clear: investing in early child development, active labour-market policies, social protection, housing and mitigating climate change will help protect populations from the adverse effects of the economic crisis and lay the basis for a healthier future.

Recommendations and action required

Theme A – Life-course

Perpetuation of inequities in health risks from one generation to the next

Recommendation 1(a).

Ensure that the conditions needed for good-quality parenting and family-building exist, promote gender equity and provide adequate social and health protection.

Specific actions

(i) Ensure that accessible, affordable and high-quality sexual and reproductive health services are available to all who need them (particularly women and girls and young people of both sexes). This includes access to evidence-based contraception and care in pregnancy and childbirth. Aside from safe delivery as a basic right, high-quality services help to decrease smoking rates in pregnancy, increase breastfeeding and promote skills and knowledge for effective parenting. Services should identify families at risk early and refer to appropriate services.

(ii) Ensure that strategies to reduce social and economic inequities benefit women of childbearing age and families with young children.

(iii) Encourage ministers of health to act as advocates for social policies that provide income protection, adequate benefits and progressive taxation to reduce child and pensioner poverty.

(iv) Ensure that parenting policies and services empower women with children to take control over their lives, support their children's health and development and promote a greater parenting role for men. In particular, strengthen family-friendly employment policies by introducing more flexible working hours – without turning to insecure contracts – and make affordable child care available to help parents combine work with their parental responsibilities.

Perpetuation of health risks from one generation to the next

Children's early development, life chances and, ultimately, health inequities are strongly influenced by: the social and economic background of their parents and grandparents; location, culture and tradition; education and employment; income and wealth; lifestyle and behaviour; and genetic disposition. Further, conditions such as obesity and hypertension, and behaviour that puts health at risk, such as smoking, recur in successive generations. Achieving a sustainable reduction in health inequities requires action to prevent the relative and absolute disadvantage of parents from blighting the lives

of their children, their grandchildren and subsequent generations. The strongest instruments to break such vicious circles of disadvantage lie at the start of life. The review recommendations address key factors that contribute to perpetuating health inequities.

The interaction between gender inequities and other social determinants increases women's vulnerability and exposure to the risk of negative sexual and reproductive health outcomes. Poor maternal health, inadequate access to contraception and gender-based violence are indicators of these inequities.

As an illustration of the early effect of the perpetuation of inequity on health, Fig. ES.4 shows that the higher the average level of household deprivation in a country, the greater the chance of a child dying before the age of five years (9). Deprivation in early life is also associated with other health problems, poor diet and deficits in physical, social, emotional, cognitive and language domains of development. These have lifelong effects on life chances and subsequent health.

Childhood development

Recommendation 1(b).

Provide universal, high-quality and affordable early years, education and child care system.

Specific actions

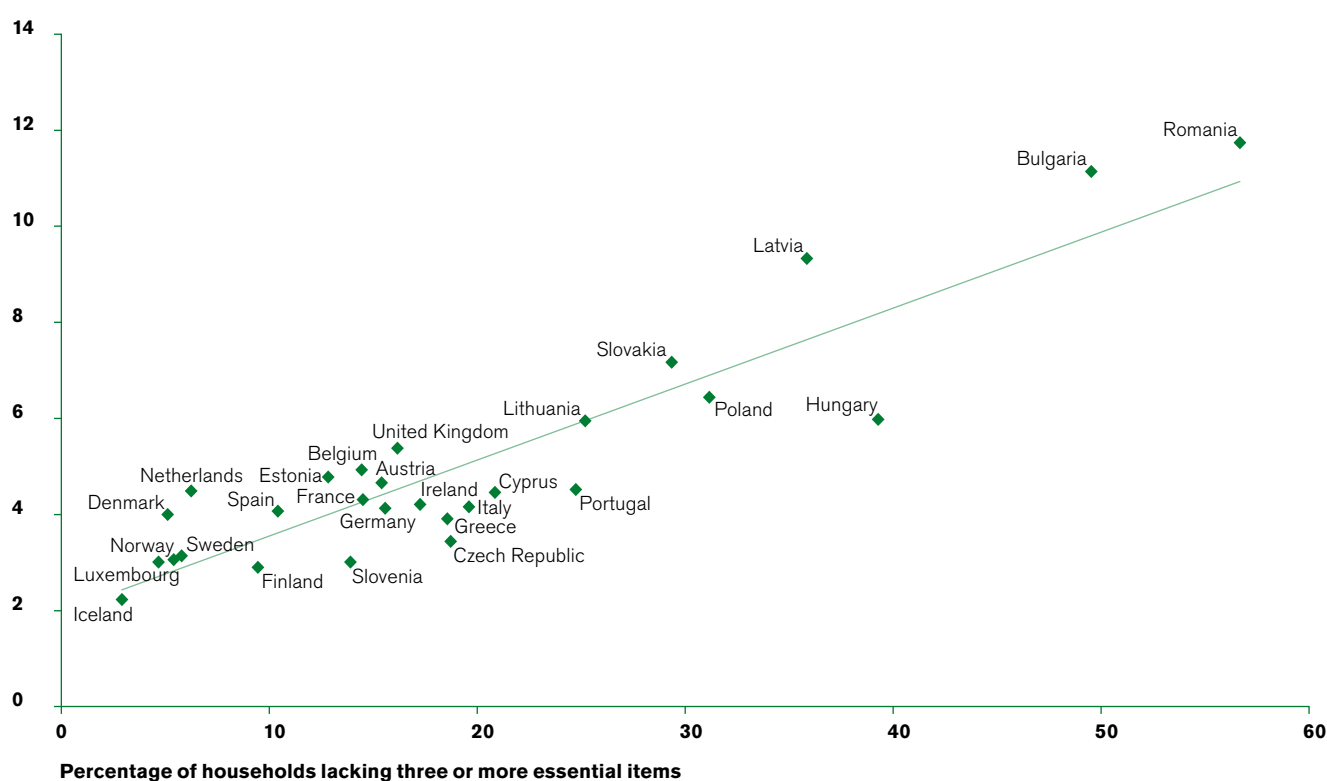
- (i) Ensure universal access to a high-quality, affordable, early years, education and child care system as the essential bedrock in levelling social inequities in educational attainment, poverty reduction and gender equality.
- (ii) Make special efforts to include in education those children most at risk of experiencing multiple exclusionary processes, particularly:
 - (a) those with disabilities
 - (b) migrants
 - (c) minority ethnic groups such as Roma.

Fig. ES.4

Mortality among under-fives and percentage of deprived households (lacking three or more essential items) in selected European Region countries

Source: WHO Regional Office for Europe (3); Bradshaw (8); Eurostat (10).

Mortality rate of children younger than 5 years old per 1000 live births



Action to promote the physical, cognitive, social and emotional development of children is crucial for all children, starting from the earliest years and reinforced throughout childhood and adolescence. Children who experience a positive start are likely to do well at school, attain better-paid employment and enjoy better physical and mental health in adulthood.

A good start is characterized by the following: a mother is in a position to make reproductive choices, is healthy during pregnancy, gives birth to a baby of healthy weight, the baby experiences warm and responsive relationships in infancy, the baby has access to high-quality child care and early education and lives in a stimulating environment that allows safe access to outdoor play. Evidence shows that high-quality early years services, with effects on parenting, can compensate for the effects of social disadvantage on early child development. Given the nature of early childhood, the services that support this stage of life are intergenerational and multiprofessional, include health, education and social welfare and are aimed at parents as well as children. In most countries, this support is unlikely to be initiated through contact with the formal education sector but through health and child care services.

The systems that encourage such a good start in life include policies characterized by excellent health care before and after birth, an employment and social protection system that recognizes the risks posed by poverty and stress in early childhood, good parental leave arrangements, support for parenting and high-quality early education and care.

Reinforcing a good start throughout childhood and adolescence requires focusing on parenting skills, the employment and social protection of parents, balancing work and the family life of women and men, equitable education and social support for boys and girls throughout childhood and good systems for developing life and work skills for young people, both during adolescence and early adulthood.

Fig. ES.5 illustrates the variation in attendance of early education programmes across countries and between the richest and poorest people within each country – children of the poorest parents are less likely to attend than the richest.

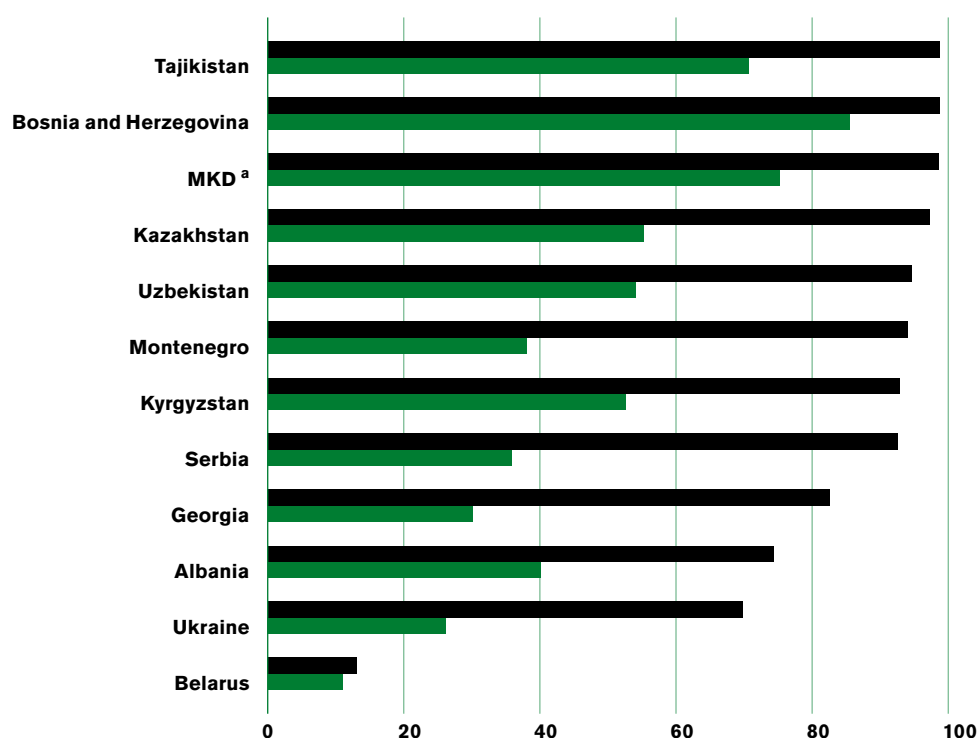
Fig. ES.5

Children aged 36–59 months in the quintiles of the population with the lowest and highest income who do not attend any form of early education programme in 12 countries in eastern Europe and central Asia, 2005/2006

■ Poorest 20%
■ Richest 20%

Source: UNICEF (11).

^aThe former Yugoslav Republic of Macedonia (MKD) is an abbreviation of the International Organization for Standardization.



Child poverty

Relative poverty in childhood strongly influences health and other outcomes throughout life and remains high in much of the Region. In the countries in the eastern part of the Region, despite 10–15 years of economic growth before the current recession, child poverty has been more or less at the same level (12). The main reason why children have not benefited from this economic growth is that the average expenditure on family benefits in this part of the Region was less than 1% of gross domestic product versus 2.25% on average in the countries of the Organisation for Economic Co-operation and Development in 2007 (13).

