



Interim first report on social determinants of health and the health divide in the WHO European Region



**World Health
Organization**

REGIONAL OFFICE FOR **Europe**

Interim first report on social determinants of health and the health divide in the WHO European Region –

Executive summary

European Social Determinants and Health Divide Review

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7 September 2010



ABSTRACT

Although health has improved for many people, there are major inequalities in health - within and between countries - across the WHO European Region. Evidence shows that these inequalities should be mostly avoidable and has significant human and economic costs. Unless action is taken, the gap between and within countries will increase. The WHO Regional Office for Europe commissioned a regional review of the health divide and inequalities in health from July 2010 to 2012 in order to inform the new health policy for the Region. The first phase of the review is assessing levels of inequalities in health across the European Region and identifying the barriers to and opportunities for reducing these. The final report on this phase will be completed in December 2010. An interim report, for which this is the summary, has been prepared for discussion in September 2010. The interim report also describes the subsequent stages and content of the rest of the review.

Keywords

HEALTH STATUS DISPARITIES
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Key Messages

1. There are major health inequalities within and between countries in the WHO European Region. Evidence shows that these inequalities should be mostly avoidable by reasonable means. Action is needed because of the significant human and economic costs.
2. Unless urgent action is taken, these gaps between and within countries will increase. This action must be both systematic and sustained and is critical in responding to the global economic downturn, allocating resources and developing a new health policy for the Region.
3. The lower a person's social position, the worse his or her health is. Everyone except those at the very top experiences some degree of inequality in health.
4. Inequality in health arises from inequalities in the social determinants of health: social policies and programmes, economic arrangements and the quality of governance. This, in turn, is responsible for inequalities in the lives people are able to lead: early years, education, working conditions and employment levels, levels and distribution of income, communities and public health and health systems.
5. Action is needed across all key government sectors to reduce health inequalities. Health ministries have a vital role to play both in ensuring the contribution of the health system and in advocating for health equity in the development plans, policies and actions of players in other sectors. The health system alone cannot reduce health inequalities.
6. Realizing the potential of health for all in the Region requires scaling up and systematizing action on the social determinants of health and reducing inequalities in health. This review will inform - in the area of social determinants of health - the new health policy for the Region by:
 - outlining existing knowledge and evidence and proposing action at the regional, national and local levels;
 - enhancing awareness and the capacity to deliver; and
 - building on the commitment by WHO, its partners and Member States in the European Region to increase policy awareness and action.

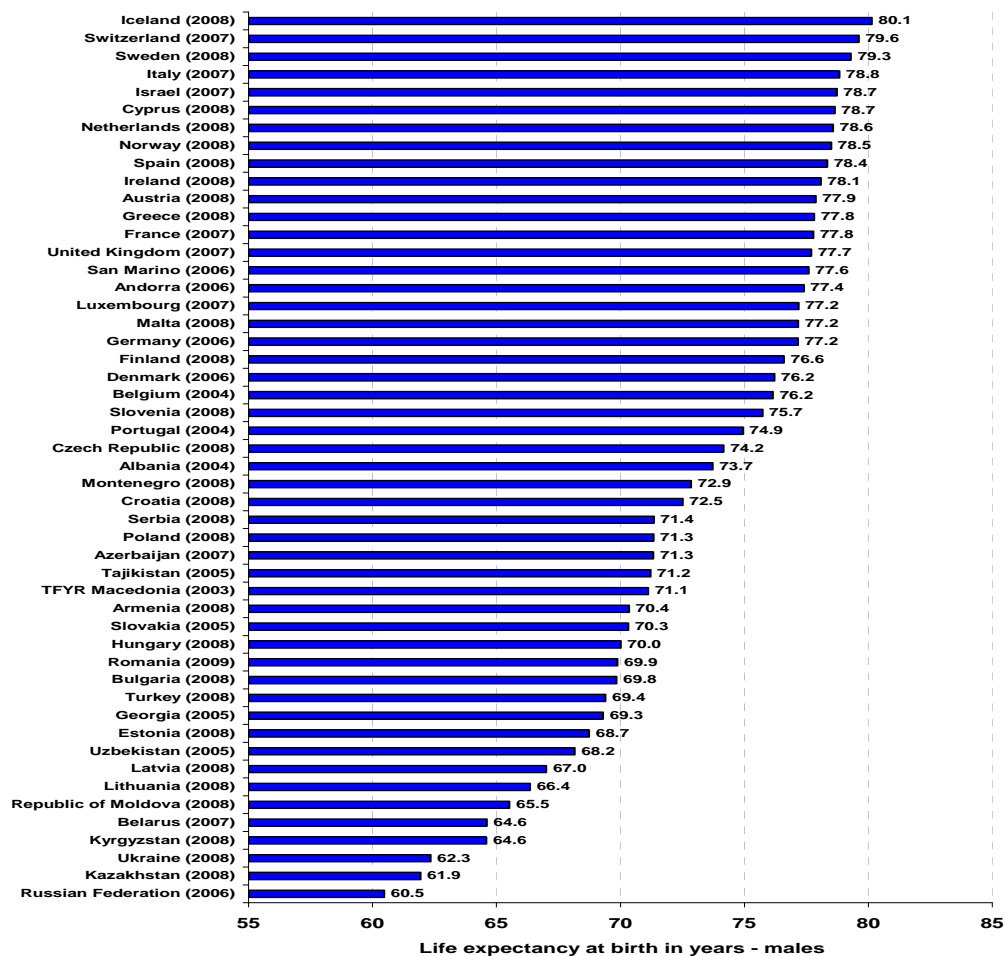
Introduction

The WHO Regional Office for Europe commissioned a review of the health divide and inequality in health in the WHO European Region from July 2010 to 2012. This will provide scientific evidence and a framework for future action to help in developing the new health policy for the Region. The first phase of the review is assessing levels of inequality in health within and between countries across the European Region and identifying the barriers to and opportunities for reducing these. The final report on this phase will be completed in December 2010. An interim report, for which this is the summary, has been prepared for discussion in September 2010. The interim report also describes the subsequent stages and content of the rest of the review.

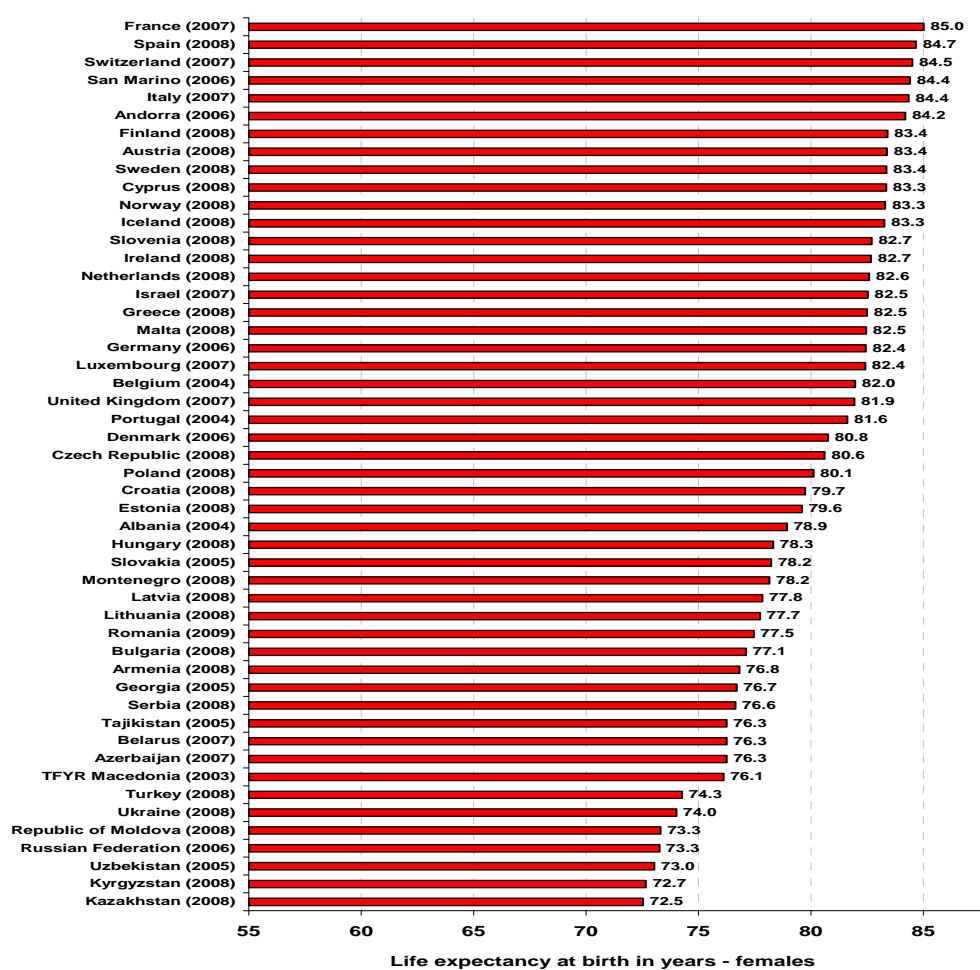
Although health has improved for many people, there is significant inequality in health across the Region, notably life expectancy differences of about 20 years for males and 12 years for females between the countries with the highest and lowest levels in the Region (Fig. 1).

Fig.1. Life expectancy at birth by sex for countries in the WHO European Region, 2008 or latest available earlier year

Males



Females



TFYR Macedonia: The former Yugoslav Republic of Macedonia.

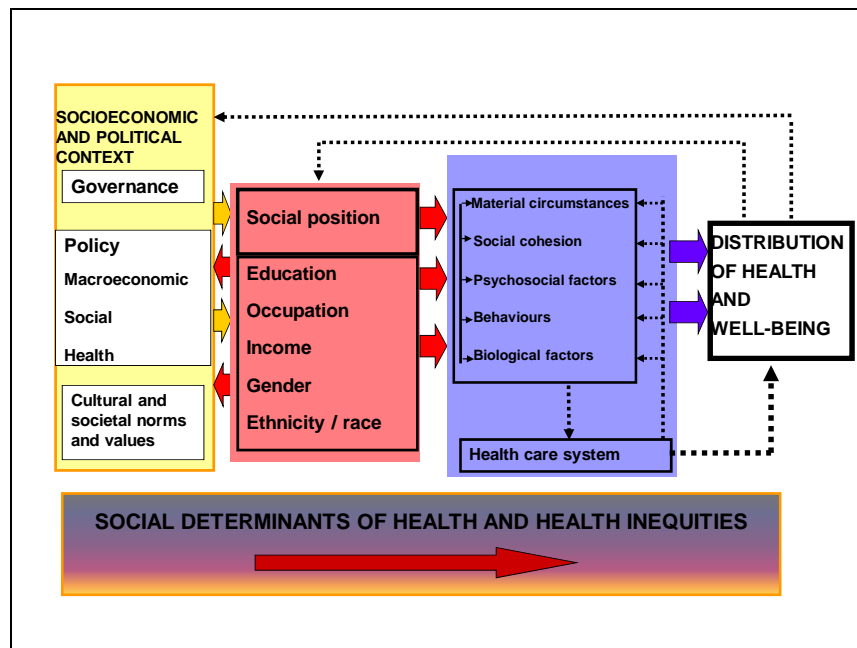
Source: European Health for All database [online database].(2010). (1).

These differences between countries and between males and females result from a worsening of mortality in some countries, particularly for men, and steady improvements for both sexes in others. Section A of this summary describes this in more detail.

