

Consultation Paper

EU action to reduce health inequalities. Input requested.

This request for input to the development of a Commission Communication aiming to support the reduction of health inequalities in the EU is being sent to key stakeholders involved in European work with the European Commission in the areas of social policy and employment policy. A list of questions is given at the end of the paper.

Responses should be sent to:

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By 1 April 2009

Consultation Paper

EU action to reduce health inequalities.

The size and scale of the differences in health of people living in different parts of the EU and between socially advantaged and disadvantaged EU citizens represents a challenge to the EU's commitment to solidarity and equality of opportunity. In this context, the European Commission has announced a communication on reducing health inequalities in the EU in its work programme for 2009 as an initiative on "Solidarity in Health".

This comes as there is increasing political will to act at European level to help bridge these differences. In June 2008 the European Council underlined the importance of closing the gap in health and in life expectancy between and within Member States and called for further work in the area. In July 2008 the Commission Communication on a Renewed Social Agenda restated the fundamental social objectives of Europe to achieving harmonious, cohesive and inclusive societies and announced a Commission Communication on health inequalities for 2009. The Commission White Paper "Together for Health, a strategic approach for the EU 2008-2013" of October 2007 stressed the need to reduce inequities in health between and within Member States and announced policy action proposals aimed at reducing health inequities. The European Parliament, the Council and the Committee of the Regions, in their opinions and conclusions on the Strategy, have all emphasised the need to address inequalities.

On the international arena, the WHO Commission on Social Determinants of Health published in August 2008 demonstrated that inequalities in health outcomes are fundamentally related to overall social and living conditions. Tackling them requires a coordinated response across relevant policy areas.

As highlighted in the 2008 Joint Report on Social Inclusion and Social Protection¹ and the 2008 report² "Monitoring progress towards the objectives of the European Strategy for Social Protection and Social Inclusion" and others³, substantial differences in overall life expectancy at birth and in the years lived in good health (Healthy Life Years) can be observed across the EU Member States. People in many new Member States live shorter lives than their Western counterparts. For example, for women, the life expectancy gap between EU countries is 8 years. For men it is 14 years. Moreover, the gap in Healthy life years is even greater - for women it is as high as 18 years. The rates of incidence and mortality of diseases also vary widely across the EU. For example, ischaemic heart diseases kill over 10 times more women in Lithuania than in France and there are 25 times more cases of tuberculosis in Romania than in Cyprus.

Large differences in health status also exist within EU Member States where there is a clear social gradient in health status.⁴ People with a lower level of education, a lower occupational class or a lower level of income tend to die at a younger age and to have a higher prevalence of most types of health problems. For example, socio-economic inequalities in healthy life years can amount to more than 10 years for men and almost 5 years for women. Similar gaps exist in health between some ethnic and migrant groups and the general population. While overall levels

¹ See http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/joint_report_en.pdf

² See http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/omc_monitoring_en.pdf

³ See for example http://ec.europa.eu/employment_social/spsi/reports_and_papers_en.htm for the annual reports of the European Observatory on Social Situation and Demography

⁴ See for example http://ec.europa.eu/health/ph_determinants/socio_economics/socio_economics_en.htm for various relevant links and publications.

of health have improved over the last 20 years the gap between the most advantaged and most disadvantaged has increased in many countries. Gender can also determine differences in health status, health risks and access to health services. Women live on average 6 years longer than men, but most of these additional years are lived with activity limitation due to bad health.

Whereas Member States have the principal role in this matter, many of them struggle to find the means to tackle these issues and may not always have in place the necessary investments to meet people's needs. The EU can add value by providing a picture of the dimensions and implications of health inequalities across the EU and by ensuring that Community policies in areas such as public health, employment, social policy and regional policy provide a positive health benefit targeted at the geographic areas and social groups that need it the most.