In the western part of the Region, despite higher average expenditure compared with the eastern part, the European Union survey of incomes and living conditions in 2009 revealed a huge range of child poverty rates across the European Union – from 10% to 33%, shown in Fig. ES.6 (12). Within countries, the rate changed between 2005 and 2009 by a percentage point or more in 20 of the countries shown, with 11 countries increasing.

Fig. ES.6

Child poverty rates^a in selected European countries in 2009 and change since 2005

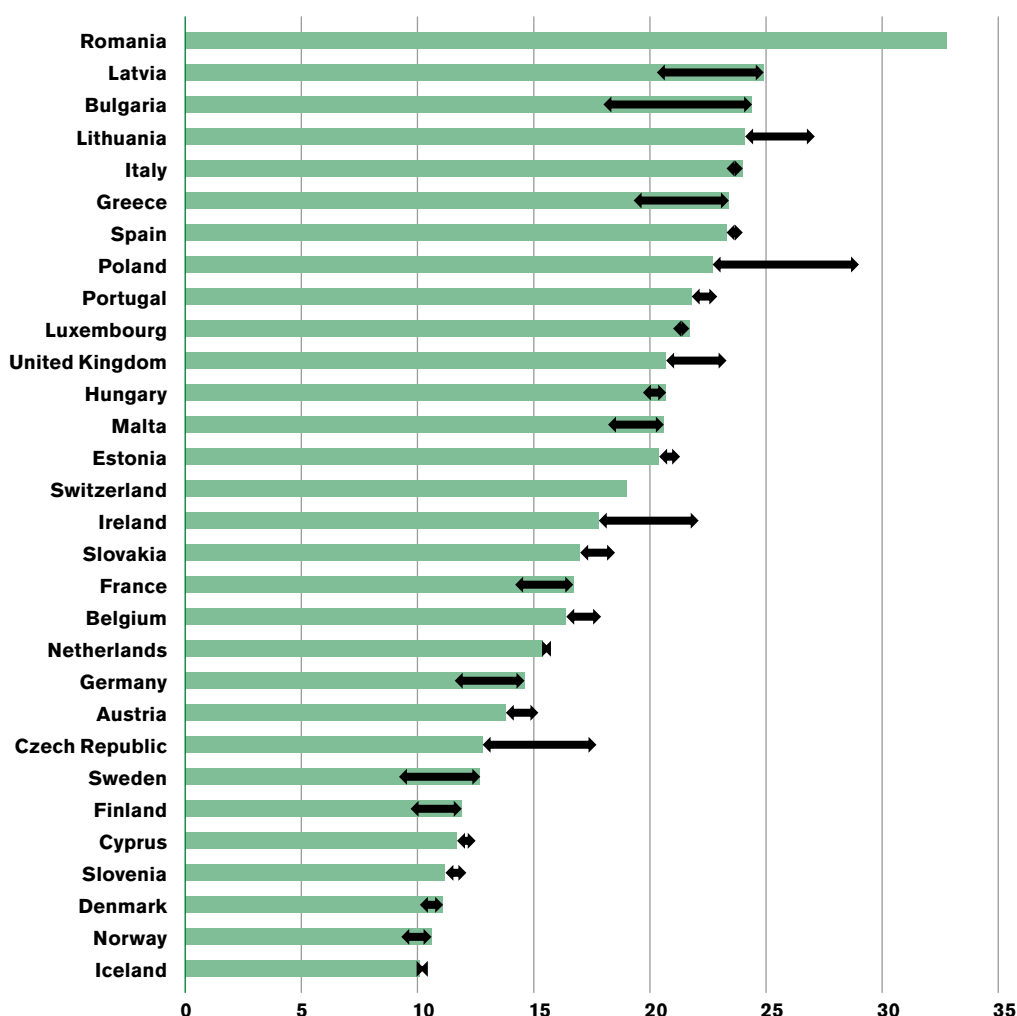
■ 2009 child poverty rate

◆ Difference between 2005 and 2009 rates

^aBased on <60% median income.

Note: solid bars represent the 2009 child poverty rate. Where arrows are to the right of the bars, this indicates that poverty rates fell between 2005 and 2009; where arrows are to the left of the end of the bar, poverty rates increased.

Source: Bradshaw (8).



Employment, working conditions and health inequities

Recommendation 1(c).

Eradicate exposure to unhealthy, unsafe work and strengthen measures to secure healthy workplaces and access to employment and good-quality work.

Specific actions

- (i) Improve psychosocial conditions in workplaces characterized by unhealthy stress.
- (ii) Reduce the burden of occupational injuries, diseases and other health risks by enforcing national legislation and regulations to remove health hazards at work.
- (iii) Maintain or develop occupational health services that are financed publicly and are independent of employers.
- (iv) At international level, intensify and extend the transfer of knowledge and skills in the area of work-related health and safety from European/ international organizations, institutions and networks to national organizations.
- (v) In low- and medium-income countries, prioritize measures of economic growth (in accordance with an “environmental and sustainability strategy”) that are considered most effective in reducing poverty, lack of education and high levels of unemployment. To achieve this, invest in training, improved infrastructure and technology and extend access to employment and good-quality work throughout major sectors of the workforce.
- (vi) In high-income countries, ensure a high level of employment in accordance with the principles of a sustainable economy and without compromising standards of decent work and policies of basic social protection.
- (vii) Protect the employment rights of, and strengthen preventive efforts among, the most vulnerable (in particular, those with insecure contracts, low-paid part-time workers, the unemployed and migrant workers).
- (viii) Address rising levels of unemployment among the young by creating employment opportunities and ensuring they take up good-quality work through education, training and active labour-market policies.

Employment and high-quality work are critically important for population health and health inequalities in several interrelated ways (14).

- Participation in or exclusion from the labour market determines a wide range of life chances, mainly through regular wages and salaries and social status.

- Material deprivation resulting from unemployment or low-paid work and feelings of unfair pay – such as high levels of wage disparities within organizations – contribute to physical and mental ill health.
- Occupational position is important for people's social status and social identity, and threats to social status from job instability or job loss affect health and well-being.
- An adverse psychosocial work environment defined by high demand and low control, or an imbalance between efforts spent and rewards received, is associated with an increase in stress-related conditions; such exposure follows a social gradient (Fig. ES.7).
- Experiences of discrimination, harassment and injustice aggravate stress and conflict at work, especially in times of high competition and increasing job insecurity.
- Exposure to physical, ergonomic and chemical hazards at the workplace, physically demanding or dangerous work, long or irregular work hours, temporary contract and shift work and prolonged sedentary work can all adversely affect the health of working people.

Levels of unemployment across the Region are high and vary substantially by country, age, sex, migrant status and educational level. They have recently risen considerably in the countries most affected by recession and the economic crisis, such as Spain and Greece. Fig. ES.8 and Fig. ES.9 illustrate the great variation across the Region.

There is comprehensive scientific evidence on increased health risks resulting from precarious employment, which carries a heightened risk of becoming unemployed, and from unemployment itself – particularly from long-term unemployment.

The review recommendations address the causes of inequities in ill health associated with work conditions and unemployment.

Fig. ES.7

Psychosocial stress and occupational class: SHARE, 2004/2005

■ **Effort–reward imbalance**
■ **Low control**

Source: Wahrendorf et al. (15); SHARE (16).

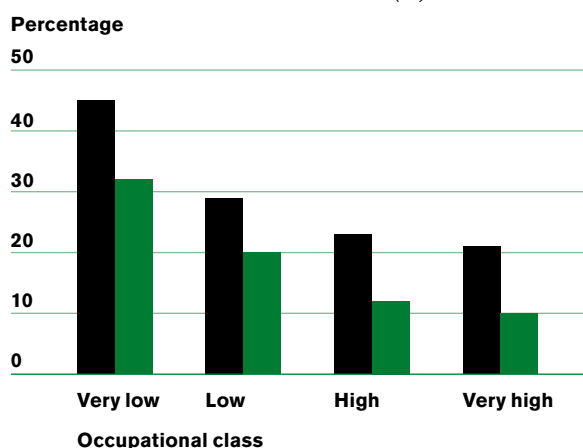


Fig. ES.8

Unemployment rates among women in selected countries in the European Region by age, 2011

■ Age 25–74

■ Age under 25

Source: Eurostat (17).

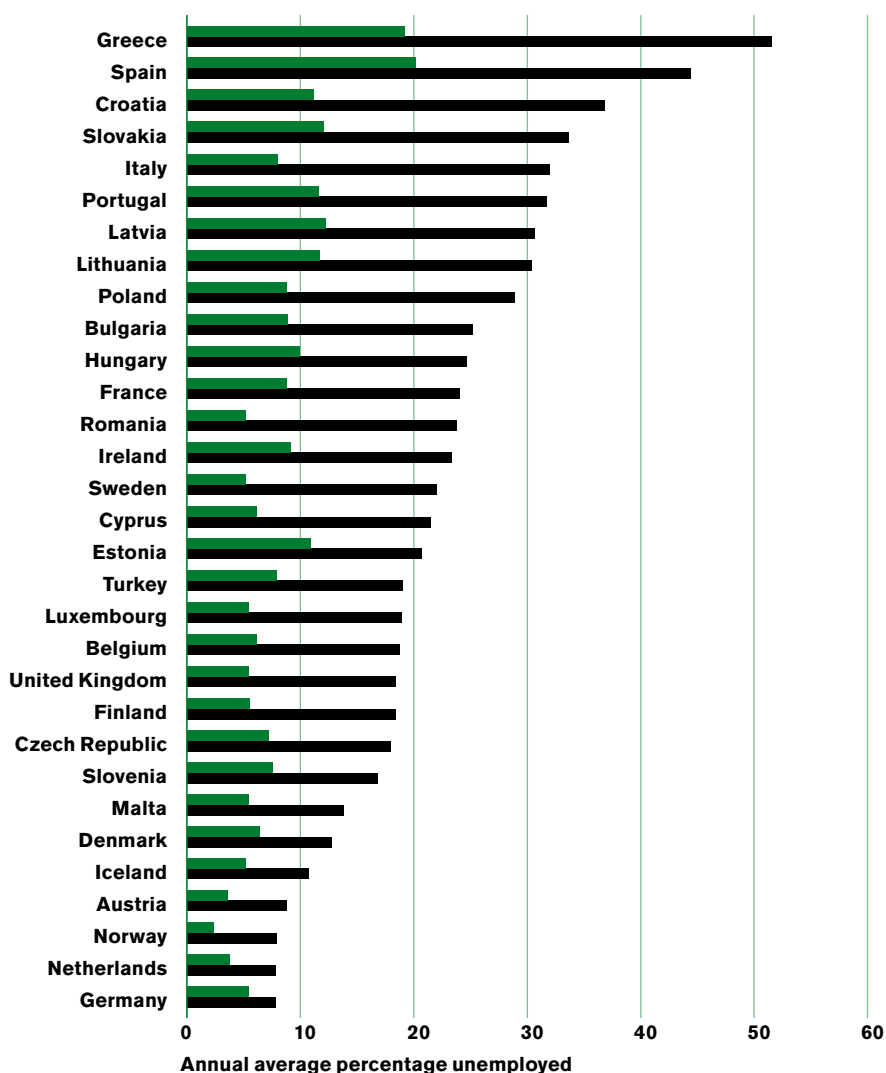


Fig. ES.9

Unemployment among 15–24-year-olds and total unemployment in countries of central and eastern Europe and the Commonwealth of Independent States, 2010 (or latest available year)

