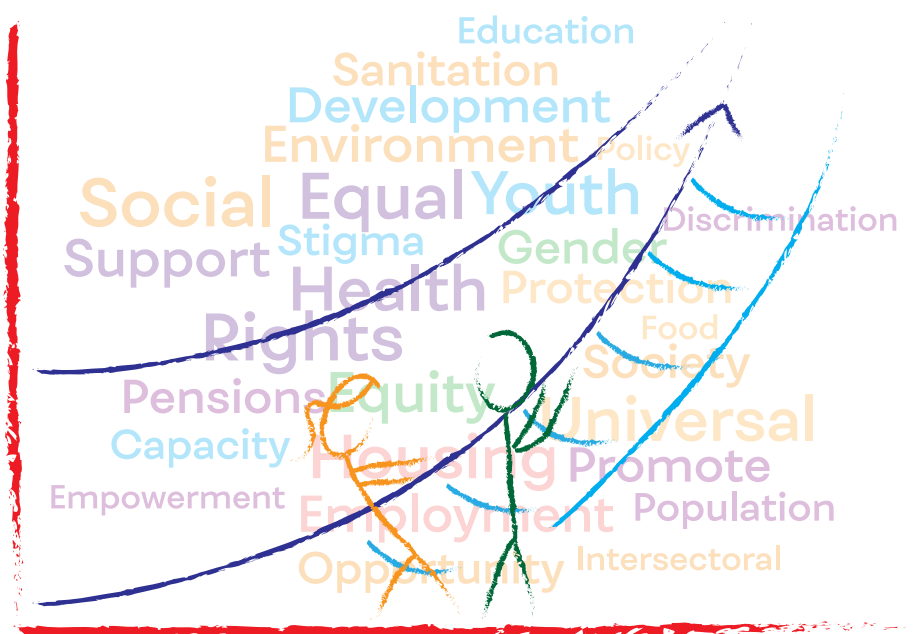




World Health  
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REGIONAL OFFICE FOR Europe



## Health Equity Policy Tool

A framework to track policies for increasing health equity in the WHO European Region





# **Health Equity Policy Tool**

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health equity in the WHO European Region**

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# Abbreviations

ALMP active labour market policy

ECEC early childhood education and care

EU European Union

HESRI European Health Equity Status Report Initiative

OOP out of pocket

SDG Sustainable Development Goal





# 1. Background

The principles of leaving no one behind and creating conditions for all people to flourish are essential to the goals of WHO and United Nations agencies and to their Member States and partners (1). They underpin the 2030 Sustainable Development Agenda (1), WHO's 13th General programme of work (2) and the strategic objectives of the WHO Regional Office for Europe's Health 2020 policy framework (3).

Health inequity is one of the main challenges of our time. Many people are prevented from enjoying a good quality of life and well-being because of barriers to fair and equal opportunities for health. Across the WHO European Region, the goals of reducing barriers to health equity, tackling vulnerability and increasing solidarity for health are reflected in the high-level commitments and strategies of Member States (which are covered in detail in Section 4).

The Health Equity Policy Tool has been developed to support WHO Member States and partners to strengthen the implementation of these commitments and strategies through specific policy actions. To accelerate progress in reaching those being left behind because of poor health and in preventing others from falling behind, policy action is required that reaches not only the most vulnerable but also those disproportionately at risk of avoidable poor health. The Health Equity Policy Tool will act as an enabler to promote and monitor such policies in the Region through:

- creating equal opportunities for health across the life-course
- reducing unequal exposure to avoidable health risks
- mitigating the consequences of accumulated social, economic and health disadvantage.

The policies to achieve these aims span five areas of multisectoral action, and there is strong evidence that these policy action areas increase equity in opportunities to live a healthy and prosperous life (Fig. 1).

**Fig. 1. Policy action areas**



The indicators in the draft Health Equity Policy Tool are classified into these five policy action areas and are drawn from existing data that are routinely collected by most Member States of the Region in accordance with international agreements.

The purpose of this document is to formally consult with Member States and partners of the WHO European Region on the Health Equity Policy Tool as a proposed instrument for monitoring progress and prioritizing multisectoral policy action for increasing health equity in the Region to be presented at the 69th session of the Regional Committee in September 2019. The consultation process provides an early opportunity to demonstrate the value of the Health Equity Policy Tool in:

- stimulating and maintaining dialogue on health equity in local, national and regional contexts; and
- focusing policy attention across all sectors on ways to prioritize policies and resource allocation to increase health equity.

It is proposed that the Health Equity Policy Tool would be used to produce progress reports every four years to complement the *European Health Report* series (4) in monitoring and reporting on health trends, progress and priorities for the Region and its Member States and partners.<sup>1</sup> This would help to achieve the overarching objectives of WHO and United Nations agencies to improve health and health equity and support sustainable development.

The Health Equity Policy Tool has been specifically designed for the WHO European Region but is aligned with a forthcoming global monitoring tool for reviewing action on the social determinants of health and health inequalities (based on a WHO consultation paper (5)). The global process proposes a set of actions that were pledged in the Rio Political Declaration on Social Determinants of Health (6,7). Although much richer sources of data are available in the WHO European Region than in the initial global framework, an initial mapping exercise shows several areas of similarity. As data sources are anticipated to improve globally, increasing alignment between the global tool and the Health Equity Policy Tool is expected.

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<sup>1</sup> The European Health Reports monitor between-country trends and inequities, whereas the Health Equity Policy Tool focuses on within-country trends and inequities.

## 2. Health equity policy action areas and indicators

The Health Equity Policy Tool is structured around five multisectoral policy action areas. All government sectors, not only the health sector, are responsible for promoting positive health environments and reducing exposure to health risks. Multisectoral action is therefore crucial for removing barriers and creating conditions across all dimensions of life to ensure equal opportunities to good health and prosperity for all.

Table 1 defines the five policy action areas of the Health Equity Policy Tool. These were selected on the basis of robust evidence, in Europe and worldwide, for their effectiveness in reducing differences in both health opportunities and risks.

This framework was informed by the work of the Scientific Expert Advisory Group to the European Health Equity Status Report Initiative's (HESRI's) sub-working group on the Health Equity Policy Tool and further developed through extensive dialogue and feedback with policy networks and at regional events between April and October 2018.<sup>2</sup>

**Table 1. Health Equity Policy Tool: policy action areas and their definitions**

Policy action area	Definition
<b>Health services</b>	Policies that ensure the availability, accessibility, affordability and quality of prevention, treatment and health-care services and programmes
<b>Income security and social protection</b>	Policies that ensure basic income security and reduce the adverse health and social consequences of poverty over the life-course
<b>Living conditions</b>	Policies that equalize differential opportunities, access and exposure to living conditions and environmental factors that impact our health and well-being
<b>Social and human capital</b>	Policies that improve human capital for health through education, learning and literacy; and policies that improve the social capital of individuals and communities in a way that protects and promotes health and well-being
<b>Employment and working conditions</b>	Policies that improve the health impact of employment and working conditions, including availability, accessibility, security, wages, physical and mental demands, and exposure to unsafe work

The Health Equity Policy Tool covers two types of indicators in each policy action area:

1. measures of the **implementation** of and **investment** in policies promoting health equity; and
2. measures of the **equity impact** of policies addressing the determinants of health or their consequences.

<sup>2</sup> The High-level Ministerial Meeting with a delegation of the Ministry of Human Capacities of Hungary, which took place in Venice, Italy, on 27–28 September 2018; Regions for Health Network (8); technical briefing at the 68th session of the WHO Regional Committee for Europe; the Extended Meeting of the Healthy Ageing Task Forces of the WHO European Healthy Cities Network, which took place in Copenhagen, Denmark, on 31 May–1 June 2018; and the WHO 70th Anniversary Conference, Progress and challenges to achieve Better Health in Europe and in Hungary: more equitable and sustainable, which took place in Budapest, Hungary, on 18 October 2018.

The **implementation** of policies known to improve health equity demonstrates political will and commitment of resources in that policy area and sustained **investment** in such policies demonstrates commitment over time.

The **equity impact** of a policy can be measured in terms of its coverage, uptake and effectiveness:

- coverage indicates the availability of a policy to certain population groups, especially those most left behind;
- uptake indicates the extent to which the policy actually reaches the groups it is intended to cover; and
- effectiveness indicates the ability of the policy to meet the intended goal of increasing equity in health and in the conditions needed to live a healthy life.

This indicator classification builds on the existing WHO indicator classification (9), which highlights the need to separate policy or action indicators from conditions. This distinction enables inputs to be aligned with measures of political will, and outcomes of policies with measures of impacts on the determinants of health inequities.

The following four criteria were used to select indicators for the Health Equity Policy Tool.

1. The indicator captures one or more of the health equity impacts of a policy.
2. There is evidence that the policy intervention or policy increases health equity within the context of the WHO European Region.
3. Member States have made a formal commitment to policy action in this area through European Union (EU), United Nations, WHO or other international resolutions.
4. A minimum of 30 Member States have routinely collected and readily available data for the indicator.

Exceptions to the criterion 4 are three new indicators proposed for inclusion in the Healthy Equity Policy Tool, which do not yet have routinely collected and readily available data. They result from gaps identified in current data, and are highlighted and discussed separately in Section 3.

The Health Equity Policy Tool indicators use data disaggregated by stratifiers such as income, years of education and sex. These stratifiers are widely recognized and used by the United Nations and other international organizations including the EU, the Organization for Economic Co-operation and Development and the World Bank, as well as by most national statistics offices and health research institutes.

Use of the various equity stratifiers allows the monitoring of equity across people in all population groups, including those who are protected under specific human rights treaties. These groups include children, migrants, minorities and people with disabilities, as well as groups protected under discrimination provisions, such as older people, youth and women.