For countries for which data are available, health outcomes have a clear gradient according to such social factors as income, education, social position and employment. Social factors that shape health across the Region and within countries are known as the social determinants of health (2). The evidence shows that key determinants of equality and inequality in health include early-years experiences, education, employment, the quality of work, the adequacy of social protection and income and the types of place and communities in which people live (2). Political empowerment, equity and human rights are also significant in relation to health and efforts to reduce inequality. Meanwhile, local, regional and global economic forces shape all these factors.

Evidence is emerging that the health and social effects of climate change and its mitigation are socially graded and will likely worsen inequality in health across the European Region. Fig. 2 depicts the conceptual framework developed in the report of the Commission on Social Determinants of Health (2). This portrays the significance of socioeconomic political and cultural contexts, an individual's social position and health systems and health behaviour in shaping the distribution of health and well-being.

Fig. 2. Conceptual framework of the Commission on Social Determinants of Health



Source: Commission on Social Determinants of Health (2).

The review will draw on the best available evidence applicable to the European Region to propose effective interventions, governance arrangements and policies at the regional, national and local levels that will reduce inequalities in health by taking action on the social determinants of health. Another key aim of the review is to support and accelerate knowledge, capacity and governance of equity in health across the Region. There is currently uneven progress within and across countries in identifying the scale of the problem, translating evidence into practice and in implementing action with the scale, size and intensity needed to be effective. These differences exist even among those with similar development conditions and governance systems, suggesting that they are amenable to action.

The review will inform a broader WHO health policy platform for realizing the health potential for the European Region for 2020 and beyond. It will build on and add value to existing developments underway throughout the European Region by WHO and its partners, notably the Tallinn Charter: Health Systems for Health and Wealth (3), the Millennium Development Goals and the European Commission communication on solidarity in health (4). The review will also take forward existing commitments such as World Health Assembly resolution WHA62.14 on reducing health inequities through action on the social determinants of health, which supports the findings of the Commission on the Social Determinants of Health, in which European Member States and partners were active stakeholders.

A. The health divide in the WHO European Region

Taking forward the review and contributing to the development of the new health policy for the WHO European Region requires assessing the evidence about the divergence in health and its social determinants across the Region. This section of the interim report describes the variation in health indicators between countries and regions in the Region. It describes how these are linked to factors such as age and sex. Section B will analyse the magnitude of, and trends in, social determinants and health within and between countries.

Life expectancy

The average life expectancy in the countries of central and eastern Europe and the countries in the Commonwealth of Independent States (CIS)¹ is lower than in the countries in the western part of the Region (Fig. 1). In the latest data from the WHO Health for All database (1), life expectancy at birth was 5.6 years lower in the countries that joined the EU after May 2004 (EU12) than in the 15 countries that were EU members before May 2004 (EU15). This difference was 12.5 years in the CIS countries. Within each of these groups, life expectancy varies between countries and between the sexes, with little overlap between countries in country groups. For males, life expectancy in CIS countries ranges from 60 to 71 years, from 66 to 76 years for the 10 new members of the EU from central and eastern Europe and from 75 to 79 years for the rest of the EU. For females, the comparable ranges were 73–77 years for CIS countries, 77–83 years for the central and eastern European EU members and 81–85 years for the rest of the EU. The ranges for central and eastern European countries outside the EU were 71–74 years for males and 76–80 years for females, respectively, which is approximately within the range of the central and eastern European EU countries.

These east-west differences in the European Region have changed over time (5). From 1945 until the 1960s, mortality improved considerably in the eastern part of the Region, largely due to the control of communicable diseases and improved hygiene and housing. As a result, life expectancy in the countries in the central and eastern part of the Region in the 1960s was only slightly lower than in countries in the western part of the Region. Between the early 1970s and late 1980s, life expectancy continued to increase in the western part of the Region but stagnated or fell in the eastern part of the Region, mainly due to rising death rates from cardiovascular diseases (6). This led to the widening of the east-west gap in life expectancy (5).

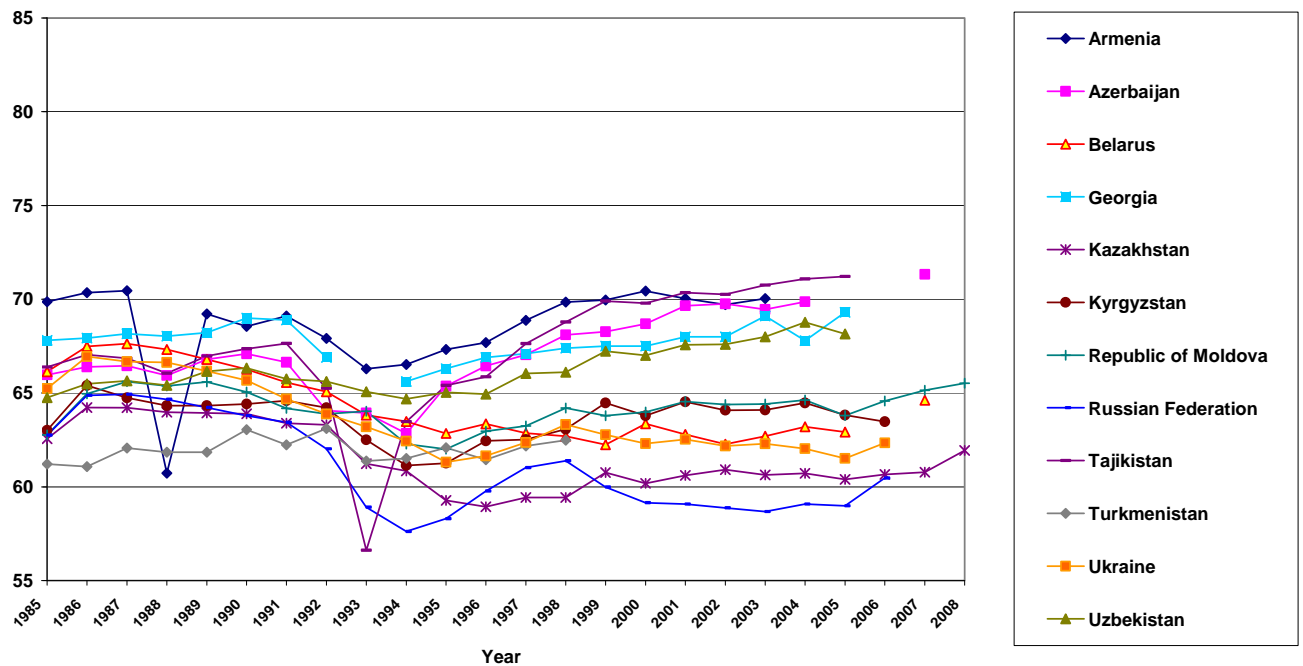
After communism collapsed in 1989, which led to profound societal changes, life expectancy diverged between countries in central and eastern Europe and CIS countries (5,7,8). Life expectancy continued to improve in the western part of the Region, but the pattern was very different in the countries in central and eastern Europe and the CIS, as Fig. 3 illustrates. Trends in central and eastern Europe were initially flat for men, but life expectancy has been improving among both men and women in most countries since 1990 but at a lower level than in most of the western part of the Region. However, the range in male life expectancy between countries in central and eastern Europe remains larger for men, about 11 years, than it is for women – about 7 years. The CIS countries have shown a more dramatic pattern, with small improvements in the

¹ The CIS consisted of Armenia, Azerbaijan, Belarus, Georgia, Kazakhstan, Kyrgyzstan, the Republic of Moldova, the Russian Federation, Tajikistan, Turkmenistan, Ukraine and Uzbekistan when the data were collected.

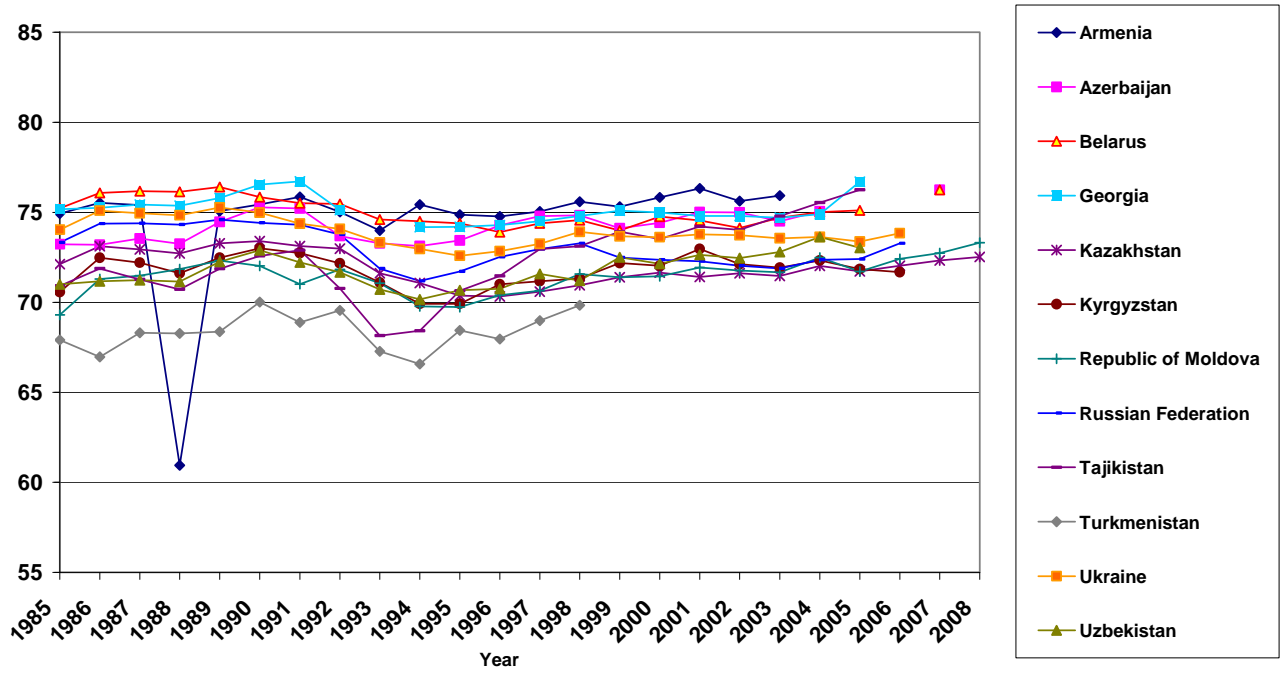
late 1980s, followed by a dramatic fall in life expectancy in the early 1990s. After a short period of improvement in 1995–1998, life expectancy fell again after 1998, only to level off in the mid-2000s, at which point the range in male life expectancy across countries was about 12 years and about 5 years for women. As a result, life expectancy in the CIS countries is falling behind that in countries in central and eastern Europe and in the western part of the Region. In particular, as shown in Fig. 1, it remains at 65 years or less for males in five CIS countries.

