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

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Foreword

Reducing health inequities is crucial for the European Region as a whole and is central to my agenda. One of my first actions on assuming the post of Regional Director in 2010 was to invite Michael Marmot to chair a review of the social determinants of health and the health divide in the European Region.

This review will inform the new European policy for health – Health 2020. It will accelerate action on socially determined health inequities by developing policies that work in low-, middle- and high-income countries. It draws on best practices, examples and experience of addressing social determinants of health and health inequities in the Region and how to take this to scale. One of the key goals of the review is to identify what works and how to implement it across the diverse context of the European Region.

Health is a key and unique resource for the European Region of today and tomorrow. It is a resource that must be nurtured. It is a resource that is much needed and that will help Europe to be more united and stronger in dealing with its present economic and social difficulties.

Can we perform better in promoting health in the European Region? Can we reduce health inequities by levelling up the health status of the weakest segments of our population and across the social gradient? Can we, with our efforts to promote population health, provide added value to the social, economic and human development of our countries, regions and cities? I firmly believe that we can.

The evidence provided, the promising practices highlighted together with an in-depth discussion of the implications of the recommendations of the review in the specific context of our 53 Member States will surely help to make progress in translating scientific findings into concrete policy action. This is my hope and my expectation as we work to address the health gap across the Region.

This interim second report already outlines some of the areas emerging as key. These include a focus on health assets, addressing processes that increase people's vulnerability and the whole-of-government approach.

I urge you to read this report and to provide your comments and feedback. Personally, I am excited to see the progress presented here and look forward to the final report and recommendations at the sixty-second session of the WHO Regional Committee for Europe in Malta.

Zsuzsanna Jakab
WHO Regional Director for Europe

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Executive summary

> Social justice is a matter of life and death. It affects the way people live, their consequent chance of illness, and their risk of premature death.
>
> Commission on Social Determinants of Health. *Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health*. Geneva, World Health Organization, 2008 (http://www.who.int/social_determinants/resources/gkn_lee_al.pdf, accessed 10 July 2011).

There are major health inequalities[1] within and between countries in the WHO European Region. The average life expectancy differs between countries by 20 years for men and 12 years for women. Within countries, the levels of both health and life expectancy relate to and are graded by social and economic position. The lower a person's social position, the worse is his or her health. Everyone except the people in the very highest social and economic positions adversely experiences some degree of inequality in health.

Most health inequalities are avoidable by reasonable means, and reducing them is a matter of social justice. Perpetuating inequities in health is not acceptable. Action to reduce inequities must be a priority for the WHO European Region, and this is why the WHO Regional Director for Europe commissioned this review of social determinants of health and the health divide in the European Region.

Progress since 2010

This interim second report sets out the approaches to tackling health inequities that have emerged from the work undertaken since WHO published the *Interim first report on social determinants of health and the health divide in the WHO European Region* in September 2010 as part of the review. This report further describes some of the Region's inequalities that were set out in the first report.

Key developments reported are:

- the review's conceptual approach to the causes of health inequities and the policies and processes required to tackle these;
- analysis of recent time trends in the WHO European Region;
- identification of the key themes and issues that have emerged from the work of topic-specific and cross-cutting task groups so far and that will underpin the formulation of recommendations to be made by the review;
- emerging thinking on the role WHO, health ministers and other important actors can play in promoting health equity for current and future generations by promoting fairer and more sustainable societies; and
- how the review fits into wider global action on the social determinants of health and the new European policy for health – Health 2020.

[1] This report refers to systematic variation in health or social conditions as "inequality". When inequalities are avoidable by reasonable means, this report uses the term "inequity" in accordance with the Commission on Social Determinants of Health.

Context

Health inequalities are not a new phenomenon, but new understanding of their origins and evidence on successful and unsuccessful interventions to tackle them continues to grow. This review builds on previous reviews of health inequities, especially the WHO Commission on Social Determinants of Health. The final report of the Commission, *Closing the gap in a generation*, concluded that achieving health equity requires action on the conditions in which people are born, grow, live, work and age and the structural drivers of these conditions at the global, regional, national and local levels. Ill health is not simply bad luck or the result of lack of health care but, as the Commission concluded, results from a toxic combination of poor social policies and programmes, unfair economic arrangements and bad politics and from the unintended and unanticipated consequences of other policies. Inequalities in the quality of early years, levels of education, employment status, welfare and health systems, level of income, the places where men, women and children live, the norms and values of society – including attitudes concerning gender and ethnicity – all contribute to inequities in health. They are known as the social determinants of health.

Reducing health inequities requires action to reduce inequities in the social determinants of health. This is a priority, both because health inequities have significant social and economic costs to individuals and the wider society and because the social determinants that lead to these health inequities have their own costs, in terms of societal and community well-being, levels of social cohesion and economic development. Equal right to health is an important principle and is explored further in this review.

The ambition of the Commission on Social Determinants of Health was to create a global movement. Encouragingly, evidence clearly indicates that a global movement to tackle the social determinants of health is gathering momentum. Following a resolution at the World Health Assembly, WHO and the Government of Brazil will host the World Conference on Social Determinants of Health in Rio de Janeiro, Brazil in October 2011; many national governments have taken initiatives; civil society organizations and academic institutions are working actively on the social determinants of health agenda; and there are many examples of concerted local actions.

The WHO European Region has put social determinants and health equity at the centre of its revitalized public health agenda by establishing this review of social determinants of health and the health divide in the Region. The review will inform the new policy for health for the European Region, Health 2020, as will a companion study on governance for health in the 21st century. The findings and recommendations of the review will be of global importance because many of the problems of health inequity seen around the world are present within the European Region.

This review is needed urgently for many reasons. First, significant health problems must be addressed.

- The health divide across the European Region continues to be unacceptably large. There is no good biological or genetic reason why there should be a 20-year gap in life expectancy between countries in the Region.
- There are persistently large, and in some case growing, health inequalities within countries – as improved social conditions lead to better health, the benefits are shared inequitably.
- The global economic downturn has profound importance for the health and well-being of populations and is likely to worsen health inequity. The people who are already most exposed to vulnerability and disadvantage feel the effects of the global economic downturn more strongly, similar to the effects of natural disasters.

- Sustaining a growing ageing population across the European Region requires increasing the focus on prolonging good health and well-being throughout the life course. This especially emphasizes taking a life-course approach to achieving equity in health and well-being and being responsive to the gender issues involved in health and survival.
- Action on the social determinants of health is required to effectively deal with the continued toll from communicable diseases in many areas and the inequalities in their distribution.
- Societies and global organizations need to respond to climate change and the rapid depletion of natural resources, which threaten catastrophic consequences for health and also have the most negative effects on people who are already most disadvantaged. Business as usual is not an option for the social and economic arrangements in the European Region; the actions required to achieve health equity and environmental justice need to be brought together.

The reasons for taking immediate action are equally compelling.

- The Commission on Social Determinants of Health provided the global evidence for what can be done to improve health equity, but the evidence and recommendations of the Commission on Social Determinants of Health need to be translated into a form suitable for the diversity of countries that make up the European Region.
- As one example, the Marmot Review of health inequalities in England, commissioned by the Government of the United Kingdom, is now being implemented in the constituent countries of the United Kingdom. Lessons from this and the accumulating evidence and experience from Denmark, Hungary, Lithuania, Norway, Poland, Republic of Moldova, Scotland, Serbia, Slovenia, Spain, Sweden and other countries need to be synthesized, lessons learned and applied across the European Region. The experiences of all countries across the Region will shape and inform the content and recommendations of the review.
- There are also strong examples of action at the subnational level. The WHO European Healthy Cities Network, for instance, can help to show that local action can make a difference locally. Cities such as Malmö in Sweden and regions such as Murska Sobota in Slovenia and Kosice in Slovakia are developing and implementing multisectoral and stakeholder plans on the social determinants of health. These will feed into the review in a timely way, using newly available evidence.
- Local-level action is key to addressing the social determinants of health, with its proximity to peoples' lives and experiences. However, it is frequently constrained by national and global economic influences and power relationships. As a result, local action – as long as it remains local – is limited in changing the underlying influence and distribution of power, money and resources that perpetuate health inequity in society. For this reason, a concerted, multi-level approach is required in the process of developing, implementing and reviewing policy. This is needed to produce sufficient coherence, scale and intensity of actions capable of transforming the social gradient in health.
- Action on the social determinants of health contributes to producing other social benefits such as well-being, improved education, lower crime rates, more sustainable communities, balanced and sustainable development and improved social cohesion and integration. For example, early-years skills gained by the time a child starts school are crucial to self-esteem, motivation, friendships and long-term health and well-being. In this way, action on the social determinants of health demonstrates that investment for health equity can directly contribute to attaining other sectoral and government goals and challenges the notion that health drains public resources.

Leadership for health

The evidence is clear: action to reduce health inequity and to promote health equity requires the whole of government and society to be involved. This includes the health system together with stakeholders and sectors within and beyond the boundaries of the health system. This sets both the imperative and opportunity to govern for health as a common and shared priority, nationally and locally. As the companion study on governance for health in the 21st century indicates, "Health ministers, permanent secretaries, secretaries of state and the like have a key role in good governance for health by engaging in transformational leadership within government." Within this context, WHO, health ministers and the wider (public) health community have a key role to play in mobilizing calls for fairer and more sustainable societies that will foster health equity for current and future generations.

This can be achieved in four main ways.

First, as advocates: population health and levels of inequality in health measure how well societies are functioning. Seen in this light, every sector is a health sector, because each social sector profoundly influences health and well-being. By calling for action to promote health equity, health ministers not only drive reductions in health inequities but also become engaged in an ethical endeavour – creating fairer societies that meet the needs of all, especially those who are most severely affected by exclusionary forces and are disadvantaged and disempowered.

Second, much should be done within the health system to emphasize core public health activities more strongly – such as health promotion, disease prevention, intersectoral working and ensuring equitable access to health care.

Third, health ministries, WHO and others in the health sector need to be active in generating the best available evidence and knowledge of what works to reduce health inequities, in monitoring the effects of actions taken across society and in using this intelligence to strengthen systems and capacity to govern better for health and health equity.

Fourth, there is a global dimension. Political, social and economic policies have transnational effects. European policies affect the fair distribution of health between and within countries of the European Region and of countries outside the Region. These include the policies of the European Commission, the donor community and international agencies and foundations. Health leaders need to advocate a social determinants approach in understanding the causes of health inequities in these international policy arenas. As advocated by the Commission on Social Determinants of Health, health equity should be at the heart of all policy-making.

Emerging thinking on themes

The recommendations of the review are likely to emerge from the following themes and issues identified so far by the task groups in their preliminary analysis of available evidence.

Key concepts

The key emerging concepts of the review are as follows.

- Assets and vulnerability resulting from the social determinants of health are at the centre of the conceptual approach.
- Social integration and cohesion are linked to the social determinants of health and health inequity.
- Vulnerability, inequity and the rapid speed of social and economic change are related.

- A human rights–based approach to health equity is needed.
- How does variation in well-being relate to health inequalities?
- The social gradient in health should be reduced by reducing inequities in society and by taking specific actions across the social gradient.
- Related to the above, the approach of proportionate universalism should be further developed.
- Concerted action is needed across the life course and across all the sectors influencing the social determinants of health.
- Gender continues to be an issue in all countries, influencing the risks and opportunities of men and women throughout their lives, but it looms particularly large in some countries in the Region.
- The review is concerned with excluded groups, but it is more helpful to view exclusion as a process than to focus on who is in and who is out.
- By focusing on exclusion as a process, the link between social gradient and specific groups can be more clearly identified.

Organizations and governance

The key themes relating to organizations and governance are as follows.

- In addition to traditional organizational interventions, co-production with families and communities is essential.
- The review will develop a clearer conception of the appropriate levels at which policy changes and interventions should be led.
- The role of the private sector is important but too often ignored, and this area is a major challenge.

Interventions and policies

The key themes relating to interventions and policies are as follows.

- Some policies and interventions clearly exacerbate health inequities.
- Policies will be examined for their effect on the whole social gradient in health.
- Contextually relevant interventions need to be identified across the diversity of countries in the European Region.
- A classification is needed of the types of interventions and policies that are required to reduce inequities.
- Action needs to be taken based on the demographic profile of inequalities.

Wider agendas

The key themes relating to wider agendas are as follows:

- the role of global processes and influences;
- making links with the agenda for climate change and environmental sustainability; and
- empowering civil society.

Economic issues

The key themes related to economic issues are as follows.

- Evidence is needed on the social and economic costs of inequities in health.
- The economic costs and benefits of action on social determinants need to be calculated.
- Mainstream budgets and investment instruments need to be adjusted to accommodate action on the social determinants of health – "bending the spend".

Outline of the main interim report

The main report summarizes the scale of health inequalities in the European Region, recent trends in the health divide and evidence on the scale of health inequalities within countries. The conceptual framework being used in the review to describe the social determinants of health across the Region and develop recommendations for addressing inequities is set out. This is illustrated by using the framework to understand recent trends in the Region.

The report describes the structure of the review, the approach being taken to arrive at the recommendations and the activities that will be undertaken to validate and strengthen these recommendations, such as case studies and a consultation process.

The review is being informed by 13 task groups that are undertaking work building on existing knowledge and proposing effective strategies for action in key areas relating to health. Eight topic groups are each covering one or more of the key social determinants of health in the European Region and/or key stages of the life cycle. A further five cross-cutting groups are each focusing on issues that span across two or more of the topic groups. This report describes the scope of each task group and any emerging proposals or recommendations at this stage of their work.

The report concludes with a synthesis and overview of the themes and issues that have emerged from the work to date.

1. Overview

1.1 Introduction

Based on concern about levels of health inequities across the European Region and to ensure that equity and social determinants of health are at the heart of the new European policy for health – Health 2020, the WHO Regional Director for Europe, Zsuzsanna Jakab, commissioned the European review of social determinants of health and the health divide. The European review has social justice at its heart and is bringing together the best evidence to lead to implementation of policies to address social determinants of health across all WHO European Member States. The review builds on the work of the Commission on Social Determinants of Health *(1)*. The aim of the European review is to develop the findings of the Commission on Social Determinants of Health so that they can be applied in all the countries in the European Region, taking account of the very different social and economic situations in countries across the Region. WHO set up the Commission on Social Determinants of Health in the spirit of social justice, with the recognition that inequalities in health within and between countries are largely avoidable. The starting-point for the Commission on Social Determinants of Health was that a global difference in life expectancy between countries of more than 40 years and the striking social gradient in health within countries is unjust.

The Commission on Social Determinants of Health concluded that the key determinants of health inequities lie in a toxic mix of poor social policies and programmes, unfair economic arrangements and bad politics. The distribution of power, money and resources and the very different conditions in which people are born, grow, live, work and age constitute the social determinants of health.

Despite Europe's overall wealth, it is a region with stark inequalities in health. Life expectancy at birth differs by 16 years between the countries with the highest and lowest life expectancy in the European Region, with men and women having different experiences. Male life expectancy at birth varies by 20 years between countries compared with 12 years for women. Even countries with similar levels of wealth and development differ substantially in terms of life expectancy. Life expectancy also differs considerably within countries. The people with greater social and economic advantage have better health and live longer than people with less advantage. The groups most severely affected by exclusionary processes, such as Roma and migrant workers, experience especially significant health disadvantage. The social and health challenges across the Region are immense but, as the evidence shows, they are not impossible to tackle.

The Commission on Social Determinants of Health brought together the evidence on social determinants of health and made recommendations on the action needed to tackle health inequity within and between countries. As the reach of the Commission on Social Determinants of Health was global, applying its findings to specific contexts will take detailed work. One such example was the review of health inequalities in England commissioned by the Government of the United Kingdom *(2)*. This review brought together experts, policy-makers, practitioners and advocates to use new evidence, in the light of the Commission on Social Determinants of Health, to develop policies and promote implementation of the review's findings and recommendations. The report was published in 2010 as *Fair society, healthy lives (2)*. It concluded that putting fairness at the heart of all decision-making across the whole of government would improve health and reduce health inequalities. Its recommendations covered six domains reaching across all the major social determinants of health. Its findings are being implemented in local areas and regions all around England and are influencing policy in Northern Ireland, Scotland and Wales. In England, the government's recent white paper on

public health *(3)* indicated that it sees the need to tackle the social determinants of health and adopts the life-course framework used in *Fair society, healthy lives (2)* for doing so.

1.2 Scope of the review

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

This interim second report sets out the approaches to tackling health inequities that have emerged from the work undertaken since WHO published the *Interim first report on social determinants of health and the health divide in the WHO European Region (4)* in September 2010 as part of the review (Annex 1).

1.3 The policy context

The findings of the review will inform the new European policy for health, Health 2020, which is a platform for realizing the health potential of the WHO European Region. The review will develop recommendations for implementation that feed directly into policy action across the European Region.

The planned goals of Health 2020 are:

- to achieve better health for the European Region and its people;
- to increase equity in health and accelerate progress on achieving the right to health;
- to make health an endeavour for all of society;
- to enhance regional and global awareness of and action for health and the determinants of health; and
- to develop suggested solutions, tools, evidence, guidance and partnerships that support health ministries, together with other stakeholders, in putting in place national policies, services and governance arrangements that realize their societies' health potential on an equal basis.

Health 2020 is a collaborative initiative between Member States and their health-related institutions to strengthen existing evidence, expertise and support for action on achieving better health for the European Region. It aims to bring the Region closer to the ideal of better health for the next decade by giving expression to health across the whole spectrum of government policy-making at the local, regional, national and European Region levels. Health 2020 will build on and add value to existing developments underway by WHO and its partners, including the Tallinn Charter: Health Systems for Health and Wealth *(5)*, and the European Commission communication on solidarity in health *(6)* in 2009. Annex 2 describes these in more detail.

The review of social determinants of health and the health divide in the WHO European Region is an expression of commitments following a resolution passed by the World Health Assembly. Resolution WHA62.14 on reducing health inequities through action on the social determinants of health *(7)* supports the findings of the Commission on Social Determinants of Health, in which European Member States and partners were active stakeholders. Work arising from the review will feed into the World Conference on Social Determinants of Health to be held in Rio de Janeiro, Brazil in October 2011.

The review is working closely with the European Commission to promote the uptake of its recommendations by European Union (EU) and candidate countries as well as other international actors active in the European Region. Although the review does not exclusively focus on the EU, the review is also considering how the EU's wider social and economic policies and actions affect health inequity both globally and within the EU and neighbouring countries. Donor organizations and other international organizations and foundations will also be engaged during the consultation phase of the review.