Further action by the EU could contribute to the following areas:

- Raise awareness about the extent and consequences of health inequalities and to promote the tackling of health inequalities as a policy priority both at Community level and in all Member States.
- Improve the mechanisms to monitor inequalities in health across the EU (between and within Member States) by improving data collection via more systematic and comparable information that complements existing data on health inequalities and via regular monitoring and analysis.
- Support Member States' actions to tackle health inequalities notably by highlighting possible ways to prevent and address health inequalities, by encouraging greater policy coordination and best-practice exchange and through financial support via the Structural Funds and other EU funding instruments.
- Mobilise all relevant EU policies to contribute to reducing inequalities in health by bringing together under a coherent framework the work of different Commission services, in line with the 2008 Renewed Social Agenda and the 2007 Health Strategy.

QUESTIONS FOR CONSULTATION

The following are provided as a guide to the kind of questions on which the Commission would like to receive contributions. Responses are invited on these questions and on any another other issue that consultees regards as relevant.

On general data:

What do you think will be the trends regarding health inequalities? – are they increasing or decreasing for example – please supply evidence if possible.
- between Member States (e.g. major differences in terms of health outcomes)
- between socio-economic groups

What kind of indicators do you think would be necessary to better monitor the extent of Health Inequalities in the EU?

Health First Europe suggests that a mix of specific health indicators and demographic indicators should be used to better and fully understand the extent of health inequalities. Such indicators should range across prevention, treatment and post recovery statistics and their correlation to broader quality of life measurements such as return to productivity or reduction of the need for follow on treatment. At the same time, non-access to certain treatments should be studied and their effects identified to provide a benchmarking exercise between accessible and non-accessible treatments.

Patient access should be refined to indicate not only access to treatments, but which type of treatments. Merely focusing on the single issue of recovery overlooks important quality of life benefits such as the time to recovery, return to productivity and restoring of lifestyle and the avoidance of follow on treatment and therapy. Also the issue of prevention should be monitored and indicators on the use and success of preventative screening, for instance, should be stored.

Broad areas of study should include:

- Demographics, gender, education, affluence, life stage and lifestyle choices should be horizontal indicators.
- Healthcare providers
- Number of doctors and nurses per inhabitant should be taken into consideration. This is important as this will ensure the quality of healthcare provision.
- Details on healthcare infrastructure
- Number of public and private hospitals per inhabitant and geography
- GDP percentage spent on healthcare
- Expand this indicator to include health policy priorities of Member States; we would invite Member States to present five years programme indicating their priorities and how this has a link with their budget line and patients quality of life.

A more detailed approach should be deconstructed from the broad areas above and include. Although not exhaustive, statistical indicators for:

- Rate of chronic disease (disability-adjusted life years)
- Cancer screening and survival rates
- Incidence of vaccine preventable diseases (Pertussis, measles, and hepatitis B)
- Coverage for basic vaccination programme, age 2, (Pertussis, measles, and hepatitis B)
- Asthma mortality rate, ages 5-39
- In-hospital mortality rate within 30 days of hospital admission for acute myocardial infarction
- In-hospital mortality rate within 30 days of hospital admission for stroke
- Waiting times for surgery after hip fracture, over age 65
- Influenza vaccination, over age 65
- Smoking rate
- Retinal exams in diabetics
- Asthma admission rate
- Annual HbA1c testing for patients with diabetics
- Patients with diabetics with poor glucose control
- Major amputations in diabetics
- Post-operative hip fracture or fall
- Transfusion reaction

- Uncontrolled diabetes admission rate
- Hypertension admission rate
- Pain treatment (pelvic pain)

If you think monitoring and reporting needs improvement in this area, what kind of monitoring tools should be used?

The most important monitoring tools are patient driven mechanisms such as surveys, examinations and post treatment monitoring. The stretch of e-health from patient records to personal monitoring allows a wealth of information about the patient viewpoint and indicators of overall health outcomes.