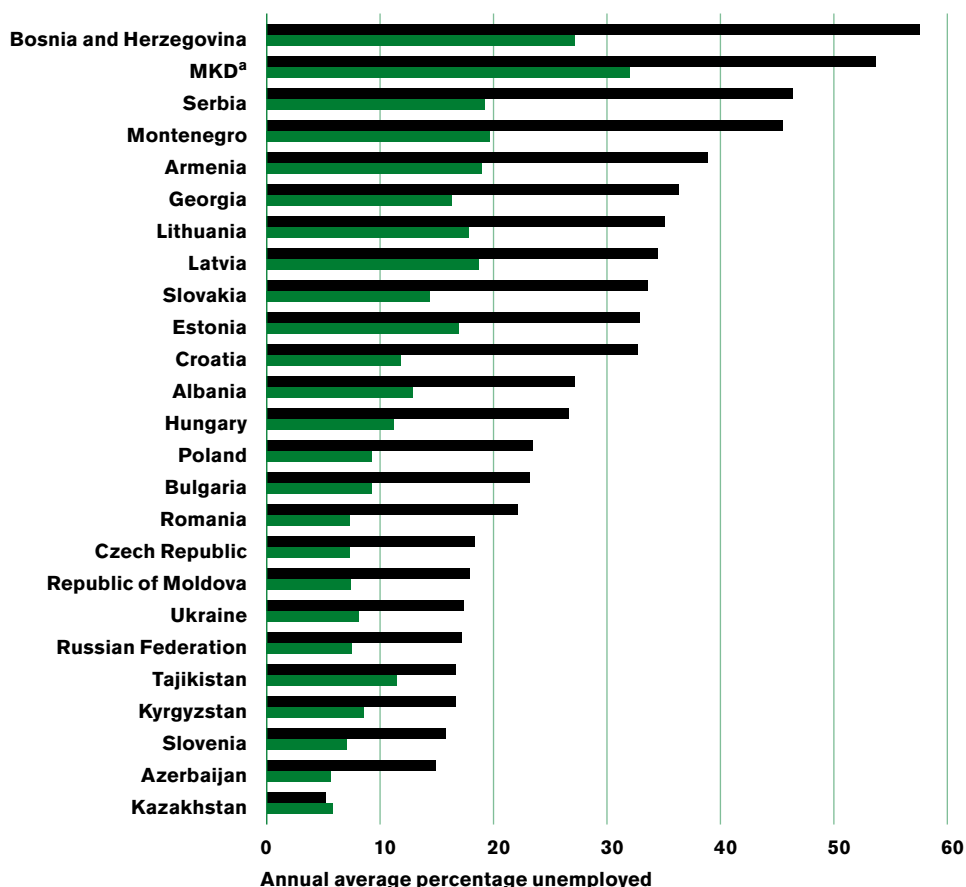
■ Among 15–24-year-olds

■ Total

^aThe former Yugoslav Republic of Macedonia (MKD) is an abbreviation of the International Organization for Standardization.

Note: the data for Tajikistan are for 2009 and the data for Albania are for 2008.

Source: TransMonEE (18).



Recommendation 1(d).

Introduce coherent effective intersectoral action to tackle inequities at older ages to prevent and manage the development of chronic morbidity and improve survival and well-being across the social gradient.

Specific actions

- (i) Ensure action is focused on addressing ageism, the right to work, social isolation, abuse, standards of living (including living conditions, social transfers and adequacy of pensions), opportunities for physical activity and access to health and social care.
- (ii) Devote particular attention and action to the social, economic and health problems of older women, who have more physical and mental health problems in old age, a greater risk of poverty and live more years with disability.

Understanding the underlying determinants of health and inequities among older people is an important priority for the Region, the part of the world in which population ageing is most advanced. Effective strategies are required to promote healthy, active and independent lives in old age through early preventive action to delay the onset of age-related mental and physical disabilities. Proportionally more attention needs to be paid to older adults with lower incomes in designing these preventive programmes. In addition, policies aimed at tackling social and economic inequities, in general, such as redistribution schemes and those focused on tackling financial barriers in access to care should all be designed to reduce inequities among the older population.

Fig. ES.10 shows how the gender gaps in the time men and women can expect to live and be in good health vary between countries in the Region. It shows that, in every country, women live longer than men but spend more years not in good health. In Portugal, women live six years longer than men but spend eight more years not in good health. Conversely, in Estonia, women live 11 years longer than men but only 6 years longer not in good health.

In addition to focusing on the causes of shorter longevity among men in the Region, special attention should be devoted to older women, who have more health problems and are at greater risk of poverty in old age because they live longer and have a different life-course. Chronic rather than acute morbidity is the most consistent explanatory factor for differences in health and disability between men and women. Many age-related mental health problems are also more common among women. Older people may experience discrimination or disregard and social isolation because of their age. Social isolation is a powerful predictor of mortality.

Social protection policies, income and health inequities

Recommendation 2(a).

Improve the level and distribution of social protection according to needs to improve health and address health inequities.

Specific actions

- (i) Ensure spending on social protection is increased effectively according to need by making proportionately greater increases in countries with lower levels of spend and ambition, as follows.
 - *Do something*: make some programme improvements in countries characterized by low levels of spend and low ambition for social protection.
 - *Do more*: further increase the ambitions of social protection programmes in countries characterized by medium–high ambitions in terms of social protection policies.
 - *Do better*: improve levels of social protection in general and for the most vulnerable in particular among the most developed welfare states, but where the redistributive and protective capacity of the welfare state has diminished.
- (ii) Make more effective use of resources already used for social protection.
- (iii) An international, multidimensional and age-related framework is required to provide a standard methodology for calculation based on the specific needs of groups within the context of the society in which they live. As such, unlike poverty levels, the minimum does not have a uniform value for a country.
- (iv) Adopt a gender equity approach to tackle social and economic inequities resulting from women being overrepresented in part-time work, having less pay for the same job and undertaking unpaid caring roles.

Social protection

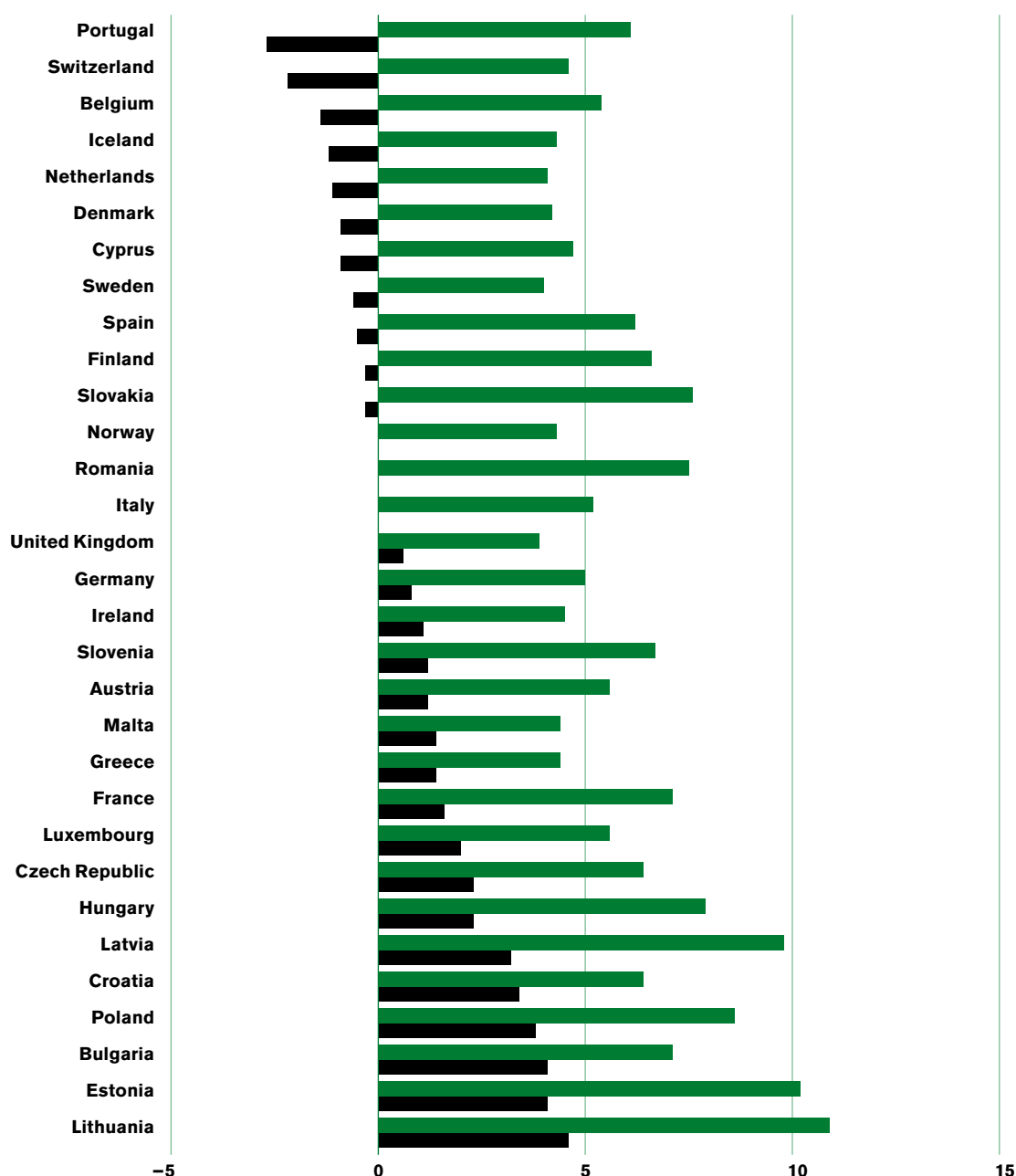
Social protection policies can create a buffer against income loss and can redistribute income both over the life-course and between individuals. Individuals and families can also draw on the collective resources provided by welfare state institutions. Both are important for health and well-being. For this reason, the welfare resources necessary to have an acceptable quality of life – including economic resources, working conditions, housing conditions, education and knowledge – constitute key social determinants of health.

Fig. ES.10

Differences between women and men in healthy life-years and life expectancy at birth in the European Union, 2010

■ Additional years lived by women
■ Additional years spent in good health by women

Source: Eurostat (19).



The less people achieve in terms of individual resources, the more important it is that they be able to draw on collective resources – welfare policies that provide more generous transfers and better-quality services are likely to improve public health and reduce health inequities. A major problem in the European Region is not only low income associated with unemployment but employment that pays too little to lead a healthy life.

People with low levels of education tend to benefit more from higher levels of social transfers than those with secondary and tertiary education. In both absolute and relative terms, educational inequities

in health decrease as social spending increases; and, the effect that increased spending has on these inequities is greater for women than for men.