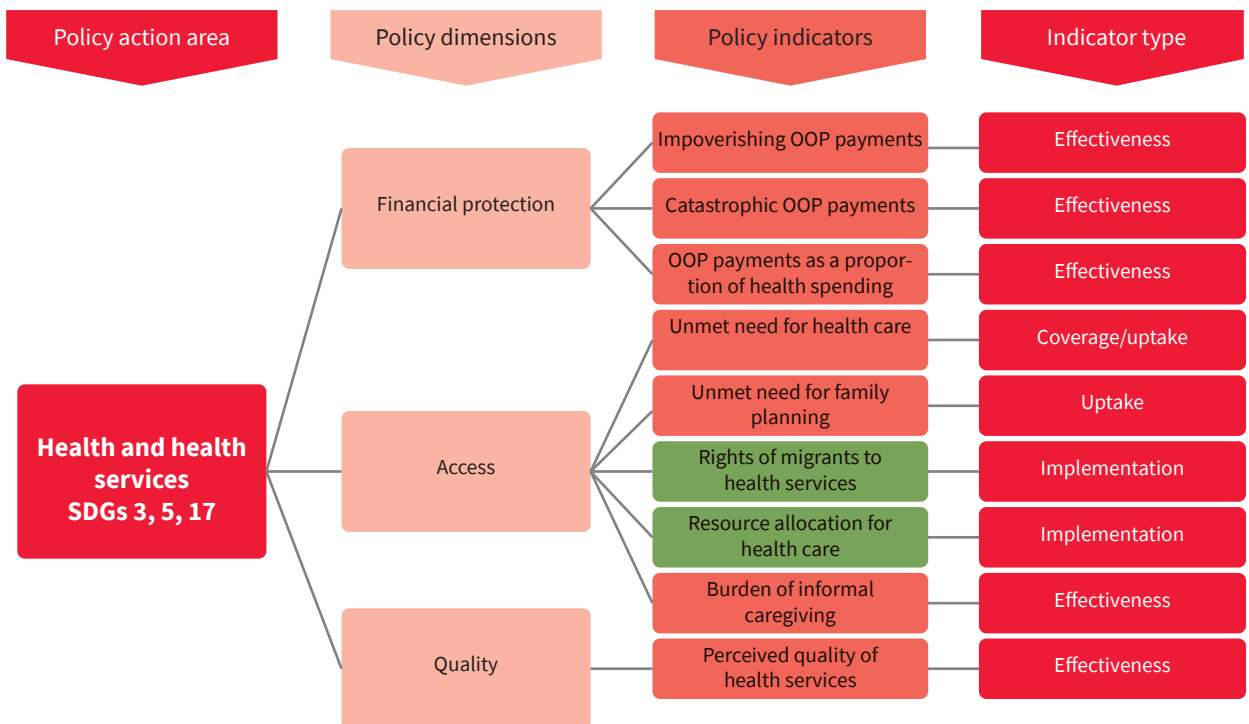
Where disaggregated data are not available, aggregate data that provide information on the coverage, uptake or effectiveness of policy on health-related conditions and outcomes can still be useful to measure health equity and the social determinants of health. For example, a number of indicators of more universalistic policies and macroeconomic conditions have been included because of their proven benefit to health and health equity.

The final set of policy action areas and indicators are based on the best available evidence and best-practice tools for monitoring progress towards health equity.

Some indicators of the Health Equity Policy Tool have a close or direct correspondence with indicators of the United Nations Sustainable Development Goal (SDG) targets. Where relevant, this is signposted with the appropriate SDG icon alongside the indicator description in Section 2, with more detailed indicator mapping provided in Section 4. All indicators with disaggregated data are linked to SDG target 17.18: “to increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts”.

## 2.1 Health and health services

*Policies that ensure the availability, accessibility, affordability and quality of prevention, treatment and health-care services and programmes*



OOP: out of pocket.

Dark green policy indicator box represents a proposed new indicator.

## 2.1.1 Ensuring universal financial protection for health

- Universal health coverage has an equity impact through ensuring that everyone can use appropriate and effective health services without experiencing financial hardship, irrespective of ability to pay, age, ethnicity, disability, geographical location, race, religion, sex, or sexual orientation.
- People experience financial hardship when out-of-pocket (OOP) payments are large in relation to their ability to pay for health services. Lack of financial protection can lead to or deepen poverty, undermine health, and exacerbate health and socioeconomic inequities.
- Where health systems fail to provide adequate financial protection, people may be forced to choose between using health services and meeting other basic needs such as food, housing and heating. This has a negative impact on health and well-being, which in turn further increases the risk of socioeconomic vulnerability and exclusion (10).
- Aligned with SDGs 3 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 1.** Proportion of households with impoverishing health spending



This indicator captures health equity because OOP payments have a greater impact on lower-income households, which face a greater financial burden in proportion to income for a given payment. It captures the extent to which OOP payments push vulnerable households below the poverty line and push households already below the poverty line further into poverty (11). The indicator captures the impact of OOP health-care spending on exacerbating health and income inequities between higher- and lower-income households.

**Indicator 2.** Proportion of households with catastrophic out-of-pocket health spending (>40% of capacity to pay)



*Disaggregated by consumption quintile*



Households with OOP payments for health care that are large relative to their capacity to pay<sup>3</sup> may be forced to forgo spending on other basic needs, such as food, housing and utilities. This increases health

<sup>3</sup> Capacity to pay for health care is defined as a household's total consumption minus a standard amount to cover basic needs.

inequities because lower-income households are less able to afford to make OOP payments for health care. This indicator measures the proportion of households making OOP payments that exceed 40% of their capacity to pay for health care.

**Indicator 3.** Out-of-pocket payments for health as a proportion of current health expenditure



This indicator measures health equity through the extent to which universal health coverage reduces OOP payments for health, which disproportionately impact lower-income households.

Indicators 1–3 are needed to monitor progress towards universal financial protection for health in the European context.

### 2.1.2 Ensuring universal access to health services

- Risks of poor health and illness are higher among people with lower social and economic resources (12–14). Health equity therefore intersects with gender and cultural norms.
- Policies that distribute more resources to areas with greater health, social and economic needs have a positive impact on reducing health gaps between social groups and geographical areas (15).
- Such policies help health systems promote human rights by ensuring that all people are treated equitably irrespective of age, disability, ethnicity, geographical area, race, religion, sex or sexual orientation (12).
- Aligned with SDGs 3, 5 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 4.** Proportion of the population reporting unmet needs for health care



*Disaggregated by sex, age, education level and income quintile*



This indicator measures health equity because people are at differential risk of unmet need for health care (due to cost, distance to services, and waiting time) depending on socioeconomic characteristics, such as their age, education level, income and sex.

**Indicator 5.** Proportion of women of reproductive age (15–49 years) reporting unmet needs for family planning services



*Disaggregated by household wealth*



Women in households with less favourable economic circumstances more commonly experience lack of agency and a mismatch between their intention to avoid pregnancy and actual contraceptive behaviour. Unwanted pregnancy, particularly for women in low-income households, can be detrimental to the physical and mental health of both infants and parents. This introduces intergenerational and gender dimensions to health equity.

**Indicator 6.** Implementation of policies protecting the rights of non-national migrants to health services in a country



This is a proposed new indicator. See Section 3 for the rationale for monitoring this indicator.

**Indicator 7.** Implementation or development of subnational resource allocation formulae for health care, incorporating a measure of socioeconomic deprivation (e.g. premature mortality)

This is a proposed new indicator. See Section 3 for the rationale for monitoring this indicator.

**Indicator 8.** Proportion of the population who are informal caregivers



*Disaggregated by sex, education level and income quintile*



Providing informal care can generate a mental health burden for caregivers via increasing emotional stress and time pressure. This indicator measures health equity because low-income households are less likely to be able to afford formal care and are therefore more likely to rely on informal care to meet health-care needs within the household. Informal caregiving has an additional gender equity dimension because the health and time burden of unpaid informal caregiving falls disproportionately on women.



### 2.1.3 Ensuring access to health services of equally good quality

- The quality of health care has an equity impact because health outcomes improve with better quality care (16). Therefore, equitable provision of good quality care reduces gaps in outcomes.
- Differences in the quality of care arise from differences in the geographical distribution of health services in low- and high-income neighbourhoods or other forms of discrimination that result in lower-income households receiving lower-quality care and poorer health outcomes.
- Aligned with SDGs 3 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 9.** Proportion of the population reporting poor-quality health care



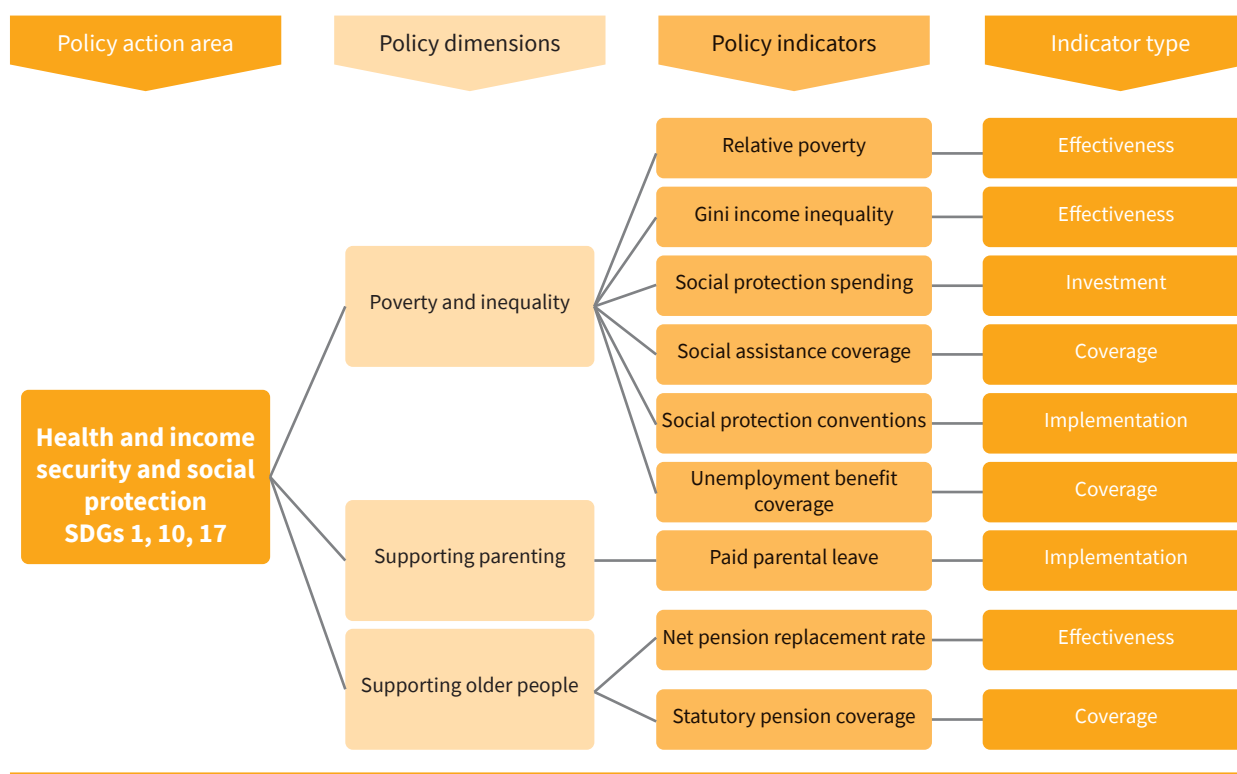
*Disaggregated by sex, education level and income quintile*



Disparities in the quality of health care are frequently found between providers catering to low- or high-income neighbourhoods. Similarly, disparities in health-care quality are also found between private and public providers, and mirror geographical inequities in socioeconomic status and health outcomes. Disaggregation by education level, income and sex allows this indicator to monitor equity in the quality of health care received based on socioeconomic status.

