

# WHO European review of social determinants of health and the health divide



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The European region has seen remarkable health gains in those populations that have experienced progressive improvements in the conditions in which people are born, grow, live, and work. However, inequities, both between and within countries, persist. The review reported here, 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 health policy framework for Europe: Health 2020. 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. 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.

## Introduction

This report presents the recommendations of the Review of Social Determinants of Health and the Health Divide, which addressed inequities in health between and within countries across the 53 Member States of the European region. The review was commissioned to support the development of the new health policy framework for Europe: Health 2020. 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-income, middle-income, 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 European region includes countries with some of the best levels of health and narrowest health inequities in the world. 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, which are increasingly affluent, with developed welfare states and high-quality education and health services, 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 (figure 1). Furthermore, 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 (figure 2). Since 2008, the economic crisis, which was more serious than most 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.

The Review of Social Determinants of Health and the Health Divide 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 open to all is to ensure universal coverage of health care. Another is to focus on types of behaviour (smoking, diet,

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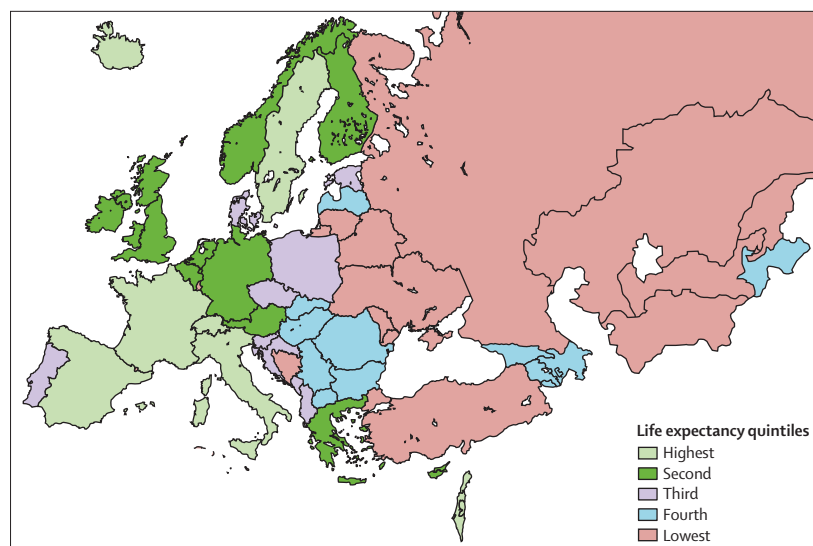


Figure 1: Life expectancy in countries in the WHO European region, 2010 (or latest available data). Data from WHO health for all database.<sup>1</sup>

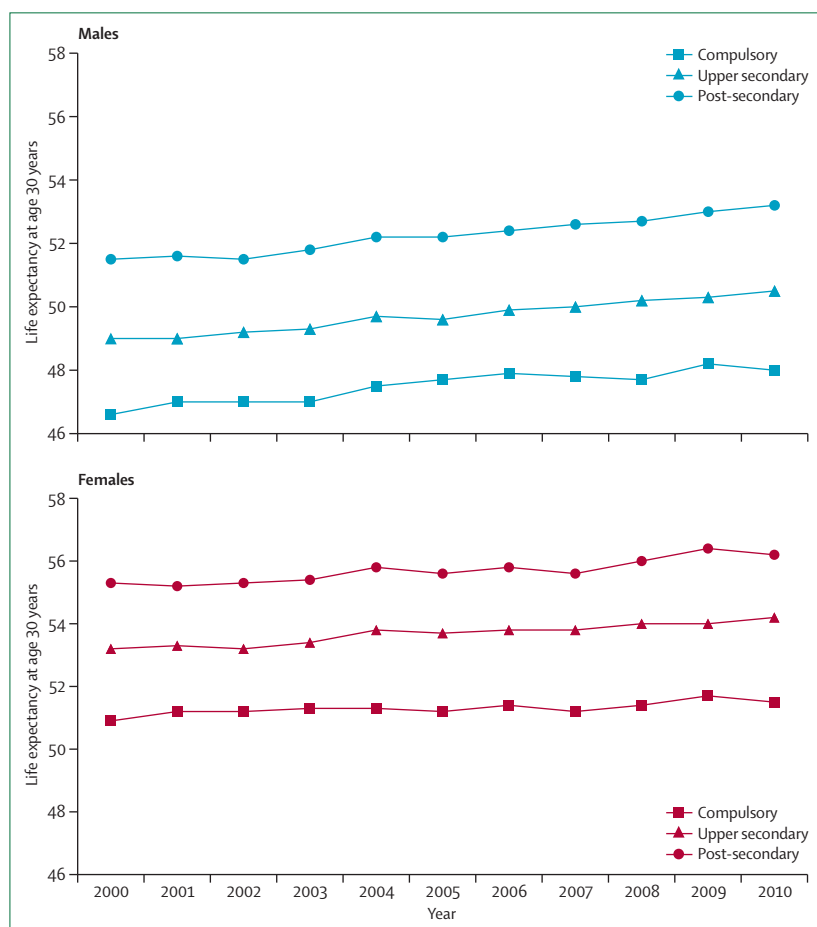


Figure 2: Life expectancy trends in Sweden 2000–10, by education and sex  
Reproduced with permission of Statistics Sweden.<sup>7</sup>

and alcohol) that are the immediate cause of part of these health inequities but are also socially determined. The review endorses both these responses. But the recommendations of the review 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 these conditions.

### Action needed across society

Systematic differences in health between social groups, that are avoidable by reasonable means, are unfair. Hence the term “health inequities” is used throughout this review to describe these avoidable inequalities.

The analysis shows that action is needed 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, but they also have a leadership role in advancing the case that health is an outcome 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 it 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 there are other unnecessary and undesirable social and health outcomes. 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 wellbeing, such as greater social cohesion, greater efforts for climate-change mitigation, and better education.

### Areas for action—emphasising priorities

Countries should have two clear aims: improving average health and reducing health inequities by striving to bring the health of everyone up to levels achieved by the most advantaged. Improving the levels and equitable distribution of the social determinants should achieve both aims. Similarly, to reduce health gaps between countries, efforts should be made to raise the level of the least healthy countries to that of the healthiest countries. To achieve this goal, two types of strategy are needed: within each country action on social determinants to improve average health, and reduce health inequities; and action at transnational levels to address the causes of inequities between countries.

The review commissioned 13 task groups that reviewed data on social determinants of health and strategies to promote health equity within and between countries in the European region and the rest of the world. On the basis of this evidence, the review grouped its recommendations into four themes—life course stages, wider society, the macro-level broader context, and systems of governance (figure 3).

#### 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 (working ages and older ages) of the life course are not important. These stages 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. Reducing stress at work, tackling long-term unemployment through active labour market programmes, and addressing the causes of social isolation are essential.

#### Wider society

The most effective actions to achieve greater health equity at a societal level are actions that create or reassert

societal cohesion and mutual responsibility. The most tangible and practical action is to ensure an adequate level and distribution of social protection, according to need. In many countries this action requires improvements in the level of provision. In all countries adequate social protection necessitates making better use of existing provisions—such as making progress to increase the proportion of people who have the minimum standard of living needed for participation in society and maintaining health.

Supporting action to create cohesion and resilience at local level is essential, through a whole-of-society approach. At the local level, this approach encourages the development of partnerships with those affected by inequity and exclusionary processes by 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 recognising their fundamental human rights—including the right to health.

#### Macro-level context

There are wider influences, both within countries and transnationally that shape the lives, human rights, and the health of people in the European region. In the short to medium term the priority is to address the health consequences of the current financial crisis. Recognition of the health and social consequences of economic austerity packages must be a priority in further shaping of economic and fiscal policy in European countries. The views of ministers for health and social affairs must be heard in the negotiations about such austerity packages. In particular, at a transnational level, WHO, UNICEF, and the International Labour Organisation 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 environmental, social and economic policy, and practice are brought together.

#### Systems of governance and delivery

Improvements in health and its social determinants will not be achieved without a significant refocusing of delivery systems to a whole-of-government and whole-of-society approach. The starting point is the health system—what it does itself and how it influences others to achieve better health and greater equity. Achieving these objectives requires greater coherence of action across all sectors (policies, investments, 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 universal access is established, it is to be protected and must progressively be extended to all countries in the European region.

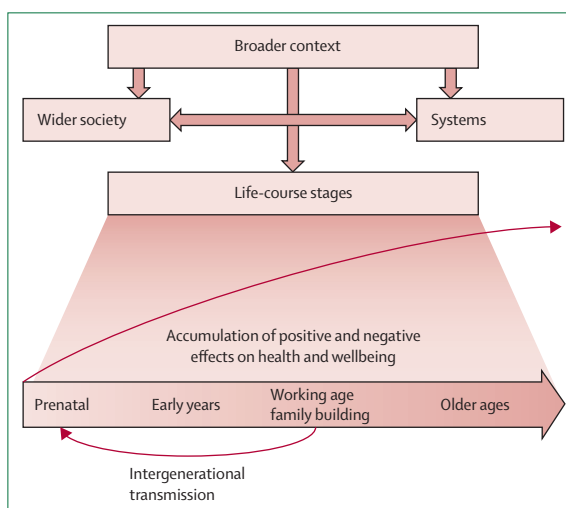


Figure 3: Broad themes

Action on prevention must include reduction in the immediate causes of inequity within and between countries (eg, alcohol consumption, smoking, and obesity). Effective strategies go beyond provision of information and include taxation and regulation. Evidence suggests that addressing the causes of the causes is the right way to proceed with these strategies; ensuring people have the skills and control over their lives to be able to change behaviours.

