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Poverty, social exclusion and health systems in the WHO European Region

**Briefing on policy issues produced through the
WHO/European Commission equity project**

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Acronyms

| | |
|----------|--|
| ACEC | Association for Culture, Education and Communication (Slovakia) |
| CSDH | WHO Commission on Social Determinants of Health |
| EC | European Commission |
| EU | European Union |
| EU10 | countries joining the EU in May 2004 |
| EU27 | countries belonging to the EU after January 2007 |
| HDI | Human Development Index |
| HPI-1 | Human Poverty Index |
| HPI-2 | Human Poverty Index for selected OECD countries |
| IFRC/RCS | International Federation of Red Cross and Red Crescent Societies |
| ILO | International Labour Organization |
| MDL | Moldovan leu (currency of the Republic of Moldova) |
| MiMi | With Migrants for Migrants programme (Germany) |
| MPI | Multidimensional Poverty Index |
| NHS | National Health Service (United Kingdom) |
| OECD | Organisation for Economic Co-operation and Development |
| PPHC-KN | WHO Knowledge Network on Priority Public Health Conditions |
| PPP | purchasing power parity |
| PSIA | poverty and social impact analysis |
| SEKN | WHO Social Exclusion Knowledge Network |
| SPF-I | Social Protection Floor Initiative |
| TB | tuberculosis |
| UNDAF | United Nations Development Assistant Framework |
| UNDP | United Nations Development Programme |
| VAT | value added tax |

Introduction

At the time of writing, poverty and social exclusion pose major threats to the health and well-being of millions of people in the WHO European Region.¹ The global financial crisis and economic downturn have worsened poverty. Estimates suggest that the World Bank Europe and central Asia Region² has been hit harder than any other region in the world by the crisis and will be the slowest to recover (World Bank, 2010a). The adverse effects of the crisis on households through credit market shocks, food and fuel price shocks and income shocks are widespread (World Bank, 2009a). The crisis has resulted in rising unemployment and worsened economic prospects, making life even more difficult for those who are already poor. In fact, the reduction in poverty seen over the last decade in Europe and central Asia has now been reversed (World Bank, 2010a).

It is against this backdrop that this briefing explores the relationship between poverty, social exclusion and health and what health systems can do to respond. The briefing draws from three principal sources:

- case studies conducted through follow up to WHO Regional Committee for Europe resolution EUR/RC52/R7 on poverty and health (WHO Regional Committee for Europe, 2002);
- the Commission on Social Determinants of Health (see Box 1); and
- health systems functions as described in the Tallinn Charter: Health Systems for Health and Wealth (WHO Regional Office for Europe, 2008a).

Box 1. Commission on Social Determinants of Health

In 2005, WHO established the Commission on Social Determinants of Health (CSDH), the task of which was to synthesize evidence on the social determinants of health and define recommendations on how that evidence could be used. The final CSDH recommendations were released in August 2008 and were endorsed by the World Health Assembly.

Source: CSDH, 2008.

The briefing is divided into three sections. The first provides background on inequality, poverty and social exclusion in relation to health inequities and discusses the impact of the financial crisis and economic downturn in the Region. The second describes what can be done by health systems to meet the needs of populations experiencing poverty and social exclusion. The third presents a non-exhaustive list of actions for health system stakeholders.

The briefing supports follow-up to key European resolutions, charters and communications which provide guidance on reducing health inequities. These include the Tallinn Charter, the European Commission (EC) communication on reducing health inequalities in the European Union (EU) (EC, 2009a) and World Health Assembly resolution 62.14 on reducing health inequities through action on the social determinants of health (World Health Assembly, 2009). The publication of the briefing coincides with the European year for combating poverty and social exclusion.

Finally, the briefing supports follow-up to the outcome document of the September 2010 high-level plenary meeting of the Sixty-fifth session of the United Nations General Assembly on the Millennium Development Goals (United Nations, 2010), which explicitly recognizes that policies and actions must focus on the poor and ensure equitable access to social services.

¹ The WHO European Region comprises 53 Member States: Albania, Andorra, Armenia, Austria, Azerbaijan, Belarus, Belgium, Bosnia and Herzegovina, Bulgaria, Croatia, Cyprus, the Czech Republic, Denmark, Estonia, Finland, France, Georgia, Germany, Greece, Hungary, Iceland, Ireland, Israel, Italy, Kazakhstan, Kyrgyzstan, Latvia, Lithuania, Luxembourg, Malta, Monaco, Montenegro, the Netherlands, Norway, Poland, Portugal, the Republic of Moldova, Romania, the Russian Federation, San Marino, Serbia, Slovakia, Slovenia, Spain, Sweden, Switzerland, Tajikistan, the former Yugoslav Republic of Macedonia, Turkey, Turkmenistan, Ukraine, United Kingdom, Uzbekistan.

² The list of countries belonging to the World Bank ECA Region is available at the following link: <http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/ECAEXT/0,,contentMDK:21776903~menuPK:5026204~pagePK:146736~piPK:146830~theSitePK:258599,00.html>

Key messages

- Poverty and social exclusion are driving forces of health inequities for millions of people across the 53 Member States of the European Region. Today, an estimated 40 million people in the World Bank's Europe and central Asia Region are living below US\$ 2.50 per day, and 160 million below US\$ 5 per day. In the EU, the latest available data (2007) indicated that 84 million people were at risk of poverty – that is, living on less than 60% of the median equivalized disposable income after social transfers. Many more people face social exclusion in the economic, political, social and cultural spheres of life, endangering their health and well-being. The financial crisis and economic downturn have worsened poverty and social exclusion.
- Health systems have a key role in addressing the relationship between poverty, social exclusion and health. A health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. It encompasses both personal and population services and engages with other sectors to address health determinants. Health systems have four functions: financing, stewardship, service delivery and resource generation. Action to improve the health of disadvantaged populations should span the four functions. It should be grounded in a human rights approach to health and the values and principles of primary health care.
- Health system **financing** policy can play an important role in reducing health inequities if focused on achieving universal coverage. Particular attention is required for the health system financing objectives of financial protection, equitable distribution of the burden of funding the system and equitable use and provision of services relative to need. For countries at all levels of income, fragmentation in financing arrangements is an obstacle to efficient redistribution of resources in relation to need. Some countries have implemented reforms that explicitly reduce fragmentation; for many others, this should be an important “target” for health financing reform. In considering all reform options, attention should be given to low-income households and to other populations such as those with chronic illnesses, elderly people and those residing in rural areas who can face larger financial barriers to health services.
- Equity should be a guiding principle in all health system **stewardship** tasks. Of particular relevance to meeting the needs of populations experiencing poverty and social exclusion, stewardship involves engaging other sectors that influence health. This can be done by using evidence on the links between social, economic and environmental determinants and health and applying tools such as equity-oriented health impact assessment, interministerial and interdepartmental committees, and legislative frameworks. The stewardship function also relates to creating mechanisms for the participation of communities experiencing poverty and social exclusion in the design, implementation, monitoring and evaluation of policy and practice, and to the oversight of information systems that can monitor health equity and social determinants of health.
- **Service delivery** should be adapted to address the “differentials” that disadvantaged populations face. These include differentials in exposure to health threats, vulnerability to those threats, access to quality health services, and outcomes and consequences of service usage. Action areas include, but are not limited to, adjusting services to account for adverse living conditions that affect service-seeking behaviour and treatment adherence, engaging staff from other social sectors as partners in delivery and providing culturally and linguistically appropriate services.
- **Resource generation** for health equity requires making the social determinants of health a standard part of the curriculum of medical and health professionals. It can involve the recruitment, training and compensation of mediators/assistants from disadvantaged communities who can help bridge the divide between health services and excluded populations. It also entails guaranteeing the availability of quality medical personnel, medical and diagnostic equipment and other infrastructure for health in disadvantaged regions and areas.
- In the context of the financial crisis and economic downturn, health outcomes and the risk of health-related financial hardship may be affected by changes in the resources available for health systems and in private resources available to households to support health service usage and healthy lifestyles. Health outcomes may also be affected by worsened living conditions and health-adverse coping strategies. Populations experiencing poverty and social exclusion are disproportionately impacted by crises, as they have less control over resources. Health systems can respond by protecting investments in health (particularly in cost-effective public health and primary health care services, including prevention). They can also work to incorporate public social expenditure into stimulus packages and improve the efficiency of resource use within the health sector.

1. Background

Health inequities cross the social gradient, a term that refers to the stepwise or linear decrease in health that comes with decreasing social position (Marmot, 2004). The extent of health inequities is typically proportionate to the level of disadvantage, with populations experiencing poverty and social exclusion having fewer opportunities for health than those in more privileged positions. As background to the subsequent sections on what health systems can do, this section describes inequality, poverty and social exclusion in relation to health inequities. It also briefly describes the impact of the financial crisis and economic crisis on the WHO European Region.

Inequality

The social determinants of health are the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices (WHO, 2009a). As inequality focuses on the distribution of attributes across the whole population, addressing inequality is essential in acting on the social determinants of health.

Inequalities are typically described as economic or social in nature. Economic inequality comprises disparities in the distribution of monetary resources (assets and income) within a population. Economic inequalities influence consumption of goods and services by individuals and households (Eurostat, 2010). The simplest measurement of economic inequality sorts the population from poorest to richest and shows the percentage of expenditure (or income) attributable to each quintile or decile of the population.

A well-known summary index for income inequality is the Gini coefficient, a ratio with values between 0% and 100%. In Table 1, presenting the Gini index for Member States of the WHO European Region, the value of “0” represents absolute equality and “100” absolute inequality.

Table 1. Gini index for Member States of the WHO European Region (1992–2007)

| Countries sorted by Gini index | | | | | |
|--------------------------------|------|------------------------|------|---|------|
| Denmark | 24.7 | Belgium | 33.0 | Uzbekistan | 36.7 |
| Sweden | 25.0 | Albania | 33.0 | Russian Federation | 37.5 |
| Norway | 25.8 | Tajikistan | 33.6 | Portugal | 38.5 |
| Czech Republic | 25.8 | Switzerland | 33.7 | The former Yugoslav Republic of Macedonia | 39.0 |
| Slovakia | 25.8 | Armenia | 33.8 | Israel | 39.2 |
| Finland | 26.9 | Kazakhstan | 33.9 | Georgia | 40.8 |
| Ukraine | 28.2 | Ireland | 34.3 | Turkmenistan | 40.8 |
| Germany | 28.3 | Greece | 34.3 | Turkey | 43.2 |
| Croatia | 29.0 | Spain | 34.7 | | |
| Austria | 29.1 | Poland | 34.9 | Andorra | ... |
| Bulgaria | 29.2 | Republic of Moldova | 35.6 | Belarus | ... |
| Hungary | 30.0 | Latvia | 35.7 | Cyprus | ... |
| Luxembourg | 30.8 | Bosnia and Herzegovina | 35.8 | Iceland | ... |
| Netherlands | 30.9 | Lithuania | 35.8 | Malta | ... |
| Slovenia | 31.2 | Estonia | 36.0 | Monaco | ... |
| Romania | 31.5 | Italy | 36.0 | Montenegro | ... |
| France | 32.7 | United Kingdom | 36.0 | San Marino | ... |
| Kyrgyzstan | 32.9 | Azerbaijan | 36.5 | Serbia | ... |

Source: UNDP, 2009a.

Income inequality increased significantly in most Organisation for Economic Co-operation and Development (OECD) countries³ between the mid-1980s and mid-2000s (OECD, 2008). This was largely driven by the rich improving their incomes relative to both low- and middle-income people (United Nations Department of Economic and Social Affairs, 2009). In 2007, the total income received by the richest 20% of the population in the 27 countries belonging to the EU after January 2007 (EU27) was five times higher than that received by the 20% of the population with the lowest incomes (Eurostat, 2010).

Average within-country income inequalities between the early 1980s and the late 1990s rose faster in eastern Europe and central Asia than in any other region (United Nations Department of Economic and Social Affairs, 2009). Some countries saw their Gini coefficient increase by more than 10 points between 1981 and 1999 (United Nations Department of Economic and Social Affairs, 2009).