## 2.2 Health and income security and social protection

*Policies that ensure basic income security and reduce the adverse health and social consequences of poverty over the life-course*



### 2.2.1 Reducing and preventing poverty and income inequality

- The risk of poverty directly correlates with early-onset morbidity and premature mortality. Repeated or long-term exposure to financial insecurity predicts the likelihood of poor self-reported health, depression and the inability to meet the basic needs to live a healthy life, such as food, fuel and shelter (15).
- Young people, people in temporary or part-time employment, people with caring responsibilities and older people are at a higher risk of poor health associated with poverty risk (17).
- Non-stigmatizing social protection policies have positive effects on reducing health inequities related to income insecurity and poverty.
- Aligned with SDGs 1, 10 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 10.** Proportion of the population living in relative poverty, as measured by the at-risk-of-poverty threshold



*Disaggregated by sex, age, disability status, employment status, education*



This indicator measures the number of people living on or below 60% of the median household disposable income after taxes and social transfers. It is a measure of the proportion of the population exposed to income insecurity and consequently at risk of poor health.

Exposure to poverty in the early years of life can have a detrimental effect on health over the life-course. Children in households that are in poverty are particularly at risk of poor outcomes in both childhood and later life. Young people with fewer years in education and older people who have been in low-paid employment or not in employment owing to caring responsibilities are at a higher risk of falling below the at-risk-of-poverty threshold (18). Disaggregation by employment status allows the monitoring of health gaps associated with in-work poverty, and disaggregation by disability status allows the monitoring of health inequities due to the associated risk of vulnerability due to disability.

**Indicator 11.** Income inequality, as measured by the Gini index

Income inequality measures the disparity in household incomes across society. It is an appropriate measure of health equity because a reduction in income inequality improves the financial position of lower-income households relative to the rest of society. When the financial resources of all households are more equal, there is greater equity in the opportunities to access health-promoting goods, services and behaviours (18).

**Indicator 12.** Expenditure on social protection (excluding health) as a proportion of gross domestic product

Public expenditure on social protection has an impact on health equity when it improves financial security for people who are vulnerable due to disability, unemployment, housing deprivation and social exclusion. The level of expenditure is an indicator of a country's commitment to ensuring that the most vulnerable in society are protected from socioeconomic shocks that could increase their risk of developing mental and physical health conditions (18,19).

**Indicator 13.** Coverage, benefit incidence and adequacy of social assistance programmes



*Disaggregated by income quintile*



This indicator measures the extent to which social assistance reduces financial insecurity among those with the fewest resources and supports people to access the resources and services needed to live a healthy life. Non-contributory social support such as conditional and unconditional social transfers, school meals, public works programmes, social pensions and fee waivers reduce the risk of financial hardship, for example due to housing, fuel, and food insecurity, and the consequent physical and mental health risks.

**Indicator 14.** Ratification of International Labour Organization social security conventions<sup>4</sup>

This is an indicator of a country's commitment to reducing inequalities, including health inequities stemming from income insecurity, by helping people satisfy their basic needs. Different countries have different types of social protection programmes and systems, which have differing degrees of effectiveness in reducing health inequities, depending on context. This indicator provides additional detail on the breadth of a country's social protection policies.

**Indicator 15.** Proportion of unemployed people receiving regular periodic social security unemployment benefits

Unemployment benefit coverage has a health equity impact when it provides an adequate minimum income for unemployed people who are seeking but not in work. It is an indicator of reduced poverty risk and economic insecurity due to unemployment, which improves health equity indirectly through reducing the risk of housing, fuel and food insecurity and directly through reducing the associated mental and physical health risks such as anxiety and cardiovascular disease (21).

### 2.2.2 Supporting parents at the early stages of child development

- Early childhood development lays the foundation for physical and mental health and well-being outcomes throughout the life-course (22). Investment that reduces health risks and vulnerability in the prenatal period and early childhood help parents with lower resources give their children a healthy start in life.
- Investment in social protection for families and early childhood reduces health inequities by weakening the link between socioeconomic disadvantage and poor child health outcomes, including infant mortality (23,24).

<sup>4</sup> The International Labour Organization defines nine branches of social security (59).

- Such investment contributes to meeting children’s basic needs and helps them reach their full potential in life and health, irrespective of their or their parents’ sex, disability, race, ethnicity, origin, religion, and economic or other status.
- Aligned with SDG 17.



Detailed indicator mapping is provided in Section 4.

### **Indicator 16.** Length of paid parental leave in weeks

*Disaggregated by sex*



This is an indicator of a country’s commitment to supporting parents and the development of young children. Financial security for the parents and primary carers of infants promotes the health and well-being of both parents and infants (22). Although this indicator captures policy commitment, in countries where a significant portion of the workforce is employed in the informal sector or part-time and is thus ineligible for statutory paid parental leave it does not necessarily translate into policy coverage (25).

Given that women bear a disproportionate responsibility for child care, disaggregation by sex captures the implications of differences in the paid parental leave allocated to mothers compared with fathers. This has an impact of health and gender equity on labour market and health outcomes related to childbearing and infant care (16).

### **2.2.3 Supporting older people**

- Social protection programmes that support older people have an impact on health equity by maintaining their capacity to avoid health risks, access health services and perform daily tasks, especially for those with financial and health vulnerabilities.
- Life expectancy has been increasing across the WHO European Region, yet this has not necessarily meant more years in good health (26). Older people, especially those from low-income backgrounds, are likely to have greater health-care needs or caring responsibilities for partners, and financial support through pension systems helps reduce their risk of ill health, disability and social exclusion (27).
- Aligned with SDG 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 17.** Net pension entitlement as a proportion of pre-retirement earnings*Disaggregated by sex*

Pension benefits provide a degree of financial security in later life when employment income is not available, and the generosity of pensions affects the ability of individuals to lead healthy lives. Many countries have begun reducing the generosity of pension schemes and/or increasing the statutory retirement age due to concerns about financial sustainability. This increases the poverty risk and associated physical and mental health conditions for those with fewest resources through reducing their ability to pay for basic necessities such as nutritious food, heating and transportation (27).

Disaggregation by sex captures the gender equity dimension of pension entitlement and its effect on health because the accumulated effect of the gender wage gap over the life-course is smaller pension entitlements for women on average. Although life expectancy is longer for women, the extra years are not necessarily healthy years, and women moving into their final years are more likely to have greater care needs.

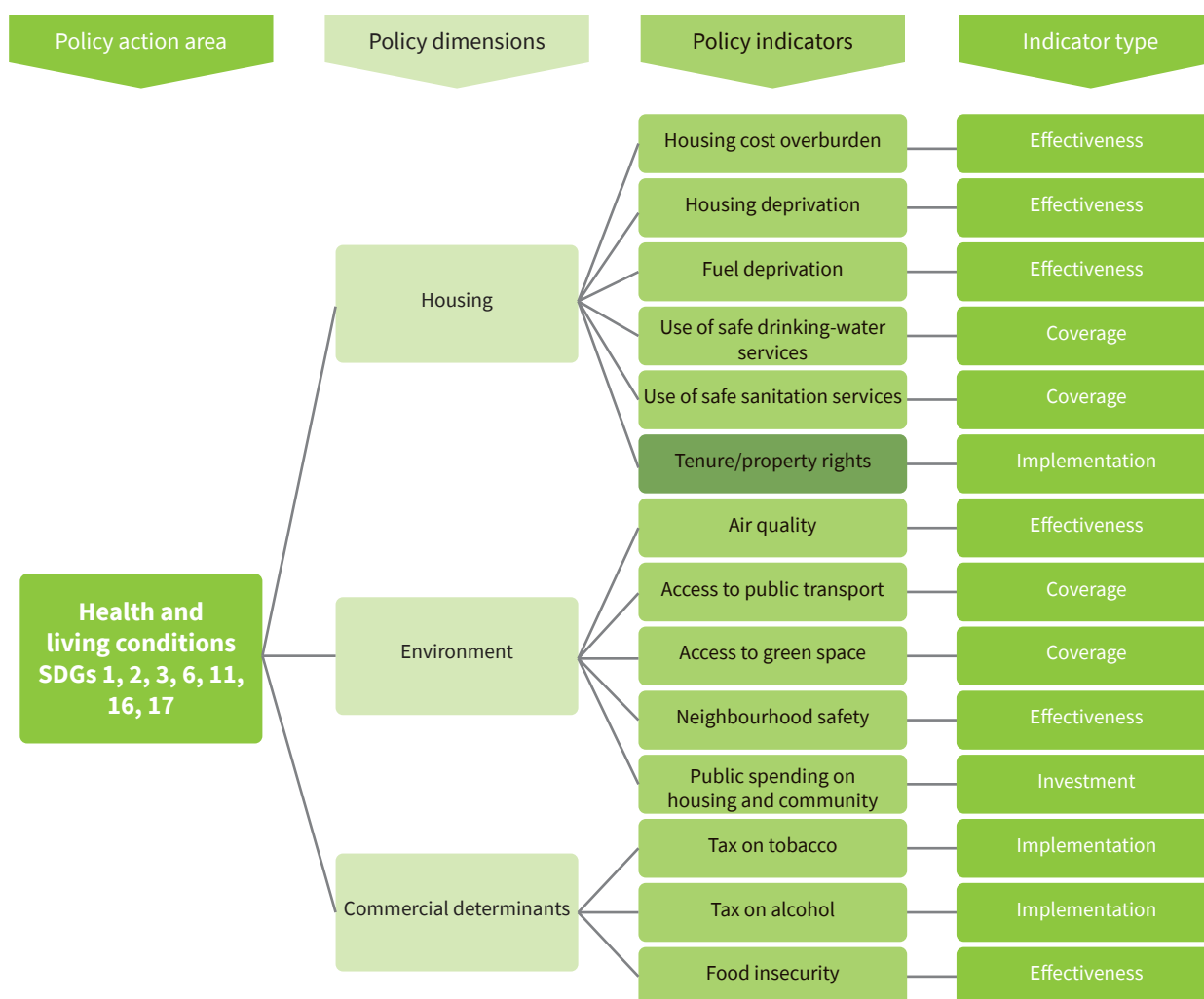
**Indicator 18.** Proportion of the population above the statutory pensionable age who receive a pension*Disaggregated by sex*

