



**World Health  
Organization**

REGIONAL OFFICE FOR **Europe**



**Evidence and resources to act on  
health inequities,  
social determinants  
and meet the SDGs**







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social determinants  
and meet the SDGs**

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The resources provide evidence on the key social determinants of health. They can help Ministries of Health, other government departments and partner organizations to ensure:

- Health is well integrated across the SDGs
- Health is seen as a contributing sector to the attainment of the 2030 Agenda for Sustainable Development
- SDG policies and actions do not have a negative impact on health or worsen inequalities.

The SDGs are **powerful mechanisms to improve health and to reduce health inequities**.

Specific sustainable development goals are also recognised social determinants of health. By making the links between health and these determinants across the SDGs countries can strengthen policy coordination for better health and to reduce inequities.

Primary SDGs linked to determinants of health and health equity



National and sub-national SDG processes are an important opportunity to clearly express:

- The health of the population is related to *inclusive* development and growth.
- There is a strong connection between sustainable development, health equity and well-being.

Evidence can be used to help frame national discussions about:

- Positioning health as a central theme in national SDG localization processes.
- Joint actions and intersectoral policies which evidence shows are most effective method of addressing key determinants of health.

The resources present evidence in different formats to reflect the different needs and stages of MS, some countries have integrated the SDGs into their national policies whilst others are at the beginning of the process. The resources aim to help countries operationalize the SDGs.

## Social determinants and SDG3

Achieving [SDG 3](#) will **directly and indirectly lead to achieving other SDGs** and targets.

Health and health inequities are influenced and **shaped by policies outside of what Ministries of Health** directly control. These policies have the potential to improve everyone's health and wellbeing and are a significant to reducing health gaps within the population of a country. Policies and laws that influence health and inequities include:

- **Income and social protection**, protecting when and if jobs end.
- **Employment** and working conditions.
- Good quality **early child development programs**.
- **Whole-school** approaches that prioritize emotional well-being as well as equitable educational attainment.
- **Minimum income**, especially for families to achieve food security
- **Housing interventions** to reduce crowding, improving conditions (damp, heat, tenure, use of solid fuels indoors).
- **Environment and green spaces**, providing equitable access to water and sanitation facilities as well as green spaces and active travel.
- **Human rights promotion and protection**, including **gender equality and minority** rights such as; class, ethnicity, disability, sexual orientation, and gender identity.

### Joining up policy actions

SDG3 will only be reached by **joining up policy action with other SDGs**. For example in terms of child mortality:

- SDG target 3.4 – By 2030, reduce by one third premature mortality from non-communicable diseases (NCD) through prevention and treatment and promote mental health and well-being)
  - Can be measured by SDG Indicator 22 *Probability of dying between exact ages 30 and 70 from any of cardiovascular disease, cancer, diabetes, or chronic respiratory disease*.
  - Will need to be implemented in partnership with health and sectors and policies responsible for;
    - [SDG4](#) Ensure inclusive and equitable quality education and promote lifelong learning opportunities for all
    - SDG 8 Decent Work and Economic Growth
    - Individuals and families with higher and more secure economic capital and more years in education live healthier lives, experience fewer social and economic health risks such as long term, involuntary unemployment and have lower exposures to environmental and occupational health risks, all of which increase the risk of premature mortality of NCD.
  - Different Ministries to address tobacco policies such as taxes and smuggling.
- Therefore reducing NCDs will contribute to SDG 3 and SDG8.
  - Health and nutrition affect education by enhancing children's physical ability to attend school and by increasing their cognitive ability to learn.
  - A healthier workforce is more productive and more resilient due to better mental health, and



there is less absenteeism. This highlights the relationship between health as an 'input' to promoting education and economic growth.

[SDG 3](#) will contribute to the attainment of other SDGs. Joining up action for health and sustainable development will be a critical success factor in the implementation of health and sustainable development through the SDGs because in almost all cases there is a bidirectional relationship between health and the other 16 development goals. See: [Health in all policies](#).

## Universal health coverage, the SDGs and SDH

Universal health coverage (UHC) cuts across all of the health goals. Moving towards [UHC requires strong, efficient health systems](#) that address the full range of health determinants.

The [WHO Alma-Ata declaration](#) states UHC is where all citizens enjoy:

- A strong and efficient health system that spans preventive and curative medicine,
- Affordable access to that health system
- Access to relevant medicines
- Sufficient human resources for the health system

Target 3.8 **Achieving Universal Health Coverage** will directly contribute to the attainment of

- SDG1 (Poverty reduction), leading to
  - SDG10 Reducing within and between country inequalities, leading to
    - SDG11 Ensuring inclusive, safe and resilient cities (Figure 1).

Target 3.8 is measured by the percentage of the population protected against impoverishment by out of pocket health expenditures and percentage of households protected from incurring catastrophic out-of-pocket health expenditure. Addressing these factors will also directly contribute to the attainment of SDGs for:

- Poverty reduction (SDG1)
- Reducing within and between country inequalities (SDG10)
- Ensuring inclusive, safe and resilient cities (SDG 11)

Achieving this mutual gain will require integrated social protection policies, financing instruments and deliver models across government and with public and private providers.

Across the European region countries made different choices and committed and improved to universal health care. For example, Tajikistan and Iceland made [great improvement in the health-related SDG index between 2000 and 2015](#). In Iceland tobacco control policies and the Universal Health Care led to significant improvements and a similar effect was seen in Tajikistan as a result of a series of health reforms beginning in the late 1990s, including providing universal health services.

## Health 2020 and SDGs

**The Sustainable Development Goals (SDGs) and Health 2020** provide **frameworks and motives** to develop **whole of government policies and approaches** to create healthier societies and reduce health inequalities. Both the SDGs and Health 2020 state *the entire population has the right to the highest attainable standard of health*.

In the European Region, Health 2020 is also a route towards the implementation of the 2030 Agenda for Sustainable Development. Health and equity are given central places in the 2030 Agenda as they are major contributors to, and beneficiaries of, sustainable development policies. The 2030 Agenda, adopted by the UN and Member States in 2015, includes the 17 SDG

Key concepts in the Health 2020 policy framework are to improve health for all, reduce health inequities and improve leadership and participatory governance for health. Therefore an approach that considers **health in all policies** is needed.

### Health leading and health as a partner visual

Ministries of health and health professionals will adopt different roles when developing policies to address health inequities and the SDGs.

1. **Health leading.** Policies have health as a primary goal.
2. **Health as partner.** Health is an equal partner in developing and evaluating policies and their outcomes. Partners include for example: NGOs; Academia; Private Sector; Development Agencies, Communities.
3. **Health as a participant.** Health is part of policy development committees and approaches.

### Selected links to WHO and EU Resolutions:

Poverty reduction

[Resolution: implementation of the International Health Regulations \(2005\); WHA61.2](#)

[Resolution: implementation of the International Health Regulations \(2005\) in the WHO European Region; Regional Committee 59th session, EUR/RC59/R5](#)

[Resolution: advancing food safety initiatives; WHA63.3](#)

[Resolution: infant and young child nutrition; WHA63.23](#)

[Resolution: strategy and action plan on healthy ageing in Europe, 2012–2020; Regional Committee, 62nd session, EUR/RC62/R6](#)

[Resolution: Health 2020: the European policy framework for health and well-being; Regional Committee, 62nd session, EUR/RC62/R4](#)

[Resolution: outcome of the World Conference on Social Determinants of Health; WHA65.8](#)

[Resolution: WHO European declaration and action plan on the health of children and young people with intellectual disabilities and their families; Regional Committee 61st session, EUR/RC61/R5 2012](#)

Resolution: Comprehensive implementation plan on maternal, infant and young child nutrition

Resolution Health 2020 – The European policy framework for health and well-being regional Committee, 62nd session EUR/RC62/R4

Resolution: outcome of the World Conference on Social Determinants of Health; WHA65.8

Resolution: strategy and action plan on healthy ageing in Europe, 2012–2020; Regional Committee, 62nd session, EUR/RC62/R6 2013

Resolution: review of the status of resolutions adopted by the Regional Committee at previous sessions and recommendations for sunseting and reporting requirements; Regional Committee 63rd session, EUR/RC63/R8

Resolution: indicators for Health 2020 targets; Regional Committee 63rd session, EUR/RC63/R3

Resolution: comprehensive implementation plan on maternal, infant and young child nutrition; WHA65.6

Resolution: follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the prevention and control of non-communicable diseases; WHA 66.10

Health in all policies: the Helsinki statement

Resolution: WHO European Region Food and Nutrition Action Plan 2015–2020; Regional Committee 64th session, EUR/RC64/R7

Resolution: physical activity strategy for the WHO European Region 2016–2025; Regional Committee 65th session, EUR/RC65/R3

Resolution Priorities for health systems strengthening in the WHO European Region 2015–2020: walking the talk on people centredness Regional Committee, 65th session, Vilnius 2015 EUR/RC65/R5

Decision: promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice; Regional Committee 65th session, EUR/RC65(1)

Resolution: the global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life; WHA 69.3

Resolution: United Nations Decade of Action on Nutrition (2016–2025); WHA 69.8

Resolution: ending inappropriate promotion of foods for infants and young children; WHA 69.9

Resolution: strategy and action plan for refugee and migrant health in the WHO European Region; Regional Committee 66th session, EUR/RC66/R6

Resolution: the Minsk declaration on the life-course approach in the context of health 2020; Regional Committee 66th session, EUR/RC66/R3

Resolution: towards a roadmap to implement the 2030 Agenda for Sustainable Development in the WHO European Region; Regional Committee 66th session, EUR/RC66/R4

Resolution: Health in the 2030 Agenda for Sustainable Development; WHA69.11

Resolution: the global strategy and action plan on ageing and health 2016–2020: towards a world in which everyone can live a long and healthy life; WHA 69.3

## NCDs

Resolution: comprehensive mental health action plan 2013–2020; WHA66.8

Resolution: the European mental health action plan; Regional Committee 63rd session, EUR/RC/RIO

Resolution: global strategy to reduce the harmful use of alcohol; WHA63/2010/REC/1, annex 3

Resolution: European action plan to reduce the harmful use of alcohol 2012–2020; Regional Committee 61st session; EUR/RC61/R4

Resolution: action plan for the prevention and control of noncommunicable diseases in the WHO European Region; Regional Committee 66th session, EUR/RC66/R11

## Disaggregate data

Resolution: WHO's role and responsibilities in health research; WHA 63.21

Resolution: action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region; Regional Committee 66th session, EUR/RC66/R12

## Environment

Resolution: safe and environmentally sound waste management; WHA 63.25

Resolution: drinking water, sanitation and health; WHA64.24

Resolution: the future of the European environment and health process; Regional Committee 64th session; EUR/RC64/R7

Resolution: health and the environment: addressing the health impact of air pollution; WHA68.8

## Gender

Resolution: strategy on women's health and well-being in the WHO European Region; Regional Committee 66th session, EUR/RC66/R8

Resolution: committing to implementation of the global strategy for women's, children's and adolescents' health; WHA69.2

Resolution: strengthening the role of the health system in addressing violence, in particular against women and girls, and against children; WHA 69.5

Resolution: action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in the WHO European Region – leaving no one behind; Regional Committee 66th session, EUR/RC66/R7

## Selected European Parliament Resolutions:

[European Parliament resolution of 12 May 2016 on the follow-up to and review of the 2030 Agenda \(2016/2696\(RSP\)\)](#)

European Parliament Resolution [reducing health inequalities in the EU \(2010/2089\(INI\)\)](#)

European Parliament [Council conclusions on closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours](#)

[First Meeting of the Issue-based Coalition on Health: health and well-being for all at all ages in the 2030 Sustainable Development Agenda](#)

## Whole of government & Whole of Society

Reducing health inequities and improving health for all requires cross-sectoral work and a strong local and regional engagement. Encouraging Ministries of Health to work alongside other sectors (including different Ministries, non-governmental organizations, private business and other UN agencies) is **central** to both the SDGs and Health 2020.

- The **targets** supporting each SDG **make explicit links** which expect countries to work across sectors with a whole of government, whole of society approach.
- **Health 2020** demonstrates that the **most effective policies** to improve health and reduce inequalities are those that **actively involve other sectors such as**; education, labor, employment and social welfare systems and agencies as well as parents, communities and young people. All of the 17 SDG have relevance to health, either directly, in [SDG3](#), or to the other SDGs which address the social and economic determinants of health.
  - See 8.2.2 in [Review of social determinants and the health divide](#).

Improving health equity and well-being requires coordinated and coherent action involving a range of stakeholders (public, private, NGOs) at all levels of government (international, national, regional, local). All systems and stakeholders that influence health and inequalities must aim to reduce inequalities and be accessible and responsive to all.

Policy development processes require new approaches based on the engagement of and co-creation with stakeholders across society. [Different funding mechanisms such as earmarking funding, delegating financing](#) (for example to an independent organization such as health promotion agency) and joint budgeting. Whole-of-society approaches include:

- Partnerships between public sector and civil society organizations (community groups, NGOs, unions)
- Partnerships between the public sector and social economy

LINK TO:

[‘Making the Connections: Our City, Our Society, Our Health’](#) – Wellesley Institute, Canada.



## People-centred health systems

Open and inclusive policy-making has proven to deliver improved outcomes, for example, in terms of compliance with decisions reached, greater trust in governments, as well as driving innovative solutions.

One of the four priority areas in the **Health 2020** policy framework is to **create supportive environments and resilient communities**. A participatory approach that engages people and communities in policy development and implementation processes is recognized as key and to deliver multiple benefits.

There is growing evidence that people's health and well-being is improved when they feel like they have a greater say and are able to influence decisions that affect them. **Participatory approaches** thus have a key role to play in addressing the link between exclusion, powerlessness, and health equity.

Much can be gained from engaging and involving people, including disadvantaged groups, in decision-making processes and in developing solutions that can inform policies and initiatives at local and national levels. Without understanding the needs and assets of the people most affected by inequitable conditions and processes, **interventions risk being mismatched** to the needs and realities of their lives and unable to achieve the intended benefits.

**These principles are important in improving health and achieving health equity and provide a strong basis for achieving SDG 16.**

**Co-creation (or co-production)** is an increasingly used method within participatory approaches. The term refers to **partnerships between civil society** (individuals, networks and associations) and public authorities. All partners are seen as **active assets-holders** capable of making contributions of equal value to processes, such as identifying problems and designing solutions to increase social cohesion and improve social inclusion.

Co-creation breaks the tradition of people being passive recipients of policies and services provided by public authorities. The approach extends beyond user consultation and strongly implies **a shift of power from public authorities to people and communities, a significant challenge in some countries**. In co-creation processes public officials, professionals and service providers will need to take on new roles and becoming brokers, facilitators, mediators and enablers, rather than providers.

## Leaving no one behind

Equity is central to the SDGs and Health 2020 and both are founded on the idea of 'leaving no one behind'. Leaving no one behind ensures the benefits of development are equally shared.

Central to sustainable development is 'leaving no one behind' and to 'reach the furthest behind first'. To achieve this requires a number of actions in addition to ending poverty including:

- Reducing inequalities within and between countries
- Building inclusive societies
- Empowering girls and women and equality in a healthy environment.

Decades of research shows a strong relationship between socioeconomic position and health. Those with **higher incomes live longer** and have **lower rates of most diseases** than those on lower incomes. **Sick people** are more likely to **lose their jobs**, stay out of work longer than healthy people, wealthy are more likely to have fewer health problems. A **decline in income** increases the likelihood of a **decline in health** and being in **poor health reduces education** and **employment opportunities**.