Nothing will happen without monitoring and adequate review. All 53 WHO European countries should 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 reviews should be reported to WHO and discussed at regular regional meetings.

#### New approaches

This review draws on the findings and recommendations of the Commission on Social Determinants of Health: 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 for promoting health equity (panel 1) that could be applied to the diversity of countries that make up the European region; a region that is diverse in national income, social development, history, politics, and culture.

Several new themes emerged from the review. Human rights are central in our approach to action on the social determinants of health; human rights embody fundamental freedoms and the societal action necessary to secure those freedoms. As well as addressing harmful influences, developing strategies and actions based on the resilience of individuals and

**Panel 1: Key issues in understanding and promoting health equity**

- A social gradient in health exists (ie, 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, as well as addressing those at the bottom of the social gradient and who are most vulnerable. To achieve both these objectives, we propose policies that are universal but with attention and intensity that is proportionate to need.
- We must address the social determinants of health, such as the conditions in which people are born, grow, live, work, and age—these components 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.
- Advantages and disadvantages in health and its social determinants accumulate over the life course. This process begins with pregnancy and early child development and continues with school, the transition to working life, employment, and working conditions, and circumstances affecting older people.
- Processes of exclusion should be addressed rather than focusing simply on addressing the 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.
- Develop strategies and actions based on the resilience, capabilities, and strengths of individuals and communities. The hazards and risks they are exposed to need to be addressed.
- 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 emphasised and the effect of actions and policies for inequities on future generations should be considered and action taken to reduce potential adverse effects.
- All the social determinants of health can affect genders differently. In addition to biological sex differences, fundamental social differences exist in the way women and men are treated and the assets and resilience they possess. In all societies, these gender relations affect health to varying degrees and should shape actions taken to reduce inequities.

communities is important; empowerment is central. The life course emerges as the right way to plan action on social determinants of health. Although the review emphasises early childhood, it also makes strong recommendations for older children and adults. Intergenerational equity features strongly in addition to intragenerational equity. Strong emphasis is needed on joint action on social determinants of health and sustainable development; both imply a strong commitment to social justice. In addressing health inequity, the strategies that should be given priority are those that are universal but are resourced and delivered with an intensity that is related to the level of social need (proportionate universalism).

Europe does not need to be so divided in health, depressed by gloomy economic prospects, and failing in its environmental ambitions. Instead, the review suggests, Europe could move towards health equity, sustainable prosperity, and social cohesion across the whole region. To achieve this change the 53 member

states of the WHO European region need to work together and take mutual responsibility.

**Do something, do more, do better**

The key message “do something, do more, do better” emerged from the work of the task groups, set up to review what actions would work in the various countries in the European region. 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 policies can be improved to deal with large and persistent health inequities. In the richest countries of Europe, there is scope for improved action to reduce these inequities.

The review, drawing on the research evidence brought together by the task groups, gives recommendations that apply across the diversity of countries in the European region and 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 countries, regions, and cities using the evidence-based recommendations in this report to develop policies and programmes specific to each of the 53 member states of the European region and, indeed, to cities and districts within those countries.

**Social determinants, human rights, and freedoms**

What is perceived as a tension between action on social determinants and individual freedoms has given rise to a vibrant debate. This review calls for social action—but individual freedoms and responsibilities are a feature of the approach taken by the review, drawing on Amartya Sen’s insights on freedoms to enable people to lead a life they have reason to value.<sup>3</sup> 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, collective resources provided by the communities of which they are part, and welfare state institutions. The right to health entails rights to equity in the social determinants of health.

In other words, as Sridhar Venkatapuram 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.<sup>4</sup>

**Action in a challenging 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 could meet the demands both of efficiency and justice. As a companion study for Health 2020 notes, prevention is a “good buy”.<sup>3</sup> Furthermore, action on social determinants of health leads to other benefits to society, which might in turn have more immediate

### Panel 2: Recommendation 1(a)—provide adequate social and health protection for women, mothers-to-be, and young families

#### Specific actions

- 1 Ensure that all women and girls have accessible, affordable and high-quality sexual and reproductive health services. This includes access to modern contraception and care in pregnancy and childbirth. Aside from safe delivery as a basic right, such services help to decrease smoking rates in pregnancy and increase breastfeeding and provide support for effective parenting. These services should identify families at risk early and refer to appropriate services.
- 2 Ensure that strategies to reduce social and economic inequities benefit women of childbearing age and families with young children.
- 3 Health ministers should act as advocates for social systems that provide income protection, adequate benefits, and progressive taxation to reduce poverty among children and pensioners.
- 4 Ensure that parenting policies and services empower women with children to take control over their lives, support the health and development of their children, and support a greater parenting role for men. In particular, family-friendly employment policies should be strengthened by introducing more flexible working hours—without turning to insecure short-term contracts—and making affordable child care available, to help parents combine work with their parental responsibilities.

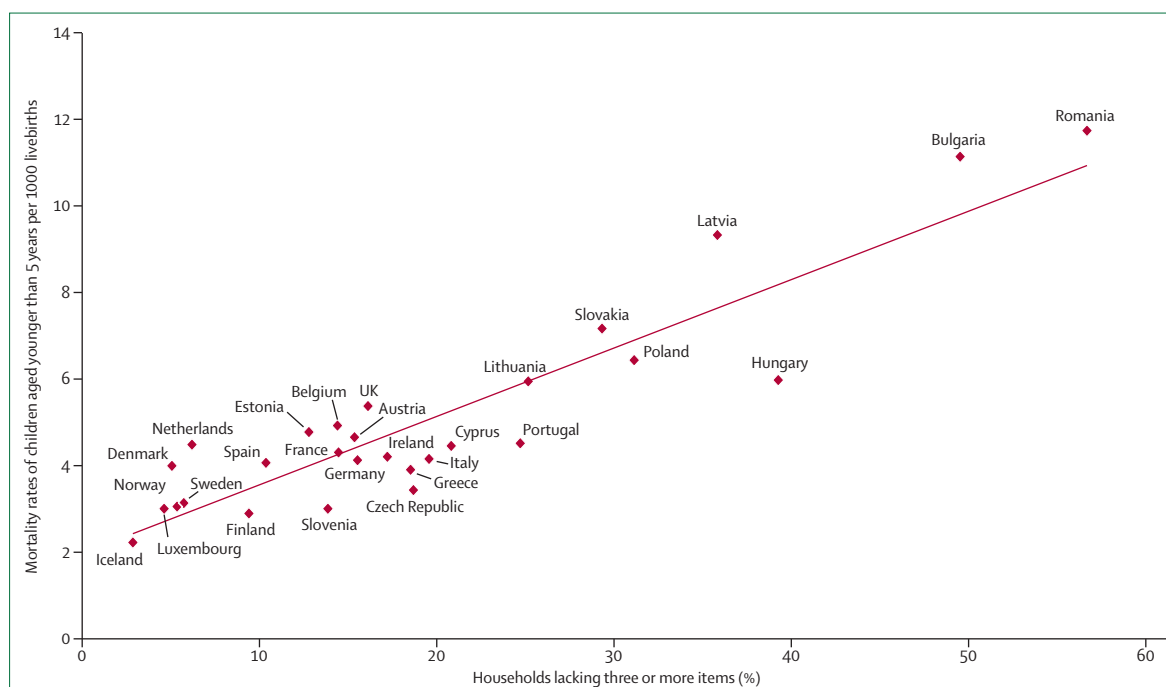


Figure 4: Mortality among children younger than five years of age and percentage of deprived households (lacking three or more essential items) in selected countries in the WHO European Region

Data from UNICEF<sup>5</sup> and Eurostat database.<sup>6</sup> Reproduced with permission of Bradshaw J and Mayhew E (University of York, York, UK, personal communication).

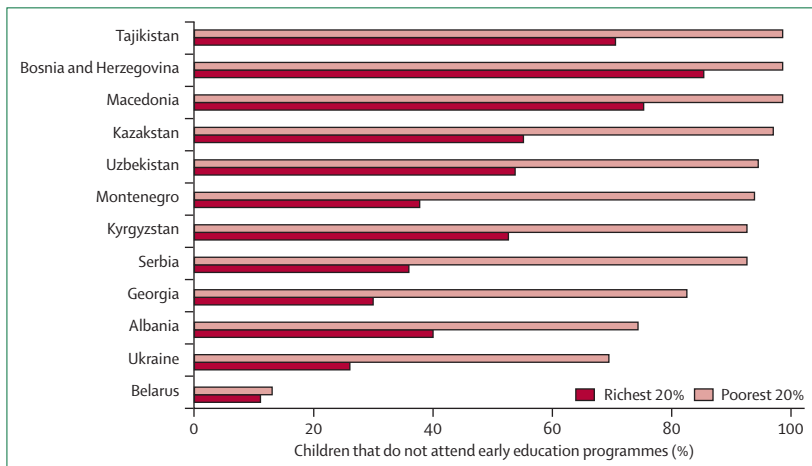
economic benefits. For example, a more socially cohesive, educated population is likely to have lower rates of crime and civil disorder, a more highly skilled workforce, and can enable people to lead lives they have reason to value, as well as having better health and greater health equity.

