Healthy, prosperous lives for all in the European Region

High-level Conference on Health Equity
Ljubljana, Slovenia
11–13 June 2019

Background paper
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**Acronyms**

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<th>Acronym</th>
<th>Definition</th>
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<tr>
<td>BFHs</td>
<td>Baby-Friendly Hospitals</td>
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<td>CDH</td>
<td>Commercial determinants of health</td>
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<td>HESR</td>
<td>Health Equity Status Report</td>
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<td>NCDs</td>
<td>Noncommunicable diseases</td>
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<td>NEETs</td>
<td>Young people not in education, employment or training</td>
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<td>SDGs</td>
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Executive summary

This Background Paper was produced to support and inform the discussion at the high-level conference on Promoting Health Equity in the WHO European Region: Healthy, Prosperous Lives for all, to be held in Ljubljana, Slovenia on 11–13 June 2019.

Health equity is a core value in the United Nations 2030 Agenda for Sustainable Development, the Health 2020 European health policy framework and the principle of universal health coverage. In addition, WHO’s Thirteenth General Programme of Work 2019–2023 emphasizes the right to the highest attainable state of health and the importance of access to universal health coverage. In addition, despite increases in life expectancy, there are profound inequities in every country in the Region in terms of sex, income level and number of years of education. Countries have taken many actions and implemented many policies at local, county, oblast and national levels, but progress in reducing health inequities has been slow.

The issues, problems and challenges concerning health inequities are well known and it is time to focus on the solutions. The WHO European Health Equity Status Report (HESR) initiative provides new evidence, equity-focused metrics and a wealth of good practices from countries that give reason to be confident.

Commonly, the narrative on health inequities is that health inequity is too complex and difficult to address and governments are unclear about the most effective policies and approaches. The underlying conditions of health equity are set out in five areas: health services; income security and social protection; living conditions; social and human capital; and work and employment. Removing barriers for all to prosper and flourish in health and in life involves identifying an essential set of conditions for all to be able to live a healthy life. These essential conditions are the foundation for effective and sustainable progress.

Implementing the policies and intervention to reduce health inequities for all requires Member States to build on universal policies and shift from single-policy interventions to adopt a basket of whole-of-government and whole-of-society solutions. Making progress towards healthy, prosperous lives for all requires systematic action, including scaling up and adapting what works and generating new solutions and alliances that break down the barriers to progress.

Addressing broader social and institutional factors is vital to accelerating the reduction of health inequities. Policy coherence, accountability, participation and empowerment to drive health equity can encourage people and communities to actively engage with decisions affecting their health and well-being, or discourage such engagement. Health policies can have a greater impact and tackle unintended negative effects on health equity from other sectors if they are combined and coordinated across actors, institutions and levels of governance.

Health equity is vital to achieving sustainable development and inclusive economies, which involves informing policies, plans, strategies, business models and investment. Including social values in financial and economic policy will help to achieve sustainable development, the Sustainable Development Goals (SDGs) and inclusive societies, and remove the barriers so all can prosper.

This Background Paper draws heavily on the Health Equity Status Report and related documents.
1. Introduction

• The WHO European Region has seen success overall, with nearly one billion people now enjoying a life expectancy that has reached 78 years for both sexes. Despite these successes and commitments, there is still a substantial Regional gap in life expectancy, with the average ranging from 71.6 years to 83.1 years.

• After 20 years of action and unprecedented commitment to addressing health inequities in the WHO European Region, we have learned that no single intervention will create equal opportunities and outcomes in terms of health and well-being for all. What is needed is a comprehensive approach that addresses political processes, creates spaces for empowerment and participation and ensures accountability of decisions, the core drivers of all policies to reduce health inequities.

• Realizing the SDGs in the WHO European Region requires sustained commitment to addressing health inequities. These inequities start at birth. In some countries of the WHO European Region, babies born to families in the lowest income quintile are more than twice as likely to die in the first year of life than babies born to families in the highest income quintile.

• Some parts of the WHO European Region are thriving but there are many others, in every country, where incomes have stalled or been reduced, and where people feel left behind. Health inequities exist in every Member State. Leaving no one behind will involve significant work and renewed efforts to allow all people to live healthy and prosperous lives.

