Opinion of the European Economic and Social Committee on the ‘Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions — Solidarity in health: reducing health inequalities in the EU’

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Co-rapporteur: Ms HEINISCH

On 20 October 2009 the European Commission decided to consult the European Economic and Social Committee, under Article 262 of the Treaty establishing the European Community, on the

Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions — Solidarity in health: reducing health inequalities in the EU


The Section for Employment, Social Affairs and Citizenship, which was responsible for preparing the Committee's work on the subject, adopted its opinion on 23 March 2010.

At its 462th plenary session, held on 28 and 29 April 2010 (meeting of 29 April 2010), the European Economic and Social Committee adopted the following opinion by 51 votes to 1 with no abstentions.

1. Recommendations

1.1 The principle of HIAP (Health In All Policies) should become a reality in all EU policies. Therefore, the Commission should evaluate and check its measures, if all policy areas contribute to a high level of health protection and reduction of health inequalities. The Commission should develop mechanisms to reverse its policy measures which have a negative impact on health and inequalities.

1.2 The EESC supports the importance of the Member States and the Commission agreeing on a set of comparable indicators and measurable targets within a relevant timeframe as a mean of enabling the national authorities to evaluate progress in reducing health inequalities and help areas where European initiatives could complement national efforts.

1.3 The EESC calls on all Member States to participate in the Commission’s plans to improve the data and knowledge base and the mechanisms for measuring, monitoring and reporting health inequalities.

1.4 The EESC urges the Commission to collaborate with the Member States to develop new indicators to monitor health inequalities and a methodology to audit the situation in the Member States in order to prioritise areas for improvement and best practice.

1.5 The EESC calls on the Member States and the Commission to create a pattern of overall economic and social development, leading to greater economic growth and better social justice, as well as greater solidarity, cohesion and health. This should be addressed as a priority in the Europe 2020 Strategy and consideration should be given to the key role of the EU Structural Funds in implementing this priority.

1.6 The Committee urges the Commission and the Member States to deploy the necessary resources to combat all social inequalities which are the source of health inequalities, particularly in terms of education, urban planning and purchasing power.

1.7 Efforts to combat health inequalities in rural areas must be stepped up, particularly in view of the challenges presented by demographic change.

1.8 The Commission should evaluate the impact of existing European platforms and fora (nutrition, alcohol, etc.) on vulnerable groups.

1.9 The Committee invites the Commission and the Member States to reconsider the series of EESC recommendations which were made in the past opinions relating to health and social issues and which, if implemented, would contribute to fighting health inequalities (1).

(1) See of Opinions of:
European Economic and Social Committee on Early childhood care and education (own-initiative opinion), rapporteur: Ms Herczog
OJ C 255/76, 22.9.2010
OJ C 255/72, 22.9.2010
OJ C 128/89, 18.3.2010
OJ C 228/113, 22.9.2009
OJ C 218/91, 11.9.2009
OJ C 175/116, 28.7.2009
OJ C 77/115, 31.3.2009
OJ C 77/96, 31.3.2009
2. Background – health inequalities in the EU

2.1 On average, EU citizens now live longer and in better health, however, there are big and growing differences in the health of citizens across the EU which is a significant concern and challenge. Rising unemployment due to the financial and economic situation is also aggravating the situation. The Commission Communication is to launch a debate to define what EU flanking measures can be put in place to assist Member States and other actors at national or regional levels to find responses to this critical situation.

2.1.1 One example of the differences in the health of people living in the EU is that mortality rates for children under one year old vary by a factor of five between Member States. The variations in male and female life expectancies vary by 14 and 8 years respectively. Major health inequalities are also found between regions, rural and urban areas.

2.1.2 Life expectancy from birth varies by ten years for men and six years for women depending on the level of education and socio-economic group. Workers in manual or routine jobs tend to be in poorer health than other groups. There is also a significant gender aspect as women live longer than men, but spend more time in ill health.

2.1.3 The causes of health inequalities originate in social inequalities which are linked to living conditions, behavioural patterns, educational level, employment and income, healthcare, disease prevention and health promotion services as well as public policies influencing the quantity, quality and distribution of these factors. Inequalities experienced in access to education, employment and healthcare, as well as those based on gender and race are critical factors. The combination of poverty with other vulnerabilities (childhood or old age, disability or minority background) further increases health risks.