Current economic difficulties are a reason for action on social determinants of health not inaction. 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 a reduction in investment in health and its social determinants. Yet the evidence in this review is clear: investment in early child development, active labour-market policies, social protection, housing, and

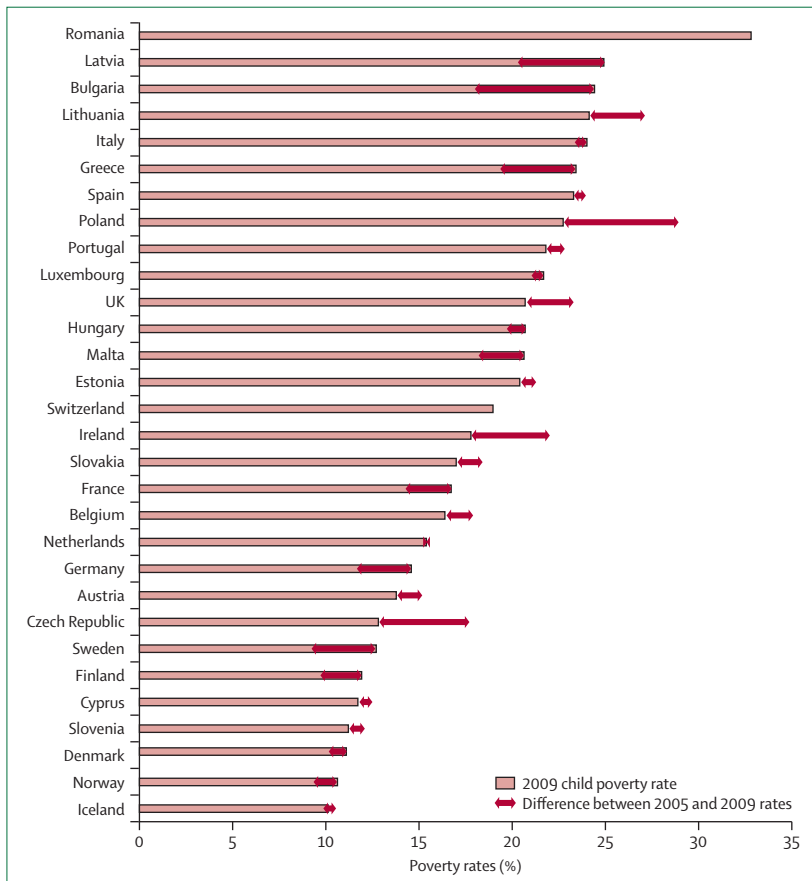
### Panel 3: Recommendation 1(b)—provide a universal high-quality, affordable early-years education and childcare system

#### Specific actions

- 1 Ensure universal access to a high-quality, affordable early-years education and childcare system as the essential bedrock in levelling social inequities in educational attainment, reducing poverty and promoting gender equality
- 2 Make special efforts to include children with disabilities and children from minority ethnic groups, such as Roma, in education services



**Figure 5: Children aged 3–5 years that do not attend any form of early education programme in selected Commonwealth of independent states and central and eastern European countries**  
Data from MICS database.<sup>7</sup>



**Figure 6: Child poverty rates in selected European countries in 2009 and change since 2005**  
Analysis of Eurostat database.<sup>10</sup> Reproduced with permission of Bradshaw J (University of York, York, UK, personal communication). Solid bars represent the 2009 child poverty rate, defined as the percentage of children living in families under 60% of median income. 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 between 2005 and 2009.

mitigation of climate change will help protect populations from the adverse effects of the economic crisis and lay the foundation for a healthier future.

## Recommendations and actions needed

### Life course

#### *Perpetuation of inequities across generations*

The review makes recommendations on inequities across generations (panel 2). 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. Furthermore, morbidities such as obesity and hypertension, as well as behaviours that put health at risk, such as smoking, recur in successive generations. Sustainable reduction of health inequities requires action to prevent relative and absolute disadvantage of parents being passed to their children, their grandchildren, and subsequent generations. The strongest devices to break such vicious circles of disadvantage lie at the start of life. The recommendations of the review address key factors contributing to the perpetuation of health inequities.

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

Household deprivation can affect the chances of a child dying before the age of 5 years (figure 4). Deprivation in early life is also associated with deficits in development across physical, social and emotional, and cognitive and language domains of development. These deficits have lifelong effects on life chances and subsequent health.

#### *Early years*

The review makes recommendations to give all children a good start (panel 3). Actions to promote physical, cognitive, and social and emotional development of all children are crucial, 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 characterised by the following: a mother 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, 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 childhood services, with effects on parenting, can compensate for the effects on early child development of social disadvantage. In view of the nature of early childhood, the services that

support this stage of life are intergenerational and multi-disciplinary: including health care, education, and social welfare services that are aimed at parents as well as children. In most countries, these services are unlikely to be initiated through contact with the formal education sector, but through health care and child-care services.

The systems that encourage such a good start in life include policies characterised by excellent health care before and after birth, an employment and social protection system that recognises the risks posed by poverty and stress in early childhood, good parental-leave arrangements, support for parenting, and high-quality early education and care. Attendance at early education programmes varies between countries and between rich and poor within countries (figure 5).

**Panel 4: 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**

- 1 Improve psychosocial conditions in workplaces characterised by unhealthy stress.
- 2 Reduce the burden of occupational injuries, diseases, and other health risks by enforcing national legislation and regulations to remove health hazards at work.
- 3 Maintain or develop occupational health services that are financed publicly and are independent of employers.
- 4 At the international level, intensify and extend the transfer of knowledge and skills in the area of work-related health and safety from European and other international organisations, institutions, and networks to national organisations.
- 5 In low- and middle-income countries, give priority to 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 high-quality work throughout major sectors of the workforce.
- 6 In high-income countries, ensure a high level of employment, in accordance with principles of a sustainable economy, without compromising standards of decent work and policies of basic social protection.
- 7 Protect the employment rights of and strengthen preventive efforts among the most vulnerable people: especially those with insecure contracts, poorly paid part-time workers, unemployed people, and migrant workers.
- 8 Address rising levels of unemployment among young people by creating employment opportunities and ensuring they take up high-quality work through education, training and active labour market policies.

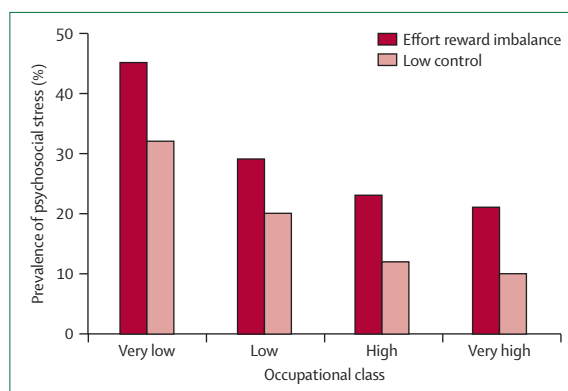
Reinforcing a good start throughout childhood and adolescence needs a focus on parenting skills, employment and social protection of parents, balancing work and family life of women and men, equitable education and social support for boys and girls throughout childhood, and good systems for developing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

**Child poverty**

Relative poverty in childhood has a strong influence on health and other outcomes throughout life and remains high in much of the WHO European region. In the eastern part of the region, despite 10 to 15 years of economic growth before the current recession, child poverty has been more or less at the same level.<sup>8</sup> The main reason why children have not benefited from this economic growth is that the average spend on family benefits in this part of the region was less than 1% of

**Panel 5: Effects of employment and good quality work on population health and health inequities**

- 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 organisations) contribute to physical and mental ill health.
- Occupational position is important for people's social status and social identity, and threats to social status due to job instability or job loss affect health and wellbeing.
- 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 disorders; such exposures follow a social gradient (figure 7). 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.



**Figure 7: Psychosocial stress and occupational class in selected European countries**

Reproduced with permission from Wahrendorf M, Dragano N, and Siegrist J.<sup>11</sup> Data are from 12 European countries in the Survey of Health, Ageing and Retirement in Europe.<sup>12</sup>

gross domestic product (GDP) compared with 2·25% in the member states of the OECD (Organisation for Economic Co-operation and Development) in 2007.<sup>9</sup>

In the western part of the region, despite higher average expenditure compared with countries to the east, the European Union (EU) survey of incomes and living conditions in 2009 revealed a huge range of child poverty rates across the region—from 10% to 33% (figure 6).<sup>6</sup> Within countries, the rate changed between 2005 and 2009 by a percentage point or more in 20 of the countries shown; 11 of which were increases.

*Working age and employment*

The review makes recommendations to reduce inequities arising from work and employment (panel 4). Employment and good quality work are of crucial importance for population health and health inequities in several interrelated ways (panel 5):

Levels of unemployment across the European region are high and vary substantially by country, age, gender, migrant status, and educational level. Unemployment levels vary substantially between countries (figures 8, 9). These levels have risen substantially in countries most affected by recession and the economic crisis—such as in Spain and Greece.

