

HIGH-LEVEL CONFERENCE ON HEALTH EQUITY: ACCELERATING PROGRESS TOWARDS HEALTHY AND PROSPEROUS LIVES FOR ALL IN THE WHO EUROPEAN REGION



ACHIEVE



ACCELERATE



INFLUENCE

Ljubljana, Slovenia
11–13 June 2019





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ABSTRACT

Many countries, regions and communities across Europe have taken actions to reduce health gaps, which is a core objective of the United Nations Sustainable Development Goals, Health 2020 and WHO's Thirteenth General Programme of Work 2019–2023. Progress in reducing health inequities nevertheless has been slow, and newly disadvantaged groups are emerging. To make further progress, the WHO Regional Office for Europe convened a high-level conference on health equity hosted by the Ministry of Health of Slovenia in Ljubljana on 11–13 June 2019, of which this report provides a brief summary of presentations, discussions and parallel sessions. The conference took as a basic document the then soon to be published Health Equity Status Report (HESR). The HESR stresses the importance of investing in policies and interventions that together will deliver five essential conditions for a healthy life: quality and affordable health services; income security and social protection; safe and affordable living conditions; social and human capital; and decent work and employment. The high-level conference focused on putting forward practical solutions to reduce health inequities. It aimed to set the European action agenda on increasing equity in health for the next 10 years by considering three action goals: Achieve, Accelerate and Influence. Meeting participants also agreed the final text of the Ljubljana Statement on Health Equity, which is presented as an annex to this report.

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The WHO Venice Office staff, in particular the policy leads, Tatjana Buzeti, Joana Madureira Lima and Tammy Boyce, coordinated the three main pillars of the conference, and Christopher Brookes, WHO consultant, coordinated overall development of the conference. Lin Yang and Andrea Bertola were influential in providing much of the data and visuals for the conference, Antonella Biasiotto coordinated the conference administration and finance management and Ekaterina Simko provided administrative support.

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Foreword

The WHO European Region has a long history and tradition of upholding universal policies, promoting welfare and rights-based approaches to health, and prioritizing the conditions needed to live a healthy life. Latterly there has been an increased focus not only on improving health and well-being overall, but also on reducing health inequities between people described by their life circumstances in relation to, for example, socioeconomic status, gender, education, housing, living conditions, employment and environmental circumstances.

All available evidence suggests that these inequities are amenable to intervention through policies and systems that create and protect the essential rights and conditions needed to be able to live a healthy life where people are born, grow up, live, work and age. In addition, interactions between individuals and their environment are not momentary or static, but extend across the life-course and across generations.

The persistence of health inequities points to the profound need for all governments to prioritize and scale up actions that level up health across the population. This calls for systematic action for accelerated improvement among those already left behind and better anticipatory policies and laws that prevent and act quickly to reduce the risk of people falling behind.

Improving health for all and the related principles of leaving no one behind and creating conditions for all people to flourish are reflected in numerous political and international commitments. The United Nations 2030 Agenda for Sustainable Development and the Sustainable Development Goals (SDGs) encourage Member States of the WHO European Region to embed the values of equity into national goals and decision-making across government, providing an opportunity to put health and equity at the centre. Health equity is also a core value of the Health 2020 health policy framework and the principle of universal health coverage and is reflected in WHO's Thirteenth General Programme of Work 2019–2023.

Inspired by the goals in these frameworks, many countries, regions and communities across Europe have taken actions to reduce health gaps. This requires equity considerations to be central to the implementation of health programmes across gender, age groups, ethnicities and disabilities to achieve equal opportunities and protect rights, close coverage gaps, promote health and strengthen the well-being and resilience of all women, men, boys and girls. Trends in reducing health gaps are mixed, however, and the rate of improvement is slower than anticipated, with new at-risk populations emerging in the last 10 years.

Accordingly, the WHO Regional Office for Europe convened a high-level conference on health equity hosted by the Ministry of Health of Slovenia in Ljubljana on 11–13 June 2019. The conference aimed to demonstrate that equity is possible, no matter a country's stage of

development or the size of its inequities, by showing how health equity can be achieved and progress can be accelerated to ensure health, well-being and prosperity for all.

The high-level conference took as a basic document the interim Health Equity Status Report (HESR). This is a flagship initiative of the WHO Regional Office for Europe, bringing forward the evidence, policy tools and metrics to reduce health inequities. The work is connecting policy-makers with the solutions to accelerate healthy prosperous lives for all and to ensure the human dimension of being left behind is visible, understood and addressed.

Closing the existing health equity gaps that persist within our societies and prevent emerging inequities from taking root in our cities, villages and regions requires systematic commitments to improve health and well-being for all. It is essential to scale up, adapt and implement what is working and innovate in solutions that can make a real difference to improving the lives of those left behind.

Piroska Östlin

WHO Regional Director for Europe, a. i.

Preface

Impressive progress has been made in health and well-being across the WHO European Region in the last decades, with average life expectancy for women reaching 82 years and for men rising to 74.5. But we cannot truly celebrate such progress when babies born in households and neighbourhoods with low levels of resources fail to thrive. It is intolerable that risks and consequences of poverty, unsafe homes, social isolation, precarious work and limited access to quality, affordable health services shorten people's lives. It is a tragedy that exposure to such inequities can shorten a woman's life expectancy by up to seven years, and a man's by up to 15.

Fifteen years – so much experience, opportunity, wisdom, laughter and love cut short.

The urgency of improving health equity becomes clearer when we recognize that while the WHO European Region is on track to achieve the United Nations Sustainable Development Goals (SDGs) overall, the lack of progress on reducing health inequities means that we are the only Region in the world in which there is negative progress on SDG 10 (reduced inequalities). It is simply not possible to have healthier lives and prosperous and sustainable societies without reducing inequities.

We must improve health equity because it is the right thing to do. It is also the smart thing to do, because health inequity challenges fiscal sustainability and leads to labour-market losses, a reduction in the tax base and increasing pension and social welfare costs. Increasing health equity is also the sustainable thing to do, strengthening our collective goals of prosperity and peace.

The public are concerned about improving health equity, with an analysis of opinion polls across Europe finding that the public view good health as a top priority for being able to get ahead in life. There is also concern about rising inequities and the impact of these on local and European cohesion and prosperity.

The polarizing effect of major gaps in health and well-being within all countries of the WHO European Region threatens the values of solidarity and stability upon which prosperity and peace are built. We need a better understanding of what is driving gaps in health over time and clearer signposting to the policies and approaches that will produce the best results for equity in health. This knowledge is crucial to fostering political support for action, focusing government attention on solutions, and enabling honest and inclusive dialogue with the public on why reducing health inequities matters for the health and well-being of everyone in the 21st century.

WHO's Thirteenth General Programme of Work 2019–2023 (GPW 13) goes to the heart of the issue by emphasizing the right to the highest attainable state of health and the importance of access to universal health care. GPW 13 has three overarching triple billion targets, namely:

1. 1 billion more people benefiting from universal health coverage (UHC)
2. 1 billion more people protected from health emergencies
3. 1 billion more people enjoying better health and well-being.

The Health Equity Status Report (HESR) is a game-changer in many ways, but here are two.

First, it is changing the narrative from only describing the problem of inequities to showing what factors are driving gaps and signposting the solutions that can turn the tide back in favour of healthy and prosperous lives for all.

And secondly, HESR is more than just a report. It represents more than two years of dialogue and testing with a wide range of professional, technical, political and academic stakeholders across the Region, many of whom attended the high-level conference on health equity. The result is a suite of tools that talk to the reality of policy-makers working in city, regional, national and European governments to tackle health inequities.

These tools, such as the online interactive platform and the health equity policy tool, support Member States to personalize the evidence in the report to their own context and priorities and strengthen alliances.

Above all, the HESR is a tool to inspire and enable us to scale up actions that can transform the lives of those being left behind and achieve the triple billion targets of GPW 13.

The Ljubljana high-level conference on health equity demonstrated this shift in mindset when it brought together more than 250 participants from many different walks of life, across government sectors, United Nations and international agencies and professions, all sharing solutions from the real world on reducing health gaps. It focused on surfacing solutions to reduce health inequities and setting the European action agenda on increasing equity in health over the next 10 years through three action goals – Achieve, Accelerate and Influence – and gave participants the chance to debate and agree the Ljubljana Statement on Health Equity.

The conference provided a springboard to ensuring that the key actions and tools of the HESR and equity-focused actions from the programmes of the WHO Regional Office for Europe are taken on board at local, regional and national levels, considered and actioned to break down the inequities that blight the lives and prospects of so many people in the WHO European Region. Together, we can achieve health equity and bring positive change to the lives of all people in our Region.

Chris Brown

Head, WHO European Office for Investment for Health and Development
WHO Regional Office for Europe

Introduction

Context

Attention to health equity, gender equality and the right to the highest attainable standard of health has never been more important, but progress in reducing health inequities has been slow. Trends to reduce health gaps are mixed, and the overall rate of improvement is slower than anticipated. There are also newly emerging groups in the population who have a disproportionately higher risk of poor health and premature morbidity. The result is that many people in societies continue to lag behind in their health and well-being, and this in turn holds back their opportunities to live full and prosperous lives.

The challenges of health inequities have extensively been studied and are well known. The Health Equity Status Report (HESR) initiative¹ was established to focus on solutions (Fig. 1). Through analysing countries in the Region, the HESR is providing policy-makers with new evidence, equity-focused metrics and a wealth of good practices from countries that give reason to be confident that health equity can be improved. Results from the HESR suggest that lack of trust, not having others to ask for help, and living in unsafe neighbourhoods and poor-quality homes are strongly associated with the gap between the top and bottom income quintiles within countries² for indicators of self-reported poor health, mental health and living with an illness that limits daily activity.

Fig. 1. The Health Equity Status Report initiative (HESRi)



Shift from describing the problem to implementing solutions:

1. set a baseline for monitoring health status and policy progress in Europe;
2. deploy user-friendly tools and guidance to drive forward equity in health (such as monitoring, policy options, WHO best buys and approaches, and advocacy tools);
3. ensure a stronger voice and action for health equity in national and local development plans in United Nations country plans and MAPS (mainstreaming, acceleration and policy support) missions; and
4. increase public and state attention, support and accountability for health equity nationally and locally.