Fig. 3. Life expectancy by sex for three country groups in the WHO European Region, 1985–2008

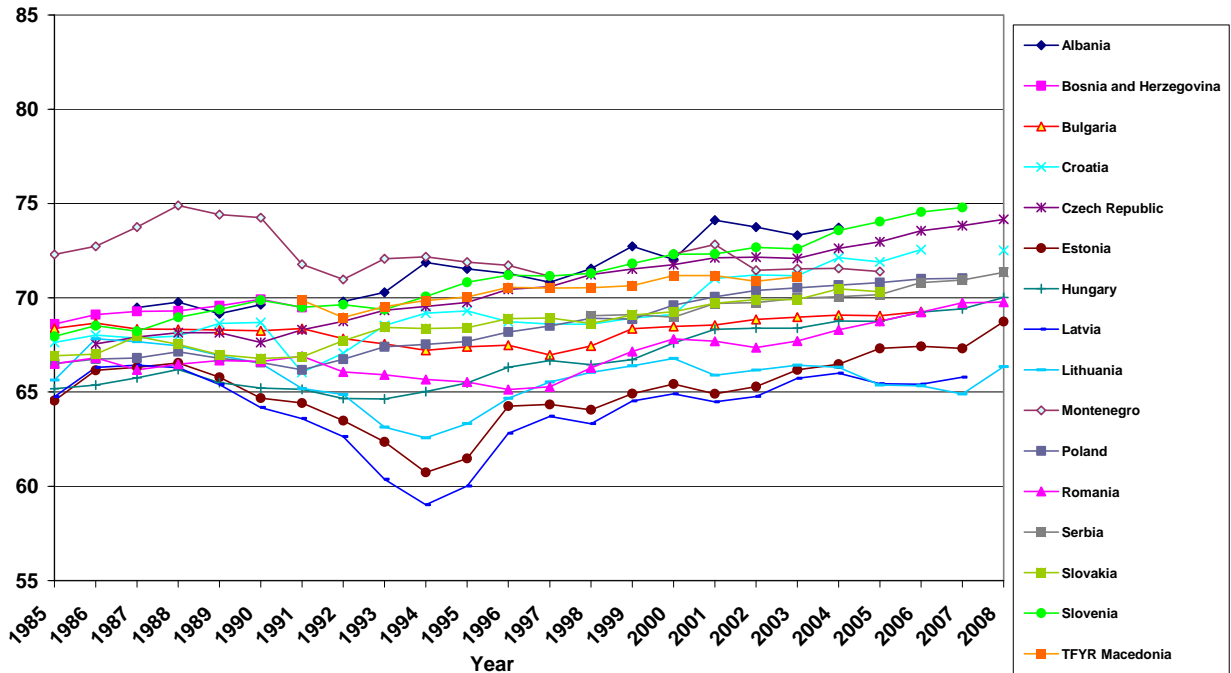
CIS - Males
Life expectancy
at birth in years



CIS - Females
Life expectancy
at birth in years.

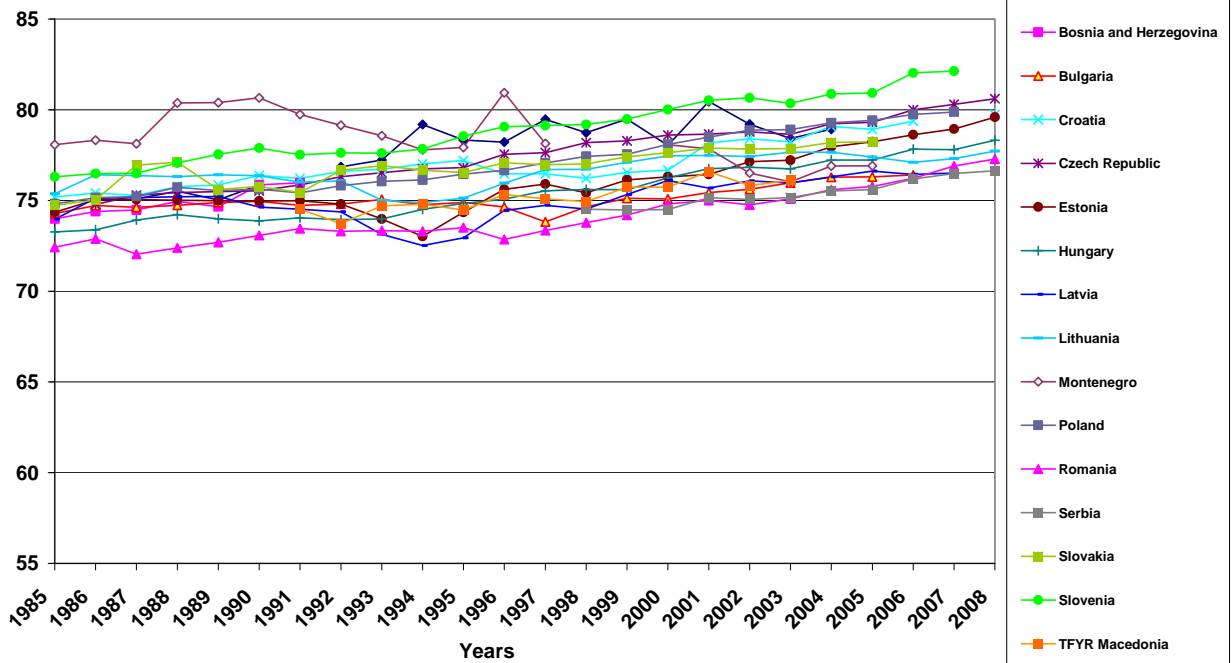


Central and Eastern Europe- Males
Life expectancy at birth in years



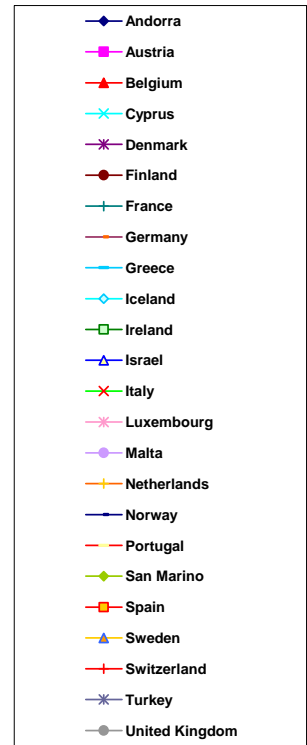
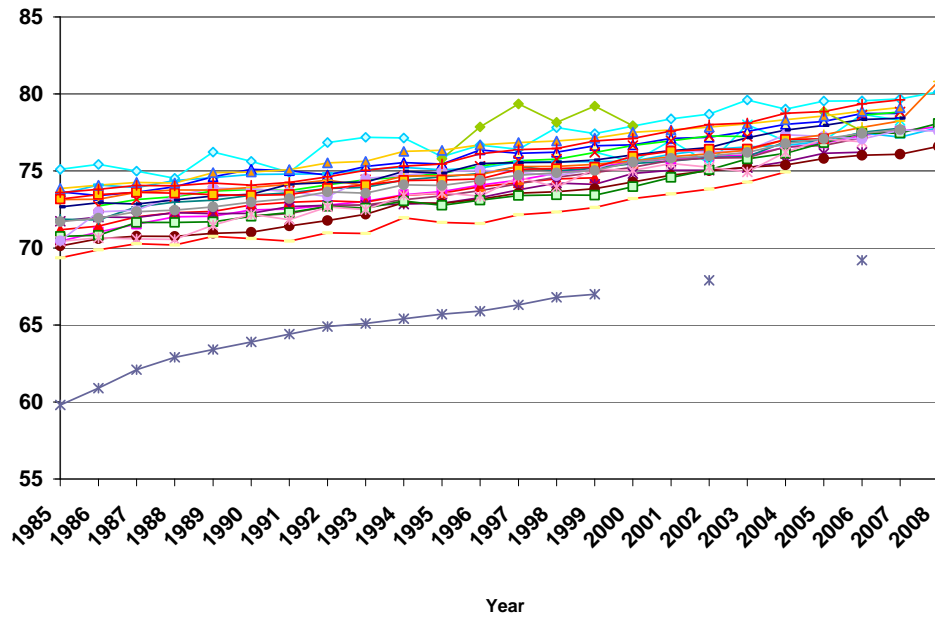
TFYR Macedonia: The former Yugoslav Republic of Macedonia

Central and Eastern Europe- Females
Life expectancy at birth in years

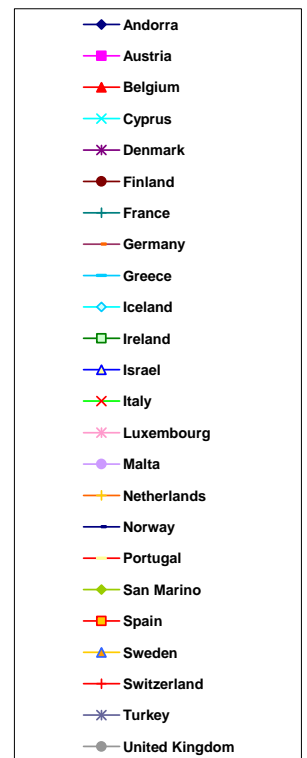
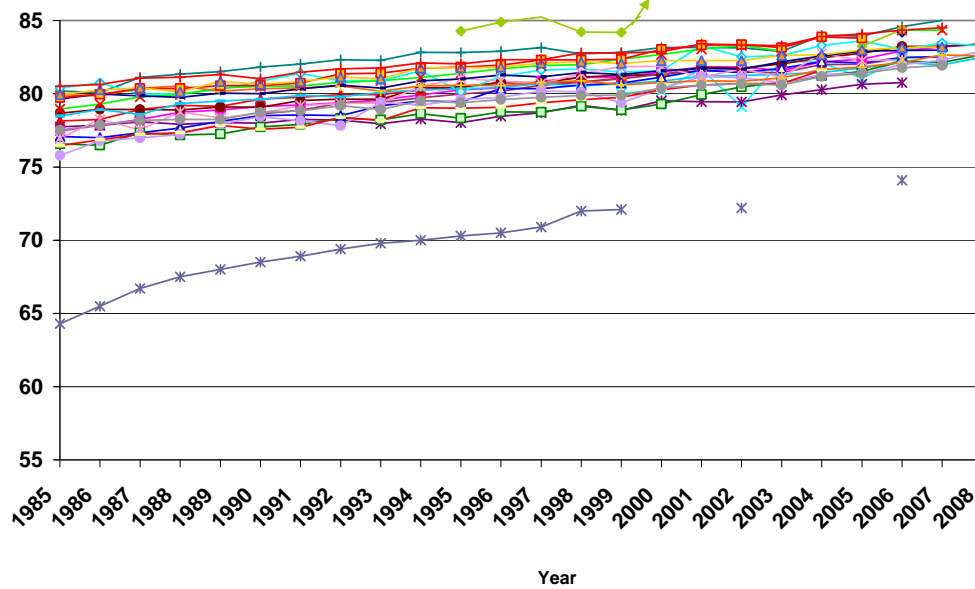


TFYR Macedonia: The former Yugoslav Republic of Macedonia

European Region excluding Central and Eastern Europe and CIS - Males
Life expectancy at birth in years



European Region excluding Central and Eastern Europe and CIS - Females
Life expectancy at birth in years



Source: European Health for All database [online database] (1).

Age structure

The interim report analyses the contribution of age-related factors to the differences seen across the Region, both how age structure affects the capacity of health systems to deliver and the scale of inequality in health across the Region at specific ages. Table 1 summarizes the demographic profile of the region now, in 2020 and in 2050. The population is projected to increase slightly by 2020 – from 894 million to 910 million – but then to return to current levels by 2050. However, the number of people of working age then will steadily decline and the number of people of older ages will increase, leading to an increase in the old-age dependency ratio. In particular, the number of people 85 years and older is projected to rise from 14 million to 19 million by 2020 and to 40 million by 2050.