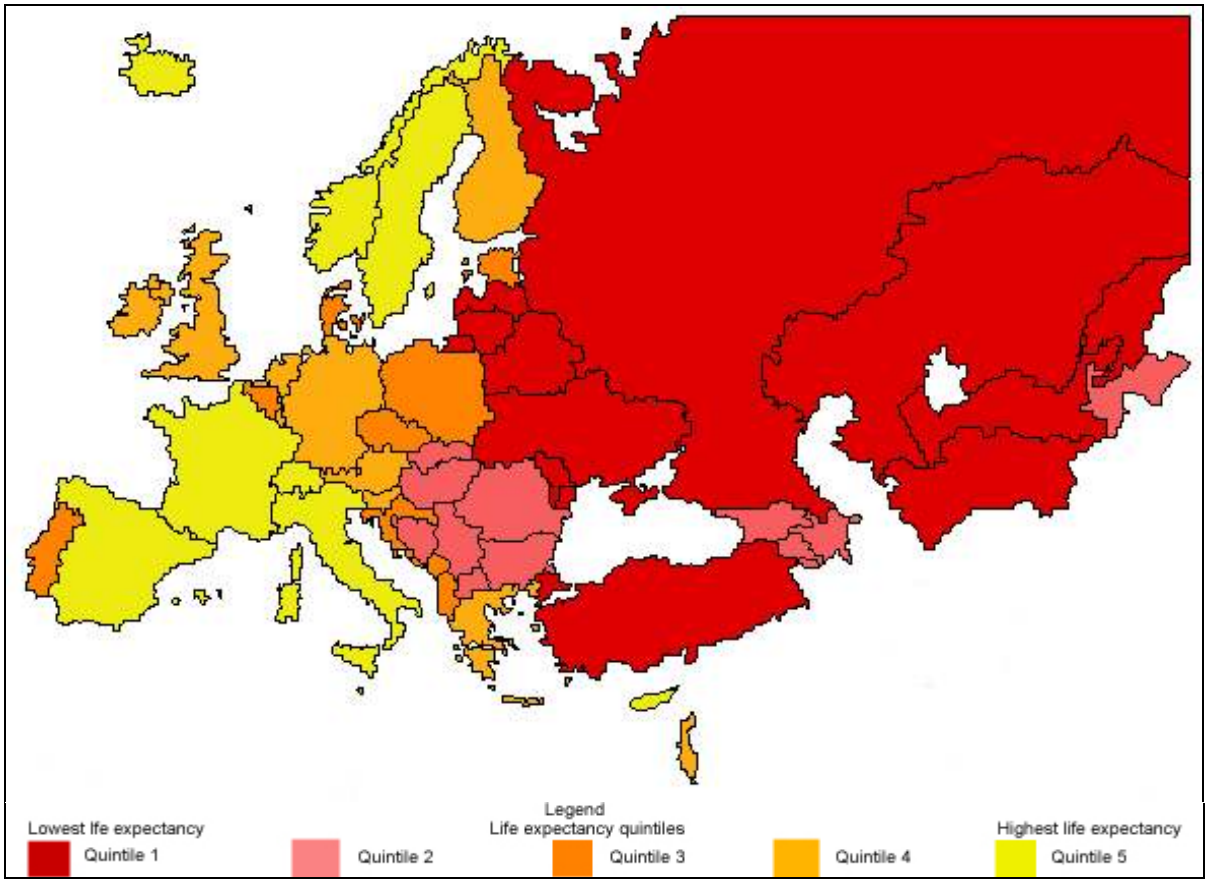
Interest is increasing in moving away from using narrow economic indicators to measure progress towards measuring social benefits and well-being. The Commission on the Measurement of Economic Performance and Social Progress, set up by France's President Nicolas Sarkozy and chaired by Joseph Stiglitz, emphasized the need to measure social progress in other than narrow economic terms and to focus on well-being as a measure of social progress *(8)*. The EU and the Organisation for Economic Co-operation and Development (OECD) are also working on indicators of well-being, and several countries have held consultations on indicators of social progress, within which interest has been expressed about integrating these with a social inequity agenda. Ill health and health inequities are clear measures of outcome consistent with the call of the Commission on the Measurement of Economic Performance and Social Progress *(8)* to measure social progress in ways that matter to the well-being of the population. In addition to health, this review is considering well-being and exploring the relationships between more direct measures of well-being and health and the benefits and disadvantages of deploying well-being indicators.

2. Health and its social determinants in the WHO European Region

2.1 Health and inequalities in Europe

Although overall population health has improved, there is significant inequality in health across the Region, notably an overall difference in life expectancy of about 16 years between countries (Fig. 1), with even greater differences when gender and other inequalities within countries are included in these comparisons.

Fig. 1. Life expectancy in years for countries in the WHO European Region, 2008 or latest available year

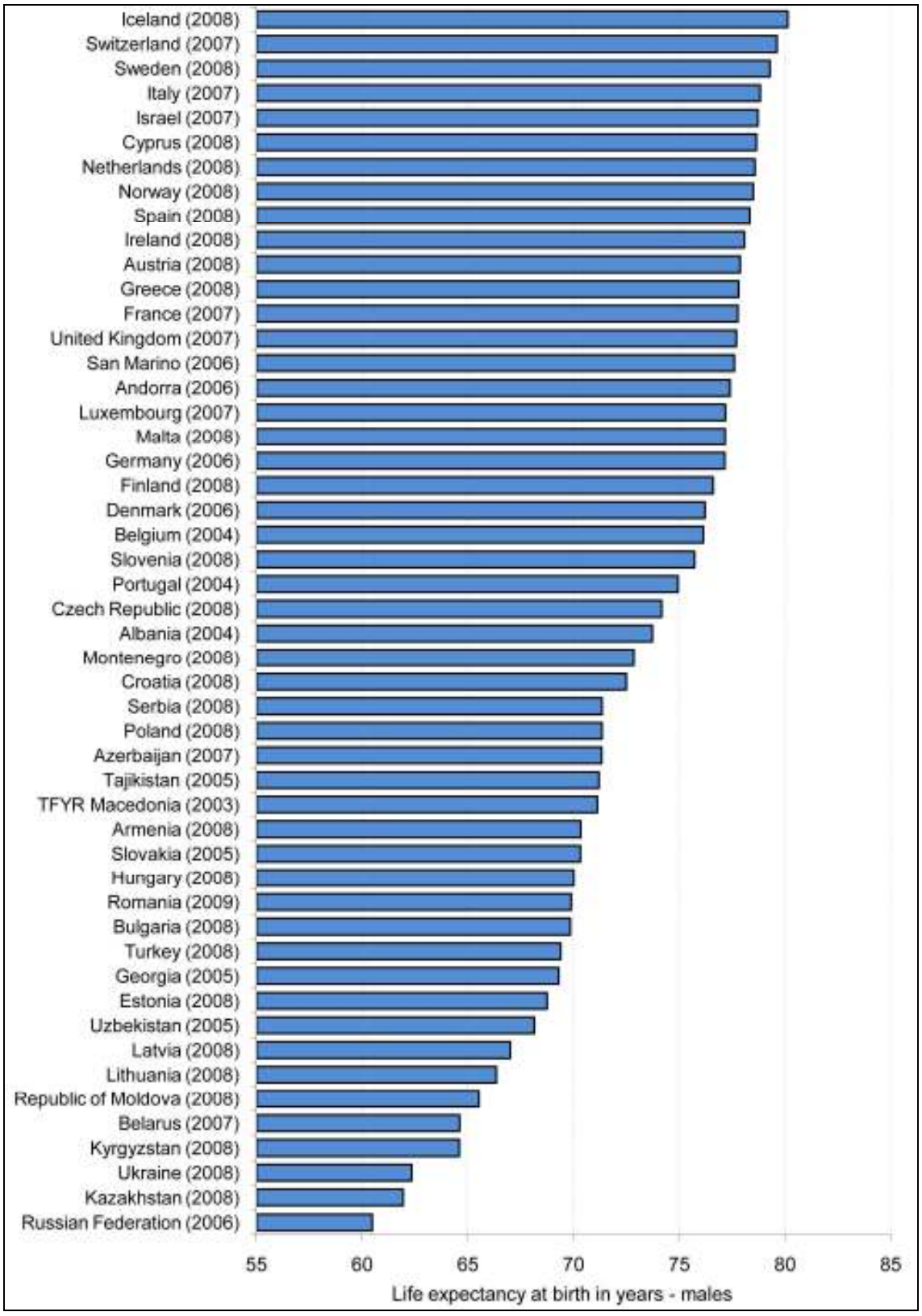


Source: European Health for All database [online database] (9).

As Fig. 2 shows, differences between countries are very different for the two sexes – with a range of 20 years for males and 12 years for females. Life expectancy for males is about 4–7 years lower than for females in most of the Region, but life expectancy for males is 12 years lower than for women in Belarus, Lithuania, the Russian Federation and Ukraine and 13 years lower in Latvia. In contrast, life expectancy for females is only one year longer than for males in Tajikistan.

Fig. 2. Life expectancy at birth by sex for countries in the WHO European Region, 2008 or latest available year

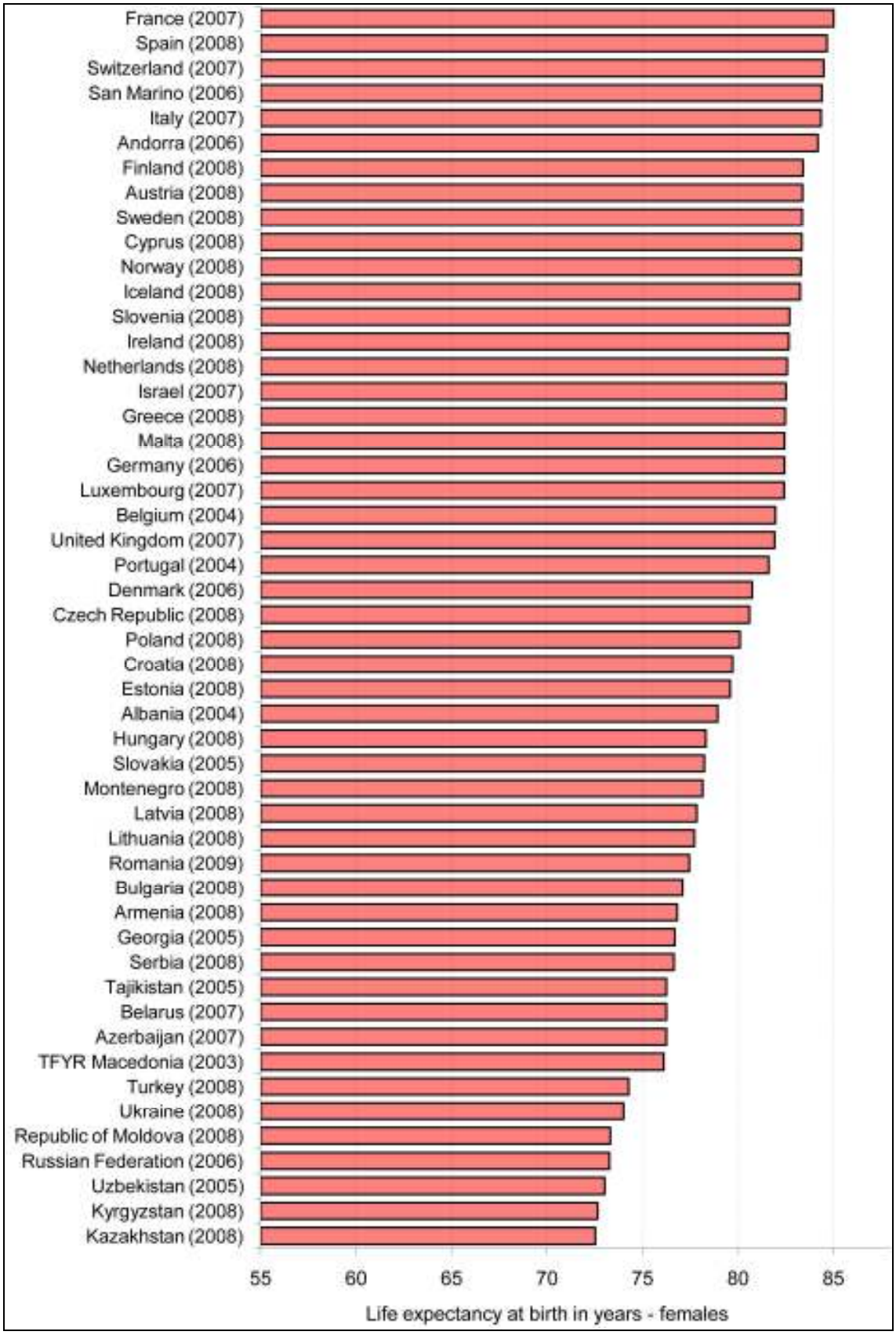
(a) Males



TFYR Macedonia: The former Yugoslav Republic of Macedonia.

Source: European Health for All database [online database] *(9)*.

(b) Females



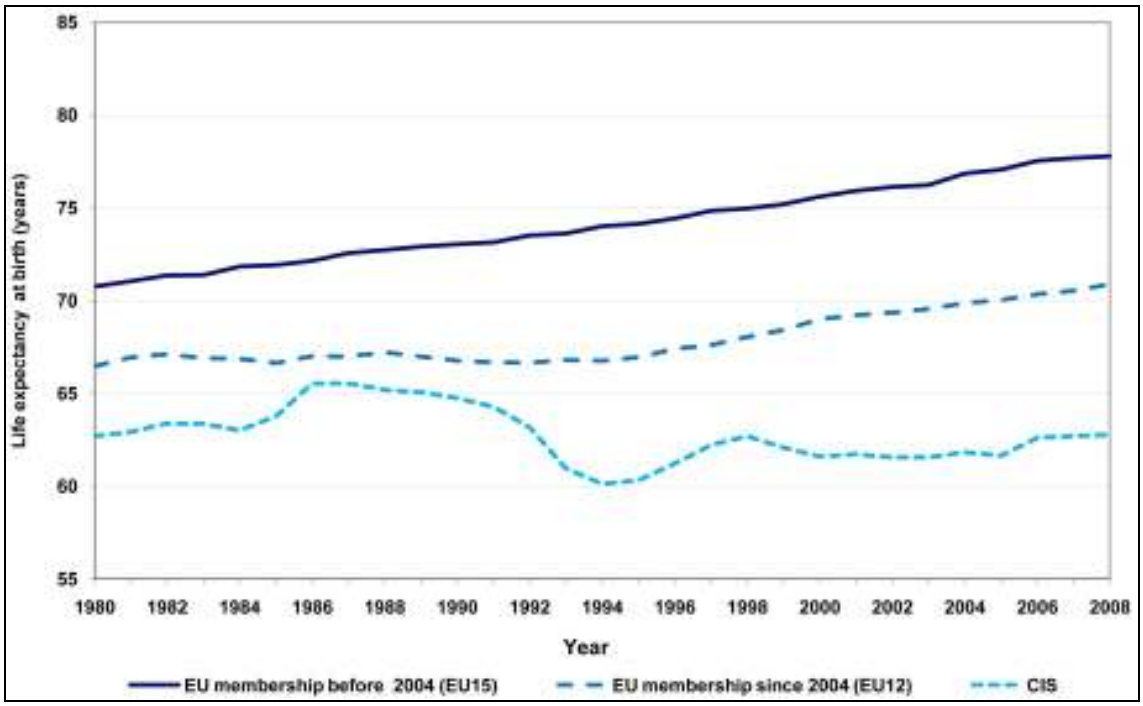
TFYR Macedonia: The former Yugoslav Republic of Macedonia.

Source: European Health for All database [online database] *(9)*.

The average life expectancy in the countries of central and eastern Europe and the countries in the Commonwealth of Independent States (CIS)[2] is lower than in the countries in the western part of the Region (Fig. 1). In the latest data from the WHO European Health for All database *(9)*, female life expectancy at birth was 4.3 years lower in the 12 countries that joined the EU after May 2004 (EU12) than in the 15 countries that were EU members before May 2004 (EU15) (Fig. 3). The difference between CIS countries and the EU15 was more than twice as large, at 9.7 years. The corresponding differences for males were more than 50% higher than for females, at 6.9 and 15.0 years, respectively.

Fig. 3. Trends in life expectancy in the EU15, EU12 and CIS, 1980–2008

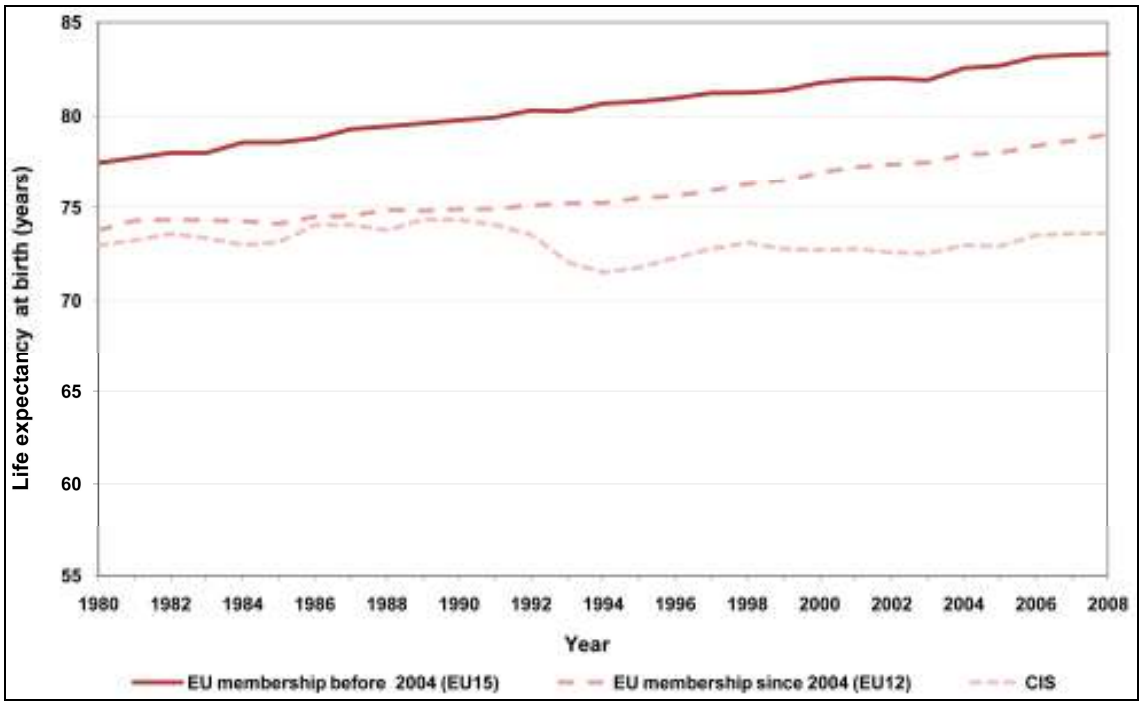
(a) Males



Source: European Health for All database [online database] *(9)*.

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

(b) Females



Source: European Health for All database [online database] *(9)*.

2.2 Trends

East-west differences in the European Region have changed over time *(10)*. As Fig. 3 illustrates, the differences have not always been as great as in the past 20–30 years. Much of the widening between 1980 and 2008 took place between 1981 and 1994. The gap in female life expectancy between the EU12 and EU15 rose from 3.7 to 5.4 years in this 13-year period and for males from 4.3 to 7.3 years. For the CIS, the gap increased from 5.4 to 9.2 years for females and from 8.1 to 13.9 for males. After 1994, the gap for the EU12 narrowed slightly, but the gap for the CIS widened a little more.