Source: WHO European Office for Investment for Health and Development.

¹ WHO Regional Office for Europe (2018). Health Equity Status Report initiative [flyer]. Copenhagen: WHO Regional Office for Europe (http://www.euro.who.int/__data/assets/pdf_file/0003/386922/hesri-flyer-eng.pdf?ua=1).

² WHO Regional Office for Europe (2019). Healthy, prosperous lives for all. Interim report: WHO European Health Equity Status Report initiative. Copenhagen: WHO Regional Office for Europe.

Implementation of the Health 2020 health policy framework since its adoption by the WHO Regional Committee for Europe in 2012 has been a main vehicle for equitable improvement in health and well-being across the Region. The interim review of Health 2020 implementation in 2015 and the later update in 2017 highlighted that all Member States are taking actions to reduce health inequities in different ways, such as scaling up financial protection for health and developing new services to improve the health of those living at the margins of society.

In addition, Member States have strengthened the ways in which action on the determinants of health can be brought into wider government policies and development plans through whole-of-government, whole-of-society and health-in-all-policies approaches. Multisectoral working groups and committees at local, county, oblast/regional and national levels are increasing support for investments to close coverage gaps, promote health and strengthen well-being and resilience in women, men, boys and girls across economic, cultural and geographic divides.

Yet in many countries, changes in policies and conditions related to health determinants, such as reductions in work and social protection, have increased the number of people at risk of income and employment insecurity. Significant numbers of countries have reduced their investments in public policies for housing and community amenities, including water supplies, green spaces, street lighting, community groups and similar initiatives. The number of people worried about making ends meet has increased, thereby raising levels of anxiety, depression and mental illness, and the related risks of food and fuel insecurity. These effects are experienced disproportionately by those who are already falling behind in health and in life.

Implementing change

Commonly, the narrative on health inequities is that health inequity is too complex and difficult to address, and governments are unclear about the most effective policies and approaches. The findings from the HESR, which were available at the high-level conference, challenge this assumption and stress the importance of investing in policies and interventions that together will deliver the five essential conditions needed for every child and adult to be able to live a healthy life and to prosper and flourish:

1. quality and affordable health services
2. income security and social protection
3. safe and affordable living conditions and neighbourhoods
4. quality education and well developed social and human capital
5. decent work and employment.

Removing barriers for all to prosper and flourish in health and in life as the foundation for sustainable and democratic development involves ensuring an essential set of conditions

for every girl, boy, woman and man to be able to live a healthy life. This requires the scaling up of effective policies and interventions to reduce health inequities (Fig. 2).

Fig. 2. What the HESRi monitors



Source: WHO European Office for Investment for Health and Development.

Governments and international organizations need to shift from single-policy interventions to:

- comprehensive solutions that address the sliding scale of risk and consequences for the population of insecurity in one or several of the five essential conditions, based on a basket of policies; and
- interventions that span the whole of government and involve the whole of society.

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

Crucial to success are new partnerships with those being left behind – the child, young person, woman or man who is not able to prosper and thrive. It is their voice, their lived experience, their passion, drive and resilience that must be heard and nurtured to make equitable progress towards health and sustainable development.

There is now increasing evidence that taking action to reduce health inequities to build and sustain better societies can achieve quantifiable economic gains. Financial protection for health is achievable, yet today, catastrophic and impoverishing out-of-pocket health spending affects up to 15% of households across the WHO European Region, contributing to increased risk of poverty and social exclusion. Evidence suggests that within-country differences in life-limiting illness can be reduced within a period of 2–6 years by combining accelerated and universal policies.

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

Today, health systems across the Region are demonstrating new ways to tackle inequities, assure health financing and innovate to deliver high-quality local health services. Alongside these health system solutions are multisectoral approaches that are showing success in reaching those being left behind and in acting to prevent others from falling behind.

Also important are innovations in using data to measure and monitor within-country health equity status, helping enable, motivate and empower decision-makers to act and guide public policies to increase health equity through creating the conditions needed for all to live a healthy life.

The Ljubljana high-level conference, June 2019

The WHO Regional Office for Europe convened a high-level conference on health equity hosted by the Ministry of Health of Slovenia in Ljubljana on 11–13 June 2019. The conference brought together Member States, international organizations and civil society organizations to take stock of progress to date and debate how to accelerate progress towards achieving healthier and more prosperous lives for all in the WHO European Region.

The conference was intended to be a forum for high-level representatives of the 53 Member States of the WHO European Region, relevant international organizations and selected non-state actors and nongovernmental organizations. Participants were representatives of the health sector and of government ministries and departments that impact on health inequities within countries.

The objectives of the conference were to:

1. inspire action for health equity by sharing country experiences to prevent and reduce health inequities within countries and identify the factors needed for successful implementation;
2. explore a range of approaches that are delivering improved policy coherence, enabling public engagement and increasing investment for health equity; and
3. galvanize existing platforms and partnerships and identify new mechanisms and opportunities to accelerate progress towards health equity.

The high-level conference focused on putting forward solutions to reduce health inequities and to set the European action agenda on increasing equity in health for the next 10 years by considering three action goals.

ACHIEVE: create the conditions and remove barriers for all to prosper and flourish in health and in life. An essential set of conditions is needed for all to be able to live a healthy life and is the foundation for effective and sustainable progress.

ACCELERATE: implement a set of policies built on inclusive and empowering approaches to reduce health gaps. Shifting from fragmented and short-term interventions to a comprehensive and coherent set of solutions is key to creating and sustaining the essential conditions for all to be able to lead a healthy life.

INFLUENCE: put health equity at the centre of sustainable development and inclusive economies. Eradicating health inequities and strengthening sustainable development for all are bold but achievable ambitions. For these, new partnerships and instruments are needed that advocate, enable, motivate and show how health equity matters for the future of countries and communities.

The main plenary sessions of the conference focused on these three action goals, with parallel sessions providing further opportunities for presentations and debate on the goals.

ACHIEVE

How can we achieve the conditions, and remove the barriers, to allow all people in Europe to prosper and flourish? Examples of achievements in promoting health equity formed the focus of this section of the conference.

Policy pushing equity

Presenters

Vaughan Gething, Minister for Health and Social Services, Welsh Government

Ilze Viņķele, Minister for Health, Latvia

A raft of measures to reduce inequity has been enacted in the United Kingdom (Wales). Two pieces of legislation – the Well-being and Future Generations Act and the Social Services and Well-being Act – provide a longer-term framework underpinned by policy choices aimed at reducing health inequities.

Helping health and social care services to work effectively together is central to achieving the outcomes the Welsh Government wants. A 10-year plan, Healthier Wales, published in 2018, sets out how this can be achieved. The plan was devised by the Government, the National Health Service (NHS), local government (which is responsible for social care) and the third sector in Wales. Intersectoral collaboration was and remains key to progress.

Changing people's attitudes is not easy, but it's really powerful. The challenge for politicians is not just to have the right policy platform, but how we talk to people about it. We need to understand that people still have the biggest influence on their own lives and choices, and our job is to get alongside them.

Vaughan Gething
Minister for Health and Social
Services

Addressing health inequities features throughout the plan. A good example is the Living Well, Living Longer programme in the Gwent Valley, a deprived area of Wales. The approach is to invite people aged over 40 for a cardiovascular risk assessment, targeting those sections of the population that traditionally do not come forward to access service opportunities. The assessments are carried out by health-care support workers in community settings. The programme addresses health equity by recognizing that the biggest agents for change for population health are people themselves.

The Government has created a £100 million transformation fund to promote integration, but health and local government agencies can only access the fund through joint plans – this has helped to drive some of the cultural change necessary to make a big impact on health inequities. While the money is important, political choices and commitment are also vital; there are many pressures on health and social care budgets, and political determination is necessary to move the system forward to meet the challenge of health inequities.

Changing people's attitudes on health priorities is not easy. In Latvia, responsibility for addressing health inequities is shared across ministries and with municipalities and civil society.

Bureaucracy has been reduced for doctors to release more time to be with patients, and patient access to medical services is being increased. Financial incentives are used to attract health specialists to rural regions, with the aim of acquiring 1400 medical professionals over five years; this would cover 24% of the total shortage. The proportion of family doctors in rural areas over the age of 60 is 37%, so a programme has been designed to support doctors nearing retirement age to transfer their practices to new specialists; the programme includes financial compensation for the doctors involved.

Holism – the idea that systems (such as physical, mental, social, emotional and economic systems) and their properties should be viewed as a whole, not just as a collection of parts – is central to the approach in Latvia. Ministries see their responsibilities as overlapping, and citizens are experiencing smoother journeys through the system.

Pursuing equity in work and education

Presenters

Juan Menéndez-Valdés, Executive Director, European Foundation for the Improvement of Living and Working Conditions (Eurofound)

Didier Jourdan, United Nations Educational, Scientific and Cultural Organization (UNESCO) Chair, Global Health and Education

Having a job matters. Unemployment is seen as a main driver of inequities in the European Union (EU), and employment is identified in the HESR as being one of the five dimensions that are key to health equity. Having a job, however, is in itself not enough to tackle inequity. Quality of work is also important (Fig. 3).

A survey by Eurofound revealed work dimensions that are correlated with good and bad health for workers. The dimensions reflect: the physical work environment; how demanding (or undemanding) the work task is; social characteristics such as support (or lack of support) from work colleagues and managers; work intensity; the structure of the post; deadlines; regulations; and contradictory priorities. The level of influence and autonomy a worker has in their work, learning opportunities within the job, career prospects, security of employment and salaries also affect health. Identifying these dimensions allows researchers to analyse the health effects of different jobs and working conditions.

Recent Eurofound research on workers' health and working conditions looked specifically at demands (physical, psychological and social) and resources at work. High demand can create exhaustion and damage health, but having resources increases workers' motivation and gives

them tools to cope with demand. The research also identifies areas and sectors in which workers seem more at risk of bad health, including the health sector.