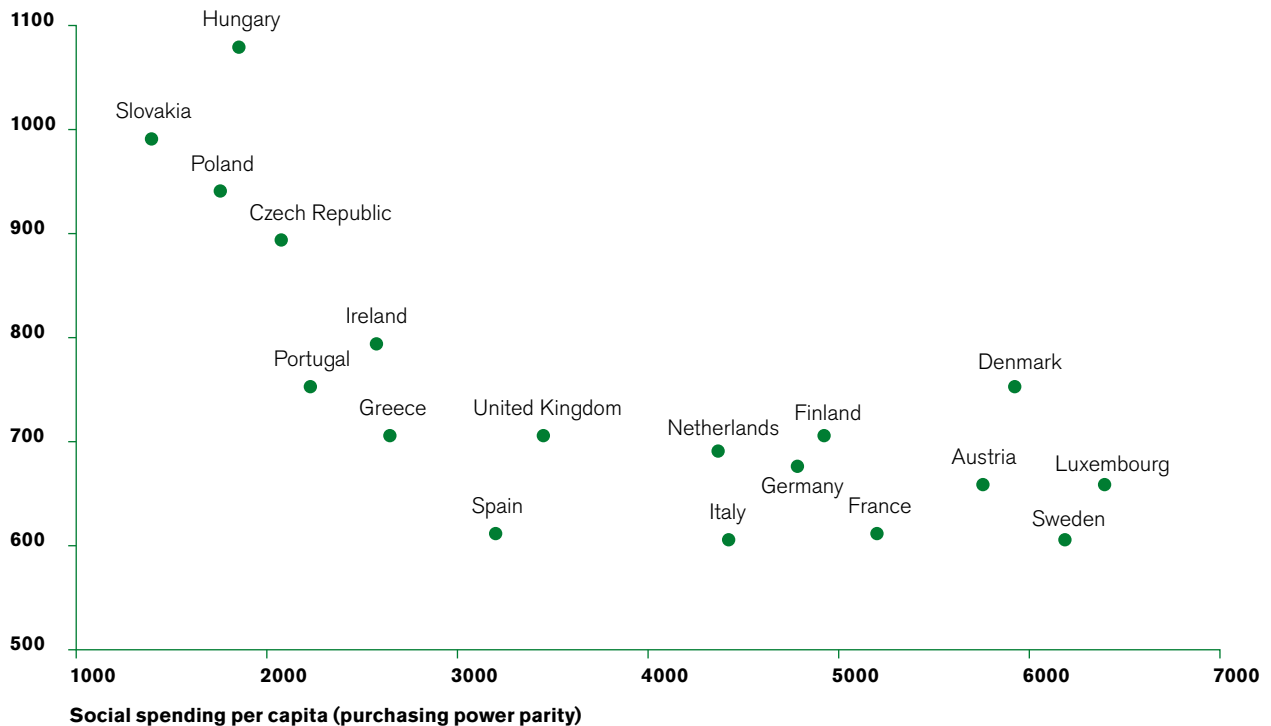
Where existing levels of social spending and social rights are in the low-to-moderate range, even **small improvements in legislated social rights and social spending are associated with improved health** (Fig. ES.11). This suggests that countries with the least-developed social protection systems can make gains most easily. Even modest increases would be of importance in poorer countries in the Region.

Fig. ES.11

**Social welfare spending
and all-cause mortality
in 18 countries, European
Region, 2000**

Source: Stuckler et al. (20).

**Age-standardized
all-cause mortality
per 100 000 population**



The objective of the joint United Nations Social Protection Floor Initiative (SPF-I) is to ensure a basic level of social protection and a decent life both as a necessity and an obligation under the human rights instruments (21). A key aim of policy in the European Region should be the maintenance of minimum standards needed for healthy living.

reasons, although differences in mortality and morbidity rates between men and women are well documented, the scale of these varies widely across the Region and is changing in many countries. The appropriate response is to adopt a gender equity approach in tackling social and economic inequities.

Gender

The social and economic roles performed by men and women significantly affect the health risks to which they are exposed over the life-course. A specific source of psychosocial stress for women over the life-course is balancing the burdens of caregiving to different generations, paid work and housekeeping. Men's health is more frequently affected by work conditions. Risk-taking and other behaviour among men, such as violence, are encouraged by gender norms and endanger the health and well-being of both men and women.

Societal and economic changes affect gender roles, but societal norms and values may limit the extent to which the people affected adapt. The combined effect of these is to alter health outcomes and the extent of the gender gap – for example, the current 13-year life expectancy gap between males and females in the Russian Federation (3). For these

Recommendation 2(b).

Ensure concerted efforts are made to reduce inequities in the local determinants of health through co-creation and partnership with those affected, civil society and a range of civic partners.

Specific actions

- (i) Ensure championing of partnership and cross-sector working by local leaders.
- (ii) Ensure all actions are based on informed and inclusive methods for public engagement and community participation, according to locally appropriate context, to empower communities and build resilience.
- (iii) Make the use of partnership-working more extensive, including using local knowledge, resources and assets in communities and those belonging to agencies, to foster cooperation and engagement to support community action and the diversity of local people. Physical resources such as schools, health and community centres should be used as the basis for a range of other services.
- (iv) Give priority in environmental policies to measures that help to improve health and apply to all population groups likely to be affected, particularly those who are excluded (such as homeless people and refugees) or vulnerable (young and elderly).
- (v) Adopt strategies to improve air quality and reduce health risks from air pollutants for all groups across the social gradient.

Communities are influenced and shaped by the complex interrelationships between the natural, built and social environments. The lower people are on the socioeconomic gradient, the more likely they are to live in areas where the built environment is of poorer quality and is less conducive to positive health behaviour and outcomes and where exposure to environmental factors that are detrimental to health is more likely to occur (22).

People who live in areas of higher deprivation are more likely to be affected by tobacco smoke, biological and chemical contamination, hazardous waste sites, air pollution, flooding, sanitation and water scarcity, noise pollution and road traffic (23). At the same time, they are less likely to live in decent housing and in sociable and congenial places of high social capital that feel safe from crime and disorder, provide access to green spaces and have adequate transport options and opportunities for healthy living.

People on low incomes are less likely to have the means and resources to mitigate the risks and effects of environmental hazards and to overcome the obstacles posed by environmental disadvantages to securing less hazardous conditions and access to opportunities.

How people experience social relationships influences health inequities. Critical factors include how much control people have over resources and decision-making and how much access people have to social resources, including social networks, and communal capabilities and resilience. Social capital has been identified as a catalyst for coordination and cooperation, serving as an essential means to achieve better social and economic outcomes. There is, however, no consistency in the factors that are associated with strong social networks and social capital. Although this argues against excessive generalization, some evidence indicates that social networks appear, in general, to be stronger in countries with higher poverty rates; social capital tends to be more easily built in countries with relatively strong democracies that have effective legal systems; and that strong civil societies contribute to building strong democracies (24).

Spatial quality – how places and spaces are planned, designed, constructed and managed – affects the distribution of environmental burdens and benefits affecting health and inequities (Table ES.1). The quality of infrastructure, including water and sanitation, are crucial to health, along with other factors. Immigrant communities and people living in slum conditions throughout the European Region often live in the most polluted areas (25). Across the central and eastern parts of the Region hazardous waste and chemicals are major contributors to environmental injustice (26). Access to safe water has recently deteriorated in several countries in the eastern part of the Region, although the situation has been improving in this area as a whole (27). Although people living in rural areas tend to have little access to sanitation (28), the poorer groups in urban areas bear the greatest impact of droughts affecting the water supply (29). Improving the environment has been one of the rallying points of civil society in the eastern part of the Region.

Table ES.1

Poor quality of the built environment affects health: summary of exposure, population-attributable fraction from inadequate housing conditions

Source: Braubach et al. (30).

Exposure	Health outcomes	Exposure–risk relationship	Population-attributable fraction (%)
Mould	Asthma deaths and DALYs ^a in children (0–14 years)	RR ^b = 2.4	12.3
Dampness	Asthma deaths and DALYs in children (0–14 years)	RR = 2.2	15.3
Lack of window guards	Injury deaths and DALYs in children (0–14 years)	RR = 2.0	33–47
Lack of smoke detectors	Injury deaths and DALYs (all ages)	RR = 2.0	2–50
Crowding	Tuberculosis	RR = 1.5	4.8
Indoor cold	Excess winter mortality	0.15% increased mortality per °C	30
Traffic noise	Ischaemic heart disease, including myocardial infarction	RR = 1.17 per 10 dB(A)	2.9
Radon	Lung cancer	RR = 1.08 per 100 Bq/m ³	2–12
Residential second-hand smoke	Lower respiratory infections, asthma, heart disease and lung cancer	Risk estimates range from 1.2 to 2.0; OR ^c = 4.4	Estimates range from 0.6% to 23%
Lead	Mental retardation, cardiovascular disease, behavioural problems	Case fatality rate 3%	66
Indoor carbon monoxide	Headache, nausea, cardiovascular ischaemia/insufficiency, seizures, coma, loss of consciousness, death	DNS/PNS ^d incidence 3–40%	50–64
Formaldehyde	Lower respiratory symptoms in children	OR = 1.4	3.7
Indoor solid fuel use	COPD ^e , ALRI ^f , lung cancer	RR = 1.5–3.2	6–15

^a DALYs: disability-adjusted life-years

^b RR: relative risk

^c OR: odds ratio

^d DNS/PNS: delayed or persistent neurocognitive sequelae

^e COPD: chronic obstructive pulmonary disease

^f ALRI: acute lower respiratory infection

Recommendation 2(c).

Take action to develop systems and processes within societies that are more sustainable, cohesive and inclusive, focusing particularly on groups most severely affected by exclusionary processes.

Specific actions

(i) Address the social determinants of health and well-being among people exposed to processes that lead to social exclusion:

- avoid focusing on individual attributes and behaviours of those who are socially excluded; and
- focus on action across the social gradient in health that is proportionate to need rather than the gap in health between the most- and least-disadvantaged groups.

(ii) Involve socially excluded individuals and groups in the development and implementation of policy and action by putting in place effective mechanisms that give them a real say in decisions that affect their lives and by recognizing their human rights (to, for example, health, education, employment and housing).

(iii) Develop strategies that:

- focus action on releasing capacity within organizations, professional groups and disadvantaged groups to achieve long-term improvements in resilience and how those who are socially excluded are able to live their lives;
- make a corresponding reduction in the focus on short-term spending projects;
- empower disadvantaged groups in their relationships with societal systems with which they have contact; and
- include cross-border action on transnational exclusionary processes (such as those affecting Roma and migrants in irregular situations).

From the perspective of the social determinants of health, it is important to understand exclusion, vulnerability and resilience as dynamic multidimensional processes operating through relationships of power. Previously, exclusion has too often been approached by focusing on the attributes of specific excluded groups.

Recognizing that exclusionary processes and vulnerabilities vary among groups and societies over time suggests that action should be based on addressing the existence of continuums of inclusion and exclusion and vulnerability. This does not deny the existence of extreme states of exclusion, but it helps avoid the stigmatization inherent in an approach that labels particular groups as “excluded”, “disadvantaged” and/or “vulnerable”. This continuum approach should also increase understanding of the processes at work and how these might be reversed and shift the focus from passive victims towards the potential for disadvantaged groups to be resilient in the face of vulnerability. The review focused on two important examples: vulnerability among Roma and among irregular migrants – people without permission to either live or work in the country of residence.

Roma

The exposure of Europe's Roma to powerful social, economic, political and cultural exclusionary processes, including prejudice and discrimination, adversely affects their human rights and self-determination. Progress in reducing the social inequities experienced by Roma has been limited. This situation is leading to gross inequities in health and well-being among the Roma compared with other populations in the Region.