2.1.4 Socio-economic factors influence living conditions and health; for example, not everyone living in the EU has access to appropriate water supplies and sewerage facilities.

2.1.5 The barriers to accessing health care include lack of insurance (especially statutory health insurance), high treatment costs, lack of information about available services, as well as linguistic and cultural barriers; in addition, poorer social groups have a lower health care take-up.

2.1.6 Health inequalities are not inevitable and are strongly influenced by individuals, governments, stakeholders, and communities and can be tackled by appropriate policies and action. Individual behaviour regarding health is not the main factor explaining the inequalities which have been noted; rather, these have mainly to do with the socio-economic, health and political circumstances in each country, the cumulative effect of which affects people throughout their lives.

3. Content of the Commission proposal

3.1 The purpose of the Communication from the Commission is to launch the debate needed to define the potential of EU flanking measures to support the actions by Member States and other actors to address the issue of health inequalities.

3.2 Despite already existing EU initiatives that help in bridging health inequalities in the EU (2), the Commission felt that it could further assist the Member States in addressing the factors that create inequalities in health.

3.3 The Commission Communication identifies five key issues that need to be addressed:

— equitable distribution of health care as part of social and economic development;

— improving the data and knowledge base and mechanisms for measuring, monitoring, evaluation and reporting;

— building commitment across society;

— meeting the needs of vulnerable groups;

— developing the contribution of EU policies.

Each key area is accompanied by a list of EU level actions to be taken forward by the Commission and the Member States.

4. General comments - taking action on health inequalities

4.1 The EESC welcomes the Communication as it regards the extent of health inequalities between different parts of the EU and between those that are socially advantaged or disadvantaged as a challenge as it agrees that such inequality undermines the EU’s commitment to solidarity, social and economic cohesion, human rights and equal opportunities.

(2) There is the Council Recommendation on cancer screening, initiatives on mental health, smoking and HIV/AIDS, as well as a European compilation of best practice, data collection, and a network of Member States and stakeholders. Support also comes from the research framework and action programmes, PROGRESS, studies, and policy innovations. In addition, health also benefits from EU legislation on employment and health and safety at work, the Common Agricultural Policy, environment and market policies. The Cohesion Fund and the Fund for Rural Development are helping to reduce regional disparities.
4.2 The Commission’s Communication is the outcome of a wide consultation and the end result is not complete. Unfortunately, some important issues have only been mentioned briefly or not at all. Several of them fall under the competence of the Member States, but the Commission could have a complementary role in addressing them and finding solutions.

4.3 The Communication sets out the key EU policy areas (social protection policy, environment, education, etc.), which interlink with health inequalities and which are mutually reinforcing. The EESC would therefore stress the importance of the Commission and the Member States evaluating the impact of different policies at all levels: local, regional, European, on the health status of the population. The EESC points out that reducing health inequalities comes about from political choices and is not a natural phenomenon.

4.4 The EESC believes that the Commission should make best use of the tools available (e.g. OMC, impact assessments, research programmes, indicators, cooperation with international organisations) and should consider with the Member States new methods to ensure that EU policies and actions address the factors which create or contribute to health inequalities across the EU. However, Commission measures to support Member States must be in line with the subsidiarity principle and the Treaties.

4.5 The EESC supports the role of the Commission in coordinating EU policies and measures, assuring policy coherence, promoting the exchange of information and knowledge between Member States, identifying and spreading good practices and facilitating the design of tailored policies for the specific issues relating to special social groups. The EESC expects better cooperation with stakeholders, including EESC, both at EU and international level.

4.6 However, the EESC underlines the role of the Member States to ensure the availability of comprehensive, high-quality, universally accessible and personal healthcare locally, as it is a key factor in reducing health inequalities. This particularly applies to children, patients with chronic illness, those with multiple diseases and the elderly, who need familiar surroundings and contacts with family, friends and acquaintances during their convalescence. Populations and especially vulnerable groups should not be forced to re-locate to areas where there is a concentration of healthcare facilities in order to escape from inequalities in access to care.