Table 1. Estimated population, percentage age distribution and dependency ratios for the WHO European Region^a, 2010, 2020 and 2050

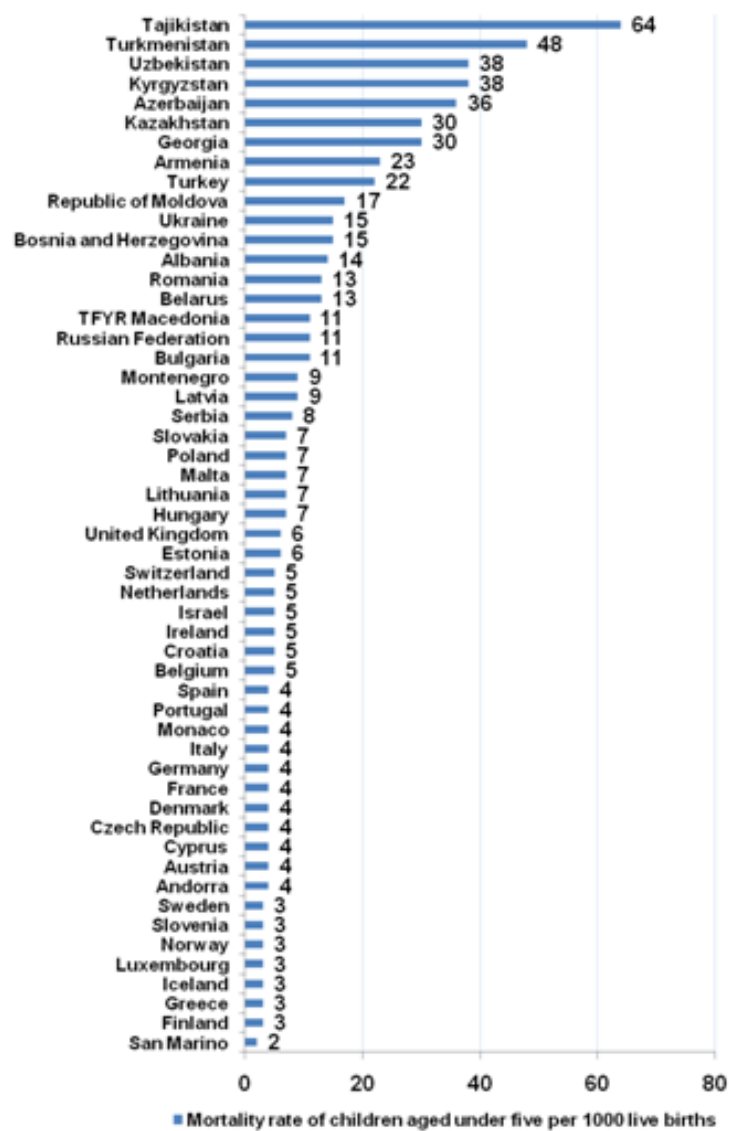
Age (years)	2010		2020		2050	
	population (thousands)	%	population (thousands)	%	population (thousands)	%
All ages	893 700	100	910 900	100	895 651	100
0–14	155 719	17	157 682	17	140 665	16
15–64	608 960	68	600 909	66	531 218	59
65–84	115 349	13	133 370	15	183 600	20
85+	13 672	2	18 939	2	40 168	4
Dependency ratios per 100 people 15–64 years old						
0–14 years	26		26		26	
≥65 years	21		25		42	

^aExcluding Andorra, Monaco and San Marino.

Source: World population prospects: the 2008 revision, population database (9).

Fig. 4 illustrates the inequality in health across the Region by showing the stark differences in mortality among children younger than five years old. Mortality was less than 5 per 1000 live births in 19 countries in the Region in 2008 but 30 per 1000 or higher in each country in central Asia.

Fig. 4. Mortality among children younger than five years old per 1000 live births for countries in the WHO European Region, 2008

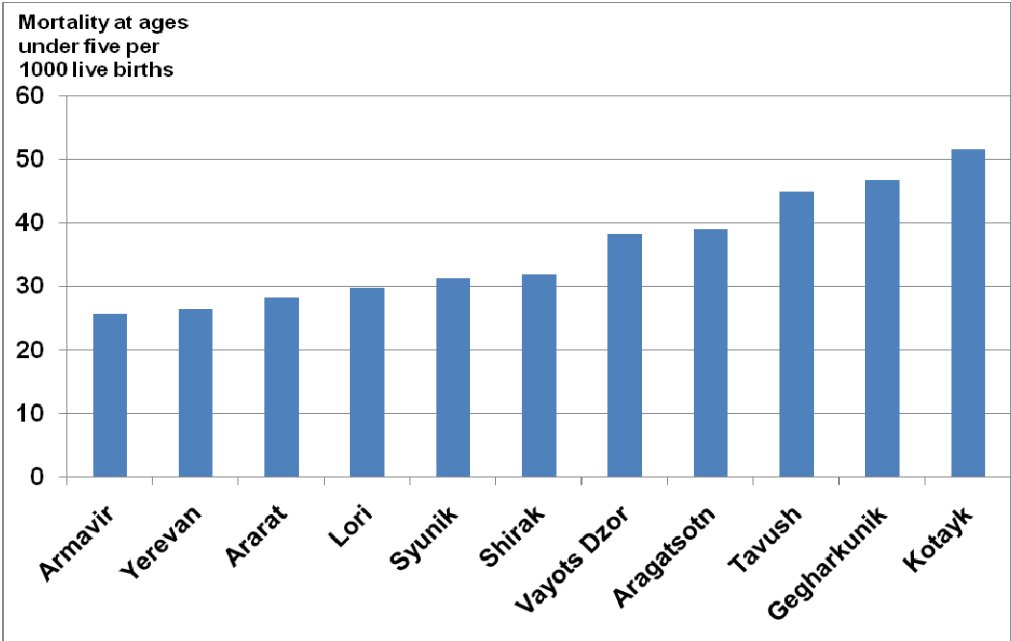


Source: World health statistics 2010 (10).

Geographical differences within countries

The report presents subnational data, based on local geography, where they are readily available. For the CIS countries with the lowest income – Armenia, Azerbaijan, Georgia, Kyrgyzstan, Republic of Moldova and Tajikistan – the report uses available data from the most recent World Bank household survey to examine the prevalence of ill health, measured by self-reported morbidity both nationally and locally. The report also presents data from the Demographic and Health Surveys (carried out by MEASURE DHS) for Albania, Armenia, Azerbaijan, Kazakhstan, Kyrgyzstan, Republic of Moldova, Turkey, Turkmenistan, Ukraine and Uzbekistan. Fig. 5 illustrates regional differences in Armenia for mortality among children younger than five years using this source.

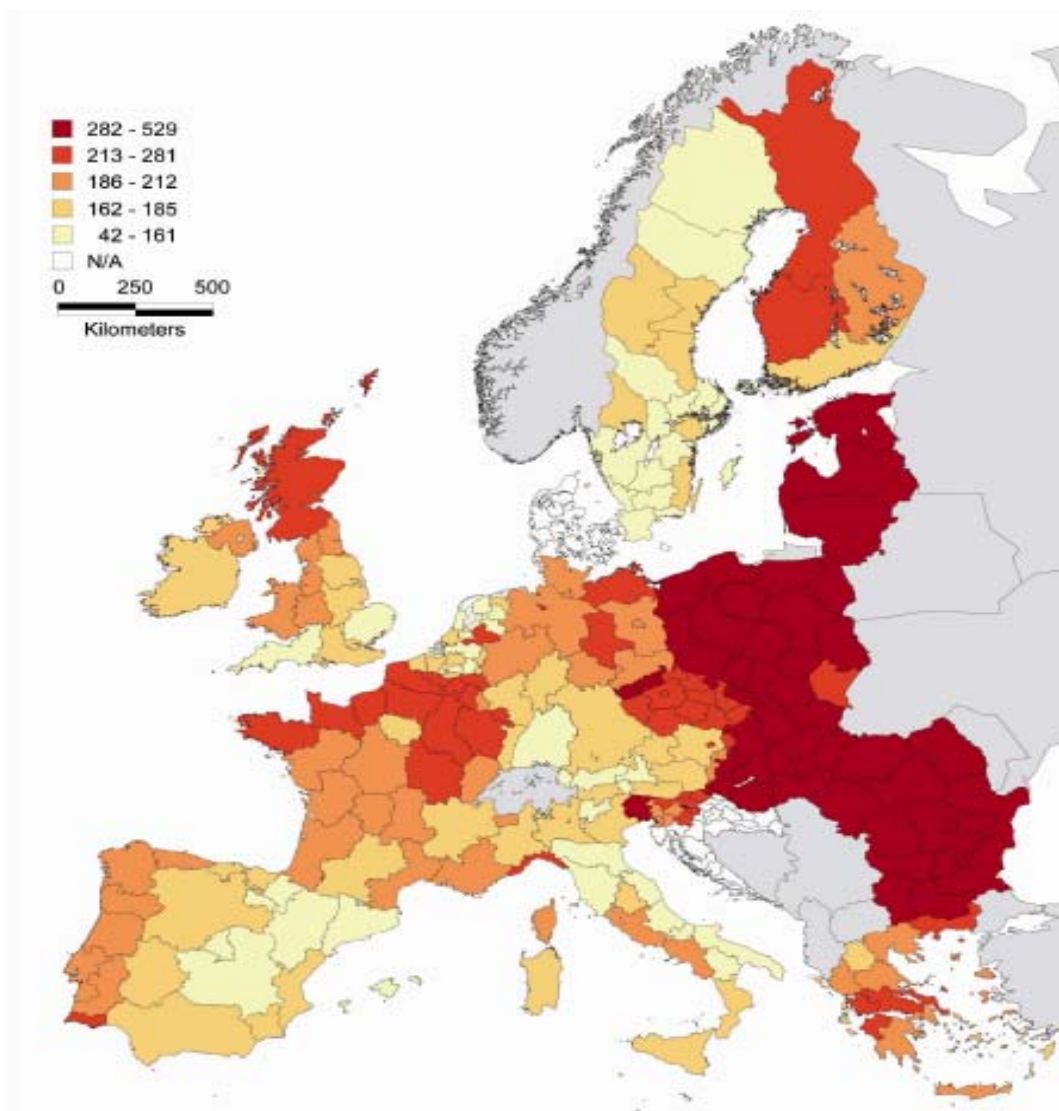
Fig. 5. Mortality among children younger than five years per 1000 live births in regions of Armenia, 1995–2005



Source: STATcompiler [web site] (11).

Regional data are also available from the EU-funded I2SARE project (12). This project compiled data from each EU country and the candidate countries – Croatia, the former Yugoslav Republic of Macedonia and Turkey – to produce quality-assured indicators for each region in these countries. The report presents key indicators (Fig. 6).

Fig. 6. Premature mortality: standard mortality ratios of those aged under 65 years per 100 000 population for regions within EU countries, 2006 or latest available earlier year



Source: I2SARE project: health inequalities indicators in the regions of Europe [web site] (12).

Health indicators

Mortality data are available annually for most countries in the Region, but the availability of other health indicators is less comprehensive. A considerable amount of information is available at the national level for EU and candidate countries on the Eurostat web site and other EU-wide portals, such as the various observatories that have been set up. The information is collected through EU-mandated surveys such as the Survey of Incomes and Living Conditions (SILC), disease registries and hospital patient records. Fig. 7 illustrates the monitoring of obesity levels for EU countries, showing the wide range across the Region in the proportion of men in each country who are obese.

Fig. 7. Prevalence of obesity among men in selected European countries, 2000–2005^a



^aSelf-report surveys (illustrated with dots) may underestimate the true prevalence.
Source: Obesity prevalence worldwide [web site] (13).