Cultural norms and practices such as the roles and rights of women and men and of girls and boys can magnify the health equity effects of the above determinants. Gendered roles and stereotypes begin in early childhood, when children are socialized.

These differences continue throughout life and **result in gender inequalities** in power and in the unequal division of paid and unpaid work. **This has an impact on the social and economic opportunities of girls and women** through-out life and an increased risk of exposure to insecure employment and income levels in working years and in pensionable age.

Improving health and ensuring **no one is left behind** in terms of health, contributes to economic growth and development and **influences macroeconomic indicators** such as GDP and unemployment rates as well as **microeconomic indicators** such as household consumption, health, education, nutrition. To leave no one behind **makes advancing equity, gender and human rights** a key cross cutting development need with systematic action in and across every sector. It means:

- Reducing inequalities in and between countries;
- Identifying and monitoring who / which groups (gender, ethnicity, geography) is falling behind;
- Focusing on interventions that will directly address those falling behind and accelerate improvements quicker.
  - For example, focusing additional in universal health coverage through additional outreach services to certain groups such as maternal groups

### Intergenerational transfer

Poor health can be transferred from one generation, affecting development. Whilst poverty is caused by macroeconomic factors, social and labor policies and individual factors such as level of education, health and social interaction in society, intergenerational disadvantages can also influence the likelihood of poverty. For example in measuring the effect of education, and examining the percentage of children who have the same level of education as the highest level of education of their parent (the 'persistence of low education');



- a person is born into a family with shorter period educated parents, the possibility to be low educated themselves is 34.2 %
- a person born into a family with longer educated parents, the possibility to be low educated is just 3.4 %

### Measuring inequalities

To reduce inequalities within and between countries and to leave no one behind, it is essential to know;

- **which inequalities exist**
- **how they are created.**

This involves understanding how health inequalities arise. Disaggregate data is needed to understand the causes and solutions of health inequalities and how to address all vulnerable groups, including; children, young people, persons with disabilities, people living with HIV, older persons, indigenous peoples, refugees, internally displaced persons and migrants.

The Sustainable Development Goals do not focus on statistical averages and national aggregates, which can conceal the rise in inequalities and structural discrimination. For example:

- Reducing under-five mortality as a national average will not address inequalities
  - MS should to target the most vulnerable and improve their health and reduce their U5MR.
    - This will improve the level of those achieving the best health outcomes and well-being.

The differences in life expectancy should not be the only focus for countries, in addition they should consider addressing the slower rate of improvement among those who already lag behind in terms of health and life expectancy and leave no one behind.

In addition, morbidity rates are generally higher in individuals with fewer years of education and lower occupational and income levels.

ADD Link to: health equity status report when it is online

Women's health and well-being in Europe: beyond the mortality advantage

## How health inequalities arise

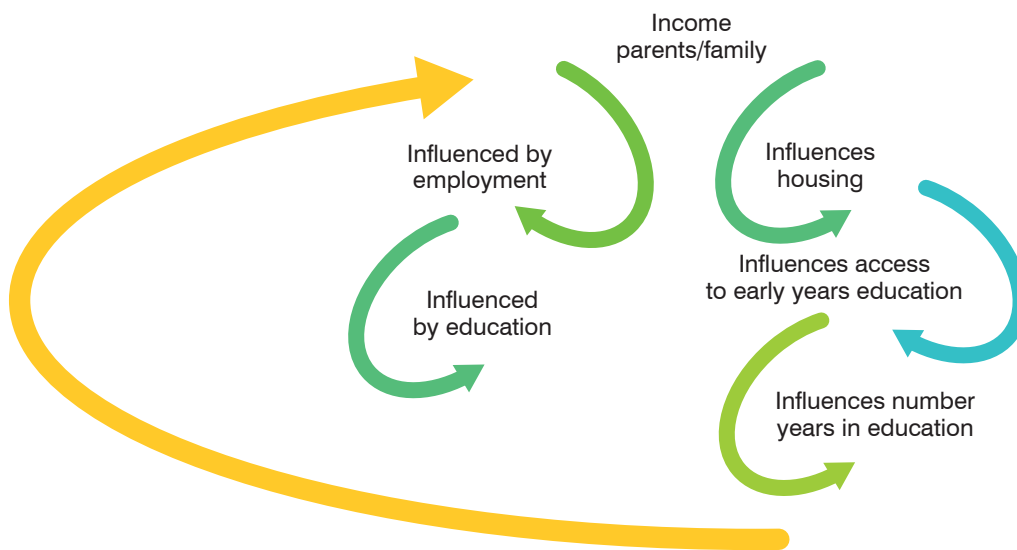
Health inequalities arise through exposure to multiple risks and exposures to adverse conditions such as:

- poor housing
- unsafe neighborhoods
- early drop out from school and training
- insecure income
- inadequate financial protection at times of need

- poor service access
- limited employment opportunities
- poor working conditions
- inadequate legal protection against discriminatory practices on the basis of gender, ethnicity and sexuality.

Exposure to multiple risk conditions increases the likelihood of poor health even in the very early years. **Repeated exposures to adverse conditions** accumulate over a life time and **explains the gaps** in health between social groups, geographic areas, and by gender.

**This figure** depicts the way income, education and employment factors interact to determine health and health inequity.

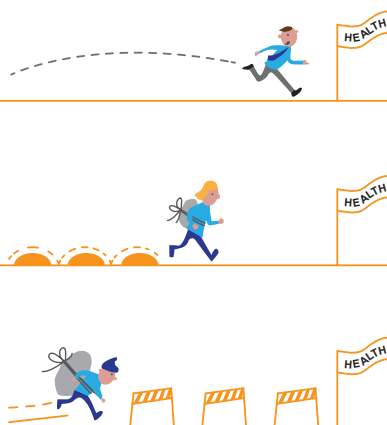


**Figure.** Cumulative effects of health inequalities

## Health disadvantages across generations

There is strong evidence in Europe that without direct and systematic interventions these inequities can be **transferred from one generation to the next**. This explains the low rate of social mobility and persistent gaps in health and human potential observed in almost all European Countries.

**The figure** illustrates how factors result in health gaps within the population with the result that many are left behind in terms of their wellbeing and opportunity to be healthy.



**Figure.** The effects of multiple risks and exposure on health and inequalities

Increasing equity in health benefits from adopting a **Life course approach** in the way government policies and services are designed, implemented and monitored. A life-course approach:

- Aims to increase the effectiveness of interventions throughout a person's life
- Focuses on a **healthy start to life**
- Targets the needs of people at **critical periods** throughout their lifetime
- Promotes timely investments with a high rate of return for public health and the economy by **addressing the causes**, not the consequences, of ill health.
- Is **whole of government** and engage citizens and society as partners for health and wellbeing.

### Early Years, Childhood and Adolescence

**Children growing up in materially deprived homes** have; poorer health, poorer educational outcomes and lower earnings throughout life.

- There is a strong association between under five mortality rate and deprivation and children who live in relative poverty report lower cognitive development scores by age 7. Investing in the health of children is justified not only because it fulfills a basic human right, but also because it is an investment with high social, emotional and economic returns.
- In the teenage years lower family affluence is associated with lower health and educational scores among teenagers who report higher feelings of isolation, lower self-esteem, and greater stress levels.
- Children living with carers who have health problems and who may be forced to take in caring roles themselves are twice as likely to leave school with lower or no grades compared with other young people.

### Working Years and Adult life

**In adult life** those who experienced longterm unemployment before the age of 33 are more likely to report risky health behaviours than those who had not experienced unemployment, including those from more advantaged backgrounds.

- Being unemployed for (3 or more years significantly predicts heavy drinking among young men and more frequent drinking at ages 27–35 years.
- Poor mental health and increased risk of CVD are more prevalent among workers with temporary, part time and non-fixed contracts and among those without an employment contract compared to workers with permanent or fixed temporary employment contracts.
- In some countries there is a gap of up to 12 years in life expectancy between those with the most and those with the least material security (income, housing, and employment) and the mortality gap for men is higher than for women.
- Every year more than 100 000 deaths occur in the WHO European Region as a result of inadequate housing conditions, many of which could be prevented.

- Young people who are exposed to adverse childhood experiences including death of a parent/principle carer/, separation from the family and siblings and those living in fear of abuse are more likely to experience mental health problems in adult life, have higher risk of employment and income insecurity and higher risk of attempted suicide.
- However throughout working life women are more at risk of lower pay (for the same work) and have higher risk of part time and insecure employment contracts with lower or no pension entitlements.
- Although women live longer than men, those with fewer years in education, those who have had unpaid caring roles in the family, those who have had part time and temporary contracts during working years are more likely to have inadequate or no pensions in later life and are at higher risk of social isolation, poverty and poor mental and physical health in later life. This shows how gender differences in health are shaped by the interaction of economic, political and cultural factors. Three SDGs specifically address gender equality: SD3, SDG 5 and SDG 10, although many other SDGs affect the determinants of health which interact with gender to produce higher morbidity experienced by women.

If a life course approach is applied to public health in Europe, the scope for improvement is vast, **for example:**

- [Life-course approach](#)
- [Chapter 4 Review of social determinants and the health divide](#)
- [Improving health equity through action across the life course: Summary of evidence and recommendations from the DRIVERS project](#)
- [Improving health equity through action across the life course](#)

## Policy pathways and stakeholders

**Pathways** explain how good health is created and how health inequalities arise and are perpetuated. They reflect the upstream 'root' **causes of poor health and inequalities**.

The pathways in the figure demonstrate how opportunities and risks accumulate throughout life, from pregnancy and early years, through to working years and later years in life. These pathways represent the conditions where people live, work and grow up and are the areas where policy action can be taken to influence health and to reduce inequalities.



The pathways through which good health and poor health arise and where policy actions can be taken to ensure no-one is left behind.

### Taking action across each pathways

Addressing health inequalities require actions in each pathway. Taking action across **each pathway** requires **interventions and policies across many sectors** of government at national, regional and local levels.

Policies in every sector of government can potentially affect health. **Many government departments and external stakeholders** (such as private industry and charities) influence these pathways.

Improving health equity and well-being requires coordinated and coherent action in and across:

- sectors (policies, investments, services, including those where policies/investments and services do not currently exist)
- stakeholders (public, private, voluntary)
- levels of government (international, national, regional, local)

LINK to: Margaret Whitehead paper when published


## Every child the best start

**Providing every child with a good start to life is a life course approach** to reduce health inequalities that influences health in the short and longer term. Developments during childhood lay the foundation for physiological and psychosocial health and well-being outcomes throughout the life-course. Being able to 'do well' during childhood involves a range of policies and stakeholders:

- Universal and appropriate health and social care before and after birth

- Employment and social protection systems that recognize the risks posed to families and children by poverty and material deprivation
- Good and equitable parental leave arrangements
- Support for parenting and families living with multiple social and economic challenges
- High-quality, affordable and accessible pre-school provision and early years education and care.

Pathway	Definition / Policies	Related SDGs
Living Conditions	<ul style="list-style-type: none"> <li>• Immediate living environment including:               <ul style="list-style-type: none"> <li>– Housing (security, safety and quality)</li> <li>– Water</li> <li>– Food security</li> <li>– Transport (access, affordability)</li> <li>– Local environment (security and quality)</li> </ul> </li> </ul>	
Education, Personal and Community Capabilities	<ul style="list-style-type: none"> <li>• Individual and community skills, assets including:               <ul style="list-style-type: none"> <li>– Social networks and capital</li> <li>– Perceived self-control</li> <li>– Family and community ties</li> <li>– Democratic voice</li> </ul> </li> <li>• Education (primary, secondary and tertiary level, costs and quality)</li> </ul>	
Employment and working conditions	<ul style="list-style-type: none"> <li>• Secure and Good Quality employment</li> <li>• Employment labor market policies (social protection including active labor market policies, parental policies, secure employment contracts, choice over working hours, adequate reward for work efforts, good management/ leadership practices)</li> <li>• Occupational health and safety – availability, coverage and costs</li> </ul>	
Income and social protection	<ul style="list-style-type: none"> <li>• Secure, Adequate income and protection from risk of poverty for all. Protection of Income affects health for individuals and families</li> <li>• Universal Social protection policies related to need</li> <li>• Living/ minimum income and wage</li> </ul>	

Pathway	Definition / Policies	Related SDGs
<p>Governance</p>	<ul style="list-style-type: none"> <li>Governance runs across all pathways, including national and transnational policies and agreements such as; EU conventions/ protocols and UN treaties.             <ol style="list-style-type: none"> <li>UN conventions and treaties relevant to addressing health inequalities include:</li> <li>Convention on the Rights of the Child,</li> <li>Education 2030 Framework for Action,</li> <li>Convention on the Elimination of All Forms of Discrimination against Women,</li> <li>Committee on the Protection of the Rights of All Migrant Workers and Members of Their Families,</li> <li>Committee on the Rights of Persons with Disabilities.</li> </ol> </li> <li>They are all reflected in SDG goals.</li> <li>MS who are signatories to the specific conventions can use them as tools to develop policies to address the causes of health inequalities, such as improving the rights of children, women and migrant workers</li> </ul>	

## Change is possible

For those with a poor start in life or on low incomes, there are actions that can be taken to intervene on inequities and to accumulate advantage.

What happens early in life continues to have effects in later life, such as life expectancy, lower income, future opportunities and risk of disease. Intersectoral action that provide every child with a good start in life forms the foundation for better physical and mental health and well-being outcomes throughout life.

The SDGs and their targets **can easily be integrated into policies and interventions** to improve health and well-being and reduce inequalities. **For example, improving the number of years in formal education:**

- Improves employment opportunities and better employment opportunities increases income.
- Those who leave school at an early age and with fewer qualifications generally have a high risk of frequent periods of unemployment, are more likely to work in sectors offering lower wages and with higher exposures to precarious employment contracts.
- Improves self-reported health in adult-life.
- This is linked to healthy behaviors such as no-smoking and reduced alcohol consumption.
- Additional years in education increase health knowledge, partly by improving health literacy.
- Individuals who are able to understand the health information they are provided will be more likely to take control of their health.

The following figure shows the effects of improving years of basic education for girls and boys – numerous SDGs are influenced by improving the number of years in education.



**Figure.** Impact of increased years of education on the SDGs

Improving the number of years in education will not, on its own, reduce all inequalities, however it is a powerful intervention that influences SDG 3 as well as bringing medium and long term benefits to wider society. Equally, giving every child a healthy start to life (such as providing services and programs which promote and protect their physical, emotional and cognitive development and wellbeing) ensures that children are better prepared for learning at school and are better able to deal with the transition to school and growing up.

Numerous WHO and UN reports as well as academic publications outline the link between the determinants of health and health outcomes. For example, the relationship between health outcomes, reducing of health inequalities and educational outcomes is available in:

- [Section 3.5 in \*Review of social determinants and the health divide\*](#)
- [Universal, quality early childhood programmes that are responsive to need promote better and more equal outcomes in childhood and later life](#)
- [Early years, family and education task group: report](#)
- [Report of Work Package 8: Access to universal services: Education](#)
- [The impact of health and health behaviours on educational outcomes in high-income countries: a review of the evidence](#)



## Health and Development

“A lot of people have been left behind, even including in developed countries where millions of old jobs have disappeared and new ones are out of reach for many.”

– António Guterres **Secretary-General, United Nations**

The aim of the SDGs is to create sustainable development that meets the needs of the present without compromising the ability of future generations to meet their own needs. High levels of **income and wealth inequality threaten economic growth** and reduce the efficiency of economic growth in contributing to poverty reduction as the benefits of economic growth flow to affluent groups, rather than the poor.