These changes need to be seen in a historical perspective. Before the Second World War, countries in the east and west differed substantially. After 1945, mortality declined considerably in all parts of the European Region until the mid-1960s, but mortality declined more rapidly in the eastern part of the Region, largely because of communicable disease control and hygiene and housing improvements. As a result, in the 1960s, the gap in life expectancy between countries in the central and eastern part of the Region and those in the western part of the Region declined considerably. However, between the early 1970s and late 1980s, life expectancy continued to increase in the western part of the Region but stagnated or fell in the eastern part of the Region, mainly because of rising death rates from cardiovascular diseases *(11)*. This led to a renewed widening of the east–west gap in life expectancy *(10)*.

After communism collapsed in 1989, which led to profound societal changes, life expectancy diverged between the countries in central and eastern Europe and those in the Commonwealth of Independent States (CIS). This divergence is most likely to have reflected different patterns of societal transition across CIS and across the countries in central and eastern Europe *(10,12,13)*. As a result, life expectancy in the CIS countries is falling behind that in the countries in central and eastern Europe and in the western part of the Region. In particular, as shown in Fig. 2, it remains at 65 years or less for males in five CIS countries. Recent national figures from the

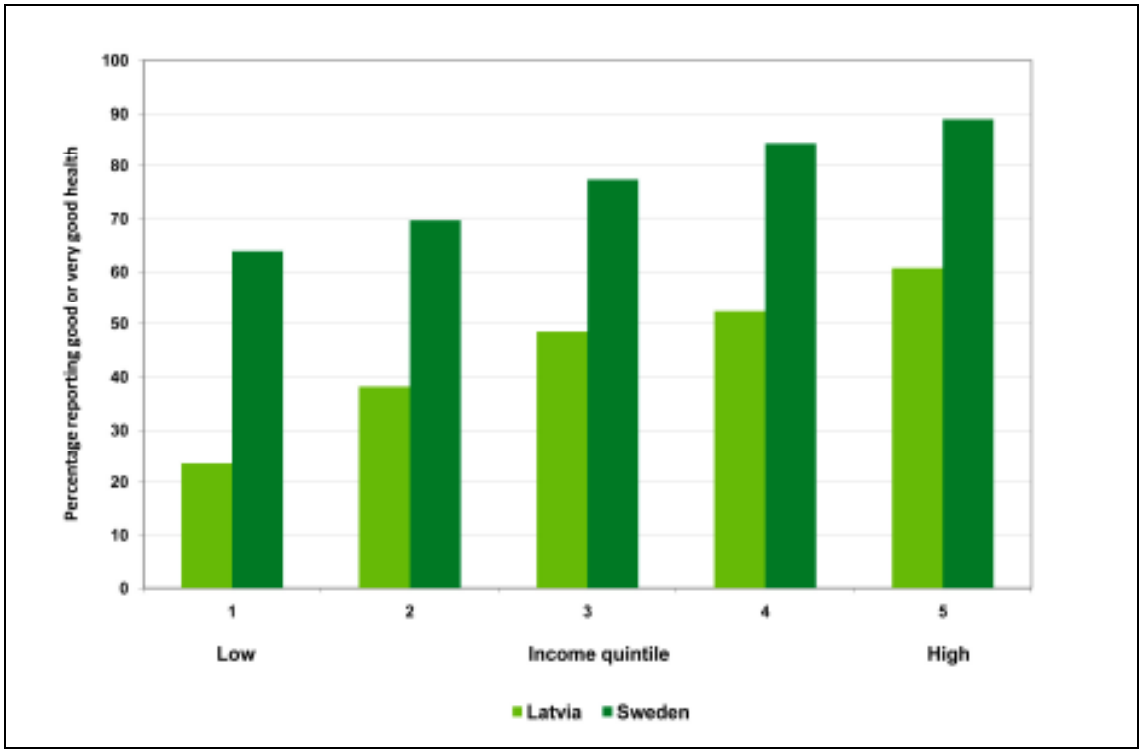
Russian Federation, not yet included in WHO data, suggest that life expectancy has improved considerably in the past few years, possibly reflecting political, economic and social stabilization; the most recent figure suggests that life expectancy at birth reached 62.8 years for males and 74.7 years for females in 2009.

The fluctuation in mortality in the CIS in the 1990s is the largest ever observed in any country with existing statistics; the increase in mortality in the first half of the 1990s in the Russian Federation alone has been estimated to be equivalent to about 3 million extra deaths above the long-term mortality level *(14)*.

2.3 Social gradient within countries

For countries for which data are available, health outcomes have a clear gradient across the population according to such social factors as income, education, social position and employment *(15,16)*. Fig. 4 illustrates this by comparing the gradient in self-reported health by educational level in Latvia and Sweden.

Fig. 4. Percentage reporting their health as being good or very good by household income quintile in Latvia and Sweden, 2008

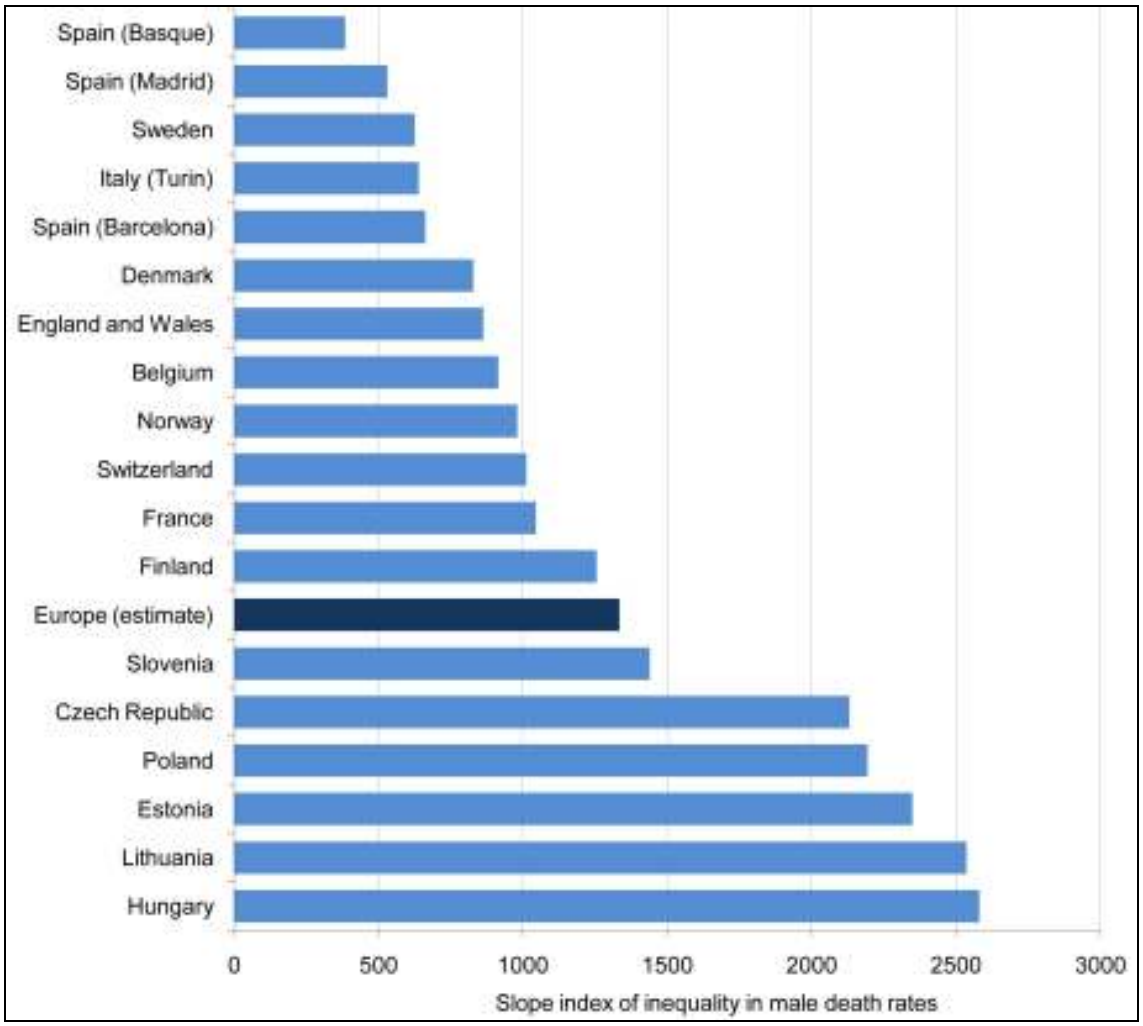


Source: personal communication, Jonathan Bradshaw and Emese Mayhew, University of York, United Kingdom, using 2007 data from: European Union Statistics on Income and Living Conditions (EU-SILC) [online database] *(17)*.

Despite very different levels of self-reported health between Latvia and Sweden, which reflect a combination of perceptions of health in different countries and different levels of signs and symptoms of ill health, both countries have a notable gradient in self-reported health. A wide variety of studies *(18,19)* have shown that self-reported health predicts future health well. Mackenbach et al. *(20)* systematically compared gradients in mortality inequality among men and women according to educational level by using individual information obtained by the

Eurothine project from studies in 16 countries in the EU and European Free Trade Association (EFTA). The evidence from this project indicates considerable variation across these countries in levels of inequality in mortality, based on the length of education of individuals included in the studies covered (Fig. 5). Inequality was greatest in the countries in central and eastern Europe included in the project and least in Italy, Spain and Sweden.

Fig. 5. Absolute inequality (slope index of inequality) in male death rates by level of education in selected EU and EFTA countries

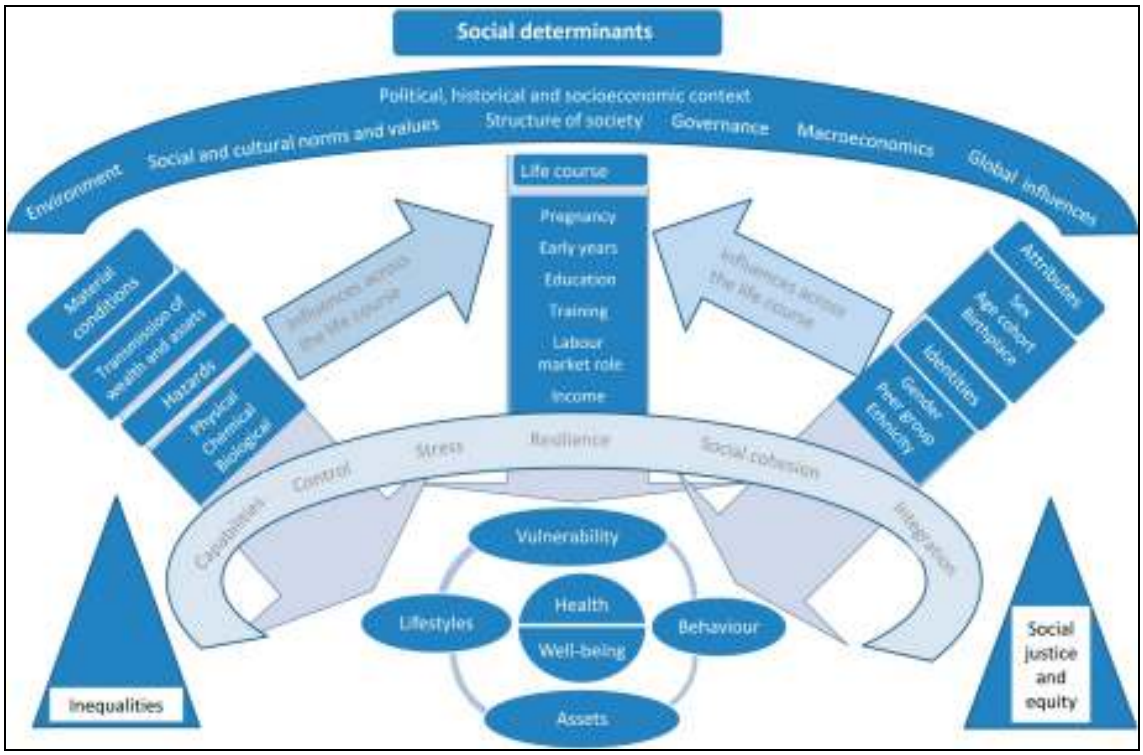


Source: Mackenbach et al. *(20)*.

2.4 Conceptual framework

The social, economic, political, environmental and cultural factors that shape health across the Region and within countries are known as the social determinants of health *(1)*. For the European review, the conceptual framework developed for the Commission on Social Determinants of Health *(1)* is being developed to highlight the main pathways to health and the policies and practices that affect these and are amenable to action that reduces inequities (Fig. 6).

Fig. 6. The social determinants of health



This framework is intended to guide understanding of inequalities in health between societies as well as those within. Many between-country inequalities in health may be understood as arising from the influences of the social determinants of health within countries – a country that fails to meet human needs of large swathes of its population will be a country with poor health. But the social determinants of health within countries are affected by influences acting beyond the country's borders, in political and economic arrangements, in trade and in international relations. Some parts of the framework in Fig. 6, especially the more distal influences, will be especially important in between-country health inequities.

The framework provides a summary of what is often referred to as "the causes of the causes" of poor health. In recent decades, much public health has focused on proximate causes of ill health. In relation to chronic disease, this has meant aspects of lifestyle: smoking, diet, alcohol consumption and physical activity. The perspective here is that of the Commission on Social Determinants of Health *(1)*: that the causes of these lifestyle causes of poor health reside in the social, legal and political context, broadly conceived. Fig. 6 provides a schematic illustration of the causes of the causes. For simplicity, the figure does not show possible links and feedback loops. These causes start with the societies in which individuals, families and communities are located as they grow and develop – their structures, governance, norms and values. These characteristics of societies are influenced by the macro economy and other global forces acting outside a particular country – the nature of trade, aid, international agreements and environmental factors, including climate change.

These societal factors and the macro processes operating on them influence the exposure of men, women and children to health-damaging and health-promoting conditions through the life course – from pregnancy and early-years development through educational experiences, reproductive ages and relationship to the labour market and income levels during normal working ages and into later years. Intergenerational effects affect the life course, including – but not restricted to – the conditions of the mother and father before conception. The influences that

operate at each stage of the life course can change the odds or level of exposure or help people beat the odds when exposed. Other factors have an influence in one or more of these ways throughout the life course. These can be categorized as:

- attributes that individuals possess – age, sex, height, weight, birthplace, the social conditions of their parents in the prenatal period and through their childhoods, including but not restricted to income, education and employment;
- the identities society and social institutions ascribe to individuals – such as those relating to gender norms and gender relations, sexuality, ethnicity, nationality and disability;
- the material and psychosocial conditions of people's lives – including both the start they had in life in terms of social conditions and material wealth and assets transmitted across generations and those acquired during their own lives, such as food and water, security and housing; and
- the specific hazards to which individuals are exposed in the womb and throughout their lives, including the risks posed by physical, chemical and biological substances.

The way other people perceive identities frequently leads to the vulnerability, exclusion and discrimination experienced by ethnic groups such as Roma populations. Perceptions of identity and differences in social roles linked to gender and education interact with biological attributes. These are key for reproductive and sexual health, which are strongly affected by societal conditions. Some but not all the causes of health differences in these groups with different identities are socioeconomic. It is important to understand how biological sex differences and gender-related social determinants of health link to the different patterns of health among men and women.

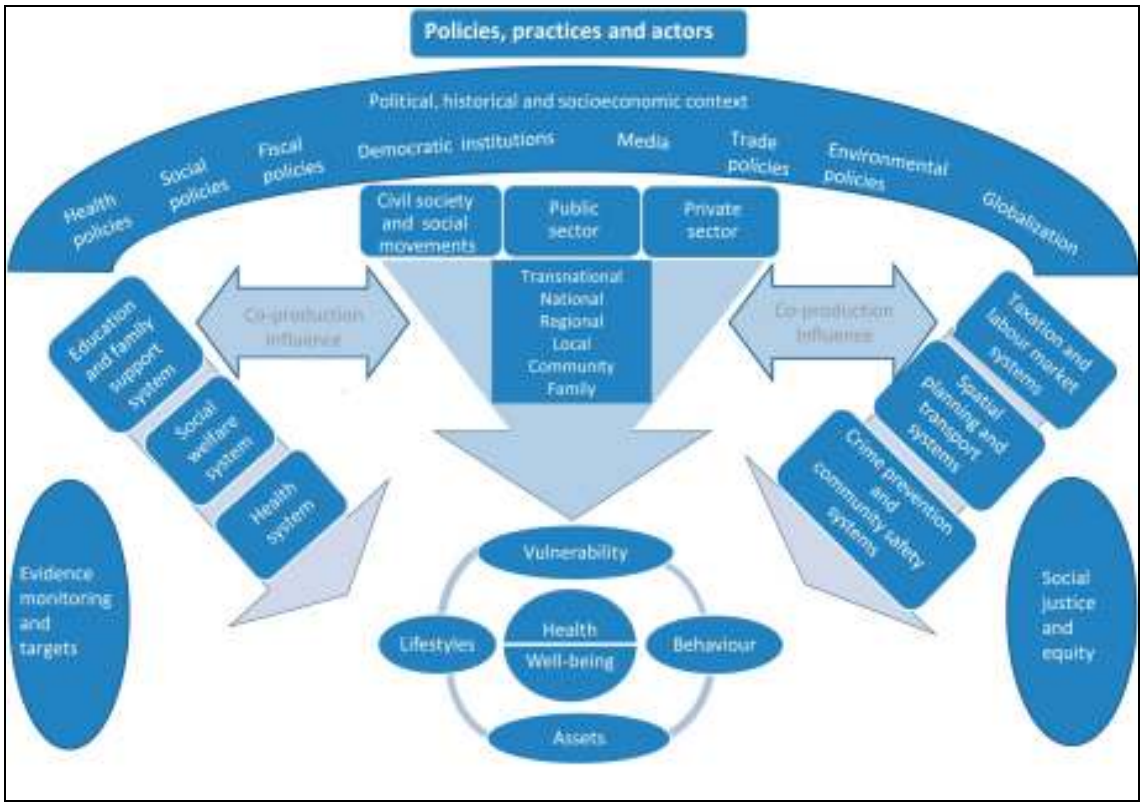
This causal framework is designed to help think through the interaction between the factors and processes that influence the risk or level of exposure to advantage or disadvantage and those that influence the vulnerability and resilience of people, groups and communities when exposed. Together these factors and processes accumulate over time, leading to different levels of various psychosocial attributes among individuals and social conditions in families, communities and social groups. This includes developing levels of resilience, capabilities, control and stress in individuals; in communities it affects levels of social cohesion, social capital, integration and resilience.

These are dynamic, in the sense that the accumulation of positive and negative influences constitutes an ongoing process. This process of accumulation leads to the factors that most immediately affect health and well-being, characterize people and communities at each point in time and influence the lifestyles and behaviour that people adopt and that are prevalent in the communities in which they live. The causal pathways that lead to vulnerability and exposure and predispose people towards unhealthy behaviour and worse health are not equally distributed. They lead to the health inequities seen across the European Region – the health divide between countries and the social gradient between people, communities and areas within countries.