Fig. 3. The importance of jobs, and job quality, for health



Source: Juan Menéndez-Valdés, Eurofound; reproduced by permission of Eurofound.

In Europe, some improvements are being seen (flexible working opportunities, for example, are increasing), but work intensity, while falling, remains high, bringing with it exhaustion and health problems. Solving these problems does not necessarily require higher expenditure – it calls for approaches that share information across the workforce and support people to implement better practices.

The main message is that to make working conditions healthier, work demands should be reduced and resources increased. This is a very simple message that is easy to say, but difficult to implement. It is therefore about finding the right compromises that can be made in a realistic and pragmatic way.

Equity in education is also vitally important. Health and education are intertwined and are the joint pillars from which human capital – defined by the World Bank³ as “the knowledge, skills, and health that people accumulate throughout their lives, enabling them to realize their potential as productive members of society” – is built and sustained throughout life. Education is a determinant of health, and health enables children and adults to participate in and pursue education and learning. It is critical to recognize, however, that education is not a magic wand for resolving health inequity. Education can reduce inequities but can also amplify them.

There is a need for more inclusive, participatory approaches to education to tackle inequities and break the vicious circle of the intergenerational transmission of educational differences.

Didier Jourdan
UNESCO Chair,
Global Health and Education

Inclusive and equitable education policies are needed. Central to these is guaranteeing universal access to kindergartens that provide good-quality teaching and safe learning environments for all children. This is the top priority for education policy – it works, and works more strongly for children with higher exposure to poor living conditions and poverty risk, and those who lack regular and unconditional emotional and social support. Also crucial is enacting measures to limit school drop-out rates and enhance opportunities for children and young people to return to school after drop-out.

Human resources are a key issue. Creating more resources to attract the most talented students to the education professions has an enormous impact on health equity. The best-performing countries in this regard are those whose priorities are to have the best teachers in place and who incentivize the distribution of educational resources to equalize learning opportunities and outcomes. Children spend one third of their time in schools, so improving the quality of school management, enhancing the school climate and improving the quality of the relationship between home and school are in themselves key determinants of health equity.

Civic activism for equity

Presenter

Alice Chapman-Hatchett, European Social Platform, European Public Health Alliance

The European Social Platform (ESP) is the largest network of organizations working on rights and values-based issues in the social sector in Europe. It advocates for a socially just and cohesive Europe and focuses its work particularly on those most at risk of exclusion. The European Public Health Alliance (EPHA) works to improve public health in Europe. Its main

³ About the Human Capital Project. In: World Bank [website]. Washington (DC): World Bank; 2019 (<https://www.worldbank.org/en/publication/human-capital/brief/about-hcp>).

focus is influencing policymaking and promoting awareness and engagement among nongovernmental organizations (NGOs) and citizens on a wide range of health issues. Achievements of the two organizations include work to support the WHO Framework Convention on Tobacco Control (WHO FCTC), which demonstrates what the NGO community can achieve in delivering major health policy change when it works together. In work on HIV/AIDS, advocacy by NGOs brought the initial 12-week treatment cost down from US\$ 86 000 per person to US\$ 6000–10 000; since the introduction of generic products, the cost has further reduced to US\$ 300 per person. On food, five years' advocacy work has helped to ensure that the European Commission adopted a regulation to limit industrially produced trans-fats to 2 g per 100 g of fats.

Other projects are taken forward at local and regional level. An example is a social economy project in Austria. The Magdas Hotel, Austria's first social-business hotel operated by refugees under the guidance of tourism professionals, is helping to integrate refugees into society and providing employment. The business model has been so successful that it has now extended into food and recycling. In the Netherlands, the Mum-to-Mum peer-support project for mothers in a very deprived part of The Hague is yielding a three-euro social return for every euro invested.

The challenges of the modern world are complex and ambiguous; inequities remain wide even in wealthy countries, and we are living through a time of fake news, fake science, changing demographics and a revolution in technology. NGOs can provide responses to these challenges through implementation of programmes such as the very successful examples highlighted here.

Activism works. It's arguable that a schoolgirl from Sweden is doing more to tackle climate change than scientists have for many years ... Maybe we all need to discover our inner Greta Thunberg.

Alice Chapman-Hatchett
European Social Platform,
European Public Health Alliance

Summing up

The practical examples of achievement emphasize the importance of the following, which are the foundations for effective and sustainable progress:

- creating an essential set of conditions that, together, are needed for all to prosper and flourish in health and in life; and
- achieving equitable improvements in health and well-being by improving each of these five conditions for all through a basket of universal measures that matches the scale and the level of disadvantage:
 - providing universal access to good-quality, affordable health services
 - ensuring basic income security and adequate social protection
 - ensuring safe and decent living conditions
 - providing inclusive social and human capital building opportunities
 - ensuring decent and nondiscriminatory employment and working conditions.

Enhancing social protection and inclusion for children in Bosnia and Herzegovina

Children's experiences of poverty and vulnerability differ from those of adults and may have a huge impact on physiological and psychosocial health and well-being outcomes throughout the life-course. Child-sensitive social protection systems have a positive impact on chronic poverty and social exclusion and contribute to building more cohesive and inclusive societies.

Authorities from different levels in Bosnia and Herzegovina, including ministries and civil society organizations, worked together with the United Nations Children's Fund to develop the SPIS (social protection and inclusion services) model, a multidisciplinary mechanism to improve social protection and inclusion systems for children at risk of poverty, social exclusion and family separation, and those with no parental care.

The project was implemented between 2008 and 2015 to empower local institutions and organizations to develop individual and collective referral plans for children living in municipalities with the lowest social protection coverage. Permanent local multisectoral coordination platforms were established to facilitate cooperation, involving municipal departments for social affairs, centres for social work, schools, health centres, youth councils and representatives from NGOs.

The project increased investments in municipalities to improve social protection coverage for children and reduce inequities. By focusing on areas with the least resources, the programme demonstrated how different social sectors can collaborate to address a common objective and increase equity.

The development of individual and municipal plans contributed to:

- reducing differences in access to social protection between children from high-income and low-income municipalities by strengthening governance and the legal framework;
- enhancing existing systems and capacities to deliver high-quality inclusive services at local level;
- establishing new social services for children, such as day care and foster care; and
- raising public awareness of social inclusion and children's rights through advocacy and awareness campaigns.

The Habitat-Microareas programme in Trieste, Italy

Like many areas in the WHO European Region, Trieste has experienced economic crises, austerity policies and high rates of unemployment over the last few decades. These factors, alongside an increasing older population (30% of the population is aged over 65 years), have resulted in higher risks of poor physical and mental health due to a lack of adequate services, financial instability and associated outcomes, such as social exclusion.

In response to these sociodemographic changes, the northern Italian region of Friuli-Venezia Giulia developed the Habitat-Microareas programme. The programme aims to develop local welfare plans involving stakeholders such as the local health agency, municipalities and the regional public housing organization, with the active involvement of local citizens being integral.

The programme adopts an intersectoral approach and supports coordinated activities among the health-care, social and employment sectors. Programme staff work with the local community to build and improve relationships between citizens with the aim of fostering social cohesion and participation.

The first year of the programme was spent getting to know the area and collecting health data. Based on this information, the strategic objectives of the programme were identified as:

- improving health for all
- reducing health inequalities
- improving participatory governance for health.

The programme implemented a set of activities of integrated care aimed at linking health-care practices to social services, housing issues and civil society networks and creating supportive environments and resilient communities.

In every microarea (with about 400–2500 inhabitants), the programme depends on volunteers, active citizens and professionals, including:

- a full-time coordinator, usually from the regional health agency, who is responsible for coordinating, integrating and monitoring health promotion and protection activities; and
- two part-time social concierges, one from the municipality's social services department and the other from the public housing organization.

Since the Habitat-Microareas programme was introduced, admissions to hospitals for psychosis, acute respiratory infections and cardiovascular conditions have decreased by 85%, 56% and 28% respectively. The programme shows that a small-scale approach is strategically important in facilitating the coordination of multisectoral actions and in promoting local community engagement.

Achieving sustainable food and nutrition security in rural areas in Tajikistan

Malnutrition (which can be undernutrition, overweight and/or micronutrient-related malnutrition) is the leading cause of ill health in Tajikistan. Despite significant steps by the Government to address the problem, malnutrition continues to impact negatively on the population's health and well-being, particularly for women, infants, children and adolescents. As access to affordable, nutritious and health-promoting food is more likely to affect lower socioeconomic groups (who are affected disproportionately through lacking access to such foods), food security is critical to health equity.

Malnutrition is significantly higher in Tajikistan than in neighbouring countries in central Asia. A survey conducted by the World Food Programme in 2017 found that 20% of children aged under 5 years in Tajikistan were malnourished and 31% were stunted.

Given the large disparity in the rates of stunting and malnutrition between rural and urban areas, the non-profit-making organization Welthungerhilfe Tajikistan sought to change the livelihoods of people in the rural areas of northern Tajikistan, which is characterized by adverse climate conditions and strong dependence on a small-plot subsistence economy.

Welthungerhilfe Tajikistan is working to improve natural resource management in the area to ensure food and nutrition security and achieve sustainable poverty reduction through the Sustainable Food and Nutrition Security project. The project is funded by the EU in the frame of the rural development programme for Tajikistan.

The project, implemented by a consortium, is led by Welthungerhilfe in coordination with the Ministry of Health and Social Protection and different departments in local government. This multisectoral approach ensures the integration of activities.

Since 2016, the project has implemented actions to:

- enhance natural resource techniques, with farmers receiving training on issues such as improved energy supplies, water preservation and soil management;
- foster collaboration between farmers to improve natural resource management;
- increase households' yields and turnover by providing innovative and adapted technologies and means, such as fertilizers and pesticides;
- create diversification of agricultural products at household level (for example, seedlings have been distributed to the rural population); and
- reduce the level of poverty in rural areas by supporting business initiatives, including agri-shops, greenhouses and community-based organizations.