The “Decade of Roma inclusion” provides a valuable example of a concerted effort to address this – a commitment by 12 European governments to improve the socioeconomic status and social inclusion of Roma. During this initiative, no single country performed consistently well across all the policy areas. However, positive outcomes were achieved by several specific initiatives: for example, active participation of Roma in housing developments in Hungary and the establishment of recycling centres and cooperatives in Serbia.

Factors affecting progress and implementation include: the complexity of funding arrangements; lack of data for monitoring and evaluation purposes; inadequate systems of governance and accountability; insufficient participation of Roma people and civil society; and an absence of political will. These problems need to be addressed through political commitment both at national and transnational levels.

Irregular migrants

As an indicator of lack of participation in societal opportunities, Fig. ES.12 shows that unemployment rates are higher among migrants in many countries. Irregular migrants who are particularly exposed to additional exclusionary processes face the greatest problems – for example, those who need health care, unaccompanied minors, irregular female domestic workers and victims of trafficking, mostly women being exploited in the sex trade. States vary in the extent to which they allow irregular migrants access to social protection, including health care.

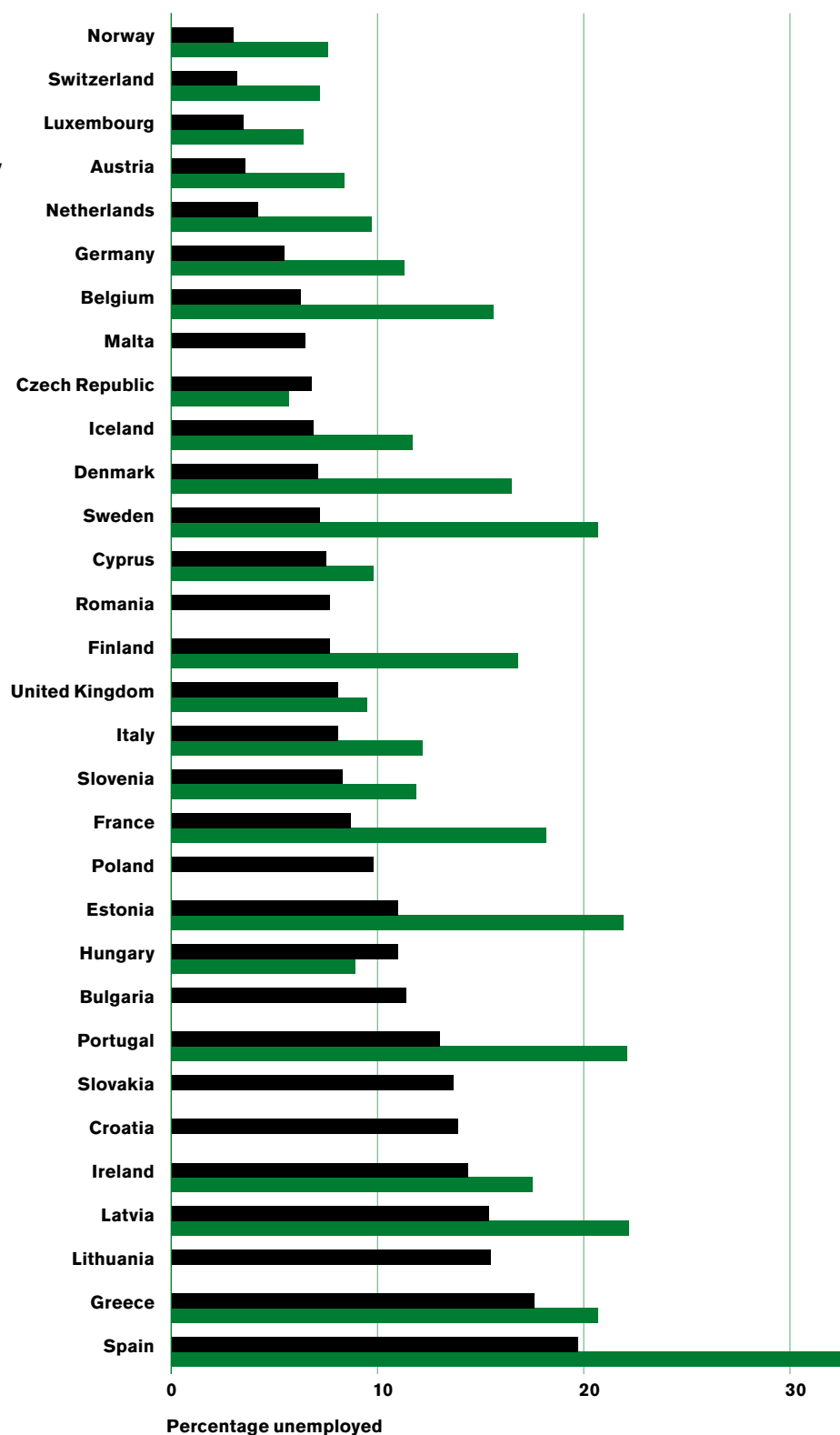
Withholding access, denying them the “right to the highest attainable health”, is seen as one important element of “internal migration control”, and detention is another. However, these measures do not seem to have much effect on the numbers of irregular migrants – their main effect is increased vulnerability to marginalization, destitution, illness and exploitation. Migration issues and the living conditions of regular and irregular migrants need to be addressed by agreements between countries in the Region that do not infringe their human rights.

Fig. ES.12

Unemployment rates in selected countries in the European Region by country of birth, 2011

■ Nationals of that country
■ Foreign nationals

Source: Eurostat (31).



Theme C – Macro-level context

Social expenditure

Recommendation 3(a).

Promote equity through the effective use of taxes and transfers. In particular, the proportion of the budget spent on health and social protection programmes should be sustained in all countries and increased for countries below the current European average.

Specific actions

(i) Improve the balance between the overall level of social spending and:

(a) spend on other programmes; and

(b) the overall level of taxation in those countries where these indicators are below the current European average.

(ii) Promote equity effectively by adopting best practice in the design of social spending programmes, including universal provision that is proportionate to need, integrated social care and labour-market policies that incorporate active labour-market programmes.

(iii) In addressing the financial crisis, ensure priority is given to the health and social consequences of the austerity packages that are now being discussed or have already been introduced in many European countries. As a step towards ensuring that the processes are inclusive of all people, the views of ministers for health and social affairs should be heard in the negotiations about such austerity packages and, at transnational level, those of WHO, United Nations Children's Fund, International Labour Organization and The World Bank.

(iv) Widen the discussion of financial stabilising mechanisms to prioritize socially progressive policies – such as those recommended in this review – by considering, for example, the likely impact of taxing financial transactions.

The background to the review is the global financial crisis and the related sovereign debt crisis. They are likely to have a direct, negative, lasting effect on health and its social determinants in Europe, particularly if the response to the financial and debt crises does not take health equity concerns into account. For example, the direct health effects are already becoming evident in some countries in the Region (Fig. ES.13).

This highlights the need to protect the social and health sectors from austerity-driven cuts and from some of the negative effects of financial support agreements between countries in the Region and transnational bodies by using other measures that have smaller negative effects, both economically and on health, whenever these are available.

Fig. ES.13

Changes in self-reported health and access to health care in Greece between 2007 and 2009, adjusted estimates

■ 2007

■ 2009

Note: the odds ratio refers to the odds of ill health or unmet need in each year compared with the odds in 2007, so that the odds ratio in 2007 equals 1 for each indicator.

Source: Kentikelenis et al. (32).

Odds ratio

1.2

1.0

0.8

0.6

0.4

0.2

0

Bad or very bad self-reported health

Unmet medical care needs

Unmet dental care needs

Recommendation 3(b).

Plan for the long term and safeguard the interests of future generations by identifying links between environmental, social and economic factors and their centrality to all policies and practice.

Specific actions

- (i) Ensure that the principles of sustainable development are applied to all policies, taking account of evidence on the impact of development in the past on current and future generations.
- (ii) Include health equity assessments for current and future generations in environmental policies at all levels.
- (iii) Introduce fiscal policies that improve the affordability of healthy and sustainable food choices:
 - (1) ensure that the cost of a nutritious and sustainable diet is reflected in calculations of a minimum standard of living for all; and
 - (2) ground agricultural policies in equity and sustainability and ensure that they promote access to safe, affordable, nutritious food for all and sustainable and equitable food systems.

Integral to facing this challenge of reducing inequitable environmental harm is an approach, endorsed in the 2011 Rio Political Declaration on Social Determinants of Health, that embraces sustainable development. Some progress has been made in the last two decades – for example, energy efficiency, in terms of energy use per dollar of gross domestic product, has improved in countries in the eastern part of the Region and in European Union countries (33) (Fig. ES.15) – but much more needs to be done.

Environmental quality is linked to social equity: where environmental harm occurs, it is often linked to the unequal distribution of environmental hazards. Factors determining health and social justice are interdependent with factors determining environmental and economic sustainability. For example, excessive consumption of animal fat is associated with increased risk of preventable diet-related diseases, including several types of cancer and cardiovascular disease, while producing animal-based food to supply demand is associated with environmental costs, including water use and greenhouse gas emissions. If low-income countries seek to develop their economies by emulating industrialized economies, this may have dire consequences for the natural environment and for health and health inequities across the Region. Populations in low- and middle-income countries in the Region are likely to reap the greatest benefit from interventions that provide a healthier and safer environment, since they tend to be disproportionately exposed to inadequate environmental conditions (25). Fig. ES.14 illustrates the unequal levels of air pollution in capital cities in the Region.

Fig. ES.14

Annual average concentrations of particulate matter in the capital city in 2009 and change since 2005, selected countries, European Region

■ Particulate matter 2009
◆ Difference between 2005 and 2009 concentrations

^aThe latest figures for Romania and Sweden are for 2008.

^bThe latest figures for Greece are for 2007.

Note: the solid bars represent the level of particulate matter in 2009. Where the arrows are to the right of the bars, this indicates that levels fell between 2005 and 2009. Where the arrows are to the left of the end of the solid bar, levels increased between 2005 and 2009.

Source: WHO Regional Office for Europe (3).