Despite significant advances in people’s health and life expectancy, relative improvements have been deeply unequal both between countries and within them. In countries **where inequalities are high, growth is slower**. Countries with higher income inequalities also have **poorer health and larger health gaps** between social group and between administrative regions. Indicators for life expectancy and health (such as infant mortality, obesity, mental illness) and social problems such as homicides and imprisonment, teenage births are worse in more unequal countries.

**Sustained growth is more difficult to achieve** in countries with inadequate health and education conditions. When illness occurs or people are injured, entire households can become locked in a downward spiral of lost income and high health care costs. Social protection, employment training and universal health coverage are an **effective package of policy measures** that mitigate negative effects and enable people cope while getting back on their feet.

## Key challenges to sustainable development in Europe

When parts of the population within a nation do not experience economic growth and associated improved health, this deepens inequality in ways that headline gross domestic product figures fail to reveal. **Redistribution through fiscal policies** and development strategies for more balanced and equal development are **effective** however they may not be always supported by the public and some stakeholder groups as they may feel they are losing out whilst a small minority prospers.

This can increase social and political tensions and instabilities.

**Reducing inequality contributes to greater political stability**, for example there is a strong association between low inequities and high trust societies, which is an important condition for economic growth and well-being.

In Europe, there is still some way to go to reach **equality in the workforce**. In particular there are **health and social consequences when women** have unequal access to economic resources such as wages, pensions and social transfers. A current and ongoing challenge in Europe is precarious work (for example, low wages, zero hour contracts and informal labor) – these all **increase the risk of social and economic inequities** and prevent achieving human capital potential.

The average labor force participation in the Region is 46% for women, compared to 70% for men. A key reason why women are unable to participate in the labor force is based on **gender inequalities in family responsibilities**, women still assume a higher share of unpaid domestic work and child care and are more likely to work in part-time or low-paid positions. Improving opportunities for women relates to equal chances or opportunities for groups of women and men to access and control social, economic and political resources, including protection under the law (such as health services, education and voting rights).

- **Women have a significant role in poverty reduction policies**, when women have equal access to education and full participation in business and economic decision-making, they are a significant driving force against poverty. Women have a key role in health improvement and poverty reduction. When development is unequal, when women are not included; economic growth and poverty reduction is jeopardized and children have worse health and education outcomes.

While women live longer than men, they do not spend longer in good health. As a result they spend more of their additional life years in ill health. In 2013, even in countries with some of the highest overall life expectancy in the European Region, women spent almost 12 years of their life in ill health.

In many European countries recent cuts to public services, including health, have deteriorated health care access, especially for vulnerable populations.

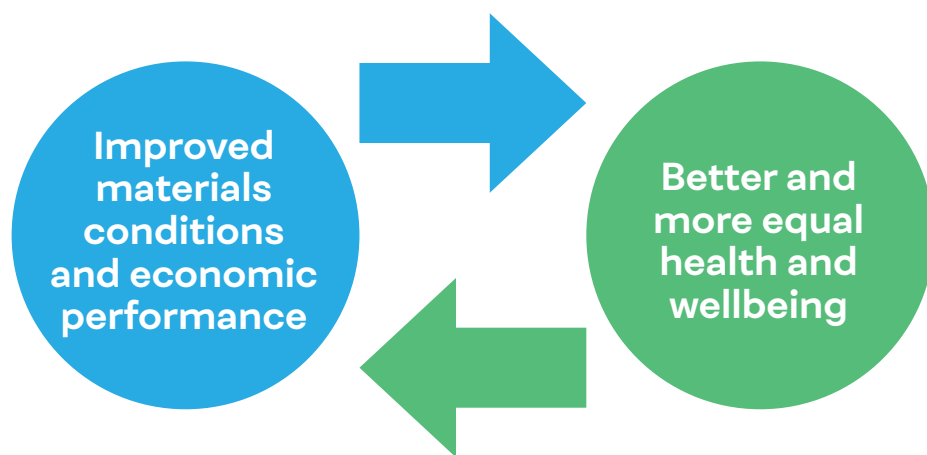
## Equitable development is more than income

Addressing inequalities involves more than addressing income, it also concerns structural barriers, reversing unequal distributions of power, resources and opportunities and challenging discriminatory laws, social norms and stereotypes.

Understanding material circumstances provides more accurate information on the mechanisms which create and maintain health inequalities. **Material circumstances** are comprised of:

1. Absolute income
2. Financial and physical assets such as housing
3. Levels of debt
4. Access to key services (such as health, education, leisure activities).

Health and poverty influence each other in a bidirectional manner, creating a cycle where poor health and poverty both perpetuate and cause each other.



**Figure .** Income / health bidirectional relationship

The effects of wealth are both:

- **indirect** – influencing social participation and people’s control over their life circumstances
- **direct** – influencing **material circumstance** that improve health.

Poverty and inequitable growth can have a detrimental effect on health and the ability to participate in social and economic life. For example, **poverty in childhood increases the risk** of:

- Reduced adult employment and working hours, poverty and welfare dependency in adulthood.
- **Poorer health** and education outcomes for children. The need for social subsistence is four times more common in children of parents with substance abuse.
- Early drop out from education programs. Children living in families or with carers who have mental health problems or who suffer for substance misuse are more than twice as likely to leave compulsory education with incomplete grades compared with other young people.
- Stress and **anxiety related mental health problems throughout life**. Protecting children and young people’s mental health and well-being is an investment that delivers significant economic returns for the individual and for society. In Sweden an economic analysis found that the **costs to society could be reduced by 3.75 billion Euros per year** if a child dealing with abuse or serious mental illness in the family does not go on to develop this her/ himself in adulthood.

#### **Poverty increases the chances of poor health:**

However a poor start in life has significant costs for health and life opportunities

- The consequences of child poverty cost the UK economy £29 billion a year in 2013. In the UK the impact of child poverty on education outcomes is clear:
  - by age five, children from the poorest fifth of homes in the UK are already on average over a year behind their expected years of development
  - by age 11, only three-quarters of the poorest children reach the government’s Key Stage 2 levels compared with 97% of children from the richest families
  - by age 16-18, only 21% of children from the poorest quintile, measured by parental socio-economic position, attain five good General Certificate of Secondary Education (grades A\*– C) compared with 75% for their rich counterparts
- Poverty forces people to live in conditions that increase their risk of ill-health – stress related to

debt, lack of control over key life choices, poor housing conditions, at greater risk of pollution from air quality, lack of clean water or adequate sanitation. It makes it more difficult for parents to enable children to enjoy adequate social, emotional and cognitive development..

- Poverty creates barriers to accessing health care.
- Those living in poverty often lack information on appropriate health-promoting practices and lack of voice needed to make services work for them.

Two factors related to poor health can lead to increases in personal debt:

- People may have to stop working or attending education due to physical/mental illness or to care for those in poor health.
- Costs of out of pocket and informal payments and transportation costs related to poor health.

**Good health reduces poverty** by increasing labor productivity, educational attainment and income. Policies and programs that seek to protect and improve the health of people can greatly help in the battle against global poverty. Good health has economic benefits that go beyond the individual. Overall improved population health can encourage greater domestic savings and foreign investment and can improve social stability.

- One extra year of life expectancy is positively correlated with steady-rate GDP per capita by about 4%.
- A 10 per cent increase in life expectancy at birth is associated with a rise in economic growth of some 0.3-0.4 percentage points a year.

## The role of health in sustainable development

The SDGs and national and sub-national localization processes are important windows of opportunity to identify:

- how the health of the population is related to inclusive development and growth;
- the connection between sustainable development and health equity and well-being.

The **cost of poor health** has a significant impact on a nation's economy. For example, being in poor health makes one less likely to move from economic inactivity to employment. Likewise persistent poor health strongly predicts drop out from the labour market and the risk of becoming unemployed. Being 'fit' to work and yet unable to find employment, particularly in the early years of working life out of employment leads to a higher likelihood of long-term effects throughout life in terms of subsequent lower pay, higher unemployment and reduced life chances.

Economic opportunity enables individuals to create their own solutions, enabling those on lower incomes to be more likely to manage their assets in ways that generate incomes and options.

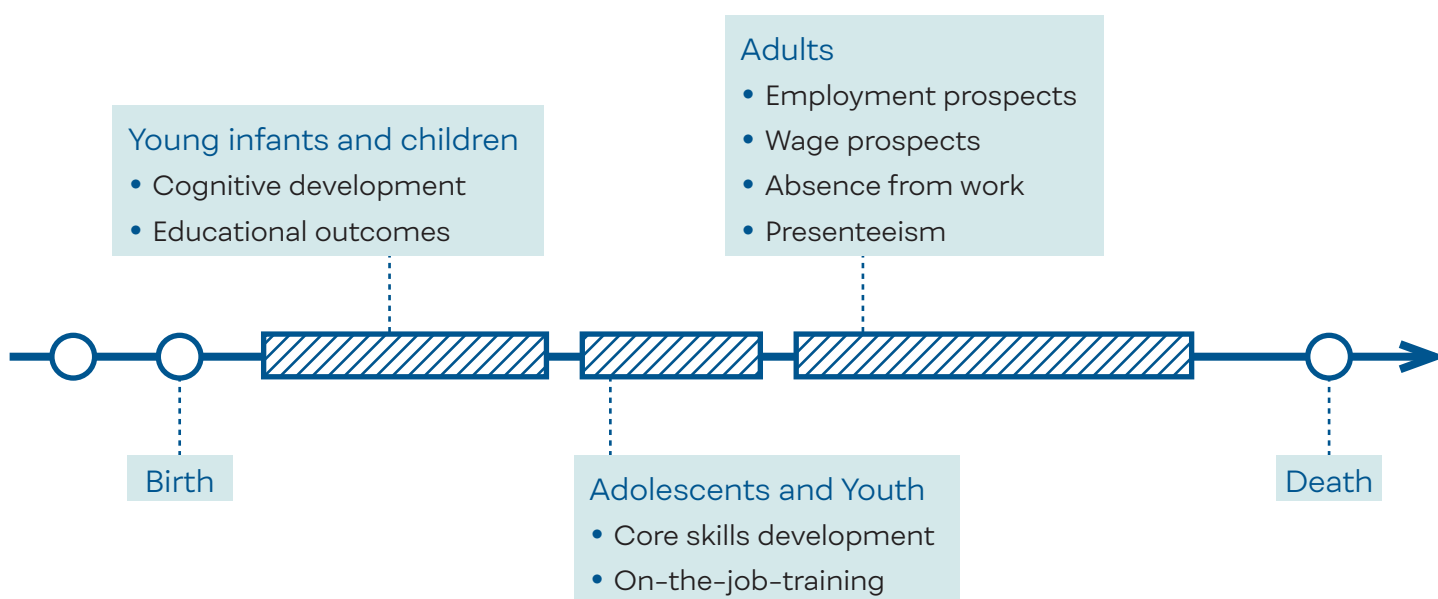
- Health is a precondition and a driving force to providing these economic opportunities.
- Providing these opportunities improves the determinants of health and wellbeing, improving housing, well-being, mental health, education.

## Investing in human capital

Investing in health is the foundation of human capital. Human capital, measured by education and health, is associated with the largest effect that economic growth has on poverty reduction. Poor health reduces security and level of earnings. When income is more equally distributed in societies physical health is better and levels of trust are higher. Individual trust is positively associated with good health (both general and mental). Social capital is an essential tool for achieving better social and economic outcomes.

Improving health and reducing social and health inequities is essential for economic and social development. For example, **investing in health and wellbeing in the early years through a combined mix of interventions including preschool education programs**, health screening, maternal and parenting support programs **improves** social, emotional and cognitive development **outcomes**. **these positive effects are carried through into adult life for example in the form of** better educational achievement, employment, income. These also have positive health effects.

- A large body of research finds **preschool programs provide a positive return on the initial investment**. In the USA, the benefits of preschool programs are estimated to pay for themselves and generate a net return on investment, for every dollar spent benefits amount to between \$7 to \$10 (due to increased parental earnings, increased earnings of child in the long term and lower rates of crime).



Economic costs of ill-health at different stages of lifecycle

## Health systems

Member states adopted the The Tallinn Charter in 2008. The Charter's key messages are that:

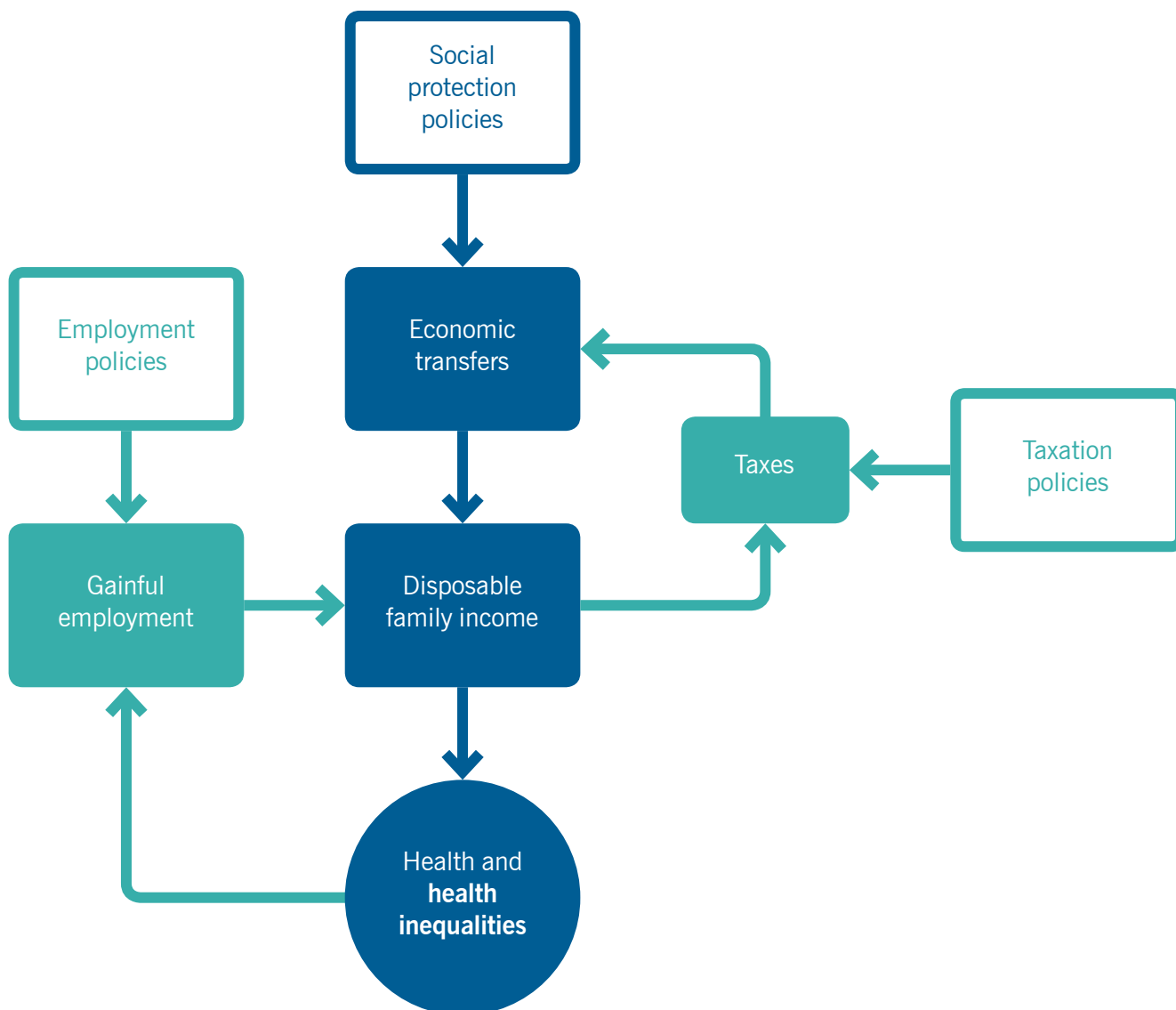
- Health systems involve more than health care, as effective health systems promote both health and wealth;
- investment in health is an investment in future human development; and
- well-functioning health systems are essential for any society to improve health and attain health equity.