1.1 Slow progress

• Many countries, regions, and communities have taken action to address health equity but the rate of improvement to reduce avoidable gaps in health is slower than anticipated and below what is possible, given the existing knowledge and commitments. Key reasons for the slow progress include:

  – The perception that health inequities are too difficult or too complex to change or that such is the natural order in society, i.e. that some people are poor and these people have poor health. All these are disincentives to prioritize and take systematic action and can result in low political commitment and policy action to reduce inequities.

  – Uncertainty about what to do and what policies and investments to prioritize.

• The lack of knowledge or failure to implement the optimal mix of policies and approaches with the necessary scale and intensity over time.

• The lack of metrics and data to measure health inequities and to monitor progress.

• Failure or inability to influence and sustain action across government, between professionals and in pan-European/international decision-making processes.

• Poor understanding of the reality of the lives of people who are being left behind or people who are at risk of falling behind. This can undermine the equity effects even of good universal policies.

• The slow progress to reduce health inequities does not correspond to Europeans’ values and priorities. An analysis of public opinion polls across Europe for the HESR shows that, across the Region, people believe good health is the top priority for getting ahead in life.

1.2 Time for action

• Making progress towards healthy, prosperous lives for all requires systematic action, which includes scaling up and adapting what works and generating new solutions and alliances that break down the barriers to progress.

• Focusing on single interventions as so-called magic bullets neglects the broader political process and power dynamics within societies and communities. This includes factors or drivers such as accountability, policy coherence, empowerment and participation.
Investment analysis commissioned by WHO reveals that if the triple billion goal were to be attained, this would result, over the five-year period of the General Programme of Work, in 29 million lives saved, 100 million healthy life years and 2–4% economic growth in low- and middle-income countries (1, 2).

1.3 Frameworks and resolutions driving health equity

Attention to health equity, gender equality and the right to the highest attainable standard of health has never been more important. The principles of health equity and universal health coverage lie at the core of many WHO commitments to leaving no one behind and creating the conditions for all people to flourish. Numerous WHO commitments and policies seek to ensure that equity is central to the implementation of its programmes across genders, age groups, ethnicities, disabilities and other differences in order to close coverage gaps, enhance participation and resilience, and empower women, men, girls and boys from diverse communities (Table 1).

These commitments are based on well-known conceptual frameworks and approaches to health inequities, such as the Dahlgren-Whitehead rainbow model (1991), which shows the social factors influencing health inequities (3). The Commission on the Social Determinants of Health and the European Review of Social Determinants have also provided evidence and frameworks showing that the causes of poor health and well-being reside in the social environment, and the conditions in which people grow, live, work, and age (4,5).

These frameworks emphasize the interaction between determinants that shape the causal pathways to equity and inequity. No single factor causes or perpetuates inequities. It is also necessary to consider the nature of society and the wider societal-level processes influencing exposures to conditions that harm and promote health and resilience. Exposures are, in general, unequally distributed across society, socioeconomic positions and other factors such as race or ethnicity or gender. These factors affect how much one is exposed to health-harming or health-promoting conditions.

Table 1. WHO commitments to leaving no one behind and creating the conditions for all to flourish

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<th>Long-standing commitments</th>
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<td>Minsk Declaration on the Life-course Approach in the Context of Health 2020</td>
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1 The Thirteenth General Programme of Work 2019–2023 aims to ensure healthy lives and promote well-being for all at all ages by: achieving universal health coverage – 1 billion more people benefiting from universal health coverage; addressing health emergencies – 1 billion more people better protected from health emergencies; and promoting healthier populations – 1 billion more people enjoying better health and well-being.
<table>
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<th>Health strategies and programmes committed to leaving no one behind</th>
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<td>Global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular, against women and girls, and against children, 2016</td>
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<th>Health equity as an input to and an outcome of inclusive and sustainable development</th>
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2. Achieve: Create the essential conditions and remove the barriers needed for health equity

- There is an essential set of conditions needed for all to prosper and flourish in health and in life. These are the foundations for effective and sustainable progress. The conditions may vary across countries and from one person to another, but the five policy areas are key to creating and sustaining the essential conditions for a healthy life for all.