Following implementation of the intervention, many people took part in natural resource management training: for example, 21 groups from different villages participated in the development of natural resource management plans and 1951 people (including 1276 women) were trained on how to save water and enhance soil fertility to increase production. More than 2000 people participated in practical agricultural training to increase food production. Following training, the gross yield increased by 35%, food security by 30% and food production for selling by 30%.

ACCELERATE

How can the reduction of health gaps be accelerated? There are some important lessons from literature and experience. It is important to create this focus in the use of resources and how policies and services are designed and implemented. Important prerequisites are:

- involving those left behind in the design of services and policies;
- using empowering approaches that build and strengthen individual and collective action for health;
- delivering coherent baskets of interventions that combine universal and targeted approaches that match the sliding scale of risks and needs across the population;
- putting people at the centre of care through integrated service approaches; and
- incentivizing equity in planning, monitoring impact and evaluating progress.

These and other issues designed to accelerate progress were the subject of this session.

Accelerating through national policy

Presenters

Giuseppe Ruocco, Secretary-General and Chief Medical Officer, Ministry of Health, Italy

Ioannis Baskozos, Secretary-General for Public Health, Ministry of Health, Greece

Taru Koivisto, Director, Ministry of Social Affairs and Health, Finland

While the Italian health system offers a full range of services to refugees and migrants, data for 2015–2018 from the Italian National Surveillance System (PASSI) have highlighted significant social inequities in health-related behaviours, access to services for prevention of cancers and adherence to safety measures for the prevention of road accidents. Accordingly, Italy has embarked on a project with WHO to systematically reduce inequalities.

The political health agenda now involves a series of community-based and multisectoral policies to align the Government agenda with the United Nations 2030 Agenda for Sustainable Development and fully achieve UHC (Fig. 4). Key drivers have been identified to accelerate health equity, such as encouraging cooperation between health and finance authorities, promoting the relationship between health services and the social assistance system, and strengthening primary health care. The three key words for access to the Italian health system are invest, innovate and include. International cooperation has been extended through the G7 and G20 international government forums.

Fig. 4. Health and the Sustainable Development Goals



Source: WHO.

Greece has faced a number of years of strict austerity. During 2009–2015, unemployment reached 28%. The health system has been affected severely and has partly disintegrated. In addition, Greece has received 2.5 million uninsured refugees and migrants.

A series of actions has been taken to ensure equitable access for all to health coverage irrespective of gender, nationality, religion or origin. Unemployment has been reduced and the minimum wage increased. User fees have been abolished.

Through a focus on strengthening public health and the primary care system, Greece has been able to provide insurance cover and health care on a universal basis, including free access for refugees and migrants who have been granted a social security number. The necessary legislation has been put in place to achieve this focus on UHC and equity, providing for the most vulnerable people.

Health-care staff numbers have been reinforced and incentives provided. Mobile health clinics and the use of telemedicine has extended access. Health-care units have been established in refugee camps and living conditions improved. Cultural mediators have also been made available.

Overall, the human right to health [in Greece] has been affirmed, and no one has been left out.

Ioannis Baskozos
Secretary-General for Public Health,
Ministry of Health, Greece

Equity is a high policy priority in Finland, with a commitment to universal access to integrated and people-centred services. Those needing more support, such as children and groups with specific health and social problems, should receive this through more targeted and tailored services – not only health and social services, but also services for unemployed people and targeted services to deprived areas. There is a strong commitment to health in all policies and

involving other sectors, such as education, housing, NGOs, the private sector and workplaces. The commitment is not only to social policies, but also to environmental support. Data and information are used to identify needs, evaluate what is working, and promote transparency and accountability. The United Nations Sustainable Development Goals (SDGs) are important for politicians at all levels to promote participation and empowerment, encourage the involvement of people locally and create partnerships at local, national and international levels.

Finland is fully committed to the Coalition of Partners for Public Health and will promote health and well-being during the forthcoming Finnish EU Presidency. Policy interests will include the economics of well-being, how well-being policies and structures can influence social security and social stability, and the importance of health impact assessments.

Accelerating through research, strategies and public health approaches

Presenters

Aaron Reeves, Associate Professor of Evidence-based Social Intervention and Policy Evaluation, University of Oxford, United Kingdom

Bente Mikkelsen, Director, Division of Noncommunicable Diseases and Promoting Health through the Life-course, WHO Regional Office for Europe

Dominic Harrison, Director of Public Health, Blackburn with Darwen, United Kingdom

The research community should contribute to achieving the policy coherence needed to reduce health inequities. This would contribute to deepening democracy through, for example, improving voter turnout among the least affluent. Political inequalities reflect power imbalances in society and are predictive of health inequalities. The HESR provides people with information, but it is vital to provide resources as well. Austerity and the cutting back of welfare limits policy space for participation and the deepening of democracy.

There are now only 11 years left to achieve the SDGs. Current progress is inspiring but also alarming in terms of what remains to be done. It cannot just be business as usual – there is a clear relationship between inequities and poverty.

To reduce inequities, WHO is ready to help Member States with noncommunicable disease strategies and action plans, data, mandates, norms and standards, and Health 2020-inspired policies for improving leadership and governance. “Best buys” have been established and what needs to be done is clearly known. Much more advocacy is needed, aligned to public information, with a simplification of messages. Return on investment arguments are important, and tools already in place, such as healthy settings movements in cities and schools, should be used fully.

Thirty per cent of deaths are avoidable, and the role for public health is to establish and communicate what is killing people and what is preventable and amenable to intervention. It

is important to denormalize many things that people are starting to accept. Questions should be asked about how integrated care systems spend money.

[We should] systematically maximize the broader health and social outcomes from health and social care investment.

Dominic Harrison
Director of Public Health,
Blackburn with Darwen, United Kingdom

It is important to shift from current models to more inclusive growth around social and place-based infrastructure, social movements such as the green new deal, and transformative investment to save the planet while reducing health inequalities. The key shift required is from an economic model based on growing now and

distributing later, to one that sees growth and social reform as two sides of the same coin. Investment in social infrastructure should go hand in hand with investment in physical infrastructure and business development. Health systems should contribute to local economic strategies, improving local procurement, increasing local employment and drawing in local employees, including people who are elderly and disabled, through creating a skills escalator, improving overall skills and training, addressing climate change and promoting digital technologies.

Summing up

Key messages to emerge from the session on accelerate were:

- acknowledge that current models of change have not been fully effective;
- put in place proportionate, universal, whole-of-government, whole-of-society and health-in-all-policies approaches to address the sliding scale of risk and consequences of insecurity in each of the five conditions that are essential to being able to live a healthy life in Europe in the 21st century;
- embed the goals of equal outcomes in laws, norms and practices of government;
- join forces and create solidarity between governments and the people;
- tackle global health drivers such as the commercial determinants of health and commercial pressures that impact negatively on health, such as high density of fast-food and alcohol outlets in low resource settings;
- reach out to other sectors, for example civil society, the social economy and the private sector;
- lead and support action that benefits health equity while building new allies and a stronger commitment to equity;
- incentivize health-enhancing products and investments through social values contracts with small- and medium-sized entities and the private sector, while recognizing the potential for conflicts of interest;
- put people at the centre of processes to achieve health equity by designing policies based on the lived experience of those who are being left behind;
- promote participation, inclusion, empowerment and accountability through listening and building trust in ways of working;

- build human resources for health while tackling inequity in access to trained health professionals through using resource formulae to increase capacity and quality in areas with highest health needs and risks;
- build resilience into primary care services; and
- protect public health by bringing social determinants back to centre stage in the WHO transformation process.

The Healthy Generation Project in the Republic of Moldova

Young people in the Republic of Moldova, like their peers throughout the European Region, face multiple challenges to their health and well-being and in access to health-care services. The Government of the Republic of Moldova has prioritized the health and development of young people in several strategic policy documents that aim to increase their access to health information and high-quality youth-friendly health services (YFHS).

The NGO Health for Youth, with support from the Ministry of Health, Labour and Social Protection, implemented the Healthy Generation Project to scale up YFHS in all 35 districts of the country. The project is being implemented through intersectoral collaboration involving international organizations, several ministries and the broader community.

The project aims to:

- increase the demand for, access to and utilization of, high-quality YFHS;
- improve health-related information and knowledge to enhance health literacy among young people;
- improve the quality of health services for adolescents and young people aged 10–24 years;
- increase health and well-being among young people; and
- prioritize the needs of young people.

YFHCs improve the health and well-being of young people and accelerate actions toward groups at most risk, including those who are socially and economically vulnerable. They

- provide a package of health services to tackle a wide range of problems, such as sexual and reproductive health, nutritional disorders, mental health problems and problems resulting from violence; and
- deliver health services, including mental health services (information and counselling), sexual health services (provision of contraceptives) and general medical examinations.

The project has helped to establish 41 YFHCs around the country that are integrated into the primary health-care system.

Data show an increasing demand from young people and improved communication between adolescents and YFHC professionals. While only 5% of young people in the Republic of Moldova accessed YFHS in 2011, this had risen to 24.5% by 2017.

Baby-friendly Hospital initiative in the Russian Federation

To reduce mortality in children under 5, the Russian Federation set up Baby-friendly Hospitals (BFHs) in 53 regions. BFHs aim to protect, promote and support breastfeeding to give every baby the best start in life by creating a health-care environment in which breastfeeding is the norm.

Many interventions have been developed to support BFHs. The principles underpinning these interventions are:

- staff focus on the mother and her situation on a case-by-case basis;
- the facility provides family-centred care; and
- the health-care system ensures continuity of care from pregnancy to after the infant's discharge.

The BFH initiative provides mothers with:

- breastfeeding counselling
- information on their health
- general support on how to breastfeed.

As a result of implementing the BFH initiative, breastfeeding of 6–12-month-old babies in the Russian Federation has increased sharply, contributing to the decrease in infant mortality and morbidity rates in the country. In addition to improving child survival and protecting against life-threatening and chronic illnesses, breastfeeding also promotes healthy growth and improves early child development. Mothers also benefit; breastfeeding protects against postpartum haemorrhage, ovarian and breast cancer, postpartum depression and heart disease. Empowering women through promoting breastfeeding gives them an increased sense of control over their health.