Access to health and social care services, mental well-being, social inclusion, good nutrition and adequate housing all depend on having a basic level of financial security. Seasonal mortality risks are higher in older people at risk of financial insecurity, with older people who have worked less in earlier life because of caring responsibilities or health reasons particularly at risk.

Although in most European countries over 90% of the population above statutory pensionable age receive pensions, inequity related to financial security and access to health-enabling resources still exists between older people who receive a pension and those who do not. People may not receive a pension if they have worked for fewer than the minimum number of years in a contribution-based system; however, these people may actually be the most vulnerable to financial and health risks if they have been unable to work as a result of health conditions or disability.

## 2.3 Health and living conditions

*Policies that equalize differential opportunities for, and access and exposure to, living conditions and environmental factors that impact our health and well-being*



Dark green policy indicator box represents a proposed new indicator.

### 2.3.1 Ensuring equal access to affordable, high-quality and secure housing

- Shelter is a fundamental human need, providing safety, a sense of belonging, peace and security. Poor housing and poor health are inextricably linked.
- People living in unaffordable, poor-quality or insecure housing are more likely to report poor health and to suffer from a variety of health problems (28,29).

- Aligned with SDGs 1, 6, 11 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 19.** Housing cost overburden rate (>40% of disposable income)



*Disaggregated by income quintile*



Housing costs affect health equity because expensive housing is more likely to force people in low-income households to reduce their expenditure on basic health needs, such as nutritious food; move to cheaper, poor-quality housing (see Indicator 20); or become homeless (16). Housing costs may also have a disproportionate impact on the mental health of people in low-income households, as levels of anxiety and worry may be greater when low income causes difficulties in keeping up with rent or mortgage interest payments.

**Indicator 20.** Severe housing deprivation rate (overcrowded dwellings with damp/leaks, no bath/shower, no indoor toilet or a lack of light)



*Disaggregated by education level and income quintile*



Housing deprivation impacts health equity because people in low-income households are more likely to suffer from housing deprivation and poor-quality housing, which negatively impacts their physical and mental health. Access to a dry, sanitary home with adequate light and space reduces the risks of development problems in children and of infections, respiratory illnesses and poor mental health in both children and adults (30,31).



**Indicator 21.** Proportion of the population unable to adequately heat their home



*Disaggregated by education level and income quintile*



This indicator captures health inequity through measuring the differences in mortality risk due to fuel poverty (especially among older people) and in morbidity risk for people in low-income households as a consequence of having to forgo spending on other basic needs as a result of high utility costs (32). This includes, for example, living in an underheated home or reducing the quality of diet by eating only food that does not require cooking. Households in fuel poverty are also more likely to use low-quality fuel for heating, such as wood, charcoal and kerosene in open fires, which can further increase the risks of poor health.

**Indicator 22.** Proportion of the population using safely managed drinking-water services



This indicator captures health equity because differential risks of waterborne disease are linked to differences in the availability, accessibility and safety of drinking-water. Safely managed drinking-water services should be accessible on the premises, available when needed and free of contamination. In some areas of the WHO European Region, this is a relevant indicator for gender equity, specifically where women and girls are responsible for fetching water and managing water at home (33).

**Indicator 23.** Proportion of the population using safely managed sanitation services



Health inequity resulting from differential risks of illnesses such as diarrhoeal disease, worm infection, and susceptibility to malnutrition and other illnesses, in particular among children, are directly linked to the household availability of safely managed sanitation services. These services should not be shared among households and excreta should be either safely disposed of in situ or transported and treated off-site (34).

Ensuring access to safe drinking-water (Indicator 22) and to adequate sanitation and hygiene services continues to be a challenge in some parts of the WHO European Region and in some geographical areas within countries.

**Indicator 24.** Existence of statutory legislation protecting the security of tenure and property rights for all



This is a proposed new indicator. See Section 3 for the rationale for monitoring this indicator.

### 2.3.2 Ensuring equal access to health-enabling environments

- Differences in the quality of the local environment in which people live has an impact on health equity.
- Low-income households and neighbourhoods are less likely than wealthy neighbourhoods to have access to safe, health-promoting environments (29).
- Local environments that are detrimental to physical health may also generate stress and anxiety, providing an additional link between physical environment and mental health (29,35).
- Policies that shape the geographical planning, construction and management of public spaces can reduce health inequities due to the local environment (15).
- Aligned with SDGs 1, 11, 16 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 25.** Annual mean PM2.5 and PM10 concentrations<sup>5</sup>



*Disaggregated by geographical area*



The impact of air pollution, as measured by PM2.5 and PM10 concentrations, on health equity derives from its recognized detrimental effects on health, including the association with cardiovascular disease, respiratory disease and lung cancer (36). Lower-income inner-city neighbourhoods tend to have higher densities of both roads and housing, which increases the risk of exposure to air pollution and therefore of adverse health effects (29). People in lower-income households are less likely to have the means to protect themselves from unequal exposures to ambient air pollution, and those in Europe are more likely to live near to main roads (15,37).

<sup>5</sup> PM2.5 is particulate matter of 2.5 µm or less in diameter, PM10 is particulate matter 10 µm or less in diameter.

**Indicator 26.** Proportion of the population reporting difficulties in accessing public transport



*Disaggregated by sex, education level and income quintile*



This indicator captures health equity because access to public transport facilitates social and economic participation, social and economic inclusion, and good mental health. People with lower incomes rely more on access to public transport for employment and education opportunities. Older people rely on public transport for social contact, mental well-being and independent living. Increased use of public transport also contributes to reducing the differences in health and mortality risks from air pollution, climate change and road injuries (15,38).

**Indicator 27.** Proportion of the population reporting difficulties in accessing green space



*Disaggregated by sex, education level and income quintile*



The way in which green spaces are integrated into communities has an impact on well-being and health equity because safe, well-managed and accessible parks and recreational and sports facilities promote respiratory health, physical activity, mental well-being and social interaction in the local community (15,29). Disaggregation by sex, education level and income allows this indicator to monitor how socioeconomic status affects access to these facilities, with their associated health benefits, and identifies which groups stand to gain most from improving access.

**Indicator 28.** Proportion of the population reporting feeling unsafe when walking alone after dark



*Disaggregated by sex, education level and income quintile*



Exposure to actual or perceived personal and property crime and violence is associated with higher rates of poor mental health, social isolation and depression (39). In some cases this may also have an impact on participation in social, economic and health-promoting activities and services.

**Indicator 29.** Public spending on housing and community amenities as a proportion of gross domestic product



In communities with few resources, investment in housing development, community amenities, and water and lighting infrastructure has an impact on health equity. Effectively meeting the needs and interests of these communities helps to promote social inclusion and community engagement and has associated physical and mental health benefits (40).

### 2.3.3 Protecting against unequal health risks from the effects of commercial interests

- Commercial organizations use marketing and product exposure to influence the consumption of alcohol, tobacco and food items in ways that affect the risks of noncommunicable diseases and mortality.
- This has an impact on health equity because commercial influence varies with how well people are educated about the health risks of detrimental consumption behaviours and whether their economic situation and social environment encourage or discourage them from such consumption behaviours.
- Aligned with SDGs 2, 3 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 30.** Value added tax on alcohol



Alcohol availability and consumption has a health equity impact because lower-income individuals are more susceptible to the harmful effects of excessive alcohol consumption (41). This can be attributed to several factors, including reduced availability of or less willingness to access sources of support, greater difficulties in coping with the adverse psychosocial effects of excessive alcohol consumption due to resource constraints, and the higher density of alcohol outlets in lower-income neighbourhoods (42). Although the level of value added tax on alcohol is an imperfect indicator of the minimum unit price and does not capture home-brewing or illicit sources of alcohol such as smuggling, policies to reduce the accessibility and availability of excess alcohol can address the health inequities resulting from harmful alcohol consumption (43,44).

**Indicator 31.** Tobacco excise tax as a percentage of retail price

Smoking contributes to inequities in mortality between lower- and higher-income individuals, with less well-off individuals being more likely to be exposed to smoking at a young age and to live in areas with a greater availability of tobacco products (18). Policies that reduce the accessibility and availability of tobacco products help to address the inequities in health and mortality generated by differential smoking rates and intensities across society.