Increased health risks are associated with precarious employment, which carries a heightened risk of unemployment, and from unemployment itself, especially

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

*Older ages*

The review makes recommendations to reduce health inequities among older people (panel 6). Understanding the underlying determinants of health and inequities among older people is a priority for Europe, the region in which population ageing is most advanced. Effective strategies are needed 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. Proportionately more attention needs to be paid to older adults with lower incomes when designing these preventive programmes. Additionally, 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 include a beneficial effect on inequities in older populations.

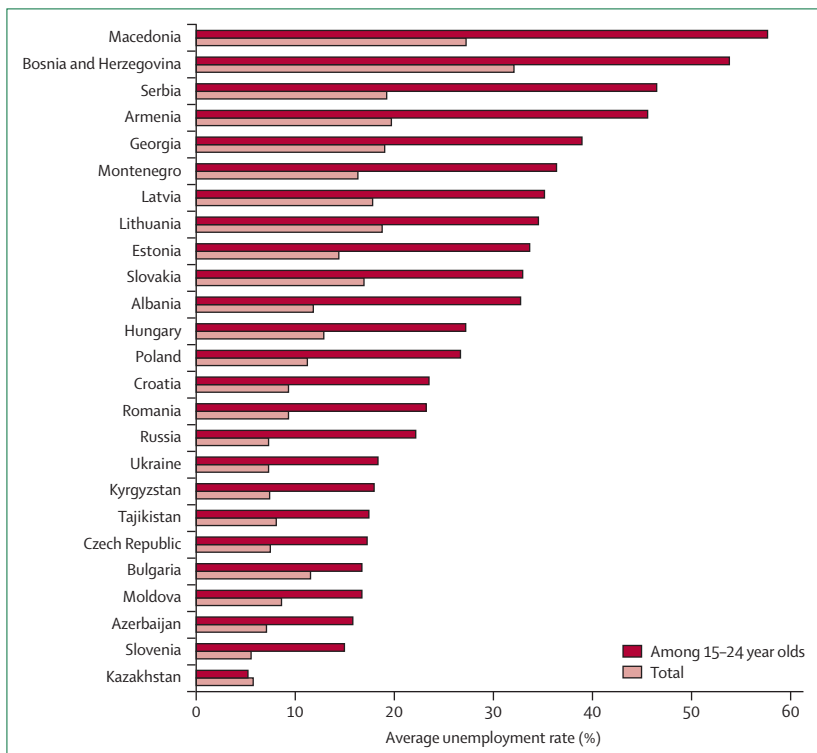


Figure 8: Unemployment rate in central and eastern European countries, Commonwealth of independent states, and Georgia by age, Labour Force Survey 2009  
Data from the TransMONEE database.<sup>13</sup>

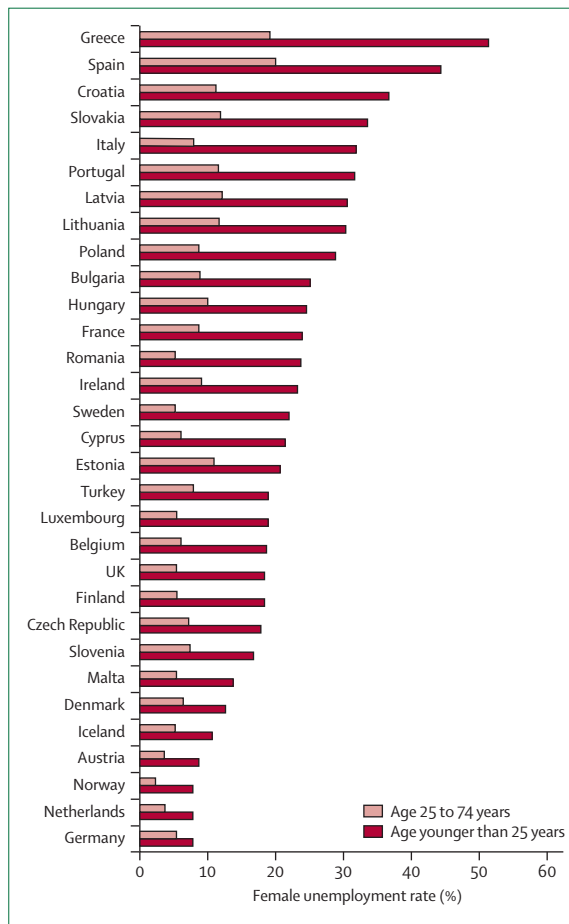


Figure 9: Female unemployment rates in selected European countries by age, 2011  
Data from the Labour Force Survey.<sup>14</sup>



In Europe, women generally live longer than men but spend more years not in good health (figure 10). The difference between the gender gaps in life expectancy and years not in good health determines who can expect to live in good health for longer. In Portugal, women live 6 years longer than men but spend 8 years more not in good health, and therefore 2 years less than men in good health. Conversely, in Estonia, women live 11 years longer than men but only 6 years longer not in good health. So they spend 5 years more in good health than men.

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

## Wider society

### Social protection

The review makes recommendations to improve social protection (panel 7). Social protection policies can create a buffer against loss of income 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 organisations. Both are important for health and wellbeing. 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.

The less people achieve in terms of individual resources, the more important it is that they are 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 Europe 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 on these inequities is greater for women than it is 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 (figure 11). This outcome suggests that gains can be made most

easily by countries with the least developed social protection systems. Even modest increases would be of importance in poorer countries in the European region.

The objective of the joint UN 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.<sup>17</sup> A key aim of policy in the European region should be the

**Panel 6: Recommendation 1(d)—introduce coherent effective intersectoral action to tackle inequities at older ages, both to prevent and manage the development of chronic morbidity and to improve survival and well-being across the social gradient**

### Specific actions

- 1 Focus action on addressing social isolation, living conditions, adequacy of pensions, opportunities for physical activity, and access to health and social care
- 2 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

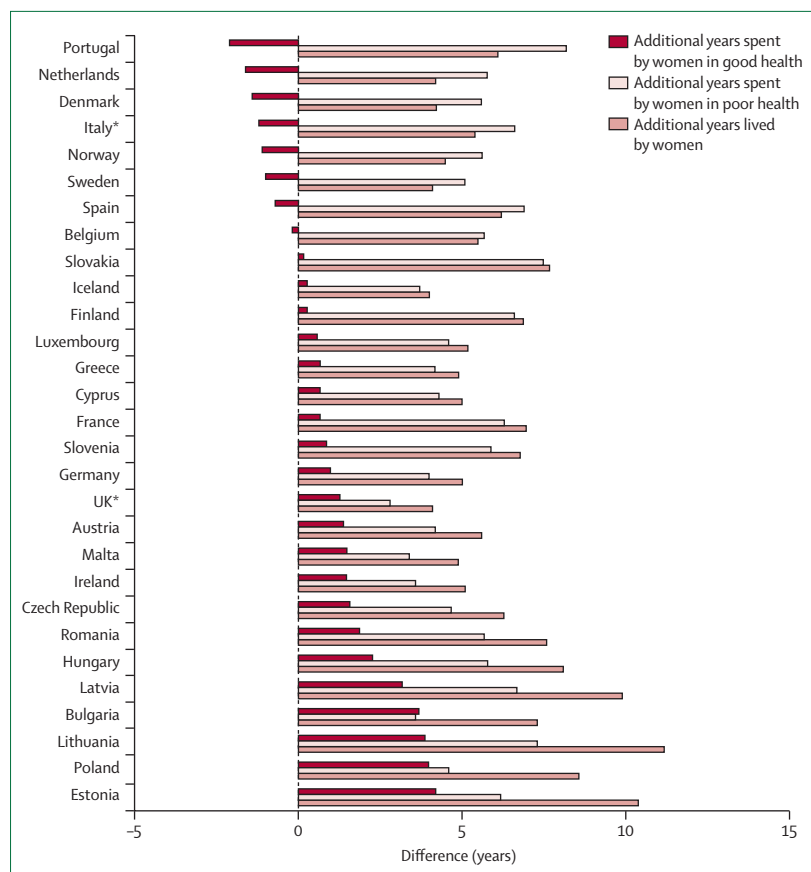


Figure 10: Differences between women and men in healthy life years, years not in good health, and life expectancy at birth in selected European countries

Data from the Eurostat database.<sup>15</sup> \* 2008 data for Italy and UK.

