POLICY BRIEF

HEALTH AND REDUCED INEQUALITIES

More equitable societies tend to be healthier societies (1). Countries with higher levels of income inequality tend to have lower life expectancies and higher infant mortality rates, as well as higher prevalence for mental illness and obesity.

Although significant improvements in health have been achieved in the WHO European Region, persistent inequities in avoidable health risks and premature deaths remain between and within countries. In some countries they have even increased.

Health inequities are avoidable and unfair. Social and economic conditions and their effects on people’s lives determine their risk of illness. These conditions also determine what action can be taken to prevent them becoming ill or to treat their illness when it occurs (2).

While there are differences in the health of those who are best off and those who are worst off across the Region, health inequities affect everyone in every nation. Health outcomes and exposure to health-harming conditions follow a social gradient; consequently, even those in the middle experience worse health outcomes and exposures than those at the top.

This social gradient in health and life chances runs from the top to the bottom of the socioeconomic spectrum, whether examining differences in indicators of mortality, morbidity or well-being. These inequities persist over the life cycle and are passed down through generations.

Growing up in favourable socioeconomic circumstances leads to improved child development and facilitates higher levels of educational attainment, which, in turn, are associated with higher incomes, greater control over daily life and better health and well-being across every stage of life.

Key messages

Taking action on one SDG gets results in others: health runs through every SDG.
Health and inequalities

There is ample evidence that income and social inequalities have substantial adverse health outcomes, regardless of whether a country is of low, medium or high income. Inequalities can create health impacts through multiple pathways, including heightened psychosocial stress and higher rates of adverse health behaviours such as smoking and harmful alcohol use. Inequalities also involve a lack of access to environments that promote health, such as decent housing, a healthy diet, opportunities for employment, health-promoting leisure, safe green and blue spaces and a physical environment that does not expose residents to adverse conditions (e.g. high levels of air pollution or noise).

The social gradient in health and well-being is consistently observed, whether the markers of socioeconomic position used are differences in years of education, income, wealth or affluence level, or a regional level of human development. Illness, disease and mortality increase as income and social status decrease; in other words, a person’s health improves as personal income and social status improve.

The level of health expenditure that a country incurs may partially help to explain its levels of health inequity. Not all health expenditure is conducive to greater equity: some types of specialist service are used disproportionately by those with higher levels of education (3). Nonetheless, when governments invest resources in equity-promoting health policies to reduce financial barriers to accessing health systems, for example by providing services that are free at the point of delivery or by reducing co-payments for medicines, those with fewest resources benefit the most (4).

Gender inequities are among the most obvious in the WHO European Region. Some progress has been made in recent years to end discrimination against women and girls in laws, policies and practice (5); however, it is still a problem in the Region and worldwide. Violence against women and girls in private and public spaces is a persistent phenomenon that no country has managed to eliminate. There is no comprehensive overview of comparable data across countries that examines the legal frameworks in place to promote, enforce and monitor equality and nondiscrimination on the basis of sex and that would provide guidance on effective policies to improve discrimination against women and girls.

Mental illness is another area marked by inequity. Mental health conditions are estimated to affect one in four people at some point in their lifetime. There is a strong link between poor mental health and poverty, as well as between mental health conditions and economic hardship resulting from the inadequate realization of economic, social and cultural rights, as
well as the rights to education, work, housing, food and water. These and other rights are also underlying determinants of mental health. Despite the negative impact of poor mental health on individuals, families and communities, there is insufficient investment in mental health promotion and prevention.

Basic environmental conditions also make a difference. Although most areas of the Region have good access to clean water and sanitation, significant numbers of households, particularly in the eastern part of the Region, still do not. Many disadvantaged households live in damp, overcrowded housing without basic amenities and are less able to afford home heating in winter or cooling in summer. These unequal conditions are important factors in generating health inequities (6). Improving access to good-quality housing has been shown to benefit physical and mental health. However, good-quality housing also needs to be made affordable to families on low incomes and other disadvantaged groups, offering them security of tenure.

Over the coming decades, climate change in the WHO European Region is expected to generate increased risks to health through extreme weather events, the spread of infectious disease and the displacement of people (7). Households and communities dependent on agriculture productivity, living in areas at high risk or with less access to resources are likely to be more vulnerable to risk, yet also less able to cope and protect themselves against such risks. Through these climate-related effects, inequities in social and economic resources could lead to a widening of health inequities.