Link to:

- [Addressing health inequalities by using Structural Funds](#)
- [Employment and Work Task Group Report](#)
- [Promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice](#)
- **Intersectoral action for health** – Experiences from small countries in the WHO European Region
- [Macroeconomics and Health](#)
- <http://healthclusternet.eu/>

## The role sustainable development in health

Development involves a sustainable transformation of the economy and wider society, to enrich human life and enhance well-being.



Links between key policies, income and health from [Social protection, income and health inequities. Final report of the Task Group on GDP, Taxes, Income and Welfare](#)

Health and well-being influences work performance and work also **drives health outcomes**. On its own, **economic growth and boosting consumption will not address poverty reduction**.

- [Countries with poorer health conditions have more difficulties reaching a sustained economic growth in comparison to countries with better health.](#)
- Ill health affects an individual's labor productivity and likelihood they will be in work and [good physical and mental health increases the probability of working in the first place.](#)

### Poor health hinders investment

**Poor health** in a given administrative region **hinders inward investment** and the growth of employment due to the effect that 'poor health stock' has in lowering lower labor market supply and productivity. For example, cardiovascular disease mortality shows that improving health does positively affect GDP growth and **lower income levels** are associated with greater increases in:

- [cardiovascular disease,](#)
- [mortality](#)
- [worse mental health](#) (Those with more precarious employment conditions are more vulnerable to poor mental ill health.)

'Enormous' economic benefits are associated with improving mortality in the lower socioeconomic groups. For example, when a woman's economic situation improves it has a substantial impact on the health and wellbeing of her family and community. [Women typically reinvest more of their income into their children than men do,](#) which in turn benefits entire households and communities.

### Sustainable development during difficult economic periods

Economic shocks, such as the rise in unemployment in 2008 and 2009 in Europe, have a significant effect on budgets, including health. **Economic recoveries have been slower in countries that have reduced government budgets** in education, health, employment and social protection [compared to countries which invested more into the crisis.](#) The **2008 recession** may have **disproportionally affected the poor** and vulnerable and had negative effects on:

- mental health, including a rise in depression and suicides
- [access to care](#)
- Rising food insecurity, in Europe this was closely linked to rising unemployment and falling wages. [Each 1 percentage point rise in unemployment rates was associated with an estimated 0.29 percentage point rise in food insecurity.](#)

Analysis of government spending patterns found [health spending is most likely to be followed by growth accelerations.](#) [Analysis of government spending in 25 EU countries](#) found investment in health and social protection both protected populations and encouraged short-term growth. Countries which have introduced greater increases in government spending have had [larger rises in per capita GDP.](#)

Link to: [The European Pillar of Social Rights](#)

## Work and health

Work drives health outcomes and the determinants of health in the workplace (e.g. stress reduction) also influence work performance. Decent Work involves opportunities for:

- work and a fair income
- safety and health in the workplace
- social protection for families
- social dialogue and equality of opportunity and treatment

### Temporary and precarious work.

Temporary workers report higher incidence of job strain, higher exposure to physical health risk factors at work and have less autonomy, fewer learning opportunities and less support from their colleagues.

Those with fewer years in education, out of work, in low paid work or with precarious employment contracts (informal /temporary/part time) have poorer health outcomes (severity of avoidable illness and life expectancy) and higher rates of GP consultations for stress and mental health disorders.

Precarious (insecure) employment and temporary/part-time work contracts are associated with poorer self-reported health.

### The informal economy.

The informal economy affects the rights of workers (low or no social protection, poor working conditions) and influences their health. It often leads to a lack of access to health care for both workers and their dependants.

The increase in the informal workforce in Europe compromises the aim of achieving inclusive and sustainable development and the wellbeing of workers and their families.

### Globalisation

Globalisation has mixed implications for the health of poor people. **Large multinational corporations bring economic opportunities** to national and local economies but they also directly and indirectly affect health and well-being. Assessing the direct and indirect health impact of transnational corporations involves understanding the impact on:

- **Workforce and working conditions** (for example, remuneration, occupational health availability);
- **Social conditions** (for example, impact of goods on locally produced goods and services, impact of operation on local living conditions, value of corporate social responsibility initiatives, impact of migrant labor);
- **Environment** (for example, impact on air/water quality, exposure to pollutants, land clearing, energy consumption);
- **Consumption patterns** (for example, impact of quality and consumption of transnational corporation goods on health)
- **Public expenditure** (as transnationals optimise their tax arrangements across countries, so less funds are available for UHC and other forms of social protection).



## GDP, human capital and health

**GDP is one facet** of growth and development, how income and human capital resources are distributed in society is also important. Investing in human capital through better skills and education policies increases investment. In 21 OECD countries human capital has a robust, positive and significant impact on long-run growth.

- The inability of individuals from poor socio-economic background to access higher education and developing their human capital is at the heart of the transmission mechanism through which income inequality lowers economic growth.
- The reverse is true as well: the trend towards higher educational attainment and better skills has been one of the most important elements to foster economic growth in the long run and, at the same time, to partially counteract the trend toward higher earnings inequality. Investment in human capital must start in the vital early childhood period and be sustained through compulsory education.

The IMF states investing in human capital is crucial for long term growth. They recommend investing in equitable access to health and education, specifically to:

- Increase investment in lower levels of education
- Ensure universal access to health services (reducing/ waiving user charges for poor households).

Investment in education and in health contributes to long-term economic growth by creating a healthier, better educated, and therefore more productive labor force.

## NCDs, development and SDGs

The risks and burden of noncommunicable disease (NCD) in all European countries cluster in the most poor and vulnerable in society, with poverty and social exclusion identified as being two of the biggest risk factors for poor health. NCDs threaten the health gains of emerging economies. NCDs account for the greatest avoidable disease burden and loss of life years in the European Region.

- **Cardiovascular disease is the leading cause of death** in Europe, causing more than half of all deaths in Europe. Cardiovascular disease cost EU economies €192 billion annually – costs to health care, employers, decreased productivity and employee turnover, reduced incomes to families and individuals, increased reliance on welfare support and loss of taxes.
- Alcohol related harm costs 2-3% of GDP in Europe, mostly from lost productivity and massive healthcare costs and accounts for over 7% of all ill health and early deaths. Heavy drinking affects employment, productivity and wages and it is estimated that **production lost to harmful alcohol use is estimated to be 1% of GDP** in high- and middle-income countries. Many alcohol policies pay for themselves through reduced health care expenditures, cost-effective alcohol policies should target heavy drinkers first and primary care physicians can play an important role in addressing heavy drinking.
- **Diseases linked to obesity** (e.g. diabetes, cancers, cardiovascular disease) increase health care costs and lost economic production and account for between 5% and 7% of total health care costs in Europe, more than €60 billion per year, and at least as much again in lost economic production.

- Other determinants for health are particularly worth targeting because of their high economic impact – for example road traffic injuries cost up to 2% of GDP in middle (and high) income countries, the annual costs of tobacco related disease in the European Union is approximately 100 billion, 1% of gross domestic product and mental health is estimated to be responsible for 13% of the global burden of disease.

Health is the main determinant of labor supply in older workers. Raising the retirement age to reflect life expectancy can significantly increase elderly labor force participation rates, it is possible as a significant share of the retired elderly population is in good health.

## Health sector as an employer

The health sector makes a significant financial contribution to national and regional economies. The **increasing demand for health care services** represent a potential for creating employment opportunities. Health and social care work constituted around 11% of total employment for OECD countries in 2014, having risen from approximately 9% in 2000. In Norway up to 38% of their workforce might work within the health and social care sector by 2060.

The health workforce and sector are opportunities for inclusive growth and to create decent jobs and accelerate sustainable social and economic development.

- Health employment increases the productivity of other sectors and amplifies the efficiency of non-health workers.

Investing in the health sector delivers additional effects on the wider economy:

- establishing infrastructure and facilities
- purchasing equipment, supplies (particularly pharmaceuticals) and technologies
- building skills through education and training.

These additional effects translates into more outputs and therefore more jobs.

Around one quarter of economic growth between 2000 and 2011 in low and middle income countries is estimated to result from the value of improvements to health. In the European region it is estimated that each dollar spent in the health sector results in an additional US\$ 0.77 contribution to economic growth as a result of indirect and induced benefits.

Whilst the health sector is sometimes regarded as an expense, there is emerging evidence that investment in a transformed health workforce has the potential to create the conditions for inclusive economic growth and job creation as well as for greater economic stability and security.

In England, the health and social care economy accounted for 9 per cent of wealth (in 2013), with an estimated value of £15 billion.

Improving health is an entry point for new market development and growth of SMEs. For example:

- In Slovenia, leadership from the Ministry of Health was critical to making progress in taking action to tackle health inequities. At the beginning of the Mura Programme, a comprehensive strategy and action plan for tackling health inequalities in the Pomurje region, the Ministry of Health

understood they needed to take responsibility to lead the program. The Mura Programme is a good example of where health is contributing to new market development in the agriculture, health and tourism sectors, strengthening SMEs and good governance. This project occurred in resource poor communities and regions lagging behind in terms of GDP. The approach builds upon local assets for development (people, local knowledge, physical resources such as land and buildings) to improve health and contribute to inclusive growth programs.

- SWIFT (Sustainable Work Initiative for a healthier Tomorrow) The SWIFT project aims to improve access to health and social inclusion and develop sustainable–employment plans among the Roma community in Belgrade, Serbia. SWIFT supports the Roma population in employment and income generation.
- Project to Reduce Vulnerability in Northern Montenegro (HELP), a region with high poverty rates. One of the principles of HELP’s work is to offer equal opportunities for both women and men and offered finance and support for income–generating activities and start-up businesses.

### **An inclusive employer**

The health sector is a growing employer of women, particularly in lower status and lower paid jobs, therefore it can have a key role in contributing to gender equality. Jobs in the health and social sectors tend to be inclusive of women.

- It is estimated women will take between 59% and 70% of future health and social care jobs, increasing the rate of women’s employment.
- It is important that these jobs are of good quality and secure to realize the health and economic dividends.

## Case studies

Case studies present the evidence on the social and economic factors that influence health and contribute to health inequities and the policy interventions that can be implemented to increase equity in health.

Two case studies, Under-five child well-being and mortality and Mental health, the evidence is presented in three different ways:

- Leading causes.
- Key pathways.
- Links to SDGs.

We give you the option of deciding how best to make the case in your own country.

Each case study also signposts to likely stakeholder and policy sectors to whom it is important to engage with to improve health.

## Under five child mortality and well-being

### SDG Target 3.2

By 2030, end preventable deaths of newborns and children under 5 years of age, with all countries aiming to reduce neonatal mortality to at least as low as 12 per 1,000 live births and under-5 mortality to at least as low as 25 per 1,000 live births.

### Health 2020 Target 3.1a

Reduction in the gaps in health status associated with social determinants within the European population as measured by... Infant mortality per 1000 live births, disaggregated by sex.

- **The Under Five Mortality Ratio reflects both overall population health and health inequities.** The Under Five Child Mortality Rate (U5MR) is a result of a wide variety of influences, most are **entirely preventable** and frequently treatable with cost-effective interventions.
  - Well-being and mortality in early childhood is associated with parental income, education, employment, occupation and socioeconomic factors.
- **A good start in life is critically important** for lifelong outcomes, including good physical and mental health. The poorer the circumstances in which a child is nurtured, the worse his or her outcomes are likely to be. Early childhood years are particularly important because this is when the foundations for the rest of life are laid.
  - Early physical and social environments can considerably influence future lives and outcomes

## Inequities and the U5MR

Socioeconomic inequity is associated with the U5MR.

The U5MR reflects inequalities between and within countries, driven by poverty, social exclusion, discrimination and gender norms. The U5MR is an important indicator of the **effect of inequities** that intersect across income, gender, race/ethnicity, socioeconomic background and geographic area of residence.

Numerous SDG have a substantial influence on the pathways which create the conditions that result in child mortality and a poor start in life for children.



Key SDGs, U5MR and poor child well-being

### Intersectorality and the U5MR and child well-being

U5MR policies and actions which adopt a whole of government approach will have better outcomes.

Health services and policies have a main role to ensure health in pregnancy and safe births but many policies and services outside of health influence the factors related to U5MR and child well-being.

Relevant WHO Resolutions

Resolution: advancing food safety initiatives; WHA63.3

Resolution: infant and young child nutrition; WHA63.23

Resolution: safe and environmentally sound waste management; WHA 63.25

Resolution: drinking water, sanitation and health; WHA64.24

Resolution: WHO European declaration and action plan on the health of children and young people with intellectual disabilities and their families; Regional Committee 61st session, EUR/RC61/R5 2012

Resolution: Comprehensive implementation plan on maternal, infant and young child nutrition

Resolution: comprehensive implementation plan on maternal, infant and young child nutrition; WHA65.6

Resolution: the European mental health action plan; Regional Committee 63rd session; EUR/RC/RIO

Resolution: WHO European Region Food and Nutrition Action Plan 2015–2020; Regional Committee 64th session, EUR/RC64/R7

Resolution: physical activity strategy for the WHO European Region 2016–2025; Regional Committee 65th session, EUR/RC65/R3

Resolution: health and the environment: addressing the health impact of air pollution; WHA68.8

Resolution: strategy on women's health and well-being in the WHO European Region; Regional Committee 66th session, EUR/RC66/R8

Resolution: committing to implementation of the global strategy for women's, children's and adolescents' health; WHA69.2

Resolution: United Nations Decade of Action on Nutrition (2016–2025); WHA 69.8

Resolution: ending inappropriate promotion of foods for infants and young children; WHA 69.9

Resolution: strengthening the role of the health system in addressing violence, in particular against women and girls, and against children; WHA 69.5

Resolution: action plan for sexual and reproductive health: towards achieving the 2030 Agenda for Sustainable Development in the WHO European Region – leaving no one behind; Regional Committee 66th session, EUR/RC66/R7

Decision: promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice; Regional Committee 65th session, EUR/RC65(1)

## The costs of child mortality and well-being

Indirect investments in policies to improve the lives of children under age five are necessary.

Investing in non-health accounts for half of reductions in U5MR and improving child mortality and well-being.

This includes interventions such as:

- Improving levels and access to education for children and mothers
- Reducing poverty
- Reducing fertility levels
- women's political and socioeconomic participation
- environmental/infrastructure changes (e.g. access to clean water)

**Direct investment also have an effective impact:**

Investing in health accounts for half of reductions in U5MR and improving child mortality and well-being.

Substantial research shows there are a number of **cost-effective of strategies** to improve the U5MR. A systematic review found cost-effective strategies include:

- the use of women's groups to share information
- adding services to routine antenatal care
- facility-based quality improvement to enhance compliance to care standards
- promotion of breastfeeding in maternity hospitals.

This includes interventions such as:

- skilled birth attendance (midwives)
- maternal and newborn care
- family planning
- immunizations.

**Early child education and care (ECEC)** is an investment in the long term and brings both:

- **Private returns** – benefits to the individual in the form of higher income and lower expenditure for ill-health and reduces out of pocket payments
- **Social returns** – benefits for society as a whole (e.g. larger tax base, improved social cohesion, increased educational attainment, savings, lower crime rates).