INFLUENCE

Influence is about:

- putting equity and health at the centre of fiscal growth and sustainable development policies;
- shaping investment decisions to deliver results that ensure healthy and prosperous lives for all;
- showing how it is not possible to have healthier lives and prosperous and sustainable societies without reducing inequities; and
- bringing into sharp focus for decision-makers and the public the fact that without creating the essential conditions that enable all people to be able to live a healthy and decent life, there is a risk of compromising the human potential upon which economic well-being and fiscal sustainability depends.

This issue provided the focus for the final main session of the conference.

Influencing through collaborations and partnerships

Presenters

Kiren Zubairi, Policy Engagements Officer, Voluntary Health Scotland, United Kingdom
Hazel Genn, Professor of Sociolegal Studies, Faculty of Law, University College London, United Kingdom

Many of the voluntary agencies with whom the third-sector umbrella organization Voluntary Health Scotland works do not have a policy or research function, so find it hard to influence policy at government level. Voluntary Health Scotland can do this on their behalf and ensure their voice is heard when policy and legislation is being shaped.

The voluntary sector is a key partner in ensuring the delivery of health. Voluntary Health Scotland works to share intelligence and bring together people who do not normally have the opportunity to engage with each other through local and wider initiatives, helping to make people's lived experience and collaborative cross-sectoral working central to the development and implementation of policy.

Voluntary Health Scotland has been involved closely in the development of Scotland's new social security agency (Social Security Scotland (SSS)), created as a result of new devolved powers to the Scottish Parliament. SSS is based on values of dignity, respect and human rights, and is working with cross-sectoral partners (including the voluntary sector) and people who will use the service to deliver these principles in practice. So-called experience panels, consisting of over 2400 people who have used benefits services in the past, have been engaged since 2017 to identify what challenges and barriers they have faced in accessing benefits and what they feel needs to change in the new system. A charter has been

developed setting out what people can expect when they access the system. None of this could have happened without the strong collaborative approach adopted from the outset.

There is much discussion on behaviours that affect health, but for the most deprived people, their basic needs – decent incomes, decent housing, work that doesn't make them ill – must be met first before they can focus on their health. There needs to be sufficient mental bandwidth for people to make healthy choices.

Hazel Genn
University College London,

Health inequity is an access-to-justice and rule-of-law issue. Rule of law embodies the notion of fair and inclusive societies, supporting social cohesion and social justice. It is positively associated with economic development, and access to justice is included in the SDGs (target 16.3). Health inequity offends rule-of-law principles – it is fundamentally unfair and disproportionately affects low-income and disadvantaged families, condemning them to an unbroken cycle of deprivation.

Law is important for reducing every health-harming social determinant but is often poorly implemented or enforced. Health–justice partnerships may offer a way forward (Fig. 5). This grassroots practitioner-led movement is already active in several countries and is spreading; the United Kingdom has over 350 health–justice partnerships in place.

Fig. 5. Health justice

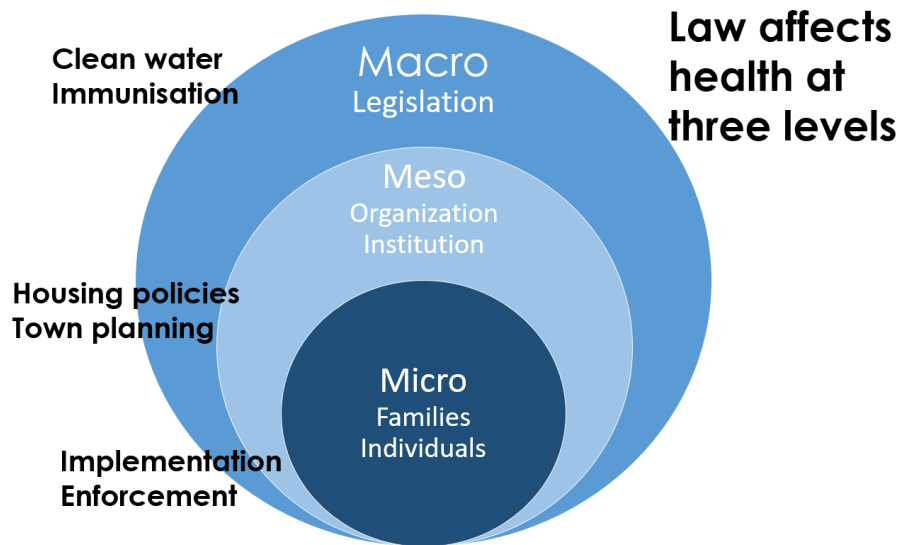


Source: Hazel Genn, UCL Faculty of Laws; reproduced by permission of University College London.

Health–justice partnerships involve integrating health and community legal services to address the causes of poor health, such as poor housing and working conditions, for which law can provide a remedy. Doctors see the effects of inequities on people every day in their clinics, but their only tools for combatting them are medicines – they cannot address the social conditions that create the inequities that make people ill. The partnerships allow them to work hand in hand with lawyers and others to access critical health-enhancing requirements for their populations, consequently mitigating inequalities. Laws, when appropriately designed and applied, provide solutions where public health alone cannot.

The health–justice partnerships movement has the potential to improve the health of the population from the bottom up (Fig. 6). It is consistent with the concept of proportionate universalism, and in the United Kingdom, policy is following practice: the departments of health and justice and NHS England are in partnership to spread the approach.

Fig. 6. Health justice – how law can impact on different levels of health



Source: Hazel Genn, UCL Faculty of Laws; reproduced by permission of University College London.

Influencing through economics and politics

Presenters

Feng Zhao, Programme Leader, Human Development Programme, World Bank

Fred Freundlich, Professor, Mondragon University, Spain

Vukica Jelić, State Secretary, Ministry of Labour and Social Welfare, Montenegro

Håkan Linnarsson, Regional Commissioner, Public Health Committee, Västra Götaland, Sweden

The World Bank mandate has twin goals – reduce poverty and share prosperity. Health equity is therefore inseparable from the World Bank’s function.

A large part of the wealth of any nation – more than half – is human capital (see page 9 for a definition of human capital). The World Bank has developed a Human Capital Index that ranks all countries in terms of investment in human capital. The Index score ranges from 0–1, with 1 being the optimum level. As an example, if a country scores 0.65 on the scale, it means a child born today will lose 35% of their productivity when they join the labour force – a significant gap. The Index therefore attempts to bring countries’ attention to the importance of human capital by revealing how inequities in human capital lead to reduced economic growth, and the potential advantages investment in human capital bring.

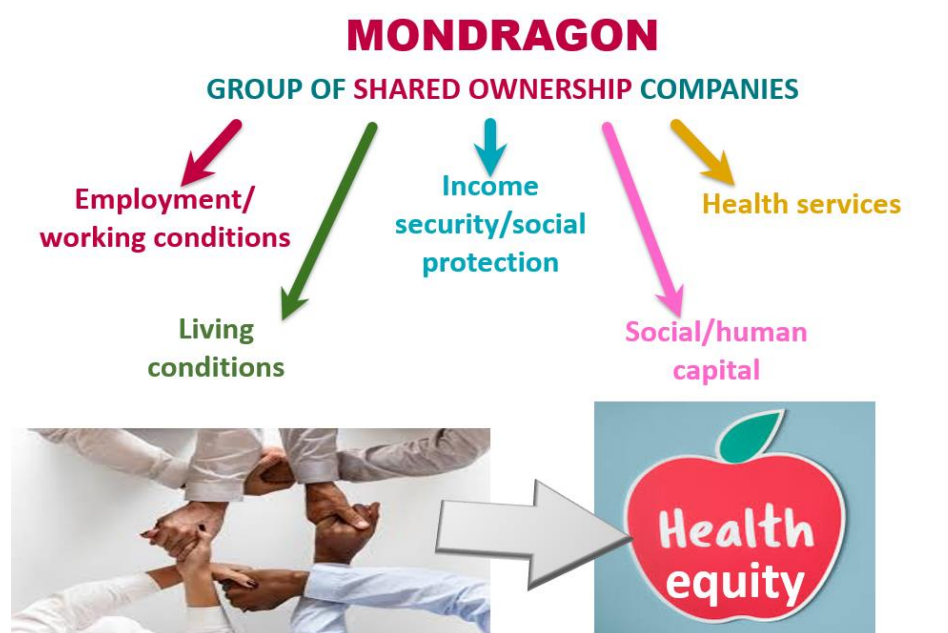
Ministers of finance tell us – health is too important to be left to ministries of health alone.

Feng Zhao
World Bank

A World Bank survey of ministers of finance in various countries shows that they believe health is very important not only for people's well-being, but also for economic growth. They nevertheless are frustrated in their engagement with the health sector; they find the whole system too complicated to understand and measure, and some feel that because they have no medical training, health ministers believe they know nothing about health. Their main argument, however, is that countries must live within their means, in health and in all other areas. No country has unlimited resources, and the most effective use of resources needs to be identified.

Mondragon University is associated with shared ownership companies that are owned by the people who work in them (Fig. 7). Mondragon emerged in 1956 in the Basque Country, Spain, with 20 people starting a shared company. There are now 80 000 people working in 110 shared companies, with another 140 or so affiliates. Mondragon works mainly in advanced manufacturing but also in retail, finance and knowledge businesses; combined sales last year came to around €12 billion.

Fig. 7. The impact of shared ownership companies on health equity



Source: Fred Freundlich, Mondragon University; reproduced by permission of Mondragon University.

The companies are integrated into a network that creates institutions and policies to promote business development and social protection. There are challenges, but the combination of shared ownership and working collaboratively in a network tends to mean problems are addressed more fairly, more economically and more effectively, which is good for health and health equity. The companies of Mondragon have agreed a policy of no layoffs – no worker/owner can be made redundant for economic reasons. All companies contribute to a joint service that provides employment support for people whose company is facing declining demand, helping them acquire a job with another network company and arranging retraining as necessary. This means the enormous economic, psychological and social stress

related to unemployment is greatly reduced. Combined with the fact that these companies often outperform conventional competitors, the county in which many of the companies are situated has the highest per capita income and the lowest poverty and unemployment rates in the Basque Country: a poverty rate of only 1.3% in a county of 60 000 signals positive effects for health and health equity.