Social inequality encompasses a range of inequalities across areas related to quality of life and daily living conditions. Health inequities⁴ are a kind of social inequality. Gender inequality is another important social inequality. Social inequalities are also seen in areas such as employment and work conditions, education, access to social protection, housing and participation. Inequalities tend to reproduce themselves over time and across generations, creating inequality traps (World Bank, 2005).

Inequality across sectors is driven by unequal opportunities for people to live lives that, as Sen (2000) states, “they have reason to value”. The World Bank’s new Human Opportunity Index is a composite indicator measuring inequalities in opportunities among children; these are crucial for understanding if the intergenerational transmission of inequality is to be broken. The index combines two elements:

1. the level of coverage of select basic opportunities necessary for human development, such as primary education, water and sanitation, and electricity; and
2. the degree to which the distribution of those opportunities is conditional on circumstances such as gender, income or household characteristics (World Bank, 2009b).

Inequalities intersect and are mutually reinforcing. Inequalities in one domain are interlinked with, are influenced by and exert an influence on other social and economic inequalities. For instance, in many EU countries, life expectancy for both sexes increases with educational attainment: people with higher levels of education live longer than those with lower education levels (Corsini, 2010). Higher education is also linked with higher income, improved employment conditions, better housing and increased participation. Addressing health inequities therefore requires addressing inequalities across a range of economic and social domains and at the intersections of these inequalities.

Poverty

Poverty can be defined as a “pronounced deprivation in wellbeing” (Haughton & Khandker, 2009). Taking into account the wide debate regarding how to measure poverty, there are currently two main ways of setting poverty lines: relative and absolute. These focus on income and consumption poverty (rather than measuring poverty in its multidimensional sense). Relative poverty lines are defined in relation to the overall distribution of income or consumption in a country (these are more properly viewed as a crude measure of inequality). Absolute poverty lines, in contrast, are based in an absolute standard of what households should be able to count on in order to meet their basic needs. They are often anchored in estimates of the cost of basic food needs to which provision is added for non-food needs. An absolute poverty line remains fixed over time, adjusted only for inflation (Haughton & Khandker, 2009; World Bank, 2009c).

At national level, countries most often use nationally defined poverty lines. For comparisons and regional analyses (including in relation to Millennium Development Goal 1 on reducing poverty and hunger), the proportion of the population living on less than US\$ 1.25 (purchasing power parity (PPP)) per person per day is commonly used as an indicator. However, it is widely acknowledged that a higher poverty line is appropriate in Europe and central Asia as the harsh climate necessitates additional expenditure on housing, heat, warm clothing and food

³ Of the 31 Member Countries of the Organisation for Economic Co-operation and Development (OECD), 23 are in the WHO European Region.

⁴ “Inequities” involve more than “inequality”. “Equity” refers to the absence of avoidable or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically (WHO, 2009b). Inequities entail a failure to avoid or overcome inequalities that infringe on fairness and human rights norms (WHO, 2009b). That said, many people and institutions use the words “inequity” and “inequality” interchangeably when referring to differences that are unfair and unjust. For the purpose of this briefing, the terms are used interchangeably in such cases except in relation to health, where, in accordance with WHO resolutions, “health equity” is used.

(Suhrcke, Rocco & McKee, 2007). The World Bank currently defines “poor” in its Europe and central Asia Region as subsisting on less than US\$ 2.50 a day, and “vulnerable” as below US\$ 5 a day (World Bank, 2010a). Today, an estimated 40 million people in the World Bank Europe and central Asia Region are living below US\$ 2.50 per day, and 160 million below US\$ 5 per day (World Bank, 2010a).

National poverty lines are used in EU countries. For comparative monitoring across the EU, the poor (or those “at risk of poverty”) are people living on incomes below 60% of the median equivalized disposable income after social transfers for that country for a given year (EC, 2009b). As the median income rises, so does the relative poverty line (Haughton & Khandker, 2009). The number of people at risk of poverty in the EU in 2007 was 84 million, or 17% of the population (Eurostat, 2010). In the hypothetical absence of social transfers, this number would have been considerably higher (social transfers lifted 34.6% of people from the risk of poverty in 2007) (Eurostat, 2010). The median income of people at risk of poverty in the EU27 was 23% below the 60% poverty threshold in 2007 (Eurostat, 2010).

The World Bank suggests that the key determinants, or at least the correlates, of poverty can be grouped by characteristics at national and regional, community, and household and individual levels (Haughton & Khandker, 2009) (Table 2). Regression analysis can be undertaken to identify the effects of each of these characteristics on income (or expenditure) per capita. It is important to acknowledge the difficulties in separating causation from correlation (Haughton & Khandker, 2009). In addition, proximate causes of poverty and their distal determinants are not the same everywhere, so country-specific and subnational analysis is essential (Haughton & Khandker, 2009). Like the determinants of health (which in many ways overlap), the determinants of poverty are dynamic and interlinked. They intersect in ways that can deepen poverty, while also producing intergenerational continuums.

Table 2. Determinants of poverty

| | |
|--|--|
| Regional and national characteristics | <ul style="list-style-type: none"> • governance • environmental policy • economic, political and market stability • mass participation • global and regional security • intellectual expression • fair, functional and effective judiciary • isolation or remoteness, including weaker infrastructure and poorer access to markets and services • resource base, including land availability and quality • weather (such as droughts) and environmental conditions (such as earthquakes) • inequality (such as gender, ethnic, and racial inequality) |
| Community-level characteristics | <ul style="list-style-type: none"> • infrastructure (such as piped water, access to a tarred road) • access to public goods and services (such as proximity of schools, clinics) • average human resource development • access to employment • social mobility and representation • land distribution • social networks and institutions, and social capital |
| Household and individual characteristics | demographic: <ul style="list-style-type: none"> • household size • age structure of household members • dependency ratio* • gender of the household head |
| | economic: <ul style="list-style-type: none"> • income or consumption • household employment • property and other assets owned by the household |
| | social: <ul style="list-style-type: none"> • health (nutritional status, disease status, availability of health services, use of health services by poor and non-poor households) • education (level of education achieved, availability of education services, proximity to primary and secondary schools, use of these services by the members of poor and non-poor households) • shelter • housing (type of building – size and type of materials, the means through which one has access to housing – renting or ownership, and household equipment) • services (availability and use of drinking water, communications services, electricity and other energy sources) • environment (level of sanitation, the degree of isolation and the degree of personal safety) |

* Ratio of the number of family members in the household not in the labour force, whether young or old, to those in the labour force.

Source: author’s adaptation, drawing from Haughton & Khandker (2009).

A multidimensional definition of poverty is highly relevant for analysing poverty as a social determinant of health. Such a definition can account for deprivation in the facets of well-being described by the Commission on Measurement of Economic Performance and Social Progress. Stiglitz, Sen & Fitoussi (2009) describe well-being as a multifaceted phenomenon that requires simultaneous consideration of the following dimensions:

- material living standards (income, consumption and wealth)
- health
- education
- personal activities, including work
- political voice and governance
- social connections and relationships
- environment (present and future conditions)
- insecurity (economic and physical).

Some European countries capture aspects of multidimensional poverty by measuring material deprivation, which is the enforced lack of a combination of items depicting material living conditions, such as housing conditions, the possession of certain durable goods and the capacity to afford basic requirements (Eurostat, 2010). The definition of material deprivation adopted by Eurostat (2010) covers an economic or “durables” strain, defined as the enforced inability to pay for at least three of the following nine items: unexpected expenses; a week’s annual holiday away from home; arrears (mortgage or rent payments, utility bills or hire purchase installments or other loan payments); a meal with meat or fish every other day; heating to keep the home adequately warm; a washing machine; a colour television; a telephone; a car (Eurostat, 2010).

Recent work has been undertaken for the creation of a Multidimensional Poverty Index (MPI), which uses 10 indicators to further measure multiple deprivation across the three basic dimensions (OPHI, 2010). These indicators include: for education, years of schooling and child enrolment; for health, child mortality and nutrition; and for standards of living, electricity, drinking water, sanitation, flooring, cooking fuel and assets. This index facilitates the identification of the share of people living in multidimensional poverty. The MPI also reflects the intensity of poverty – the sum of weighted deprivation that each household faces at the same time (OPHI, 2010). The MPI is preceded by diverse analyses of approaches to measuring multidimensional poverty (for instance, see Atkinson, 2003; Bourguignon & Chakravarty, 2003).

The human development paradigm refers to people’s denial of choices and opportunities to lead a life one finds worth living – one that includes material well-being (such as income, education, health and safe water) as well as opportunities to enjoy dignity, self-respect and other basic rights (UNDP, 2007). The Human Development Index (HDI) is a summary measure of average achievements in a country of three basic dimensions of human development: a long and healthy life, knowledge, and a decent standard of living (UNDP, 2008). There is great variation in HDI rankings across the Member States of the WHO European Region. In 2009, Norway ranked first out of the 182 countries for which the HDI had been calculated. Tajikistan was the country in the Region with the lowest ranking (at 127) (UNDP, 2009a).

Building on the HDI, there are two indices for measuring human poverty in a given country. The Human Poverty Index (HPI–1) measures deprivation across three basic dimensions for developing countries. It measures:

- the chances of people having a long and healthy life, reflecting vulnerability to death at a relatively early age as measured by the probability at birth of not surviving to age 40;
- the opportunities for people to acquire knowledge, by recording exclusion from the world of reading and communications through measuring the adult literacy rate;
- the chances of having a decent standard of living, by assessing lack of access to overall economic provisioning as measured by the unweighted average of two indicators: the percentage of the population not using an improved water source, and the percentage of children underweight for age (UNDP, 2008).

The Human Poverty Index for selected OECD countries (HPI–2) assesses the same deprivation as the HPI-1 and includes social exclusion as measured by the rate of long-term unemployment (UNDP, 2008). In 2009, the HPI-2 was calculated for 25 OECD countries, of which 20 belong to the WHO European Region. Higher ranks refer to lesser levels of deprivation. Sweden ranked first, followed by Norway and the Netherlands. Italy ranked twenty-fifth (UNDP, 2009c).

Social exclusion

The WHO Social Exclusion Knowledge Network (SEKN) of the CSDH was charged with exploring the links between social exclusion and health inequities. According to the SEKN (2008), social exclusion processes result in a continuum of inclusion/exclusion characterized by inequalities in:

1. access to resources (means that can be used to meet human needs)
2. capabilities (the relative power people have to utilize the resources available to them)
3. rights.

This continuum results in health inequities (SEKN, 2008). Social exclusion influences health directly, through its manifestations in the health system,⁵ and indirectly, by affecting economic and other social inequalities that influence health. These inequalities contribute to social exclusion processes, creating a vicious circle.

Social exclusion is a much broader concept than income or consumption poverty, as it directs analysis to the determinants of poverty referred to in Table 2. Social exclusion theory builds on the evidence that the causes of poverty and inequality are embedded in the structures of social systems and relationships – in exclusionary processes – and not in individual inadequacies (SEKN, 2008). Sen (2000) argues that social exclusion's emphasis on relational features in the deprivation of capability is of particular value, as this highlights the relationship between poverty and inequalities in societies.

SEKN (2008) defines social exclusion in the following way:

Exclusion consists of dynamic, multidimensional processes driven by unequal power relationships interacting across four main dimensions – economic, political, social and cultural – and at different levels including individual, household, group, community, country and global levels.

The characteristics of the four main dimensions – economic, political, social and cultural – are described in Box 2.

Box 2. Dimensions of social exclusion

I. The social dimension is constituted by proximal relationships of support and solidarity (such as friendship, kinship, family, neighbourhood, community, social movements) that generate a sense of belonging within social systems. Social bonds are strengthened or weakened along this dimension.

II. The political dimension is constituted by power dynamics in relationships which generate unequal patterns of formal rights embedded in legislation, constitutions, policies and practices and the conditions in which rights are exercised, including access to safe water, sanitation, shelter, transport and power and to services such as health care, education and social protection. Along this dimension, there is an unequal distribution of opportunities to participate in public life, to express desires and interests, to have interests taken into account and to have access to services.