Inequities can particularly affect the physical and mental health of refugees and migrants, depending partly on the type of migration. Labour migrants are generally selected for good health, the so-called healthy migrant effect, but refugees may have different needs associated with adverse conditions in their country of origin and their journeys to the host countries. For example, refugees fleeing conflict zones may present with injuries resulting from armed conflict, and prognosis may be worsened by the adverse conditions encountered on the journey away from conflict areas (8). Evidence shows that there are also inequities for refugees and migrants in quality of life upon arrival in their host countries, including the accessibility and quality of health services available to them.

When addressing these health inequities, it is useful to take a life-course approach, recognizing the accumulation of advantage and disadvantage across the lifetime of every individual. It can go beyond that. Negative health outcomes can have an intergenerational element; for example maternal mental ill health negatively affects the physical and mental health of children. Poverty is also transmitted across generations, and when adverse factors are present in childhood they are likely to determine lower socioeconomic status and poorer health later in life and into the next generation.
Facts and figures

Average life expectancy at birth in the WHO European Region increased from 76.7 years in 2010 to 77.9 years in 2015, an average annual increase of 0.24 years. However, the absolute difference in life expectancy between countries with the highest and lowest life expectancy at birth is still more than 10 years (9).

Inequalities in socioeconomic status have an impact on health outcomes, including mortality, morbidity, risk behaviours and mental health. In England (United Kingdom) in 2010, for example, life expectancy for men in the most deprived areas was 9.1 years fewer than for those in the richest areas. For women this gap was 6.8 years (10).

The relationship between socioeconomic inequalities and health works both ways. On the one hand, health and health equity are affected by factors such as differences in income, living conditions and exposure to environmental conditions; access to health services, education and employment opportunities; and social protection and social connections. On the other hand, differences in health status drive differences in ability to engage in paid work and in social interactions and access to educational opportunities, as well as in levels of health expenditure. If you are healthy, you can learn, work and get on.

Differences in health are not inevitable and there is substantial evidence identifying effective measures that improve health equity. It is increasingly understood that, while universal health coverage is essential, the health-care sector acting alone cannot effectively address the social determinants of health. Although, ultimately, individuals make decisions that impact on their health, their decisions are constrained by the conditions in which they live; these conditions encompass political, social, economic, environmental and cultural domains (2).

Differences between the highest and the lowest values of other indicators linked to social determinants of health in Member States of the WHO European Region have also decreased over time: infant mortality, primary school enrollment and unemployment (11). Preliminary data suggest that this trend is continuing. However, here too, the absolute differences between countries remain large (9). The persistence of these differences among countries can be explained by different levels of investment in the conditions needed to live an equitably healthy life – health services, living conditions, income security and social protection, social and human capital and employment and working conditions.
The differences in life expectancy between the sexes and between countries are decreasing. The gender gap in life expectancy fell from 7.7 years in 2000 to 6.9 years in 2010 and 6.6 years in 2015.

Gender inequality drives poverty, which greatly influences health outcomes. Entrenched social norms and power structures hold girls and women back, resulting in their lack of autonomy and decision-making over their sexual and reproductive health, which can severely limit their health and economic outcomes. Women and girls bear a disproportionate burden of unpaid care and household work, which undermines their access to education and the labour market (12). Differences in pay for equal work between men and women still exist in all countries across the Region.

Data for 87 countries from 2005 to 2016, including 30 from developed regions, show that 19% of girls and women aged 15–49 years had experienced physical and/or sexual violence by an intimate partner in the previous 12 months. Gender-based violence affects physical and mental health in many ways; women who have experienced intimate partner violence are 50% more likely to acquire HIV than women who have not (13).

Individuals with tertiary education are exposed to fewer risk factors associated with health inequalities than those with only secondary education or below. They enjoy better opportunities in the labour market and have increased health literacy (14). In Denmark in 2011, life expectancy at age 30 was 6.4 years higher for men with tertiary education than for men with lower education. For women this gap was 3.7 years (14).

Unemployment is associated with a range of adverse health consequences, including worse self-reported health (15), as well as increased physical and mental health problems (16,17). In some studies, unemployment is linked to a higher prevalence of risky health behaviours, particularly among young men, including smoking and harmful alcohol use (18,19). The negative health experiences of unemployment or underemployment are not just limited to the unemployed but also affect their families and the wider community (20).