- These five conditions are statistically significant in explaining the gaps in health inequities within countries:
  1. Inequity in access to and quality of health care
  2. Financial insecurity and not being able to make ends meet
  3. Poor-quality housing and neighbourhood environment
  4. Higher levels of social exclusion in more disadvantaged groups
  5. Lack of decent work and poor working conditions.

- Achieving equitable improvements in health and well-being is intimately connected with improving each of the five conditions for all, through a basket of universal measures that match the scale and the level of disadvantage. The HESR dataset provides evidence and guidance so countries can remove the barriers that hold people back and can create the conditions for all to prosper and flourish in health and in life.

2.1 Health and health services

- The drive for universal health coverage is a vital step towards reducing health inequity. Policies are needed to ensure the availability, accessibility, affordability and quality of prevention, treatment, and health services and programmes, ensuring everyone can use the quality health services they need without experiencing financial hardship.

- Inequities in the quality, affordability and accessibility of health care services are key contributors to health inequities. Health systems are vital to achieving fiscal sustainability and in driving implementation of local and national goals for sustainable development.

- Differences in the quality of services involve unfair distribution of health care, where some individuals receive more or better care than others. Quality of health services affects those who are at risk of being left behind (such as people with disabilities, poorer households, single-parent households, migrants, ethnic minorities), as they face a higher risk of poor-quality services.

- In the WHO European Region, several million people experience financial hardship driven by out-of-pocket payments for health. Out-of-pocket expenditure on health may prevent people from spending enough on other basic needs, such as food, housing and heating, which contributes to increased risk of poverty and social exclusion.

- Impoverishment caused by out-of-pocket expenditure affects up to 15% of households in countries in the European Region. In the European Region, in over half of the countries (32/52) out-of-pocket expenditure as a proportion of current health expenditure increased or remained similar between 2000 and 2016. This suggests that inequitable access to health care along with an elevated level of financial risk has not changed or has increased, leading to greater impoverishment and the perpetuation of economic vulnerability.

- As the European Review of Social Determinants concluded, inequity in access to health services is an issue influencing health inequities in the eastern part of the Region. Whilst access is not a factor in the north, south and west of the Region, better-quality disaggregated data is needed to better understand access to health services in the eastern part of the Region.
2.2 Health and income security and social protection

- Income and employment insecurity and worries over making ends meet are strongly associated with inequality gaps between income quintiles in reporting mental health within European countries.

- From a health and well-being perspective, income security is considered critical to health and well-being and one of its central determinants (4, 7). Reducing income poverty and social exclusion tends to reduce poverty rates, and lower poverty rates are associated with lower health risks (8, 9, 10). Social protection enhances the accumulation of human and social capital, thereby promoting individual productivity, which is essential for economic growth and sustainable development.

- The relationship between income and poor health is well understood and there is strong cross-country evidence of a link between income insecurity and poor health.

- Social protection expenditure has not increased in most countries. Each country has different types of social protection programmes and systems and, consequently, different levels of social protection. In two thirds of countries in the Region where data is available, social protection expenditure as a percentage of gross domestic product remained similar between 2000 and 2012 (6).

- These negative health outcomes are exacerbated by fiscal constraints and rising bureaucratic barriers of access to basic income security and social protection (11, 12).

2.3 Health and living conditions

- Inequities in living conditions, such as quality and availability of housing and community amenities, fuel and availability of green spaces, reflect inequities in safety, and a sense of belonging and security. Housing is more than where you live, it provides a sense of belonging, and feelings of safety, security and privacy. Insecure housing generates stress. Housing can be insecure for many reasons - due to costs, weak security of tenure, fuel deprivation and overcrowding (13, 14). Every year, more than 100 000 deaths occur in the WHO European Region as a result of inadequate housing conditions (15).

- The socioeconomic gradients in housing and fuel deprivation and overcrowding are very strong. In virtually all countries, those in the lowest income quintile are at higher risk of poor housing conditions than those in wealthier quintiles.

- Countries with lower expenditure per head on housing and communities tend to have larger gaps in severe housing deprivation, yet a quarter of the countries in the Region have decreased their expenditure per head on housing and community amenities since 2000 (6).