III. The cultural dimension is constituted by the extent to which diverse values, norms and ways of living are accepted and respected. Diversity is accepted in all its richness at one extreme along this dimension, and at the other there are extreme situations of stigma and discrimination.

IV. The economic dimension is constituted by access to, and distribution of, material resources necessary to sustain life (such as income, employment, housing, land, working conditions and livelihoods).

Source: SEKN (2008).

Significant work has also been undertaken by Member States to measure social exclusion across a range of indicators. The 2010 statistical portrait of the EU (Eurostat, 2010) features EU data for labour market exclusion, education-related exclusion, health-related exclusion, housing-related exclusion and exclusion from social networks and the information society.

In multiple countries, social exclusion has been measured through the development of national indices. One example of a national index is from Bosnia and Herzegovina. The country's national human development report in 2007 presents analysis of social exclusion using seven proxy indicators:

⁵ An example of social exclusion processes that operate within the health system is out-of-pocket expenditure. See the subsection on financing for details.

- the population below the income poverty line (proxy indicator 1) and long-term unemployment (2) for living standards;
- those without health insurance (3) for health;
- those over 15 years who did not complete primary school (4) for education;
- those who do not vote in elections (5) and do not participate in organized social activities (6) for participation in society; and
- households without a telephone (7) for access to services (UNDP in Bosnia and Herzegovina, 2007).

Social exclusion can be a useful concept for exploring why certain population groups may be more at risk of poverty and associated health inequities. World Bank studies for eastern Europe and central Asia find that when looking beyond national averages, certain characteristics can raise poverty risk above average. These include being young, living in a rural area, being unemployed and having low levels of education (Alam et al., 2005). There is also evidence that certain social groups suffer considerably higher rates of poverty. These include refugees and internally displaced persons, ethnic minorities (including Roma) and disabled and institutionalized people (Alam et al., 2005). In the EU27 as a whole in 2007, groups particularly at risk of poverty included the unemployed, the elderly, children and those with low levels of education (Eurostat, 2010). These “vulnerable groups” are more exposed to adverse living conditions that result in health inequities. In fact, many of these groups are identified as suffering a markedly greater burden of mortality and disease (EC, 2009a). Ill health may also contribute to poverty and social exclusion, especially when service usage results in catastrophic and impoverishing health expenditure (discussed more in the subsection on financing). In addition, people living with HIV and mental disorders also face exclusion and stigma that can further exacerbate health inequities.

Social exclusion in any of the four dimensions can intersect with exclusion in other dimensions. Discrimination is a powerful example of this. While relating to the cultural dimension, it can also influence the economic, political and social dimensions. For example, respondents to a survey on discrimination in the EU were asked how comfortable they would feel about having various minority groups as a neighbour (with “1” being very uncomfortable and “10” being totally comfortable). The level of comfort about having a neighbour of a different ethnic background was 8.1, but dropped to 6.0 if the neighbour was Roma (EC, 2008).

Discrimination against Roma⁶ has been documented in other areas (such as employment and education). With discrimination experienced across a range of sectors, it is not surprising that poverty rates among Roma are much higher than those in the general population and other socially excluded groups (Alam et al., 2005). Such multifaceted exclusion has clear consequences for health: the Roma can expect to live 10 years fewer than the majority population in some countries (EC, 2009a).

Gender inequality also intersects with other types of inequality to result in exclusion across the four dimensions. Across the European Region, women still work part time more than men, predominate in less-valued jobs and sectors, are on average paid less than men, and occupy fewer positions of responsibility. In the EU, gender segregation in the labour market contributes to the persistent gender pay gap (17.5% on average in 2007) (Eurostat, 2010). Because women are more likely to work part time and interrupt their career for family reasons, they are likely to face negative consequences in terms of pay, career advancement and accumulated pension rights. The resulting financial and employment insecurity can contribute to women’s typically longer lives not necessarily being healthier lives (WHO, 2009c). In both high- and low-income countries, there is evidence of higher rates of illness among women, indicating that women’s potential for greater longevity rarely results in their being or feeling healthier than men during their lifetimes (Sen, Östlin & George, 2007). Women can also face greater challenges in getting the services they need and inequities in education, income and employment can limit their ability to protect their health (WHO, 2009c).

A forthcoming United Nations Development Programme (UNDP) regional human development report analyses social exclusion as the result of multiple and mutually reinforcing deprivation in central and south-eastern Europe, the Russian Federation, the Caucasus and central Asia across three dimensions – economic exclusion, exclusion from social services and civic exclusion. The report indicates that inequalities in access to health care have widened during transition, with less access for the poor, elderly and minorities (particularly Roma) and between urban and rural areas (UNDP, 2010). A major reason for the rising inequality appears to have been significant growth in private expenditure, in out-of-pocket or informal payments and in fees for medicines and services.

⁶ The briefing on policy issues, *How health systems can address health inequities linked to migration and ethnicity* (WHO Regional Office for Europe, 2010a), which is also part of the WHO/EC equity project series, further explores social exclusion experienced by the Roma population.

The report also argues that besides these financial barriers to health care, absence of community-based and tailored services, as well as attitudes and discrimination in the health sector, are similarly important in explaining exclusion from health care services (UNDP, 2010).

The financial crisis and economic downturn

The countries of the European Region have been strongly hit by the financial crisis and economic downturn. A negative impact of the global crisis on human development indicators is already underway (Horváth, Ivanov & Peleah, 2010) and this will significantly affect human capital accumulation and social capital (World Bank, 2009a). The influence of the crisis will be seen across different human development indicators at different times. The lag is shorter for the unemployment rate, young male suicides and life expectancy; it is longer for infant mortality, crime rates and the incidence of various diseases. Income poverty rates also react to changes in income growth with a lag of up to three years (Horváth, Ivanov & Peleah, 2010).

Based on available data, it is evident that the impact of the current crisis on consumption has been considerable and that households experiencing income shocks are reducing expenditure in ways that increase vulnerability to further shocks. For example, about 43% of the surveyed households in Armenia reduced food consumption, reduced or stopped medicine purchases and reduced or stopped visits to health services (Guerschanik Calvo, 2010). In Turkey, where 91% of the poorest 20% of households lost income, 53% of surveyed households reduced food consumption and about 21% reduced visits to health services (Guerschanik Calvo, 2010). In the EU, about 30% of citizens reported that it had become “more difficult” to bear the costs of general health care for themselves or their relatives in the previous six months, 11% felt it had become “much more difficult”, and 18% thought it had become “somewhat more difficult” (EC, 2010). Research conducted in France, Germany and the United Kingdom found reductions in routine health care related to job losses and economic distress (Lusardi, Schneider & Tufano, 2010). In Montenegro, households that experienced an income shock reduced investments in health, life and car insurance, preventive health care and training (Hirshleifer, 2009). Those in the lowest quintile were most likely to cancel insurance or reduce preventive care as a coping mechanism.

Data gathered by the International Federation of Red Cross and Red Crescent Societies (IFRC/RCS) show increasing food insecurity and adverse living conditions linked to the crisis (IFRC/RCS, 2009). The Hungarian Red Cross is distributing much greater quantities of food to meet the growing demand for food aid. More people are asking for money to pay debts or electricity bills and the Hungarian Red Cross is working with electricity companies to reconnect homes cut off due to unpaid bills. The Italian Red Cross reports increases in poverty in big cities and an increased demand for food aid.

Past financial crises in low- and middle-income countries have had a significant adverse impact on nutrition, resulting in worsening of health outcomes for infants and children or slowing down of health improvements (Ferreira & Schadv, 2008). Evidence from past crises shows that children who experience short-term nutritional deprivation can suffer long-lasting effects, including retarded growth, lower cognitive and learning abilities, lower educational attainment and lower earnings in adulthood (Ferreira & Schadv, 2008).

Employment, a key social determinant of health, has been considerably affected by the current crisis. Unemployment in the EU was 9.1% at the end of 2009 and could reach 10.3% in 2010; this is up from 7.0% in 2008 (Council of the European Union, 2010a; EC, 2009c). The unemployment rate at the end of 2009 was more than double for young workers (20.7%) and migrants (19.1%).⁷ Increased unemployment has led to a drop in income for many households, exposing them to poverty and increased debt (Council of the European Union, 2010a). The crisis has also made it much harder for workers who lost their job to return to employment. With the number of unemployed rising and the number of job vacancies falling, competition for jobs has increased. For instance, among the countries joining the EU in May 2004 (EU10), the increase in the number of unemployed per vacancy between the first quarters of 2009 and 2010 ranged from 65% to over 200%. In the first quarter of 2010, there were some 140 unemployed per vacancy in Latvia and 12 unemployed per vacancy in the Czech Republic (World Bank, 2010c).

⁷ Higher unemployment among migrants has led to a considerable decline in remittances in households in countries of origin, with negative implications for household savings and investment (including for health and education). In newly independent states (NIS), remittance flows exceed official development assistance by several multiples. In January 2010, the World Bank announced that remittances to NIS countries had fallen 20–25% since the global financial crisis hit (World Bank, 2010b).

The rise in unemployment has direct and indirect effects on the health of workers (Benach et al., 2010). Loss of income from employment can lead to lower consumption. Anxiety from unemployment can also lead to mental health problems and coping strategies with adverse health consequences.⁸ Layoffs are associated with a higher risk of heart attacks and other stress-related illnesses in the short term. In the long term, the mortality rate of laid-off workers is higher than that of comparable workers who kept their jobs (IMF/ILO, 2010). In addition, existing evidence suggests that parental job and income loss has both short- and long-term negative and persistent effects on children's well-being (IMF/ILO, 2010).

Since 2009, the United Nations Development Programme (UNDP) and partners have been carrying out poverty and social impact analysis (PSIA) to assess the impact of the economic crisis and to generate policy responses to mitigate human development impacts. Box 3 highlights the findings of PSIA national reports.

Box 3. Findings from PSIA projects on the impacts of the financial crisis

The PSIA shows that the crisis in Ukraine spread to virtually all economic and social spheres. Household income fell. In the first quarter of 2009, food spending declined in 8 out of 10 categories. Poverty risks were the greatest among households with children, the elderly and rural households. The modelling results based on the average forecasted macroeconomic indicators suggest that the poverty rate according to the US \$5 (PPP) per capita per day criterion will grow in 2009/2010 by approximately two percentage points.

The economic decline in Armenia is expected to have particularly serious consequences for poor and vulnerable groups who have limited means to deal with successive shocks. Due to the current crisis, another 172 000 people could fall below the poverty line between 2009 and 2010. The achievements of Armenia in poverty reduction over previous years will be erased. Difficulties for 64% of surveyed households are related to high food prices, the difficulties are related to health care for 40% of households, 16% have difficulties due to loss of jobs, and another 16% have difficulties due to decreased remittances.

The PSIA in the Republic of Moldova provides evidence of increasing and deepening rural poverty. Contrary to expectations, the impact of the social crisis is not mainly driven by the loss of remittances; rather, employment and income loss are much stronger, primarily due to the depression of the agricultural sector and the rural economy. Further deterioration in poverty rates is likely if the significant return of migrants continues, with consequent falls in remittances and rising unemployment as returning workers re-enter the domestic labour market. For many of the groups affected by the crisis, social payments are not sufficient to compensate for income losses.

Sources: UNDP (2009b); National Institute of Labour and Social Research of Armenia (2010); United Nations in the Republic of Moldova (2009).

A review of country responses to the crisis is beyond the scope of this briefing. That said, across the European Region, countries' measures to reduce fiscal deficit have varied considerably (Darvas, 2009). Examples of measures include cuts to civil servants' wages, reductions or freezing of pension levels and social security fund savings, and value added tax (VAT) increases (Darvas, 2009). Measures to respond to the social aspects of the crisis have also varied widely across countries. They include the launch of public works schemes, the expansion of actions targeting people living in poverty, enhanced unemployment insurance, the provision of subsidies to retain employment in firms, tax cuts for lower- and middle-income groups and the reduction of social health contributions by employees and employers (WHO Regional Office for Europe, 2009; Darvas, 2009; Islam & Nallari, 2010). Such measures synergize with evidence of the need for public social expenditure to be safeguarded and even increased in the current crisis to protect human capital over the short and long term (United Nations Department of Economic and Social Affairs, 2009).