Job loss increases the risk of unmet health need, exacerbated by financial hardship. But in countries where out-of-pocket payments are low or in countries where unemployment benefits provided sufficient income, fewer people experiencing job loss also lost access to health care (21).

Job loss appears to affect the health of men and women equally, but they differ in recovery. For men, employment recovery was insufficient to alleviate financial strain and associated health consequences, whereas with women, regaining employment is more likely to lead to health recovery (22).
Inadequate housing is responsible for more than 100 000 deaths in Europe each year, and stark housing inequalities persist.

In 2015, more than 90% of the European population had access to improved sanitation facilities and piped drinking water. However, there are still inequalities in access within and between urban and rural areas in the Region, ranging from 93.1% to 100% for populations in urban areas and from 66.7% to 100% for populations in rural areas (9).

Limited published data indicate that approximately 18% of investigated disease outbreaks in the WHO European Region may be associated with water. Leptospirosis, cryptosporidiosis, giardiasis and legionellosis show the highest percentages of outbreaks specifically linked to contaminated water, including public drinking water supplies, lakes, swimming pools, spas and cooling towers (23).

The WHO European Region has a population of almost 920 million, and in 2017 international migrants made up almost 10% of this population (90.7 million) and accounted for 35% of the global international migrant population (258 million). The proportion of international migrants in Member States of the Region varies from more than 50% in Andorra and Monaco to less than 2% in Albania, Bosnia and Herzegovina, Poland and Romania (24).

Asylum-seeking children face particular risks, including being exposed to discrimination, exploitation, marginalization, institutionalization and exclusion. During 2015–2017, 1 million asylum-seeking children registered in the European Union (EU), of whom 190 000 arrived unaccompanied (25).

There are large differences in levels of total health expenditure as a percentage of gross domestic product among the Member States of the WHO European Region; in 2014, these ranged from 2.1% to 11.9%. There are also large intraregional differences, with expenditure ranging from 6.6% of gross domestic product in countries of the Commonwealth of Independent States to 10.8% in Nordic countries (9).

Where health care is expensive, health can suffer. Across the Region, individuals are more likely to report barriers to accessing health care in countries with higher out-of-pocket expenditure. Out-of-pocket payments have a greater impact on lower-income households, who face a greater financial burden proportional to income for a given amount, making it more difficult to afford other basic needs such as food, housing and utilities.

In 2014, there were large differences between Member States of the Region in the percentage of private household expenditure needed for out-of-pocket payments, varying from 5.2% to 72.1%. There were also considerable differences between subregions, with 14.7% in Nordic countries and 46.2% in countries of the Commonwealth of Independent States (9).
Priorities for action: what now?

The 2030 Agenda for Sustainable Development outlines a series of ambitious goals (26). Each goal has targets with indicators attached to support countries and to help in monitoring progress.

Member States of the WHO European Region committed to the 2030 Agenda and produced a roadmap for its implementation in 2017 (27). The Roadmap proposes ways in which countries can address health and its determinants and make investments for health through evidence-informed policies across sectors. Priorities for action are grouped around five strategic objectives (Fig. 1). It is important that policies and interventions act across the whole population but action to address health inequities should aim to accelerate improvements for the most vulnerable, disadvantaged and poor (28).

Fig. 1 The strategic directions and enablers of the WHO SDG roadmap
Government action sets the direction of travel. If there is political will, countries can more effectively address the challenges of health inequities. Governments can make health equity a national goal by integrating health and well-being and their determinants into national development strategies or action plans across the sectors, and monitoring progress. This requires participatory governance and coherent actions that prioritize and support health and well-being and integrate health and equity into all policies (Box 1). There is often a lack of understanding of the social, cultural and economic conditions of the disadvantaged and poor population when policies are being designed. Equity of voices and perspectives should be a basis for decision-making processes. Social inclusion and social justice can be served by supporting local people and communities in participating in local decision-making and strengthening the capacity of nongovernmental organizations and local authorities in their use of participatory planning for health and equity (30).

Four key drivers of health equity play an important role in achieving progress: policy coherence, accountability, participation and empowerment. Each of these social and institutional drivers contributes to health equity in itself, but they are also dynamic and interact with each other and are particularly powerful where people and communities are empowered to make decisions and take more control of their destiny. Governments have a role in promoting these drivers of health equity.