- Feeling unsafe in your own home is more likely if you have fewer years of education. Those with fewest years of education are most likely to feel unsafe in their own homes compared to those with more years of education. In 80% of countries, expenditure on housing and community amenities either stayed the same or declined between 2006 and 2017 (6).

- There remain inequities in access to basic drinking water in some countries in the Region. In 4 countries in the Caucasus and Central Asia subregion, there are substantial inequities,
with those on the lowest incomes going without basic drinking water services (6). In 2015, inequalities in access were reported within and between urban and rural areas in the European Region, ranging from 93.1% to 100% for populations in urban areas, and from 66.7% to 100% for populations in rural areas (16).

**Box 3. Case studies – Living conditions**

**Case study 5:** To reduce the number of households living in fuel poverty in Wales, the United Kingdom, the Welsh Government’s Warm Homes Programme adopted a whole-house approach to home energy efficiency improvements, which provides low-income households with free new installed systems.

**Case study 6:** After conducting a self-assessment on equitable access to water and sanitation by applying the Equitable Access Score-card, Armenia developed a two-year Action Plan to improve access to water for 579 rural communities.

### 2.4 Health and social and human capital

- Inequities in social and human capital reflect inequities in a sense of power and control over life and health. Inequities relating to a sense of security, belonging, and control over life are some of the largest contributors to differences in mental and physical health and well-being. A sense of belonging, trust in others and feeling safe are important to human well-being.

- Trust is one of the broader measures of social capital and a strong marker of well-being, both at the individual and societal level, as well as a fundamental condition of collective action and cooperation (17, 18).

- The education gradient in health has an intergenerational element, and across the Region children of parents with the fewest years of education are much less likely to meet minimum proficiency levels in mathematics and reading at age 15 than children of parents with the most years of education. There are positive signs of policy action to break this intergenerational transmission of education gaps and associated health gradient through investment in early childhood education and care; government expenditure on pre-primary education has been rising in most countries across the Region from 2012 to 2015 (6).

**Box 4. Case study – Human and social capital**

**Case study 7:** To reduce discrimination and enhance social cohesion between Roma and local communities, the TOY for Inclusion initiative aims to promote diversity and inclusion through community-based early childhood education and care in Belgium, Croatia, Hungary, Italy, Slovakia and Slovenia.

### 2.5 Health and decent work and employment conditions

- Equity in opportunities for secure, decently paid employment with decent working conditions is important for promoting health inequity. Employment and high-quality work are critically important for population health and health inequities. Participation in or exclusion from the labour market determines a wide range of life chances, mainly through regular wages and salaries and social status.

- Quality of work is a central but still underestimated factor in terms of adverse effects on health and well-being, which are affected by job instability or job loss. Income insecurity resulting from unemployment or underemployment or low-paid work heavily contributes to physical and mental ill health (19).

- Being in employment is not necessarily sufficient to reduce health-harming conditions. Excessive hours, a form of quality of work, also substantially influences health inequities. The rise in non-standard employment renders access to productive and rewarding jobs increasingly difficult. At the same time, these jobs carry increased health risks. Temporary workers face lower earnings, higher levels of labour market insecurity and higher job strain. They are also more exposed to physical health risk factors at work and workplace intimidation, while having less autonomy and fewer learning opportunities, and receiving less support from their colleagues (20).

- In every country, the number of men in temporary employment with the fewest years of education worsened or stayed the same compared to the number of men with temporary contracts with the most years of education between 2000 and 2017.
Box 5. Case studies – Work and employment conditions

Case study 8: To respond to an increasing older population and to ensure equal access to employment for all, Germany increased participation of older people in the labour market by establishing regional pacts, which supported productive ageing and enhanced sustainability of the society.

Case study 9: Given the high percentage of young people not in education, employment or training (NEETs), Italy has implemented the SELFIEmployment programme, which gives NEETs the chance to become entrepreneurs or self-employed by starting a business. Youth submit their business plan proposal and, if it is sustainable, they receive a 0% interest rate, non-collateral loan of up to €50,000.

2.6 Measuring and monitoring health equity

• To understand what influences the conditions needed to live a healthy life, it is essential to monitor and assess policies on health equity across health services and across sectors.