	Child self-assessed health status	Poor health outcomes		
		Child chronic conditions	Missed school due to health reasons	Child hospitalised
parent home owner at birth	0.086***	-0.110***	-0.051**	-0.081***
parent provided regular healthcare to child	0.089**	-0.241***	-0.209***	-0.120*
parent heavy drinker	-0.173***	0.204***	0.126***	0.199***

### Relationship between child's health status and parental wealth/lifestyle

**Note:** Child at age 10. \*\*\* p<0.01, \*\* p<0.05, \* p<0.1

Source: OECD (forthcoming) social mobility.

Early education programs involves upfront costs and whilst some benefits are realized immediately, (such as parents re-entering the labor market) most benefits, from reduced crime to higher earnings, accrue later in life.

Without state investment, **ECEC is often a considerable financial burden on families**. Across the OECD ECEC costs 12 per cent of an average family's income.

The cost of ECEC can be made accessible. Between 2000 and 2013 Norway massively increased the state grants for the costs of ECEC. Public grants cover the majority of costs of kindergartens (85% in 2012), and parents contribute the remaining costs.

## Disaggregate data and child mortality and well-being

### Accurate disaggregate data

Effectively addressing the child mortality and well-being requires data that will allow MS to:

- Identify populations at high risk
- analyze gaps in services.

In some countries in the European Region, data coverage is incomplete, especially for those with the highest infant mortality rates. Collecting birth data in civil registration is necessary and regarded as a basic human right. The collection of birth data requires data disaggregated by population subgroups, without it, it is difficult to assess U5MR.

- This level of data analysis will enable MS to monitor and identify where action is needed and determine the most effective policies and actions to be implemented which will benefit the people who need them the most.

Link to:






[Technical Guidance on the application of a human rights based approach to reduce and eliminate preventable under-5 child mortality and morbidity](#)

[Eurostat INVESTING IN CHILDREN](#)



[UNICEF neonatal mortality](#)

## Key SDGs and child mortality and well-being









Evidence can be presented in terms of the relationship between particular SDGs, key research findings and child mortality and well-being (and the link to other SDGs).

SDG	Evidence of relationship between Child mortality and Well-Being	Links to other SDGs
 <p><b>1 NO POVERTY</b></p>	<p><b>Lower poverty</b> is associated with lower U5MR and better child well-being.</p> <p><b>Social protection</b> including family generosity policies and receipts, influence child mortality and well-being.</p> <p>Income during early years has a substantial impact on child outcomes.</p> <p>Child nutrition is linked <u>to breastfeeding</u>, involves employment and social protection policies enabling mothers to stay <u>at home with their children in the first few months and access to safe water</u>.</p> <p><b>Clean water and sanitation facilities are important influences.</b> <u>High costs or lack of access to utilities (e.g. water)</u> can increase child mortality.</p> <p>Low levels of education are linked to risk of living in poverty.</p> <p>Child poverty rates are higher in 'low education' households and in <u>most countries a majority of poor children live in 'low education' households</u>. This is because education is a predictor of employment and income security in adult life which in turn has a key influence on parental exposure to material deprivation.</p>	 <p><b>4 QUALITY EDUCATION</b></p>  <p><b>6 CLEAN WATER AND SANITATION</b></p>  <p><b>16 PEACE, JUSTICE AND STRONG INSTITUTIONS</b></p>  <p><b>17 PARTNERSHIPS FOR THE GOALS</b></p>



SDG	Evidence of relationship between Child mortality and Well-Being	Links to other SDGs
	<p><b>Maternal education is a strong indicator of child nutritional standard.</b> Child malnutrition of children is linked to maternal educational standard. In mothers with the lowest level of education the rate of chronic malnutrition is almost double.</p> <p>In transition countries chronic malnutrition tends to be higher in rural areas, reflecting long-term differences in living standards. Any strategy to reduce the health divide needs to <u>address differences at every level of geography</u></p>	    
	<p><b>Importance of preschool education.</b></p> <p>Countries with the highest investment in early years development programs and services tend to <u>have better child outcomes overall</u>; including social cognitive and physical health and wellbeing.</p> <p><b>Pre-school reduces costs to the state in long-term.</b></p> <p>There is <u>substantial evidence of the benefits of preschool experience in many countries</u>, particularly for high-quality early childhood education and care. Quality is directly linked to better child outcomes, and <u>cost-benefit analysis has also shown positive results</u>.</p> <p><b>Education inequalities influence health throughout the life-course.</b></p> <p>Those with primary-level education <u>self-report substantially poorer health throughout life</u> compared with those than those with basic tertiary education. There is a strong <u>relationship between level of education and health</u>, these education inequalities <u>continue to influence health throughout the life-course</u>.</p> <p><b>Improve maternal education.</b></p> <p>Individuals with more years of schooling tend to have better health, well-being and health behaviours in adulthood, effects are particularly robust and large for a range of health indicators including:</p> <ul style="list-style-type: none"> <li>• adult depression</li> <li>• adult mortality</li> <li>• child mortality</li> <li>• child anthropometric measures at birth</li> <li>• self-assessed health</li> <li>• physical health</li> <li>• smoking</li> <li>• hospitalizations</li> <li>• use of social health care.</li> </ul> <p>There is a relationship between the number of years a woman is in education and the number of children they have <u>in their teenage years</u>. Reducing the number of teenage pregnancies reduces the risks of U5MR.</p>	   

SDG	Evidence of relationship with Child Mortality	Links to other SDGs
	<p><b>Equal rights for parents in employment.</b></p> <p>Child care which is not flexible to families' needs and does not allow women to return to paid employment increases the risk of poverty, <u>which increases the risk of child mortality.</u></p> <p><b>Equal rights for women in education.</b></p> <p>There is a positive association between a mother's education level and her child's survival chances.</p> <p><b>Equal rights for women in society.</b></p> <p>Maternal health is linked to the status of women and girls in society. The level of a woman's empowerment, reflecting her autonomy and decision-making power, and her ability to make healthy choices are important for optimal child <u>development.</u> <u>An analysis of demographic health surveys in Albania, Armenia and Azerbaijan</u> showed that women's decision-making power and roles appear to be stronger predictors of maternal health service utilization than their education and employment status</p> <p>There are different methods of improving women's participation in society. Providing high-quality ECEC is one method and <u>can have multiple benefits:</u></p> <ul style="list-style-type: none"> <li>• Increasing family income, thus helping lift families out of poverty.</li> <li>• Improving women's financial independence, higher lifetime income and greater scope to accumulate pension entitlements.</li> <li>• Giving women better choices to pursue a career, making it more attractive to have fewer children.</li> <li>• When ECEC alleviate parents of a part of their duties, they help women, in particular, to <u>re-enter the labor market.</u></li> </ul>	   
	<p><b>Lack of access to clean water and proper sanitation.</b> <u>Approximately 90% of the cases of diarrhoea worldwide</u> can be prevented by adequate sanitation, hygiene and water supply.</p> <p>In the WHO European region child mortality is linked to waterborne gastrointestinal diseases, the main cause of diarrhoea, <u>14 diarrhoea deaths a day in this region are estimated to be attributable to inadequate water, sanitation and hygiene.</u> In the WHO European region <u>a substantial proportion of the population lacks access to clean water and proper sanitation,</u> particularly in south-eastern Europe, the Caucasus and central Asia and for a significant number of disadvantaged minority groups in other countries in the Region.</p>	   
	<p><b>Parents and work.</b> Sharing the parenting role reduces pressures on both parents and improves mothers' capacity to work, <u>increasing family income and decreasing the risk of poverty.</u></p> <p><b>Minimum / Living wages.</b> Income during early years has a substantial impact on child outcomes. In-work poverty affects nearly 1/10 in Europe.</p>	  










SDG	Evidence of relationship with Child Mortality	Links to other SDGs
	<p><b>Migrants.</b> <u>Migrant status affects a wide range of reproductive health outcomes.</u> Immigrant women have increased risks (compared to native population) related to child mortality:</p> <ul style="list-style-type: none"> <li>• 50% higher risk of perinatal mortality</li> <li>• 43% higher risk low birth rate</li> <li>• 24% higher risk of preterm delivery</li> </ul> <p>Migrant children are <u>prone to respiratory infections and gastrointestinal illnesses</u> because of poor living conditions, poor hygiene and deprivation during migration.</p> <p>Strong integration policies <u>significantly reduce these risks.</u></p>	  
	<p><b>Housing conditions and tenure.</b> In most transition economies <u>child poverty is predominantly a rural problem and the majority of poor children live in thinly populated areas.</u> In some of these countries <u>inadequate water supply continues to be an issue, particularly for rural populations.</u> <u>Low income households,</u> particularly single-parent households, are more likely to lack flush toilets, live in cold, damp housing, live in crowded housing, be unable to keep a home warm in the winter and cool in the summer. In some MS, less than 40% of the rural population have access to piped water in their homes.</p>	  

## Leading causes







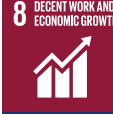


Evidence to address the U5MR and improve child well-being can be presented by framing in terms of the leading causes.

**Pneumonia** and **diarrhoea** are two of the leading causes of child mortality. The causes of these medical conditions are rooted in the social and economic factor of the family, local community and services.

- Interventions and policies that **only involve primary health-care** services for mothers and children (including pre and ante-natal care) will **only partially address** the risk factors.
- Addressing all of the risk factors of U5MR **will involve intersectoral work,** with social care, education, human rights departments and improving infrastructure such as housing and sanitation facilities.

Cause of child mortality	Risk factors	Policy intervention areas	Relevant SDG
Pneumonia (& other acute respiratory infections)	Low birth weight	<ul style="list-style-type: none"> <li>• Maternal nutrition</li> <li>• Child nutrition</li> <li>• Breastfeeding education and training</li> <li>• Universal vaccination</li> <li>• Equitable early childhood education provision</li> <li>• Maternal Education</li> <li>• Crowded homes, indoor air pollution (including tobacco smoke, solid fuel heating/cooking), hot and cold homes</li> <li>• Water quality and sanitation facilities, equitable access</li> <li>• Gender equity</li> </ul>	        
	Malnutrition		
	No or delayed vaccination		
	Non-breastfed children		
	Overcrowded conditions		
Childhood diarrhoea	Non-breastfed children	<ul style="list-style-type: none"> <li>• Maternal nutrition</li> <li>• Child nutrition</li> <li>• Breastfeeding education and training</li> <li>• Universal vaccination</li> <li>• Equitable early childhood education provision</li> <li>• Maternal Education</li> <li>• Crowded homes, indoor air pollution (including tobacco smoke, solid fuel heating/cooking), hot and cold homes</li> <li>• Water quality and sanitation facilities, equitable access</li> <li>• Gender equity</li> </ul>	
	Unsafe drinking water and food		
	No or delayed vaccination		
	Poor hygiene practices		
	Malnutrition		

Reducing child mortality and giving every child a good start in life requires provision of a **comprehensive range of policies:**

Cause of child mortality	Risk factors	Policy intervention areas	Relevant SDG
Poverty	Low income	<ul style="list-style-type: none"> <li>• Fair employment policies</li> <li>• Adequate social protection for families.</li> <li>• Parenting and family support</li> <li>• Good healthcare during pre and post-natal period</li> <li>• Child nutrition</li> <li>• Universal vaccination</li> <li>• High quality and equitable early childhood education provision</li> <li>• Maternal Education</li> <li>• Crowded homes, indoor air pollution, hot and cold homes</li> <li>• Water quality and sanitation facilities, equitable access</li> <li>• Gender equity</li> </ul>	        
	Inequitable employment policies		
	Low birth weight		
	Malnutrition		
	Overcrowded conditions		
	Unsafe drinking water and food		

## Key pathways

Evidence to address the U5MR and child well-being can be presented by framing in terms of the key pathways.

**Pathways** explain how the U5MR and child well-being is created, how health inequalities arise and are perpetuated. These pathways provide evidence of the upstream 'root' causes.

### Living Conditions

- **A good start.** Health outcomes in the first stages of life and early years are strongly associated with living conditions. Quality of care during pregnancy will improve the chances of a healthy birth.
  - In 2011, children (aged 0-17) in the EU-27 also had the highest rate (10.0 %) of severe material deprivation, higher than adults (8.9 %) and the elderly (7.2 %).
- **Intersectoral policies are key.** Policies and actions to improve child well-being and U5MR and to give every child the best start in life should be multi-dimensional and integrated aiming to reduce child poverty and improve living conditions.
- **Children who experience a positive start are** likely to do well at school, attain better paid employment and enjoy better physical and mental health in adulthood. There is a strong association between child well-being and U5MR and deprivation. The higher the average level of household deprivation in a country, the greater the chance of a child dying before the age of five years.
- **Nutrition is important.** In a number of transition countries more than 1 in 10 (in some countries 1 in 4) children do not eat fresh fruit and vegetables once a day as families cannot afford to purchase them.

### Education, Personal and Community Capabilities

- **Family and community contexts** influence the development of education/personal and community capabilities; some families are more nurturing than others, some communities safer than others, and some political systems more supportive than others.
- **Stakeholders are found across governments.** Services that support this stage of life, including health, education and social welfare, are intergenerational and multi-professional in nature and are aimed at parents as well as children.
  - Informal culturally sensitive advice and support alongside more formal, highly structured programmes will enable the targeting of more intensive support to the families who are finding raising a child difficult, while helping to reduce the possible stigma associated with the acceptance of support in parenting.
- **Early childhood services are made up of two main categories:**

- Parenting and family support. Focusing on parenting is important, it is also necessary to address the pathways which make positive parenting difficult. Family support is essential.
- Early childhood education and care (ECEC). The impact of ECEC for children from poor families is twice as high as for those from more advantaged backgrounds.
- **Peri and post natal care is important.** Women of reproductive age should have equitable access to quality support before, during and after pregnancy to ensure their own health, improve outcomes for babies and mitigate against the intergenerational transfer of disadvantage.
  - Lack of access to contraception and gender-based violence had direct effect on maternal physical and mental health, which results in the transfer of disadvantage to the child.
- **Maternal health affects mortality.** Maternal health is central to determining the health and well-being of children and adolescents from preconception on.
  - Parental mental illness (including substance abuse), particularly in the mother, is associated with poor birth outcomes, heightened risk of sudden infant death and increased mortality in offspring.
  - Children of parents who have depression or anxiety are more likely to have these mental health problems.
- **Long-term health trajectories**, such as the risk of obesity, CVD, mental illness, are set very early.

#### Employment and working conditions

- **Parents and work.** Sharing the parenting role reduces pressures on both parents and improves mothers' capacity to work, increasing family income and decreasing the risk of poverty.
  - Family income is a critical component in stress. An integrated approach considers parental leave arrangements, the availability of child care at particular ages and stages, the systems of social benefit supports (including cash transfers and other policy areas that support parental employment and progression in work).
- **Equal rights in employment.** Child care which is not flexible to families' needs and does not allow women to return to paid employment increases the risk of poverty, which increases the risk of U5MR and poor child well-being.

#### Income and social protection

- **Deprivation, debt.** Relative poverty in childhood strongly influences health and other outcomes throughout life. **Lower poverty is associated with lower child mortality.** An increase in child poverty of one percentage point corresponds to approximately a 2.2% increase in child mortality among girls and a 2.4% increase among boys.
  - Under-five mortality rates and poor child well-being are correlated with deprivation. Poverty and particularly debt are linked to higher rates of maternal mental ill health and impact on the

quality of parenting which is an important factor in early year's development.