Box 1. Advancing governance and leadership for health and reduced inequities: measures improving health related to targets 10.2 and 10.4

Target 10.2: empower and promote the social, economic and political inclusion of all

Drivers of health equity are relevant to broader agendas of sustainability, inclusiveness and fairness. They contribute to healthier, fairer and more prosperous societies. They contribute to achieving target 10.2, which emphasizes that empowerment and promotion of inclusion should encompass all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status. Ultimately, these drivers have the potential to improve people’s living conditions; increase social capital; improve social, environmental and financial protection; create a greener society; and increase security at all levels. Given current and projected growth patterns, reducing inequality can play an important role both in ending extreme poverty by 2030 and in ensuring that growth works for the poorest. Countries can and should make deliberate policy decisions to combat high inequality and to equalize opportunities for all, making smart use of both fiscal and social systems to improve the lives of their citizens (29).

Target 10.4: adopt policies, especially fiscal, wage and social protection policies, and progressively achieve greater equality

Well-designed and implemented social protection floors, in particular, can powerfully transform development in a country by reducing economic insecurity and social exclusion. Evidence shows the impact that social protection policies have on reducing poverty and vulnerability, addressing inequality in health and increasing inclusive growth. The income security provided by social protection systems can be instrumental in improving livelihoods and providing a safety net that reduces stress and supports good health for everyone. If social protection policies are good and equitable, they have greatest impact on the least educated. They increase the resilience of those on the lowest incomes and create opportunities for education, geographic mobility, employment and productive activity, thus contributing to SDG 1, SDG 3 and SDG 10.
For example, funding for social participation (e.g. community centres, public libraries, youth centres and urban farming spaces) enables people to come together around common health goals, such as reducing the levels of pollution or violence in their communities. This, in turn, empowers communities to demand accountability from those taking decisions that affect their health (31). This means that action for health equity is accelerated where accountability mechanisms are strong, where policies are coherent across sectors and different levels of government, and where there is inclusive and quality participation.

The determinants of health are not to be found in clinics but in the home, workplace, school, street and environment, and in how society treats its citizens. Whether people are healthy or not is determined by their circumstances and environment. The 2014 European Review of Social Determinants of Health and the Health Divide in the WHO European Region (32) put forward specific measures and strategies to develop a comprehensive response to the long-term goal of preventing ill health and treating it equitably when it occurred, with the aim of achieving a sustained change (33).

Prevention measures include:
- reducing harmful alcohol consumption by measures such as introducing a tax on alcoholic beverages that is proportional to the alcohol content;
- initiating wider actions to reduce fats, particularly trans-fats, in diet and control the growth of fast-food consumption;
- taking action to reduce smoking under the WHO Framework Convention on Tobacco Control; and
- encouraging active living, focusing on needs across the social gradient.

Treatment areas to target include:
- making health-care systems more equitable – universal health coverage is required to provide a critical foundation for addressing health inequities; and
- removing financial, geographical and cultural barriers to the uptake of health-care services (such as co-payments) and ensuring adequate resource allocation that takes account of extra need in disadvantaged areas.

Steps to accomplish strategies for a comprehensive response include:
- providing external support for developing and implementing strategies to address inequities in countries where they are weakest, including a number of countries in the central and eastern parts of the Region;
- ensuring a balance between strategies that have short-, medium- and longer-term results and between simpler and more complex integrated interventions; and
- ensuring that strategies are developed to address inequities within and between countries (including those related to gender) through:
  - developing systems able to adequately assess, plan and deliver sustained action to reduce health inequities;
improving the capacity of public health systems to address health inequities;

strengthening health promotion, health protection and disease prevention systems to ensure universal coverage for all social groups, and linking these to policies and programmes that specifically address the determinants of lifestyles and behaviours;

improving accessibility and quality of health-care services; and

ensuring there are no adverse effects from transnational agreements and regulations.

Specific areas for action are:

strategies that give societies, groups and individuals greater control over their exposure to preventable hazards, such as regulation and control over the workplace and the environment; tobacco, alcohol and food content availability and pricing; and addressing societal norms and values;

screening programmes for cardiovascular risk factors and early detection of cancers to be accessible by all, particularly those exposed to multiple vulnerabilities and those who are vulnerable and disadvantaged;

effective implementation of strategies for the infectious diseases that disproportionately affect socially disadvantaged and vulnerable people (e.g. tuberculosis and HIV), including addressing the causes of vulnerability, gender inequities and adequate, sustainable access to screening, diagnosis and treatment services; and

monitoring and assessing population health equity impacts across these recommendations disaggregated by sex, age and two or three key socioeconomic determinants.