2. Implications for health systems

This section reviews how health systems are working to address the relationship between poverty, social exclusion and health. It does this by drawing from case studies produced by Member States through follow-up to Regional Committee for Europe resolution EUR/RC52/R7 (WHO Regional Committee for Europe, 2002) (see Box 4), as well as select recommendations from the CSDH and other sources. The section starts with an explanation of key concepts and underlying principles referred to in the subsequent analysis. It ends with considerations on challenges to health systems presented by the financial crisis and economic downturn.

⁸ For example, Popov (2009) suggests that unemployment-related stress was the main factor behind the adult male mortality crisis in the Russian Federation during the transition.

Box 4. Follow up to resolution EUR/RC52/R7

In 2001 and 2002, the WHO Regional Committee for Europe passed resolutions EUR/RC51/R6 and EUR/RC52/R7 (WHO Regional Committee for Europe, 2002) calling for increased action on the links between poverty and health. These resolutions emphasized the need for a rights-based approach to tackling the impacts of poverty on health. They stressed that all Member States of the European Region are affected by poverty, albeit to different degrees, and urged governments to formulate and further develop actions to combat the harmful effects of poverty on health. Resolution EUR/RC52/R7 called for the development, analysis and dissemination of knowledge on the relationship between poverty and health, including through the use of case study research methodology.

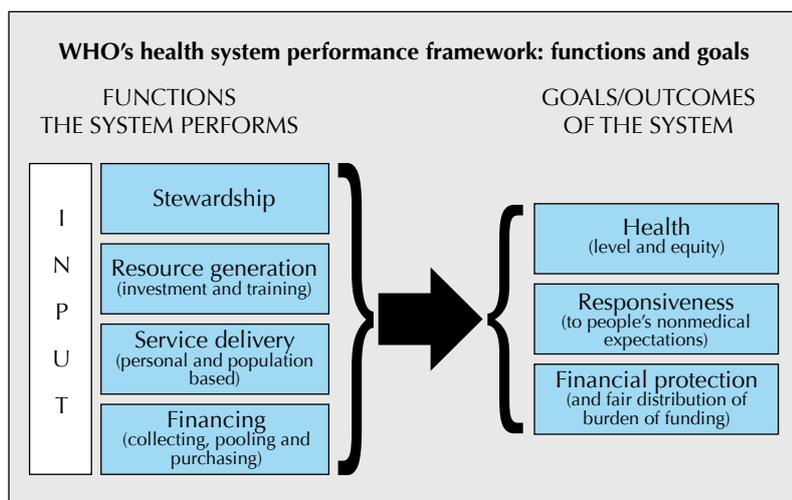
In 2010, WHO released the second book in a series produced through follow-up to the resolution (WHO Regional Office for Europe, 2010b). The book's 22 case studies were written by focal points nominated by their governments. The studies documented lessons learnt in national and subnational experiences in meeting the health needs of people experiencing poverty and social exclusion. The book did not aim to highlight "best practices" (as this would have entailed a systematic evaluation of interventions against tested criteria and the subsequent identification of best practices); rather, the purpose was to use the case studies for qualitative research in which they can be analysed singularly, as a set, and in relation to other comparable case studies.

Key concepts and underlying principles

Three concepts are particularly salient in exploring how health systems can better meet the needs of populations experiencing poverty and social exclusion. The first is an acknowledgement that actions towards this end must simultaneously and synergistically span the four health system functions and encompass action on the wider determinants of health. The second is health as a human right. The third concept is strengthening health systems through a primary health care approach. These three concepts are briefly described below.

A **health system** is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services and activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health (WHO Regional Office for Europe, 2008a). The Tallinn Charter, which was endorsed by European ministers of health in 2008, embodies a commitment by Member States to ensure that health systems pay due attention to the needs of poor people and other vulnerable groups (WHO Regional Office for Europe, 2008a). Actions to address poverty and social exclusion must span all health system functions (financing, stewardship, service delivery and resource generation: see Fig. 1) because action through one function alone will not lead to the desired results. Likewise, actions should go beyond an ad hoc project approach: they should be or become integrated and sustained components of the system, serving as means to attain health system goals (improved level and equity of health, responsiveness and financial protection).

Fig. 1. Health systems performance framework:⁹ functions and goals



Source: WHO Regional Office for Europe (2005).

⁹ This framework was first featured in the world health report for 2000 (WHO, 2000) and has since been depicted in different ways. Some depictions use six building blocks rather than four functions, but essentially the blocks are a disaggregation of the functions. The basic framework is the same.

The **right to health** is a fundamental pillar of efforts to improve the health of populations experiencing poverty and social exclusion. This right is addressed in Article 12 of the International Covenant on Economic, Social and Cultural Rights, and is explained by General Comment 14. The comment indicates that the right to health embraces social factors that promote conditions in which people can lead a healthy life, extending to underlying determinants of health such as food and nutrition, housing, access to safe and potable water and adequate sanitation, safe and healthy working conditions and a healthy environment (ECOSOC, 2000). Furthermore, it sets out the following four criteria by which to evaluate the right to health (WHO, 2008).

- Functioning public health and health facilities, goods, services and programmes have to be **available** in sufficient quantity.
- Health facilities, goods and services have to be **accessible** to everyone without discrimination, within the jurisdiction of the state party. Accessibility has four overlapping dimensions:
 1. non-discrimination¹⁰
 2. physical accessibility
 3. economic accessibility (affordability)
 4. information accessibility.
- All health facilities, goods and services must be **acceptable** to users in terms of being respectful of medical ethics, culturally appropriate and sensitive to gender and life-cycle requirements, and through being designed to respect confidentiality and improve the health status of those concerned.
- Health facilities, goods and services must be scientifically and medically appropriate and of good **quality**.

National focal points conducting case studies through follow-up to resolution EUR7RC52/R7 were asked to reflect on the above criteria in their descriptions of policies and interventions aiming to improve the health of populations experiencing poverty and social exclusion.

The primary health care approach, as highlighted by World Health Assembly resolution WHA62.14 and the CSDH, is essential for addressing the relationship between poverty, social exclusion and health. The values and principles of primary health care are: equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation. Local health services, which provide the first point of contact with the health system, are especially important for meeting the needs of disadvantaged populations. They have a responsibility to provide on-site care where possible and navigate people to other services as necessary. The strength of local health services strongly influences inequities in health and health system access (Ministry of Health and Social Policy, 2010). Ensuring “equity and health in all policies” (Council of the European Union, 2010b) is a key element of the primary health care approach. It includes the provision of evidence, tools and support to the formulation of policy and regulation so that the actions of other sectors support – or at least do not adversely impact upon – health and health equity.

Financing

The way a health system is financed can be assessed in terms of revenue collection, pooling of funds, purchasing of services and development of policies on benefit entitlements and patient cost-sharing obligations. The way these are implemented affects the extent to which policy objectives are achieved. These objectives (WHO Regional Office for Europe, 2008b), include:

1. promoting universal protection against financial risk (“financial protection”)
2. promoting a more equitable distribution of the burden of funding the system
3. promoting the equitable use and provision of services relative to needs
4. improving transparency and accountability of health financing for the population
5. promoting quality and efficiency in service delivery
6. improving efficiency in the administration of health system financing.

¹⁰ Non-discrimination calls for the prevention of “any discrimination in access to health care and the underlying determinants, as well as to means and entitlements for their procurement, on the grounds of race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth, physical or mental disability, health status (including HIV/AIDS), sexual orientation, civil, political, social or other status, which has the intention or effect of nullifying or impairing the equal enjoyment or exercise of the right to health” (ECOSOC, 2000).

Health financing policy can play an important part in reducing health inequities if focused on achieving universal coverage through, for example, removing financial barriers to health services (WHO, 2010b). Evidence globally shows that in systems where public funding dominates, financial protection for patients tends to be better.

The CSDH recommends that national governments ensure adequate public funding for essential health services, focusing on achieving universal coverage of health services regardless of ability to pay and minimizing out-of-pocket health spending (CSDH, 2008).

Ensuring “financial protection” (objective 1 above) means that people should not become poor as a result of using health services, nor should they be forced to choose between their health and their economic well-being (WHO Regional Office for Europe, 2008b). Two indicators are widely used to measure the performance of a health system in terms of providing financial protection, and both can be produced by analysing household survey data:

- the percentage of households experiencing “catastrophic” health expenditure (health spending that exceeds a certain threshold percentage of total or non-subsistence household spending); and
- impoverishing expenditures, measured as the impact of health spending on the “poverty headcount” (the number or percentage of households that fall below the nationally defined poverty line as a consequence of their health spending) or “poverty gap” (the extent to which households fall below the poverty line as a consequence of their health spending) (WHO Regional Office for Europe, 2008b).

In many countries, catastrophic health expenditure is driven principally by spending on medicines, especially for lower-income households. For instance, more than 60% of out-of-pocket expenditure in Latvia was on medicines. Medicine expenditure was more than 80% of household health spending among the poorest quintile, while it was less than 50% among the richest quintile (Xu et al., 2009). Lower-income households with elderly members who have chronic conditions requiring medicines may face particular challenges (Habicht et al., 2006; Xu et al., 2009).

Equitable financing (objective 2 above) implies that, relative to their capacity to pay, the poor should not pay more than the rich. Evidence suggests that compulsory prepaid sources (general taxation and payroll contributions for compulsory health insurance) tend to be more equitable, with voluntary prepaid sources (voluntary health insurance) less equitable, and out-of-pocket payments the most inequitable (WHO Regional Office for Europe, 2008b). In some European countries, current out-of-pocket ceilings per person per year mainly benefit higher-income households (given smaller expenditures on health by the poor); as such, these ceilings do not adequately promote equity in financing (Habicht et al., 2006; Xu et al., 2009).

Equity in utilization means that health services and resources should be used according to need, not by people’s ability to pay (WHO Regional Office for Europe, 2008b). Poorer people can be disproportionately restricted from using services because of their cost. When this occurs, both utilization and out-of-pocket payments by richer people comprise a greater share of the total. In this case, household survey data on health spending will appear to be more equitable than if the poor and the rich used the services equally and paid the same amounts (WHO Regional Office for Europe, 2008b).

The case studies related to resolution EUR/RC52/R7 raise a range of issues related to health system financing and poverty and social exclusion. They highlight the need to address catastrophic health expenditure and impoverishing expenditure, ensure equitable financing and equity in utilization, address informal payments and finance interventions in a way that is sustainable over the long term. Box 5 provides examples of how two countries (Poland and Georgia) are working to tackle these issues through progressively increasing the number of insured individuals and providing benefits packages for poor people.

Informal payments for health care contribute to “catastrophic” and impoverishing health expenditure and inequities in financing and utilization. Informal payments are direct contributions made in cash or in kind by patients (or others acting on their behalf) that are paid in addition to, or are separate from, any payments to health care providers required by the terms of entitlement for services and related inputs (WHO Regional Office for Europe, 2008b).

In some countries, such as Tajikistan, informal payments can comprise a significant source of income for many physicians and nurses. In Tajikistan in 2007, the average monthly salary for doctors and nurses in the health sector was US\$ 17 and US\$ 11 respectively, compared with a workforce average of US\$ 53 (Hamidova et al., 2010). Taken from a resolution EUR/RC52/R7 case study, Box 6 shows an example of efforts to address informal payments in Tajikistan.