The companies in the network have also created a health and well-being service to which they all contribute, resulting in the rate of industrial accidents over the last 15 years in Mondragon companies being 30–40% lower than the Basque average. Reducing industrial accidents through collaboration is a key way of addressing health equity.

Company ownership succession is a huge problem in many countries. Small companies all over Europe close every day because they have no ownership succession plan. As a means of developing partnerships and reducing health inequity, agencies locally and nationally could carry out pilot studies to determine how many business owners aged 55 and over in their

Addressing health inequities requires effective multisectoral cooperation and the participation of all of society. Inequities can be reduced only if the health sector works closely with departments within which other determinants of health inequity are addressed – employment, education, social protection, urban planning and fiscal policy.

Vukica Jelić

State Secretary, Ministry of Labour and Social Welfare, Montenegro

area or country have no succession plan in place, and persuade them through financial and other means to sell their business to their employees. This would help to avoid unemployment, community destruction and health problems, and help create new enterprises based on the concept of membership and partnership.

Health and health inequity are at the heart of the political commitment of the Government of Montenegro. Its health plan and other strategic documents provide guidance for improving significantly the health and well-being of the population by reducing health inequities,

strengthening public health and providing people with a health system that is universal, equitable and sustainable.

The Social Council, in which employers, employees and government participate equally, helped to create partnerships for problem-solving and ensuring economic and social growth. This approach has made it possible to create solutions that are acceptable to all.

Like other countries in the Region, Montenegro has been undergoing complex and difficult economic restructuring and other elements of transition over the last three decades.

Unemployment among young people, women and vulnerable groups is a particular problem and is a significant source of inequity. The main problem, however, is volatility in public finances, which creates instability and has a negative impact on people's health and well-being.

Given all of these challenges, aiming to achieve inclusive growth and ensure equal health protection for all seems a bold ambition for a small country. Social and economic reform is

If technical data show that a particular health intervention results in a reduction in mortality of 0.002%, politicians will say – so what? It does not have sufficient strength to engage, or enrage, them to act.

Håkan Linnarsson
Regional Commissioner, Sweden

nevertheless underway and the country is investing in a business environment that promotes growth and development and protects citizens' welfare. Gross domestic product growth last year was high at 4.5%; consequently, employment and growth are increasing, and the conditions for increased investment in education, social and health care, and public administration are being created.

How can politicians in Sweden and elsewhere most effectively be influenced? Most politicians want to improve society, and to do that, they need finance. They need to be assured that creating health equity is a wise financial investment in a highly competitive environment for resources and require proof that an investment in health equity can pay off in the short term. They also want to know that the investment will make a difference – to do this, data need to be understandable and impressive not only to politicians, but also to the public, on whom politicians depend to remain in office.

Summing up ...

Key messages to emerge from the session on influence were:

- governments need to be open to enabling change and creating dynamic alliances to tackle the root causes of inequities and to invest in those with the least power;
- legal services should be seen as health providers, and health–justice partnerships can enable people to access the protections to which they are entitled that address the underlying causes of ill health – law can do things that public health alone cannot;
- the root causes and determinants of health inequity are outside the scope of the health sector, so the health sector has to be prepared to move beyond its comfortable inner circles;
- policy measures taken over the last half century to address economic growth, as important as they are, are equity-blind; they therefore are not going to be sufficient in the new global economic environment to genuinely address inequality, particularly in wealth;
- interagency taskforces and initiatives need to be developed to look at how people can share the ownership of their enterprises – shared ownership needs to be one of the approaches to addressing economic inequality;
- a multidisciplinary health equity alliance should be established to generate cutting-edge evidence and strengthen alliances that enable ministries of various sectors and governments to make the case for, prioritize and scale up innovations (scientific, technological, social, business or financial) to increase equity in health and ensure that the social values of solidarity, equity, well-being, inclusion and gender equality are considered and included in growth and development policies;

- it is important to “engage and enrage” not only politicians, but also the media and communities with data that are understandable and impressive; and
- approaches should be integrated and person-oriented.

Cross-party Group on Health Inequalities in United Kingdom (Scotland)

Voluntary Health Scotland provides the Secretariat for the Cross-party Group on Health Inequalities at the Scottish Parliament, bringing together elected politicians, policy-makers, researchers, voluntary groups and members of the public to share ideas and experiences and promote discussion, debate and action to reduce inequities.

The official aim of the Group is to raise awareness of the causes of health inequities among:

- parliamentarians, who can influence legislation; and
- policy-makers, to promote evidence-based actions to reduce health inequalities and avoid legislation and policies that will worsen health inequities in Scotland.

The key objectives are to:

- build stronger links and engagement between politicians, policy-makers, the public and third sectors, academia, the private sector and civil society;
- take action on the least-understood and less-well examined areas of health inequalities;
- accelerate cross-sectoral actions and collaboration;
- gather evidence, ideas and views; and
- focus on how specific issues and partners could and should contribute to addressing Scotland’s health inequities.

Issues addressed by the Group include inequities experienced by prison populations that lead to re-offending, and clustering of alcohol, fast-food and betting outlets in areas of deprivation.

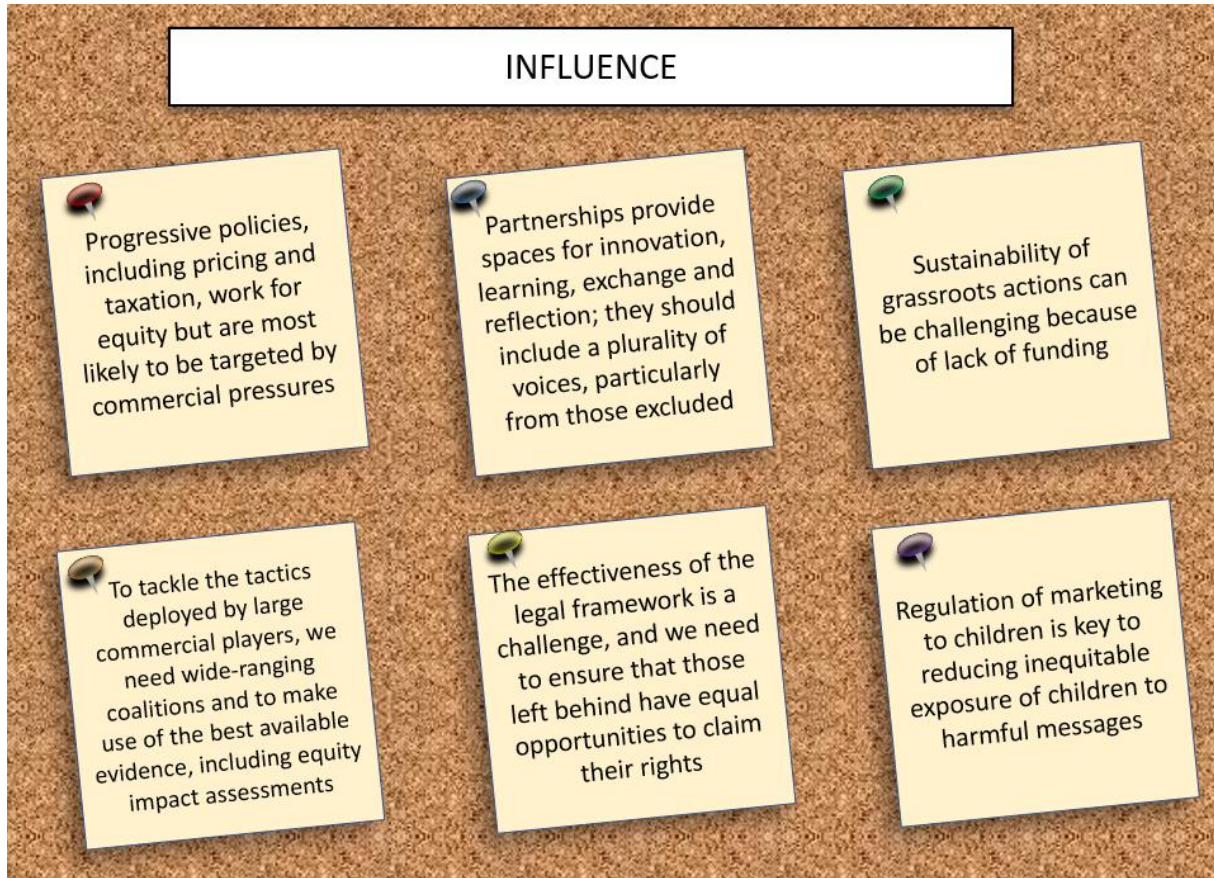
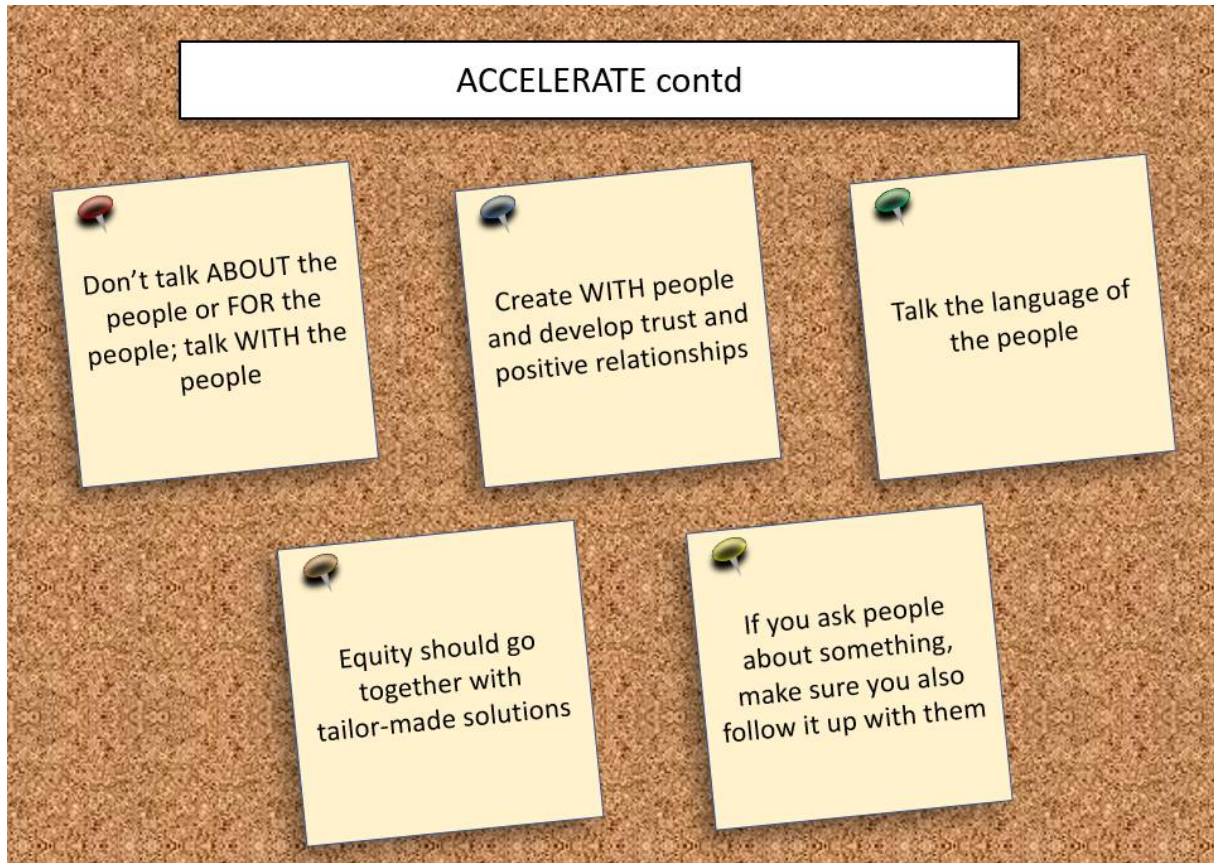
Although the Group is entirely independent of the Scottish Government, its work aligns with a number of ongoing and new policy initiatives, including measures to reform public health, reduce inequities and poverty, promote fair work, human rights and environmental protections, and foster collaboration across sectors to address Scotland’s six public health priorities (a Scotland in which people: live in vibrant, healthy and safe places and communities; flourish in their early years; have good mental well-being; reduce use of alcohol, tobacco and other drugs; have a sustainable, inclusive economy with equality of outcomes for all; and eat well, have a healthy weight and are physically active).