The determination to leave no one behind underlies all the SDGs. Leaving no one behind involves making policy decisions that reduce the inequalities and exclusion that leave segments of society stuck in poverty. The empowerment of women and girls and of groups that are subject to exclusion or discrimination provides a sound basis for economic efficiency and reduction of poverty and inequalities. Special attention is required by all actors to promote social inclusion, gender equality and human rights. Achieving equitable improvements in health and well-being is intimately connected with improving living conditions for all through universal measures, for example income security, social protection and quality of housing, access to services, and safe and green public spaces and transportation. This is an approach known as proportionate universalism.

Since the early 2000s, new challenges, such as the increased risk of poverty and exclusion, have arisen that have shifted from older age groups to young people and children. Such trends must be monitored so that policy investments can further prevent the loss of health and well-being. Improvements in child development have positive effects for lifelong health and educational and employment trajectories into adulthood.
Measures to promote health and well-being that can only be developed and implemented with other sectors and across settings include:

- ensuring quality conditions for early childhood development;
- improving access to high-quality health and education services and protection from financial hardships in using those services;
- developing universal social protection and policy priorities and strategies in order to reduce inequities and remove barriers to protecting households from deprivation and poverty;
- addressing sexual and reproductive health, building women’s capabilities and positioning women as agents of change for sustainable development;
- fostering a healthy workforce and having active labour market policies to tackle the health risks of being unemployed or insecurely employed;
- implementing coordinated social, economic and environmental policy measures that target groups that are being left behind or excluded (such as young people, see Case study 1);
- addressing the structural causes of discrimination; ensuring policies and measures to reduce gender-based violence and to eliminate child and forced labour, trafficking and sexual exploitation;
- investing in environmental protection to reduce environmental inequalities and to maximize the impacts on health equity;
- investing in sustainable and resilient urban and rural settings and sustainable agriculture and food systems;
- providing the conditions of daily living that prevent disease and premature death among refugees and migrants, and securing the appropriate health services for existing health conditions; and
- ensuring these population groups have opportunities to work and create economic, social and transcultural capital so that they can integrate and build their futures as equals.

Case study 1. Scaling up youth-friendly health services in the Republic of Moldova: the Healthy Generation Project

Young people in the WHO European Region face multiple challenges to their health and well-being. Difficulty in accessing health services results in higher unmet needs for health and in wider inequities. The Republic of Moldova has prioritized youth health and development in several strategic policy documents to promote adolescent health and to increase access to comprehensive health information and high-quality adolescent-friendly health services.

The organization Health for Youth, with support from the Ministry of Health, has implemented the Healthy Generation Project to scale up youth-friendly health services in each of the 35 districts of the country. The aim of the Project is to increase the demand, access and utilization of high-quality youth-friendly health services and increase health and well-being among all youth. By increasing the availability of services and prioritizing young adults’ needs, the project generates the opportunity to improve health of all young people, including those from lower socioeconomic backgrounds and minorities. The Project also empowers young people by providing them with health-promoting spaces in which to improve health literacy.

Youth-friendly health services provide a package of services to tackle a wide range of problems (e.g. sexual and reproductive health) and deliver health services, including information and counselling.

The Project has contributed to the establishment of 41 youth-friendly health centres around the country that are integrated within primary health care and provide a comprehensive strategy to improve the health and well-being of all young people.
Addressing the social determinants of health that generate inequalities means meeting the immediate health requirements of large numbers of refugees and migrants on arrival, as well as ensuring the longer-term provision of health care and public health strategies for those in host countries that also protect, without discrimination, the public health of the host population. This is in line with target 10.7 (facilitate orderly, safe, regular and responsible migration and mobility of people, including through the implementation of planned and well-managed migration policies). The persistent differences in access to basic services (e.g. health and education) are incompatible with Member States’ commitments to secure equal rights for all, undermine social cohesion and can further exacerbate poverty and deprivation.