Box 5. Progressively increasing the number of insured individuals

A system of universal mandatory health insurance was introduced in Poland in 1999. People have to pay a contribution to the social insurance fund based on their income, with the state paying the contributions of specific groups such as the unemployed and people on social security benefits and pensions. Even though this achieved a high level of coverage of the population (it covers the majority), some people were still not covered by insurance. This prompted the introduction of a voluntary component to the universal health insurance system which allowed people to voluntarily contribute to the national health fund and receive the same rights to health care as insured people. Since the voluntary scheme required contributions that may not be affordable to very poor people, a further scheme was introduced. Based on an application to the local authority, a local decision can now be made to allow free access to health services for poor uninsured people. The many posters and leaflets distributed to places such as homeless hostels contributed to the high rates of uptake in some regions.

Public spending on health care decreased considerably in Georgia during the early 1990s, causing a significant increase in out-of-pocket expenditure. This has imposed an extremely heavy financial burden on the poorest segment of the population and contributed to a decline in equity in service utilization, with poor people refraining from using services. The government launched a medical assistance programme for the population below the poverty line in 2006. This provides 650 000 people identified through a database with a health care package consisting of outpatient and inpatient services. The programme could cover the costs of medication in the future, as a survey indicated that 24% of programme beneficiaries could not afford to purchase prescribed medicines. In line with the government's priority of progressively ensuring financial access to essential health services and protection of the population from the financial risks associated with illness, the programme has expanded to cover more beneficiaries (including some people just above the poverty threshold who may be pushed into poverty as a result of high expenditure on health care). Additional measures are required to address the low levels of insurance coverage of the rest of the population.

Sources: Marek (2010); Chanturidze (2010).

Box 6. Addressing informal payments

In Tajikistan, informal payments constitute a significant part of overall spending on health care and such payments are a major impediment to health care reform. Implementation of the guaranteed benefit package is the first attempt to legitimize these informal payments and to incorporate them into formal health care financing. While deemed the most realistic scenario under current socioeconomic conditions, there is concern about keeping a balance between expenses covered by the state and patient payments, to ensure access, affordability and sustainability of services for low-income people. The case study illustrates that if the issue of low wages of health workers is not addressed alongside the introduction of copayments, then informal payments may continue alongside the official system, exacerbating existing inequities.

Source: Hamidova et al. (2010).

Further case studies on interventions to improve the health of migrant and Roma populations underline the importance of financial sustainability. Often interventions can be of the "project" type, being conducted within a certain period with financing limited to the specific time frame. Once the period is over, these projects often disappear, with elements only occasionally becoming institutionalized in permanent structures. A second, less frequent yet much more optimal, approach is represented by sustained systemic changes to improve the responsiveness of the health system to meeting the needs of populations experiencing poverty and social exclusion. This approach includes the identification of longer-term financing options. Box 7 provides an example of how this is being done in Switzerland.

A range of key issues that requires further action in relation to health system financing and poverty can be identified from the case studies. Supported by other sources of evidence and policy guidance (Xu et al., 2009; World Health Assembly, 2005; WHO Regional Office for Europe, 2008b), these include the following.

- Increased work is required for health system financing objectives of financial protection, equitable distribution of the burden of funding the system and equitable use and provision of services relative to need.

- Fragmentation in financing arrangements is an obstacle to efficient redistribution of resources in relation to need for countries at all levels of income. Some countries have implemented reforms that explicitly reduce fragmentation; for many others, this should be an important “target” for health financing reform.
- In considering all reform options, attention should be given to low-income households and other populations such as those with chronic illnesses, elderly people and those residing in rural areas, all of whom can face higher financial barriers to health services.
- It is necessary to ensure that health financing systems include a method for prepayment of financial contributions for health care with a view to sharing risk among the population and avoiding catastrophic health expenditure and impoverishment of individuals as a result of seeking care.
- Reviews of user charge policies should be conducted for all health services with a view to simplifying, improving targeting and strengthening direct and indirect protection mechanisms.
- It is important to plan for the progressive transition to universal coverage, conducting research to understand the barriers faced by populations who are not covered and the options for expanding coverage within the particular macroeconomic, sociocultural and political context of the country.
- There is a need to rationalize and expand basic packages of health services provided as a universal guarantee within country contexts. This approach weakens the link between contributions (such as earmarked health taxes) and entitlements, in turn strengthening the right to essential health services.
- Given the role of medicine expenditure in many countries in driving catastrophic payments, it may be appropriate to expand benefit packages to cover a wider range of pharmaceutical products. This will require strategies on medicine production, price setting, marketing, sales, doctors’ prescribing behaviours and patients’ consumption behaviours.
- It is necessary to ensure sustainable financing for health system interventions addressing specific situations of social exclusion, such as those faced by Roma and migrant populations.

The forthcoming world health report for 2010 (WHO, 2010a) will explore many of these issues in greater detail.

Box 7. Sustained financing of strategies and interventions

The migration and public health strategy in Switzerland comprises health improvement activities targeting migrant populations. These include actions in five main areas: education; public information, prevention and health promotion; health care provision; therapy for traumatized asylum seekers; and research. Sustainable support was facilitated by a federal council decision to support the strategy over the medium term from 2002 to 2013. While most of the strategy is funded by the Federal Office for Public Health, components are funded through the Federal Office for Migration and the Federal Commission for Foreigners.

Source: Spang & Zuppingen (2010).

Stewardship

Health systems formulate strategic policy direction, oversee regulation and its implementation, provide intelligence to ensure accountability and transparency and align development assistance with national priorities through the stewardship function. In all of these tasks, health equity should be a core consideration. Particularly relevant to improving the health of populations experiencing poverty and social exclusion, stewardship also involves engaging other sectors that influence health (Gilson et al., 2007) by using evidence on the links between social, economic and environmental determinants and health.

The case studies relating to resolution EUR/RC52/R7 provide evidence of the importance of the stewardship function for actions. These include, but are not limited to:

- ensuring mechanisms to involve population groups experiencing poverty and social exclusion and civil society organizations working with these populations in decision-making and practices;
- establishing information systems that have the capacity to routinely collect, collate and disseminate information on health inequities and social determinants of health (stratifying data by gender, social and regional groups); and

- working across sectors to improve the health of populations experiencing poverty and social exclusion.

These action areas are further explored in the subsections that follow.

Participation of people experiencing poverty and social exclusion

The final report of the CSDH underlines the importance of inclusion, agency and control for social development, health and well-being. It states that any serious effort to reduce health inequities will involve empowering individuals and groups to represent their needs and interests strongly and effectively and, in so doing, to challenge and change the unfair and steeply graded distribution of social resources (the conditions for health) to which all have claims and rights (CSDH, 2008).

Multiple case studies conducted through follow-up to resolution EUR/RC52/R7 highlighted measures to involve people experiencing poverty and social exclusion in the design, implementation, monitoring and evaluation of interventions. Such measures included participatory assessment and monitoring activities, involvement in decision-making bodies, involvement as community mediators or as programme staff, and participation in evaluation. Participation of members from the communities in which interventions are intended to produce benefits was cited as being beneficial in relation to outcomes, including:

- overcoming cultural and linguistic barriers and barriers presented by service providers having insufficient knowledge about the dynamics and dimensions of social exclusion facing the community;
- improving marginalized communities' understanding of the health system and other social services impacting on important determinants of health;
- building not only human capabilities in marginalized communities in relation to health, but also developing the important skills that are necessary for community development, such as leadership, community organization and representation; and
- ensuring the long-term sustainability of an intervention.

Moving away from a tokenistic approach to participation, it is important to include intended beneficiary groups in all aspects of policy and programme development, implementation and evaluation. Measures to achieve this should be institutionalized and adequately resourced (in terms of know-how and finances). Efforts should be made to include marginalized groups at all levels of governance on issues that concern their health and well-being. Box 8 features an example of participatory mechanisms at national and local levels in Spain. While it is essential that governments strengthen political and legal systems to ensure they promote the equal inclusion of all, there are parallel opportunities to empower bottom-up action for health equity by supporting civil society to develop, strengthen and implement relevant initiatives (CSDH, 2008). The role of Roma associations in contributing to governance for health equity at national and local levels is also evident in Box 8.

Box 8. Participation

Nationally, the State Council of the Roma Community (Consejo Estatal del Pueblo Gitano) in Spain was created in 2005 as a mechanism for consultation and assessment. The Council is composed of 40 members (50% from Roma associations and 50% from state sector administrations, with representatives from employment, housing, health, education, culture and other sectors). Linked to the Council are working groups composed of representatives from Roma associations and state administrations and other topic-specific experts. There is a working group on health which contributes to the national strategy for health equity for the Roma population.

Locally, a health promotion programme among ethnic minorities in Navarre works in 15 health zones. An intersectoral commission represents the programme in each implementation health zone. The commission typically consists of representatives from the health centre, municipal social services, education centre, a Roma association and a Roma mediator from the health zone. This local commission analyses the community situation, records Roma requests and needs, monitors local activities and objectives and evaluates the programme.

Source: Perez Jarauta, Goya Arive & Merino Merino (2010).

SEKN noted the importance of considering the constraints to effective community participation. Constraints may include a lack of appropriate skills and knowledge on the part of professionals, engagement practices that exclude people (such as the style and timing of meetings) and high transaction costs for lay participants (in terms, for example, of the time commitment required and travel costs). SEKN notes that unrealistic expectations may also undermine initiatives to engage the recipients of policy in planning and implementation, particularly when too much reliance is

placed on the ability of local planning structures to alleviate intractable social problems which require macro solutions.

Information systems that monitor health inequities and social determinants of health

Houlihan (2010) reports that:

Using data from a national household study, research conducted by the Combat Poverty Agency (Ireland) found that 38% of those at risk of poverty and 47% of those living in consistent poverty report having a chronic illness, compared with 23% of the general population.

The CSDH recommends for all countries that health information systems should have the capacity to routinely collect, collate and disseminate in a coherent fashion information on health, health inequities and health determinants. Going beyond the presentation of national averages, health equity surveillance systems stratify data according to gender, social and regional groups. They also include measures of equity in health and determinants between these groups (CSDH, 2008). In many countries, data on different social and environmental determinants of health are currently dispersed across a range of information systems: a surveillance system that monitors health equity brings together data on a broad range of social determinants of health (CSDH, 2008). Such systems should pay attention to inequities that have arisen more recently, including those linked to migration (Stiglitz, Sen & Fituossi, 2009).

The case studies related to resolution EUR/RC52/R7 show that many countries lack the information systems necessary to produce regular data on health inequities and social determinants of health. Problems vary by country and range from lack of adequately updated census data, to there being no uniform standards to documenting the situation of some marginalized groups (such as homeless people), to lack of data disaggregated by ethnicity, among a wide range of other deterrents. The need to move beyond random ad hoc assessments to regular monitoring practices is reflected in many case studies. The importance of qualitative data in relation to the dynamics of social exclusion is also cited. Case study findings synergize with the Spanish EU Presidency's call for further information on health inequities across the whole social gradient and on particularly vulnerable groups (Council of the European Union, 2010b).

In addition to improving data collection to highlight the situation and needs of populations experiencing poverty and social exclusion, attention should also be given to making better use of this information in policy and programme planning and evaluation. Box 9 provides an example of data use from one of the case studies.

Box 9. Information systems that monitor health inequities and social determinants of health

The community health partnership of the north-western zone of Florence (Italy) aims to better integrate social and health services and improve services for disadvantaged populations. The 2005 health profile of the north-western zone was the first assessment of needs produced by the community health partnership. Its purpose was to analyse population needs and to steer the integrated health plan and the design of services. It uses the material deprivation index – which takes into account the variables of unemployment, overcrowding and non-car and non-home ownership – to include aspects of socioeconomic status such as education level, unemployment and housing conditions. Such an assessment of the situation provides data that can be used to compare and evaluate the outcomes expected from community health partnership implementation.

Source: Naldoni (2010).

Data on poverty and social exclusion are important inputs for understanding health equity. Stewardship for health equity surveillance systems comprises advocating at cross-government levels for these data to be collected regularly. UNDP suggest that in some countries of the European Region, income poverty data are collected on an inconsistent basis, weakening the poverty database (Horváth, Ivanov & Peleah, 2010). UNDP recommends that each country compiles, at least annually, an absolute and relative poverty measure on an internationally comparable basis.