**On scope of level of EU action/subsidiarity:
Do you think action at EU level could make a difference in addressing health inequalities?**

The achievements seen at EU level cannot be properly understood or appreciated if health disparities continue to persist and the gap between regions, member states and demographics such as gender and affluency remains so high. When looking at the figures in Europe, we are aware that regions and member states are the ones closest to patients. The role that Europe can play in reducing health inequalities is one that involves first analysing health trends in different EU member states, then analysing and gathering the necessary data to explain health inequalities. Finally, the EU should provide platforms involving all healthcare stakeholders to share this information with member states to identify and promote better practices, pilot ideas to reduce health inequalities, reduce health inequalities and readdress ineffective health policies.

The EU can apply soft pressure by establishing best practice codes and benchmarks which analyse the results between Member States, thus encouraging mutual learning amongst Member States about advanced solutions to access, treatment and overall health and health policy.

**Why?
How should relevant stakeholders be supported and engaged at EU level in tackling health inequalities?**

We call for two main rules concerning stakeholder involvement.

First, Democratic involvement of all healthcare stakeholders. One example is the decisions about the benefits, risks and costs of mainly new technologies, interventions and practices, so-called Health Technology Assessments (HTA). All stakeholders should be involved in a transparent and equal way in the development and ongoing deliberations about HTA. This involvement will prove to be a very effective tool to help decision makers to make informed decisions.

Secondly, patients and healthcare workers should be given the opportunity and information to play an active role in the healthcare policy decision making process

Third, patients and healthcare workers should be an integral part when assessing the quality of healthcare (both in terms of treatment and outcome) provided.

Should there be a common commitment at EU level to reduce health inequalities for example by committing to common milestones and reduction targets? If yes, what do you think these milestones or targets should be (what variables? what extent?)?

Targets are an efficient way to assess the effectiveness of certain policies and they also are a good tool with which to send the right messages. However, targets need to be credible and reachable but targets and milestones cannot be and cannot become the strategy but the results of such a health strategy.

Targets are useful as measures and less as strategic goals. Targets should be formulated on the basis of guidance for Member States.

What would be the right tools to ensure that common goals are achieved on national and EU level (reporting, benchmarking, OMC, etc)?

As it has been stated in the Council's conclusions on the EU Health Strategy of December 2007, health inequalities need to be addressed. In this sense, the European Union should take a leading role in setting priorities and helping in the establishment of priorities so as to identify clear targets and to facilitate the exchange of data and best practices and use them to recommend better policies to Member States.

The use of the Open Coordinator Method to design benchmarking against best practice standards should clearly be prevalent in EU health policy.

To what degree can health inequalities be addressed through health policy? How? Which and to what extent should other policy areas, such as social policy, contribute to reducing health inequalities.

Possible Actions and impacts:

- Given the current economic situation can you think of any immediate action that EU or Member States could take to avoid an increase of health inequalities in the short term?

One of the key dangers in the current economic climate is to now ensure that current health equalities do not become inequalities.

In line with Health First Europe's core messages we call upon the EU and Member States

- to rethink European healthcare in order to meet current and future health challenges;
- to keep in mind that health is a productive economic factor in terms of employment, innovation and economic growth.

Both the EU and Member States should be cautious to not raise risks for patients, particularly in hospital settings. Drastic action needs to be taken to reduce patient safety risks, especially those ones acquired in health settings.

- Do you believe that investments through structural funds could help to reduce health inequalities. If so how and why?

Data produced by the ECDC and other research institutions, demonstrates that a significant inequality regarding the risk of healthcare acquired infections faced by patients in the different member states. The Netherlands is an example of very safe environment, which has been achieved by the application of the so-called search and destroy approach. The Commission

should actively promote such best practices and provide financial support, via the structural funds, for member states to implement pilot and/or seeding programmes.

- Where do you think should future investments through structural funds be mainly spent to be effective for reducing health inequalities and what would be the expected impact of that spending?

To date, structural funds have mainly been spent on facilitating patient access to better treatment but not on improving the quality of the treatment. This should be added going forward.

- What in your opinion are other areas that EU and Member States should be encouraged to focus on to achieve a reduction of health inequalities?