The unequal distribution of the determinants of health, as described above, stems from the politics and history of countries and areas, the socioeconomic stratification of societies within these geographical entities and the unequal distribution of power, prestige, money and resources within and between countries. Social institutions can play a role in creating this unequal distribution by discriminating between people, groups and communities in the distribution of life opportunities, such as education and entry to and progress within the labour market, based on their attributes, identities and material conditions. This has an important divisive effect on the subsequent accumulation of relative social and economic advantage. The extent to which inequalities may be counterbalanced in a society or community relies on equity – a sense of

what constitutes social justice, human rights and equality. Underpinning this approach conceptually is the importance of empowerment: material, psychosocial and political. Having the material requirements for a decent life, having control over one's life and having political voice and participating in decision-making all create good health. These two contradictory influences, inequity versus equity and social justice, are shown as opposing forces on either side of Fig. 6.

Fig. 7. Policies and practices



The political and historical situation in a country, its policies and practices, the cultural and social norms of a society and its government, at every level, set the context in which the social determinants operate and hence are potentially amenable to change. They vary across countries and societies. If correctly channelled, changes in policies, practices and norms can lead to reductions in health inequities and improvements in health for all in a country, as well as and greater community cohesion and well-being. If not, they can lead to widening inequities and worse health and well-being. The causal pathways for an individual's health are complex and long term. Tackling health inequity requires the participation of all of government and of grassroots social movements as well as other sections of society. The cumulative effect of interventions across society has a cumulative impact in reducing health inequities and improving overall health within each country.

The processes and systems that need to be aligned are shown in Fig. 7. The tensions across these systems are such that aligning policies, processes and movements to support better health outcomes is no easy task. It is highly organizationally complex both across the systems shown in Fig. 7 and between the different levels of governance and delivery – from transnational organizations through local and community organizations. It is also often not in the common interest of those concerned. For example, whatever else is achieved by improving education, higher levels of attainment across the gradient increase competition for jobs at the middle and

higher ends. Economic growth and climate change policies can be in conflict. The review will explore and recommend ways of effective working across systems and structures.

The social and political context for the policies that affect individual health, while including those bearing directly on health, also includes social, fiscal, trade and environmental policies as well as globalization, for the reasons described above. These policies are implemented through the relevant systems – education, family, social welfare, health care, tax, labour market, spatial planning, transport and crime and community safety – at each level of governance and delivery. Strategies need to be operationalized at every level, both through formal government sectors and through social movements. The levels at which these strategies need to operate run from the families, neighbourhoods and communities in which people live to the local, regional, national and international agencies that influence their lives. Action at all these levels and types of governance also needs to involve civil society and social movements and take account of the private sector. As indicated earlier, ideally these actions should be taken together rather than in isolation.

There needs to be co-production between systems and between agencies – from both government and civil society – charged with implementing policies and practices. Communities, social organizations and institutions affected by these changes also need to be involved in co-production – change should be carried out with and not to people and their communities.

Action that takes place in sectors other than health, with the primary intention of addressing outcomes relevant to these sectors, frequently affects both the social determinants of health and health equity. Examples include education, social welfare and the environment. Where agendas can be aligned, this will produce multiple benefits. The policies and interventions of other ministries and agencies, as well as those of the health system, should be strengthened as a result. Efforts to mitigate climate change and conserve natural resources, for instance, can also affect health – for example, more active travel, more open spaces and better insulated homes. Environmental and health agendas should be aligned where possible. Similarly, reducing unemployment by providing jobs with good working conditions will have multiple benefits including effects on health inequalities, improving social integration and cohesion and reducing poverty. This does, however, pose significant challenges when jobs are scarce or are only available in small business enterprises. In addition, as previously indicated, alignment is complex, and there are often tensions between policies and the organizations that design and deliver them. However, health equity in all policies is a central principle through which to embed and deliver greater health equity across social policies.

In applying these approaches, a sequence of preliminary steps is required, using two lenses through which policy implementation needs to be viewed. First, the equity lens ensures that the policies are, in principle, those that will lead to greater equity in health and its determinants. Second, the evidence lens provides a focus for understanding the nature and magnitude of the social gradients to be addressed and enables any reduction in the gradient to be monitored, measured and interpreted and progress against any targets set assessed. This focus on monitoring the evidence throughout also enables policies to be adapted so as to ensure greater effectiveness. It also provides a means of auditing and evaluating policies against the aspiration of equity in all policies and assessing the gap between current levels of inequity and the aspiration of achieving health equity.

2.5 Applying the framework to understand the time trends in the WHO European Region

Economic transition in eastern Europe has been associated with factors likely to widen health inequities and worsen overall health *(21–23)*, specifically:

- initial reductions in gross domestic product (GDP) to between 50% and 85% of the 1989 levels, affecting 400 million people and barely recovering by 1999;
- a rise in poverty and inequality that persists today;
- increased alcoholism, smoking and drug use;
- disruption of health care and child care;
- a transition from unemployment rates of near zero to double digits; and
- disruption of a guaranteed standard of living perceived to be adequate.

These factors provide the background to the several explanations related to this conceptual framework that have been proposed for the rapid changes in mortality and other dimensions of health that were accompanied by a rapid increase in social inequality in health in many countries in the European Region *(24)*. The most commonly discussed broad groups of explanation are health behaviour – such as smoking, alcohol consumption and diet – and socioeconomic and psychosocial factors. Both groups of factors are consistent with the fact that much of the difference in mortality between the eastern, central and western parts of the European Region and between lower and higher socioeconomic groups within countries mainly results from cardiovascular diseases and injuries and violence. An important role for health behaviour and socioeconomic and psychosocial factors in both these causes of death is plausible.

The discussion that follows illustrates the importance of proximal influences, such as lifestyle, on trends in ill health. Gauging the magnitude of the role played by these influences contributes to understanding trends. The approach taken by the review, consistent with the conceptual framework above, is that these lifestyle causes must be put in the context of "the causes of the causes". This is particularly important in considering the policy response. A social determinants framework is essential to taking action on these major causes of health inequity within and between countries.

Accidents, injuries and violence may be important in emerging economies and those that have experienced transition, when deregulation has occurred, especially if health and safety laws have been weakened. For example, Lithuania has one of the highest levels of gross national income per person in central and eastern Europe and the CIS. It ranked fourth among these countries in 2005. However, despite falling death rates, Lithuanians still have a high risk of dying from external causes – excluding exposure to smoke, fire and flames *(9)* – with the highest mortality rate from motor vehicle traffic accidents in the WHO European Region in recent years, the second highest from all transport accidents and the third highest from accidental drowning. Violence is also a significant cause of death.

Smoking, high alcohol consumption and an unhealthy diet have been widespread in central and eastern Europe and the CIS for several years. An indirect estimate suggested that, in the Russian Federation in 1990, about 30% of all deaths among males and about 4% of deaths among females were attributable to tobacco. Among men and women aged 35–69 years, these proportions were 42% and 7%, respectively *(25)*. Given the lack of any decrease in smoking among men and an increase in smoking among women *(26)*, the importance of smoking for mortality among women in the CIS has probably increased further. Within populations, tobacco smoking shows an inverse social gradient (with a higher prevalence of smoking among people

of lower social status), which is stronger among men, in central and eastern Europe *(26–28)*. This is likely to contribute to the social gradient in ill health *(29,30)*. However, the role of smoking among women is less consistent, and the contribution of smoking to inequalities in health probably differs by the country's stage in the epidemiological transition from the predominance of communicable diseases to noncommunicable diseases.

Alcohol has similarly been linked with high mortality in central and eastern Europe and the CIS *(31,32)*, and heavy drinking, particularly among men, has probably contributed substantially to fluctuations in mortality during the economic transition in these countries *(33,34)*. However, the social distribution of alcohol consumption in central and eastern Europe and the CIS is inconsistent *(35–37)*, as it is in many countries in the western part of the European Region *(38)*. Alcohol contributes to the social gradient in mortality among men in Finland and Sweden *(39,40)*, but its role in other countries remains to be clarified. For example, the patterns of binge drinking and the total amount consumed in a year differ both within and between countries, resulting in variability of health outcomes. Alcohol also plays a significant role in gender differences. It contributes significantly to the gender gap in life expectancy in many countries, especially in the eastern part of the European Region. It also plays a key role in the sexual behaviour of both men and women *(41)* and in domestic and sexual violence experienced by women *(42)*.

High levels of obesity have been common in central and eastern Europe and the CIS, particularly among women *(43)*. Similar to other types of behaviour, the relationship between social status and obesity depends on the stage of the nutritional transition reached by a society *(44)*. For instance, obesity is initially most common among affluent and educated people, because they are the first to adopt new lifestyles and technologies and because they can afford diets high in animal fat – which are more expensive. However, as observed in high-income countries and more recently in many middle-income countries, the social gradient in obesity reverses when the obesogenic environment changes, such as wider access to energy-dense and nutrient-poor food and, in time, obesity becomes associated with poverty and low social status *(45,46)*. This has happened in western Europe, central and eastern Europe and the CIS. In the 1980s and early 1990s, the educational gradient in obesity among men in central and eastern Europe was similar to that in low-income countries *(43)*. However, by the mid-2000s, the male gradient in central and eastern Europe seemed to have changed into the inverse association typical of high-income countries, and the CIS does not seem to have any clear educational gradient in men *(47)*. Given the dependence that exists between the size and direction of social gradients in smoking, obesity and nutrition and the stage of the epidemiological transition in a given country, the contribution of health behaviour to inequities in health at any time is likely to differ between countries.

As previously indicated, a large body of evidence supports the role of socioeconomic factors in both long-term and short-term trends in population-level mortality in central and eastern Europe and the CIS *(47–52)*. Among individuals within countries, both in the western and the eastern parts of the European Region, psychosocial factors, such as perceived control of one's life, depression, job stress, low trust and absence of social networks, are all strongly associated with socioeconomic status. Since several prospective studies *(31,53–56)* have shown an association between many of these factors and mortality and other health outcomes, psychosocial exposure is a plausible mediator of the association between socioeconomic disadvantage and ill health. However, the number of relevant studies in central and eastern Europe and CIS countries is relatively small, and more are required to reliably quantify the role of psychosocial factors in these countries.

A third group of commonly proposed explanations of these trends relates to the health system. This is a complex area. For example, most studies rely on classifying the causes of death into those that are thought to be amenable to health care and those that are not *(57)*. Several studies

suggest that inadequate access to effective health services contributes to the high long-term mortality levels in the CIS *(58)*, especially from coronary heart disease *(11,59)*, to declining mortality in the Czech Republic after 1990 *(60)* and to short-term fluctuation in mortality in the Russian Federation *(61)*. There has been a shift to increasing inequality of access to health care in central and eastern Europe *(62,63)*, resulting from factors such as service design, accessibility, acceptability, affordability and financing mechanisms. As inequities in health care have been associated with inequity in health within high-income countries *(64,65)*, they may well also contribute to inequities in health within countries in central and eastern Europe and CIS countries. Variation in access to maternal health care, including antenatal care, in many countries in the European Region *(42)* has a particularly important effect on infant and maternal health and early-years development.

This analysis has illustrated the importance of using the conceptual framework (Fig. 6) to understand the development of the current health divide and health inequity in the European Region. The magnitude of both health and social determinants differs significantly within and between countries in the European Region. As has been demonstrated, these are related in terms of time trends, spatial distribution and causal pathways. These causes act both at the societal level, for example during the economic transition in central and eastern Europe, and on the health of particular socioeconomic groups or geographic areas. They may operate directly on the individuals concerned, or their effects may be mediated through health-related behaviour. More importantly, substantial evidence now shows that social determinants acting through the life course, from conception and the early years of life through every life stage, have a cumulative effect on health. This results in a graded relationship between social factors, economic position and health outcomes, both within and between countries. It follows that the magnitude and direction of these gradients crucially depends on the very varied experiences of the cohorts on which the measurement of health outcomes is based.

It also follows that developing a strategy for reducing health inequities requires building on the conceptual framework and the life-course approach and making explicit the role played by various identities and attributes – such as gender, ethnicity and disabilities.

3. European review of the social determinants of health and the health divide

3.1 Structure of the review and the approach to be taken

The aim of the review is to propose strategies for action based on the best and most recent evidence. To achieve this, 13 task groups are informing the review by undertaking work to build on existing knowledge and propose effective strategies for action in key areas relating to health. Eight topic groups are each covering one or more of the key social determinants of health in the European Region and/or key life-cycle stages. Five cross-cutting groups are each focusing on issues that span across two or more of the topic groups. Annex 3 provides more detail about the scope of each task group. The methods of working vary between groups according to the issues to be addressed. Each topic or cross-cutting task group comprises either a chair or two co-chairs and other independent members, who are all experts in the field.

3.2 Task groups

The eight topic task groups are as follows:

1. early years, education and the family;
2. employment and working conditions, including occupation, unemployment and migrant workers;
3. disadvantage, social exclusion and vulnerability;
4. GDP, taxation, income and welfare;
5. sustainability and community;
6. preventing and treating ill health;
7. gender; and
8. older people.

The five cross-cutting task groups are as follows:

1. economics;
2. governance and delivery systems;
3. global factors;
4. equity, equality and human rights; and
5. measurement and targets.

3.3 Activities

The task groups and the review secretariat are developing the evidence base into clearly defined, practical recommendations and actions to reduce inequities in health across the European Region. These range from overarching general recommendations to more local and specific ones and encompass policy in all the areas covered by the task groups – including health systems, methods of measurement and governance.

To complement the work of the task groups in gathering and formulating practical recommendations, the review secretariat will undertake additional tasks to add real-life examples to its recommendations and to act as a reality check on them.

3.3.1 Promising practices and country experiences

Countries' experiences and examples of promising practice are used to illustrate significant policies or actions taken to address inequities in health. There will be a range of cases from the local, national and European Region levels.

3.3.2 Consultation

A consultation paper is being developed, based on this report and the preliminary reports of the task groups. This is intended to stimulate debate on the social determinants of health and the reduction of health inequities within and between countries in the European Region. It also aims to build further political support, policy alliances and capacity for a social determinant approach across government and partner organizations. This will be linked to the consultations on the new health policy for the WHO European Region. Through these processes of consultation and dialogue, a diversity of voices and country perspectives will be reflected in the development of the review, increasing its relevance and robustness as a tool for action to improve health on equal terms in the European Region. At the same time, the process is intended to directly increase support for action on the social determinants of health and health equity at the national and local levels and to facilitate testing of the policy options developed through the review.

Task groups will submit their final reports between September and December 2011 and, following a stakeholder consultation, a final review report will then be prepared for the sixty-second session of the WHO Regional Committee for Europe in September 2012.

3.3.3 Examination of future trends in inequalities in health

Finally, the review will identify likely future trends in inequalities in health, taking into account existing data and other relevant factors. This is likely to include the economic downturn and the associated cuts in public expenditure and other pressures on policy and politics within and between countries, as this has the potential to influence other social determinants of health. The demographics of many countries in the European Region show an ageing population, and this trend is expected to continue, so this will need to be considered when making recommendations, as will both the effects of climate change and the need to act to reduce carbon emissions.

This section outlines some of the main barriers to and opportunities for reducing health inequities across the European Region. Subsequent work during the review, including that of the task groups and consultation responses, will build on this initial analysis and propose effective ways of creating and maximizing opportunities and overcoming barriers based on the available evidence.

4. Emerging themes

4.1 Emerging thinking on themes

This section brings together some of the themes emerging from analysis outlined in previous sections and the work of task groups to identify overarching challenges and particular issues (such as achieving a whole-of-government approach and the role of international organizations and donor agencies). Where possible, the section identifies emerging themes from the task groups. It examines what can be proposed around the financial and human costs of health inequity across the European Region (such as the cost of doing nothing) and the potential uses of evaluation to develop costed cases. It outlines some of the challenges arising from the various health inequity issues in low-, middle- and high-income countries and explains the proposals for meeting these challenges in the review.

4.2 Thematic areas and issues

The recommendations of the review are likely to emerge from the following themes and issues identified so far by the task groups in their preliminary analysis of available evidence.

4.2.1 Key concepts

4.2.1.1 Assets and vulnerability resulting from the social determinants of health are at the centre of the conceptual approach

As described in Section 2.4, causal pathways that stem from the social determinants of health create vulnerability and exposure that predispose individuals and social groups towards worse health. Conversely, some pathways lead to increased development of capabilities, control and resilience providing individuals and communities with the power to act in their own best interest to strengthen health and well-being, both directly and through healthy lifestyles and health-promoting behaviour.

4.2.1.2 Social integration and cohesion are linked to the social determinants of health and health inequities

The degree of social integration and cohesion in a society is the product of the same social determinants as is health, and social integration and cohesion may themselves be social determinants of health. It follows that inequalities in the social determinants of health are closely associated with differing levels of integration and cohesion across the European Region. This observation provides an important way of linking review recommendations and analysis to wider concerns across the Region. For example, high levels of unemployment and insecure employment worsen social insecurity, heighten unrest, intolerance and racism and are bad for health. This gives tackling many of the social determinants of health additional political relevance and urgency. It is potentially useful for health ministers to be able to make that point across government and for the EU, WHO and United Nations to have an aligned agenda.

4.2.1.3 Vulnerability, inequity and the rapid speed of social and economic change are related

Vulnerability is not an innate characteristic of individuals but a product of the circumstances in which people are born, live and work. Particularly toxic combinations of circumstances can adversely affect all but the most resilient people. Among communities living in poverty, such combinations are and have always been particularly likely to lead to a range of adverse social

and health outcomes. However, in periods of rapid social, political and technological change, the conjunction of adverse circumstances can lead to a rapid increase in vulnerability for many people who may have previously led relatively secure lives. The following are examples of increasingly common insecure conditions.

- Many forms of employment are insecure. These include seasonal work, temporary contracts and informal or illegal work.
- Employment that emerges from labour market deregulation and liberalization, in the context of new economic policies and globalized competition, is frequently precarious. There are different types of precarious employment, including subcontracting, marginal self-employment, freelancing and similar forms of temporary contracts.
- Processes of organizational downsizing and restructuring frequently result in job instability and insecurity.
- Insecurity is heightened when these insecure forms of employment result in either frequent periods of short-term unemployment or in a period of long-term unemployment. The absence of adequate and appropriate social welfare provision exacerbates the effects of unemployment.
- Irregular migration leads to insecurity, especially when instigated by economic deprivation, human rights infringements or civil unrest.
- Having refugee or asylum status may lead to insecure conditions, especially when the reception in the host country is mixed or mostly hostile.
- People and groups of people become insecure and vulnerable when they are exposed to negative and/or stigmatizing attitudes towards them. This becomes more extreme in situations of economic insecurity, and they become susceptible to rapid shifts in attitudes. For example, the rapid escalation of negative attitudes towards Roma has increased their vulnerability to exclusionary processes. This has reduced their opportunities for obtaining employment, accessing health and education services and residing in some areas.
- The complexity and increasing speed at which attitudes are formed and dispersed (partly but not exclusively as a result of technological change and the rapid globalization of ideas) may increase vulnerability very rapidly.
- Rapidly changing social welfare provision leads to insecurity, with a greater lack of certainty about the capacity and breadth of social support systems. Such rapid shifts exacerbate the increasing vulnerability of groups of people in need of such support. Further, stress, anxiety and other mental health problems are likely to increase as a result of these rapid changes to social support systems.