**Panel 7: Recommendation 2(a)—improve the level and distribution of social protection, according to needs, as to improve health and address health inequities**

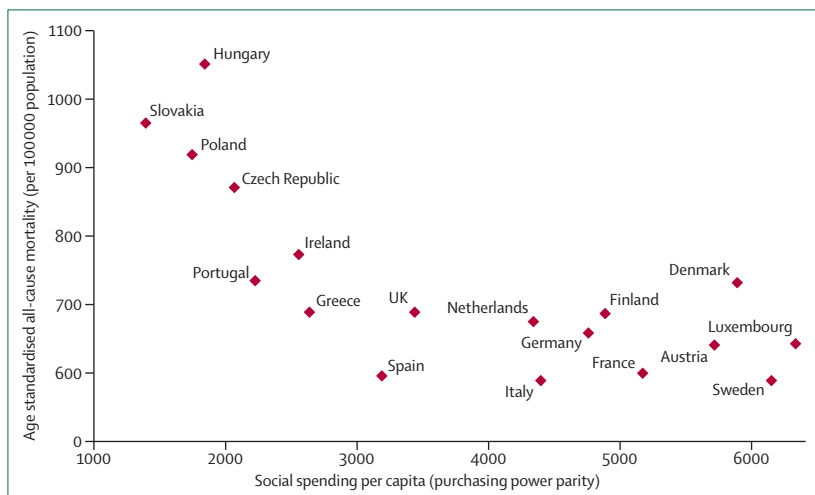
**Specific actions**

- 1 Spend more on social protection, particularly in countries with the lowest levels of social spending in the WHO European region. Increasing social protection for those countries with very small social protection systems has proportionately greater impact than increased spending in countries with more generous social protection systems. This can be summarised as follows:
  - Do something; in countries characterised by small amounts of effort, in terms of social protection, make some programme improvements.
  - Do more; in countries characterised by medium to high ambitions in terms of social protection policies, further increase the ambitions of social protection programmes.
  - Do better; among the most developed welfare states, where the redistributive and protective capacity of the welfare state has diminished, improve the levels of social protection in general and for the most vulnerable people in particular.
- 2 Make more effective use of the resources already used for social protection.
- 3 Ensure a minimum standard for healthy living for all. This is not an absolute standard but one that needs to be determined country by country, based on developing national criteria using a standard international framework.
- 4 Adopt a gender equity approach to tackle social and economic inequities resulting from women being overrepresented in part-time work, getting less pay for the same job and undertaking unpaid caring roles.

**Panel 8: Recommendation 2(b)—ensure that concerted efforts are made to reduce inequities in the local determinants of health through both co-creation and partnership with those affected, civil society, and a range of civic partners**

**Specific actions**

- 1 Ensure championing of partnership and cross-sector working by local leaders
- 2 Ensure that 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
- 3 Make partnership working more extensive, including the use of individual agencies and physical resources—schools, health and community centres—as the basis for a range of other services
- 4 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 people (such as young and older people)
- 5 Adopt strategies to improve air quality and reduce health risks from air pollutants for all groups across the social gradient



**Figure 11: Social welfare spending and all-cause mortality in 18 European countries, 2000**  
Reproduced with permission from Stuckler D and colleagues.<sup>16</sup>

maintenance of minimum standards needed for healthy living.

### Gender

The social and economic roles of men and women have a significant effect on 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 burdens of care giving to different generations, paid work, and housekeeping. Men's health is more often affected by work conditions. Risk-taking and other

behaviours among men, such as violence, are encouraged by gender norms and endanger the health and wellbeing of both men and women.

Societal and economic changes affect gender roles, but societal norms and values can limit the extent to which affected people can adapt. The combined effect of these factors is to alter health outcomes and the extent of the gender gap (eg, the current 12-year life expectancy gap in Russia<sup>1</sup>). For these reasons, while differences in mortality and morbidity rates between men and women are well documented,<sup>18,19</sup> the scale of these rates varies widely across the WHO European region and is changing in many countries. The appropriate response is to adopt a gender-equity approach in tackling social and economic inequities.

### Local communities

The review makes recommendations to reduce inequities in the social determinants of health at local level (panel 8). Communities are influenced and shaped by the complex interrelations between 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, less conducive to positive health behaviours and outcomes, and where exposure to environmental factors that are detrimental to health is more likely to occur.<sup>20</sup>

People who live in areas of high deprivation are more likely to be affected by tobacco smoke, biological and chemical contamination, hazardous waste sites, air

	Health outcome	Exposure–risk relation	Population attributable fraction
Mould	Asthma deaths and DALYs in children aged 0–14 years	RR=2.4	12.3%
Dampness	Asthma deaths and DALYs in children aged 0–14 years	RR=2.2	15.3%
Lack of window guards	Injury deaths and DALYs (all ages)	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 <sup>3</sup>	2–12%
Residential second-hand smoke	Lower respiratory infections, asthma, heart disease, and lung cancer	Risk estimates ranges from 1.2–2.0 (odds ratio 4.4)	Population-attributable-fraction estimates range from 0.6–23%
Lead	Mental retardation, cardiovascular disease, behavioural problem	3% case fatality rate	66%
Indoor carbon monoxide	Headache, nausea, cardiovascular ischaemia or insufficiency, seizures, coma, loss of consciousness, death	DNS/PNS incidence 3–40%	50–64%
Formaldehyde	Lower respiratory symptoms in children	Odds ratio 1.4	3.7%
Indoor solid fuel use	Chronic obstructive pulmonary disease, acute lower respiratory infections, lung cancer	RR=1.5–3.2	6–15%

Reproduced with permission from WHO.<sup>23</sup> Summary of exposure and the population-attributable fraction of inadequate housing conditions. DALYs=disability adjusted life-years. RR=relative risk. DNS=delayed neurological sequelae. PNS=persistent neurological sequelae.

**Table: The health effects of poor-quality housing environments**

pollution, flooding, sanitation and water scarcity, noise pollution, and road traffic.<sup>21</sup> These people are less likely to live in decent housing and places that are sociable and congenial, of high social capital, that feel safe from crime and disorder, and have access to green spaces, adequate transport options, and opportunities for healthy living.

People with 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 living conditions and access to opportunities.

The way in which people experience social relationships influences health inequities. Crucial factors that might affect social relationships include how much control people have over resources and decision making, how much access they 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. However, the factors associated with strong social networks and social capital are not consistent. Some evidence suggests that social networks seem, in general, to be stronger in countries with higher rates of poverty, social capital tends to be more easily built in countries with relatively strong democracies and effective legal systems; strong civil societies contribute to the building of strong democracies.<sup>22</sup>

Spatial quality—how places and spaces are planned, designed, constructed, and managed—effects the distribution of environmental burdens and environmental benefits that affect health and inequities (table). The quality of infrastructure, including water and sanitation, are crucial to health, along with other factors.

**Panel 9: Recommendation 2(c)—take action on socially excluded groups, building on and extending existing systems that are in place for the wider society, with the aim of creating systems that are more sustainable, cohesive, and inclusive**

**Specific actions**

- 1 Address the social determinants of health and well-being among people exposed to processes that lead to social exclusion:
  - Avoid focusing on the individual attributes and behaviours of those who are socially excluded; and
  - Focus on action across the social gradient in health that is proportional to need rather than the gap in health between the most and least disadvantaged groups
- 2 Involve individuals and groups who are socially excluded in developing and implementing policy and action by putting in place effective mechanisms that give them a real say in decisions that affect their lives and by recognising their fundamental rights (such as to health, education, employment, and housing)
- 3 Develop strategies that:
  - Focus action on releasing capacity within organisations, 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; and
  - empower disadvantaged groups in their relationships with societal systems with which they have contact

Immigrant communities, as well as people living in slum conditions throughout the European region, often live in the most polluted areas.<sup>24</sup> Across central and eastern Europe, especially in the former Soviet republics, hazardous waste and chemicals are major contributors to environmental inequity.<sup>25</sup> Access to safe water has recently deteriorated in many eastern European countries, although the situation has been improving in the area as a whole.<sup>26</sup> While people living in rural areas tend to have limited access to sanitation,<sup>27</sup> the poorer groups in urban areas bear the greatest burden of

droughts that affect water supplies.<sup>28</sup> Improving the environment has been one of the rallying points of civil society in the east of the WHO European region.

*Social exclusion, vulnerability, and disadvantage*

The review makes recommendations to reduce social inequities resulting from exclusion (panel 9). 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 addressed by focusing on the attributes of specific excluded groups.

Recognising 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 vulnerabilities. This continuum does not deny the existence of extreme states of exclusion but it helps avoid the stigmatisation inherent in an approach that labels specific groups as excluded, disadvantaged, or vulnerable. This approach should also increase understanding of the processes at work and how these processes might be reversed and shift the focus from passive victims towards the potential for disadvantaged groups to be resilient in the face of vulnerabilities. The review focused on two

important examples, vulnerability among Roma and irregular migrants (ie, those without permission to either live or work in the country of residence).

The exposure of Europe's Roma to powerful social, economic, political, and cultural exclusionary processes, including prejudice and discrimination, has a negative effect on their human rights and self determination. Progress in reducing the social inequities experienced by Roma has been variable across the region. This situation is leading to gross inequities in health and wellbeing among Roma compared with other populations in the WHO European region.

Progress and implementation of programmes to reduce social inequities has been affected by the following factors: the complexity of funding arrangements; lack of data for monitoring and assessment; 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.