B. Social determinants of inequality in health

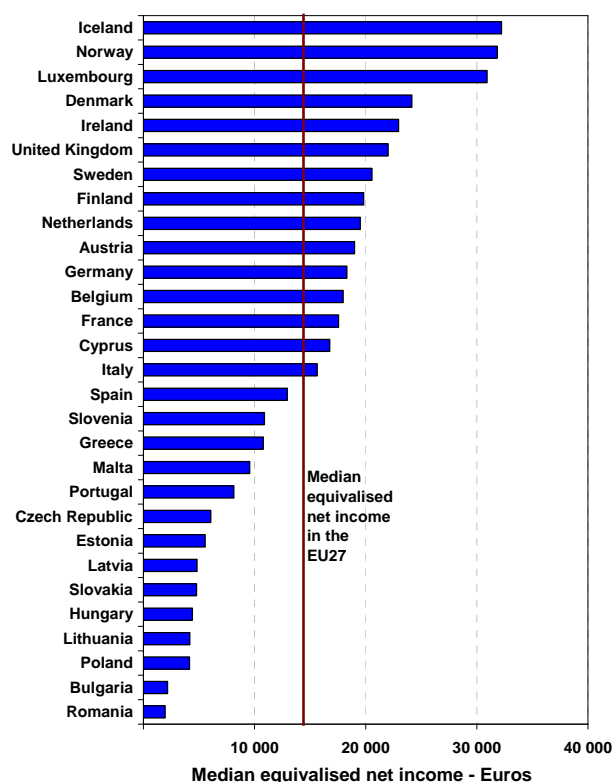
Social and economic variation

Understanding the patterns and trends in health across the WHO European Region in recent years requires considering social and economic variation across the Region and the changes that have taken place. The interim report discusses the key social determinants: early years, education, working conditions and employment, welfare and social protection, poverty, communities and health systems.

Income distribution

Fig. 8 shows the median equivalized² income for countries that provided these data for 2008 from the EU SILC: the 27 EU countries, Iceland and Norway. The median income in Iceland, Luxembourg and Norway was more than twice the median income for the EU as a whole but was lowest in the new member states from central and eastern Europe covered by the survey, except Slovenia, ranging between 13 and 41 per cent of the EU average. The median income in Slovenia was three quarters of the EU median.

Fig. 8. Annual median equivalized net income for countries reporting from the EU SILC, 2008

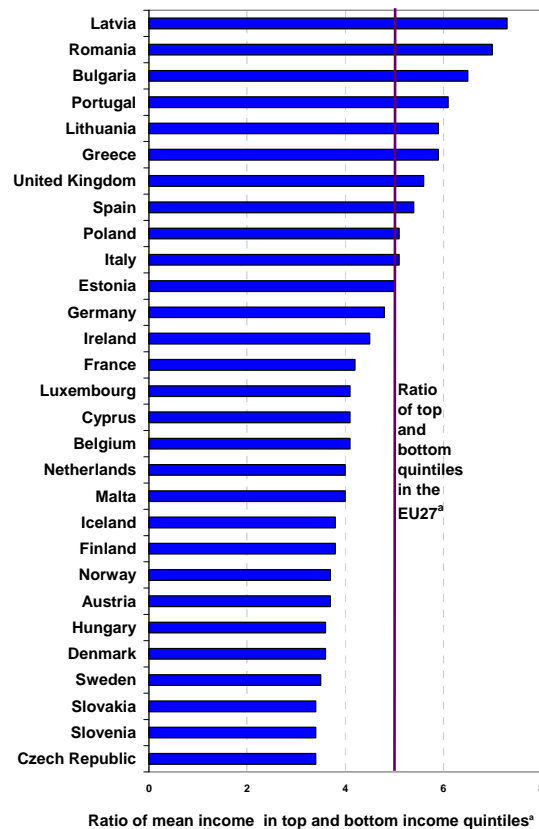


Source: Income, social inclusion and living conditions [online database] (14).

² To take into account the impact of differences in household size and composition, the total disposable household income is "equivalised". The equivalised income attributed to each member of the household is calculated by dividing the total disposable income of the household by the equivalisation factor.

Fig. 9 shows the extent of relative income distribution within countries, based on the EU overarching indicator (15). The ratio between mean income per person in the top and bottom income quintiles of the population was largest in some of the countries with the lowest median incomes – more than seven in Latvia and Romania. In contrast, some countries for which income levels were below the EU average – Czech Republic, Slovakia and Slovenia – had the smallest ratios, slightly below Sweden’s level of 3.5.

Fig. 9. EU income distribution indicator: ratio of mean income per person in the top income quintile to that in the bottom quintile^a in the EU countries, Iceland and Norway, 2008



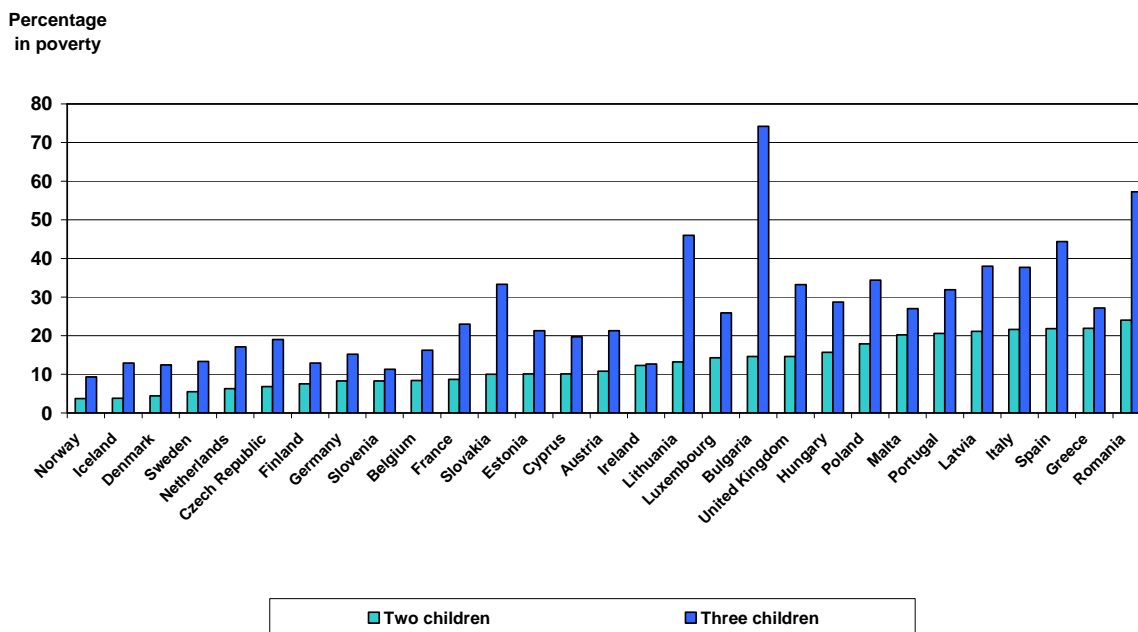
^aRatio of the total equivalized disposable income per person received by the population quintile with the highest income to that received by the lowest quintile.

Source: Income, social inclusion and living conditions [online database] (14).

Family poverty

A particular issue in relating income to early-years development is the extent to which children live in poverty. Fig. 10 shows how poverty for children with families varies across the EU countries, Iceland and Norway and depends to a considerable degree on family structure – in this example, whether there are two or three children in the family.

Fig. 10. Percentage of couples who have two or more children in poverty^a among families with two and three children in the EU countries, Iceland and Norway, 2008



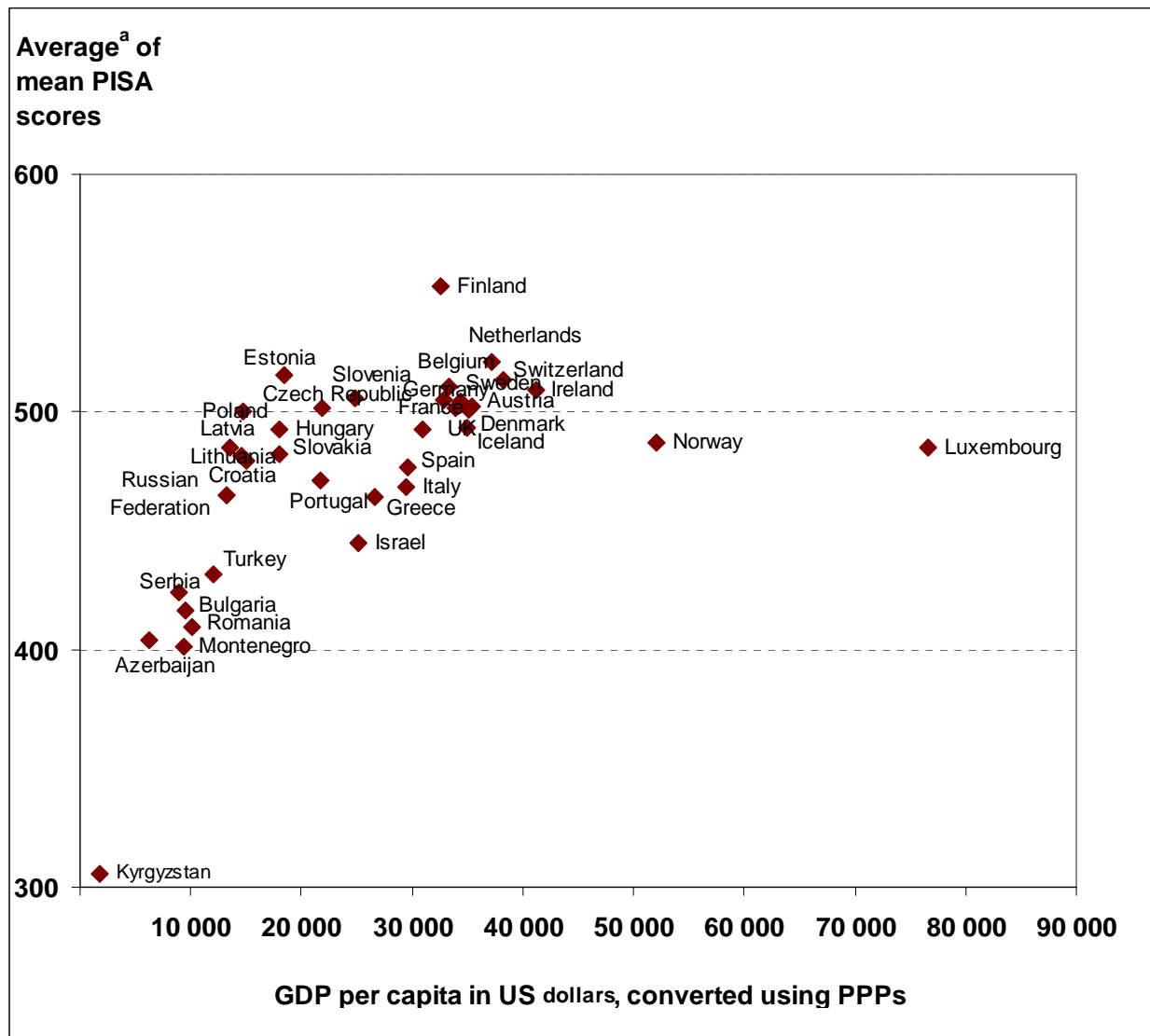
^aThe EU poverty indicator is defined as the share of people with an equivalized disposable income below the risk-of-poverty threshold, which is set at 60 per cent of the national median equivalized disposable income (after social transfers).

Source: Emese Mayhew and Jonathan Bradshaw, University of York, personal communication, 2010: analysis of EU SILC data from 2008.