**Indicator 32.** Proportion of households unable to afford a protein-rich meal every other day

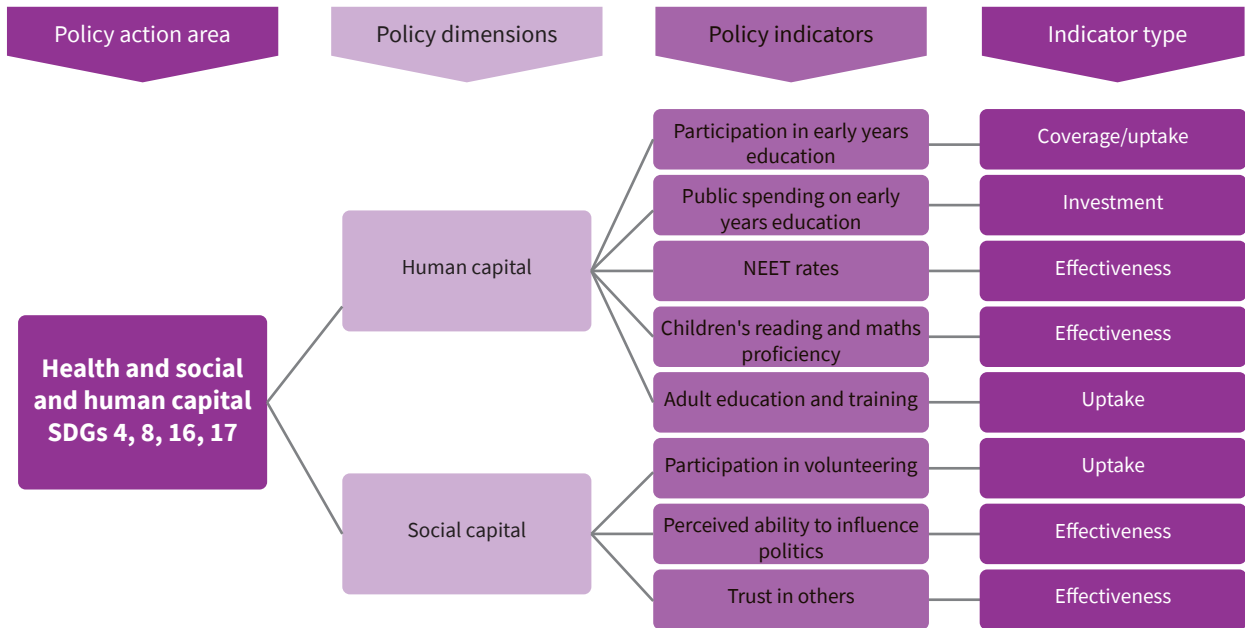
*Disaggregated by education level and income quintile*



Food insecurity among low-income households has an impact on health equity, particularly among children (22). Differences in the quality and nutritional content of diets between high- and low-income households produce differential risks of malnutrition and nutrition-related health conditions among adults and children, learning and concentration problems in school-aged children, and infant development issues linked to deficiencies in the prenatal diet (15).

## 2.4 Health and social and human capital

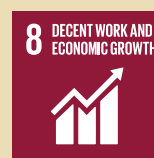
*Policies that improve human capital for health through education and learning, and policies that improve the social capital of individuals and communities in a way that protects and promotes health and well-being*



NEET: young people not in employment, education or training

### 2.4.1 Improving human capital for health by reducing barriers to participation in education and learning across the life-course

- Equal access to good quality education from an early age has a strong impact on reducing differences in opportunities and risks, which has both direct and indirect impacts on health.
- Continued provision of education and lifelong learning opportunities has a direct effect on promoting social and economic inclusion and mental well-being (45).
- It also has indirect effects linked to increased health and social literacy, such as awareness of health risks and behaviours and mediating life chances and the effects of social and economic shocks (46).
- Aligned with SDGs 4, 8 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 33.** Participation rate in early childhood education and care<sup>6</sup>

*Disaggregated by sex and geographical area*



Early childhood education and care (ECEC) enables every child, irrespective of their household income, to participate in structured learning that develops fundamental social and cognitive abilities (47). The benefits of ECEC are greatest for children from families with lower levels of income and maternal education, and participation in ECEC produces returns over the life-course in terms of better health and better social and economic opportunities and outcomes.

**Indicator 34.** Government expenditure on early childhood education as a percentage of total education expenditure

Spending on ECEC reflects governmental commitment to investing in a healthy and equal start for every child and combating the negative effects of intergenerational inequities. This includes spending on crèches, day-care centres and pre-primary education services such as kindergartens. The health equity impact of high-quality ECEC is discussed under Indicator 32.

**Indicator 35.** Proportion of young people not in employment, education or training

*Disaggregated by sex and education level*



This indicator measures health equity because young people who are not in employment, education or training for prolonged periods are at greater risk of social exclusion, depression and engaging in behaviours detrimental to health such as smoking, excessive drinking and gambling (48). In the WHO European Region, the rates of young people who are not in employment, education or training have increased over the last decade (49). Young people from families with poor economic and social resources (including those formerly in care or being looked after), from minority backgrounds and early school-leavers are most at risk of not being in employment, education or training.

<sup>6</sup> For children between age 4 years and the age of enrollment in compulsory primary education.

As with ECEC, providing opportunities for young people who are not in employment, education or training is important to ensure health equity at later stages of the life-course. Minimizing the length of time out of employment, education or training decreases the likelihood of being in precarious and low-paid work, being unemployed and engaging in behaviours risky to health, including violent acts such as crime, which in turn decreases the risks of associated negative health outcomes (45).

**Indicator 36.** Proportion of children and young people at the end of primary and lower secondary education achieving at least a minimum proficiency level in reading and mathematics



*Disaggregated by sex and the education level of parents*



Raising numeracy and literacy levels and reducing gaps in proficiency have a direct effect on health literacy and an indirect effect on future opportunities in the labour market and consequently on income security and social inclusion. Important impacts in terms of developing health-promoting skills also include relationship management, ability to exert control over life, social participation, ability to reason, communication, decision-making, and accessing health and other resources.

**Indicator 37.** Participation rate of adults aged 25–64 years in formal and non-formal education and training



*Disaggregated by sex and education level*



Participation in lifelong learning through formal and non-formal education and training builds the skills for more robust labour market capacity. Lifelong learning helps to equalize the chances of obtaining meaningful and satisfying employment and reduces the rates of poor mental well-being and sickness absence.

Adult formal education and training can break the link between limited education in earlier life and the risks of poverty and social exclusion, which are linked to morbidities, such as early-onset cardiovascular disease (50). Non-formal education contributes to building good social relationships and to mental well-being.



## 2.4.2 Improving the social capital of individuals and communities in a way that protects and promotes health and well-being

- Meaningful participation in society, trust in others and being able to influence decisions affecting health and life chances have important direct and indirect health effects. They contribute to stronger individual and social resilience and lower levels of morbidity and poor mental health.
- Exposure to low-trust environments characterized by higher crime rates, social isolation and lack of ability to influence politics and decision-making in society are strongly associated with poor mental health and a higher risk of morbidity (51).
- Participatory public services empower people to take control over their lives and the determinants of their own health. Investment in civic participation, reducing crime and generating social connections have positive impacts on the health and well-being of individuals through their engagement with, and trust in, the local community and wider society (15,52).
- Aligned with SDGs 16 and 17.



Detailed indicator mapping is provided in Section 4.

### Indicator 38. Proportion of the population participating in voluntary activities

*Disaggregated by sex, education level and income quintile*



Volunteering promotes health equity by providing opportunities for social connections, relationships, informal learning, physical activity and civic engagement.

Volunteering is an indicator of civic cohesion, which promotes health equity by providing opportunities for community participation to those at risk of social exclusion (37). Volunteering often involves physical activity and social interaction, which generates benefits for both physical and mental health (53).

### Indicator 39. Proportion of the population reporting lack of ability to influence politics

*Disaggregated by sex, education level and income quintile*



A socioeconomic gradient exists in the ability to influence politics through shaping investments, decisions and policies that affect health both directly, in terms of access to health services and financial protection for health, and indirectly, in terms of income security and employment opportunities.

Effective political participation is important to promote the conditions needed to ensure health equity (15). For vulnerable people and those at risk of social exclusion, having a degree of influence over local, regional and national development decisions confers the potential to improve their health and well-being as well as a sense of control over their lives (18,48).