There is a major inequality faced by healthcare staff with regard to potentially fatal occupational injuries. Injuries from contaminated needles can result in infections, such as HIV and Hepatitis C. The majority of these injuries can be prevented by a combination of safer working procedures, specialised staff training and the use of medical devices incorporating sharps protection mechanisms. A proportion of Europe's healthcare workers benefit from such protection, and in some parts of the European Union the implementation of these preventative measures is mandated by law. Yet in many parts of the EU no such protection is provided for workers. The Commission should implement the proposed amendments to the Directive 2000/54/EC on *the protection of workers from risks related to exposure to biological agents at work* without delay in order to remedy this serious inequality.

Health inequalities are the consequences of various factors: socio-economic factors, health behaviours and lifestyles, environmental conditions. Therefore to reduce health inequalities in EU Member States, different EU policies need to try to converge. These include:

Patients access to treatment

- Treatment should be available across the EU for all patient needs, regardless of patients' condition or injury;
- Treatments should be available locally when feasible or in centres of reference when expertise and experience is required to ensure patients' safety;
- Reliable, timely and transparent information on available healthcare facilities and treatments should be made accessible to patients;
- Patients should respect healthcare workers' key role as a "discerner of information" and "determinant of best advice";

Investing in health quality

- Health First Europe's core message is that patients and clinicians should have equitable access to modern, innovative and reliable medical technology.
- The EU should invest commitment, time and leadership into medical innovation – the solution to the sustainability of Europe's social and economic model
- Programs should be developed to promote long-term investments leading to productivity enhancement, and to the efficient redeployment of resources, within national Healthcare systems

Information and education

Individual health behaviours in relation to tobacco, alcohol and nutrition are key drivers in contributing to health inequalities and reducing life expectancy across Europe. All stakeholders should be involved in designing and improving European citizens' health behaviours.

Healthcare workers' role in health policy

- Most European countries have a shortage in healthcare personnel. Quality and quantity are the common reasons for this shortage. The European Commission has recently published a Green Paper on Healthcare workers that addresses the main problems in retaining skilled workers, the mobility of professionals, the training qualifications needed etc. As this problem is common to all European countries and the sustainability of healthcare systems is in danger, the EU needs to call on Member States to treat this healthcare personnel shortage as a priority.
- All healthcare workers conduct an indispensable job in providing good care and treatment provision to patients. It is therefore essential to allocate resources accordingly in order for them to ensure this provision of quality health care;
- It is also essential to rethink the systems to adequately support healthcare workers while protecting patient safety and safeguarding healthcare workers quality;
- Sustainable investment in healthcare workers is vital to tackle the challenges brought about by an ageing society in Europe;
- Patients are not only demanding more in terms of new treatment and medical innovations but also ask for individualised and patient-centred care;
- There is a gradual change in demographics throughout the EU, therefore the mobility of qualified personnel is a way of helping reduce the problem, but this needs to be done without weakening other, less fortunate countries.

- To what extent would existing coordination and monitoring processes at EU level need to be improved to strengthen joint action on health inequalities?

Actions need to take on the tone of obligations as opposed to soft measures that only encourage. The use of targets and best practice codes would go a long way in encouraging Member States to develop plans to tackle health inequalities.

- What could be possible actions in other EU policy areas on health inequalities and what could be there impact?

Sexual health care is an area of inequality that would benefit significantly from EU support. This could take the form of EU funded communication campaigns and the provision of financial support for effective, life-saving screening programmes for such as Chlamydia and Cervical Cancer.

- What shall be done by the EU in order to facilitate the exchange of experiences between Member States, regions and cities?

- How should EU policies be stream-lined in order to reach targeted beneficiaries in the best way? (Disadvantaged, women, migrants, children)

- To what extent do you think is the improvement of research capacities advantageous for fighting HI? Can you name any concrete examples?

Other points

Do you know of any examples of good practice in addressing health inequalities which would be helpful to share with the Commission or other stakeholders – if yes please supply details.

Please provide any other contributions which you wish to add.

Thank you for your help

Please send comments to SANCO-C4-HEALTH-INEQUALITIES@ec.europa.eu

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