Working across sectors

The health sector has a key role in facilitating the “equity and health in all policies” approach and contributing to cross-government efforts to improve the well-being of populations experiencing poverty and social exclusion. Relevant cross-sectoral strategies and programmes described in the case studies include:

- national action plans for social inclusion, national economic development strategies, poverty reduction programmes and national integration plans, all of which should feature health equity and action on determinants of health as an integral part;¹¹

¹¹ Work done by the WHO Regional Office for the Western Pacific (2006) explains that health sector involvement in such policies and strategies helps put “health on the poverty agenda”, and “poverty on the health agenda”.

- comprehensive welfare and social protection policy that includes social health protection, unemployment benefits and pensions, and services and transfers for households living in poverty (see the subsection on responding to the financial crisis and economic downturn for more on social protection); and
- national health inequities strategies that require cooperation across government departments at all levels (see Box 10).

Box 10. Working across government for health equity

The United Kingdom government established a national health inequalities target for England in 2000. The target provided a focus for action, facilitating cross-government action on both upstream and downstream determinants. The government announced a cross-cutting spending review in 2001 to identify the contribution that public services across central and local government can make to deliver this target. This informed the development of the national health inequalities strategy, which was launched in 2003. The delivery of this strategy requires cooperation across government departments at all levels. It assigns roles and responsibilities for action, both within the National Health Service (NHS) and across government departments. Local strategic partnerships are responsible for local delivery: these are found in each county and district and bring together public sector organizations, communities, businesses and the voluntary sector. These partnerships coordinate local action, ensuring mainstream services are responsive to the needs of the most disadvantaged populations. A review of the strategy found that further work is needed to encourage awareness and ownership of the target at local level and to further join up services provided by different sectors.

Source: Earwicker (2010).

In addition, the case studies describe the following mechanisms and means for cross-sectoral collaboration.

- Empowering health workers (including community health mediators/assistants) can provide patients with information on relevant social services and, if appropriate, enable health workers to serve as “bridges” to guide their access to these services.
- Integrated service points that aim to increase accessibility and demand by disadvantaged populations can provide information on health, housing, employment and other services in one location.
- Intersectoral working groups can be created for specific populations at risk of social exclusion: as an example, the Italian Region Veneto case study describes the creation of a high professional immigration body that regularly convenes multisectoral and interdisciplinary stakeholders to review service delivery issues in relation to evolving population needs (Barzon et al., 2010).
- Cooperation between relevant ministries for information products and training can build the health system literacy of disadvantaged populations.
- Engaging in the process of using EU Structural Funds for projects can improve the health and social inclusion of populations experiencing poverty and social exclusion.¹²

Health system stewardship involves having the necessary tools and know-how for cross-sectoral work. Table 3 (WHO, 2010d) describes tools and instruments that have been useful at different stages of the policy cycle. Useful guidance has also been provided on this approach by the Finnish and Spanish EU presidencies (Ståhl et al., 2006; Ministry of Health and Social Policy, 2010).

Table 3. Tools and instruments for applying the “equity and health in all policies” approach

| | |
|---|--|
| • Interministerial and interdepartmental committees | • Community consultations and citizens’ juries |
| • Cross-sector action teams | • Partnership platforms |
| • Integrated budgets and accounting | • Health lens analysis* |
| • Cross-cutting information and evaluation systems | • Impact assessments |
| • Joined-up workforce development | • Legislative frameworks |

* For more information on health lens analysis, see: <http://www.health.sa.gov.au/pehs/HiAP/health-lens.htm>

Source: WHO (2010d).

As Table 3 highlights, equity-oriented health impact assessment methodology is a relevant tool. The CSDH acknowledges that the institutionalization of equity-oriented health impact assessment is at a very early stage and that many countries face challenges in relation to acquiring the required technical skills and institutional capacity. A long-term approach that aims to integrate measures into existing activities and to build institutional capacity

¹² The briefing on policy issues, Opportunities for health systems to influence the use of Structural Funds to reduce health inequities in the European Union (WHO Regional Office for Europe, 2010c), which is also part of the WHO/EC equity project series, further explores this issue.

steadily (without overburdening institutions in the short term) may be required (CSDH, 2008).

As health system stewardship also entails effective donor/aid coordination and the alignment of aid with national priorities, it is important that donors are cognizant of the potential impact of their actions on the social determinants of health and health inequities and that they work to support national equity-oriented development objectives in the health sector and beyond. The United Nations Development Assistant Framework (UNDAF) is the key vehicle for United Nations support to national development priorities at country level. Its results matrix is the collective, coherent and integrated programming and monitoring framework for country-level contributions. UNDAF is a means for United Nations agencies responsible for health to help ensure that their support to the health sector is oriented on equity and that United Nations support provided to other sectors does not unintentionally increase health inequities. There are other donor/aid coordination mechanisms involving nongovernmental organizations (NGOs) and donor agencies that can facilitate similar action.

Service delivery

The most visible function of any health system is the delivery of services. Key issues are the choice of services to be delivered, in what settings, and by what mechanisms. In considering how service delivery can address poverty and social exclusion, it is useful to draw from the CSDH Knowledge Network on Priority Public Health Conditions (PPHC–KN) (WHO, 2010c). This knowledge network analysed how the social context within which a person lives, including the extent of social inclusion or exclusion, can result in:

- differential exposure to health threats and differential vulnerability to those threats;
- differential access to quality health services due, for instance, to geographical barriers and/or differential service-seeking behaviour influenced by financial and other constraints; and
- differential outcomes and consequences as a result of service usage, such as those related to treatment compliance and success, and the potential for catastrophic health expenses.

Service delivery that accounts for poverty and social exclusion must be adapted to address the “differentials” that disadvantaged populations face. The work of the PPHC–KN built on existing frameworks regarding access to, and provision and use of, health care services. For instance, Table 4 features frameworks developed by Tugwell et al. and Tanahashi. The former highlights additional steps required for a successful outcome to be achieved, while the latter focuses on access and proposes four steps to effectively establishing contact with the health service: a user’s experience of access and effectiveness depends on a combination of service provision factors and social determinants related to the user (WHO, 2010c).

Table 4. Two complementary frameworks for viewing obstacles to achieving effective and equitable outcomes of health care interventions

| | Four-step framework (Tugwell et al.) | Five-step framework (Tanahashi) |
|----------------------|--|---|
| Access | Access | Availability coverage Accessibility coverage Acceptability coverage Contact coverage |
| Effectiveness | Diagnostic Accuracy Provider compliance Consumer Adherence | Effectiveness coverage |

Source: WHO (2010c).

Case studies related to resolution EUR/RC52/R7 provided examples of adjusting service delivery to better meet the needs of people experiencing poverty and social exclusion. The case studies underlined the importance of establishing service delivery points in disadvantaged communities, engaging community representatives as partners in delivery, providing culturally and linguistically appropriate services, and accounting for adverse living conditions that affect service-seeking behaviour and treatment adherence (see Box 11).

The case studies also described a patient-centered approach that takes a comprehensive view of well-being. For instance, the study from Austria (Fuchs, Reidl & Schmied, 2010: see Box 11) stated the relevance of practising interdisciplinary and holistic case management when working with homeless people, drawing on social medicine skills. It explained that homeless people require more time during consultations (the longer the period of homelessness, the more time is needed) and that skills in effectively diagnosing and medicating multimorbid patients are essential.

Box 11. Adapting service delivery to meet the needs of populations experiencing poverty and social exclusion

Homeless populations in Austria face considerable barriers to accessing health care. As homeless people prioritize more pressing needs (such as shelter and food), they often tend to ignore symptoms. When they do make contact with the health system, they are often critically ill and require inpatient care. Other barriers include lack of relevant documentation and difficulties in keeping appointment times. The overall aim of the programme *neunerHAUSARZT*, based in Vienna, is to safeguard and improve homeless people's access to standard health services. Currently, four physicians provide regular low-threshold health services at 10 of 24 Viennese hostels for homeless people. From March to December 2006, 661 hostel occupants visited a general practitioner at the hostels. The pilot phase was completed in September 2007 and the programme became permanent, with the Vienna district health insurance fund and the Viennese social fund agreeing to cover all of the costs.

The rates of tuberculosis (TB) notified from the Roma population in Romania are considerably higher than those from the non-Roma population. To address this issue, the Ministry of Public Health and the nongovernmental organization Doctors of the World (United States) developed a community based and culturally sensitive information, education and communication campaign in Bucharest, Ilfov and Neamt. The purpose was to improve the Roma population's knowledge of TB, reduce stigma towards people with TB and improve case detection and the completion of treatment. The target of the campaign was to reach 16 000 people (Roma and other community members) living in conditions that may increase their chances of acquiring TB. The campaign involved the recruitment and training of 40 peer health educators (representatives from the Roma community), the development of educational messages and materials and the delivery of educational sessions. All of the health services promoted during the project were offered within the Romanian public health system.

Sources: Fuchs, Reidl & Schmied (2010); Berger et al. (2010).

The World Bank has done considerable work on improving service delivery for populations experiencing poverty and social exclusion (see Annex 1: World Bank, 2009d). To measure how well a programme is serving populations experiencing poverty, the World Bank suggests looking at its focus and cover.

- **Focus**, also called benefit–incidence, is the proportion of a programme's benefits that go to different groups within a population. If more than 35% of people served by a programme are from the poorest 35% of a population, the programme would be considered "pro-poor". If less than 35% of services go to that group, the programme would be regressive, as it benefits the better-off more than the disadvantaged (Gwatkin, Wagstaff & Yazbeck, 2005).
- **Cover** relates to the percentage of poor people within a country who are reached by the programme. Unlike focus or benefit–incidence measures, which explicitly or implicitly compare coverage among groups within a society, coverage measures refer to a programme's record with regard to the poor alone (Gwatkin, Wagstaff & Yazbeck, 2005).

Resource generation

Resource generation includes the production and deployment of the right mix of human resources, maintaining their competence and productivity through continuous education and training, ensuring the necessary investment in physical infrastructure and facilities, and achieving the best affordable mix of pharmaceuticals and health technologies.

The CSDH underlines the need for health professionals, including physicians, nurses, auxiliary personnel and community workers, to be aware of health inequities and their social determinants (CSDH, 2008). It calls for education institutions and relevant ministries to make the social determinants of health a standard and compulsory part of the curricula of medical and health professionals. It states that all health professionals should receive such training at a basic level as a minimum, and that certain groups should be trained at more specialist levels. The training should address:

- how the social conditions in which a person lives influence health
- the role of the health system in exacerbating or reducing health inequities

- communication and listening skills (such as tailoring communication to meet patient needs)
- gender-linked health inequities (CSDH, 2008).

Case studies related to resolution EUR7RC52/R7 explain how training of health professionals provided in addition to, or as part of, the above issues can cover:

- the possibilities and limitations of patients' treatment cooperation or compliance resulting from their difficult living circumstances and how to deal with them;
- available social and health services for the target group and how patients can access them;
- transcultural understanding and awareness;
- using interpreters;
- conflict management; and
- migration, including how health can be influenced throughout the migration process.

Case studies also focused on mediators/assistants recruited from the community in which the programme intends to confer benefit (see examples in Box 12). These staff can help bridge the divide between health services and excluded populations. The case studies touched on the importance of establishing standard criteria for the recruitment, training and compensation of mediators/assistants from disadvantaged communities.

Box 12. Using and training staff from the target community

The "With Migrants for Migrants" (MiMi) programme was developed in Germany by the Ethno-Medizinisches Zentrum [ethno-medical centre] and was launched in 2003. MiMi's goal is to recruit, train and support intercultural mediators and enable them to teach the German health system and other health topics to their respective migrant communities. As of December 2008, MiMi had trained 781 mediators from 65 different countries and involved over 17 700 migrant attendees at community group sessions. Each mediator receives 50 hours of training before running group sessions for their communities. They are paid €150 for each session they hold or €200 (€100 each) if two mediators opt to have a joint session. Evaluation of programme outcomes point to the importance of using well-qualified mediators and providing fair compensation.