• Measuring and increasing health equity is a key step in accelerating progress towards inclusive development and prosperity in the WHO European Region. Data can enable, motivate and empower decision-makers and the public.

Box 6. Case study – Measuring and monitoring health inequities

Case study 10: As many people at risk of frailty are not identified or supported by relevant institutions, the local health sector in Friuli Venezia Giulia, Italy, interviewed thousands of older people to better detect frailty and improve the response of health and social services to older people’s needs. As a result, they better developed local welfare plans and coordinated activities among the health care, social and employment sectors to reduce health inequalities and improve health and participation at the local level.
3 Accelerate: Implement a basket of policies built on inclusive and empowering approaches

Evidence shows that single-policy interventions will not reduce health inequities. A basket of solutions addressing the causes, drivers and pathways of health inequities will create and sustain the essential conditions for all to lead a healthy life.

3.1 Drivers of health equity

- The governance factors that shape policy processes and generally have been identified as being important for inclusive decision-making include: policy coherence, accountability, participation, and, underlying them, empowerment.

- Accountability mechanisms and processes can play an important role in driving health equity and underpin the legal commitment that all persons and institutions, including the State, are subject to the laws and commitments made by States. Where accountability is weak or absent, progress on health equity falters. Whilst accountability mechanisms may take various forms (for example, monitoring or creation of disaggregated data to identify hidden health inequalities or gaps), for accountability to be truly transformational, it needs to expose the structural barriers (that is, the social, economic and political structures, policies, and mechanisms that shape the unfair and inequitable distribution of and access to power, wealth, and other resources), including the commercial determinants that constitute barriers to health equity. Improving accountability through political, social and judicial systems can help to reduce inequities in sense of control and trust (21).

- Social participation is involvement of a population in the decisions that affect its health. It is a prerequisite for health protection and promotion, as acknowledged by the Declaration from the International Conference on Primary Health Care in Alma-Ata defining it as the “maximum community and individual self-reliance and participation in the planning, organization, operation and control of primary health care” (22).

- Policy coherence across all areas of public policy is important for realizing health equity and well-being for all. Health policies can have a greater impact and tackle unintended negative effects on health equity by other sectors if they are combined and coordinated across actors, institutions and levels of governance. The SDGs are a useful framework for strengthening policy coherence for health equity, which is related to increasing transparency and participation, an important factor when working with stakeholders.

- Empowerment at the individual and population level can have significant positive health and social benefits. Empowerment can drive civil society engagement with formal political processes (for example, affecting voting rates) and increase public demand for transparency and accountability at local, regional, national and global levels of governance. A commitment to empowerment – to act to ensure that all people individually and/or collectively gain greater control over their destiny – is fundamental to the SDGs and their underlying values.

Box 7. Case studies – Drivers of health equity

Case study 11: In response to persisting health inequalities, which are determined by several circumstances, Scotland set up the Scottish Parliament Cross-Party Group on Health Inequalities to promote intersectoral actions and influence parliamentarians and policy-makers to promote evidence-based actions to reduce health inequalities.

Case study 12: To tackle challenges currently faced by young adults in relation to health, well-being and access to health care services, the Republic of Moldova scaled up youth-friendly health services in every district of the country through joint action of several ministries, local actors, and international organizations.

Case study 13: To support and empower migrants and refugees in Turkey, WHO and the International Organization for Migration, together with the Turkish Government, set up mobile psychosocial teams and municipal migrant centres to improve health, protect human rights and engage them in the community.
3.2 Scale and proportionate universalism

- While government policies and interventions have often focused on addressing one or several of the determinants, such as the lived environment, education, and employment, which are known to be crucial in giving people an equal chance in life, evidence has increasingly demonstrated that addressing one of these aspects or a combination thereof in isolation from the broader social and institutional factors in a society has meant that progress has not been as fast as expected. Policies and interventions are more effective when actions address the many causes and drivers that lead to health inequity.

- Making progress towards healthy, prosperous lives for all requires systematic action, which includes scaling up and adapting what works, and generating new solutions and alliances that break down the barriers to progress.