The Decade of Roma Inclusion provides a valuable example of this commitment—a commitment by 12 European Governments to improve the socioeconomic status and social inclusion of Roma. During this initiative, no single country did consistently well across

For more on the Decade of Roma Inclusion see <http://www.romadecade.org>

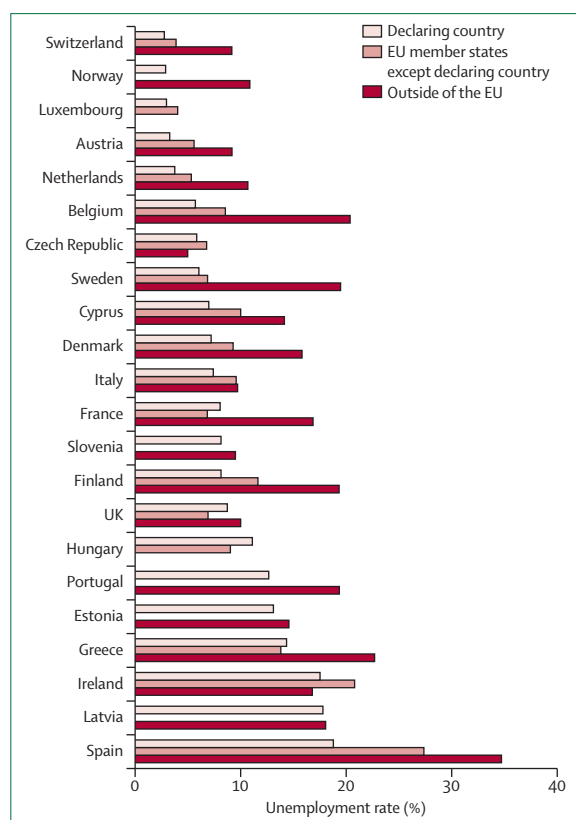


Figure 12: Unemployment rates in selected countries by country of birth, 2011. Data from the Eurostat database.<sup>29</sup>

**Panel 10: Recommendation 3(a)—use the system of taxes and transfers to promote equity as effectively as possible. The proportion of the budget spent on health and social protection programmes should be increased for countries below the current EU average**

**Specific actions**

- 1 Improve the balance between the overall level of social spending and (a) expenditure on other programmes and (b) the overall level of taxation in the countries in which these indicators are below the current EU average. In achieving these balances, promote equity effectively by adopting best practices in designing social spending programmes, including universal provision that is proportional to need and integrated social care and labour market policies that incorporate active labour market programmes.
- 2 In addressing the economic crisis, ensure that 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 countries in the region. Ensure that the views of health and social affairs ministers are heard in the negotiations about such austerity packages. In particular, at a transnational level, ensure that WHO, UNICEF, ILO, and the World Bank are given a voice.
- 3 Widen the discussion of financial stability mechanisms to give priority to socially progressive policies: for example, by considering the likely impact of taxing financial transactions.

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.

Migrants have fewer social opportunities in many countries (figure 12). Problems faced by irregular migrants are greatest among those exposed to additional exclusionary processes—for example, those who are in need of health care, unaccompanied minors, female domestic workers. States vary in the extent to which they allow irregular migrants access to social protection, including health care. Withholding access and denying them the right to the highest attainable health is seen as one important element of internal migration control—detention is another. However, these measures do not seem to have much effect on the numbers of irregular migrants; they mainly increase vulnerability to marginalisation, poverty, illness, and exploitation. Migration issues, and living conditions of regular and irregular migrants, need to be addressed by agreements between countries in Europe that do not infringe their human rights.

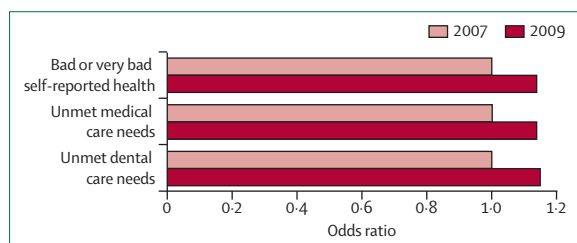


Figure 13: Changes in self-reported health and access to health care in Greece between 2007 and 2009, adjusted estimates  
Reproduced with permission from Kentikelenis A and colleagues.<sup>30</sup>

**Panel 11: 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**

- 1 Ensure that the principles of sustainable development are applied to all policies, taking account of evidence on how development in the past affects current and future generations
- 2 Include health equity assessments for current and future generations in environmental policies at all levels
- 3 Introduce fiscal policies that improve the affordability of healthy and sustainable food choices:
  - Ensure that the cost of nutritious and sustainable diet is reflected in calculations of a minimum standard of living for all;
  - 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

**Macro-level context**

*Economic issues*

The review makes recommendations on health and social expenditure (panel 10). The background to the review is the global financial crisis and the related sovereign debt crisis. These issues will have a direct, negative, lasting effect on health and its social determinants in the European region, especially if the response to the financial and debt crises does not take account of health equity. For example, the direct health effects are already becoming evident in some countries in the European region (figure 13).

These effects highlight the need to protect social and health sectors from austerity-driven cuts, and from some of the negative effects of financial support agreements between member states of the WHO European region and transnational bodies, by using other measures that have smaller negative effects both economically and on health, whenever these are available.

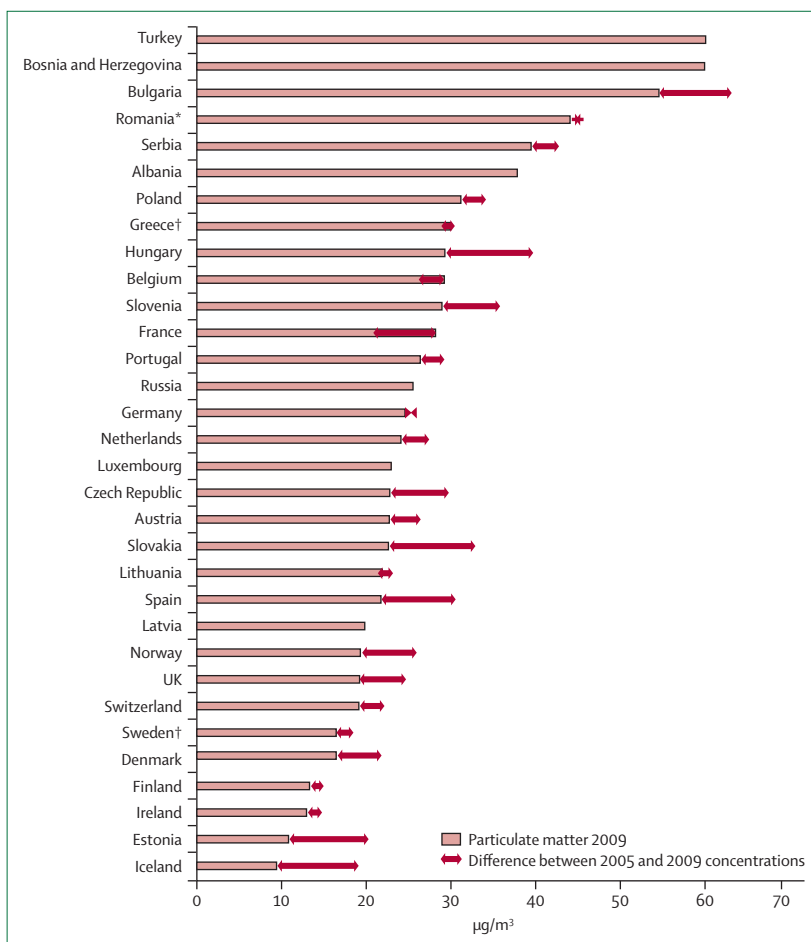


Figure 14: Annual average concentrations of particulate matter in the capital city in 2009 and change since 2005  
Data from WHO health for all database.<sup>3</sup> Solid bars represent the concentration of particulate matter in 2009. Where arrows are to the right of the bars, this shows that concentrations fell between 2005 and 2009. Where arrows are to the left of the end of the solid bar, concentrations increased between 2005 and 2009. \*2007 data. †2008 data.

### Sustainability and environment

The review makes recommendations on sustainability and environmental factors (panel 11). 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, over-consumption of animal fats is associated with increased risk of preventable diet-related diseases, including several cancers and cardiovascular disease,<sup>31</sup> while production of animal-based food to supply demand is associated with environmental costs, including water use and greenhouse gas emissions.<sup>32,33</sup> If low-income countries in the European region seek to develop their economies by emulating high-income countries, the consequences could be dire for the natural environment, equity, and health across the region. Populations in low-income and middle-income countries in Europe are likely to reap the greatest benefit from interventions that provide a healthier and safer environment because they tend to be disproportionately exposed to inadequate environmental conditions (figure 14).<sup>24</sup>

Integral to facing this challenge of reducing inequitable environmental harm is an approach endorsed in the 2011 Rio Political Declaration 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 GDP, has improved in the Commonwealth of independent states and EU countries, but much more needs to be done (figure 15).<sup>34</sup>

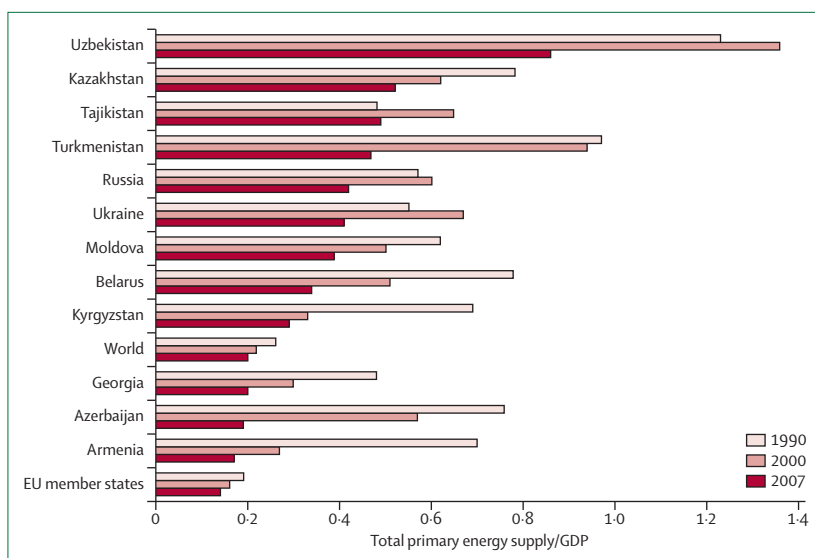


Figure 15: Energy use per dollar of GDP in selected Commonwealth of independent states, countries in the European Union, and world average

Reproduced with permission from Olshanskaya M and colleagues.<sup>34</sup> EU=European Union. GDP=gross domestic product.