4.7 The EESC stresses the fact that Member States have the responsibility for the delivery of health care. In discussing the issue of inequalities it is critically important to take into account the role of national governments in securing social protection systems and in ensuring that there is sufficient, well trained staff to provide services - on a local basis - which does not disadvantage those living in remote communities or vulnerable groups.

4.8 Mostly determined by factors external to the healthcare system, ill-health can be remedied by healthcare and social systems. However, in some cases, new developments in healthcare systems can exacerbate health inequalities (?). New technologies should not lead to new health inequalities.

4.9 In particular, it is important to make the young generation aware that a healthy lifestyle reduces the risk of illnesses. Such knowledge among young people, who in due course will become parents, can have a major impact on their children and future generations.

5. Specific comments on the key issues to address

5.1 An equitable distribution of healthcare as part of overall social and economic development

5.1.1 Health inequalities also have an impact in relation to the Lisbon process, as production losses and the costs of treatment and social benefits may undermine the economy and social cohesion.

5.1.2 The EESC supports the view of the Commission that there is a need to create a pattern of overall economic and social development, which leads to greater economic growth and better social justice, as well as greater solidarity, cohesion and health. This should be addressed as a priority in the Europe 2020 Strategy which should include an indicator measuring health inequalities to monitor social progress achieved under the Strategy. Consideration should be given to the key role of the EU Structural Funds in implementing this priority.

5.1.3 The EESC reminds the Member States of the importance of social health protection, access to health services and health funding in achieving equality in health outcomes. This seems especially important given the demographic trends in the EU.

5.1.4 It should be mentioned that social protection in health - health financing mechanisms such as social and national health insurance or tax-based systems - need to be implemented and extended based on solidarity in financing and on risk pooling, which is the key for achieving equality in access to health services. Effective access to health services should be defined by affordability, availability, quality, financial protection and information about a range of essential services (?) .

(?) For example, in France limited access to antiretroviral treatment has increased health inequalities between HIV-positive patients.

(?) Conventions, nationally and internationally agreed objectives, maternity benefits including sick and maternity leave, most important ILO Conventions and Regulations in the field of social health protection include ILO Convention 130 on Medical Care and ILO Conventions 102 that specifically focuses on social security, particularly social health protection. It has been signed by many countries most recently by Romania and Bulgaria. For full EU ratification, only 2 Baltic states and Finland are missing (due to gender-related wording).
5.1.5 Health inequalities should be addressed by a pragmatic strategy that aims to achieve universal coverage and effective access, as defined above, by coordinating all health financing schemes and systems (social and private insurance, social assistance schemes, public health systems etc.) in order to close gaps in access i.e. of the poor, minorities such as migrants — irrespective of their administrative situation —, ethnic or religious groups, or age and gender-related inequities.

5.1.6 Related reforms should lead to a rights-based approach that is founded on social dialogue in order to ensure a broad consensus and thereby sustainability of solutions for financing and decent work conditions for both the insured and the healthcare workforce. In this context, the EESC feels that further privatisation could have adverse effects, introducing a system based on competition rather than solidarity.

5.2 Improving the data and knowledge base and mechanisms for measuring, monitoring, evaluation and reporting

5.2.1 The EESC agrees with the Commission that the measurement of health inequalities is fundamental for effective action, monitoring and progress.

5.2.2 Therefore, the EESC calls on all Member States to participate in the Commission’s plans to improve the data and knowledge base and the mechanisms for measuring, monitoring and reporting health inequalities (including the economic and social impact). In this regard, it is very important that the Member States are committed to submit timely and comparable data.

5.2.3 Given the significant importance of data and related gaps, the EESC urges the Commission to collaborate with the Member States to develop new indicators to monitor health inequalities and a methodology to audit the situation in the Member States in order to prioritise areas for improvement and best practice.

5.2.4 The EESC supports the inclusion of measuring and monitoring effective access to health services and universal social protection coverage as an indicator for progress and importance of breaking down the data by gender and age, socio-economic status and geographical area. The EESC encourages the Commission and the Member States to benefit from the experience of the WHO, ILO, the Dublin Foundation and the EU Agency for Fundamental Rights in this regard.