Education

The quantity and quality of educational experience reinforces the effects of early-years development on subsequent social and economic well-being, health and other outcomes. Fig. 11 shows a modest correlation between average test scores among 15-year-olds in 36 countries in the European Region and gross domestic product (GDP) per capita – especially at lower levels of GDP.

Fig. 11. Average Programme for International Student Assessment (PISA) test scores for 15-year-olds by GDP per capita, selected countries in the WHO European Region, 2006



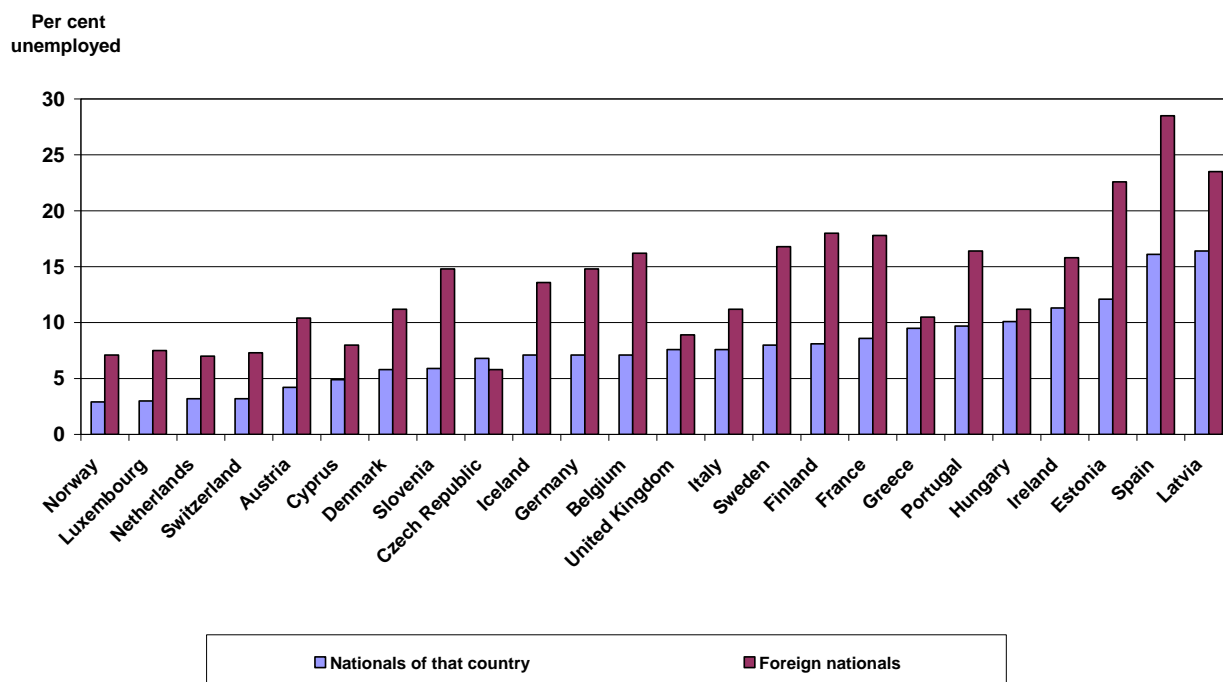
^aAverage of PISA reading, mathematics and science mean scores. UK: United Kingdom.

Sources: test scores: PISA 2006 database [online database] (16); GDP: *Gross domestic product 2009, PPP* (17).

Work and employment

The work people do profoundly affects their health, both when they are working and beyond. The health effects of work depend both on whether individuals obtain secure employment when they need it and the quality of that work – for example, the amount of control workers have on the demands placed on them. Fig. 12 illustrates how levels of unemployment varied across the European Region in 2009 following the recent economic downturn and how, in most countries, foreign nationals fared worse than nationals of that country.

Fig. 12. Unemployment rates by country and nationality, selected EU countries, Iceland, Norway and Switzerland, 2009



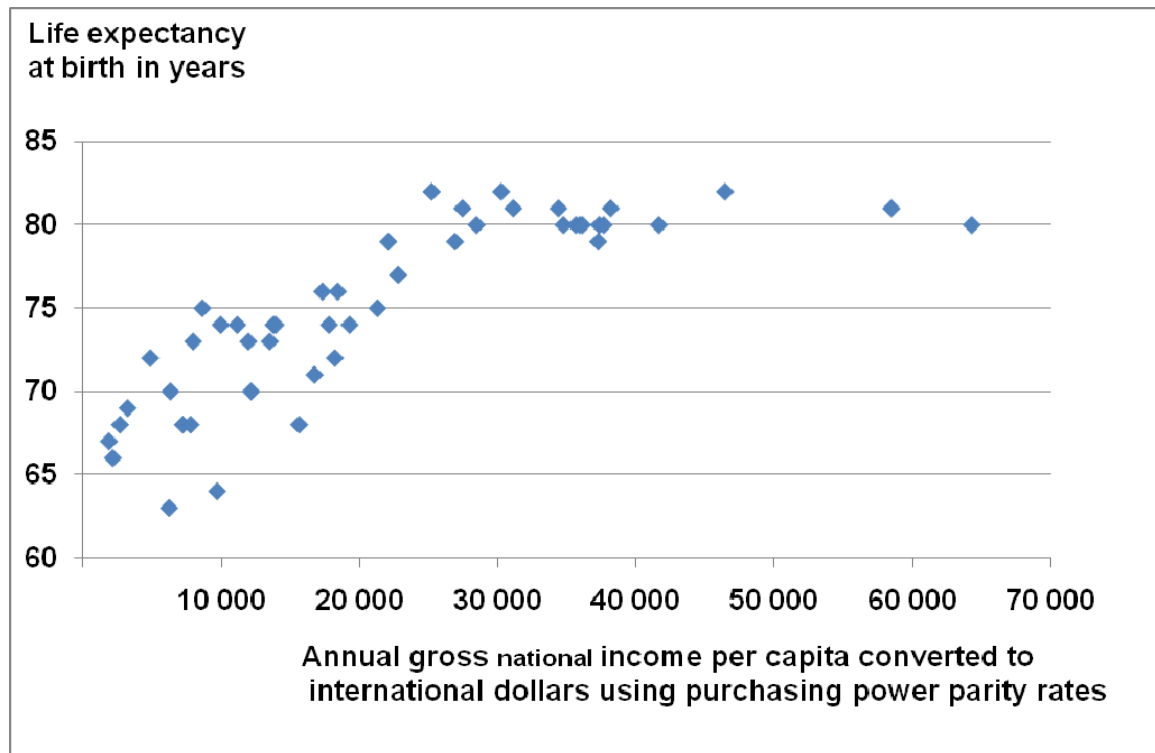
Source: Unemployment rates by sex, age groups and nationality (18).

Health and social determinants

The report brings together new and existing analyses of data for the European Region relating health to its social determinants. The information comes from a range of sources, such as WHO reports, EU publications, the Eurothine project, the I2SARE project, the Organisation for Economic Co-operation and Development, PISA, the study of Health, Alcohol and Psychosocial Factors in Eastern Europe (HAPPIE), the Health Behaviour in School-aged Children survey, the EU SILC and the EU Labour Force Survey (LFS). Highlights of these analyses are illustrated here.

For countries in the European Region with a GDP per person of less than US\$ 25 000, life expectancy and GDP per person are correlated (Fig. 13).

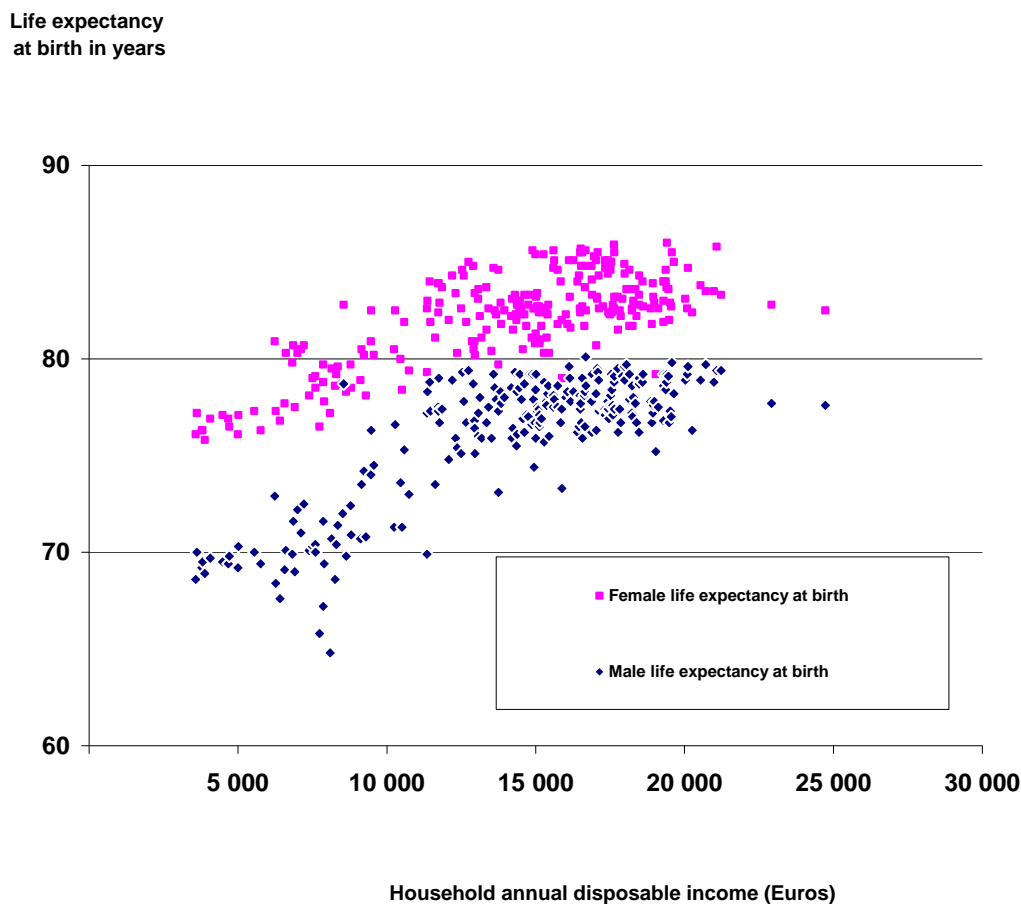
Fig. 13. Life expectancy by gross national income per head of population (Preston curve) for countries in the WHO European Region, 2008



Source: World health statistics 2010 (1).

Fig. 14 relates average disposable income in subnational areas to male and female life expectancy for EU and candidate countries. The relationship is strongest in poorer areas and decreases with increasing income levels – so that there is little evidence of a correlation above €12 000 per head of population.

Fig. 14. Life expectancy by disposable income and region within EU and candidate countries, 2007



Source: I2SARE project: health inequalities indicators in the regions of Europe [web site] (12).