Rapid changes compound the difficulty associated with trying to reduce vulnerability for some groups – such as women exposed to domestic violence. The nature of vulnerability changes continually, as do the groups of people being made more or less vulnerable. In addition, the systems of support are themselves changing rapidly.

This theme clearly links to the overarching theme of social cohesion and integration.

4.2.1.4 A human rights–based approach to health equity is needed

Oldring & Jerbi *(66)* discussed human rights and health.

> Today there is growing recognition of the links between health and a wide range of human rights, as well as a growing appreciation of the right to the highest attainable standard of health itself. There is broad agreement that health policies, programmes and practices can have a direct bearing on the enjoyment of human rights, while a lack of respect for human rights can have

serious health consequences. Protecting human rights is recognized as key to protecting public health.

The right to health means that governments must generate conditions in which everyone can be as healthy as possible. A human rights–based approach to health gives importance not only to goals and outcomes but also to the processes in trying to achieve these goals and outcomes. Health policy-making should be guided by human rights standards and aim at developing the capacity of those in positions of responsibility – for policy-making and delivery – to meet their obligations and empower rights-holders (the public) to effectively claim their rights. Eliminating all forms of discrimination is at the core of a human rights–based approach, with a particular focus on gender equity in all policies. Human rights standards and principles, such as participation, equality, non-discrimination, transparency and accountability, should be integrated into all stages of policy-making and implementation.

The human rights principles and efforts to improve health equity should be mutually reinforcing. The right to health complements the health equity concept by aiming for everyone to enjoy his or her full health potential. Moreover, the human rights principles of non-discrimination and equality strengthen the conceptual foundation of health equity for the groups in society for whom inequities in health are related to wider vulnerability.

4.2.1.5 How does variation in well-being relate to health inequalities?

There needs to be a discussion about well-being, how strongly it relates to health inequalities and therefore whether it should be in the foreground of recommendations produced by this review. Some groups with poor health report good well-being; among other reasons, this relates to expectations of health in diverse population groups and societies. This highlights how some self-reported measures of well-being are difficult to use as indicators, especially for comparing social class groups and countries. Efforts are being made to provide systematic indicators for well-being that can overcome these difficulties, at least in part. The review will assess these indicators and draw on them in developing the proposed indicator set and targets for health inequalities.

4.2.1.6 Achieving a reduction in the social gradient in health by reducing inequities in society and by specific actions across the social gradient

Central to the review is the nature of the targeted reduction sought in health inequities and the distribution of the social determinants of health. The review is likely to suggest combining two key approaches. First, social inequities in society should be narrowed, with the aim of moving towards flattening the social gradient in health. The second will be based on specific interventions across the social gradient, so that everyone's health moves closer to that of the people who are best off.

4.2.1.7 Related to the above, further developing the approach of proportionate universalism

Because of the need to help people move out of poverty, the review will develop further the concept of proportionate universalism that provides a more nuanced view about how interventions should be designed, implemented and monitored to achieve the target reduction in inequity.

4.2.1.8 Concerted action is needed across the life course and across all the sectors influencing the social determinants of health

As the conceptual framework illustrates, the social determinants of health are strongly interlinked and act through the life course and intergenerationally. Health inequity cannot be reduced through one instrument or in a short period of time. It requires concerted action across the various determinants and across the life course, achieved through the actions taken by a variety of sectors and agencies co-producing with communities. As the title of the report of the Commission on Social Determinants of Health *(1)* indicates, the challenge is "closing the gap in a generation".

4.2.1.9 Gender continues to be an issue in all countries, influencing the risks and opportunities of men and women throughout their lives, but it looms particularly large in some countries in the Region

Gender norms and relationships affect the exposure to risk and the opportunities for health of both women and men. Societal values and the distinctive gender identities assigned to men and women can both lead to discrimination and adversely influence behaviour. In these various ways, gender influences the other determinants of health throughout the life course to a greater or lesser extent in different societies.

Action is needed in all societies, but the need is greatest where the resulting health differences are unfair and avoidable and are amenable to intervention.

4.2.1.10 The review is concerned with excluded groups, but it is more helpful to view exclusion as a process than to focus on who is in and who is out

Viewing disadvantage, social exclusion and vulnerability in terms of processes rather than as a state experienced by particular groups will improve the identification of key characteristics of action by governments and other actors that have the potential to exacerbate or positively influence these processes and hence increase or reduce health inequities. This should enable the review to produce a framework for identifying principles for action to reduce exclusion and any associated health inequities.

4.2.1.11 By focusing on exclusion as a process, the link between social gradient and specific groups can be more clearly identified

In accordance with the definition adopted by the Social Exclusion Knowledge Network of the Commission on Social Determinants of Health *(67)*, social exclusion can be regarded as comprising dynamic, multidimensional processes that are driven by unequal power relationships interacting across four main dimensions – economic, political, social and cultural – that operate at different levels. These processes result in a continuum of inclusion and exclusion that is characterized by unequal access to resources, capabilities and rights and that lead to a social gradient in health inequities.

4.2.2 Organizations and governance

4.2.2.1 In addition to traditional organizational interventions, co-production with family and communities is essential

A conclusion emerging from many task groups is that traditional organizational interventions are not always the most successful when, for example, they do not engage communities in

design, delivery and review. A more creative approach should be taken to co-production – for example, in relation to family and community interventions.

Consideration is required of how interventions are framed and where they come from.

- Some community-led interventions can be illustrated with examples from the CIS countries – with local community groups that have been funded by aid agencies for instance.
- There is a need to be specific and to assess how community and family interventions might operate in a way that can be scaled up.
- The evidence clearly shows that conventional interventions neglected the voice of the people targeted. The organizational implications of this are not necessarily that community and voluntary groups should be delivering service and interventions instead of professionals and the public sector, but that they should be involved in designing and delivering these interventions and services – in partnership with professionals and the public sector and with joint review and adaptation with formal government and public bodies.
- For many conventional organizational interventions, there is a lack of evidence supporting their effectiveness – rather than there being any evidence that they do not work. Evidence is also lacking on the consequences of replacing traditional public services with community-based action. The latter may increase social cohesion and integration at the local level, in contrast to conventional public sector interventions, but could undermine cohesion across societies. This highlights the need for more thorough evaluation of the relative merits of both approaches.

4.2.2.2 The review will develop a clearer conception of the appropriate levels at which policy changes and interventions should be led

More emphasis should be given to where the appropriate lead lies in considering interventions such as those that are community based, those directed at parents, families, employers and workplaces and those that are focused on transnational and supragovernmental organizations and nongovernmental organizations.

4.2.2.3 The role of the private sector is important but too often ignored, and this area is a major challenge

The marketization of public services and the role of the private sector in delivering goods and services that influence the social determinants of health, either positively or negatively, raises important issues. What are the societal and economic costs and benefits involved in increasing this role, in deregulation and other market mechanisms? Where the role has changed, has this led to a widening or narrowing of health inequities and to improving or worsening overall health? If so, what are the processes that have led to this impact on health?

4.2.3 Interventions and policies

4.2.3.1 Some policies and interventions clearly exacerbate health inequities

In addition to looking at what might work to reduce health inequities, a growing body of evidence exists on what policies exacerbate health inequities and what practices and interventions do not work. This includes examples both of a lack of concern for equity and the unforeseen or unanticipated effects of policies on health equity and its social determinants. The review needs to include policy analysis about what has gone wrong. For example, short-term, small-scale policies tend to not produce the results needed and are frequently the result of short

political time frames rather than being informed by the best available evidence. In particular, the global financial situation is clearly an exacerbating factor for health inequities and a constraint on action to tackle them. Several task groups are assessing the implications this has for health and the formulation of policy recommendations by the review.

4.2.3.2 Policies will be examined for their effect on the whole social gradient in health

Financial and welfare interventions are often narrowly focused, time-limited actions targeting particular groups. This reduces the potential to alter the gradient significantly. For example, welfare minimalism focuses on the bottom of the gradient and ignores the middle sections.

Although these approaches may have their place, their effectiveness is likely to be limited and they may simply disguise the extent to which policy as a whole reproduces inequities. This is most evident when providing supportive services for individuals living in poverty without actually tackling the poverty itself. Equally, the effects of most policy actions on distinct parts of the gradient, in terms of differential impact and the potential for redistribution, are poorly understood.

4.2.3.3 Contextually relevant interventions need to be identified across the diversity of countries in the European Region

Work still needs to be done on how the review will cover the very different situations across the European Region. Task groups have identified potentially different approaches, so further discussion is needed on how this should be done. One agreed course of action is to establish a network for the eastern part of the Region to specifically cover some of the issues that some or all of the task groups are not in a position to address.

4.2.3.4 A classification is needed of the types of interventions and policies that are required to reduce inequities

The possible actions that can be taken to reduce health inequities include legislation, regulation, stakeholder agreements, shifting cultural norms, specific interventions and programmes and organizational change.

The levels at which actions are directed or delivered also vary, as indicated in Fig. 7: for example, government, local, community based and/or family based. This framework needs to be further developed around each level – – family, community, organization, government and international. The logic and theory of change underpinning proposed actions also needs to be considered, to identify how they are intended to reduce health inequities.

Definitions used for policy purposes – such as those of disadvantage and exclusion – directly affect the design of interventions. This can constrain or redirect the action being taken, so that they end up being less successful than theory or pilot studies would predict. Paying attention to the concepts underpinning definitions is important in avoiding such outcomes. Greater focus is needed on these.

4.2.3.5 Action needs to be taken based on the demographic profile of inequalities

It is important to consider how actions can be taken that focus on the vulnerability currently associated with specific demographic groups across the European Region or in specific countries, such as the public health crisis in the Russian Federation. This needs to recognize that membership of particular groups – such as based on ethnicity, migration status or gender – is

not inevitably associated with advantage or disadvantage but that vulnerability is often situation-specific and is magnified by the role being played by other social determinants.

Policies need to be responsive to gender and ethnicity and acknowledge the importance of responding to the health inequities that flow from these situations. The European Region has undergone a significant reproductive transition in the past 25–30 years. Women's childbearing has changed – from having many children to having only a few. Marriage and partnering patterns have changed, as have family structures, women's rights, etc. This has affected infant mortality and maternal mortality and health more generally. However, countries and social groups within countries are at very different stages of this transition. This provides part of the explanation for differences, both within and between countries, in some of the health inequities in the European Region.

4.2.4 Wider agendas

4.2.4.1 The role of global processes and influences

Global factors, such as the economic downturn and migration pressures, influence the social determinants of health in the European Region. The increasing securitization of foreign policy – in terms of border protection and economic competitiveness – provides a specific example of a policy that has wider global ramifications that influence health equity in the European Region.

Similarly, foreign policies in the European Region have wider global effects on other countries. These have both a direct health equity effect on these countries and also an indirect (feedback) effect on health and its social determinants in the European Region. The main channels of influence are trade, development and aid policies. For instance, how foreign policies in the European Region are affecting health and development equity more globally, given the rebound effects on global economic and financial stability, migration and pandemic security risk. The critical issue to be addressed here is that of increasing coherence in the foreign policies of countries in the European Region and of European transnational organizations such as the European Commission, Organization for Security and Cooperation in Europe and the Council of Europe.

4.2.4.2 Making links with the agenda for climate change and environmental sustainability

The agendas of climate change and the social determinants of health are linked in many ways. It is important to find common causes and to understand the different effects on different social groups, recognizing that both environmental damage and measures to safeguard natural resources, including climate change mitigation, may worsen health inequities, whereas some interventions, such as home insulation, more active travel and green space, may reduce them.

4.2.4.3 Empowering civil society

The role played by civil society in these and other similar developments is important. The role of civil society was relevant during societal transformation processes in countries in the eastern part of the European Region. Civil society organizations operated as an engine during the system changes from politically directed economies to market economies and from directive political systems to democracies. Twenty years after the transformation began, the education and health care systems have funding problems, and a role has emerged for civil society in supporting more equal distribution of services. Family resources are also mobilized to cope with health problems. Achieving more equity in health potentially requires co-production – the

concerted action of the state and private sectors as well as civil society and families. In this model, activity and adaptivity by all these actors plays an important role.

4.2.5 Economic issues

4.2.5.1 Evidence is needed on the social and economic costs of inequities in health

The social costs of health inequities and the health divide need to be considered in addition to those that can readily be expressed in financial terms. For example, social inequalities (educational inequality and unemployment) tend to worsen attitudes towards migrants, cause social unrest and this, in turn, widens health inequities. This poses significant challenges in quantifying non-monetary items.

4.2.5.2 Calculating the economic costs and benefits of action on social determinants

Policy-makers need to know the magnitude of the benefits of policies and interventions when making comparisons with other policy options. In an ideal world, information would be readily available that allows meaningful comparison between interventions based on the social determinants of health and other types of interventions. However, there are real issues in either measuring the efficiency of benefits in terms of a single agreed common currency or in measuring equity benefits in terms of a single agreed equity target. High-quality, comparable information is hard to obtain. The review will assess what is available and its quality.

When no information is available on costs and benefits, the relevant cost and benefits associated with a policy and who, or which sectors, might bear the costs and reap the benefits need to be described qualitatively.

In making recommendations, the review will also need to assess the causal impact of proposed interventions if benefits are to be quantified. This is also difficult to measure. However, the review will document the type of evidence of effectiveness available for each recommended intervention.

Understanding the relationship between equity (the distribution of benefits resulting from a specific intervention) and efficiency (the total or average outcomes for the population as a whole) is key to making policy choices. Identifying cases when they might be complementary and achieve both equity and efficiency will be particularly valuable. Nevertheless, in situations in which there is a trade-off, knowing the shape of that trade-off will allow policy-makers and societies to make informed decisions according to other criteria, such as social justice and other qualitative benefits of equity.

Finally, the review will identify, where possible, the likely unintended consequences that might result from the recommendations. This will allow a broader assessment of the full range of potential side effects or benefits of each recommendation.

4.2.5.2 Mainstream budgets and investment instruments need to be adjusted to accommodate action on the social determinants of health – "bending the spend"

Existing spending needs to be adjusted to accommodate action on health inequity. For example, spending on social cohesion and integration – such as via EU funding – is very important, especially if a sufficiently strong case has been made for common causes with health inequities. All aspects of funding and investment on the social determinants of health across the European Region should be explored, with the aim of proposing how to align spending to more effectively

achieve action that will reduce inequities in health. In a fiscal and economic environment with finite resources and cutbacks, strong arguments are required for why it is an effective strategy.

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Annex 1. Key messages reported in phase 1 of the review

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

Annex 2. Review of systems, processes and contexts affecting action on the social determinants of health

1 Introduction

This annex outlines some of the main barriers to and opportunities for reducing inequity in health across the Region. Subsequent work during the review, including that of the task groups and consultation responses, will build on this initial analysis and propose effective, evidence-based ways of creating and maximizing opportunities and overcoming barriers if these systems are to more effectively engage with health inequities in the future.

2 Systems

2.1 Governance structures

Governance structures and capacity at the international, national and local levels are critical to the ability of the European Region to develop and implement policies to tackle health inequity. These vary considerably across the European Region. Taking this diversity into account is a significant challenge when making cross-national and regional recommendations and requires more localized responses that complement the overarching regional strategies. Divergent governance structures create difficulties in collecting comparable data and disseminating and advocating policies and practices across national boundaries. WHO is publishing a study on governance for health in the 21st century during 2011, which will inform this review and Health 2020. The review of governance will assess the best forms of governance that can deliver on reducing inequities in health through action on social determinants of health, with a focus on cross-government structures and systems. Good governance is essential to being able to reduce health inequity across the Region.

Insufficient capacity within organizations and systems creates problems when people and implementation efforts are restricted as a result. This lack of capacity may be because of a lack of material resources – compounded by the economic downturn, a lack of power or remit and the influence of history and culture on styles of governance. As such, low and/or fragmented levels of effective action on health inequities can often simply be attributed to a lack of expertise, capacity and familiarity rather than a deliberate lack of will to do anything about it – although the latter may also be a barrier.

Citizen engagement and participation is integral to governance. Democratization, democratic institutions, the participation of people and the role of civil society are all important in introducing the changes needed.

The review will assess the areas of promising practice in which strategies, actions and systems have delivered effective action on health inequities despite limited capacity.

2.2 Regional, national and local action

Strategies to address health inequity and the social determinants of health tend to be developed at the national and supranational levels. Local innovation is also crucial, however, and ensuring consistency of efforts and coherence at different levels of governance requires bolstering the

capacity of the subnational level – regions and municipalities. Local agencies have a more immediate democratic imperative, as they are literally closer to the public they service and the level at which ordinary people are best placed to act. Local agencies and authorities face several challenges in attempting to reduce health inequity, including the influence of wider legislative context on their ability to act, tensions between different levels of government or different local governments and lack of capacity and resources. One aspect that requires particular attention is the scale, focus and intensity of action needed to appreciably reduce health inequities – the social gradient can only be reduced measurably through actions that require refocusing mainstream funding and making hard political choices. The coherence of governance between the national systems and the regional and local systems and stakeholders needs to be ensured to strengthen the overall coherence of governance within a country. In addition to the review of governance, this review's task groups on governance and delivery systems and on measurements and targets will assess and propose actions on how best to ensure coherence and sufficient capacity across all levels of delivery systems and in governance structures.

2.3 Health systems

Action is needed across all key government sectors to reduce health inequity through action on the social determinants of health. Although health systems alone cannot reduce inequities in health, they play a vital role with the potential to reduce health inequities, ensuring equitable access to services and in advocating for health equity in the development plans, policies and actions of other sectors (see subsection on intersectoral working below). When health systems have democratic deficits, empowerment is an issue. With the dominance of the medical model in these systems, they have been slow at empowering service users as individual patients or as communities to serve as a genuine voice in designing and delivering services. Health systems are typically one of the most hierarchical public services. Not only is public empowerment essential, but more equal relationships between health professionals are needed to provide effective and efficient delivery. The review's task group on preventing and treating ill health and the task group on governance and delivery will make recommendations and proposals for the review to consider around the potential roles for the health system in addressing health inequities.

One of the key messages of both the Tallinn Charter: Health Systems for Health and Wealth *(1)* and the report of the Commission on the Social Determinants of Health *(2)* was that well-functioning health systems are essential for any society to improve health and health equity. Health systems are very diverse across the European Region, and improving the performance of health systems would help to reduce health inequities between countries and localities. However, it is possible and important to go further, using health systems as organizations with the potential to combat socially determined inequities in health *(3)*.

One of the clear responsibilities for a health system is to address the inequitable impact of copayments, especially informal payments by service users. Inequity in health is worse when vulnerable citizens forego care because of the cost and/or fear of being forced into poverty because of high out-of-pocket health care costs. Countries lacking a system of universal health care funded by general taxation or mandatory universal insurance are likely to face much greater inequities in health and find it harder to narrow this gap *(2)*. Although the commitments made in the Tallinn Charter *(1)* do not identify a single approach to health care funding, they indicate that each country should "distribute the burden of funding fairly according to people's ability to pay".