**Indicator 40.** Proportion of the population reporting a high level of trust in other people

*Disaggregated by sex, education level and income quintile*

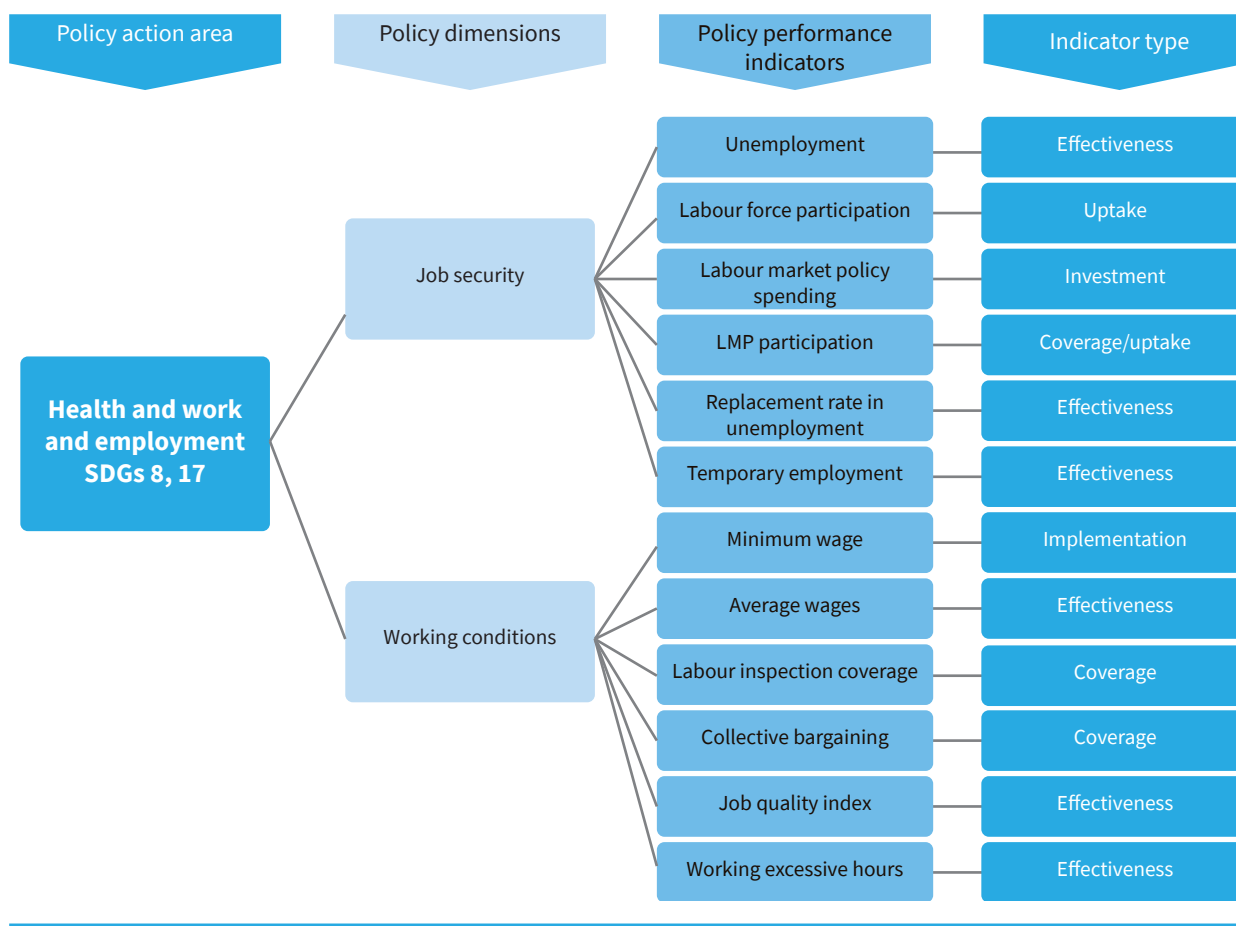


The level of trust in others is a measure of social justice and inclusivity in societies. Disaggregation by sex, education and income captures whether the level of trust is based on socioeconomic status. Higher levels of trust are found in societies with better physical and mental health and more equally distributed incomes (54).

Trust between people is a key component of social capital and encourages more effective community integration, cooperative efforts for community development, and resilience against potential economic or environmental risks to health and well-being (21). The health-protective effect may be particularly important for low-resource communities, where social capital has a more important role than financial and human capital in improving resilience and security (55).

## 2.5 Health and employment and working conditions

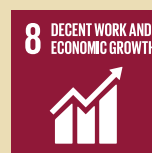
*Policies that improve the health impact of employment and working conditions, including availability, accessibility, security, wages, physical and mental demands, and exposure to unsafe work*



### 2.5.1 Improving job security, reducing unemployment and reducing discrimination in labour force participation

- Productive participation in the labour market has a health equity impact through its effects on day-to-day life and on life chances.
- People who have experienced long-term unemployment are at a higher risk of premature mortality. Young people who have experienced long-term unemployment are more likely than those who have not experienced unemployment to report risky health behaviours, for all levels of socioeconomic status.

- Job insecurity, temporary employment and poor working conditions are associated with poor mental health, self-reported ill health and an increased risk of fatal and non-fatal cardiovascular events. These work-related stressors follow a social gradient (56).
- Inequities and discrimination in the labour market exist between sexes, socioeconomic and migrant groups, and persons with disabilities. Ensuring equitable participation in secure and decent employment has the potential to address health and social inequities, including gender inequities, by providing equal opportunities to obtain a secure income (18).
- Aligned with SDGs 8 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 41. Unemployment rate**



*Disaggregated by sex, education level, age and disability status*



Unemployment is directly associated with increased self-reported poor health and lower scoring on the WHO 5-point mental health scale (57). Long-term involuntary worklessness (three years or more) is a predictor of more frequent heavy drinking, increased risk of cardiovascular disease (58) and more frequent behaviours risky to health, such as accidents, crime and violence (59,60).

Young people, women, people from low-income backgrounds, people with disabilities and non-national migrants tend to experience higher barriers to securing employment and experience inequitable opportunities to participate in the labour market (54). This is particularly the case in countries where recovery from the global financial crisis is incomplete in terms of employment creation so that although the gross domestic product may have recovered to pre-crisis levels, employment levels may remain low. In particular, long-term employment rates have not recovered among young people aged 15–24 years, with many negative impacts including mental health effects among the young and long-term unemployed (61).

**Indicator 42. Labour force participation rate**

*Disaggregated by sex, education level and age*



Many individuals who are out of work, particularly in the post-crisis period, are not counted as unemployed because they are not actively seeking work in the labour market. These individuals face

similar or greater health risks compared with unemployed people. If their exit from the labour market was due to poor long-term employment prospects and discouragement, then they may also be more vulnerable to poor mental health and have reduced access to social protection systems, including health services and pensions. Disaggregation by age, sex, education and ethnicity captures bias in employment practices and wages, which contribute to unequal health risks and outcomes, particularly those related to mental health and cardiovascular disease.

**Indicator 43a.** Public expenditure on active labour market policies as a proportion of gross domestic product



Active labour market policies (ALMPs), which include peer mentoring, apprenticeship schemes, on-the-job-training and job-seeking training, have an impact on health equity by reducing work-related stress and its negative health effects. ALMPs improve mental health, increase the sense of control and reduce sickness absence across the income spectrum, but particularly for those with fewer years of education and lower skill levels and those in insecure work (54).

Expenditure on ALMPs is an indicator of a country's commitment to improving the employment prospects of people who are out of work or in low-wage work, along with the associated health and well-being benefits (15). Investment in ALMPs, alongside effective lifelong learning and vocational training, equitable employment legislation and adequate social security systems, has the potential to improve health equity, as well as to increase employment (19) and contribute to economic growth (23).

**Indicator 43b.** Number of participants in ALMPs per 100 wanting work

*Disaggregated by sex and age*



This indicator measures the coverage and uptake of ALMPs and gender equity in ALMP uptake (Indicator 43a) for those who are not employed and seeking work. Whereas Indicator 43a provides a measure of investment, this indicator provides a measure of the equity-promoting impact of ALMPs.

**Indicator 44.** Net replacement rate of unemployment benefits

Protection against income insecurity associated with unemployment helps to promote health equity by reducing the poverty risk from moving into unemployment. This indicator measures the proportion of previous in-work income that is maintained after entering unemployment. People who are frequently in and out of employment and those who were in in-work poverty prior to unemployment are most likely to lack the financial security to withstand labour market shocks and are at a higher risk of poverty (16). Protection against financial insecurity in turn improves the ability of unemployed people to sustain a standard of living that allows them to meet basic needs, including physical and mental health needs. The existence of this safety net also improves perceptions of health and well-being, even for those in work (see Indicator 45).

**Indicator 45.** Proportion of temporary employees as a percentage of the total wage employees



*Disaggregated by sex and education level*



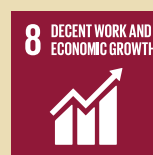
This indicator measures the risk of exposure to health-harming conditions due to temporary, insecure employment in terms of low pay and poor working conditions, including a lack of benefits and insurance coverage. It includes those in fixed-term, seasonal and casual work.

Poor mental and physical health is more prevalent among workers in non-fixed temporary employment than among workers in permanent employment. This includes psychological stress and depression, as well as noncommunicable diseases and work-related injuries.

A high prevalence of temporary employment leads to health inequity because this type of employment is more common among vulnerable groups, such as young people, migrants, women and individuals from lower-income and lower-education backgrounds. Actions to slow down the recent expansion of temporary employment across the WHO European Region (55) and minimize the negative health, social and economic effects of temporary employment would help to reduce the number of vulnerable people at risk of economic, psychological, and physical stress and anxiety due to precarious employment (62).

### 2.5.2 Ensuring decent working conditions for all

- For people in work, differential exposure to hazardous or stressful working conditions, excessive hours and few contractual rights directly and indirectly contributes to inequities in physical and mental health.
- Systematic differences in exposure to poor working conditions are closely associated with gender norms and the workers' age and education level.
- Aligned with SDGs 8 and 17.



Detailed indicator mapping is provided in Section 4.

**Indicator 46.** Statutory gross monthly minimum wage as a proportion of the median wage

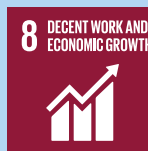
Wage levels impact on health equity through having a direct effect on income security and a consequent indirect effect on health. Low-wage jobs are associated with poorer self-reported health, lower life satisfaction and a risk of poverty and social exclusion.

Lower-wage jobs are disproportionately occupied by younger people, people with fewer years of education, migrants and women (owing to gender norms in family and caring responsibilities). In the

absence of other income support and financial protection mechanisms (such as social transfers), low-wage earners are at risk of poverty and social exclusion, which are linked to poor physical and mental health.

Existing European and international standards for minimum wages have a positive impact on guaranteeing those in employment a basic level of resources for meeting health and other basic needs (18).

#### Indicator 47. Average nominal monthly wages



*Disaggregated by sex*



Although the minimum wage indicator focuses on the lowest wage earners, the average wage level takes into account the whole range of wages and, therefore, the health-enabling resources available to people across society. Disaggregation by sex provides an important measure of equity by capturing differences between men and women in the level of resources attained through wages.

#### Indicator 48. Average number of labour inspectors per 10 000 employees

Inspectors play a fundamental role in tackling informal and undeclared work and unsafe work environments, as well as various forms of abusive contractual employment relationships that are associated with increased psychosocial stress, depression and possible early exit from the workplace. This indicator is an important health equity measure related to governance, accountability and regulation to ensure that employers provide safe working conditions for all employees and to prevent and mitigate occupational health hazards. Hazardous jobs are disproportionately occupied by migrant workers and those with fewer years of formal education; therefore, ensuring the safety of these workers reduces their burden of work-related health conditions (16,54).