Achieving the SDGs will be easier if local communities are engaged – whether schools, local enterprises or individuals – and dialogue is opened with public agencies, spatial planners, voluntary bodies, business, industry and other actors in taking action to tackle both inequality and health. Partnerships can also be made with patients, their families and carers to identify the physical, social and cultural characteristics of places that are most supportive of the health and well-being of the inhabitants. Ensuring access to good housing, mitigating the impact of climate change and reducing air pollution are all essential for achieving SDG 11 (sustainable cities and communities) and will contribute to SDG 3 (healthy lives and well-being), SDG 8 (decent work and economic growth) and SDG 13 (climate action) through supporting sustainable economic growth and green industries. Identified policy options for improving the living environment include those targeting housing, climate change and air quality.

The health inequalities resulting from poor housing conditions can be targeted by a number of measures.

- **Ensuring legal security of tenure for all.** Legal frameworks guaranteeing rights for tenants and protecting against forced evictions that are contrary to the law need to be in place, including for disadvantaged groups such as refugees and migrants (35). These frameworks can also include legal minimum periods for rental contracts to enable tenants to have fixed long-term and stable tenancies (36).

- **Ensuring minimum housing standards.** Minimum housing standards can be established and enforced to ensure that newly built dwellings are safe, healthy and hazard free (37). For existing housing, there should be national and local policies and programmes that prioritize target areas where the worst housing conditions are likely to occur.

- **Upgrading homes in poorer areas.** Existing housing in disadvantaged areas can be improved to ensure access to safe water and sanitation (38), greater energy and water efficiency and improved ventilation and indoor air quality (37). These changes can bring multiple benefits, including reducing the direct health risks of poor housing, increasing disposable income and reducing fuel poverty (Case study 2), plus mitigating climate change.

- **Increasing the supply of affordable housing.** Provision of public housing, regulatory measures and market incentives can all be used to increase the supply of houses (35).
Preventing homelessness and support people at risk of homelessness. Well-timed family counselling to prevent early school leaving can prevent homelessness among young people and associated socially stratified health effects. Early interventions are needed to identify groups most at risk of youth homelessness (e.g. those leaving care, people with mental health problems, families in poverty and some minority groups) (36), including tailored job search assistance, housing support and follow-up.

Case study 2. Arbed and Nest schemes as part of the Welsh Government Warm Homes Programme

Living in cold homes and in fuel poverty (when more than 10% of a household’s income is spent on energy costs) contributes to poor physical and mental health. In Wales (United Kingdom), it is estimated that there are 291 000 households living in fuel poverty (23% of all households).

The Welsh Government’s Warm Home Programme gives citizens from lower-income backgrounds the chance to improve the energy efficiency in their homes by installing new energy-saving systems without cost or by receiving advice on how to save money. The Programme reduces inequalities by making these services and resources more accessible for households on low incomes, in turn generating a positive health impact (38).

In addition, local authorities and communities, as well as small and medium-sized enterprises and civil society organizations, play a key role in identifying opportunities for community benefits and ensuring their delivery. By engaging with the local supply chains, the initiative creates new jobs for the local community and sustains income growth that is more equally shared across Welsh society.

In addition, the aggravating effects of climate change on health inequalities can be targeted by a number of measures.

Optimizing the health impact of climate change mitigation and adaptation strategies. Many measures to mitigate climate change have a high potential for health cobenefits, particularly those promoting energy-efficient buildings and renewable energy; access to safe transport modalities that encourage physical activity and social contact; improved outdoor and indoor air quality; and food choices with a lower carbon footprint (3).

Optimizing early warning surveillance and emergency preparedness systems. The extent to which an individual’s health is affected by extreme weather events and changes in disease distribution caused by climate change will depend on the resilience and ability of local systems to identify and respond to these events (39,40). Preventing adverse health and health equity impacts depends on adequate preparedness and community resilience, particularly for more vulnerable populations. Poorer citizens and excluded groups often suffer disproportionately worse health effects during natural disasters (41).

Implementing public awareness programmes on climate change and health. Actions include developing curricula, communication strategies and advocacy campaigns and activities to increase knowledge about health and climate change, as well as training health and environment professionals on the health effects of climate change and cobenefits and risks of mitigation and adaptation measures (39,40).
Increasing health sector contributions to reducing greenhouse gas emissions. Health sector leadership should be strengthened in efficient and sustainable management of health sector supplies, utilities and waste, with the aim of stimulating other sectors to do the same. The health sector could also engage in research and innovation to develop mitigation and adaptation measures, sharing best practices (39,40).