- Universality in policy design and investment are not sufficient to reduce inequities in health and well-being. Accelerated and proportionate actions are needed. Levelling up the gradient in health cannot be achieved by extending a universal offer to everyone equally. Universal policies will, at best, improve everyone’s health but the gradient will remain unchanged. At worst, demand for what is on offer will be greatest among those who already have the most access to resources and health inequities will be widened as a result.

- The proportionate universal approach aims to extend a universal offer to all, supplemented by additional resources that are distributed according to level of need. Policies that are proportionate to need and accelerate actions in areas with greater health, social and economic needs have a positive impact on reducing health differences between social groups and geographic areas.
4 Influence: Place health equity at the centre of sustainable development and inclusive economies

4.1 Beyond health

- The most effective policies to address inequities work across sectors and adopt a whole-of-government approach. The health sector will reduce health inequities when it works in partnership with other sectors. The health sector can act as a leader in bringing different sectors together and show the effectiveness of investments in multisectoral policies that address the underlying causes of the conditions that create health inequities.

- New partners and alliances are vital to maximizing the impact of actions in sectors outside health for inclusive development and improving health and well-being for all.

4.2 Sustainable development

- Health equity is central to achieving sustainable and inclusive development. The impact of economic and fiscal policy on population health, and health equity, in particular, has been largely neglected when States and supranational organizations discuss these issues.

- The trade-off between economic growth and equity or between efficiency and equity has for a long time been considered natural; economic growth led to increasing inequities, and there was little countries could do to avoid these inequities. Yet evidence shows that high levels of inequality slow economic growth (24). Unless policies are developed to ensure a more equitable distribution of income and other social services, current inequities are likely to weaken economic growth, adversely affecting income and poverty levels and, as a consequence, health and well-being.

- Well-designed macroeconomic and social policies can increase economic growth and make it more inclusive and equal.

- Economic stability is health equity and social justice concern. Global marketization of development comprising trade and finance liberalization, privatization and labour market deregulation, as well as fiscal pressures on States, all contribute to changes in income insecurity and poverty, and can have negative consequences for health equity. The conditions imposed on countries by international organizations and financial institutions often tend to prioritize a certain type of economic growth that is not sustainable, which has a negative effect on wage growth, taxes and provision of key services, such as health and social care (25).

- Unsustainable development leads to a widening of the inequality gap, worsening health and well-being for those who are already left behind. There is an unequivocal link between labour deregulation, employment growth, reduced work quality, and rising inequality (26).

4.3 Social values

- Embedding social values - such as fairness, equality, trust, belonging, resilience, and respect for human dignity - in economic policy-making is essential to removing the barriers to achieving sustainable development and inclusive societies, so that all can prosper and flourish.

- Considering social values in policy-making means considering economic, social and environmental well-being in contracts. This is because the conditions imposed on countries by international organizations and financial institutions are often at odds with the aim of improving health for all. For example, conditionalities prioritize a type of economic growth that is not sustainable. This leads to weak wages, tax increases and cuts to key services, such as health and social care (27,28).
Box 8. Case study – Social values

Case study 14: Social values are central to key pieces of legislation in Wales. The Well-being of Future Generations (Wales) Act requires public bodies in Wales to think about the long-term impact of their decisions, to work better with people, communities and each other, and to prevent persistent problems such as poverty, health inequalities and climate change. The Social Services and Well-being (Wales) Act states that “Local authorities with local health board partners must establish regional forums to support social value based providers... to encourage a flourishing social value sector which is able and willing to fulfil service delivery opportunities”.

4.4 Human rights

- The realization of human rights, including the right to health, is an essential aspect of equity. As human rights are universal entitlements, human rights commitments require that States pay particular attention to the needs of society’s most vulnerable and marginalized people.

- Human rights have a direct and spillover effect on health and other sectors and they contribute to healthier, fairer and more prosperous societies (29).

- The drivers of health equity – accountability, policy coherence, participation and empowerment - seek to move forward rights-based approaches that underpin the delivery of laws, policies and programmes that enable health equity (30).