- **Being in work does not always provide security.** Reducing poverty and social exclusion needs to go hand in hand with addressing the problems of the working poor. 9% of the EU population in work lives below the poverty threshold and 17% of the EU-28 population are still at risk of poverty after social transfers.
- Policies that reduce risks of poverty and increase family incomes will contribute to better health and well-being and reduced U5MR. This includes policies and services which promote a greater parenting role for men, strengthen family-friendly employment policies by introducing more flexible working hours (without turning to insecure contracts) and supporting child care for all parents to help them combine work with parental responsibilities.

## Governance

- Rights for women and girls to education, income, employment
- Equal rights for ethnic groups and migrants
- Equal rights in employment and education
- Equal rights in society

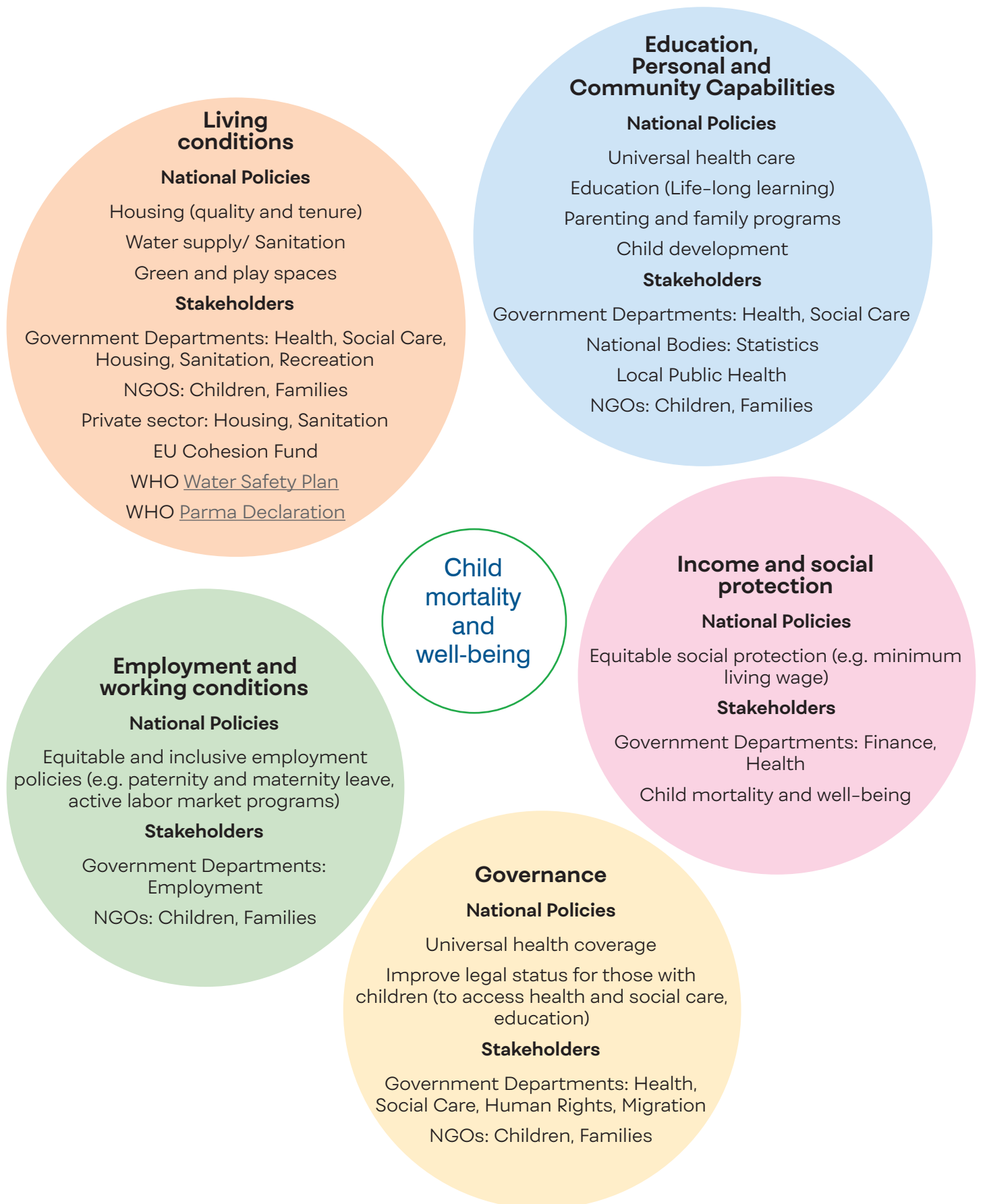
Links to:

- The UN Social Protection Floor Initiative
- Towards a roadmap to implement the 2030 Agenda for Sustainable Development in the WHO European Region

## Stakeholders, policies and interventions

Evidence to improve the U5MR and child well-being can be presented by framing in terms of the actions different sectors and stakeholders can take.

Most MS will have existing policies and plans to address the SDGs. When entering into localization discussions, WHO Country Teams should be aware of existing policies, level of new funding, if any, available to deliver the SDGs related to reduce U5MR.





## European and national policies and plans

**European funding programs** such as the [European Regional Development Fund](#) and [European Social Fund](#) can be used to implement early child health and development interventions in areas of social deprivation. [Twenty per cent of the overall ESF envelope has to be allocated by member states to social inclusion](#), which could include funding for child poverty and early childhood education and care interventions.

**WHO declarations**, such as the [Parma Declaration](#) which states; MS should 'provide all children with access to safe water and sanitation in homes, child care centers, kindergartens, schools, health care institutions and public recreational water settings by 2020'.

**Poverty reduction strategies** should be result-oriented, partnership-oriented, and based on a long-term perspective. In terms of child mortality, the SDGs and Health 2020 provide the result for countries to aim towards. Addressing the SDH involves working across the whole of government, including health, education, social protection and social care.

**National Investment plans** ensuring equitable access to quality preschool education, universal health care. Ensuring labor market and social protection support all families and provide minimum income.

**Local development plans** ensuring equitable access to quality preschool education, health care.

## Example interventions and policies

Many interventions in early childhood aim to reduce the risk of the transmission of inequality between generations.

- [A systematic review to identify interventions that improve health during early childhood](#) found the effective programs offered intensive support, information and home visits using a psychoeducational approach which aimed to develop children's and parents' skills.
- Another review of ECEC services found integration through co-location (i.e. health and social sharing the same offices), sharing of data about families, joint budget arrangements or locality team arrangements [help to make services more accessible to the widest range of families](#).
- [The Family Network, Austria](#): a targeted referral service aimed at families in need, with children aged 0-2.
- [The Theotokos Centre, Romania](#): a service aimed at providing unemployed and Roma single mothers and their children with childcare support and programmed activities such as parenting advice in Romania.
- [Baby and toddler health centers, the Netherlands](#): These have three main tasks: vaccination, screening of health and physical development problems, and educating young parents on nutrition, hygiene and family health care. They are free and neighbourhood-located. Initiatives launched to set up a system of family support culminated in the creation of centers for youth and family, which include the baby and toddler health centers.
- [Association Aprender em Parceria \(A PAR\) \[Learning in Partnership Association\] programme, Portugal](#): A PAR is an early childhood primary intervention that aims to support and help parents of young children living in disadvantaged communities by combining individual and community-level approaches. It seeks to promote: bonding between parents and children; development

of self-esteem; dispositions towards learning, curiosity and confidence; children's educational achievement; school attendance; and social support among families within their community. Evaluation has shown evidence of positive effects.

- Effective Early Childhood Education, Norway: Preschool education for 3–6-year-olds was expanded in the 1970s, with children attending preschool having higher education levels and better job outcomes later in life.
- Getting a good start in life: Turkey The Municipality of Tepebaşı uses community houses and cultural facilities, which are usually located in the suburbs of the city, to reach children and adolescents with projects and services. Expert teachers in the fields of education, pedagogy, sociology, psychology, art and sports are assigned in these social centres to provide services free of charge for children 3–18 years old. The project provides support to mothers before giving birth to eliminate the inequality in starting a good life. It then has been continuing to support with diapers and milk for babies 6 months to 2 years old and preschool education for children 3–4 years old.

## Mental Health

### Health 2020 Priority area 1.

Investing in health through a life-course approach and empowering people. Strengthening mental health promotion programmes is highly relevant.

### SDG 3.4

3.4 By 2030, reduce by one third premature mortality from non-communicable diseases through prevention and treatment and promote mental health and well-being.

Mental health is one of the greatest public health challenges in the WHO European Region.

Poor mental health contributes to poorer outcomes in most areas of life which can reinforce inequalities as those in the most disadvantaged groups are most likely to experience mental illness and poorer mental wellbeing.

- In all countries, most mental health problems are more prevalent among those who are most deprived. **Depression and anxiety**, which this resource considers, **are more common in the most poor and vulnerable in society**.
- Socioeconomic status (SES) impacts on children life satisfaction. Four surveys of over 700,000 children across 14 years consistently finds children with the lowest

### WHO European Mental Health

#### Action Plan: Core objectives

1. Everyone has an equal opportunity to realize mental well-being throughout their lifespan, particularly those who are most vulnerable or at risk.
2. People with mental health problems are citizens whose human rights are fully valued, protected and promoted.
3. Mental health services are accessible and affordable, available in the community according to need.
4. People are entitled to respectful, safe and effective treatment.

SES are more likely to be at the bottom of the life satisfaction scale.

Links to:

WHO Europe [Mental Health](#)

WHO Europe [Social determinants of mental health](#)

[Global burden of disease attributable to mental and substance use disorders](#)

OECD **[Making Mental Health Count](#)**: The Social and Economic Costs of Neglecting Mental Health Care

World Bank [Mental health](#)

Relevant WHO resolutions:

[Resolution: follow-up to the Political Declaration of the High-level Meeting of the General Assembly on the prevention and control of non-communicable diseases; WHA 66.10](#)

[Resolution: global strategy to reduce the harmful use of alcohol; WHA63/2010/REC/1, annex 3](#)

[Resolution: comprehensive mental health action plan 2013–2020; WHA66.8](#)

[Resolution: the European mental health action plan; Regional Committee 63rd session, EUR/RC/RIO](#)

[Decision: promoting intersectoral action for health and well-being in the WHO European Region: health is a political choice; Regional Committee 65th session, EUR/RC65\(1\)](#)

[Resolution: European action plan to reduce the harmful use of alcohol 2012–2020; Regional Committee 61st session; EUR/RC61/R4](#)

[Resolution: action plan for the prevention and control of noncommunicable diseases in the WHO European Region; Regional Committee 66th session, EUR/RC66/R11](#)

[Resolution: strategy and action plan for refugee and migrant health in the WHO European Region; Regional Committee 66th session, EUR/RC66/R6](#)

[Resolution: the Minsk declaration on the life-course approach in the context of health 2020; Regional Committee 66th session, EUR/RC66/R3](#)

## **The cost of mental health**

[The direct and indirect costs of mental ill-health is estimated to be approximately 3.5 per cent of GDP.](#)

Mental health and cardiovascular disease are [the dominant contributors to the global economic burden of non-communicable diseases \(NCDs\)](#). Across Europe, mental health is a major burden on health and well-being.

- One in four people in the European Region **directly experience mental health problems** during their lives.
  - For every person directly experiencing mental health, numerous family members, friends and work colleagues experience the **indirect effects of mental health**, adding to the burden of disease.

Depression has become one of the leading causes of years lived with disability (YLD) in almost every country in Europe.

Mental health problems such as depression and anxiety place a substantial burden on individuals, families, communities, and society. The total cost of depression and anxiety disorders includes costs to communities, families, individuals, employers and governments. It is substantial and includes costs beyond the health sector, estimates suggest close to two-thirds, of the costs of mental health are indirect. These indirect and direct costs result in millions of Euros of lost resources (from the value of lost production due to unemployment, absences from work and premature mortality).

Direct costs of depression in the EU27 by sector (in €2011) for one year

Sector	Costs
Employers (absenteeism)	€272bn
Economy (reduced productivity)	€242bn
Health system	€63bn
Social welfare system	€39bn
Total	€617bn

### Interventions are cost effective and a human right

- Every \$1 spent on treatment for depression and anxiety can lead to a \$4 return in better health.
- The World Bank supports a strong argument that adequate mental health treatment should be considered a fundamental human right and a moral imperative.
- Mental Health policies and actions which adopt a **whole of government** approach will have better outcomes.
- Prevention works. Research repeatedly shows interventions can reduce incidence of new depressive episodes by between 25-50 %

### The increasing costs to employers

The **cost of poor mental health to employers is estimated to be €272 billion.** These costs relate to the impact of depression on absenteeism and presenteeism. Employees' mental health status affects employees' performance and rates of illness, absenteeism and staff turnover. Sickness absenteeism can lead to substantial productivity losses. Early retirement and exclusion from the labor force due to work-related stress and mental health problems account for an enormous share of long-term social welfare benefits.

- Evidence-based workplace interventions to promote mental health could help save up to €135 billion a year by reducing absenteeism and early retirement.
- Interventions that promote health within the workplace can increase productivity and economic

returns. As a result, some countries have agreed cross-sector funding to public health approaches in order to reflect these wider benefits.

- Integrated comprehensive approaches are increasingly shown to be more effective and cost-effective than single interventions. Such approaches are targeted, take full account of psycho-social and cultural factors, and build on assets, as well tackling deficits.

### The increasing costs to health systems

- Additional impacts and costs of mental health are the associated higher rates of morbidity and mortality. A person with mental health problems is at higher risk of obesity, heart disease and stroke, cancers, respiratory disorders, infectious diseases and diabetes. The reverse is also true – among those with chronic somatic diagnoses, depression and anxiety are 2 to 3 times higher.
- People with long-term conditions are two to three times more likely to experience mental health problems than the general population.
- **Investing in mental health services during difficult economic periods.** Budget reduction measures such as cutting mental health services have a detrimental effect on capacity to treat problems such as depression and anxiety.
- Countries with strong social safety nets have supported the mental health of their population during times of economic crisis.
- Long-term conditions and mental health: The cost of co-morbidities

### The increasing burden on society – individuals, families and communities

Community services rely on the commitment of families who often make great sacrifices to look after their loved ones with mental health problems. The coping capacity and skill of families requires regular assessment and families benefit from support, education and the provision of resources.

- Strong families and communities can also act as buffers and sources of support to ameliorate the impact of mental health problems.

### The increasing costs to social welfare systems

The costs of mental health problems to social welfare systems in the EU27 are **estimated to be €39 billion**. This relates to disability benefits that are claimed by people who are unable to work due their mental health condition.

In addition, a high percentage of people who receive social welfare benefits or pensions because of disability have mental health problems as their primary condition. Data from countries where information is available find mental health problems account significant amounts of social welfare benefits/disability pensions:

- 44% in Denmark
- 43% in Finland and Scotland
- 37% in Romania.

### The treatment gap

Common conditions like depression and anxiety are often **highly treatable** but many people with a mental health problem **do not receive treatment**.

