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Accelerating progress for equity in health in the context of Health 2020 and the 2030 Agenda for Sustainable Development towards leaving no one behind in the WHO European Region

This document contains the evidence and rationale for the draft resolution on accelerating progress towards healthy, prosperous lives for all in the WHO European Region, which is submitted, along with the present document, to the WHO Regional Committee for Europe for consideration at its 69th session.

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Background and commitments

1. The commitments to leaving no one behind and creating the conditions for all people to flourish underpin the strategic objectives of equitable improvement of health and well-being contained in Health 2020, the European health policy framework, WHO's Thirteenth General Programme of Work, 2019–2023 (GPW 13), the 2030 Agenda for Sustainable Development and the Sustainable Development Goals. The principles of health equity and universal health coverage lie at the core of these commitments.

2. Member States have a long-standing commitment to tackle the determinants of health inequities. In the Declaration of Alma-Ata of 1978, they acknowledged that the existing gross inequality in health status both between and within countries was "politically, socially and economically unacceptable and … of common concern to all countries". In 2011, Member States globally committed themselves to addressing the social determinants of health equity in the Rio Political Declaration on Social Determinants of Health. The Declaration of the Sixth Ministerial Conference on Environment and Health (Ostrava, Czechia, 13–15 June 2017) further committed Member States in the WHO European Region to consider equity, social inclusion and gender equality in policies related to the environment and health.

3. The principle of health equity over the life course is embedded in several documents, including: the United Nations Convention on the Rights of the Child; the European Declaration on the Health of Children and Young People with Intellectual Disabilities and Their Families, and its action plan; the Global strategy and action plan on ageing and health; the Paris Declaration on partnerships for the health and well-being of our young and future generations; the report of the high-level conference on promoting intersectoral and interagency action for health and well-being in the WHO European Region: working together for better health and well-being; and the Minsk Declaration on the Life-course Approach in the Context of Health 2020.

4. In many health strategies and programmes, countries have committed themselves to leaving no one behind. Equity is embodied in many WHO resolutions, strategies and programmes, including: the European Mental Health Action Plan 2013–2020; the European Food and Nutrition Action Plan 2015–2020; the WHO global plan of action to strengthen the role of the health system within a national multisectoral response to address interpersonal violence, in particular against women and girls, and against children, of 2016; the Global disability action plan 2014–2021; the Action plan for sexual and reproductive health of 2016; and World Health Assembly resolution WHA70.15 on promoting the health of refugees and migrants of 2017.

5. Gender equality and human rights to health and well-being: the powerful effects of gender norms and rights on health and well-being are recognized in the Strategy on Women's Health and Well-being in the WHO European Region of 2016 and the Strategy on the Health and Well-being of Men in the WHO European Region of 2018.

6. Making sure that health systems do not unintentionally contribute to health inequities: the Declaration of Astana, adopted at the Global Conference on Primary Health Care (Astana, Kazakhstan, 25–26 October 2018), emphasizes the critical role of primary health care around the world and its role in ensuring that everyone, everywhere is able to enjoy the highest attainable standard of health. The meeting on Health Systems for Prosperity and Solidarity: Leaving No One Behind (Tallinn, Estonia, 13–14 June 2018), which marked the

10th anniversary of the signing of the Tallinn Charter: Health Systems for Health and Wealth, reaffirmed the commitment of Member States to strengthening the equity perspective in health systems.

7. Health equity as an input to, and an outcome of, inclusive and sustainable development: the roadmap to implement the 2030 Agenda for Sustainable Development builds on Health 2020 and commits each Member State to leaving no one behind, addressing the social determinants of health using a life-course approach, establishing healthy places, settings and resilient communities, strengthening health systems for universal health coverage, and advancing governance and leadership for health and equity.

Progress and challenges

8. The European Region has seen success overall. Nearly 1 billion people living now have an average life expectancy of 78 years – both women and men. Despite these successes, however, profound inequity persists in every Member State. Despite the high regional average, there is still a substantial regional gap in life expectancy, ranging from 72.3 years to 82.7 years in different Member States.

9. Across the Region, there are discrepancies in life expectancy within countries, marked by sex, income level and number of years of education. The slow progress in reducing health inequities is inconsistent with European values and priorities, as shown by recent analyses of public opinion polls across Europe for the Health Equity Status Report released in September 2019: across the Region, people agree that good health is the top priority for getting ahead in life.

10. Inequities start from birth. In some countries of the Region, babies born to families in the lowest income quintile are more than twice as likely to die in their first year of life than babies born to families in the highest quintile.