The Association for Culture, Education and Communication (ACEC), a nongovernmental organization in Slovakia, initiated a healthy communities programme in 11 Roma settlements in 2003. As of January 2008, the programme had expanded to 67 Roma settlements with more than 45 000 inhabitants. The programme aims to improve the health status of the Roma population through increased human resource capacity, health literacy, health care access and assessments of Roma health. Most programme staff (including four coordinators and 88 health assistants) are Roma women recruited from within Roma settlements. They complete a Ministry of Education-accredited course that is designed by the ACEC and aims to build their capacity to undertake community health work. Monitoring, supervision, training and support are important in maintaining motivation and facilitating continued growth in staff capability. Likewise, the empowerment of health assistants, coordinators and volunteers from the target communities is essential to the long-term sustainability of the programme.

Sources: Salman & Weyers (2010); Slušná (2010).

Other case studies highlighted the importance of ensuring the presence of adequately trained medical personnel and the availability of medical and diagnostic equipment and other infrastructure in disadvantaged regions and areas. The following excerpt from the case study from the Republic of Moldova describes the challenges in ensuring coverage of family physicians in poor rural areas.

The number of family physicians per 10 000 population was considerably lower in rural areas than in urban areas. Based on the norm of 1500 people to a family doctor, the average for urban areas in 2007 was 6.9 family doctors per 10 000 population. In Chisinau and Balti for that year, it was 7.0 and 6.6 family doctors per 10 000 population, respectively. In the rayons,¹³ the number of family doctors per 10 000 population was 3.9 in Leova, 3.4 in Rezina, 2.9 in Hincesti, 2.8 in Cantemir and 2.5 in Cimislia. Thus, in some cases, one family doctor serves between 5000 and 7000 people, and these people are dispersed between 5 and 6 villages. To improve this situation and create incentives for medical personnel to work in rural areas, the Law of Health Protection was enacted with stipulations about benefits, such as free living accommodation, compensation for a portion of housing expenditures, and an employment allowance of 30 000 Moldovan leu (MDL) (US\$ 2300) for doctors and 24 000 Moldovan leu (MDL) (US\$ 1840) for nurses going to work in rural areas after graduation (Nemerenco, 2010).

Health workers' unwillingness to practise in underserved areas, such as rural or poor areas, presents challenges to improving the health of populations experiencing poverty and social exclusion. Retention of health workers in these

¹³ A rayon is a district.

areas is influenced by political, socioeconomic and cultural factors and often requires a multisectoral response. As part of WHO's efforts to strengthen health systems through a primary health care approach, it has launched a programme on increasing access to health workers in remote and rural areas through improved retention. The programme aims to expand the knowledge base in this domain, provide evidence-based recommendations and supply technical assistance to Member States (WHO, 2009d).

Responding to the financial crisis and economic downturn

In times of crisis, health outcomes and the risk of health-related financial hardship may be affected by changes in the resources available for health systems (financial and human resources, drugs and medical devices, running costs and infrastructure) (WHO Regional Office for Europe, 2009; World Bank, 2009e). In addition, health outcomes can be affected by changes in private resources available for health service usage and healthy lifestyles. They can also be influenced by worsening living conditions and coping strategies.

Populations experiencing poverty and social exclusion are disproportionately impacted by crises as they have less control over resources. Utilization of health services by poor people may decline during crises, as they have less ability to afford them (World Bank, 2009e). As government health expenditure declines, the quality of available services can also decline, with services in disadvantaged areas being most affected. Available services may also be "captured" by the non-poor, as evidence shows that service usage by the population during crises can shift away from private towards public service providers, putting more pressure on the public sector (World Bank, 2009e).

In the European Region, the current crisis has resulted in the emergence of a significant group of "new poor" who must be distinguished from those who have held that status for some time. As existing safety nets much better serve the needs of the latter than the former group, crisis-response policy measures should account for the needs of the new poor (Horváth, Ivanov & Peleah, 2010).

Health systems can respond to the above challenges in multiple ways. As the need to close the fiscal deficit can lead to cuts in social expenditure (Guerschank Calvo, 2010), health systems must protect investment in health, in particular in cost-effective and high-quality public health and primary health care services (WHO Regional Office for Europe, 2009). Public social expenditure, including expenditure on health, should be incorporated in stimulus packages (United Nations Department of Economic and Social Affairs, 2009). The composition of such investments is critical. They should focus on both improving/protecting health and reducing the long-term growth in expenditure through, for example, cost-effective investment in prevention. Even with efforts to protect social spending, there will be a longer-term challenge in sustaining investment as governments adjust their fiscal position. This gives added emphasis to the ongoing need for all countries to improve the efficiency of resource use within the health sector while ensuring quality. By getting more benefits from existing resources, it will be possible to mitigate the severity of the inevitable tradeoffs that arise from the need to bring expenditure into balance with available revenues (Thomson et al., 2009).

The current crisis presents an opportunity to scale up measures to ensure financial access of all people to the health system. Reforms towards creating equity in financing can be undertaken through universal, compulsory and redistributive forms of revenue collection. The forthcoming world health report for 2010 (WHO, 2010a) examines how countries at all stages of development can take actions towards this aim.

At cross-government level, the current crisis requires that the health sector works with other sectors to strengthen comprehensive social protection to safeguard human capital in the short and long term. Health systems can provide tools and know-how for considering the health and equity effects of all political reforms undertaken as part of the crisis response (WHO Regional Office for Europe, 2009). Monitoring and analysing the impact of the crisis in relation to health and the social determinants of health, with proportionate attention to the most disadvantaged populations, are important parts of this.

Health systems can advocate for protecting population health by investing in policies and practices that keep people employed, help those who become unemployed to cope with the negative effects, and get unemployed people back into work as soon as possible (Benach et al., 2010). In this context, particular attention shall be devoted to working conditions and entitlements related to social security and services. Informally employed workers are particularly vulnerable, as they are easily dismissed and do not have the same entitlements as their formally employed equivalents. Health professionals have a role in addressing the health consequences of adverse employment and working conditions (including mental health problems and coping strategies with adverse health effects) (Benach et al., 2010).

In the current crisis context, much attention is being given to how social protection policies and actions can best provide for those in need using the limited resources available. Governments are considering strengthening universal social protection measures and improving the focus of targeted initiatives. According to the SEKN (2008), while targeted measures have benefits, they also have important limitations. Targeted means-tested cash transfers can improve household incomes, increase household assets and create incentives for people to seek work to raise their living standards. They can also trigger multiplier effects in local economies. Targeted means-tested policies providing access to essential services such as health care and education are also resulting in significantly increased coverage. However, the SEKN highlights disadvantages of targeted policies and measures which include, but are not limited to, the following.

- Differential access to information, complex eligibility rules and stigma all restrict the reach of targeting.
- There is potential for fraud in systems for proving eligibility and monitoring compliance.
- The complexity of eligibility processes can facilitate leakages of resources to people who are not eligible.
- Delayed or incorrect payments to recipients and/or service providers can arise because of complex systems combined with weak administrative processes.
- Perverse incentives can be created by eligibility rules or provider payment systems.

Targeting can also demand levels of administrative sophistication or capacity that do not exist in most developing countries (United Nations, 2010). In most lower-income countries, leakage to the rich costs less than means testing (CSDH, 2008).

With regard to conditionality, the SEKN highlights that, while conditional transfer programmes can have significant positive impacts on living standards and health and education outcomes, evidence on the added value of conditionality is inconclusive (SEKN, 2008), as households may undertake the same actions without conditions. Conditional transfer programmes are not always responsive to changes in the need for assistance, making it critical that governments reassess eligibility when a crisis occurs (World Bank, 2009e). In addition, conditional transfer programmes do not improve the quality of services provided: while they may serve to increase demand, they should be implemented in parallel with measures that ensure adequate access to, and quality of, service delivery (World Bank, 2009e).

Universal approaches to social protection are built on the principle that social protection is a social right of all people (CSDH, 2008). As all people, rather than just one targeted group, potentially benefit, this approach strengthens social cohesion. Measures to reinforce social cohesion are particularly timely given the social distress caused by the current crisis. According to the International Labour Organization (ILO), cases of social unrest related to the financial and economic crisis have been reported in at least 25 countries globally – many of them in advanced economies (International Institute for Labour Studies, 2010). Perceptions of unfairness are growing in 46 out of 83 countries with available data. People have less confidence in governments than prior to the crisis in 36 out of 72 countries with data. The report shows that higher unemployment and growing income inequalities are key determinants of the deterioration in social climate indicators.

Budgets for universal social protection systems (which can be tax-based, contribution-based or a combination of these) tend to be larger and possibly more sustainable than budgets for targeted systems (CSDH, 2008). Countries that have universal systems generally have less poverty and income inequality than countries with targeted systems (CSDH, 2008). Universal systems can be achieved progressively, one block at a time, through the application of a long-term view in social policy planning. While resource constraints can constitute barriers to their advancement in the short term, there are important arguments for creating systems that from the outset have as their goals the progressive attainment of universality and enhanced generosity.

Acknowledging their benefits and drawbacks, the SEKN recommends that targeted policies and actions only be implemented within a framework of guaranteeing human rights and universal access to essential services and socially acceptable living standards (SEKN, 2008). This view is reflected in the final CSDH recommendation on social protection:

Governments, where necessary with help from donors and civil society organizations, and where appropriate in collaboration with employers, build universal social protection systems and increase their generosity towards a level that is sufficient for healthy living; ... use targeting only as back up for those who slip through the net of universal systems; and ... ensure that social protection systems extend to include those who are in precarious work, including informal work and household or care work (CSDH, 2008).

Evidence shows that social protection helps to build human capital and labour productivity, contributing to sustainable economic growth (IMF/ILO, 2010). In developed countries, studies have shown the positive correlation between the level of social security expenditure per capita and productivity and reduction of poverty rates, and that the effects can be even higher for developing countries (IMF/ILO, 2010). The current crisis presents an opportunity for governments to update their social protection frameworks and policies and, where available, their poverty reduction strategies and other strategies for social inclusion (Horváth, Ivanov & Peleah, 2010). As was stated above, the health sector has an important contribution to make to such endeavours. In the process of making updates, governments should weigh the short-term costs and benefits (such as savings on social programmes) against long-term ones (eroding the human capital base for human development, for instance) (Horváth, Ivanov & Peleah, 2010). The Social Protection Floor Initiative (see Box 13) aims to provide support to Member States in the process of updating their social protection framework and policies.

Box 13. Social Protection Floor Initiative

The Social Protection Floor Initiative (SPF-I) was adopted by the United Nations Chief Executive Board as one of the key priorities to cope with the current global crisis. The SPF approach entails the provision of a set of essential transfers, services and facilities that correspond with meeting basic human rights. By working on both supply- and demand-side measures, the SPF approach includes:

- ensuring the availability, continuity and geographical and financial access to essential services such as water and sanitation, food and adequate nutrition, health, education, housing, life- and asset-saving information and other social services; and
- realizing access by ensuring a basic set of essential social transfers, in cash and in kind, to provide a minimum income and livelihood security for poor and vulnerable populations and to facilitate access to essential services.

Led by ILO and WHO and bringing together the expertise of agencies from across the multilateral system, the SPF-I offers technical assistance to countries for building, expanding, extending or reorienting their social protection systems. SPF-I activities include capacity building for national governments on social protection and the development of a methodology for assessment-based national dialogues on social protection options. The initiative will also support the creation of national SPF task forces that will: take stock of the present SPF situation and the impact of the crisis, as well as the country's response to the crisis; identify viable policy options and concrete proposals; evaluate the cost and long-term financial sustainability; carry out fiscal space analysis; and support the implementation, monitoring and evaluation of identified policy measures.

Source: ILO/WHO (2009).

3. Select stakeholder action areas

What follows is a non-exhaustive list of example action areas for health system stakeholders working to improve the health of populations experiencing poverty and social exclusion. It draws from the analysis presented in the previous section on health system implications and World Health Assembly resolution 62.14, which endorsed the findings of the CSDH.