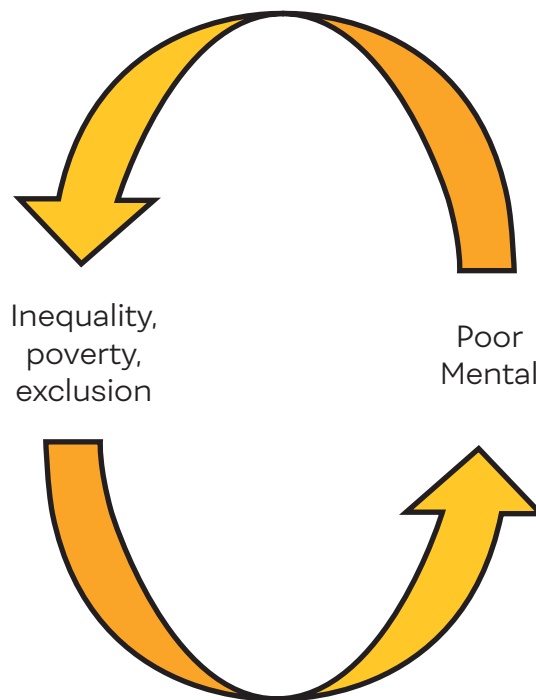
- In the WHO European Region the treatment gap for major depression is estimated to be 45% for depression and 62% for anxiety; almost **half of people with depression and two-thirds with anxiety receive no treatment or support**.
- One of the main reasons for the treatment gap is the lack of a skilled workforce. In high income countries the number of mental health workers is often inadequate, in low/ middle income countries there is an estimated shortage of 1.18 million workers.

Links:

- [Mental Health Promotion and Prevention: The Economic Case](#)
- [The burden of mental disorders in the European Union](#)

## SDGs and mental health: The causes of causes

Health 2020 states poor mental health can be both a **consequence** and **cause** of inequity, poverty and exclusion, see Figure 1.



**Figure.** Consequence and cause of poor mental health

Numerous SDGs have a significant influence on mental health and the pathways which create the conditions that result in poor mental health, see Figure 2.



**Figure 2.** Key SDGs and Mental Health

**For example, poverty in childhood** strongly influences mental health and other outcomes throughout life.

- Poverty, and particularly debt, are linked to higher rates of **maternal mental ill health**.
  - This impacts on the quality of parenting, an important factor in early year's development.
- Children living in poverty have poorer mental and physical health and **perform less well at school**. Higher levels of education are associated positively with improved health seeking behaviours and health literacy.
  - This has a negative impact on their future in the labor-market and on earning/ income levels and their future health chances.
  - Fewer years in education are associated with lower levels of self-reported health in adult life.
- Those who leave school at an early age and with fewer qualifications generally have a high risk of frequent periods of **unemployment**, are more likely to work in sectors **offering lower wages** and with higher exposures to **precarious employment** contracts.
- Interventions that promote mental health in childhood contribute to better educational outcomes and employment opportunities.
- Youth **not** engaged in employment, education or training (NEET) face many health, economic and psychosocial challenges. These youth have higher rates of poor mental health and addictions problems, including depression and substance use.
- Unemployment, lower wages and precarious employment are risk factors for increased mental health problems including stress and depression, high blood pressure and heavy drinking in adult life.
  - Long-term unemployment (without work but seeking employment for 2 years or more) is a predictor of alcohol consumption, increased stress, fatal and non-fatal CVD, and mental health disorders.
  - Poor working conditions (e.g. in-work poverty (low wages), repetitive task jobs (low control and rewards) are associated with higher rates of stress and more frequent consultations with medical practitioners for mental health disorders.

### **Mental health and material circumstances.**

There is a strong relationship between mental health and the material circumstances of people's lives. People who have the lowest incomes are more likely to live in the crowded or damp houses, have poor access or unable to afford public transport, go to poor quality schools and have poor or no access to greenspaces. Poverty, unemployment, substandard housing, poor school education, poor access to green spaces, poor transport links and poor working conditions combine to have a significant impact on mental health problems such as depression and anxiety.

Material circumstances involves both income and wealth, it is comprised of;





- Absolute income
- Financial and physical assets such as housing
- Levels of debt
- Access to key services (such as health, education, leisure activities).

The material circumstances of people's lives can have a negative impact on well-being, as well as significantly increasing the risk of mental health problems. Those who face difficult economic, social, and environmental conditions throughout life often have fewer skills to handle the accumulative stress of these conditions



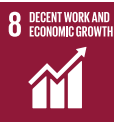



Understanding material circumstances provides more accurate information on the mechanisms which create and maintain health inequalities.













## KEY SDGs and mental health




Evidence can be presented in terms of the evidence of the relationship between particular SDGs and mental health (and the link to other SDGs).

SDG	Evidence of relationship with Mental Health	Links to other SDGs
	<p>A two-way relationship exists between mental health problems and socioeconomic status.</p> <ul style="list-style-type: none"> <li>• Mental health problems lead to reduced income and employment.</li> <li>• Reduced income and unemployment entrenches poverty and increases the risk of mental health problems.</li> </ul> <p>Relative deprivation and social injustice damage <u>the emotional, spiritual and intellectual resources essential to psychological wellbeing</u>. The social gradient in health means at each level of income or wealth, better-off people have better mental and physical health than those who are less well-off.</p> <p><u>In Europe, out-of-pocket payments are a reality for many people, including in high income countries</u>. These informal payments can <u>cause financial hardship and push households into poverty</u> which in turn can worsen mental health in adults and children.</p> <p>A country's <u>social protection system can have a substantial impact on poverty and as a consequence, on mental and physical health</u>. There is a strong association between <u>social protection expenditure per capita and the proportion of the population reporting bad mental and physical health</u>.</p>	  



SDG	Evidence of relationship with Mental Health	Links to other SDGs
	<p><b>Spending on mental health should reflect genuine need.</b> The highest funded mental health systems in Europe, such as in Germany and England, allocate approximately <u>10% of their health system budgets to mental health</u> but in other EU countries spending is below 5% of health systems budgets.</p> <p><b>Scaling up mental healthcare workforce needed.</b> The number of health professionals working in mental health, such as psychiatrists and nurses, varies widely and <b>affects access to services</b>. In Europe, the rate of nurses working in mental health care <u>varies from 163 to 3 per 100 000 population</u>.</p> <p><b>Deinstitutionalization and the development of community-based mental health services.</b> Care and treatment should be <u>provided in local settings</u>.</p> <p><b>Mental and physical health interact.</b> Improving mental health will influence wider burden of disease and help to meet SDG 3.4. People diagnosed with chronic conditions suffer from very high rates of depression (often undiagnosed) which is associated with higher mortality. Likewise, many people with cardiovascular diseases, cancer and diabetes also suffer from depression which increases their mortality rates significantly.</p> <p>People with mental disorders tend to have earlier mortality than the general population, many <u>dying more than 20 years younger</u>.</p> <p><b>Measurement indicators</b> for mental health problems could <u>include number of</u>:</p> <ul style="list-style-type: none"> <li>• anti-depressants prescribed</li> <li>• persons on disability pension due to depression</li> <li>• medical education (physicians and other health care professionals) courses with topics of depression, suicide and crisis</li> <li>• treated patients due to depression and crisis</li> <li>• hospital admission due to depression and crisis</li> <li>• treated patients in outpatient services</li> <li>• suicides / attempted suicides.</li> <li>• See for example <u>Scotland's Mental Health indicators</u> for adults and children.</li> </ul>	 
	<p><b>Low levels of education are linked to risk of living in poverty, which is linked to poor mental health.</b> Education is a predictor of employment and income security in adult life which in turn has a key influence on parental exposure to material deprivation.</p> <p><b>Improving maternal education is important.</b> Individuals with more years of schooling tend to have better health, well-being and health behaviours in adulthood. Effects are particularly robust and large for a <u>range of health indicators including</u> adult depression.</p> <p><b>Education gives children skills for life.</b> <u>Education influences a range of later life outcomes</u> such as employment, income, and community participation, all linked to mental health problems.</p> <p><b>Preschool education is important.</b> Countries with the highest investment in early years development programs and services tend to <u>have better child outcomes overall</u>, including social, cognitive and physical health and wellbeing.</p> <p><b>Schools are important as institutions</b> capable of delivering upstream, preventive programmes to young people.</p> <p><u>Children with physical and mental disabilities should attend mainstream schools</u> with adjustments and supports relevant to their disabilities.</p>	 

SDG	Evidence of relationship with Mental Health	Links to other SDGs
	<p><b>Employment, income and maternal health.</b> Child care which is not flexible to families' needs and does not allow women to return to paid employment increases the risk of poverty, which increases the risk of poor mental health for children and mothers.</p> <p><b>Depression is twice as common in women as in men</b>, with <u>lack of access to contraception and gender-based violence having a direct effect on maternal mental and physical health.</u></p> <p>Violence against women <u>has consequences to women's physical</u> (e.g. worse sexual health, increasing premature births and low birth-weight) <u>mental</u> (e.g. increased depressions, use of alcohol, prescription medication, tobacco or other drugs) and reproductive health (e.g. more unintended pregnancies).</p>	    
	<p><b>Mental health problems and work-related stress</b> are the <u>leading causes for absenteeism from work and early retirement in the European Region and account</u> for an enormous share of long-term social welfare benefits. People with mental health problems have <b>twice the risk of losing their jobs</b> and are disproportionately out of work.</p> <p><b>Employers have a significant role in potentially reducing or exacerbating mental health problems</b> among working age populations. <u>Good mental health is essential for maintaining a sufficient and productive workforce.</u> Mental health and wellbeing promotion in the workplace has health, social and productivity benefits. Job security and a sense of control at work are protective of good mental health.</p> <p>In many cases, <b>stressful work is preventable.</b> <u>A small number of companies have adopted strategies for mental health prevention and promotion.</u> These companies and organizations translate them into measures from which employees, competitiveness and innovation can profit. In some countries the problem is <b>lack of action, not lack of knowledge</b> as many countries are adopting interventions to influence health (for example <u>EU Joint Action on Mental Health and Wellbeing</u>).</p> <p><b>Precarious, temporary and stressful work</b> can have significant impacts on mental health. <u>Precarious work arrangements are associated with poor health conditions.</u> These workers are often exposed to hazardous work environments, stressful psychosocial working conditions, increased workload and disproportional travel time between multiple jobs at multiple sites.</p> <p>Changes in the labor market have led to increasing part-time and temporary employment within the EU, <b>particularly for young people.</b> No European Member State has managed to <u>reverse the trend of growing temporary employment</u> among the young (age 15–29). Being unemployed between the ages of 15 and 24 leads to negative mental health outcomes. Unemployment during these ages increases the likelihood of <u>long-term 'scarring' in later life, including subsequent lower pay, higher unemployment and greater mental health problems in their 40s or 50s.</u></p> <p>People with a <u>lower educational qualifications have higher levels of stressful work.</u> Different individuals and groups have different risks of work-related stress. Some workers such as women, ethnic minorities, migrant workers and immigrants and young and old people, are more vulnerable to stress than others.</p>	    

SDG	Evidence of relationship with Mental Health	Links to other SDGs
	<p><b>Unemployment</b> is strongly related to poor mental health, <b>affecting adults, children and young people</b>. Depression is a consequence of unemployment; becoming depressive increases the probability of future unemployment and loss of income. People with a history of mental problems are at greater risk of unemployment, job insecurity, early retirement, absenteeism, presenteeism / "reduced productivity" (<a href="#">more common than sickness absence</a>) and low salaries.</p> <p>Depression is associated with <a href="#">decreased productivity and increased absenteeism</a> and has a negative impact on the economy. Total productivity costs of absenteeism due to mood disorders were <a href="#">estimated at €72 billion (in EU-25 in 2010)</a>, about twice that of cardiovascular disease.</p> <p><b>Children of unemployed parents</b> are at <a href="#">increased risk of dropping out of school</a> and have an increased incidence of disruptive behaviour.</p>	
 <p><b>(SDG Target 11.7</b> "Provide universal access to safe, inclusive and accessible, green and public spaces, in particular for women and children, older persons and persons with disabilities.")</p>	<p>Both <a href="#">mental and physical health can be strongly influenced</a> by places and spaces are planned, designed, constructed and managed. The way <b>cities and communities are designed and connected influences mental health</b>. When parks, recreation and sports facilities are accessible and easily available they can improve physical activity levels, which also affects mental health.</p> <p>Good quality transport systems have:</p> <ul style="list-style-type: none"> <li>• high connectivity (e.g. easy routes between destinations)</li> <li>• good pedestrian and cycling facilities (well-maintained pavements, cycle routes, traffic calming measures)</li> <li>• good accessibility (easily-reached destinations or facilities, greenspace, and transport links).</li> </ul> <p>These type of transportation systems can <a href="#">encourage people to make sustainable travel choices</a>. These approaches are similar to the priority goals in the <a href="#">Amsterdam Declaration</a> which seeks to improve transport choices for health, environment and prosperity.</p> <p><b>Exposure to ambient air pollution, noise, second-hand smoke and lack of access to green spaces</b> differ according to socioeconomic status. <a href="#">Living close to natural environments</a> and engaging in outdoor activities such as walking, running, cycling, horse riding, and gardening have <b>known benefits for mental health</b>. They activities reduce stress, anxiety and depression in addition to conferring the mental health benefits of exercise (whether indoors or outdoors).</p> <p><a href="#">Neighbourhoods that engender high levels of social capital create better mental health, more health-promoting behaviours.</a></p> <p>'Greenspace' in urban areas includes parks and private gardens which offer space for recreational activity. <b>Greenspace is important for mental health</b> as it is where social activities take place, and provides people with places to <a href="#">escape the stress of urban living and promote good mental health</a>. <a href="#">Contact with green areas can improve cognitive function, social cohesion and recovery from stress.</a></p>	 

## Leading causes

Evidence to address mental health can be presented by framing in terms of the leading causes.

**Framing the evidence** helps to explain the relationships between the leading causes of poor mental health and the SDGs.

**For example, the relationship between mental health problems and work is strong and multi-faceted.** In Europe, a quarter, 25%, of workers say they are affected by work-related stress. **Poor quality employment**, such as precarious employment, employment with no or short-term contracts, and jobs with low reward and control at work, have significant harmful impacts on mental health.


Those at particular risk of precarious employment are;

- young people
- lower paid workers
- women (particularly mothers and women returning to work)
- migrants.

People who leave school with fewer qualifications have are more likely to have frequent periods of unemployment and work in precarious employment. Mental health problems, including stress and depression, increase as employment instability / precariousness increases.

Links to:

- [Making the link: Mental Health, Equity and Work](#)
- [OECD Youth not in employment, education or training](#)
- [Eurofound NEETS: Young people not in employment, education or training: Characteristics, costs and policy responses in Europe. 2012.](#)

Cause of poor mental health	Risk factors	Policy intervention areas (for example)	Relevant SDG
<b>Employment</b>	Type/quality employment	<ul style="list-style-type: none"> <li>• Employment legislation, rights for temporary workers</li> <li>• Support to return to work after poor mental health (occupational health)</li> </ul>	
	Stress		
	Unemployment		
<b>Income</b>	Poverty	<ul style="list-style-type: none"> <li>• Active Labor Market Programs</li> <li>• Equitable and good quality education provision</li> <li>• Maternal Education</li> <li>• Social Protection / Minimum Income</li> </ul>	
	Unemployment		
	Poor Maternal health		

## Key pathways

Evidence to address mental health can be presented by framing in terms of the key pathways.

**Pathways** explain how good and poor mental health is created and how health inequalities arise and are perpetuated.

These pathways provide evidence of the upstream 'root' causes of poor mental health and inequalities.

### Living Conditions

- The poorer the circumstances in which a child is nurtured, the worse his or her outcomes are likely to be, including worse mental health. Young people living in low income households are more likely to be exposed to psychosocial stress.
- Inadequate housing affects mental health. On its own housing will not usually precipitate serious mental health problems however poor quality housing and stressful tenure can induce chronic stress with symptoms of anxiety, depression, hostility and frustration.
- Work and home environments show there can be a strong relationship between social settings and short and long-term emotional well-being.
- Social isolation raises the risk of mental health problems among older people (especially for women).