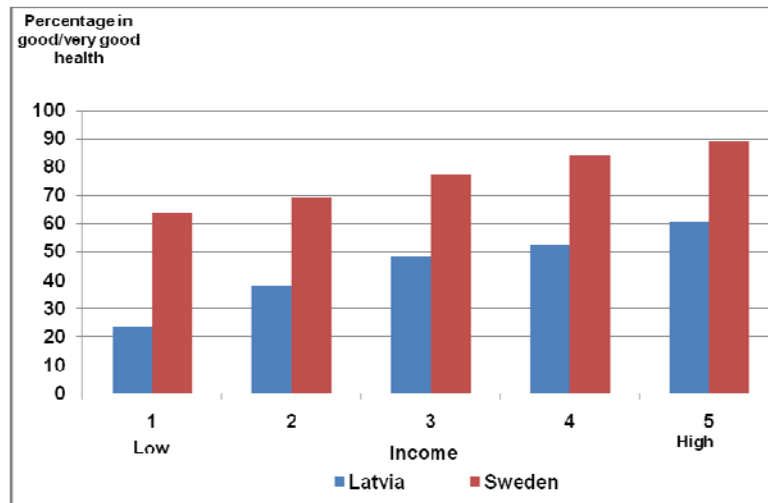
Inequality in health between individuals based on their personal circumstances

Several sources of data in the WHO European Region can be used to examine how health varies according to each individual's own social conditions. Some, especially the larger EU-wide surveys – such as EU SILC – relate health to contemporaneous social conditions. Others, available in fewer countries – such as Scandinavian registry-based studies, relate long-term health outcomes to earlier social conditions. The interim report describes recent information from these sources. This summary illustrates examples.

Income and health

There is a gradient in health according to income when individuals report their own health status. In EU SILC, the higher the household income, the more people report favourable health. The strength of this relationship varies by country. Fig. 15 illustrates this, showing the sharper gradient with income in Latvia compared with Sweden. However, despite this steeper gradient, the most affluent quintile in Latvia reports lower levels of health than the least affluent quintile in Sweden.

Fig. 15. Percentage reporting their health as good or very good by household income quintiles in Latvia and Sweden, EU SILC, 2008

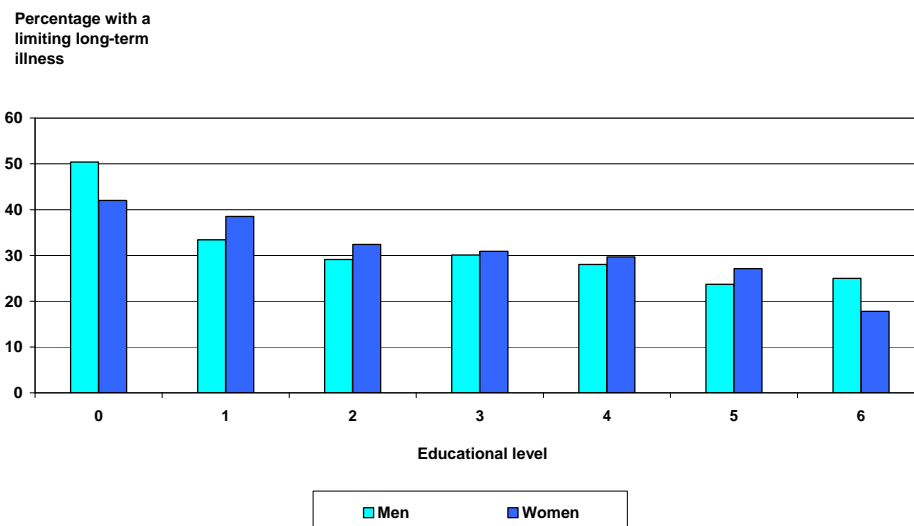


Source: Emese Mayhew and Jonathan Bradshaw, University of York, personal communication, 2010: analysis of EU SILC data from 2008.

Education and health

Limiting long-term illness becomes more common with increasing age. However, its prevalence among people 45–54 years old is strongly socially graded. Fig. 16 shows the steep gradient recorded in EU SILC according to level of education. The gradient in limiting long-term illness is steeper at this age than at other ages.

Fig. 16. Percentage of men and women aged 45–54 years with a limiting long-term illness by educational level^a in the EU countries, 2008



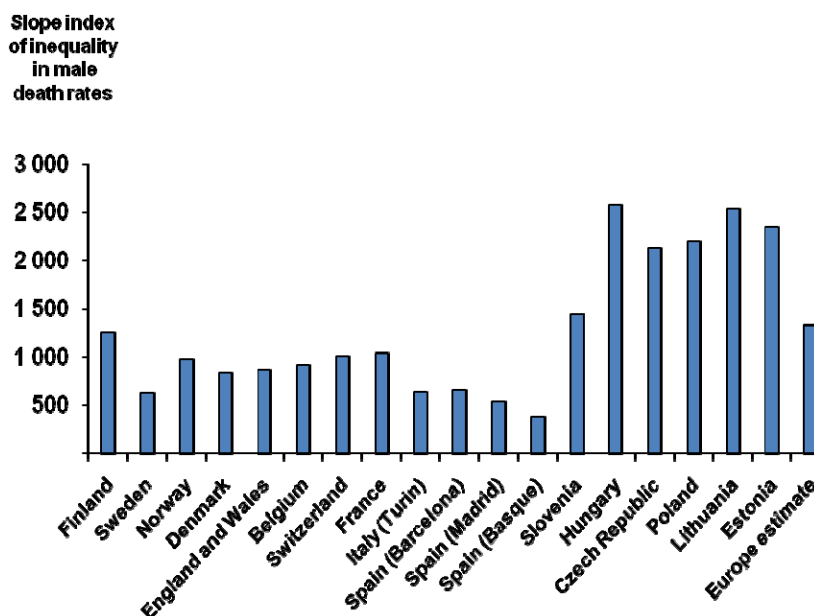
^aEducational level: International Standard Classification of Education classification (19):

- Level 0 Pre-primary education
- Level 1 Primary education or first stage of basic education
- Level 2 Lower secondary or second stage of basic education
- Level 3 Upper secondary education
- Level 4 Post-secondary non-tertiary education
- Level 5 First stage of tertiary education
- Level 6 Second stage of tertiary education leading to an advanced research qualification

Source: Income, social inclusion and living conditions [online database] (14).

The report summarizes key findings from the Eurothine project (20), which compares inequality between individuals in several countries. Fig. 17 shows considerable variation across the European Region in inequality in mortality based on the length of education of individuals included in the studies covered by the project. Inequality was greatest in the countries in central and eastern Europe included in the project and least in Italy, Spain and Sweden.

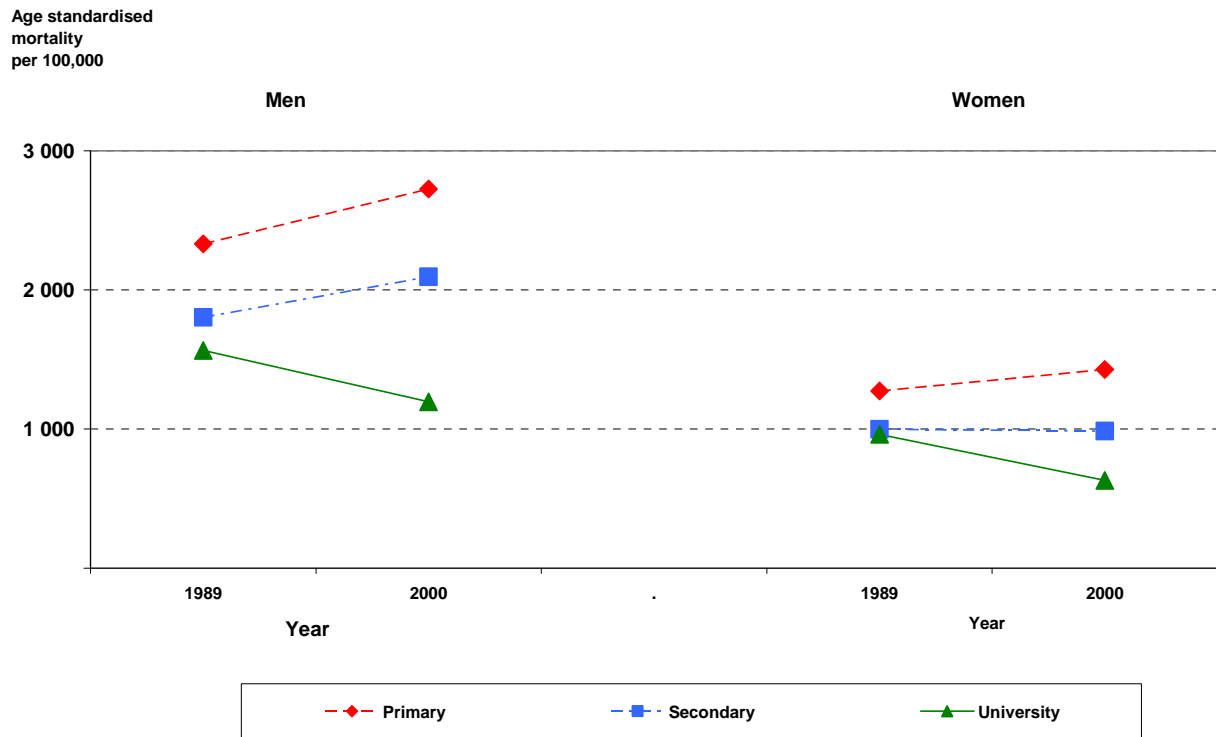
Fig. 17. Absolute inequality (slope index of inequality) in male death rates by level of education



Source: Mackenbach et al. (20).

A growing body of data shows an inverse socioeconomic gradient in various health outcomes in the central and eastern parts of the European Region: the lower the socioeconomic status, the higher the rate of ill health (21). However, it is the changes over time in the social gradient in health during the rapid societal transformation that are important. Given the macroeconomic changes within these countries in recent years, with rising income inequality and often dramatic declines in living standards, a rise in social inequality in health would be expected. All studies that have examined this have found this to be the case (for example, Fig. 18).

Fig. 18. Mortality by highest level of education in Estonia, 1989 and 2000



Source: Leinsalu et al. (22).

C. What can be done?

Evidence about existing interventions and strategies to reduce inequalities in health in the Region has been outlined by the Commission on Social Determinants of Health (2), the strategic review of health inequalities in England post-2010 (23), papers produced for the Spanish Presidency of the EU (24) and various WHO publications, such as Strand et al (25). The review builds on this evidence base through a network of task groups summarizing the most recent evidence (Section D) and proposing effective interventions and delivery systems to tackle inequalities in health across the Region.

This section summarizes some of the main barriers to and opportunities for reducing inequalities in health across the Region. The interim report and the report in December 2010 further describe these points. Subsequent work during the review will build on this analysis and propose effective, evidence-based ways of creating and maximizing opportunities and overcoming barriers.

Systems for action

Governance structures

The governance structure and capacity at the national, regional and local levels vary considerably across the European Region (26), and supranational governance structures also strongly influence national policy and tackling inequalities in health. Taking this diversity into account is a huge challenge when making cross-national and regional recommendations and also requires more localized responses that complement the overarching regional strategies. Divergent governance structures create difficulty in collecting comparable data and disseminating good practices across national boundaries.

Regional, national and local action

Inequality in health and the social determinants of health tend to be addressed at the national and supranational levels. Ensuring consistency of efforts and coherence at different levels of governance requires bolstering the capacity of the subnational level (regions and municipalities). The coherence of governance between the national systems and the regional and local systems and stakeholders needs to be ensured to strengthen the overall coherence of governance within a country.

Health systems³

Health systems alone cannot reduce inequalities in health, but they play a vital role. Health ministries have an important role as active stewards, influencing the development plans, policies and actions of players in other sectors. The full report outlines this in more detail. The latest evidence shows how keeping equity in health on the intersectoral agenda is particularly important in times of economic recession as health risks increase.

³“A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities.... It includes intersectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well-known determinant of better health.” (27).

Health systems are very diverse across the Region. Countries lacking a system of universal health care funded by general taxation or mandatory universal insurance are likely to face much greater inequalities in health and find it harder to narrow this gap (2). Other features of health systems that may also affect inequalities in health include how accessible health services are in all geographical areas and for vulnerable groups and how services are funded.