#### Indicator 49. Collective bargaining coverage rate



Healthy working conditions and lower sickness absence rates are more common in workplaces that have collective bargaining arrangements in place. Collective bargaining empowers and supports workers to benefit from equal opportunities to decent financial and physical working conditions (16). In turn, reducing differences in wages levels, job security and working conditions promotes more equitable health and economic outcomes.

**Indicator 50. Skills and discretion (job quality) index***Disaggregated by sex, education level and income quintile*

Lower levels of decision-making autonomy, control over work and job satisfaction are strongly associated with an increased risk of cardiovascular disease, musculoskeletal disorders and poor mental health for both men and women (57). ALMP programmes that improve these conditions, including mentoring, on-the-job training and opportunities for progression and skill development, have a positive effect on self-reported health, mental health and labour market outcomes for people in all types of occupations.

Low-paid and precarious jobs (see Indicators 36–38) are unlikely to offer good prospects for skill advancement; therefore, actions to improve the quality of such work can help to improve equity in related health outcomes.

**Indicator 51. Proportion of workers working in excess of 40 hours per week***Disaggregated by sex*

This indicator measures health equity because differences in rates of overwork generate differential risks of stress-related health outcomes, both physical and mental. Although many of the other employment and work indicators follow a socioeconomic gradient, both high- and low-wage employees may be exposed to overwork and excessive hours, and their associated health risks.



### 3. Proposed new indicators

Three new indicators have been proposed for inclusion in the Health Equity Policy Tool (detailed below) based on gaps identified in existing data; however, the data necessary for these indicators are not currently routinely collected or readily available.

An agreement or commitment to collecting data for these indicators is not being sought at this stage: rather, this HESRi consultation document seeks to reach agreement on whether the proposed new indicators should be considered for inclusion as additional indicators in the Policy Tool.

#### 3.1 Ensuring universal access to health services

**Indicator 6.** Implementation of policies protecting the rights of non-national migrants to health services in a country

This indicator measures health equity because in many countries across the WHO European Region, non-national migrants and asylum seekers face different entitlements to primary and secondary health services compared with nationals (63).

This indicator would monitor the rights of non-national migrants to equitable access to health services. If agreed, it will be further developed in collaboration with United Nations sister agencies and EU bodies.

**Indicator 7.** Implementation or development of subnational resource allocation formulae for health care, incorporating a measure of socioeconomic deprivation (e.g. premature mortality)

Areas with higher levels of need and socioeconomic deprivation require greater resources to achieve equitable opportunities and outcomes in health (64). Health systems using a capitated budget (a budget calculated per person) to distribute funding subnationally can increase care provision and quality to under-resourced areas and ensure that health systems do not generate inequity by providing more resources to more affluent households.

This indicator would monitor the subnational allocation of resources for health care to promote health equity between socioeconomically advantaged and disadvantaged regions. If agreed, it will be further developed in collaboration with United Nations sister agencies and EU bodies.

#### 3.2 Ensuring equal access to affordable, high-quality and secure housing

**Indicator 24.** Existence of statutory legislation protecting the security of tenure and property rights for all

Having a secure home free from the risk of eviction and homelessness is important for physical and mental health, and is particularly important for children's development outcomes linked to family stability and for mortality risk associated with homelessness among young people and adults. Those at risk of poverty and exposed to discrimination on the basis of sex, ethnicity or sexual orientation (in

particular, non-nationals and women in certain countries) have a higher risk of insecure tenure and barriers to property ownership.

This indicator would monitor equity in tenure security, property rights and ownership. If agreed, it will be further developed in collaboration with United Nations sister agencies and EU bodies.

## 4. Commitments of Member States and alignment with SDGs





### 4.1 Health and health services

Table 2 shows commitments made by Member States of the WHO European Region and Table 3 shows the detailed mapping of HESRi indicators in this policy action area.

**Table 2. Health services: Member State commitments**

Global and regional development goals	Rights-based instruments	Policy declarations (publication year)
Health 2020 Priority area 3 (3) SDGs 3, 5 and 17 (65)	European Social Charter (1996) (66) International Covenant on Economic, Social and Cultural Rights (1966) (67)	Tallinn Charter (2018) (14) Rio Political Declaration on Social Determinants of Health (68) United Nations Resolution 67/81 on universal health coverage (69) European Pillar of Social Rights (2017) (70)

**Table 3. Health services: detailed mapping of indicators to SDGs**

HESRi indicators	SDG indicators	SDG targets	SDGs
All	17.18.1. Proportion of SDG indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics (71)	17.18. By 2020, increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts	
1–3	3.8.2. Proportion of population with large household expenditures on health as a share of total household expenditure or income	3.8. Achieve universal health coverage, including financial risk protection, access to quality essential health-care services and medicines and vaccines for all	
4, 6, 8 and 9	3.8.1. Coverage of essential health services	3.8. See Indicators 1–3 (above)	
5	3.7.1. Proportion of women of reproductive age (aged 15–49 years) who have their need for family planning satisfied with modern methods	3.7. By 2030 ensure universal access to sexual and reproductive health-care services, including for family planning, information and education, and the integration of reproductive health into national strategies and programmes	

HESri indicators	SDG indicators	SDG targets	SDGs
8	5.4.1. Proportion of time spent on unpaid domestic and care work, by sex, age and location	5.4. Recognize and value unpaid care and domestic work through the provision of public services, infrastructure and social protection policies and the promotion of shared responsibility within the household and the family as nationally appropriate	

Source: United Nations, 2019 (65).



## 4.2 Health and income security and social protection


Table 4 shows commitments made by Member States of the WHO European Region and Table 5 shows the detailed mapping of HESri indicators in this policy action area.

**Table 4. Income security and social protection: Member State commitments**

Global and regional development goals	Rights-based instruments	Policy declarations (publication year)
Health 2020 Priority area 4 (3) SDGs 1, 10 and 17	European Social Charter (1996) (66) International Covenant on Economic, Social and Cultural Rights (1966) (67)	Rio Political Declaration on Social Determinants of Health (2011) (68) Declaration: Partnerships for the Health and Well-being of our Young and Future Generations (2016) (72) Strategy and Action Plan for Healthy Ageing in Europe, 2012–2020 (2012) (73)

**Table 5. Income security and social protection: detailed mapping of indicators to SDGs**

HESri indicators	SDG indicators	SDG targets	SDGs
All	17.18.1. Proportion of SDG indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics (71)	17.18. By 2020, increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts	
10	10.2.1. Proportion of people living below 50% of median income, by age, sex and persons with disabilities	10.2. Empower and promote the social, economic and political inclusion of all, irrespective of age, sex, disability, race, ethnicity, origin, religion or economic or other status	

HESRI indicators	SDG indicators	SDG targets	SDGs
13	1.3.1. Proportion of population covered by social protection floors/ systems, by sex, distinguishing children, unemployed persons, older persons, persons with disabilities, pregnant women, newborns, work-injury victims and the poor and the vulnerable	1.3. Implement nationally appropriate social protection systems and measures for all, including floors, and achieve substantial coverage of the poor and the vulnerable	

Source: United Nations, 2019 (65).








## 4.3 Health and living conditions







Table 6 shows commitments made by Member States of the WHO European Region and Table 7 shows the detailed mapping of HESRI indicators in this policy action area.

**Table 6. Living conditions: Member State commitments**

Global and regional development goals	Rights-based instruments	Policy declarations (publication year)
Health 2020 Priority area 4 (3) SDG 17	European Social Charter (1996) (66) International Covenant on Economic, Social and Cultural Rights (1966) (67)	Rio Political Declaration on Social Determinants of Health (2011) (68) European Pillar of Social Rights (2017) (70)
Housing SDGs 1, 6 and 11	–	Geneva United Nations Charter on Sustainable Housing (2014) (74) Protocol on Water and Health (1999) (75)
Environment SDGs 11 and 16	–	Ostrava Declaration on Environment & Health (2017) (76) Parma Declaration on Environment and Health (2010) (77) Paris Declaration: City in motion: People first (2014) (78) Amsterdam Declaration: Making THE Link: Transport choices for our health, environment and prosperity (2009) (79)
Commercial determinants SDGs 2 and 3	–	Ashgabat Declaration (2013) (80) Roadmap of actions to strengthen implementation of the WHO Framework Convention on Tobacco Control in the European Region (2015) (81) European action plan to reduce the harmful use of alcohol 2012–2020 (2012) (82)

**Table 7. Living conditions: detailed mapping of indicators to SDGs**

HESri indicators	SDG indicators	SDG targets	SDGs
All	17.18.1. Proportion of SDG indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics (71)	17.18. By 2020, increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts	
19–21	11.1.1. Proportion of urban population living in slums, informal settlements or inadequate housing	11.1. By 2030, ensure access for all to adequate, safe and affordable housing and basic services and upgrade slums	
20, 21 and 29	1.4.1. Proportion of population living in households with access to basic services	1.4. By 2030, ensure that all men and women, in particular the poor and the vulnerable, have equal rights to economic resources, as well as access to basic services, ownership and control over land and other forms of property, inheritance, natural resources, appropriate new technology and financial services, including microfinance	
22	6.1.1. Proportion of population using safely managed drinking-water services	6.1. Achieve universal and equitable access to safe and affordable drinking-water for all	
23	6.1.2. Proportion of population using safely managed sanitation services	6.2. Achieve access to adequate and equitable sanitation and hygiene for all	
24	1.4.2. Proportion of total adult population with secure tenure rights to land, with legally recognized documentation and who perceive their rights to land as secure, by sex and by type of tenure	1.4. See Indicators 20, 21 and 29 (above)	
25	11.6.2. Annual mean levels of fine particulate matter (e.g. PM2.5 and PM10 <sup>3</sup> ) in cities (population weighted)	11.6. By 2030, reduce the adverse per capita environmental impact of cities, including by paying special attention to air quality and municipal and other waste management	

HESri indicators	SDG indicators	SDG targets	SDGs
26	11.2.1. Proportion of population that has convenient access to public transport, by sex, age and persons with disabilities	11.2. By 2030, provide access to safe, affordable, accessible and sustainable transport systems for all, improving road safety, notably by expanding public transport, with special attention to the needs of those in vulnerable situations, women, children, persons with disabilities and older persons	 11 SUSTAINABLE CITIES AND COMMUNITIES
27	11.7.1. Average share of the built-up area of cities that is open space for public use by all, by sex, age and persons with disabilities	11.7. By 2030, provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities	 11 SUSTAINABLE CITIES AND COMMUNITIES
28	16.1.4. Proportion of population that feel safe walking alone around the area they live	16.1. Significantly reduce all forms of violence and related death rates everywhere	 16 PEACE, JUSTICE AND STRONG INSTITUTIONS
30	–	3.5. Strengthen the prevention and treatment of substance abuse, including narcotic drug use and harmful use of alcohol	 3 GOOD HEALTH AND WELL-BEING
31	–	3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control	 3 GOOD HEALTH AND WELL-BEING
32	2.1.2. Prevalence of moderate or severe food insecurity in the population, based on the Food Insecurity Experience Scale	2.1. By 2030, end hunger and ensure access by all, in particular the poor and vulnerable, including infants, to safe, nutritious and sufficient food all year round	 2 ZERO HUNGER

<sup>a</sup> PM2.5 is particulate matter of 2.5 µm or less in diameter, PM10 is particulate matter 10 µm or less in diameter.  
 Source: United Nations, 2019 (65).