11. Impoverishment caused by out-of-pocket health spending affects up to 15% of households in the Region. Out-of-pocket expenditure has increased slightly, from 25.5% of total health expenditure in 2010 to 26.6% in 2014, which implies that financial risk and inequitable access to health care may be increasing, leading to greater impoverishment and the perpetuation of economic vulnerability.

12. In 2015, over 90% of the European population had access to improved sanitation and piped drinking water. Nevertheless, inequalities in access were reported within and between urban and rural areas, with access ranging from 93.1% to 100% for people in urban areas and from 66.7% to 100% for people in rural areas.

13. In self-reported mental health, 30% of the difference between those in the top and bottom income quintiles is accounted for by poor-quality and insecure housing, unsafe neighbourhoods, and poor-quality local environments. There is a strong correlation between housing deprivation and lower life expectancy.

14. Among the poorest 20% of households, food security is a major issue. In some countries in the European Region, up to 82% of the poorest people are unable to afford meat, or nutritionally equivalent vegetarian food, every second day. In some countries, rates of food

insecurity among the poorest people have increased between 2011 and 2016. Food insecurity and poor health are strongly correlated.

15. Income and employment insecurity and not having enough money to manage are strong contributors to differences in self-reported mental health between the top and bottom income quintiles.

16. Exposure to unhealthy commercial pressures compounds material disadvantage and contributes to health inequities. People with limited social and economic resources have a disproportionately higher exposure to these pressures, and there is evidence to show that they are more often targeted – for example, there is evidence of a higher density of gambling and fast-food outlets in deprived neighbourhoods.

17. A sense of belonging, trust in others and feeling safe are important for human well-being. People who are more socioeconomically disadvantaged feel lower levels of trust, control, perceived safety and social support than those with greater socioeconomic resources.

18. Violence against women and girls in both private and public spaces is a persistent phenomenon that no country has yet managed to eliminate. Comparability of data regionally and globally remains a major challenge. The latest comparable data for 87 countries between 2005 and 2016, including 30 countries from developed regions, show that 19% of girls and women aged between 15 and 49 years had experienced physical and/or sexual violence at the hands of an intimate partner in the previous 12 months. Women who have experienced intimate partner violence are 50% more likely to contract HIV than women who have not.

19. The impact of global migration is also making itself felt. In the European Region, with a population of almost 920 million, international migrants make up almost 10% of the population (90.7 million). One million child asylum-seekers were registered in the European Union in the period 2015–2017, of whom 190 000 had arrived unaccompanied. These children face particular risks, including being exposed to discrimination, exploitation, marginalization, institutionalization and exclusion.

Reasons for slow progress

20. Many countries, regions and communities have taken action to address health equity, but avoidable gaps in health are narrowing more slowly than anticipated and by less than is possible, given the existing knowledge and commitments. Key reasons for slow progress include those described below.

- It is not possible: the perception that health inequities are a “wicked” issue, that they are too complex to change or that they reflect the natural order in society; these perceptions discourage prioritization and systematic action and can result in low political commitment and policy action to reduce inequities.
- What to do: uncertainty about, for instance, the policies and investments that should be given priority.
- How to do it: failure to implement the optimal mix of policies and approaches with the necessary scale and intensity over time; gaps in the health equity skills of existing human resources.

- How to measure: lack of metrics and data to measure health inequities and monitor progress.
- How to influence and sustain action: the difficulty of influencing and sustaining action across government, between professionals and in pan-European and international decision-making processes.
- Whom to involve: lack of understanding of the reality of the lives of people who are already left behind, or those who are at risk of falling behind; this can undermine the equity effects of even good universal policies.

New ideas and new evidence

21. Accelerating progress towards healthy, prosperous lives for all is possible with systematic action, by scaling up and adapting approaches that work and generating new solutions and alliances that break down major barriers. Key principles for success and for guiding effective action for health equity are listed below.