5.2.5 In terms of research and knowledge base, the EESC supports the stronger emphasis on health-related and socio-economic issues in the EU Research Framework Programme. The EU Health Programme should also include a priority on fighting health inequalities in the next budgeting period.

5.2.6 The Commission should also put in place tools and a framework enabling the Member States to exchange research results as well as create opportunities for pooling research resources between the Member States.

5.2.7 The EESC recognises that tackling health inequalities is a long-term process. The actions in the Communication are intended to create the framework for sustained action in this area and the EESC will look forward to the first evaluation report which should be produced in 2012.

5.3 Building commitment across society

5.3.1 The EESC welcomes the Commission’s plans to cooperate with Member States and to consult relevant stakeholders at European and national level on:

- making the subject of health inequalities one of the priority areas within cooperation arrangements on health;

- developing actions and tools on professional training to address health inequalities using the health programme, ESF and other mechanisms;

- encouraging reflection on target development in the Social Protection Committee through discussion papers.

5.3.2 The EESC would emphasise that building a strong commitment across society depends not only on governments, but also on the involvement of civil society and the social partners. The consultation process, policy-making and implementation should include stakeholders at European, national and local level and the EESC believes that there is potential to increase the effectiveness of these aspects, the development of partnerships and better dissemination of good practice. Clear monitoring and evaluation programmes need to be established in Member States to measure the progress made.

5.3.3 Creating more effective partnerships with the stakeholders will help to promote action on various social determinants and help to tackle health inequalities. For instance, they can play an important role in improving access and appropriateness of health services, in promoting health and preventive care for migrants, ethnic minorities and other vulnerable groups, in promoting the exchange of information and knowledge, identifying and spreading good practices and in facilitating the design of tailor-made policies for the specific issues prevailing in Member States and/or special social groups. The stakeholders can also help with the measurement of health inequalities at work and at leisure in the community as well as support knowledge and training both for health professionals and for other sectors.
5.3.4 The EESC would like to see a more effective consultation with vulnerable groups. The EESC would welcome an opportunity to give further consideration to this point with the Commission.

5.4 Meeting the needs of vulnerable groups

5.4.1 It must be remembered that vulnerable groups will be the first victims of the current crises, both in terms of health and access to healthcare.

5.4.2 Therefore, the EESC welcomes:

— collaborative measures between the Commission and Member States to improve access to health services and preventive care for vulnerable groups;

— measures to reduce health inequalities in future initiatives on healthy ageing;

— activities on health inequalities as part of the European Year for Combating Poverty and Social Exclusion 2010;

— in view of demographic change, use of the Cohesion Policy and structural funds in support of the health of vulnerable groups;

— focus on a limited number of measures; however, these need to be developed in greater depth.

5.4.3 The EESC recommends that health inequalities and vulnerable groups, including disabled, should be looked at from the general perspective of equality and discrimination. One of the examples is the gender aspect of ageing. Women tend to live longer, but in ill-health and due to a generally shorter working life, have lower retirement benefits, which have a direct impact on access to healthcare and medicines. Also the situation of migrant women needs special consideration with regard to health education and access to healthcare.

5.4.4 Preventive healthcare and screening programmes, as well as health promotion and education (about healthy lifestyles, treatments available, patients' rights, etc.) are very important, especially within disadvantaged communities. The EESC would recommend that the Commission and Member States come up with campaigns and services targeted at relevant vulnerable groups. Health campaigns addressing the population at large usually have low penetration rates within disadvantaged groups. Targeted campaigns should empower disadvantaged communities in defining their needs and spreading information.

5.4.5 In this context, the Commission should evaluate the impact of existing European platforms and fora (nutrition, alcohol, etc.) on vulnerable groups. The EESC proposes to organise a platform for patients' organisations to share experience and spread information.

5.4.6 The EESC sees the quality and accessibility of early childhood education as one of the means to prevent health inequalities among future generations. The availability of different forms of childcare is a vital component of social and economic development, and it plays a particularly crucial role in disadvantaged areas and for disadvantaged groups and households living in otherwise good conditions. The provision of childcare can help address the social, economic and health issues that such disadvantaged households face, and support the social integration of excluded groups (5). Similarly, as health inequalities mainly derive from educational inequalities, the EESC deems it essential to guarantee equal access to quality schooling and education so that everyone can acquire the skills enabling them to regain control of their lives.