Promoting integrated urban planning and transport policies. Integrated policies that promote effective, sustainable urban planning and transport provision by encouraging cleaner, more energy-efficient and healthier modes of transport can have multiple benefits for the local environment, climate change and health. Increasing the use of fuel-efficient and clean public transport, and active transport such as walking and cycling, will reduce air pollution, reduce greenhouse gas emissions and promote physical activity, with added public health benefits (3,42).

Implementing ambient air quality legislation. Countries should seek to implement and enforce air quality legislation, with the aim of moving closer to WHO recommended levels. Reducing air pollution is a well-established and successful policy area for the EU, which has achieved successful reductions in pollutant emissions through enforcing legal limits to emissions and mitigation controls (43). Investment in air pollution monitoring and compliance is, however, limited in some countries, and measures could be adapted and applied to achieve positive outcomes in non-EU countries.

Member States in the WHO European Region have committed to progress towards universal health coverage: providing the population with high-quality health promotion, disease prevention, curative, rehabilitative and palliative services needed without causing financial hardship. Universal health coverage embodies two important equity objectives:

- **equity in access to health services**, those who need the services should get them not only those who can pay for them; and
- **financial risk protection**, ensuring that the cost of using care does not put people at risk of financial hardship.

There is a need to strengthen the capacities of public health services delivery, in particular primary care and prevention services in the most deprived areas (27), and increase the social, economic and environmental sustainability of health systems. Health literacy follows a social gradient in all countries across the Region whereby the poor and most vulnerable have the worst literacy levels. Limited health literacy often correlates with a lack of ability to effectively self-manage health, access health services, understand available and relevant information and make informed health-related decisions (15,17,18,44). Health literacy tools have to be available and tailored to encompass all socioeconomic groups including the most disadvantaged.

A movement towards equity in health also depends on strong health information systems that collect, analyse and report disaggregated data covering all health areas. This is recognized in target 17.18, which calls for efforts to build capacity to enable data disaggregation by a number of stratifying factors, including income, sex, age, race, ethnicity, migratory status, disability, geographic location and other characteristics relevant in national contexts.
Disaggregated data enable policy-makers to identify inequalities and populations in the most vulnerable situations, thus supporting reforms and direction of resources towards achieving equity in health and universal health coverage (45). This has relevance for all the health-related SDG targets; in order to reduce health inequalities, equity-oriented approaches are required that support accelerated progress among those most often left behind.

There are no “magic bullet” measures that will reduce health inequities; what is needed is a comprehensive approach. Universal health coverage, while necessary, is not sufficient. It is essential to address the wider social determinants of health – the conditions of daily life, its economic arrangements, distribution of power and resources, gender equity, policy frameworks and the values of society. Actions to ensure equal opportunity and reduce inequalities in outcomes will contribute towards all SDGs, in particular SDGs 1, 3 and 10.

**Commitments to act**

There are a number of formal commitments that support achievement of SDG 10.

- **The Rio Political Declaration on Social Determinants of Health, adopted during the World Conference on Social Determinants of Health in 2011** (46)
- **The United Nations resolution 67/81 on Global Health and Foreign Policy, adopted in 2012, which recognized the importance of universal health coverage** (47)
- **The WHO European policy framework Health 2020** (48)
- **The Roadmap to implement the 2030 Agenda for Sustainable Development building on Health 2020, the European policy for health and well-being** (27), which defines strategic directions and calls for action on equity (49)

**Resources**

- **General on health inequities**

- **Health inequities and commercial determinants of health**
Health inequities and economics

Health inequities and governance

Health inequities in the life-course

Health inequities and living conditions

Health inequities and mental health

Health inequities and participation

Health inequities and social justice
Health inequities and social protection


Health inequities and working conditions


Key definitions

Equality

The absence of differences in socioeconomic outcomes or determinants, including health status, between different population groups: for example, differences in income and wealth between people from different social classes or differences in mortality rates between men and women. It is important to distinguish between equality and equity (50). Some inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first, it may be impossible or ethically or ideologically unacceptable to attain equality. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that attaining equality is necessary to also achieve equity.

Equity

The absence of avoidable, unfair, or remediable differences among groups of people, whether those groups are defined socially, economically, demographically or geographically, or by other means of stratification. Health equity, or equity in health, implies that ideally everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential (51).

Social protection floors

“Nationally defined sets of basic social security guarantees that should ensure, as a minimum that, over the life cycle, all in need have access to essential health care and to basic income security which together secure effective access to goods and services, defined as necessary, at the national level” (52).

References