### Systems

#### Governance and delivery

The review makes recommendations on systems of governance and delivery (panel 12). Governance for social determinants of health and health equity seeks to strengthen the coherence of actions across sectors and stakeholders in a manner which increases resources to redress current patterns and magnitude of health inequities and reduce inequities in the distribution of social determinants of health and of the risk 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 wellbeing through both a whole-of-society and a whole-of-government approach”.<sup>35</sup>

At a European-regional level, it is necessary to develop a much stronger institutional framework for this governance, on the basis of mutual agreements between countries, and involving the WHO European Office and

#### Panel 12: Recommendation 4(a)—governance for social determinants of health and health equity 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

- 1 At the regional level, ensure that WHO Regional Office for Europe and its partner United Nations organisations in Europe work together through the United Nations collaboration mechanism to have a voice in transnational agreements affecting the social determinants of health.
- 2 Strengthen the role of WHO to be in a position where it has the capacity and legitimacy to advise member states on developing policies on the social determinants of health and be an advocate for health equity in other relevant sectors.
- 3 Develop partnerships at all levels of government that put in place collaborative models of working based on shared priorities with other sectors.
- 4 Ensure that the coherence of actions across sectors and stakeholders is strengthened, to achieve:
  - Sufficient intensity of action—increase the resources devoted to redressing current patterns and magnitude of health inequities;
  - Long-term investment and sustainability of actions; and
  - Levelling up the gradient in health equity and the social determinants of health.
- 5 Ensure that the different needs, perspectives, and human rights of groups at risk of marginalisation and vulnerability are heard through their involvement in decision-making processes. Accompany this by effective mechanisms for adequate participation, engagement and consultation with all parts of civil society.

its partner organisations. 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 organisations, and of ordinary people, with a common interest in improving health on equal terms (panel 13, figure 16).

A key action area is to develop or strengthen mechanisms that empower people and ensure that the opinions and perspectives that are conveyed in decision-making processes reflect arguments about equity. Empowering people includes promoting civil society, enabling unions to be formed, and the free development of political and non-political organisations.

Participatory mechanisms such as citizen's 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. These mechanisms also promote greater political involvement across societies and contribute to more equitable allocation of resources.

#### Prevention and treatment

The review makes recommendations on prevention and treatment of ill health (panel 14). A comprehensive health system response is required to prevent and treat ill health equitably. Many actions can now be taken to improve population health in the short-term and medium-term while others will take longer to have an effect. To achieve sustained and equitable change in this area, a balance is therefore needed between strategies that have short-term, medium-term, and long-term results and between simpler and more complex, integrated interventions (panel 14).

Part of the health divide between European countries is associated with differences in exposure to preventable health hazards that result from inequities in the social determinants of behaviours and lifestyles—including

tobacco, alcohol, unhealthy diets, high blood pressure, cervical cancer, conditions leading to road injury, dangerous or stressful working conditions, and air pollution—and differences in accessibility and quality of health-care services. The contribution of these

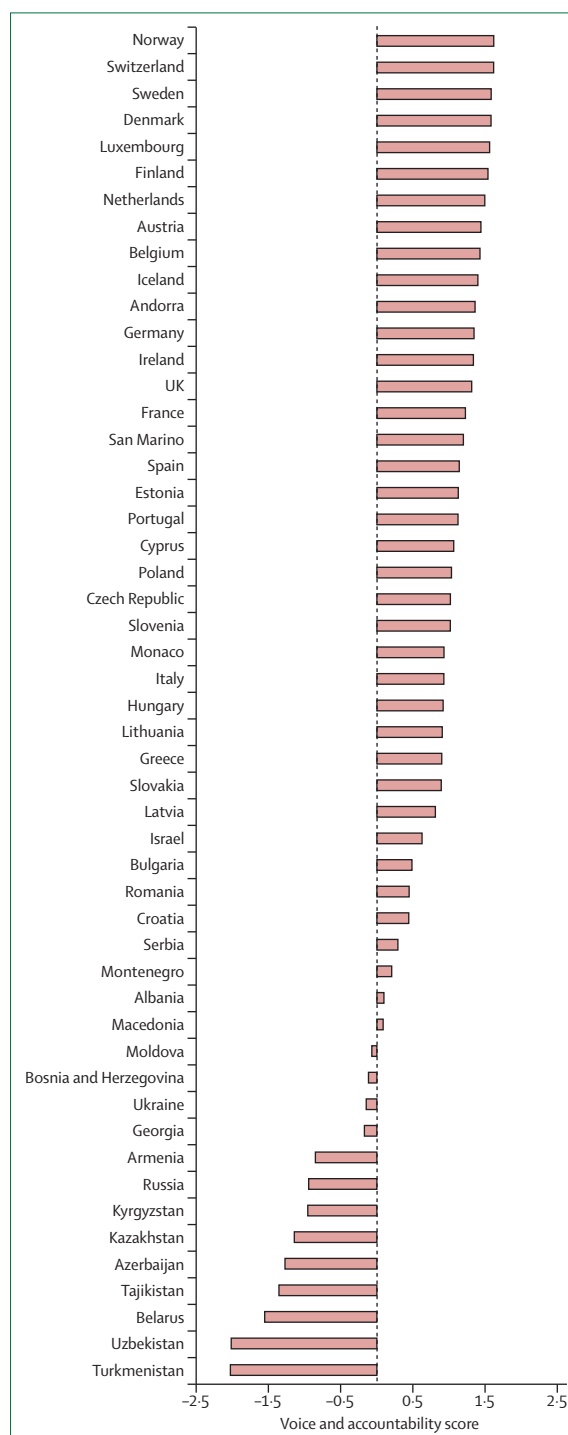


Figure 16: Voice and accountability  
Reproduced with permission from the World Bank.<sup>36</sup>

#### Panel 13: Features that governance for health systems should possess to address the social determinants of health effectively

- High level of political will and commitment, globally, nationally, and locally
- Transnational mechanisms that promote health and equity (eg, accountability mechanisms that are transparent and are 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)

**Panel 14: Recommendation 4(b)—the long-term nature of preventing and treating ill health equitably requires a comprehensive response to achieve sustained and equitable change in preventing and treating ill health**

**Specific actions**

*Prevention*

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

- Reduce harmful alcohol consumption—such as a tax on alcoholic beverages that is proportional to the alcohol content in the beverage.
- Initiate wider action to reduce fat, particularly trans-fatty acids, in diet, and control the growth of fast-food consumption.
- Take action to reduce smoking under the WHO Framework Convention on Tobacco Control.
- 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 action to do the following:

- Make health care systems more equitable—universal health coverage is required to provide a critical foundation for addressing health inequities.
- Remove financial, geographical, and cultural barriers to the uptake of health care services—such as co-payments—and ensure adequate resource allocation to disadvantaged areas.

*Strategies*

Ensure that strategies to address inequities within and between countries, including those related to gender, cover the following:

- 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 behaviour.
- Improve the accessibility and quality of health care services.
- WHO, the European Union, and individual countries in the western part of the region must provide support for developing and implementing these strategies to address inequities in countries where they are weakest, including some countries in the eastern part of the region.

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:

- 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 and availability and pricing as well as addressing societal norms and values.
- Design screening programmes to be accessible by all, particularly the most vulnerable and disadvantaged people, for cardiovascular risk factors and early detection of cancer.
- Ensure the effective implementation of infectious disease strategies (such as tuberculosis and HIV) 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.
- Across these recommendations, monitor and assess the effects on population health equity disaggregated by sex, age and 2–3 key socioeconomic determinants.

factors, however, differs between countries and over time. For example, excessive alcohol consumption is more of a problem in central and eastern Europe compared with the rest of the region; smoking, one of the main downstream determinants of health inequities in the north and west of Europe, is not yet as much of a

problem in the south of the region. While inadequate access to effective care may make only a modest contribution to health inequities in the north, west, and south of Europe, it is likely to have a stronger influence on the larger inequities in mortality in eastern Europe and central Asia.

The available evidence on these factors provides important entry-points to prevention of ill health and treatment policies designed to reduce the health divide between countries. Two important strategies are strengthening health promotion, health protection, and disease prevention in central Asia and central and eastern Europe, and making improvements that reduce differences in accessibility and quality of health-care services.

The exposures to preventable health hazards that arise from social determinants contribute to socioeconomic inequities in health within countries. Such health inequities can be seen in relation to levels of obesity by education (figure 17). The contribution of health risks, such 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 these inequities need country-specific priorities and strategies that focus on equity. 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.