- Integrating the human dimension of inequity into the core rationales for action: fundamental to progress is tackling the stigma experienced by those left behind.
- Incorporating social values into fiscal and growth policies: the conditions imposed on countries by international organizations and financial institutions are often at odds with the aim of improving health for all. For example, they may prioritize a certain type of economic growth that is not sustainable; this leads to stagnating wage growth, tax increases and cuts in key services, such as health and social care.
- Maximizing the social and economic benefits of health systems: health systems play an increasingly important role in driving inclusive and sustainable development through responsible practices in employment and the purchasing of goods and services. This social benefit of health systems is not well documented or taken into account in many mainstream policies and practices.
- Developing local solutions based on empowerment and social participation that will influence inequities in health and well-being: given the increasing emphasis on tackling health inequities, it is important to engage communities and individuals, together with local and national authorities, in the creation of solutions. When participation and engagement strategies are used as mainstream approaches in public policy and services, they deliver additional benefits for health and well-being, such as improving accountability in public policies and services; communities and individuals also feel more involved which, in turn, builds individual and community capacity.
- Creating new partnerships for health for all: health systems alone cannot eradicate health inequities unless they are partners in a multisectoral approach. The report released in September 2019 by the WHO European Health Equity Status Report Initiative (HESRi) shows that increases in investment in multisectoral policies that address the social, environmental and economic determinants of health are associated with a narrowing of gaps in health outcomes over a period of 2–6 years between the poorest and richest quintiles within countries across the Region. Coherent policy action across sectors is

crucial in order to reach those being left behind due to poor health and to prevent others from falling behind.

22. Several new analyses by the WHO Regional Office for Europe – including the publications *Women's health and well-being in Europe: beyond the mortality advantage* (2016), *The health and well-being of men in the WHO European Region: better health through a gender approach* (2018), and *Can people afford to pay for health care? New evidence on financial protection in Europe* (2019) – have identified the conditions underlying the current status of and trends in health inequities and identified the specific policy action required to reduce these inequities.

Health services

- Countries with lower out-of-pocket payments for health care as a proportion of total health expenditure tend to have lower inequities in unmet need for health care at a given point in time; differences in the quality of that health care account for a large proportion of health inequity. There remain large differences between countries in the Region in levels of out-of-pocket expenditure incurred by private households as a proportion of total health expenditure.
- Evidence from countries in the Region shows that it is possible to achieve a level of financial protection at which no one is impoverished as a result of using health services.

Living conditions

- Countries with lower per capita expenditure on housing and communities tend to have larger discrepancies in the quality of housing, yet one quarter of countries in the Region have decreased their per capita expenditure on housing and community amenities since 2000.
- Investment in affordable housing and food and fuel security, together with safe and accessible public and green spaces, is generating improvements in well-being, social inclusion and mental health.

Social and human capital

- The education gradient in health is influenced by factors that occur across the life course. A child's education outcomes are influenced not only by their current status, but also by their parent's socioeconomic status. Across the Region, the children of parents with the fewest years of education are much less likely to meet minimum proficiency levels in mathematics and reading at the age of 15 years compared with the children of parents with the most years of education.
- There are positive signs that policy action is being taken to interrupt this intergenerational transmission of education gaps, and the associated health gradient, through investment in early childhood education and care: government expenditure on pre-primary education rose in most countries across the Region between 2012 and 2015.

Employment and working conditions

- In-work poverty due to poor employment conditions rose among those with the fewest years of education between 2003 and 2017, accompanied by increases in associated health risks.
- Countries with higher expenditure on active labour market policies as a proportion of gross domestic product tend to have smaller gaps between those with the most and those with the fewest years of education in terms of in-work poverty and poor mental health, although only just over one quarter of countries increased expenditure on such policies between 2005 and 2016.

Income security and social protection

- While the overall trend across the Region shows declining income security among the least well-off people, there is a positive trend for income security in later life. Gaps in income in the over-65 age group between those at the middle and those at the bottom of the income distribution narrowed in half of all countries between 2005 and 2017, in tandem with increases in pension expenditure per beneficiary in almost all countries in the Region over a similar period. This increases the financial capacity of older people to meet health needs. An analysis of investment in health and social protection in 25 European countries carried out in 2013 found that investment in these two sectors protected populations and encouraged short-term growth.

23. The intrinsic importance of these conditions for a decent and prosperous life are enshrined in the International Covenant on Economic, Social and Cultural Rights, adopted by the United Nations in 1966.

Rationale for the regional high-level conference on accelerating progress for equity in health

24. The high-level conference aspired to embed health equity in national policy decision-making across sectors, investments and implementation and ensure that it is a central consideration, as well as to set the European agenda for action on health equity for the next 10 years.

25. Taking action to reduce health inequities not only builds and sustains societies, but also brings quantifiable economic gains. GPW 13 aims to ensure healthy lives and promote well-being for all at all ages by: achieving universal health coverage – 1 billion more people benefiting from universal health coverage; addressing health emergencies – 1 billion more people better protected from health emergencies; and promoting healthier populations – 1 billion more people enjoying better health and well-being. Investment analysis commissioned by WHO reveals that, if the triple billion goal in GPW 13 were to be attained, it would save 230 million lives, gain 100 million healthy life-years and create economic growth of 2–4% in low- and middle-income countries. In addition, creating the conditions for everyone in every society to participate more actively and thrive will enhance social and human capital.