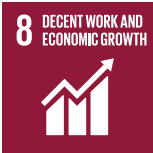

## 4.4 Health and social and human capital

Table 8 shows commitments made by Member States of the WHO European Region and Table 9 shows the detailed mapping of HESRi indicators in this policy action area.



**Table 8. Social and human capital: Member State commitments**

Global and regional development goals	Rights-based instruments	Policy declarations (publication year)
Health 2020 Priority area 1 (3) SDG 17	European Social Charter (1996) (66) International Covenant on Economic, Social and Cultural Rights (1966) (67)	Declaration: Partnerships for the Health and Well-being of our Young and Future Generations (2016) (72) Rio Political Declaration on Social Determinants of Health (2011) (68) European Pillar of Social Rights (2017) (70)
Education & learning SDGs 4 and 8	–	–
Social & community capital SDG 16	–	–

**Table 9. Social and human capital: detailed mapping of indicators to SDGs**

HESRi indicators	SDG indicators	SDG targets	SDGs
All	17.18.1. Proportion of SDG indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics (71)	17.18. By 2020, increase significantly the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts	
33 and 34	4.2.2. Participation rate in organized learning (one year before the official primary entry age), by sex	4.2. By 2030, ensure that all girls and boys have access to quality early childhood development, care and pre-primary education so that they are ready for primary education	
35	8.6.1. Proportion of youth (aged 15–24 years) not in education, employment or training	8.6. By 2020, substantially reduce the proportion of youth not in employment, education or training	
36	4.1.1. Proportion of children and young people: (a) in grades 2/3; (b) at the end of primary; and (c) at the end of lower secondary achieving at least a minimum proficiency level in (i) reading and (ii) mathematics, by sex	4.1. By 2030, ensure that all girls and boys complete free, equitable and quality primary and secondary education leading to relevant and effective learning outcomes	



HESri indicators	SDG indicators	SDG targets	SDGs
37	4.3.1. Participation rate of youth and adults in formal and non-formal education and training in the previous 12 months, by sex	4.3. By 2030, ensure equal access for all women and men to affordable and quality technical, vocational and tertiary education, including university	
39	16.7.2. Proportion of population who believe decision-making is inclusive and responsive, by sex, age, disability and population group	16.7. Ensure responsive, inclusive, participatory and representative decision-making at all levels	

Source: United Nations, 2019 (65).


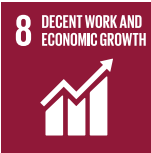
## 4.5 Health and employment and working conditions

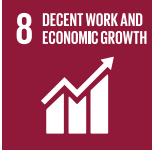
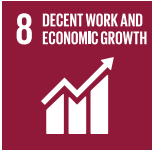
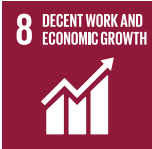
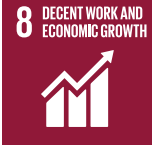
Table 10 shows commitments made by Member States of the WHO European Region and Table 11 shows the detailed mapping of HESri indicators in this policy action area.

**Table 10. Employment and working conditions: Member State commitments**

Global and regional development goals	Rights-based instruments	Policy declarations (publication year)
Health 2020 Priority area 4 (3) SDGs 8 and 17	European Social Charter (1996) (66) International Covenant on Economic, Social and Cultural Rights (1966) (67)	Declaration: Partnerships for the Health and Well-being of our Young and Future Generations (2016) (72) Rio Political Declaration on Social Determinants of Health (2011) (68)

**Table 11. Employment and working conditions: detailed mapping of indicators to SDGs**

HESri indicators	SDG indicators	SDG targets	SDGs
All	17.18.1. Proportion of SDG indicators produced at the national level with full disaggregation when relevant to the target, in accordance with the Fundamental Principles of Official Statistics (71)	17.18. By 2020, increase the availability of high-quality, timely and reliable data disaggregated by income, gender, age, race, ethnicity, migratory status, disability, geographical location and other characteristics relevant in national contexts	
41	8.5.2. Unemployment rate, by sex, age and persons with disabilities	8.5. By 2030, achieve full and productive employment and decent work for all women and men, including for young people and persons with disabilities, and equal pay for work of equal value	

HESri indicators	SDG indicators	SDG targets	SDGs
43	8.b.1. Existence of a developed and operationalized national strategy for youth employment, as a distinct strategy or as part of a national employment strategy	8.b. By 2020, develop and operationalize a global strategy for youth employment and implement the Global Jobs Pact of the International Labour Organization (83)	
45	8.3.1. Proportion of informal employment in non-agriculture employment, by sex	8.3. Promote development-oriented policies that support productive activities, decent job creation, entrepreneurship, creativity and innovation, and encourage the formalization and growth of micro-, small- and medium-sized enterprises, including through access to financial services	
47	8.5.1. Average hourly earnings of female and male employees, by occupation, age and persons with disabilities	8.5 See Indicator 41 (above)	
49	8.8.2. Level of national compliance of labour rights (freedom of association and collective bargaining) based on International Labour Organization textual sources and national legislation, by sex and migrant status	8.8. Protect labour rights and promote safe and secure working environments for all workers, including migrant workers, in particular women migrants, and those in precarious employment	

Source: United Nations, 2019 (65).

## 5. Data sources

Table 12 shows the data sources for each HESRI indicator.

**Table 12. Data sources for HESRI indicators**

HESRI indicator	Description (abbreviated)	Data source(s)
1	Households with impoverishing health spending	WHO Barcelona Office for Health Systems Strengthening
2	Households with catastrophic health spending	WHO Barcelona Office for Health Systems Strengthening
3	Out-of-pocket payments for health	WHO Global Health Expenditure Database
4	Self-reported unmet need for health care	EU-SILC
5	Unmet need for family planning services	DHS program
6	Rights of non-national migrants to health-care services	New indicator
7	Subnational resource allocation formulae for health care	New indicator
8	Informal caregiving	EQLS
9	Perceived quality of health services	EQLS
10	Relative poverty	EU-SILC
11	Gini index	World Bank
12	Social protection expenditure	Eurostat
13	Coverage, benefit incidence and adequacy of social assistance programmes	World Bank
14	Ratification of ILO social protection conventions	ILO
15	Proportion of unemployed receiving unemployment benefits	ILO
16	Length of paid parental leave	OECD
17	Pension net replacement rate	OECD
18	Statutory pension coverage rate	ILO
19	Housing cost overburden rate	EU-SILC
20	Severe housing deprivation rate	EU-SILC
21	Inability to adequately heat home	EU-SILC
22	Use of safely managed drinking-water services	WHO/UNICEF joint monitoring programme (84)
23	Use of safely managed sanitation services	WHO/UNICEF joint monitoring programme (84)
24	Legislation protecting security of tenure and property rights	New indicator
25	PM2.5 and PM10 concentrations <sup>a</sup>	WHO Global Urban Ambient Air Pollution Database (2016 update)
26	Access to public transport	EQLS
27	Access to green space	EQLS, WVS
28	Feeling unsafe walking alone after dark	WVS
29	Public spending on housing and community amenities	Eurostat

HESRI indicator	Description (abbreviated)	Data source(s)
30	Value added tax on alcohol	WHO
31	Tobacco excise tax	WHO
32	Food insecurity	EU-SILC, WVS
33	ECEC	UNICEF, Eurostat
34	Government expenditure on early childhood education	Eurostat
35	Young people not in employment, education or training	ILO, Eurostat
36	Children and young people minimally proficient in reading & maths	PISA Database (OECD), International Social Survey
37	Adult participation in education and training	Eurostat, UNESCO
38	Participation in volunteering	EU-SILC
39	Perceived ability to influence politics	ESS
40	Trust in others	ESS, EQLS
41	Unemployment rate	ILO
42	Labour force participation rate	ILO
43a	Public expenditure on ALMPs	OECD, Eurostat
43b	Labour market policy participation	Eurostat
44	Net replacement rate of unemployment benefits	OECD
45	Share of temporary employees	Eurostat
46	Minimum wage	ILO
47	Average wage	ILO
48	Labour inspectors per 10 000 employed persons	ILO
49	Collective bargaining coverage	ILO
50	Skills and discretion (job quality) index	EWCS
51	Working in excess of 40 hours per week	EWCS, ILO

DHS: Demographic and Health Surveys; EQLS: European Quality of Life Surveys; ESS: European Social Survey; EU-SILC: European Union Statistics on Income and Living Conditions; EWCS: European Working Conditions Surveys; ILO: International Labour Organization; OECD: Organization for Economic Co-operation and Development) PISA: Programme for International Student Assessment ; UNESCO: United Nations Educational, Scientific and Cultural Organization; UNICEF: United Nations Children’s Fund; WVS: World Values Survey.

<sup>a</sup> PM2.5 is particulate matter of 2.5 µm or less in diameter, PM10 is particulate matter 10 µm or less in diameter.

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