Policy-makers and advisers

Policy-makers and advisers can work to address the needs of populations experiencing poverty and social exclusion through their roles in formulating strategic policy direction, overseeing regulation, providing intelligence for accountability and transparency and working across sectors on the wider determinants of health. Example action areas include the following.

- Policy-makers and advisers can ensure that measures to address the health needs of populations experiencing poverty and social exclusion include simultaneous equity-oriented action across all health system functions (financing, stewardship, service delivery and resource generation), as action through one function alone is unlikely to achieve the desired result.
- Drawing from the four criteria for evaluation of the right to health (that is, availability, accessibility, acceptability and quality) and related guidance, they can invest in identifying the civil, political, economic, social and cultural factors that impact on the health of people who are experiencing poverty and social exclusion. They can then use this analysis to inform policy and programme design to support progressive realization of the right to health (WHO, 2008).

- They can use the values and principles of the primary health care approach (equity, solidarity, social justice, universal access to services, multisectoral action, decentralization and community participation) as the basis for health system strengthening.
- They can enable health system financing to be a key policy instrument to reduce health inequities by focusing it on achieving universal coverage through, for example, removing financial barriers to health services.
- They can ensure adequate and sustainable funding of interventions to improve the health of populations experiencing poverty and social exclusion. In this regard, attention should be paid to the concept of “proportionate universalism”, which entails that programmes targeting poorer groups should not advance at the expense of universal programmes (Marmot et al., 2010), as this approach has proven insufficient for reducing health inequities.
- They can build the competencies and platforms for facilitating “equity and health in all policies”, which is highly relevant to tackling socially determined health inequities as they are largely driven by forces outside of the health sector. This includes overseeing the health sector’s contribution to national plans and strategies that address social inclusion and poverty reduction so that health equity measures can be integrated into these.
- They can create, use and finance institutional platforms and tools for systematically engaging with other sectors for “equity and health in all policies” at national, subnational and local levels. These include, but are not limited to, equity-oriented health impact assessments, interministerial and interdepartmental committees and legislative frameworks. This involves anticipating and acting on opportunities to advance health equity through broader social and economic policies where health equity is not a stated goal (Gilson et al., 2007).
- Participation, while benefiting programme outcomes, is an intrinsic value in itself. As such, policy-makers and advisers can ensure mechanisms to enable disadvantaged populations and civil-society organizations to work with them in the development, implementation, monitoring and evaluation of policy and practice.
- Policy-makers and advisers can facilitate accountability for the transfer of national policy objectives and targets related to equity to local level, specifically in the most disadvantaged areas, and ensure that services in disadvantaged areas have the necessary human and financial resources and infrastructure to be responsive to the needs of the population. This may entail strategies for the retention of health professionals in these areas (including compulsory service programmes).
- As comprehensive social protection reduces poverty and safeguards human capital in a way that can reduce health inequities, they can work towards the progressive realization of a universal social protection floor, or set of essential transfers, services and facilities, using targeting only for those who fall through the cracks of universal services (CSDH, 2008).
- In the context of the current financial crisis, they can protect investments in health (particularly in cost-effective public health and primary health care services, including prevention), incorporate public social expenditure into stimulus packages and work to improve the efficiency of resource use within the health sector.
- As the financial crisis has become an employment crisis with negative implications for health, they can advocate at cross-government levels policies and practices that keep people employed, help those who become unemployed to cope with the negative effects, and get unemployed people back into work as soon as possible.

Programme and project managers

It is important that all aspects of a programme or project consider the needs of populations experiencing poverty and social exclusion. Example action areas include the following.

- Programme and project managers can build equity considerations into needs assessments during the design of a programme or project and subsequently reflect them in all aspects of development, implementation, monitoring and evaluation. Equity should be accounted for in availability, accessibility, acceptability,

contact coverage, diagnostic accuracy, provider compliance and consumer adherence (WHO, 2010c). To measure how well a programme is benefiting populations experiencing poverty, both its focus/ benefit–incidence and cover should be reviewed.

- They can consider the feasibility of health interventions that could be coordinated with other sectors to address the social determinants of health and consider, as appropriate, options for integrated/joined service provision. This would enable health professionals to work with professionals from other social sectors to provide the multifaceted services necessary to improve the well-being of populations experiencing poverty and social exclusion.
- They can improve information and communication to strengthen demand for services among populations experiencing poverty and social exclusion. This can be done in the context of a wider strategy to ensure participation of these populations.
- When discrimination contributes to social exclusion, and/or where cultural and linguistic barriers present barriers to quality care and obstruct health system responsiveness to population needs, they can ensure that programme or project staff have the necessary guidance, knowledge and tools.
- They can maximize synergies between vertical disease-specific programmes and strengthening health systems based on the values and principles of primary health care (including equity and universal coverage).

Information system managers/analysts and researchers

Information systems are at the core of guiding development processes sensitive to the needs of people experiencing poverty and social exclusion, since what is measured affects what is done (Stiglitz, Sen & Fitoussi, 2009). Researchers (in academia, research institutes and other entities) also play a key role in expanding the knowledge base. Example action areas include the following.

- Information system managers/analysts and researchers can improve health information systems to monitor and measure the health and health system access of all populations within their jurisdiction, with data disaggregated according to age, sex, education, employment, socioeconomic status, ethnicity (wherever legally possible) and migrant status so that inequities can be detected.¹⁴ Specific attention should be paid to children and elderly people (that is, those aged above 65 years) as these groups are, on average, more exposed to poverty and have specific needs.
- They can ensure that information on inequities in health and health system access is regularly synthesized and shared with relevant health system stakeholders and users.
- They can strengthen efforts on measurement and evaluation of the social determinants of health, enabling better monitoring of the impact of policies and interventions, and develop and monitor targets on health equity (the definition of a small but specific set of indicators should be encouraged). They can also ensure an ongoing dedicated budget line for these activities.
- They can invest in qualitative research that can help to develop understanding of how the intersecting dimensions of poverty and social exclusion impact on health and the potential entry points for improved service delivery. This type of research can also further expose how power dynamics (such as gender and age differences) within a community influence inequities.
- They can regularly gather and analyze data on the service provider network and human resource availability in relation to population needs. This may entail strengthening human resource information systems and evaluating strategies to retain health professionals in disadvantaged areas.
- They can carry out research on the economic consequences of health inequities, as this provides relevant evidence in relation to the costs of interventions and equity-oriented reforms to the health system.

¹⁴ More information on monitoring health inequities can be found in Chapter 16 of the final report of the CSDH (2008) and in the background report of the Spanish EU Presidency (Ministry of Health and Social Policy, 2010).

- They can advocate at cross-government levels for improvements in data on poverty and social exclusion, as this is an important input for understanding health equity.

Trainers/educators

Making health systems more responsive to the needs of populations experiencing poverty and social exclusion will rely on building the capacity of health professionals. Pre-service training, continuing education programmes and special training activities are key platforms for this. Example action areas include the following.

- Trainers/educators can provide training on poverty and social exclusion as determinants of health inequities (ideally as part of training on a cross-gradient approach to reducing health inequities). Modules on nondiscrimination and how to address the impacts of poverty and social exclusion on vulnerability to ill health, care-seeking behaviour, treatment compliance and consequences of care could be included. The curriculum should also examine intersecting inequities (such as by gender and age) and explore effective communication styles.
- They can offer capacity building on means for engaging with other sectors for “equity and health in all policies”, with attention to policy areas most salient to the needs of populations living in poverty and social exclusion. This type of training could include a focus on the use of equity-oriented health impact assessment tools.
- They can provide training for health professionals on enabling effective participation of intended beneficiary groups in policy and programme development, implementation, monitoring and evaluation.
- They can develop criteria for community mediators/health assistants to be recruited from disadvantaged communities, devise pre-service training and continuing education opportunities for them and work to oversee fair and adequate compensation for their services.

Civil-society and international organizations

The state has the primary responsibility for ensuring the human rights of all people living in its jurisdiction (WHO, 2008), including people experiencing poverty and social exclusion. However, civil-society and international organizations also have important duties and roles. Example action areas include the following.

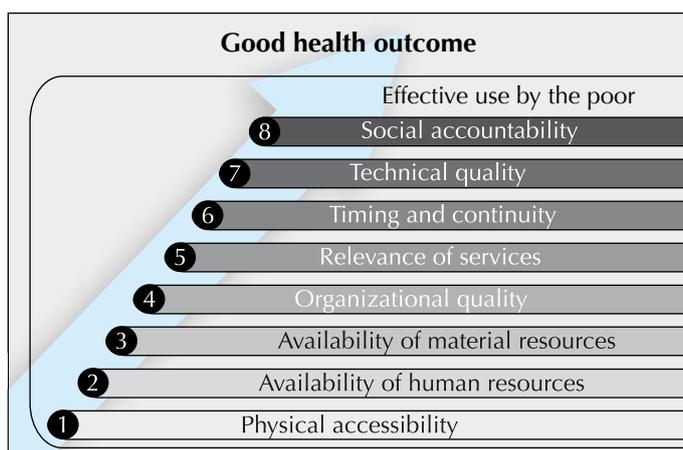
- Civil-society and international organizations can incorporate equity considerations into planning, implementing, monitoring and evaluation processes. This should be done systematically for all activities, whether these are short-term projects, the provision of ongoing technical support to a national authority, or normative/evidence-gathering work. They should reflect equity principles in how the organization is staffed and managed.
- With regard to donor/aid coordination, they can assess the potential impact of aid on the social determinants of health and health inequities in the recipient country and align aid to support national equity-oriented development objectives in the health sector and beyond. They can use UNDAF and other donor/aid coordination mechanisms as vehicles for this.
- They can improve cooperation among multilateral system entities endeavouring to improve the health of populations experiencing poverty and social exclusion. This would involve bringing together areas that currently tend to advance in silos (on human development, the right to health, health care for the poor, and follow-up to the CSDH, for instance).

Annex

The diagnostic tool in Fig. 2 (World Bank, 2009d) takes a linear approach to analysing the complex, interlinked and nonlinear constraints that disadvantaged populations face in effective service usage. This is explained as follows by the World Bank (2009d).

1. The first step is to consider whether health services are available and sufficiently accessible to the poor. Distance is clearly an important factor, and travel time, regardless of distance, can become a significant factor.
2. The second step in the diagnostic tool considers the availability of human resources. Services may be geographically accessible, but trained staff may be unavailable or in short supply part of the time.
3. The third step in the diagnostic tool examines the availability of essential medicines and supplies at public and private facilities or outreach programmes serving the poor.
4. The fourth step examines the organizational quality of service delivery mechanisms. The organization of health services that serve poor populations may deter, rather than attract, poor patients.
5. The fifth step examines the degree to which the health sector provides services that are relevant to the diseases that affect the population, especially the poor. Although a core package of interventions may be defined, it may not be delivered in practice. Examining the mix of services is critical in judging whether priority is really given to the most relevant.
6. Step six in the diagnostic tool relates to the timing and continuity of services. Some key health services, such as emergency obstetric care and epidemic control measures, must be delivered in a timely manner.
7. The seventh step, technical quality, comprises several issues. Are the services used by the poor of lower technical quality compared with those provided to the better-off population?
8. The last step, social accountability,¹⁵ examines to what extent health systems are accountable to poor and socially excluded communities.

Fig. 2. Eight steps to effective use of health services by the poor



Source: World Bank (2009d).

While these steps can contribute to improved health outcomes, they must be complemented by cross-government measures to improve the daily living conditions of populations experiencing poverty and social exclusion, as the bulk of health inequities linked to poverty and social exclusion are driven by forces outside of the direct control of the health system.

¹⁵ According to the Health Systems Knowledge Network of the CSDH, accountability involves answerability (that is, the obligation to inform and explain) and enforceability (that is, the holding of authorities to task over commitments of obligating a review of practice) (Gilson et al., 2007).

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Notes



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



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Health systems will not automatically gravitate towards greater equity or naturally evolve towards universal coverage. Economic decisions within a country will not automatically protect the poor or promote their health. Globalization will not self-regulate in ways that ensure fair distribution of benefits. All of these outcomes require deliberate policy decisions.

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