26. The focus of the high-level conference was on solutions to reduce health inequities. To this end, several new innovative approaches, tools and solutions were presented, shared and debated. These were organized around the following three overarching themes.

Achieve: create conditions and remove barriers for all to prosper and flourish

27. Governments should not stop investing in what is working, such as financial protection, providing safe, high-quality housing, and high-quality work and social protection policies.

28. Governments and health systems have the information and understanding required to provide the essential prerequisites for a healthy life:

- health services
- decent living conditions
- social and human capital
- decent work and employment conditions
- income security and social protection.

29. The health sector's actions and interventions need to align with those of other sectors and partners to reduce inequities and improve health and well-being for all.

Accelerate: implement a set of solutions to reduce inequities for everyone

30. Systematic action is needed, shifting from single-policy interventions to a whole set of solutions, to create and sustain the minimum conditions for a healthy life for all.

31. Most factors influencing health equity have not changed in the last 10 years across the entire Region. It is time to move on from identifying and explaining the problem of health inequities to identifying and implementing solutions. HESRi provides this evidence, even in data-poor countries.

32. Member States and WHO have the knowledge to accelerate action; it is now a matter of political will and choice.

33. Policies and interventions are more effective when the action addresses multiple causes of health inequities, as well as the pathways ("drivers") that lead to inequity.

Influence: put health equity at the centre of sustainable development and inclusive economies

34. Eradicating health inequities and strengthening sustainable development for all are bold but achievable ambitions.

35. To achieve these ambitions, it is necessary to stimulate conversation about why equity matters for the future of countries and communities, and to inform policies, plans, strategies,

business models and investments, in order to create and sustain equitable growth and development from which everyone benefits.

Aims and outcomes of the regional high-level conference

36. The aim of the conference was to bring together Member States, international organizations and civil society to take stock of progress to date and debate ways of accelerating progress towards healthier and more prosperous lives for all, and specifically to:

- inspire action for health equity by sharing experiences of preventing and reducing health inequities in countries and identifying the factors needed for successful implementation;
- explore a range of approaches that are delivering improved policy coherence, enabling public engagement and increasing investment for health equity;
- galvanize existing platforms and partnerships and identify new mechanisms and opportunities to accelerate progress towards health equity.

37. A total of 280 participants from 36 countries across the Region attended the conference. They represented a range of government sectors and roles and included politicians, policy-makers, planners and service providers. There was strong representation from civil society organizations, academia and international organizations (including the International Labour Organization, the United Nations Children's Fund, the United Nations Educational, Scientific and Cultural Organization, and the United Nations Population Fund) and European agencies (including the Council of Europe and Eurofound).

38. The conference represented a milestone in health equity; interim findings from the Health Equity Status Report were presented and the Health Equity Policy Tool, which details 51 policies that are effective in reducing health inequities, was launched. The conference also made available technical documents and policy briefs that supported a dynamic and innovative dialogue on solutions to increase equity in health. A key focus of the solutions shared and discussed was giving a human face to inequities and drawing on the lived experience of those who are being left behind, as they are essential partners for achieving health and well-being for all in our societies.

39. The event concluded with the adoption by acclamation of the Ljubljana Statement on health equity. This encouraged WHO to launch a European Region health equity solutions platform as a mechanism for policy-makers to exchange best practices and share innovations in sustainable solutions that accelerate equity in health and well-being, nationally and at the subnational levels of regions and cities. The Ljubljana Statement also welcomed the proposal to establish a multidisciplinary health equity alliance of scientific experts and institutions, to generate cutting-edge evidence and methods that will enable ministries of health and governments to make the case for, prioritize and scale up innovations (scientific, technological, social, business or financial) in order to: (i) increase equity in health; and (ii) ensure that the social values of solidarity, equity, well-being, inclusion and gender equality are considered and included in growth and development policies.

Looking ahead

40. Building on the conference and the Ljubljana Statement, a resolution on accelerating progress towards healthy, prosperous lives for all in the WHO European Region was drafted and shared for consultation with Member States and partners in June 2019. The draft resolution, which will be submitted for adoption at the 69th session of the WHO Regional Committee for Europe, aims to support values-based national policies and health systems development in Europe that will empower and enable countries to reduce health inequities.

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