Some lower-income countries in the European Region, including Armenia, Azerbaijan, Georgia and Tajikistan, were heavily constrained in their spending during the 1990s, and as a result, growth in the dependence of health systems on private spending increased inequity in health *(4)*.

In some cases, even if no formal health service charges are levied on users, individuals make informal payments when they need health care. Recent health care reforms in some countries in the eastern part of the European Region, such as Kyrgyzstan and the Republic of Moldova *(4)*, successfully reduced the inefficiency of the health care systems they inherited from the USSR. However, progress is inconsistent across countries, and the effects of reforms vary. For example, some countries have relied on private rather than public health care *(5)*.

There is also scope for health systems to put their own house in order *(6)*. This can include building on current efforts by the health system to tackle inequities in health. For example, solidarity in health system funding can be implemented to ensure universal access so that services are free of user fees and provided based on need and not ability to pay. The extent to which health care delivery is directed to the social factors shaping health is important in addressing health inequity, including specific guidelines, backed by adequate resources, for ethnic groups, and health care services that recognize the levels of health literacy across the population.

Putting health systems in order also includes understanding and reducing health inequities within each health system's own workforce, often a sizeable section of the population. England's National Health Service, for instance, employs about 1 million people.

Health ministries have an important role to play as active stewards of health equity and can be instrumental in improving equity in health in other sectors' policies. The latest evidence shows how keeping equity in health on the intersectoral agenda is particularly important in times of economic downturn.

2.4 International institutions

At the international level, many institutions affect levels of health inequities in the European Region, including the EU, WHO, Council of Europe and nongovernmental organizations. A focus on inequities in health and social determinants, particularly within the EU and WHO, is a promising development resulting in some positive outcomes, detailed below.

Health governance affecting the European Region includes other international organizations such as the United Nations Children's Fund (UNICEF) and the Joint United Nations Programme on HIV/AIDS (UNAIDS), national development agencies such as the United States Agency for International Development and the United Kingdom Department for International Development, the International Monetary Fund, the World Bank and nongovernmental organizations such as Oxfam and the International Federation of Red Cross and Red Crescent Societies. The impact and potential role of these institutions needs to be assessed, to avoid duplication of activity and to emphasize effective coordinated action. Institutions working together increase efficiency and power: an example is the EU working closely with WHO on the WHO Framework Convention on Tobacco Control, the International Health Regulations and the Commission on Social Determinants of Health.

2.5 Nongovernmental organizations

Nongovernmental organizations are distributed unevenly across the European Region, with more prevalent and active organizations in the western part of the Region. The review's task groups will assess the role and potential impact of these and other institutions across the Region, to recommend effective action to increase their ability to reduce health inequity through action to reduce inequalities in the social determinants of health.

3 Processes

3.1 Intersectoral working

Coherent effective intersectoral action is needed to tackle health inequities and inequalities in the social determinants of health. The social determinants are related to a wide range of sectors, such as early years, employment, tax and welfare systems, housing, environment, transport and public health. Reducing health inequity requires coherent action in all these sectors. The need for and mechanisms to further intersectoral action have been reinforced through European and global frameworks, including the EU health in all policies framework in 2006, the WHO Commission on Social Determinants of Health in 2008 *(2)* and World Health Assembly resolution WHA62.14 on reducing health inequities through action on the social determinants of health *(7)*; and the Tallinn Charter *(1)* in 2008.

The countries in the European Region vary widely in the nature and extent of intersectoral mechanisms being used to address public health challenges. Most official health strategies and policy documents refer to the importance of work with other sectors, and many of these have or indicate the existence of some form of intersectoral or joint planning group or committee. At the same time, how well these approaches are working in practice varies widely. This variation in the performance of intersectoral planning mechanisms reflects gaps in knowledge and human resource capacity as well as fragmentation of institutional arrangements that are critical for success. Recognizing the role of small-scale innovations within intersectoral arrangements is important if these can then be used to demonstrate the potential of large-scale solutions and rolled out appropriately.

Intersectoral working is almost impossible where silo working arrangements result in sectors being held tightly to account for different sets of outcomes. Co-production is more likely to happen when outcomes are shared for accountability purposes. The implication is that important opportunities are being missed to (a) health-proof the impact of other policies, (b) develop coherent action to address major health priorities and (c) secure improved resources and policy investment in the social determinants of priority public health issues. The review's task groups on equity, equality and human rights, measurement and targets and governance and delivery systems will assess these opportunities and propose actions for the review to consider.

Examples of some of the explanations provided for the current gaps and fragmentation in intersectoral approaches and policy coherence are described below.

3.2 Underinvestment in public health capacity and systems during health system reform

This underinvestment can be seen clearly in many countries in the eastern part of the Region. In this part of the Region, health care reform has been emphasized, which has led to giving priority to investment in health care services rather than in public health. This health service investment has been important for countries in the early and middle stages of economic transition but appears to have taken place at the expense of either (a) maintaining previously good public health services or (b) parallel investment in strengthening new public health systems and capacity. As such, the level and capacity for health promotion, disease prevention and developing public health evidence and policy are often generally weak. This limits systematic progress in attaining better policy coherence for health at a time when public health needs are increasing. All health systems should have public health as their foundation rather than isolating public health functions.

Economic and social change is now taking place in many parts of the Region with a more rapid rhythm and tempo than before – reflecting climate change, economic downturn, globalization and demographic changes. Consequently, public health systems need to be more flexible to respond to these changes while recognizing the stability and continuity required for policy interventions to be sustained for long enough to change the underlying determinants of ill health.

3.3 Small-scale intersectoral projects and initiatives

Strategies to deliver systematic joint action on major public health priorities such as noncommunicable diseases or social inequity in health have proliferated. Small-scale demonstration projects are useful for testing what works, but their impact is limited unless they are part of a broader commitment to scale up learning across the systems that promote and protect public health. This was one of the clear messages from *Fair society, healthy lives (8)*, the analysis of existing and previous policies in England.

High-level ministerial support is key to the success of intersectoral planning and action, but ensuring participation from various institutions with different institutional cultures, objectives and experiences cannot depend on presidential or ministerial will alone. Technical and political leadership should be accompanied by objectives and goals shared and understood across the workforce. This requires ongoing support to building the knowledge, skills and tools and developing the leadership potential of those in key roles. This is essential to ensure that relevant policies and initiatives are taken forward across all sectors that have the potential to affect the social determinants of health. This requires both advocacy around mainstream policies and effective partnership work on joint projects. The governance and delivery systems task group and the WHO governance review will cover these issues, which will feed into this review and into Health 2020.

3.4 Global processes

3.4.1 Tallinn Charter: Health Systems for Health and Wealth

WHO European Member States and a range of international partners adopted the Tallinn Charter: Health Systems for Health and Wealth *(1)* in 2008, providing guidance and a strategic framework for strengthening health systems in the European Region.

3.4.2 Millennium Development Goals

The heads of state of 189 countries adopted the Millennium Development Goals in 2000. They provide a framework for focus and accountability in addressing some of the most pressing global development challenges. All the Millennium Development Goals affect health, and health affects all the Millennium Development Goals. There are health-specific goals on child health, maternal health, HIV/AIDS, malaria and TB, and those addressing key determinants of health: reducing the proportion of the population living in poverty; universal primary education; promoting gender equality and empowering women; integrating the principles of sustainable development into country policies and programmes; reversing the loss of environmental resources; and developing a global partnership for development. Delays and barriers to progress towards achieving the targets of the Millennium Development Goals endanger health and well-being. Across all sectors, development efforts must reach the people in need across the social gradient, with proportionately greater attention to the most vulnerable population groups.

This review will consider how addressing the social determinants of health is key in achieving the Millennium Development Goals. Education is a key determinant of health, and a recent article by the Brookings Institution *(9)* argues that achieving the Millennium Development Goals will be virtually impossible without achieving Millennium Development Goal 2, universal primary education.

Education and gender parity in education, to address education and gender inequity, could have a major effect on attaining Millennium Development Goal 4, reducing child mortality *(6)*. A UNICEF study, *Narrowing the gaps to meet the goals (10)*, concluded, "An equity-based strategy can move us more quickly and cost-effectively towards meeting Millennium Development Goals 4 and 5 – reduce child mortality and improve maternal health – than our current path, with the potential of averting millions of maternal and child deaths by the 2015 deadline." This illustrates how addressing the social determinants of health is vital to achieving the Millennium Development Goals.

3.4.3 European Commission communication on solidarity in health

The European Commission communication on solidarity in health *(11)* outlined EU processes relevant to addressing the social determinants of health and inequalities in health, including (a) collaborating with national authorities, regions and other bodies, (b) assessing the impact of EU policies on health inequalities to ensure that the policies help to reduce these inequalities when possible, (c) regular statistics and reporting on the magnitude of inequalities in the EU and on successful strategies to reduce them and (d) better information on EU funding to help national authorities and other bodies address the inequalities.

3.5 Economic forces

3.5.1 Inequality in income and the role of social protection

As illustrated in Section 2, income levels vary across the Region, both within and between countries, and inequalities in health are correlated with this variation. The lower a person's socioeconomic status, the worse are the prospects for his or her health. Some countries have managed to narrow inequality in income through effective redistributive tax systems, but the countries lacking an effective safety net to support the more deprived people in society will experience greater inequalities in health.

Social protection has a clear role in addressing health inequities. The effects of welfare state regimes on health demonstrate that both the type of welfare state and its size affect health and inequities in health *(12–15)*. The extent of social protection (going beyond income to cover a range of other services) provided by the public sector influences the social determinants of health and resulting inequities in health. A state's provision of social protection is important for safeguarding the right to health, encapsulated in Article 12 of the United Nations International Covenant on Economic, Social and Cultural Rights. Comment 14 on the right to health specifies that the social, economic and environmental conditions required for health are part of this right. As such, social protection that works to reduce inequity in health should comprise both social health protection, in relation to removing financial barriers to the health system, and social protection across a range of sectors responsible for providing the conditions required for health.

The concept of comprehensive social protection is particularly salient in the current economic downturn. The United Nations Chief Executives Board adopted the United Nations Social Protection Floor Initiative in 2009 as one of nine key priorities to cope with the economic crisis. The social protection floor approach includes:

- services: ensuring the availability, continuity and geographical and financial access to essential services, such as water and sanitation, food and adequate nutrition, health, education, housing, life- and asset-saving information and other social services; and
- transfers: realizing access by ensuring a basic set of essential social transfers, in cash and in kind, to provide a minimum income and livelihood security for poor and vulnerable populations and to facilitate access to essential services *(16)*.

Safeguarding universal systems of social protection is crucial from a basic human rights perspective, to protect or limit the loss of past investments, to reduce the future burden on human, social and economic development potential and to have the potential for a balanced recovery from the economic crisis. A social protection floor includes measures to encourage and support self-help, mutual aid and participative models of service design and delivery (co-production). The review's task group on GDP, taxes, income and welfare will consider the evidence relating to the impact of various welfare and tax systems on inequities in health and its social determinants and propose most effective action and systems for the European Region.

3.6 Measurement and monitoring

The lack of data in some areas presents a significant challenge in addressing inequity. The recent report on monitoring the social determinants of health and the reduction of inequalities in health in the EU *(17)*, for example, pointed to gaps in existing knowledge, particularly relating to the effects and effectiveness of policies of the health sector and other sectors in reducing inequalities in health. The lack of appropriate, routinely available and comparable data within each country and across the EU was highlighted as a key barrier to the greater knowledge and effective analysis needed to reduce inequalities in health.

Data on inequalities in health and related policies in the countries in the Region outside the EU are equally limited. All countries have health surveys, but many surveys have limited comparability because of the size and representative nature of the samples and the nature and frequency of follow-up *(18)*, especially in the central and eastern parts of the European Region *(19)*. Further, evidence indicates that studies based on unlinked data led to underestimating mortality in disadvantaged groups and overestimating mortality in advantaged groups *(20)*. Across the European Region, many health measures are not linked to the policy monitoring systems of other sectors and, when they are, the access to and use of these measures in policy-making is limited. Current challenges include an inability to collect and analyse data from the health sector and other sectors and a lack of adequate measures of social position or advantage (equity stratifiers).

The review will examine the most effective mechanisms for improving reporting and monitoring across the Region, particularly through the work of the measurement and targets task group. Strengthening monitoring within and across countries will require increased coordination, harmonization and accessibility of data from population- and institution-based sources that complement rather than replace in-depth existing mechanisms at the national level. An important part of what the review will develop is a monitoring framework: a simple package that could be measured in all countries in the European Region: if not now, then adopted progressively over time.

The report commissioned through the Spanish Presidency of the EU in 2010 *(17)*, for example, identified the need to go beyond incrementally improving existing data sources to a shift in the approach to data collection, analysis and application, to ensure timeliness and periodicity; comparability and harmonization; and accessibility. The report pointed to gaps in existing knowledge, particularly regarding the impact and effectiveness of health policies and policies of other sectors in reducing inequities in health. The lack of appropriate, routinely available and comparable data within each country and across the EU was highlighted as one of the key barriers to greater knowledge and effective analysis of how to reduce inequities in health.

The evidence base for measurement and action has advanced considerably in the last decade. However, the Measurement and Evidence Knowledge Network of the Commission on Social Determinants of Health identified six problems that make developing the evidence base on the social determinants of health potentially difficult:

- lack of precision in specifying causal pathways;
- conflating the causes of health improvement with the causes of health inequities;
- lack of clarity about health gradients and health gaps;
- inadequacies in the descriptions of axes of social differentiation in populations;
- the impact of context on interpreting evidence and on the concepts used to gather evidence; and
- problems in translating knowledge into action *(21)*.

They also made the case for methodological diversity in building the evidence base for action on social determinants of health to ensure that all relevant knowledge can be collected and learning from practice in a systematic way *(22)*: "... much can be gleaned from the tacit knowledge of practitioners about how things work by supporting them to document the processes that lead to effective delivery of social interventions".

Health measures are not usually well linked to the policy monitoring systems of other sectors and, when they are, access and use in policy-making and decision-making is limited. What is required is the capacity to link to information from several sectors, such as employment rates, educational performance, preschool participation and tax and social protection systems across the entire social gradient *(23,24)*.

Several recent developments offer a step in this direction. These include the Millennium Development Goals and the Istanbul Declaration to support broader national monitoring efforts *(25)*. Measures of health across the population that extend beyond mortality, such as the distribution of years of healthy life by social conditions, would also be a major step forward. The Eurothine project and EU Statistics on Income and Living Conditions (EU-SILC) provide valuable information on individuals. Similarly, Ageing and Retirement in Europe (SHARE), which collects panel data on individuals aged 50 years and older, and the recent development of the European Core Health Interview Survey (ECHIS), will offer further assistance *(26)*. The recent report by the Commission on the Measurement of Economic Performance and Social Progress *(27)* also favours using equitable and sustainable development indicators to overcome the primacy of GDP measures. Many WHO Member States and the EU are developing such indicators. For example, in 2010 the Government of the United Kingdom announced they would develop measures to monitor national levels of well-being in England.

4 Contexts

4.1 Economic downturn

The recent international economic recession hit the European Region harder than any other region, and it will be the slowest region to recover according to the World Bank *(28)*. Some countries in the Region have particularly severe problems. This is likely to cause inequities in health to widen considerably across the Region. Rises in food prices, for example, are a significant issue in the Region, with significant potential implications for inequity. The review will describe and assess how the economic downturn is affecting the social determinants of health and inequities in health and propose effective measures to counteract the potentially damaging and uneven effects of the crisis on health *(29)*.

Keeping equity in health on the intersectoral agenda is particularly important in times of economic downturn and recession, when the effects on the social determinants of health and risk of illness increases. For example, mental health problems such as depression and anxiety associated with job losses and the fear of unemployment increase, relationship conflicts because of money problems increase and unemployment also triggers increased problematic drinking *(30–33)*. The unemployment rate in Estonia, Hungary, Latvia, Lithuania, Slovakia and Turkey exceeded 10% in 2010 *(28)*.

Although most people move back into work swiftly following job loss, some groups are more at risk of negative social and health outcomes as a consequence of the recession. These include (1) those with fewer years in education and job experience; (2) young people and families with higher ratios of debt to income; (3) people with disabilities and/or chronic conditions; and (4) older workers who lack transferable skills. Negative and stigmatizing attitudes towards minority groups have historically worsened in a recession, particularly among social groups most vulnerable to job loss and economic insecurity, as these groups come to be seen as a threat. This is a key issue in relation to the social cohesion and integration agenda. The impact of recession also tends to vary according to pre-existing labour market position, such as the differences that are commonly seen between men and women.

The economic downturn is likely to have a long-term impact on the European Region. Data from the 1990s in the United Kingdom show the delayed impact of recession: about 40% of individuals who lost their jobs reported financial difficulties for 1–2 years, and 24% reported financial difficulties for 3–6 years after becoming unemployed *(34)*. Social problems also remain long after the economy begins to recover. For example, evidence from Sweden shows that people who lost their jobs because their workplace closed had a 22% (men) and 44% (women) increased risk of alcohol-related hospitalization over a subsequent 12-month period *(35)*, demonstrating that the effects of an economic downturn can have long-term effects on the health of those hardest hit. The review's task group on employment and working conditions, including occupation, unemployment and migrant workers, will consider evidence about the effects of unemployment, low paid and low-quality work on health and propose strategies and actions to reduce the effects and improve levels of employment, pay and quality of work.

For example, the recent EU communication on solidarity in health *(11)* highlights how avoidable inequities in health constitute a significant loss in economic growth. But other processes are important. The report by the Commission on the Measurement of Economic Performance and Social Progress *(27)* gives greater priority to equitable and sustainable development indicators over GDP as measures of development and progress of society. These processes recognize the need to create equity in access and use of the means to participate in development and equity in how the benefits of development are distributed across society. This implies governments deliberately acting to ensure that development policy is governed in such a way that it contributes to greater solidarity, cohesion and equity in health.

4.2 Country differences and specific contexts

The WHO European Region is diverse in terms of cultures, history and development. This variety of experiences and contexts means that universal policy recommendations are often inappropriate, and policies cannot be transferred across countries without considering local factors, cultures and capacity.

Some countries and regions have made significant progress in tackling health inequities, through action on social determinants, acting as positive role models within subregions of the European Region. The review will assess what these leading countries and regions have achieved and how and will use such evidence to inform recommendations and proposals for other countries and regions. The review is working with partner countries that will help inform its recommendations and approaches, and these partner countries will also inform Health 2020.

Various cultural factors may provide a barrier to addressing health inequities. Long-term and recent history and traditions are important. For example, about 75% of women aged 15–49 years in Tajikistan who are married or in a union believe that their partners have the right to beat or hit them *(36)*. An estimated 500 000 girls and women living in the European Region are suffering with the lifelong consequences of female genital mutilation *(37)*, and "honour" killings of women have increased substantially in Turkey *(38)*. These not only have consequences for women's health but represent violations of their human rights. Further, ongoing disputes and refusal to acknowledge the rights of certain cultures or ethnic groups to reside in a country cause isolation, violence and segregation within and across borders.