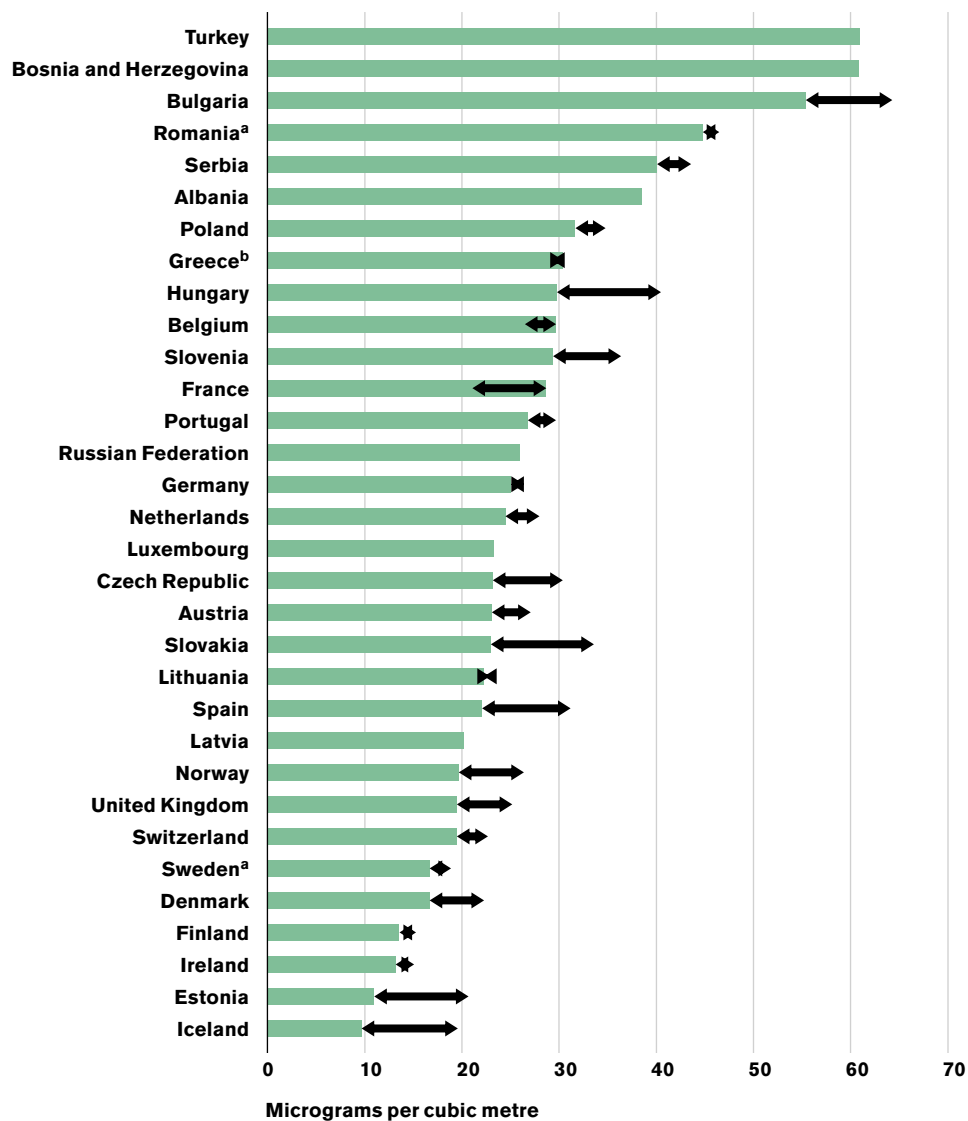


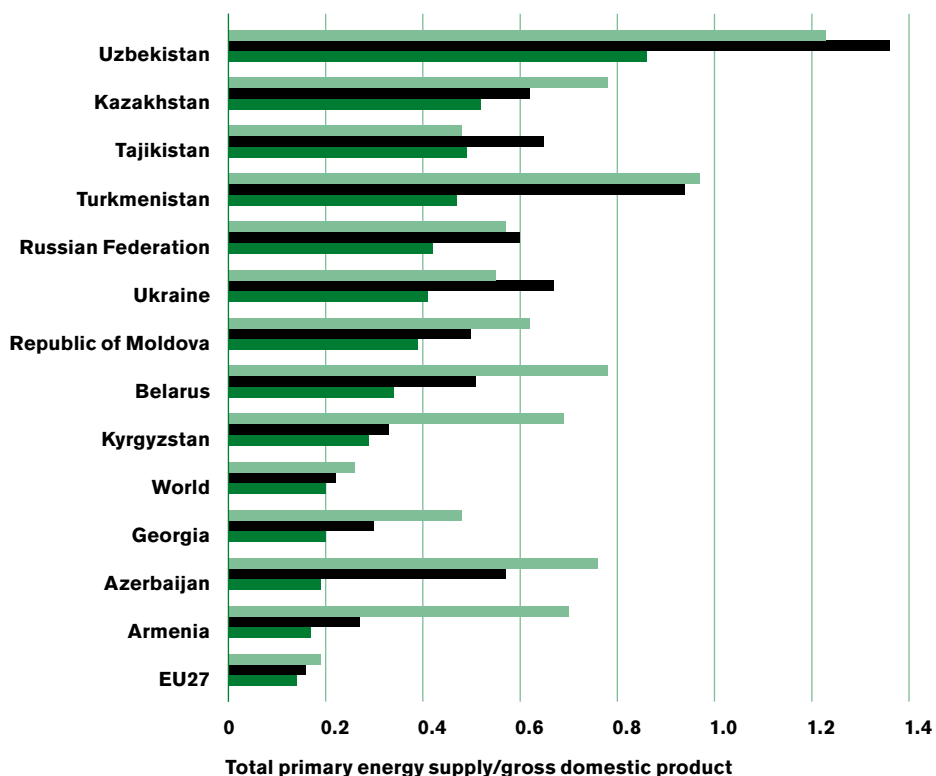
Fig. ES.15

Gross domestic product energy intensity in selected countries in the eastern part of the European Region, EU27^a and world average

■ 1990
■ 2000
■ 2007

^aEU27: countries belonging to the European Union after January 2007.

Source: Olshanskaya (34).



Recommendation 4(a).

Improve governance for the social determinants of health and health equity. This requires greater coherence of action at all levels of government – transnational, national, regional and local – and across all sectors and stakeholders – public, private and voluntary.

Specific actions

- (i) Develop partnerships at all levels of government that enable collaborative models of working, foster shared priorities between sectors and ensure accountability for equity.
- (ii) Ensure that the coherence of actions across sectors and stakeholders is strengthened to achieve:
 - (1) sufficient intensity of action – increase the resources devoted to redressing current patterns and magnitude of health inequities;
 - (2) long-term investment and sustainability of actions; and
 - (3) levelling-up the gradient in health equity and the social determinants of health.
- (iii) Ensure that the different needs, perspectives and human rights of groups at risk of marginalization and vulnerability are heard through their involvement in decision-making processes, with effective mechanisms for adequate participation, engagement and consultation with all parts of civil society.
- (iv) At regional level, ensure the Regional Office and its partner United Nations organizations in Europe work together through the “United Nations collaboration mechanism” to have a voice in transnational agreements affecting the social determinants of health.
- (v) Strengthen WHO's role and capacity to better advise Member States on developing policies on the social determinants of health and advocate for health equity in other relevant sectors.

Governance for social determinants of health and health equity seeks to strengthen the coherence of actions across sectors and stakeholders in a manner that increases resources to: (a) redress current patterns and magnitude of health inequities; and (b) reduce inequities in the distribution of the social determinants of health and of the risks and consequences of disease and premature mortality across the population.

Governance for health comprises: “the attempts of governments or other actors to steer communities, whole countries, or even groups of countries in the pursuit of health as integral to well-being through both a whole-of-society and a whole-of-government approach” (35).

At European Region level, it is necessary to develop a much stronger institutional framework for this, based on mutual agreements between countries and involving the WHO Regional Office for Europe and its partner organizations. At every level of governance, arrangements are needed that are capable of building and ensuring joint action and accountability of health and non-health sectors, public and private actors and ordinary people, with a common interest in improving health on equal terms. Fig. ES.16 illustrates the different levels of voice and accountability seen across the Region.

Key competencies that governance for health systems need to deliver strategies for addressing the social determinants of health are shown in Box ES.2.

Box ES.2

Key competencies to deliver strategies for addressing the social determinants of health

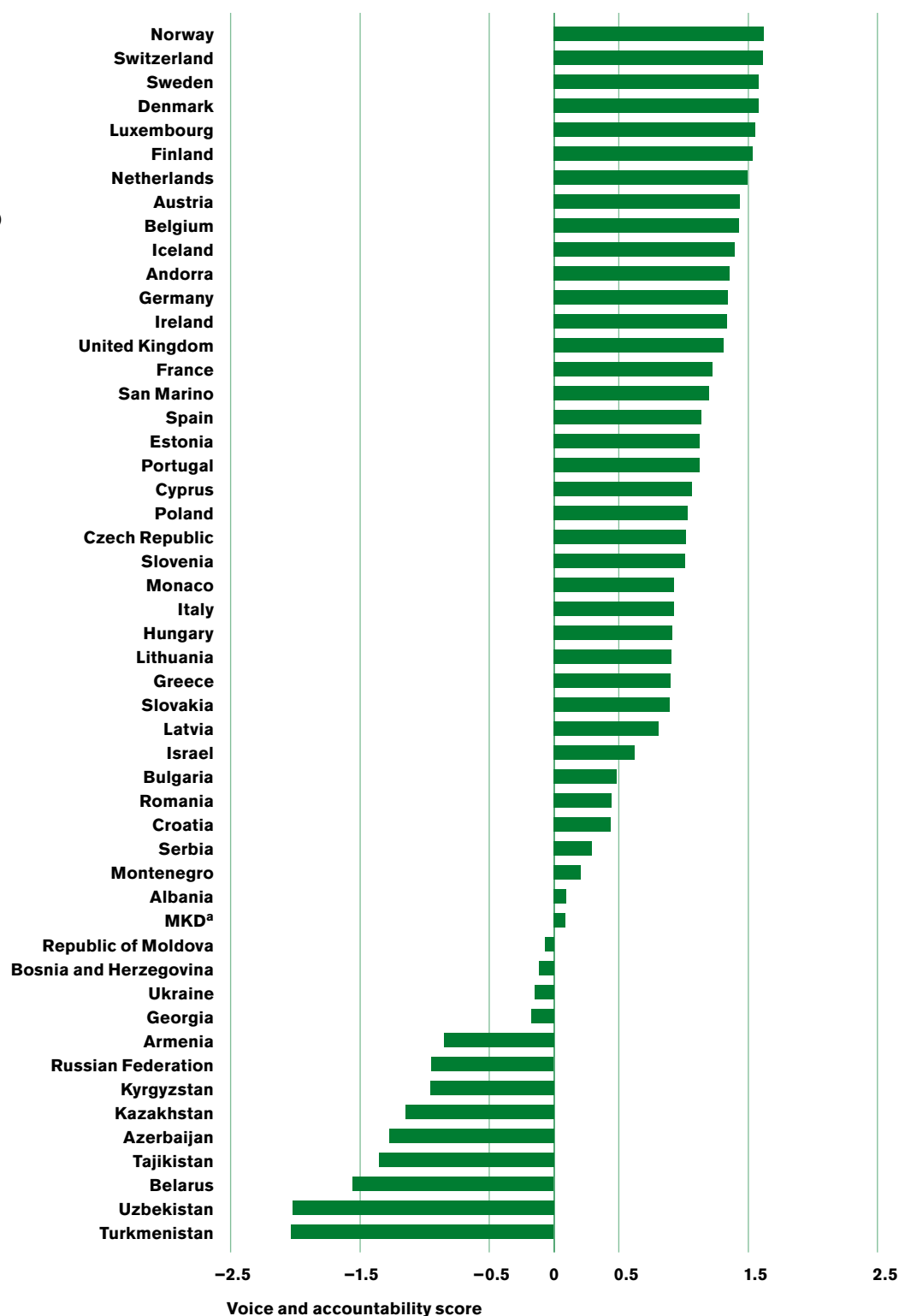
- High level of political will and commitment, globally, nationally and locally
- Transnational mechanisms that promote health and equity
- Accountability mechanisms
 - transparent
 - based on empowerment
- Equity in all policies
- Appropriate levers and incentives
- Institutional readiness
- Collaboration and action from key stakeholders
- Rights-based approach
- Involve communities
 - draw on and strengthen capabilities and assets
- Cross-sectoral and partnership working
 - embedded in existing management and performance systems

Fig. ES.16

Voice and accountability scores of countries in the European Region according to The World Bank worldwide governance indicators

^aThe former Yugoslav Republic of Macedonia (MKD) is an abbreviation of the International Organization for Standardization.