There is also scope for health systems putting their own house in order. This can include:

- building on current efforts by the health system to tackle inequalities in health. For example, solidarity in health system funding can be implemented to ensure universal access so that services are free at the point of access and provided based on need and not ability to pay.
- realizing the full extent and scope of the contribution of health systems to health, such as working across the different parts of the health system and with other sectors to create the social conditions that improve health for all groups within the population and preventing ill health.

International institutions

At the international level, many institutions affect inequalities in health. These include the EU, WHO and nongovernmental organizations. A focus on inequalities in health, particularly within the EU and WHO, is a promising development resulting in a number of positive outcomes. The interim report outlines these in more detail. The review will assess the role and potential effects of institutions across the Region for the purpose of recommending effective action to increase their ability to reduce inequalities in health by reducing inequalities in the social determinants of health.

Intersectoral work

Coherent effective intersectoral action is necessary to tackle inequalities in health and inequalities in the social determinants of health. Countries in the European Region vary widely in the nature and extent of the intersectoral mechanisms being used to address public health challenges. Most official health strategies and policy documents refer to the importance of work with other sectors, and many of these have created or indicated some form of intersectoral or joint planning group or committee. Further, these approaches vary widely in how well they work in practice. The interim report provides more detail on the processes that undermine effective intersectoral action.

Global processes: the Millennium Development Goals

The heads of state of 189 countries adopted the Millennium Development Goals in 2000. They provide a framework for focus and accountability in addressing some of the most pressing global development challenges. All the Millennium Development Goals affect health, and health affects all the Millennium Development Goals. Delays and barriers in progress towards achieving the targets of the Millennium Development Goals endanger health and well-being. Across all sectors, development efforts must reach those in need across the social gradient, with proportionately greater attention to the most vulnerable population groups. This review will analyse how addressing the social determinants of health is key to scaling up efforts towards achieving the Millennium Development Goals.

Economic forces

Inequality in income and the role of social protection

As illustrated in Section B, income levels vary across the Region, both within and between countries, and inequality in health is correlated with this variation. The lower a person's socioeconomic status, the worse his or her health. Some countries have managed to narrow inequality in income through effective redistributive tax systems, but the countries lacking an effective safety net to support the more deprived people in society will experience greater inequality in health.

Social protection has a clear role in addressing inequalities in health. The impact that welfare state regimes have on health demonstrates that both the type of welfare state and its size affect health and inequalities in health (28–31). The extent of social protection (going beyond income to cover a range of other services) provided by the public sector influences the social determinants of health and resulting inequity in health. The concept of comprehensive social protection is particularly salient in the current economic downturn. The United Nations Chief Executives Board adopted the United Nations Social Protection Floor Initiative in 2009 as one of nine key priorities to cope with the economic crisis, and the final report of the first phase of the Review will assess this approach.

Economic downturn

The recent international economic recession hit the European Region harder than any other region, and it will be the slowest region to recover, according to the World Bank (32). Some countries in the Region have particularly severe problems. This is likely to cause inequalities in health to widen considerably across the Region. Rises in food prices, for example, are a significant issue in the Region, with significant potential implications for inequality. The review will describe and assess how the economic downturn is affecting the social determinants of health and inequalities in health and propose effective measures to counteract the potentially damaging and uneven effects of the crisis on health (33).

The recent EU communication on solidarity in health (4) highlights how avoidable inequity in health constitutes a significant barrier to economic growth in the within European Region. The strategic review of health inequalities in England post-2010 (23) calculated that inequalities in health costs England between £31 billion and £33 billion in productivity losses, and lost taxes and higher welfare payments cost between £20 billion and £32 billion each year. Additional costs of inequalities in health to the health care system in England are estimated to be more than £5 billion each year.

Country differences and specific contexts

Country context

The WHO European Region is diverse in terms of cultures, history and development. This provides varied experiences and contexts and means that universal policy recommendations are difficult, and policies cannot be transferred across countries without considering local factors, culture and capability.

Some countries and regions have made significant progress in tackling inequalities in health, acting as positive role models within subregions. The review will assess what these leading

countries and regions have achieved and how and will use such evidence to inform recommendations and proposals for other countries and regions.

Vulnerable groups

Recent research on vulnerability has focused on the interaction of risk, hazard and degree of vulnerability (34). The more a group is marginalized, the more vulnerable it is. Nevertheless, being a migrant, from a certain ethnic group or a person with a disability does not make a person inherently more vulnerable or at increased risk. Rather, it is the interaction between several factors that creates increased vulnerability. These factors include poverty, inequality, discrimination, exposure to various threats (such as sexual abuse), the prevailing incidence or prevalence of disease (such as HIV) and the possibilities of epidemics (such as influenza).

The review for the European Region will look at specific social exclusion processes in relation to the inequity in health experienced by vulnerable migrant and Roma populations. There are about 74 million migrants in the WHO European Region, accounting for 39% of all migrants in the world. The review will identify factors associated with vulnerability, such as refugee or asylum-seeker status, poorly paid and insecure work, human trafficking, discrimination, and the policy responses affecting health outcomes. Roma and Travellers are the largest single ethnic minority group in the Region, with an estimated 10 million in the EU alone. The review will examine how equitable access to resources, capabilities and rights – across sectoral domains – for migrants and the Roma ethnic minority can reduce inequity in health. It will explore the role of health systems and cross-government inclusion efforts towards this end. The review will identify factors across the four dimensions of social exclusion: economic, political, social and cultural.

Measurement and monitoring

The lack of data in some areas presents a significant challenge in addressing inequality. The recent report on monitoring the social determinants of health and the reduction of inequalities in health in the EU (24) pointed to gaps in existing knowledge, especially gaps relating to the effects and effectiveness of policies of the health sector and other sectors in reducing inequalities in health. The lack of appropriate, routinely available and comparable data within each country and across the EU was highlighted as a key barrier to the greater knowledge and effective analysis needed to reduce inequalities in health.

Data on inequalities in health and related policies in the countries in the Region outside the EU are equally limited. All countries have health surveys, but many surveys have limited comparability because of the size and representative nature of the samples and the nature and frequency of follow-up, especially in the central and eastern parts of the Region (35). Further, evidence indicates that studies based on unlinked data led to underestimating mortality in disadvantaged groups and overestimating mortality in advantaged groups (36). Across the European Region, many health measures are not linked to the policy monitoring systems of other sectors and, when they are, the access to and use of these measures in policy-making is limited. Current challenges include the inability to collect and analyse data from the health sector and other sectors and a lack of adequate measures of social position or advantage (equity stratifiers).

The Review will examine the most effective mechanisms for improving reporting and monitoring across the Region. Strengthening monitoring within and across countries will require increased coordination, harmonization and accessibility of data from population- and institution-based sources that complement rather than replace in-depth existing mechanisms at the national level.

The report commissioned through the Spanish Presidency of the EU (24), for example, identified the need for a vision that goes beyond incrementally improving existing data sources to a shift in the approach to data collection, analysis and application, to ensure timeliness and periodicity; comparability and harmonization; and, accessibility.

D. What are the next steps for the review?

WHO launched a consortium to review the health divide in the WHO European Region. It will run from July 2010 to 2012. Professor Sir Michael Marmot is chairing the review, supported by task groups and other experts across the Region.

The first phase of the review runs until the end of 2010. In phase 2, from 2011 to 2012, the task groups and experts will assess the evidence and put forward effective interventions and governance systems across the diverse countries in the European Region. The process of conducting the review and the ongoing efforts at WHO, the EU and elsewhere will enhance awareness of inequalities in health and increase the capacity to deliver measures that can reduce this inequality. The final report will be submitted in April 2012 for the session of the WHO Regional Committee for Europe in September 2012.

Role of task groups

To extend and build on existing knowledge, the review will commission several expert task groups on social determinants covering the key determinants of health. These task groups will be divided into three regional subgroups covering broadly the countries in eastern, central and western parts of the Region. There will be five other task groups on cross-cutting issues. The full report summarizes the task groups, and this is briefly outlined below.

The task groups will conduct extensive evidence reviews, assess examples of best practice and consult with experts and practitioners across Region. The task groups and members of the review will develop the evidence base into clearly defined recommendations and actions to reduce inequalities in health across the Region.

Specific recommendations on policy, methods of measurement and governance

A clear grasp of the challenges that inequalities in health pose for the European Region will lead to the formation of recommendations to tackle it. These will range from overarching general recommendations to more local and specific ones and encompass policy in all the areas covered by the task groups – including health systems, methods of measurement and governance.

Case studies on countries and policies

Case studies will be used to highlight significant policies or actions taken to address inequalities in health. There will be a range of case studies from the local, national and European Region levels.

Capacity-building

Engaging a wide range of stakeholders in the review will help build capacity and understanding within the organizations needed to implement measures to address inequalities in health. The relationships built and the knowledge garnered will also inform the recommendations and approach of the review. They will link closely with other aspects of work on capacity-building being taken forward as part of the new health policy for the WHO European Region.

Consultations

WHO and the Review Secretariat at the University College London will undertake consultations on key parts of the review, engaging stakeholders from a range of sectors, countries and organizations. These will be closely linked with the related consultations on the new health policy for the WHO European Region. This will give Member States and stakeholders across the

Region the opportunity to shape the scope and content of the review and to give feedback, learn about initial findings and test the policy options developed by the review.

Examination of future trends in inequalities in health

Finally, the review will identify future trends in inequalities in health, taking into account existing data and other relevant factors. This is likely to include the economic downturn, cuts in public expenditure and other pressures on policy and politics within and between countries.

Structure of the review of social determinants and the health divide in the European Region

The Review Secretariat at the University College London will collate and analyse proposals for task groups. The proposed themes to be covered by the task groups are listed below. These are in draft and require further discussion.

Task groups

Seven task groups will each cover a particular set of social determinants of health in the European Region. Each will consist of a chair and the chairs of three regional subgroups, each of which will comprise experts who will examine issues relevant to specific subregions of the Region. All task groups will consider demographics, older people, mental health and well-being. The task groups will identify promising initiatives, make recommendations for action, propose delivery mechanisms and propose a time frame for implementation and a framework for monitoring improvement in performance.

The seven task groups on the social determinants of health will be as follows:

- early years, education and the family
- working conditions, occupation, unemployment and migrant workers
- disadvantaged, excluded and vulnerable groups, including vulnerable migrant workers and Roma
- GDP, taxation, income and social welfare
- sustainability and community
- preventing and treating ill health
- gender issues.

Cross-cutting task groups

Five groups will be set up to tackle cross-cutting, generic issues. Each will consist of about five experts and a chair. The groups will consider the proposals of the task groups on the social determinants of health. They will also commission work before receiving proposals from the task groups on the social determinants of health to prepare the ground for making their own proposals and to assist in developing their proposals.

The five cross-cutting groups will be as follows:

- governance and delivery systems
- measurement and targets
- economic considerations
- equity and equality issues
- effect of global factors.

Draft timeline

August 2010	Preliminary first-phase report submitted to WHO
September 2010	Interim first-phase report submitted to WHO for consideration by the WHO Regional Committee for Europe
December 2010	Final report on the first phase submitted for publication
April 2011	Report for consultation, based on emerging findings of the task groups
July 2011	Papers prepared for the September 2011 session of the WHO Regional Committee for Europe
September 2011	The WHO Regional Committee for Europe considers the consultation report and recommendations
April 2012	Draft final report submitted to WHO
September 2012	The WHO Regional Committee for Europe considers the final report and recommendations

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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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