Less visible, but equally important, is the influence of historical developments on the social determinants and the influence this has on health behaviour and other risk factors, as discussed in Section 2. For example, all countries in which cigarettes are smoked are at some point on a trajectory, although the exact nature of the epidemic will be population-specific *(39)*. At the beginning of the epidemic, smoking is most common among those of higher socioeconomic status, but as the detrimental health effects of smoking become understood, many middle- and upper-class men begin to quit smoking, and most women in these social groups do not start smoking. In the later stages of the epidemic, the association between socioeconomic status and smoking is reversed. Although most countries in north-western Europe have reached these stages, most CIS countries are at earlier stages of the epidemic. Similar to the smoking epidemic model, the concept of the nutritional transition is also closely linked to the epidemiological transition and describes the progress of human societies through changes in diet and nutrition. In some stage of the transition, salt and fat consumption increase, activity levels decrease and obesity and cardiovascular diseases are prevalent *(40)*. Similarly to the smoking transition, it again appears that some countries in the eastern part of the European Region and especially CIS countries are at an earlier stage of the transition and, as they enter the later stages, rapid increases in obesity, diabetes and related conditions are expected.

The internal situations of individual countries within the European Region should be taken into account, such as wars or natural disasters. All countries and regions in the European Region will be considered, particularly those on the margins geographically or those facing unique or more challenging barriers and opportunities. The review aims to include all the varied experiences and situations in all 53 countries in the Region. Language may be a barrier to understanding health inequities: although health inequities and the social determinants of health are common terms in the English-speaking academic and political sphere, they are not yet widespread in some other languages. The review process includes plans to work with countries as partners for mutual learning of how the conceptual framework of the Commission on Social Determinants of Health and the recommendations of this review can be applied in specific cultural contexts.

4.3 Vulnerability

Recent research on vulnerability has focused on the interaction between risk, hazard and degree of vulnerability *(41)*. The more a group is marginalized, the more vulnerable it is to experiencing adverse events and the less capacity the group will have to respond to these events to minimize negative consequences. Nevertheless, being a migrant, being from a certain ethnic group or a having a disability does not make a person inherently more vulnerable or at increased risk. Rather, the interaction between several factors creates increased vulnerability. These factors include poverty, inequality, discrimination, exposure to various threats (such as sexual abuse), the prevailing incidence or prevalence of disease (such as HIV infection) *(42)* and the possibilities of epidemics (such as influenza).

The Social Exclusion Knowledge Network of the Commission on Social Determinants of Health *(43)* defines social exclusion as comprising dynamic, multidimensional processes that are driven by unequal power relationships interacting across four main dimensions – economic, political, social and cultural. These processes operate at different levels – including the individual, household, group, community, country and global levels – and result in a continuum of inclusion and exclusion that is characterized by unequal access to resources, capabilities and rights and that lead to health inequities.

The review will examine social exclusionary processes that increase the vulnerability to health inequities experienced by disadvantaged groups, including irregular migrants, Roma populations and people with disabilities and that contribute to health inequality (Annex 3 describes the work of the task group considering disadvantage, social exclusion and vulnerability). About 74 million migrants live in the European Region, accounting for 39% of all migrants in the world. Roma and Travellers are the largest single ethnic minority group in the Region, with an estimated 10 million in the EU alone. The review will identify factors associated with vulnerability, such as refugee or asylum-seeker status, poorly paid and insecure work, human trafficking, discrimination and the policy responses affecting health outcomes. Further, it will examine how equitable access to resources, access to basic services, capabilities and rights – across sectoral domains – for disadvantaged groups can reduce inequity in health. It will also explore the role of health systems and cross-government inclusion efforts towards this end.

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Annex 3. Summaries of the interim reports of the task groups

Thirteen task groups are informing the review by undertaking work to build on existing knowledge and proposing effective strategies for action in key areas relating to health.

Role of task groups

Eight topic groups (TG) are each covering one or more of the key social determinants of health in the European Region and/or key life-cycle stages. Five cross-cutting groups (TC) are each focusing on issues that span across two or more of the topic groups.

Each task group is identifying the issues and processes within its thematic area that act as social determinants of health and influence health inequity in the European Region. They will identify the relevance to the topic of the work of the Commission on Social Determinants of Health and other work in the European Region. The groups will then identify evidence to support specific interventions with the potential to reduce health inequity in the Region and highlight specific processes in the European Region that are relevant to achieving these interventions, taking account of the diversity of countries that make up the Region. Finally, each task group will propose effective implementation and delivery systems to tackle inequities within and between countries in the Region and identify gaps in knowledge and research needs and options for addressing these gaps. The task groups will work closely with the University College London and WHO secretariats and consult with experts and practitioners across the European Region.

The task groups liaise with each other when considering related issues. The cross-cutting task groups will outline how the issues they consider affect the themes considered by the topic groups. The topic task groups will take account of these themes and ensure that they consider gender and social exclusion, disadvantage and vulnerability. In addition to the specific work they commission, cross-cutting groups will consider and review emerging findings, proposals and examples of effective practice from the topic task groups and provide feedback.

Summaries of the interim reports of the topic groups

TG1: early years, education and the family

1) Aims, objectives and purpose

This task group will identify approaches that can make a difference to developmental and learning outcomes for children and young people and thereby influence health and health inequities.

Children and young people develop through active engagement with a series of contexts, and those likely to most strongly influence outcomes are family, school (and the wider education system) and the communities to which they belong (peer, cultural, faith and neighbourhood). Interventions will be identified with the child as agent and/or within each of these contexts, and how these interventions might change over the childhood and adolescent years will be considered.

The task group's work will focus on three broad and overlapping areas – early years, later childhood and adolescence and formal education – with the role of family considered a cross-cutting issue.

2) Plan of work to achieve the aims, objectives and purpose

Within this framework, the task group will identify approaches across the European Region and consider how and why these vary between countries and groups of countries. The group will gather evidence and analyse the effectiveness of various approaches in reducing learning, developmental and health inequities, looking also at approaches outside the European Region that may be appropriate to European contexts. Finally, the group will discuss how the most effective approaches might be implemented, identifying underlying principles and how approaches can be made contextually appropriate.

To develop the evidence base, the group will review reports from transnational organizations that will focus on evidence of links between early years, education and health, examples of approaches for intervening in these links and recommendations for action. Further, up to 20 local expert-led country case studies will be commissioned, covering a range of country contexts in the European Region, to provide examples of effective practice and policy approaches and contextually appropriate implementation. The task group will analyse this work and make recommendations.

3) Any emerging proposals and recommendations

Existing evidence suggests the crucial significance of the early years in shaping later outcomes. The family has a key role here. Interventions to promote the physical health of children, to stimulate their cognitive, social and emotional development and to support the family in providing a nurturant environment are therefore considered to be particularly important in the work of this task group.

Interventions relating to later childhood and adolescence are likely to focus increasingly on children and other contexts outside the family in which the children or adolescents grow and develop because of their growing autonomy in this period.

Formal education will be considered in part as an existing major intervention aimed at promoting learning and development with clear health outcomes. Schools will also be considered a point of access to children and families for other kinds of interventions.

The group aims to consider both targeted interventions for groups at higher risk and the wider system context in which interventions might be set – avoiding the assumption that inequities are always best addressed by targeting the people who do worst rather than improving the social, health and education systems as a whole.

The group will discuss other organizations that deliver or support education and early-years programmes.

TG2: employment and working conditions, including occupation, unemployment and migrant workers

1) Aims, objectives and purpose

The task group will review existing evidence from across the European Region on how employment conditions (including unemployment and employment trajectories) and working conditions (including physical and chemical occupational hazards, injuries and accidents and organizational and psychosocial adversity) affect health and health inequalities, identify and discuss interventions and policies, propose indicators and measurement tools and make recommendations for intervention and policy in a variety of arenas – not just about government but also private sector employers, the third sector, trade unions, the EU etc.

2) Plan of work to achieve the aim, objectives and purpose

The review of existing evidence will include two commissioned papers. M. Harvey Brenner will consider the health effects of unemployment, and Carles Muntaner and Joan Benach will examine the health effects of precarious work, job instability, temporary work and informal work (who is most exposed or vulnerable). The level of instability in employment status and changes in the labour market are important to health status and are changing rapidly.

The group will identify and discuss interventions and policies at the micro, meso and macro levels designed to reduce health inequities related to employment and work. At the meso level, the group will compare available methods of implementing interventions in organizations to identify characteristics that enhance intervention effectiveness most significantly and critically reflect on their far-reaching methodological challenges and limitations. At the macro level, the task group will consider how national labour and social policies can be linked to the quality of work and employment and to the effect these have on workers' health in countries with diverse policies. The task group may additionally conduct a few examples of comparative research on associations between macro-level labour and social policies and work-related inequities in health by performing secondary analysis of available data from cohort studies in countries in the European Region. The group will look at relationships with social policies and the costs of poor employment (including poor health and social cohesion).

The task group has developed close relationships with regional networks and organizations such as the International Commission on Occupational Health, the South Eastern Europe Network on Occupational Health and Safety, the Baltic Sea Network on Occupational Health and Safety and the principal investigators of the PRIMA-EF (Psychological Risk Management – Excellence Framework) project to be informed about programmes and policies to meet the challenges in countries across much of the European Region – but not necessarily central Asia.

The task group will propose indicators and measurement tools that can be applied in routine monitoring and evaluation systems, taking account of substantial variation between countries and different levels of policy developments. Monitoring systems are needed related to the health of employed and unemployed people and related to work and employment conditions. Special attention will be given to opportunities for data linking and cross-referencing between monitoring systems.

Based on this knowledge and discussions among task group members and external experts, the group will recommend short-, medium- and long-term interventions and policy programmes that could be implemented by responsible partners and authorities within their specific contexts. In developing these recommendations, the group will critically assess options for labour market regulations, labour standards and social protection measures in a globalized economy.

3) Any emerging proposals and recommendations

Nothing has emerged directly yet, but many themes emerge that will feed directly into recommendations on the need for stable, flexible work and the implications of insecure, precarious and atypical work contracts. The quality of work is important.

The emphasis is that the issues raised are not just about government policies but about the levels at which interventions are made: via workplaces and employers as well as national employment policies – labour market regulations, labour standards and social protection measures.

TG3: disadvantage, social exclusion and vulnerability

1) Aims, objectives and purpose

The task group will explore commonalities and differences across the European Region in the salience of and meanings attached to the concepts of disadvantage, social exclusion and vulnerability and highlight the implications of any differences in salience and meanings for action aiming to address these. The group will view disadvantage, social exclusion and vulnerability in terms of processes rather than as a state experienced by particular groups.

The group will identify the key characteristics of action by governments and other actors that can potentially exacerbate or positively influence disadvantage, social exclusion and/or vulnerability and hence can potentially widen or reduce health inequities. This work will allow the group to produce a preliminary framework identifying principles that characterize actions with potential for having positive and/or negative effects. The group will also contribute to the consultation process led by the WHO Regional Office for Europe.

2) Plan of work to achieve the aims, objective and purpose

Part 1 of the group's report will analyse the multiple and often divergent meanings attached to the concepts of social exclusion, disadvantage and vulnerability across the European Region and their status as social determinants of health. The topics covered by this task group will be introduced and the rationale for choosing them will be explained.

Part 2 of the report will comprise more detailed studies of four example topics – three thematic topics of child poverty, irregular migration or displacement and disability and one on Roma. Each study will indicate the salience of the topic across the European Region, any differences in how the topic is understood and whether and how concepts of disadvantage, social exclusion and vulnerability are used in relation to the topic. Each will highlight the characteristics of significant policies and actions that have potential to exacerbate problems or positively influence in the topic area and identify any ways in which these characteristics may be expected to vary according to socioeconomic, political or cultural contexts. They will pay particular attention to the potential of action that aims to empower and/or give voice to groups differentially affected by exclusionary processes in their thematic area. Particular efforts will be made to include evidence from the eastern part of the European Region, particularly the central Asian republics.

The work on the experience of the Roma involves collating existing evidence on the social determinants of health of Roma people and current action to address this. Significant initiatives underway in the European Region to improve the living conditions and life chances of Roma people are being reviewed, especially the Decade of Roma Inclusion. The evidence base for specific interventions included in the Decade of Roma Inclusion is also being assessed. The group hopes that time and resources will allow some telephone interviews with Roma focal points in a sample of countries.

The group's report will identify the extent to which comparable data on child poverty exist across the region and how the availability of such data influences approaches to defining the nature and extent of child poverty. Evidence on the association between child poverty and health has been reviewed and highlights the value of the comparative indices of child well-being in demonstrating this relationship at the macro level. The associations between child poverty and other adverse outcomes such as educational deprivation are reviewed, and the relationship between significant variation in the risk and composition of poor children across the European Region and differences in policy approaches are considered.

The work on irregular migration and displacement is documenting the rise in irregular migration over the past two decades and describing the associations between irregular migrant status and the experience of disadvantage, social exclusion and vulnerability, including the experience of groups exposed to extreme situations of exclusion and/or vulnerability such as unaccompanied minors. Evidence on measures that can be taken to alleviate these problems is being reviewed, and a few case studies will highlight contrasts between the situation in the countries or regions covered.

The work on disability is considering data on the prevalence of disability in the context of different understandings of disability. Evidence on health inequalities is reviewed from a disability perspective and the social determinants of health inequities experienced by people with disabilities are described, including differences in health status among people with disabilities, secondary health conditions and impairment associated with disability and the independent effects of social determinants of health. There is a particular focus on disablism: the widespread negative and stigmatizing attitudes towards people with disabilities that increase their risk of exposure to the wider social determinants of health and reduce their access to timely and effective health care. Policy options – in relation to improving daily living conditions and tackling the unequal distribution of power, money and resources – and issues relating to measuring and evaluating the effects of policies will be reviewed.

Part 3 of the group's report will synthesize key findings and provide a draft action framework. This will identify the common characteristics of actions across the themes covered that can either potentially promote more inclusive social systems and reduce disadvantage and vulnerability or exacerbate problems.

3) Any emerging proposals and recommendations

How definitions are produced and statements made on the nature of the problem end up defining the problem and subsequent actions.

Exclusion is not static or a state; it is a process driven by powerful social, economic, political and cultural forces.

The group will consider two types of action to alleviate the situation of irregular migrants: (a) structural long-term measures that would change the nature of their situation and (b) forms of immediate assistance for those in need. The group will consider the following areas for action.

- The free movement of people should be promoted (developing larger governance systems such as in the EU), although inequalities between countries cannot be too extreme if this is to be successful.
- The growth of the system of international law and human rights has led to an increasing acknowledgement that people who are not citizens of the country in which they live nevertheless have certain fundamental rights that must be respected. Rights-based arguments would seem to be the only way to improve the situation of irregular migrants, and gains have already been made.
- Regularization campaigns are often promoted, but this solution can only be used sparingly, because it undermines the notion of immigration control.
- As migrants will only be able to exercise political influence within a country as a small minority whose interests can easily be overruled, international bodies and nongovernmental organizations are in a better position to promote their interests and therefore might deliver the recommendations most effectively.

- The most systematic attempt by an international body to affirm the rights of migrants, the United Nations Convention on the Protection of the Rights of all Migrant Workers and Members of their Families (1990), has not yet been ratified by a single industrialized migrant-receiving state (perhaps this will emerge as a recommendation).
- Dissemination of accurate information about the realities underlying irregular migration is an important first step towards improving the situation of migrants, as the zero-tolerance attitude towards irregular migrants reinforces the discrimination and intolerance to which irregular migrants are subjected.
- The group will also look at what safety nets can be constructed for irregular migrants, and what good practices in humanitarian assistance can be found.

The most important determinant of child poverty is social policy, particularly social transfers. It is suggested that UNICEF and other United Nations agencies be supported in the debate about the need for a social floor in low- and middle-income countries, in contrast to the World Bank, which has been dominating the evidence and technical support and imposing a model that is ineffective.

Increased risk of exposure to common social determinants of health is a key driver of the health inequities faced by people with disabilities. As such, policies that successfully reduce exposure to these determinants should also reduce the health inequities faced by people with disabilities. There is a particular focus on disablism, which increases the risk of exposure to the wider social determinants of health among people with disabilities and reduces access to timely and effective care.

An overarching recommendation of the disadvantage, social exclusion and vulnerability task group will be that the review should establish an equity impact assessment panel (to include representatives from organizations led by and working with people with disabilities, migrant groups, Roma populations and other disadvantaged and marginalized groups across the European Region) to consider for each recommendation made in the group's report: (a) the likely impact of the recommendation on these groups and (b) what specific modifications or adjustments need to be made to ensure that these groups experience equal benefits from the proposed recommendation.

TG4: GDP, taxes, income and welfare

1) Aims, objectives and purpose

The task group will look at the economic resources necessary to lead a good and healthy life and how the policies that in various ways support the generation and maintenance of family incomes can contribute to better health at the individual and societal levels. The group will look at welfare states, social policies and poverty per se and has created a preliminary schematic model of the complex relations between policies, income and health. A core issue for the task group is how the policies that support the generation and maintenance of family incomes in various ways can contribute to better health at the individual and societal levels and whether policies can be identified that might better accomplish this.

2) Plan of work to achieve the aims, objectives and purpose

The task group has identified some gaps in existing knowledge, and based on this will consider how income affects health: whether the absolute income levels among people with low income or income inequalities as such are more important. The relationship between income and health is complicated. There are probably several pathways linking income to health, and it is certainly

not a simple issue of more being better but rather an issue of poverty as well as the gradient. The task group will conduct a focused review to clarify what is known and where evidence is still inconclusive and will bring up and clarify central theoretical issues and empirical facts – including whether compression of the income distribution, as such, or redistribution to the poorer segments of society is more important for health and health inequities.

For policy effects, it is essential to differentiate between income effects at the lower end of the income distribution (poverty effects), more general income effects linked to purchasing power and the possible effects linked to the income distribution itself. One priority of this group will be to establish what is known on the individual-level relationship between income and health, possibly drawing on ongoing European research on the topic.

The other key issue the group will consider is whether specific features of income maintenance policies across the European Region can be identified that are linked to better health and less inequity and, if so, the group will suggest policy reforms on this basis. The task group identifies the weaknesses of using social expenditure to measure the extent and ambitions of the welfare state and argues that the institutional organization of welfare states in several ways influences the command of resources central for the distribution of individual well-being. Analysing the organization of welfare states and identifying the precise institutional mechanisms that produce positive health outcomes will therefore be a central feature of the task group's work, and it will assess the effects of welfare state programmes. Depending on time and resources, the task group will initiate institutionally informed analysis that explores links between social policy institutions and health-related inequalities across several countries in the European Region. This might include commissioned analysis in which legislated social rights are analysed across time and space in relation to health inequities.

3) Any emerging proposals and recommendations

The work of this task group is linked explicitly to the poverty agenda. There will be some conclusions concerning the relative versus absolute poverty and inequity debates. Further, the task group will consider how institutional organization and social welfare arrangements affect health inequities.

TG5: sustainability and community

1) Aims, objectives and purpose

The task group is considering how the natural, built and social environments affect health inequalities and the wider determinants of health inequities. Their approach is framed by the five principles of sustainable development. The group considers that interventions should have a rounded, whole-system approach and take account of intergenerational equity and aim to achieve positive co-benefits for health inequities and sustainable development.