Source: The World Bank (36).



A key action area is to develop new instruments and mechanisms – and strengthen those that exist – to empower people and ensure that the opinions and perspectives that are heard in decision-making processes include a better reflection of equity arguments. Empowering people includes promoting civil society, enabling unions to be formed and developing political and non-political organizations freely.

Participatory mechanisms such as citizens' juries, consumer panels and community planning methods have the potential to engage the diversity of stakeholders with an interest in the social determinants of health and provide new ways of holding decision-makers more accountable for their actions. They also promote greater political involvement across societies and contribute to more equitable allocation of resources.

Recommendation 4(b).

Develop a comprehensive, intersectoral response to the long-term nature of preventing and treating ill health equitably to achieve a sustained and equitable change in the prevention and treatment of ill health and the promotion of health equity.

Specific actions

Prevention

Ensure that actions on preventable health hazards are based on addressing the substantial differences in exposure within and between countries, including:

- (i) reduce harmful alcohol consumption by, for instance, introducing a tax on alcoholic beverages that is proportional to the alcohol content;
- (ii) initiate wider actions to reduce fats, particularly trans fats, in diet and control the growth of fast-food consumption;
- (iii) take action to reduce smoking under the Framework Convention on Tobacco Control; and
- (iv) encourage active living, focusing on needs across the social gradient.

Treatment

Reduce differential access to good-quality health care services within and between countries, including actions to:

- (i) make health care systems more equitable – universal health coverage is required to provide a critical foundation for addressing health inequities; and
- (ii) remove financial, geographic and cultural barriers to the uptake of health care services (such as copayments) and ensure adequate resource allocation that takes account of extra need in disadvantaged areas.

Strategies

- (i) Ensure that strategies to address inequities within and between countries (including those related to gender):
 - (1) develop systems able to adequately assess, plan and deliver sustained action to reduce health inequities;
 - (2) improve the capacity of public health systems to address health inequities;

- (3) strengthen health-promotion, health-protection and disease-prevention systems to ensure universal coverage for all social groups, and link these to policies and programmes that specifically address the determinants of lifestyles and behaviours;

- (4) improve accessibility and quality of health care services; and

- (5) ensure no adverse effects from transnational agreements and regulations.

- (ii) Provide external support for developing and implementing these strategies to address inequities in countries where they are weakest, including a number of countries in the central and eastern parts of the Region.

- (iii) Ensure a balance between strategies that have short-, medium- and longer-term results and between simpler and more complex integrated interventions. Specific areas for action are:

- (1) strategies that give societies, groups and individuals greater control over their exposure to preventable hazards, such as regulation and control over the workplace and the environment, tobacco, alcohol and food content, availability and pricing and addressing societal norms and values;

- (2) design screening programmes to be accessible by all, particularly the most vulnerable and disadvantaged, for cardiovascular risk factors and early detection of cancers; and

- (3) ensure effective implementation of infectious disease strategies (for tuberculosis and HIV/AIDS, for example) that disproportionately affect socially disadvantaged and vulnerable people, including addressing the causes of vulnerability, gender inequities and adequate, sustainable access to screening, diagnosis and treatment services.

- (iv) Monitor and assess population health equity impacts across these recommendations disaggregated by sex, age and 2–3 key socioeconomic determinants.

Actions can be taken now to improve population health in the short and medium term, whereas others will take longer to have an impact. Achieving sustained and equitable change in preventing and treating ill health therefore requires achieving a balance between strategies that have short-, medium- and longer-term results as well as between simpler and more complex, integrated interventions.

Between-country differences

Reasonably good evidence indicates that part of the health divide between countries in the Region is associated with: (a) differences in exposure to preventable health hazards that result from inequities in the social determinants of health and of behaviour and lifestyles – including inequities in exposure to tobacco, alcohol, unhealthy diets, high blood pressure, risk of cervical cancer, conditions leading to road injury, dangerous or stressful working conditions and air pollution; and (b) differences in the accessibility and quality of health care services.

The contribution of these factors, however, differs between countries and over time. For example, excessive alcohol consumption is relatively more important in some countries in central and eastern Europe as a determinant of poor population health, and smoking, while being one of the main downstream determinants of health inequities in northern and western parts of the Region, is not a major determinant of health inequities in the southern part. The contribution of differential access to good-quality health care services also varies between countries. Although inadequate access to effective care may make only a modest contribution to the observed health inequities in northern, western and southern Europe, it is likely to have a stronger influence on the larger inequities in mortality observed in the eastern part of the Region.

The evidence on these different contributions provides important entry-points to policies for preventing and treating ill health designed to reduce the health divide between countries. Two important strategies are: (a) strengthening health promotion, health protection and disease prevention in the central and eastern parts of the Region; and (b) making improvements that reduce differences in the accessibility and quality of health care services.

Within-country differences

The exposure to preventable health hazards that arises from social determinants, as described above, contributes to socioeconomic inequities in health within countries. This is observed, for example, in relation to levels of obesity according to education (Fig. ES.17). The contribution of such health risks as exposure to tobacco smoke, unhealthy diet, physical inactivity and misuse of alcohol differs across the Region because of local social norms and values and the stage that behaviour-related epidemics have

reached. The response to this requires appropriate country-specific priorities and strategies that encompass equity issues. Where WHO strategies and framework statements exist, they provide a basis for developing this response.

Similarly, treatment strategies to tackle health inequities within countries must also be adapted to national priorities and specific health systems within a framework of equity and an aspiration of universal provision for the population as a whole – with resources allocated according to social need and provision for disadvantaged groups.

Fig. ES.17

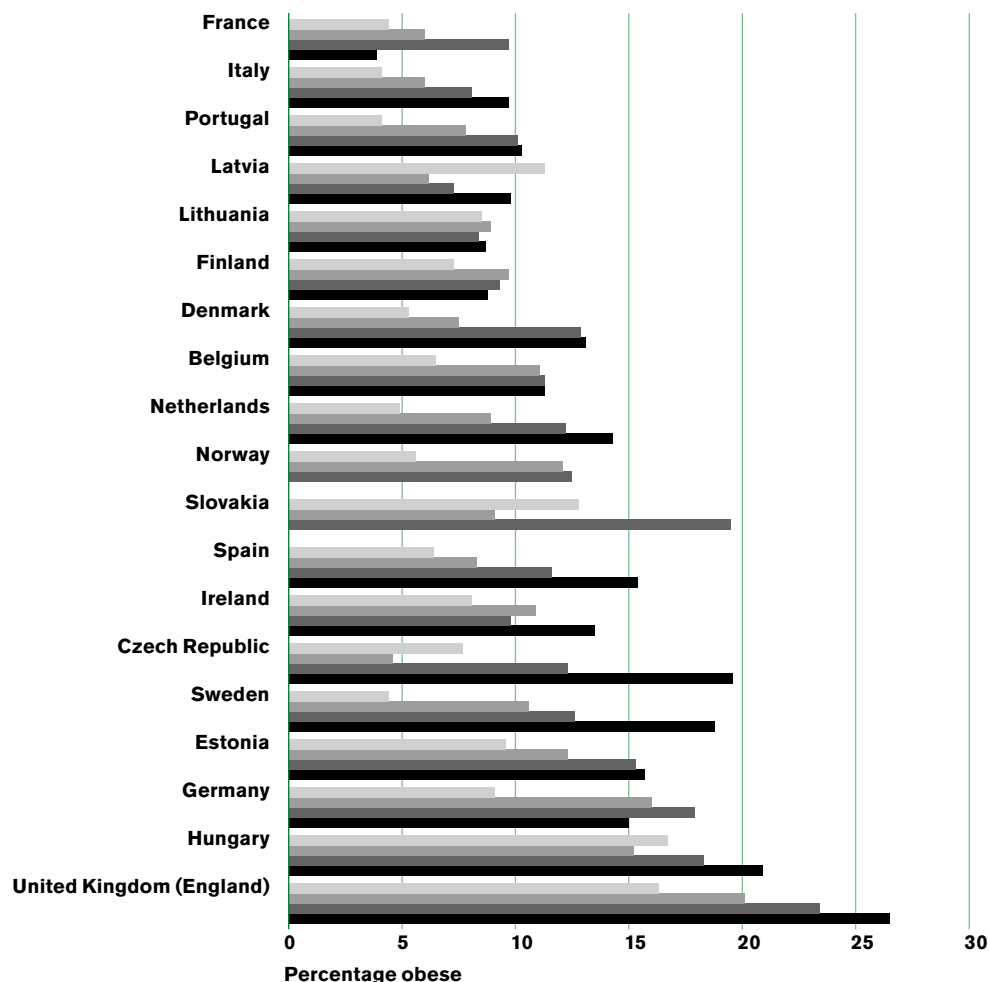
Percentage of the population that is obese^a by level of education and sex, selected countries, European Region

^aBody mass index ≥ 30 kg/m².

Source: Roskam et al. (37).

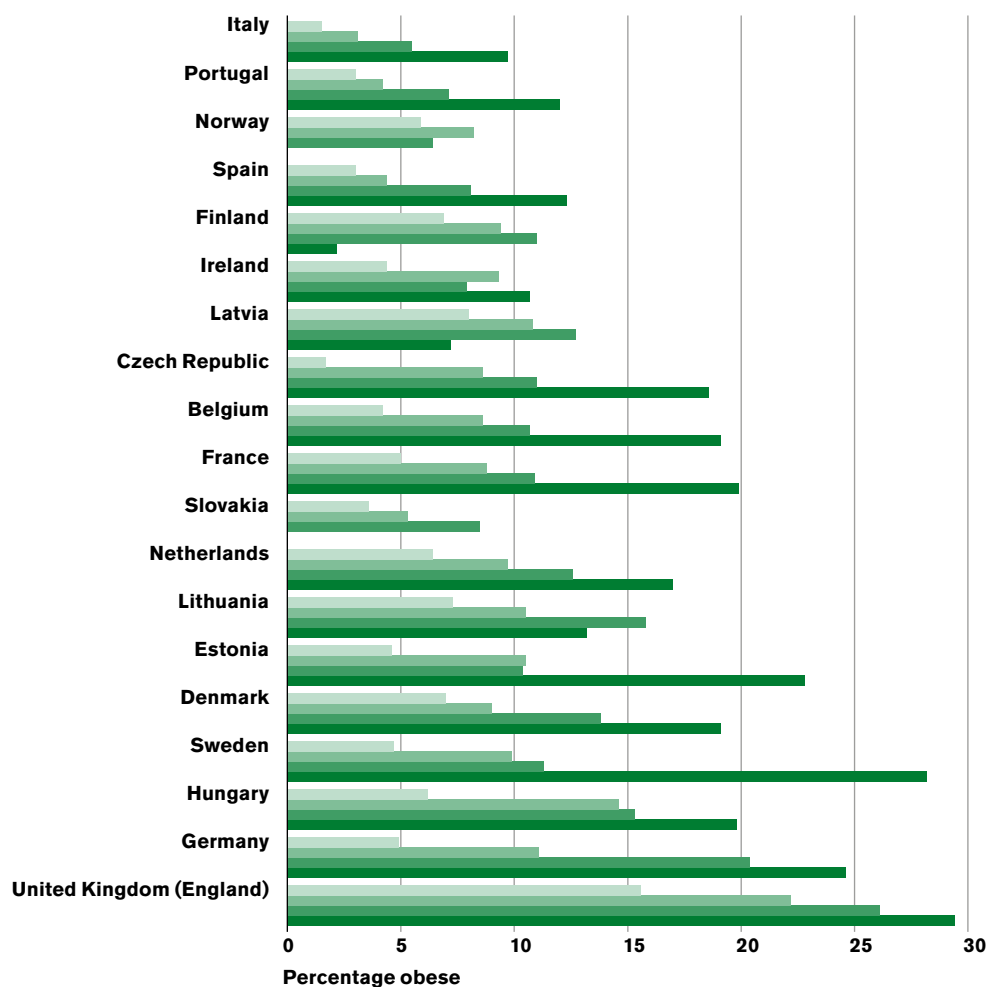
Men aged 25–44

■ Highest education
■ Second highest
■ Second lowest
■ Lowest education



Women aged 25–44

■ Highest education
■ Second highest
■ Second lowest
■ Lowest education



Conclusions

There are persistent and widespread inequities in health across the European Region. These inequities, both between and within countries, arise from inequities in the distribution of power, money and resources. As such, they are unnecessary and unjust, and tackling them should be a high priority at all levels of governance in the Region.