The Group’s multisectoral nature contributes to making health inequities relevant for all ministries and sectors, thereby helping to address factors outside of the health system that are related to the determinants of health.

Calls for action

The three main themes of the conference – ACHIEVE, ACCELERATE AND INFLUENCE – were debated in parallel sessions. The sessions allowed participants to hear presentations relevant to the themes and engage in discussions and exchanges of experience with colleagues. What follows is the key messages – the calls for action – developed by participants at the parallel sessions and collated under the theme structure.





Moving forward

The conference

The conference took a new stance on inequities, with a focus on the human side of inequities and not only the numbers, and on real-world solutions that are being implemented to improve the lives of those left behind and those at risk of falling behind.

The event provided a platform for different stakeholders and interest groups within and beyond government to debate the political, policy and institutional challenges that continue to hinder progress and to argue and provide evidence on the ways forward to create the essential conditions for all people to prosper and flourish in health and in life.

The dialogue over two days forged new alliances around the three action pillars of the conference.

Towards a health equity resolution and renewed partnerships and commitment to act for increasing health equity in Europe

The Ljubljana Statement on Health Equity was adopted by acclamation during the conference. It provides practical and political steps to move ahead to reduce health inequities within countries and will support the resolution on health equity considered at the 69th session of the WHO Regional Committee for Europe.⁴ The supporting statements by the Regions for Health Network, the Healthy Cities Network and the Small Countries Initiative, as well as the country representatives and other delegates at the conference, highlight the support and commitment across all levels of government and communities of practice to advance solutions for health equity.

There was strong support for the WHO Regional Office for Europe to:

- launch a WHO European regional health equity solutions platform as a mechanism for policy-makers to exchange best practices and share innovations and sustainable solutions that accelerate progress towards equity in health and well-being, both nationally and at subnational levels of regions and cities;
- establish for three years a multidisciplinary health equity alliance of scientific experts and institutions to facilitate the implementation of this resolution by generating cutting-edge evidence and methods that enable ministries of various sectors and governments to make the case for, prioritize and scale up innovations (scientific,

⁴The resolution was adopted by the WHO Regional Committee for Europe in September 2019: EUR/RC69/R5. Resolution on accelerating progress towards healthy, prosperous lives for all, increasing equity in health and leaving no one behind in the WHO European Region. Copenhagen: WHO Regional Office for Europe; 2019 (<http://www.euro.who.int/en/about-us/governance/regional-committee-for-europe/69th-session/documentation/resolutions/eurrc69r5-resolution-on-accelerating-progress-towards-healthy,-prosperous-lives-for-all,-increasing-equity-in-health-and-leaving-no-one-behind-in-the-who-european-region>).

- technological, social, business or financial) in order to increase equity in health; and ensure that the social values of solidarity, equity, well-being, inclusion and gender equality are considered and included in growth and development policies; and
- monitor and, without imposing any additional reporting burden on Member States, report on the implementation of this resolution to the Regional Committee in four years' time at its 73rd session in 2023.

Strengthening alignment across the WHO Regional Office technical programmes on health equity

The conference also indicated the importance of working for health equity across the various programmes of the WHO Regional Office for Europe, including noncommunicable diseases, communicable disease, health emergencies, life-course, health system strengthening, primary health care, environment and health, gender equity and human rights, and sustainable development, and further strengthening work with the Regions for Health Network, the Healthy Cities Network and the Small Countries Initiative.

Strengthening partnerships and alliances for health equity

The conference highlighted the imperative and value of ensuring that a diverse range of partners, including social economy, NGOs and citizens' networks, are engaged and have a strong voice in advocating for and implementing solutions for health equity. Many are already working towards these goals, but there was strong support for better information-sharing, joint action and inclusive decision-making in engagement and action among these important stakeholders. The need for better flow and cross-fertilization of information and tools and stronger outreach to and engagement with these partners in regional and local fora and decision-making processes was highlighted as a priority. Making connections across public and private, formal and informal stakeholders was highlighted as being key to action on the pathways from health policies towards improved living and working conditions, income security, community cohesion, trust and a sense of belonging. These are the pathways to healthy prosperous lives for all.

Another key driver of action at country level, and one which touches on many of the issues identified in the HESR, is the focus on effective country-level action on the range of SDGs, particularly SDG 10 on reduced inequalities. To support this process, the conference included delegates from the United Nations Development Programme (which is concerned with inequalities and poverty, HIV, and health and development), the United Nations Population Fund and the International Labour Organization (focusing on employment and social protection), as well as a World Bank representative (from the Human Development Programme).

Overall, there remains a need to connect with effective policy solutions and how they are implemented, evaluated and reported, so that countries can build on the strengths of

effective evidence-based actions and continue the work endorsed by the conference. Areas for action include achieving universal good-quality health services, addressing income and employment insecurity, ensuring good-quality and available housing and community amenities, creating healthy environmental conditions, embedding good neighbourhood safety, and ensuring the affordability and availability of utilities such as clean water and fuel, and the availability of green spaces and financial protection to ensure economic and social well-being for current and future generations. It also includes: reducing exposure to adverse childhood experiences, and providing safe and nurturing environments for all children; reducing population exposure to crime and violence; increasing sense of belonging and control over life; aiming for secure, decent working conditions and fairly paid employment; reducing inequities in health literacy; and reducing exposure to unhealthy commercial pressures.

It remains a truism that to understand which policies and programmes are making a difference, there needs to be a commitment to adequately resourcing the monitoring of health inequalities and evaluation of policy impacts, with clear accountability for action at all levels of governance. This will require the involvement of researchers, delegates of professional associations and representatives of civil society in monitoring and accountability processes.

It is recognized that social values need to be brought into economic, environmental and fiscal policies and decisions, and into health systems. Embedding social values such as fairness, equality, gender equality, trust, solidarity, a sense of belonging, resilience and respect for human dignity into policy-making is essential for removing the barriers to achieving sustainable development and inclusive societies, so that all people can prosper and flourish. It is also recognized that to tackle disadvantage, the most deprived neighbourhoods must be revived, reducing social exclusion and supporting society's most vulnerable groups.

The conference recognized that health equity is central to achieving sustainable development and inclusive growth. Within this, well-functioning health systems are vital for achieving fiscal sustainability and play an important role in driving sustainable development at national, subnational and local levels through socially responsible procurement, investment and employment policies. Building safe and resilient communities needs to be at the heart of strategies for accelerating progress towards health and prosperity for all, recognizing that single, isolated policy interventions will not reduce health inequities. Making progress towards healthy and prosperous lives for all requires systematic actions across government and wider society, including scaling up and adapting what works and generating new solutions and alliances that break down the barriers to progress.