2) Plan of work to achieve the aims, objectives and purpose

Evidence in English and mainly relating to western Europe has been reviewed. This draws together evidence of how a limited number of themes within the social, built and natural environments affect health inequalities and identifies interactions, overlaps and synergy between these effects. These should be seen as priority areas for intervention.
The group has developed some initial thoughts on how the effects vary across the European Region, and, crucially, the next phase of the group's work will focus on drawing together evidence and insights from the eastern part of the Region. The group will draw on this evidence to identify interventions effective for the whole Region.

3) Any emerging proposals and recommendations

The review of evidence has led to several proposed interventions, both for changing systems and for changes relating specifically to natural, built and/or social environments.

Efforts to mitigate climate change should be linked with health inequities.

The following are interim proposed recommendations for changing systems.

1. Take account of health in all policies and promote intersectoral collaboration with shared outcomes.
2. Apply the principles of sustainable development, especially the links between environmental, social and economic factors, to all policy and practice; acknowledge and act on the central role of health in environmental policies and the role of climate change and other environmental factors in health policies.
3. Plan for the long term and safeguard the interests of future generations.
4. Actively encourage the prevention of avoidable causes of poor health and health inequities.
5. Improve epidemiological surveillance and research into the separate and combined impacts of natural, built and social environments; measure all interventions for direct and indirect effects on health and health inequities.

The following are interim proposed recommendations for changes relating specifically to natural, built and social environments.

1. For new and existing buildings and houses – improve energy efficiency, measure health inequalities outcomes for interventions.
2. Reduce exposure to harmful and hazardous air pollutants.
3. Promote sustainable policies for transport and travel.
4. Maintain and improve the quality and accessibility of green spaces.
5. Build resilience in social environments by promoting local engagement, encouraging good governance, emphasizing inclusion in all policies and improving local neighbourhood management.

TG6: preventing and treating ill health

1) Aims, objectives and purpose

The group will:

- assess the causes and effects of the preventable communicable and noncommunicable diseases that have the greatest role in health inequities in the European Region; and
- propose interventions and or the overall features of approaches to address the social determinants of risk factors of preventable mortality and morbidity and to improve the level and distribution (equity) of health gain within the European Region.

2) Plan of work to achieve the aim, objectives and purpose

The group will build on the evidence of previous global and local exercises for generating knowledge on the social determinants of preventable mortality and morbidity. This includes the relevant knowledge networks and working groups established as part of the Commission on

Social Determinants of Health and the Marmot Review for England – specifically, the groups on health systems, priority public health conditions and mechanisms for service delivery. Examples include the four critical features of health systems that promote health equity: leveraging intersectoral action, universal coverage, participation and engagement and revitalizing primary health care. The group will also consider the role of health system responsiveness in contributing to inequities in the burden of disease and health outcomes. In addition, this group will build on work and evidence from within the European Region relating health system actions and services that promote health and prevent and treat ill health effectively. See, for example, the case studies on health systems confronting poverty and social exclusion. Specific issues to be considered include alcohol, cardiovascular diseases and their risk factors and TB, including multidrug-resistant TB.

The work of the group will be consistent with the principles of the overall review, which is to look at whole-of-government approaches to preventing inequities in the burden of disease and health outcomes. It will consider the role of health system in levelling up the social gradient through actions and services that take a proportionate approach to preventing and treating ill health effectively, promoting health and well-being and advocating action across sectors in addressing "the causes of the causes" of ill health or as consistent with the patterning of health inequities across specific conditions and their risk factors.

Part 1 of the group's report will be a general descriptive analysis:

- to assess the cause and impact of preventable disease (both communicable and noncommunicable) that have the greatest role in health inequity;
- to assess differences between specific countries and groups of countries – western Europe as a standard contrasted with central and eastern Europe and with the CIS countries;
- to assess differences within a selection of countries (1–2 countries) from each of the three groups; and
- to estimate the most important social determinants of the direct risk factors for smoking, alcohol, poor diet and obesity, such as the links between education and smoking and alcohol use and misuse.

This will be developed further by undertaking a similar and detailed analysis using the following as worked examples:

- cardiovascular conditions;
- TB; and
- intermediate risk factors for health outcomes for the above, including alcohol and tobacco use.

Part 2 will build on Part 1 and includes a systematic literature review and key informant interviews on the above issues and, based on these, develops draft recommendations outlining possible interventions and a set of key features to be incorporated into general or issue-based public health programmes and strategies to reduce inequities.

TG7: gender

1) Aims, objectives and purpose

Based on the findings of the Gender Knowledge Network of the Commission on Social Determinants of Health, the task group will identify the most effective policy interventions and

governance arrangements for countering gender-related health inequities and produce evidence-based recommendations for reducing these inequities across the European Region.

2) Plan of work to achieve the aims, objectives and purpose

The group will consider explanations for gender differences in quality of life, mortality and disability between and within countries in the European Region. They will focus on gender-specific exposures to health risks and their relationship with other social determinants of health. This will include gender differences in self-destructive behaviour such as smoking, alcohol and drug abuse and suicide. They will also focus on tackling the values, norms, practices and behaviour within households and communities that contribute to gender-based health inequities. Finally, the group will identify good practice examples of interventions within and outside the European Region and make recommendations based on the evidence.

The work of this group might overlap with other task groups in many areas, such as reproductive health, childbearing and fertility or gender differences in work stress. This should be taken into account when carrying out the work.

3) Any emerging proposals and recommendations

This group has begun to identify some examples of good practice in intervention from across the European Region, such as Spain's programme to combat gender-based violence, the Polish Siemacha day care centre and a safe motherhood education and counselling programme in Istanbul.

The task group has identified that mainstreaming gender analysis into policy-making is vital, specifically:

- addressing the essential structural dimensions of gender inequity;
- addressing family protective actions;
- addressing reproductive risks in prevention strategies;
- transforming the gendered politics of health systems by improving their awareness and handling of women's problems as both producers and consumers of health care, improving women's access to health care and making health systems more accountable to women;
- taking action to improve the evidence base for policies by changing gender imbalances in both the content and the processes of health research, strengthening information and analytical capacity; and
- taking action with interventions to make organizations at all levels function more effectively to mainstream gender and social equality and equity and empower women for health by creating supportive structures, incentives and accountability mechanisms.

TG8: older people

1) Aims, objectives and purpose

The task group will assess health and well-being inequalities for older people across the European Region and develop proposals for tackling inequities and their social determinants. These inequalities reflect a complex range of dynamic factors relating to individuals and their families and the wider social and economic context, past as well as present. These include older

peoples' resources and attributes, their current societal factors and the dynamic balance between challenges faced in later life.

The task group will consider different dimensions of health inequities. It will consider differences within the older population of a country or region, differences between older populations of countries or regions, differences between younger and older people and differences in the relative importance of mechanisms by which social determinants influence the variation in health and well-being of older populations.

The task group will draw on commissioned reviews of available published literature alongside some use of routinely available statistical data and, to a very limited extent, some new commissioned analysis. It will focus on examining five outcome indicators of health and well-being: mortality; disability; depression; subjective well-being; and smoking behaviour. Constraints on resources and data mean that the group will focus on example investigations that relate to specific countries, topics and outcomes.

2) Plan of work to achieve the aims, objective and purpose

The first work package will look at differences in health and well-being, between and within country, by sex, age and socioeconomic status. This will focus on the five outcomes listed above and involve a commissioned review of literature and a limited amount of additional analysis for selected contrasting countries.

The second work package will consider inequalities in the use of health (and to some extent social) care by older people. The group will commission a literature review and write a report on macro-level influences based on analysis of the Survey of Health, Ageing and Retirement in Europe (SHARE) and comparable data sets. There will also be some case study comparisons of inequalities in access to care for a small selection of countries based on existing work.

The third and final work package will be an evaluation of policy implications, based on consultation and commissioned input on possible policy responses to findings.

3) Any emerging proposals and recommendations

Older people are not a homogeneous category, and the health challenges vary between younger and older members of the older population. There are also gender and ethnic differences.

Vulnerability depends on exposure over the life course and what is externally available (resources, support etc.).

Resilience is built from vulnerability and exposure, which vary through the ageing process depending on the above factors and on country, region, and cultural contexts.

Indicators (not just mortality) include mental health (depression) and health behaviour.

Inequities in access and use of health care should be addressed.

Summaries of the interim reports of the cross-cutting groups

TC1: economics

1) Aims, objective and purpose

This task group will consider economic issues around addressing health inequities in the European Region. Their work is based on the premise that the economics and public health perspectives can complement and support each other in many areas and that any divergent conclusions should be explicitly acknowledged. The group will work with other task groups to look specifically at five areas in which economic issues should be considered when forming recommendations within each group.

2) Plan of work to achieve the aims, objectives and purpose

First, the task group will collect and report any information on costs or benefits of interventions related to the social determinants of health, questioning the quality of these cost–benefit estimates. Policy-makers want to know the magnitude of the benefits compared with other policy options, so information that allows meaningful comparison with other interventions – including both those that are based on the social determinants of health and those that are not – would be ideal. Having said this, the group is not in a position to measure efficiency benefits in terms of a single agreed common currency or to measure equity benefits in terms of a single agreed equity target. When no information on costs and benefits is available, qualitative descriptions of the relevant costs and benefits associated with a policy and who (which sector) might incur the costs or receive the benefits should be developed.

Second, the task group will consider the evidence of the causal impact of interventions – based on the social determinants of health – that underlie the policy recommendations of the other task groups. Causal impact is difficult to measure, and it would be useful to understand to what extent the evidence of effectiveness of each recommended intervention relies on correlation studies or on studies that apply more advanced econometric and statistical techniques (or even – in rare cases – on truly randomized experiments).

Third, the task group will look at what market failure(s) might justify government intervention from an economic perspective. Although market failures help to explain government involvement in health care markets, it is not a priori clear that there are serious market failures affecting people's health behaviour outside the health care context. It would be of great value to be able to sell the justification for public policy intervention with the help of a market failure argument relating to economic inefficiency, as a supplement to equity arguments. Potentially relevant market failures include externalities, asymmetric information between market participants, abuse of market dominance by monopolies and boundedly rational behaviour in which market participants are influenced, to their own disadvantage, by non-rational mental factors.

Fourth, the task group will identify any information on the relationship between equity (the distribution of benefits resulting from a specific intervention) and efficiency (the total or average outcomes for the population as a whole). It is particularly valuable to identify cases where they might be complementary and achieve both equity and efficiency. If there is a trade-off, it is useful to know the shape of that trade-off to allow policy-makers and societies to make informed decisions according to their own preferences.

Finally, the task group will consider whether any unintended consequences might result from recommended interventions based on the social determinants of health. This would reduce the risk of potential side effects undermining or counteracting the benefits of any intervention that would seem promising at first glance.

3) Any emerging proposals and recommendations

Including factors other than efficiency is crucial in economic analysis.

TC2: governance and delivery systems

1) Aims, objectives and purpose

The task group will analyse current regional, national and local efforts to address health inequities and propose the most effective governance mechanisms and delivery systems (or changes needed to existing systems) for reducing health inequities.

The task group will work with the same conceptual framework as the study on governance for health in the 21st century Thus, governance is about how government and other social organizations interact, how they relate to citizens and how decisions are taken in a complex world. In accordance with this, the task group will concentrate specifically on governance principles, arrangements and delivery instruments, including how progress is monitored and how accountability is defined and managed, relevant to actions addressing the effects of the social determinants of health.

2) Plan of work to achieve the aims, objectives and purpose

Phase 1 of the task group's work will identify the core principles of governance in systems that aspire to address the social determinants of health. It includes a review of relevant governance documents and other literature and interviews with key stakeholders. This will include a review and analysis of the whole of government approach that is being carried out by the WHO European Office for Investment for Health and Development in partnership with several countries in the European Region. The main outcome is to identify the main governance principles, arrangements and delivery instruments that are used in a sample of countries with formal strategies to address the social determinants of health and health inequities. An understanding of weaknesses, gaps and barriers to effective governance will also emerge.

In phase 2, the task group will build on the phase 1 findings to analyse in detail specific elements of governance and delivery mechanisms for policy action addressing the social determinants of health. This will include accountability for health inequities, a whole-of-government approach, policy consistency among different levels of policy-making and monitoring progress. The group will further develop a tool to appraise and develop capacity at the national and subnational levels to strengthen governance for the social determinants of health, encompassing elements ranging from expression of political commitment to stakeholder involvement in policy-making.

In phase 3, the task group will test their main findings and recommendations and consider the findings of the other task groups. A special meeting of task group chairs and a selection of experts from different levels across the European Region will be organized for this purpose, and their discussions will be reflected in the final task group report.

3) Any emerging proposals and recommendations

Existing analyses indicate that strengthening governance and delivery mechanisms to address the social determinants of health and tackle health inequities requires efforts to develop and sustain: political leadership and long-term commitment; engaged civil society; appropriate cross-government institutional arrangements and incentives for intersectoral cooperation, coordination and integration of action; human resources with appropriate skills and expertise effectively deployed at the various levels of policy-making; and a learning environment to allow policy innovation and conflict resolutions.

TC3: global factors

1) Aims, objectives and purpose

How global factors affect the social determinants of health in the European Region will be understood in two (interrelating) ways.

- Global factors that extend beyond the European Region influence social determinants of health within the Region, where the principle channels of influence are considered to be global economic downturn and migration pressures. An umbrella theme concerning global factors is the effects on health equity globally and in the European Region of an increasing securitization of foreign policy (border protection and economic competitiveness).
- Foreign policies in the European Region influence global factors, with effects on other countries outside the Region. These effects pose indirect (feedback) effects on health and the social determinants of health in the European Region and pose direct health equity effects on third countries. The main channels of influence are considered to be trade, development and aid policies. An umbrella theme explored here is how foreign policies in the European Region affect health and development equity more globally, with rebound effects on global economic and financial stability, migration and pandemic and security risk, and how these rebound effects might influence social determinants of health in the European Region. The critical issue to be addressed here is that of increasing coherence in the foreign policies of countries in the European Region and within the EU.

2) Plan of work to achieve the aims, objective and purpose

Commissioned papers will review the evidence. The topics for papers include the following:

- synthesizing the evidence from recent studies on how the global economic downturn has affected health (and some social determinants of health), with an emphasis on options for regulating the financial system;
- reviewing migration pressures on health and the social determinants of health, with a focus on: global drivers of increased migrant movement towards the European Region; the role of migration in European Region labour markets; European Region migration policies in the light of human rights obligations; migration as a vector for extremely drug-resistant and multidrug-resistant diseases; migration effects on access to health services and social protection; and the causes and consequences of current and rising anti-migrant sentiments;
- the impact (both positive and negative) of trade policies on health inequities and the social determinants of health; and

- the impact of European Region development policies on other countries, with a detailed account of health aid policy already produced and future development topics for analysis focusing on education, agriculture, water and sanitation as key social determinants of health pathways, and other components including food security, an assessment of EU development policy and a desk review and key informant study of EU overseas development assistance and the social determinants of health in three target countries.

3) Any emerging proposals and recommendations

Based on the evidence review, the task group will select two or three major policy initiatives that the EU could foster that would promote domestic and global health equity by positively affecting the global influences on the social determinants of health. Two that could be considered include:

- equity and human rights oversight of trade treaties to ensure coherence with global development goals (the general issue is one of subordinating trade to rights and development, rather than the reverse); and
- global taxation systems for development and global redistribution (solidarity levies), the major rationale being that modest forms of wealth redistribution (especially in the context of escalating wealth inequalities in the past 10–20 years) are more effective, efficient, equitable and environmentally sustainable than high levels of economic growth and trickle down.

A major emerging issue of importance is the perfect storm of migration, recession and racism and the risk this creates for social conflict within the European Region and internationally.

TC4: equity, equality and human rights

1) Aims, objectives and purpose

Reducing health inequity is a matter of fairness and social justice. However, these values are more likely to be adhered to in the political arena. This -is essential since the allocation of public resources heavily influences the social determinants of health. It is in the political arena that these values can be based on human rights instruments. This cross-cutting group will therefore focus on the potential of a human rights approach to hold governments to account for inequities in health. Particular attention will be paid to how such approaches and instruments can be successfully applied in policies to tackle health inequity in different parts of the European Region and how this works out for these subregions. It will also discuss the shortcomings of the human rights approach and how it can be improved to more effectively address health inequity.

International basis for a human rights approach
The international system for protecting and promoting human rights has its origins in the United Nations Charter and was subsequently developed through international treaties at the global and regional levels. The WHO Constitution adopted in 1948 was the first international legal instrument enshrining a right to health. The normative content of the right to the highest attainable standard of health has developed over the years, but in an increased pace during the past 10 years after the Committee on Economic, Social and Cultural Rights issued General Comment 14 on the right to health in 2000. The value base of Health 2020 needs to draw on these developments as well as the common understanding built through major WHO policy documents, such the Health for All policy, the Declaration of Alma-Ata, Ottawa Charter for Health Promotion, World Health Declaration of the World Health Assembly and Health21. In

the European Region, the most recent declaration by Member States of common values for health was the Tallinn Charter: Health Systems, Health and Wealth.

2) Plan of work to achieve the aims, objective and purpose

The group will identify various human rights approaches and instruments that might support and promote equity in all policies that address the social determinants of health (with a particular focus on the policy sectors covered by other task groups). This will include analysing the legally binding components of these instruments.

A conceptual framework will be developed in which inequities in health will be analysed in view of the key principles of equality and non-discrimination that underlie all human rights. The group will consider whether it is possible to develop a framework that links social determinants to specific human rights instruments and look specifically at which human rights declarations and conventions as well as EU legislation are relevant given the themes covered by the other task groups.

The task group will identify situations in which social justice or human rights approaches have been successfully applied to generate political priority for health equity issues and analyse the conditions that promoted this success. Good practice examples should emerge along with some recommendations of what can be done.

3) Any emerging proposals and recommendations

The group has no direct proposals yet.

TC5: measurement and targets

1) Aims, objectives and purpose

The group aims to identify gaps in existing indicators and supporting data and make recommendations for future indicators and data collection regarding both health outcomes and measures of social determinants of health.

2) Plan of work to achieve the aims, objectives and purpose

Initially, the task group will create a grid of the key indicators of health status and the main dimensions of the social determinants of health. The group will give an overview of data sources, including routinely collected data reported to WHO, EU and other international organizations, and ad hoc studies with internationally comparable methods. They will provide an overview of the availability (and, where possible, the quality) of specific data on (a) health outcomes across the European Region, including mortality, morbidity, self-reported health outcomes and objective and self-reported functional outcomes and (b) social determinants of health across the Region, with a special focus on the measures collected or required by EU institutions.

The task group will then identify gaps and make recommendations for addressing these in future data collection. It will do this for both health outcomes and measures of social determinants of health, with particular attention to what is available from and required by the EU. They will also review the reports by specific topic task groups, particularly in order to assess: the appropriateness and quality of data used; the quality of evidence reviewed; the way the evidence is evaluated and appropriateness of the conclusion and recommendations, given the availability

and quality of data and evidence; and the appropriateness of targets, mainly in terms of availability of suitable data.

3) Any emerging proposals and recommendations

The group has no direct proposals yet.