Action is needed on the social determinants of health – across the life-course, in wider social and economic spheres and to protect future generations. Human rights approaches support giving political priority to improving health and reducing inequities in its social determinants.

The European economic crisis and the response to it have adversely affected the social determinants of health. Taking action to reduce inequities in the social determinants of health would both improve the prospects for health and bring wider social benefits that enable people to achieve their capabilities.

Countries can use health equity in all policies as a key commitment to inform further action to reduce inequities in health, address its social determinants and reduce the perpetuation of inequities.

Nevertheless, new systems of governance and delivery are also required. These need to operate at all levels of governance – involving both the whole of society and the whole of government. They need to give individuals, groups and communities a real say in decisions that affect their lives.

In all countries in the Region, it is recommended that reducing health inequities should become one of the main criteria used to assess health system performance and the performance of government as a whole. It should also be a principal criterion for assessing the work of WHO in the Region.

It is recommended that all 53 countries in the Region establish clear strategies to redress the current patterns and magnitude of health inequities by taking action on the social determinants of health. Countries should undertake regular reviews of these strategies. These should be reported to WHO and discussed at regular regional meetings.

It is recognized that European countries are at very different starting points in terms of health, health equity and socioeconomic development. For some countries in the Region, the recommendations are ambitious and aspirational. Although this may limit what is feasible in the short term and the time scale for addressing specific issues, it should not affect the long-term aspirations of the strategy. Progressive steps towards realizing these ambitions should be developed, covering: the life-course – perpetuation across generations, early years, working and older ages; wider societal influences – social protection, communities and social exclusion; the

broader context – the economy, sustainability and the environment; and the systems needed for delivery – governance for health, prevention, treatment, the evidence base and monitoring.

This review has compiled robust evidence on what should be done and the action required for implementation. It is crucial that countries across the Region work together to reduce health differences both within and between countries by using and building on this evidence to create strategies that deliver better health for all their populations.

References

1. *Health 2020: a European policy framework supporting actions across government and society for health and well-being*. Copenhagen, WHO Regional Office for Europe, 2012 (<http://www.euro.who.int/en/what-we-do/health-topics/health-policy/health-2020-the-european-policy-for-health-and-well-being>, accessed 15 July 2013).
2. Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008 (http://www.who.int/social_determinants/thecommission/finalreport/en/index.html, accessed 15 July 2013).
3. European health for all database [online database]. Copenhagen, WHO Regional Office for Europe, 2013 (<http://data.euro.who.int/hfad/>, accessed 15 July 2013).
4. Livslängden i Sverige 2001–2010. *Livslängdstabeller för riket och länen [Life expectancy in Sweden 2001–2010. Life tables for the country and by county]*. Stockholm, Statistics Sweden, 2011 (Demografiska rapporter [Demographic reports] 2011:2; http://www.scb.se/statistik/_publikationer/BE0701_2001110_BR_BE51BR1102.pdf, accessed 15 July 2013).
5. Sen A. *Development as freedom*. New York, Alfred A. Knopf, 1999.
6. Venkatapuram S. *Health justice*. Cambridge, Polity, 2011.
7. *Health 2020: policy framework and strategy*. Copenhagen, WHO Regional Office for Europe, 2012 (http://www.euro.who.int/__data/assets/pdf_file/0020/170093/RC62wd08-Eng.pdf, accessed 15 July 2013).
8. Bradshaw J. *Social exclusion, disadvantage and vulnerability task group background paper 3: child poverty in the WHO European Region*. Copenhagen, WHO Regional Office for Europe, 2012.
9. *The state of the world's children 2007*. New York, UNICEF, 2007.
10. European Union Statistics on Income and Living Conditions (EU–SILC) [online database]. Luxembourg, Eurostat, 2013 (http://epp.eurostat.ec.europa.eu/portal/page/portal/microdata/eu_silc, accessed 15 July 2013).
11. Emerging challenges for children in eastern Europe and central Asia. Multiple indicator cluster survey in 12 countries [online database]. Geneva, UNICEF, 2008 (<http://www.micsinfo.org/home.aspx>, accessed 15 July 2013).
12. Bradshaw J, Mayhew E, Alexander G. *Minimum social protection for families with children in the CEE/CIS countries in 2009: a report for UNICEF*. York, University of York, Social Policy Research Unit, 2010.
13. *Innocenti social monitor 2009. Child well-being at a crossroads: evolving challenges in central and eastern Europe and the Commonwealth of Independent States*. Florence, UNICEF Innocenti Research Centre, 2009.
14. Siegrist J, Rosskam E, Leka S. *Report of task group 2: employment and working conditions including occupation, unemployment and migrant workers*. Copenhagen, WHO Regional Office for Europe, 2012.
15. Wahrendorf M, Dragano N, Siegrist J. Social position, work stress, and retirement intentions: a study with older employees from 11 European countries. *European Sociological Review*, 2012, DOI: 10.1093/esr/jcs058.
16. Survey of health, ageing and retirement in Europe [web site]. Munich, Research Unit SHARE, 2012 (<http://www.share-project.org>, accessed 15 July 2013).
17. Unemployment rate by sex and age groups – annual average, % [online database]. Brussels, Eurostat, 2011 (http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=une_rt_a&lang=en, accessed 15 July 2013).
18. TransMonEE [online database]. Geneva, TransMonEE, 2004–2013 (<http://www.transmonnee.org/>, accessed 15 July 2013).
19. Healthy life years and life expectancy at birth, by gender [online database]. Brussels, Eurostat, 2012 (http://epp.eurostat.ec.europa.eu/portal/page/portal/product_details/dataset?p_product_code=TSDPH100, accessed 15 July 2013).
20. Stuckler D, Basu S, McKee M. Budget crises, health, and social welfare programmes. *British Medical Journal*, 2010, 340:3311.
21. Social protection floor initiative [web site]. Geneva, Social Protection Floor Work Group, International Labour Organization, 2010 (<http://www.ilo.org/public/english/protection/secsoc/downloads/spfibrochure-en.pdf>, accessed 15 July 2013).
22. *Environment and health risks: a review of the influence and effects of social inequalities*. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/__data/assets/pdf_file/0003/78069/E93670.pdf, accessed 15 July 2013).
23. *2010 EPHA briefing on health inequalities*. Brussels, European Public Health Alliance, 2010.
24. Putnam RD. *Making democracy work: civic traditions in modern Italy*. Princeton, NJ, Princeton University Press, 1993.
25. *Social and gender inequalities in environment and health*. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/__data/assets/pdf_file/0010/76519/Parma_EH_Conf_pb1.pdf, accessed 15 July 2013).
26. CEU Center for Environmental Policy and Law, Health and Environment Alliance and Coalition for Environmental Justice. *Making the case for environmental justice in central and eastern Europe*. Brussels, Health and Environment Alliance, 2007.
27. *Health and environment in Europe: progress assessment*. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/__data/assets/pdf_file/0010/96463/E93556.pdf, accessed 15 July 2013).
28. *Access to improved sanitation and wastewater treatment*. Copenhagen, WHO Regional Office for Europe, 2009 (http://www.euro.who.int/__data/assets/pdf_file/0009/96957/1.3-Access-to-improved-sanitation-and-wastewater-treatment-EDITED_layouted.pdf, accessed 15 July 2013).
29. Castro JE. *Water, power and citizenship: social struggle in the Basin of Mexico*. Basingstoke, Palgrave Macmillan, 2006.
30. Braubach M, Jacobs DE, Ormandy D. *Environmental burden of disease associated with inadequate housing*. Copenhagen, WHO Regional Office for Europe, 2011 (http://www.euro.who.int/__data/assets/pdf_file/0017/145511/e95004sum.pdf, accessed 15 July 2013).
31. Supplementary indicators to unemployment by sex and nationality – annual average [online database]. Brussels, Eurostat, 2013 (http://appsso.eurostat.ec.europa.eu/nui/show.do?dataset=lfsl_sup_nat_a&lang=en, accessed 15 July 2013).
32. Kentikelenis A et al. Health effects of financial crisis: omens of a Greek tragedy. *Lancet*, 2011, 378:1457–1458.
33. *Governance and delivery mechanisms task group report*. Copenhagen, WHO Regional Office for Europe, 2012.
34. Olshanskaya M. *Overheated: two decades of energy transition in the former Soviet Union*. New York, United Nations Development Programme, 2009.
35. Kickbusch I, Gleicher D. *Governance for health in the 21st century: a study conducted for the WHO Regional Office for Europe*. Copenhagen, WHO Regional Office for Europe, 2011 (http://www.euro.who.int/__data/assets/pdf_file/0010/148951/RC61_InfDoc6.pdf, accessed 15 July 2013).
36. *The Worldwide Governance Indicators, 2011 update*. Washington, DC, The World Bank, 2011 (<http://www.govindicators.org>, accessed 15 July 2013).
37. Roskam AJ et al. Comparative appraisal of educational inequalities in overweight and obesity among adults in 19 European countries. *International Journal of Epidemiology*, 2010, 39:392–404.
38. *Fair society, healthy lives: strategic review of health inequalities in England post-2010*. London, Marmot Review Team, 2010 (www.instituteofhealthequity.org, accessed 15 July 2013).

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

World Health Organization Regional Office for Europe

UN City
Marmorvej 51
DK-2100 Copenhagen Ø
Denmark

Tel.: +45 45 33 70 00
Fax: +45 45 33 70 01
E-mail: contact@euro.who.int
Web site: www.euro.who.int

Member States

Albania
Andorra
Armenia
Austria
Azerbaijan
Belarus
Belgium
Bosnia and Herzegovina
Bulgaria
Croatia
Cyprus
Czech Republic
Denmark
Estonia
Finland
France
Georgia
Germany
Greece
Hungary
Iceland
Ireland
Israel
Italy
Kazakhstan
Kyrgyzstan
Latvia
Lithuania
Luxembourg
Malta
Monaco
Montenegro
Netherlands
Norway
Poland
Portugal
Republic of Moldova
Romania
Russian Federation
San Marino
Serbia
Slovakia
Slovenia
Spain
Sweden
Switzerland
Tajikistan
The former Yugoslav Republic of Macedonia
Turkey
Turkmenistan
Ukraine
United Kingdom
Uzbekistan