5.5 Developing the contribution of EU policies

5.5.1 The EESC calls upon Member States to make the elimination of health inequalities a priority and to ensure that the policies which have an impact on social, economic and health issues are better co-ordinated, monitored and evaluated in order to promote good practice and disseminate information across the EU.

5.5.2 The impact of different EU policies on health status should be examined.

5.5.3 The EU contribution to reducing health inequalities can be improved, for example through better understanding of policy impact on health and via greater policy integration: education, working conditions, territorial development, environment policy, transport policy, etc. However, the Commission needs to ensure, first and foremost, that the proposed measures do not result in any new inequalities, especially if they impact on vulnerable groups (6).

5.5.4 The objective of ensuring a high level of health protection is enshrined on an equal footing with the Single Market in the Treaty of Lisbon, which also sets out a complementary role for the EU in safeguarding the well-being of EU citizens. The EESC hopes that the Lisbon Treaty will breathe new life into the slogan 'health in all policy areas (HIAP)', which to date remains rather an empty formula at EU level, used to conceal the imbalance with the ubiquitous dominance of the Single Market.

(5) European Economic and Social Committee on Early childhood care and education (own-initiative opinion), rapporteur: Ms Herczog
(6) Particularly vulnerable groups include persons who are not mobile due to illness, do not actively look for the best possible treatment, do not know the language of the preferred country of treatment, do not have the financial resources to pay for specialist treatment/treatment abroad, or are hesitant to seek treatment either abroad or in a distant treatment centre. In particular, demographic change will create new health challenges.
5.5.5 In this context, the EESC calls on the Commission to:

— carry out an evaluation of its measures (before, during and after completion) in all its policy areas, to check if all policy areas are helping to ensure a high level of health protection and to reduce health inequalities (7);

— develop mechanisms to evaluate the health impact of existing policies (ex ante and ex post) on different population groups to produce information for further policy development;

— develop mechanisms to reverse Commission policy measures which have a negative impact on health and inequalities;

— take steps to raise awareness among Member States, associations and professionals about the real impact of health inequalities, the factors determining them and the means of overcoming them.

5.5.6 The EESC would also like Member States to address health inequalities in their work programmes and to develop appropriate cross-sector strategies.

5.5.7 The EESC supports the Commission’s proposal to assist Member States to coordinate policy measures more effectively, to analyse the relationship between these policies and the resulting health outcomes for different groups across the Member States. Tackling health inequalities should also be underpinned by better use of the EU Cohesion policy and better information and coordination of the cohesion funds, enhanced capacity to develop investments in health and social care sectors in the Member States, options under EU rural development policy and CAF.

5.5.8 However, in doing so, it must not encroach on the rights of Member States to organise and finance healthcare systems, in particular their right to define and implement an appropriate level of health protection (Article 168 of the Treaty).

5.5.9 Efforts to combat health inequalities in rural areas must be stepped up, particularly in view of the challenges presented by demographic change. In this connection, the key role played by small healthcare providers (especially self-employed medical practitioners) in ensuring comprehensive, individual and local treatment of patients must be acknowledged and given special support.

5.5.10 The EESC welcomes:

— the proposed policy dialogue with Member States and stakeholders on equity and other key fundamental values in health as set out in the EU Health Strategy and EU Strategy on Health and Safety at Work, and the proposal to set up a forum on health and restructuring to examine measures to reduce health inequalities;

— the Commission’s initiative at international level to support other countries in health and related fields by exchanging EU experience on tackling health inequalities.

Brussels, 29 April 2010.

The President
of the European Economic and Social Committee
Mario SEPİ

(7) While it is true that many legislative acts already require impact assessments, in most cases there is no evaluation to check whether they genuinely and efficiently achieve their objectives. This is all the more necessary in the current financial and economic crisis, which is increasingly becoming an employment and healthcare system financing crisis, with repercussions on public health.