- Much work on understanding and advancing accountability in health is rooted in the human rights-based approach to health. As part of this approach, both policy-making and programmes that impact health should be guided by human rights principles. They should aim to empower rights holders to claim their rights and the duty bearer, the State (national, regional and local), to meet its human rights obligations (30). For example, gender-based violence against women is one of the most common human rights violations in the WHO European Region. Gender-based violence affects society and individuals, has substantial effects on public health and is an obstacle to active participation of women in society. Empowering women affects social and human capital and has a positive effect on economic growth and development (31).

4.5 Commercial determinants

- Better health in the WHO European Region is a shared responsibility of Member States, WHO and partners beyond the health sector, both within countries and at the regional level. This also includes the commercial sector and private companies. The Commercial Determinants of Health (CDH) are strategies or approaches the private sector uses to promote products and choices, including those that are detrimental to people’s health. Exposure to unhealthy commercial pressures compounds material disadvantages, contributing to health inequities (32).

- The CDH directly contribute to the growing burden of noncommunicable diseases (NCDs) (33). WHO recommends best buys to reduce NCDs, many of which are legislative acts and can be implemented and enforced only by States (34).

- Without actions to address the impact of CDH on health equity, there is a risk that there will be people who are legislatively left behind, who are not equally protected by the laws and regulations affecting their health and well-being. Reducing the effects of the CDH, health inequities and the burden of NCDs involves a whole-of-society and multisectoral approaches that place action on causes at the centre (37).

- Multisectoral work is crucial to address the economic, political and cultural systems affected by the CDH. Political, social and democratic accountability mechanisms are useful tools to assess the multiple social and commercial determinants of health that drive health equity (30). System-wide approaches, such as price policies and taxation, are effective methods to reduce inequities and NCD risk factors, such as smoking and unhealthy diets (38).
4.6 Solutions Platform and alliances

- The WHO Regional Office for Europe can support innovative thinking and be a catalyst for transformational change for health in Europe, and ensure that all communities and nations can realize their full potential and promise in today’s increasingly competitive global economy.

- The WHO Regional Office for Europe can convene high-level technical expertise, which will serve as a significant asset in developing solutions to address the WHO European Region’s most critical health issues in a manner that fully responds to the collective needs and priorities of the Member States.

- A WHO European Region Health Equity Solutions Platform (Solutions Platform) will aim to link innovations, innovators and innovation funders with governments and policymakers to reduce health inequities and scale up successful approaches within and between countries.

- The WHO Regional Office for Europe aims to create solutions by building and expanding collaborative networks that encompass all sectors of society; forging commitments and creating alliances to achieve better health and well-being; and through partnering with the public and private sectors and other organizations to extend the reach of its technical cooperation.

- The Solutions Platform seeks to be a dedicated space for policy-makers to exchange best practices and share innovations in how to implement solutions to increase equity in health, both nationally and locally. It will also be a network of multidisciplinary scientific experts and institutions who generate cutting-edge evidence and methods that enable governments to prioritize and scale up innovation to increase equity in health and bring social values into inclusive economic growth policies.

- The Solutions Platform will take forward the commitments made by Member States and partners to accelerate progress in achieving healthier prosperous lives for all, as set out in Health 2020 – The European policy framework for health and well-being (EUR/RC62/R4) and in World Health Assembly resolution WHA 65.9 on Health conditions in the occupied Palestinian territory, including east Jerusalem, and in the occupied Syrian Golan. A draft resolution will be presented to the 69th session of the WHO Regional Committee for Europe (Resolution RC69 Accelerating progress for Health Equity in the WHO European Region).

- New Alliances will be part of the Solutions Platform. These Alliances will seek to promote dialogue and mediate between different stakeholders with competing interests and priorities. The first Alliance created will be the Economics and Equity Alliance, which will generate knowledge and solutions, share innovations and exchange best practices in treating health equity as central to achieving sustainable development and inclusive economies.

Box 10. Case study – Alliances

Case study 16: In response to high levels of youth unemployment and underemployment across CIS countries, the International Labour Organization has supported the creation of strategic alliances at the subregional level among Azerbaijan, Kazakhstan, Kyrgyzstan, the Russian Federation, Tajikistan, Turkmenistan and Uzbekistan to share good practices and replicate effective models across national contexts.
References


The WHO Regional Office for Europe

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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