### Education, Personal and Community Capabilities

- Parental mental illness, particularly in the mother, is associated with poor birth outcomes, heightened risk of sudden infant death and increased child mortality. Children of parents who have depression or anxiety are more likely to have these mental health problems.
- Children and adolescents from families with low socio-economic status were up to three times more likely to have mental health problems than their peers from families with a high SES, the more frequently a child is exposed to poverty, the greater the risk of mental health problem.
- The burden of unemployment and family affects women and men differently. It is especially harmful for **mental health of women** in **Southern and Central European** countries and the **mental health of men** in market-oriented countries (e.g. Norway, Germany, United Kingdom, Spain).
- Low levels of social cohesion in neighbourhoods and institutions (such as schools and workplaces) are associated with poorer health and higher stress, which follows a social gradient. Participatory approaches play a key role in addressing the link between marginalization and powerlessness, and in tackling the determinants of health inequities.
- First-time pregnant women, especially those who are single, adolescent or from impoverished backgrounds, are at increased risk of mental health problems and more likely to fail in providing a healthy start for their children.

- **Perinatal anxiety** and **depression** prevalence are **often overlooked** by health professionals. Less than 50% of women will seek help or be identified as needing help even in well-funded health systems.
- **Maternal health affects children's mental health**, including prenatal maternal stress. Children of mothers, with mental health problems are five times more likely to have mental health problems themselves, including emotional and behavioural difficulties. Paternal depression affects older children, suggesting that treating parental depression benefit the patients themselves and their children: the treatment of depression is a family matter.
- Developing social and emotional skills supports later life outcomes such as achieving higher educational outcomes, improved employment and health. Interventions in early childhood that strengthen social and emotional learning, improve coping skills and bonds between parents and children can generate benefits lasting into adulthood.
- Preventing stress experiences in school, at home and with peers is vital in promoting healthy development. Children and young people with poor mental health are more likely to have:
  - poor educational attainment
  - poor employment prospects
  - social relationship difficulties
  - physical ill health
  - substance misuse problems
  - and to become involved in offending
- Good social, emotional and mental health helps to protect children against emotional and behavioural problems, violence and crime, teenage pregnancy and misusing drugs and alcohol, and determines how well they do in school. Child care should be flexible to families' needs and allow women to return to paid employment which decreases the risk of poor mental health for both children and adults.

### Employment and working conditions

- Work plays a central role in any society, providing the means of acquiring income, prestige and a sense of worth and a way of participating in, and being included as, a full member in the life of the community. Being unemployed effectively excludes people from this participation and the benefits employment brings.
- **Good-quality employment is good for health and its determinants** (such as a good standard of living, self-esteem, social participation). This can also contribute to a healthy and productive workforce.
- **Employment conditions and quality of work influence mental health.** Employment quality an important determinant of health inequalities.
- Precarious, temporary and stressful work can have significant impacts on mental health. Precarious employment constitutes an important social determinant of health in contemporary labor markets. Precarious employment is more common among women, manual workers, immigrants and workers with low educational attainment and temporary contracts.
- **Stress, bullying** and other adverse workplace experiences are risk factors for depression and

anxiety. **Job insecurity**, the real or perceived fear of becoming unemployed, is linked to a large number of adverse health outcomes, ranging from psychological distress, anxiety and depression to an increased level of mental, emotional and psychological exhaustion.

- A **healthier workforce** is more productive and more resilient due to better mental health and reduces **absenteeism**. Social protection policies for those of working age reduce material hardship and reduce stress and improve mental health. Active labor market programs include subsidized employment, training, and job search assistance and can be powerful tools. Research shows that as states increase spending on ALMP, health also improves. ALMPs are particularly effective for women, those with low skills and those who have been unemployed in the long term.

## Income and social protection

- Income and employment are key factors in understanding the link between the SDGs and the social determinants of health.
- Mental health problems reflect the stress and disadvantage in people's lives.
- Depression is significantly more common in **working people with low socio-economic status**.
- Living on a low income is associated with a greater risk of poor mental health.
- **Poverty, and debt**. There is a strong relationship between debt and mental health. People in debt are three times more likely to have a mental health problem than those not in debt.
- Family income level and security is a critical component in stress. Relative poverty in childhood strongly influences health and other outcomes throughout life. Income during early years has a substantial impact on child outcomes, affecting children's well-being and development, their cognitive ability, achievement and engagement in school, anxiety levels and behaviour.
  - An integrated approach involves improving parental leave arrangements, the availability of child care at particular ages and stages, systems of social benefit supports (including cash transfers) and other policy areas which enables families to increase their income. Children and adolescents from socio-economically disadvantaged families are two to three times more likely to develop mental health problems and are more likely to feel lonely.

## Governance

- Gender stereotypes (such as women being more prone to emotional problems and men more prone to alcohol) reinforce social stigma and can discourage seeking help. These stereotypes make it more difficult to find accurate identification and treat psychological disorders (WHO, 2010).
- From mid-adolescence, females are much more likely to be depressed than males. At 11 years and ages 13 and 15 girls are more likely than boys to have fallen behind in life satisfaction, the gap is largest at age 15. However, by adulthood, men are more likely than women to have undiagnosed depression.

- The [UN Convention on the Rights of Persons with Disabilities](#) includes mental health in its definition of disability. Countries which have ratified the Convention are required to promote, protect, and ensure all persons with disabilities have the full enjoyment of human rights and ensure full equality.
- People with mental disorders are also [at risk of human rights infringements](#), both of their universal rights and those related to people with disabilities. They experience negative consequences in the community, such as stigma and discrimination, and in institutions, where they can suffer from neglect and abuse.
- See: The World Bank. [Mental health among displaced people and refugees: making the case for action](#)

## Stakeholders, policies and interventions

Evidence to address mental health can be presented by framing in terms of the actions the intersectoral can take.

All sectors in society are responsible for mental health and mental health activities. All sectors, not only health, are affected by the cost of mental health.

The **health sector alone cannot be** responsible for all aspects of mental health activities. [Policies across government](#) can increase mental well-being and reduce exposure to risk factors.

In many countries community mental health systems are fragmented and poorly coordinated, **Ministries of Health can coordinate** and be responsible to achieve change.

[Health 2020](#) states primary care, home care, social care, nongovernmental organizations and specialist care should work together to address mental health. Addressing mental health problems such as depression and anxiety offers opportunities to establish links between sectors that do not traditionally work together.

**Figure.** Stakeholders, policies and interventions to address mental health



### Living conditions

#### National and local Policies

Welfare policies including:  
Parenting and family programs

Green and play spaces

Housing tenure and financial security

#### Stakeholders

Government Departments: Social Care, Housing, Recreation

NGOs: Children, Families

### Education, Personal and Community Capabilities

#### National and local Policies

Health care:  
universal provision  
unified assessment procedures between mental health and social care agencies  
incentives to pool budgets of agencies that need to work in close partnership

Education policies including:  
Life-long learning  
Child development

#### Stakeholders

Government Departments: Health, Social Care, Education (early years, adults)

Local Public and Primary Health

NGOs: Children, Families

### Employment and working conditions

#### National Policies

Labor/ workplace policies including:  
Occupational safety and health legislation  
Working time  
Maternity and Paternity working leave  
Disability

Small/ medium enterprizes promote mental health and access support for their employees.

#### Stakeholders

Government Departments: Labor, Business, Trade, Health, Social Care

Human Resources (private and public)

Trade Unions

Local Public Health

EU Cohesion Fund

### Income and social protection

#### National Policies

Minimum/Living income  
Parental and family leave and rights

#### Stakeholders

Government Departments: Finance, Social Protection, Immigration

NGOs: Children, Families

### Governance

Equitable social protection (e.g. minimum living wage, paternity and maternity leave, active labor market programs)  
Universal health coverage  
Improve legal status for families (access health and social care, education)  
Rights of workers (discrimination and equality)

#### Stakeholders

Government Departments: Health, Social Care, Human Rights, Migration

NGOs: Children, Families

## European resolutions, policies and plans

Addressing and implementing European and UN resolutions, policies and plans will help to support the SDGs and mental health. For example,

- **National investment plans** – to ensure equitable access to education (pre-school, primary and secondary) and universal health care.
- **Labor market and social protection policies** – to ensure support to all families and provide minimum income.
- [European Mental Health Action Plan](#).
- The Convention and Protocol on the [Rights of Persons with Disabilities](#)
- [European Regional Development Fund](#) and [European Social Fund](#) – both support numerous projects to improve mental health in individuals, communities and at work. Twenty per cent of the ESF budget is allocated to social inclusion, which could include funding to improve mental health and reduce depression and anxiety.
- European Commission guidance on [risk assessment at work](#).
- [ILO-OSH 2001 Guidelines on occupational safety and health management systems](#).

## Example interventions and policies

### Education and health

- [NICE Guidance](#) on social and emotional wellbeing in **primary education**. Guidance for teachers and school governors, and staff in local government children's services, primary care and child and adolescent mental health services.
- **'This is Me' is a mental health programme developed by the regional Institute of Public Health in Celje, Slovenia. The Ministry of Health supports the development of the programme as well as its inclusion into the school system.**
  - Established in 2001, the aim of the programme is **to raise the level of organized mental health care for adolescents** in Slovenia. The prevention-based approach means taking action even before a problem manifests.
  - The Institute of Public Health in Celje developed the two-part school-based prevention programme and included adolescents in the programme development (for example, in the initial design of the programme and contents selection).
  - [Online counselling service](#)
    - The web-based counselling service gives adolescents online access to various experts without waiting times and referrals. This Is Me **provides teens with a friendly, simple, fast, free, anonymous and efficient public access to expert information and problem-solving assistance.**
    - Counselling service is daily managed by editorial board (the editorial staff reads each question, codes it, selects a counsellor, checks the answer and publishes it online)
    - Experts answer 3,000 questions a year
    - Over 70 experts (psychologists, medical doctors, social workers, educators) volunteer their time to staff the service
    - More than 100,000 unique users registered per year

- Majority aged 14–18 years.
- Majority answered in less than 5 days.
- Annual running costs approximately €20,000 (for technical operations and editorial board, assuming web counsellors volunteer).
- Prevention workshops in schools
  - **The programme published two manuals following the concept of '10 Steps to a Better Self-Esteem', one aimed at teachers and the other at adolescents.** The manuals have been distributed to 65% of schools in Slovenia.
  - Training for teachers is provided.
  - Teacher's manual – instructions for teachers to lead 10 workshops with adolescents aged from 13 to 17. Provides **guidance** on helping adolescents build their personal resilience.
  - Adolescent's manual – 10 steps adolescents can take to improve their personal strength and self-respect.
  - Annual running costs approximately €15,000 (for coordinator and evaluation).
- [ifightdepression.com](#) section for young people
- [Supporting Secondary Schools to play a central role in early intervention mental health services](#)

## At work

- **Comprehensive policies of mental health at work.** Including workplace mental health promotion (reducing stress and building resilience) as well as assessments of psychosocial risk factors.
  - [Job-stress interventions](#) can focus on: the organization, the individual, or the organization (addressing working conditions). Individual-focused interventions account for the most frequently used types of interventions yet they tend to result in little positive sustained outcome change other than at the level of the individual. See also increase job control, EU [Employee Involvement](#) strategy.
  - Companies promote the mental health of their employees in [three complementary fields of action](#):
    - **Prevention - Measures which help to lessen, reduce or entirely avoid mental stress.** This form of stress may result from the working environment, workflows, the quality of cooperation and the individual assessment of the relationship between personal effort and recognition received.
    - **Promotion - Measures which promote and boost resources for mental health.** These resources can be personal (e.g. qualifications, health literacy, sense of self-worth), social (e.g. social support among employees and between employees and managers) as well as organizational (e.g. high level of autonomy, high quality of employee-centered management).
    - **Measures which support employees with mental health problems in everyday working life,** as well as in their care and reintegration.
- **Screening.** In a large Dutch hospital nurses and allied health professionals [were screened for symptoms of stress, burnout, depression and anxiety](#). Screen-positive nurses received personalized online feedback. This intervention was successful in improving work function and work-related fatigue and a small meaningful effect on stress was found. Health-economic simulation models suggest that preventive interventions at the work place have paid back their cost one year as interventions costs are more than compensated for by reduced absenteeism and presenteeism.
- The most cost-effective intervention at the population level is **creating and protecting**

**employment**, either in the public sector or by creating incentives for expanding.

- The negative effects of unemployment on mental health are smaller in countries with strong employment protection systems than in those with poor employment protection.
- Actions to help people to find employment: include labor market training, special programmes for young people in transition from school to work; programmes to provide or promote employment for people with disabilities
- **Supporting unemployed to return to work.** For example, psychological support for people who lose their jobs as part of redundancy package that employers must provide.
- European countries with more developed **active labor market policies** which provide protection for the poor have more health-conducive work environments.
- Mental Health Innovation Network
  - Includes evaluations of numerous interventions such as screening and treatment for depression in the workplace and improving access to therapies.
- NICE Guidance for those with a direct or indirect role in, and responsibility for, **promoting mental wellbeing at work.** Provides information on interventions to promote mental wellbeing through productive and healthy working conditions.

### Housing and urban spaces

- **Improving housing.** In Spain, Caritas is one of the institutions focused on helping people with housing problems. An evaluation of the effect of relocation to a new house was studied. Mental health improved more in those who experienced relief regarding their precarious socioeconomic situation as well as improvements in housing conditions.
- **Improving urban spaces.** In Barcelona, a large scale urban renewal project (Llei de Barris) aimed to improve the built and social environment. Self-rated health and residents' perceptions were measured to assess their views on changes in their neighbourhoods to explore the pathways between urban renewal and health inequality. After renewal, self-rated health, including mental health, improved in the neighbourhoods in which intervention was carried out.

### Older people

- Interventions which prolong and/or **improve older people's social activities**, life satisfaction, and quality of life can significantly reduce depressive symptoms and protect against risk factors, such as social isolation. Effective interventions include:
  - psychosocial interventions
  - interventions to reduce social isolation
  - exercise and physical activity programmes
  - programmes promoting lifelong learning
  - reducing poverty
  - improving physical health
  - improve heating in the home
  - help older people make new friends
  - provide opportunities for older to people to volunteer

#### Additional resources:

- [WHO Mental Health Atlas](#)
- **Exchange and analyze** information on policy and stakeholder activities in **mental health** at [EU-Compass for Action on Mental Health and Wellbeing](#).
- [Foresight Mental Capital and Well-being](#)
- [What works for well-being](#)
- [Mental health Systems in the European Union Member States, Status of Mental Health in Populations and Benefits to be Expected from Investments into Mental Health](#)
- [Mental Health, Well-being and Disability: A New Global Priority](#). Key United Nations Resolutions and Documents





## 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.

### Member States

Albania  
Andorra  
Armenia  
Austria  
Azerbaijan  
Belarus  
Belgium  
Bosnia and Herzegovina  
Bulgaria  
Croatia  
Cyprus  
Czechia  
Denmark  
Estonia  
Finland  
France  
Georgia  
Germany  
Greece  
Hungary  
Iceland  
Ireland  
Israel  
Italy  
Kazakhstan  
Kyrgyzstan  
Latvia  
Lithuania  
Luxembourg  
Malta  
Monaco  
Montenegro  
Netherlands  
North Macedonia  
Norway  
Poland  
Portugal  
Republic of Moldova  
Romania  
Russian Federation  
San Marino  
Serbia  
Slovakia  
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Tajikistan  
Turkey  
Turkmenistan  
Ukraine  
United Kingdom  
Uzbekistan

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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  
E-mail: [eurocontact@who.int](mailto:eurocontact@who.int)