*Evidence and monitoring*

The review makes recommendations on the approach to evidence and monitoring that is needed to improve equity in health and its social determinants (panel 15). Improving health and health equity needs an evidence-based approach and up to date information. A monitoring system that supplies information to policymakers and other stakeholders about the distribution and trends of health outcomes, risk factors, prevention and treatment of ill health, and determinants is an essential part of the social-determinants approach to improving health equity.

One role of a monitoring system is to enable stakeholders to assess the effects of policies and interventions and whether the benefits are fairly distributed to promote a long and healthy life for all. However, the time lags between policy interventions and their effect on health status, as well as the difficulties of attributing an effect to specific policy interventions, make it necessary to use process and output indicators, rather than relying solely on indicators of outcomes. However, outcome data are necessary and, in the final analysis, the definitive criteria.



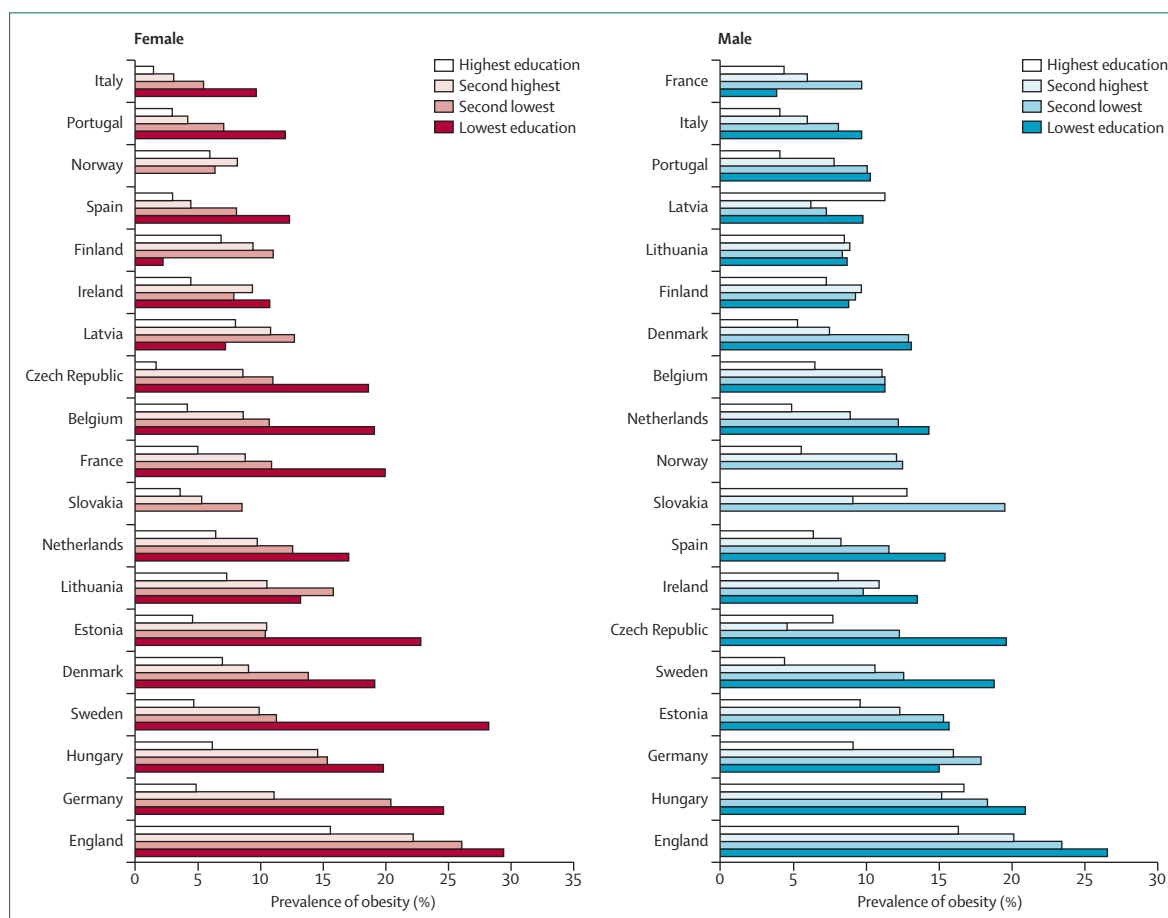


Figure 17: Percentage of population who are obese by level of education and gender for selected countries  
Reproduced with permission from Roskam AJ and colleagues.<sup>37</sup>

While indicators of process, outputs, and outcomes are necessary, they are not sufficient to guide policy. Effective mechanisms are needed to enable individuals and groups who are the targets of policy to be heard and meaningfully involved in decisions that affect their lives.

An effective monitoring system is essential to support the setting of targets, which are identified as desirable goals. The goals in a health-equity-oriented approach are ultimately improvements in health outcomes that improve the health of all groups to the highest level in the society. Currently, the main challenges to setting targets and monitoring progress on social inequities in health and, more broadly, social determinants of health, in the European region are the lack of reliable data on the one hand and the plethora of existing but not standardised data on the other hand. European data legislation, including the relevant EU directives, should help rather than hinder such monitoring.

Setting equity-oriented targets needs to be the result of a political process involving all relevant stakeholders. However, targets require a monitoring framework that is accompanied by data that are reliable, comparable over time, and can be disaggregated, so that progress towards

**Panel 15: Recommendation 4(c)—undertake regular reporting and public scrutiny of inequities in health and its social determinants at all governance levels, including transnational, country, and local levels**

**Specific actions**

- 1 In all countries, establish clear strategies—based on local evidence—to redress the current patterns and magnitude of health inequities by taking action on the social determinants of health
- 2 Include in these strategies monitoring of both the social determinants of health across the life course and the social and geographical distributions of outcomes
- 3 Undertake periodic reviews of these strategies at all governance levels that include in-depth analytical descriptions of the magnitude and trends in inequalities in health and the main determinants that generate them
- 4 At the country level, provide regular reports on their reviews to WHO for discussion at regular regional meetings
- 5 Ensure progressive improvement in the availability and access to data needed to achieve this—both in terms of monitoring of trends and evaluation of what actions are most effective
- 6 WHO and the EU ensure that they work together to set minimum standards for the data required to achieve this
- 7 Initiate the strategy review process today—there is currently sufficient information in every country in the region to do this

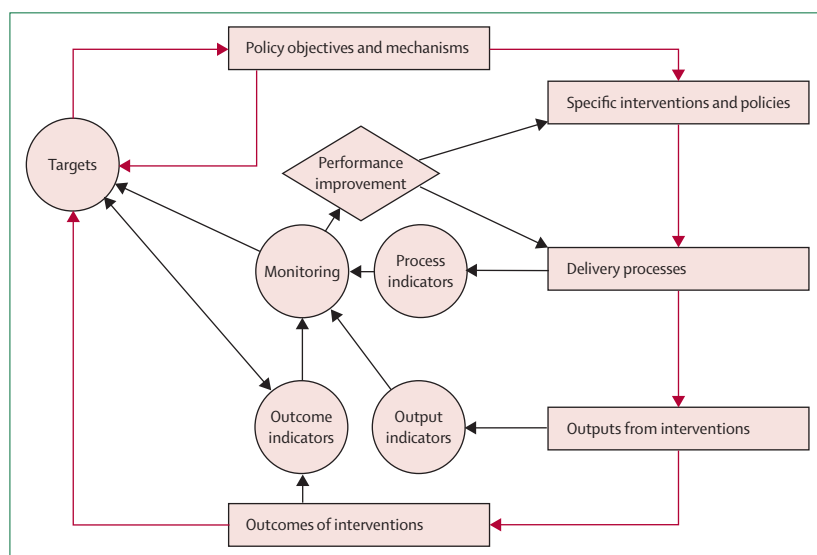


Figure 18: Indicator framework

Reproduced with permission from UCL Institute for Health Equity.<sup>38</sup>

the target can be assessed effectively as part of a regular review cycle (figure 18).

## Conclusions

Persistent and widespread inequities in health occur 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-based approaches support the political prioritisation of 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 and political 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 to reduce the intergenerational perpetuation of inequities. But new systems of governance and delivery of equity in health and its social determinants are also needed. These systems need to operate at all levels of governance—involving both the whole of society and the whole of government. These systems need to give individuals, groups, and communities a real say in decisions that affect their lives.

In all countries in Europe, reduction of health inequities should become one of the main criteria used to assess the

effectiveness of the health system and the government as a whole. Reduction of health inequities should also be a key criterion for assessing the work of WHO in Europe.

All countries in the European region should 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 reviews should be reported to WHO and discussed at regular regional meetings.

Countries are at very different starting points in terms of health, health equity, and socioeconomic development. For some countries in the European region, the recommendations are ambitious and aspirational. While these differences in health and socioeconomic development could limit what is feasible in the short term and the timescale for addressing specific issues, they should not affect the long-term aspirations of the strategy. Progressive steps towards realisation of these ambitions should be developed, covering the life course (perpetuation of inequities 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 brought together robust evidence on what should be done and the actions needed for implementation. Countries across the European region must work together to reduce health differences both within and between countries by using and building on the evidence in this review to create strategies that deliver better health for all their populations.

## Contributors

MM led the drafting of the report. PG coordinated contributions and redrafting. All authors provided content and comments that informed the drafting process.

## Conflicts of interest

We declare no conflicts of interest.

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