Annex 1. The Ljubljana Statement on Health Equity



THE LJUBLJANA STATEMENT ON HEALTH EQUITY

13 June 2019

Accelerating progress towards healthy and prosperous lives for
all in the WHO European Region

High-level conference
11–13 June 2019, Ljubljana, Slovenia

1. We, representatives of the Member States of the WHO European Region, from the health, social and development sectors, regions and cities, United Nations agencies, international organizations and civil society organizations, have come together to affirm our commitment to reducing health inequities as a necessary contribution to inclusive development and stable and prosperous societies, in line with the Sustainable Development Goals, the Health 2020 European health policy framework, the Universal Declaration of Human Rights and the principle of universal health coverage.
2. We note that health equity is a core value and an overarching goal of all of these interconnected frameworks, thus emphasizing the right to the highest attainable state of health and the importance of universal health coverage for all. These principles are strongly supported by WHO's Thirteenth General Programme of Work, 2019–2023.
3. We note that investment analysis commissioned by WHO reveals that if the triple billion goal contained in WHO's Thirteenth General Programme of Work, 2019–2023, were to be attained, it would result in 29 million lives saved, 100 million healthy life years gained and a 2–4% increase in economic growth per year in low- and middle-income countries.^{1,2}
4. We note that the European Social Charter (adopted in 1961, revised in 1996), ratified by 43 European States, is an important human rights instrument which guarantees a broad range of fundamental social rights and the protection of the most vulnerable.
5. We note that the WHO European Region has seen success overall, with nearly 1 billion people enjoying a life expectancy that has reached 78 years. However, despite this success, health inequities exist within and between Member States.
6. We recognize that attention to health equity, gender equality and the right to health has never been more important. We note that gender inequalities intersect with other forms of discrimination, contributing to inequities in income, living conditions, social and human capital, work and employment, and that addressing these inequities is a prerequisite for achieving universal health coverage.
7. We note that many countries, regions and communities have taken action to address health inequities. However, progress has been slow for reasons such as the view that health inequities are too difficult or too complex to address, and uncertainty about which policies and investments are effective and which should be prioritized.

¹ Financial estimate for the 13th General Programme of Work (2019–2023). Geneva: World Health Organization; 2018 (https://www.who.int/docs/default-source/documents/gpw/white-paper-financial-estimate-gpw13-may2018-en.pdf?sfvrsn=9bff80e2_12).

² Draft proposed programme budget 2020–2021. Geneva: World Health Organization; 2018 (EB144/5; https://apps.who.int/gb/ebwha/pdf_files/EB144/B144_5-en.pdf).

8. We recognize that there is an essential set of conditions we need to achieve in order for all people to prosper and flourish in health and in life, and that these conditions are statistically significant in explaining the gaps in health inequities within countries.

9. We note that policy responses to economic cycles need to protect those at the bottom 20% of society during recession and accelerate improvements for all during periods of growth to prevent worsening income inequalities. Financial austerity measures introduced during economic downturns have contributed to widening income inequalities and the relative impoverishment of those already left behind.

10. We note that to be able to enable healthy choices, we need to create the social, economic and environmental conditions in which people can live and prosper. Laws, policies, regulations, services, and planning and investment decisions that respect diversity in society, empower individuals and communities, and prevent corruption are essential for achieving well-being and social cohesion.

11. We recognize that fair and sustainable health financing and high-quality universal health services need to be part of systematic, multisectoral policies and actions in order to close health gaps, and that a primary health care approach is conducive to that purpose.

12. We note that income and employment insecurity, as well as stress and anxiety associated with the inability to afford a basic standard of living, are strongly associated with inequities in mental health within European countries. Income insecurity is of major importance through the life-course, with potential detrimental impact on health and well-being.

13. We note that inequities in living conditions, such as quality and availability of housing and community amenities, environmental conditions, neighbourhood safety, affordability and availability of utilities such as clean water and fuel, and availability of green spaces, cause inequities in risk exposure, quality of life, safety, a sense of belonging and security and, ultimately, in health outcomes.

14. We note that there have been widespread social and demographic changes in the WHO European Region, including population ageing and increased economic and political migration.

15. We recognize that population ageing, together with early exit from the labour market due to poor health, represent key challenges to fiscal sustainability. It is necessary to reduce inequities in health during working years and later in life and provide new models of financial protection in order to ensure economic and social well-being for current and future generations.

16. We note that health systems across Europe are challenged by changing demands resulting from social and demographic trends, and by workforce shortages and the need for new skill mixes to address these demands. People-centred service development and innovative solutions are required to achieve better integration and faster responses. Transfer of knowledge and intercountry capacity building provide opportunities to address these challenges.

17. We note that exposure to adverse childhood experiences, such as domestic violence or other forms of maltreatment, can damage children's well-being and their health and economic outcomes through the whole life-course. Providing safe and nurturing environments for all children and supporting their families to provide them with the best start in life are critical elements in improving population health and reducing health inequities.

18. We note that exposure to crime and violence, together with a weak sense of belonging and control over life, greatly contribute to inequities in mental and physical health and well-being within the population.

19. We note that secure, decent working conditions and fairly paid employment are important factors for achieving health equity.

20. We note that reducing inequities in health literacy is an effective approach to minimizing the effects of digital marketing of health-harming products and services among the most vulnerable.

21. We note that exposure to unhealthy commercial pressures compounds material disadvantage and contributes to health inequities in noncommunicable diseases. People with limited social and economic resources more often live in neighbourhoods with a higher density of, among other things, fast food and gambling outlets, and high-cost credit providers.

22. We recognize that health equity is central to achieving sustainable development and inclusive growth. Well-functioning health systems are vital for achieving fiscal sustainability and play an important role in driving sustainable development at the national, subnational and local levels through socially responsible procurement, investment and employment policies.

23. We recognize that building safe and resilient communities needs to be at the heart of strategies for accelerating progress towards health and prosperity for all, in addition to making the economy work towards the same goal. Creating healthy and sustainable societies is essential for achieving fiscal and economic stability.

24. We recognize that measuring health equity and its underlying determinants is a key step in accelerating progress towards inclusive development and prosperity in the WHO European Region. Disaggregated data on health trends and on policy progress in equity across sectors can aid efforts to understand the factors that influence the conditions needed to live a healthy, happy, prosperous life, and can enable, motivate and empower both decision-makers and the public.

25. We recognize that single, isolated policy interventions will not reduce health inequities. Making progress towards healthy and prosperous lives for all requires systematic actions across government and wider society, including scaling up and adapting what works and generating new solutions and alliances that break down the barriers to progress.

26. We recognize that we can accelerate actions to reduce health inequities through an integrated basket of universal and targeted policies, designed to reduce the magnitude and gradient of inequities in health and well-being between people in different economic and social groups.

27. We recognize that health inequities can be reduced through transparent, whole-of-government approaches, and by incentivizing and rewarding policy coherence and shared accountability across sectors for delivering integrated solutions, based on social value and social return on investment, that can accelerate progress for health for all and the rate of improvement for those left behind.

28. We recognize that effective solutions for health equity require political commitment and new partnerships and alliances with non-State actors, including young people, in order to engage those who are being left behind. They hold essential elements of knowledge for effective solutions and for sustaining impact over time.

29. We recognize that in order to successfully reduce inequities, it is imperative to work with civil society and the regional, municipal and city levels of government, as these levels of government are closest to the people and it is there that we can work to ensure that no individual is left behind. We welcome partnerships with existing networks and platforms such as the WHO European Healthy Cities Network and the Regions for Health Network.

30. We recognize that vulnerable and marginalized groups in society have higher exposure to and are more deeply affected by emergencies arising from natural disasters, civil unrest, and political and economic crises. Concerted efforts are needed to reduce vulnerability and include these groups in better and fairer emergency prevention, preparedness, response and recovery activities.

31. We commit to building on the legacy of Health 2020, the San Marino Statement on Equity: ensuring no one is left behind, adopted at the Sixth High-level Meeting of Small Countries, held in San Marino on 31 March–2 April 2019, the Ostrava Declaration of the Sixth Ministerial Conference on Environment and Health, signed on 15 June 2017, and the Paris Declaration on Partnerships for the Health and Well-being of our Young and Future Generations, adopted at the WHO High-level Conference, Working Together for Better Health and Well-being, held in Paris, France, on 7–8 December 2016, as well as to increasing investments in multisectoral and intersectoral policies that address the underlying causes of the conditions that create health inequities. Accordingly, we will work with partners in key sectors, such as labour, education, environment, urban planning, housing and communities, among others.

32. We commit to working in partnerships based on participation and empowerment to create healthy places to live where all people feel safe and have a sense of hope and belonging in their neighbourhoods and shared spaces. We commit to engaging with the public to address health inequities in their own countries, regions or cities.

33. We commit to bringing social values into economic, environmental and fiscal policies and decisions, and into health systems. Embedding social values – such as fairness, equality, gender equality, trust, solidarity, a sense of belonging, resilience, and respect for human dignity – into policy-making is essential for removing the barriers to achieving sustainable development and inclusive societies, so that all people can prosper and flourish.

34. We commit to upholding equity principles when developing health services based on a primary health care approach and a competent health workforce and when responding to social, environmental, technological and demographic trends. We commit to enabling universal health coverage and financial protection for all.

35. We commit to tackling disadvantage by reviving the most deprived neighbourhoods, reducing social exclusion and supporting society's most vulnerable groups.

36. We reaffirm our commitments to taking gender-responsive and rights-based approaches to improving the health and well-being of all, leaving no one behind, and recall the recently adopted Strategy on Women's Health and Well-being in the WHO European Region (2016), and the Strategy on the Health and Well-being of Men in the WHO European Region (2018), which set a path for accelerating progress in these areas.

37. We commit to adequately resourcing monitoring and accountability processes, and to developing and strengthening monitoring and evaluation capacities, as they are the foundation for health systems' ability to address health inequities, both internally and across government. We commit to involving researchers, delegates of professional associations and representatives of civil society in monitoring and accountability processes.

38. We encourage WHO to launch a European Region health equity solutions platform as a mechanism for policy-makers to exchange best practices and share innovations in sustainable solutions that accelerate equity in health and well-being, nationally and at the subnational levels of regions and cities.

39. We welcome the proposal to establish a multidisciplinary health equity alliance of scientific experts and institutions, to generate cutting-edge evidence and methods that enable ministries of health and governments to make the case for, prioritize and scale up innovations (scientific, technological, social, business or financial) in order to: (i) increase equity in health; and (ii) ensure that social values of solidarity, equity, well-being, inclusion and gender equality are considered and included in growth and development policies.

40. We call for action by requesting that the Member States of the WHO European Region adopt a health equity resolution at the 69th session of the WHO Regional Committee for Europe in order to accelerate progress towards closing the health gap and achieving healthy prosperous lives for all.

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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World Health Organization Regional Office for Europe

UN City, Marmorvej 51, DK-2100 Copenhagen Ø, Denmark

Tel.: +45 45 33 70 00 Fax: +45 45 33 70 01

Email: eurocontact@who.int

Website: www.euro.who.int