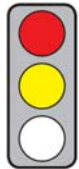


MAIN ISSUES

Objective of the Communication: The Commission intends to reduce “health inequalities” between Member States, specific population groups and between men and women.

Parties affected: All citizens, in particular patients and health care professionals, Member States.



Pros: The data base on the extent and causes of health inequalities is to be extended and the exchange of best practice among Member States is to be improved.

Cons: (1) The Commission does not set out exactly which health care inequalities it wishes to combat and which not.

(2) The Commission wishes to increase the use of cohesion policy to help tackle health inequalities.

(3) The Commission’s plans could lead to a gradual erosion of the EU’s system of allocating competences between the EU and Member States.

CONTENT

Title

Communication [COM\(2009\) 567](#) of 20 October 2009: **Solidarity in Health – Reducing Health Inequalities in the EU** and Accompanying Working Document [SEC\(2009\) 1396](#)

Brief Summary

► Objective of the Communication

- The Commission regards combatting health inequalities as a major political challenge for Member States and the EU. It is a “challenge to the EU’s commitments to solidarity, social and economic cohesion, human rights and equality of opportunity” (p. 2).
- According to the accompanying working document [SEC(2009) 1396, p. iv], for the Commission it is not so much a question of the “inequality” of health but – without actually being any more specific – the differences in health, which are deemed avoidable, “unfair and unjust” (“inequity”). The Communication itself, however, does not contain any such statement.
- According to the Commission, the aim of a more equal distribution of health is reinforced by the Lisbon strategy’s objective to “create economic growth with social solidarity” (p. 4).

► Health inequalities in the EU

- The Commission points out that the average level of health in the EU has continued to improve over the last decades.
- Nonetheless, there are still differences between:
 - Member States
 - different population groups
 - men and women.
- The current economic crisis can further aggravate health inequalities.
- **Differences between Member States**
 - There are significant differences in the life expectancy between citizens of different Member States.
 - For instance, the average life expectancy of men in Sweden and Cyprus is 14 years longer than that of men in Lithuania and Latvia. The average life expectancy of women in Spain, France and Italy is 8 years longer than that of women in Bulgaria, Latvia and Romania [SEC(2009) 1396, p. 71].
 - The difference between the average life expectancy in Bulgaria, Denmark and Lithuania and that of the EU has even increased over the last twenty years [SEC(2009) 1396, p. 74].
 - Infant mortality is five times higher in Romania than in Luxembourg [SEC(2009) 1396, p. 76].
- **Differences between population groups**
 - The following groups are especially affected by health inequalities: the homeless, people in poverty (in particular children), disadvantaged migrant and ethnic minority groups (in particular the Roma), people with disabilities and the elderly.
 - According to the Commission, health inequalities between population groups are mainly influenced by the following factors: living conditions, health-related behaviours, education and access to education, occupation and income, health care, disease prevention and health promotion services.
 - These factors can be influenced by policy measures and therefore health inequalities are not inevitable.

– **Gender inequalities**

- Statistically, women live on average longer than men.
- However, they spend a larger part of their lives in “ill health”.

► **Fields of action for reducing health inequalities**

– **Equal distribution in the health sector**

- Although there are indications that a higher level of wealth entails better health conditions, the Commission doubts that this correlation applies to all population groups at all times.
- The Commission would like the EU cohesion funds in particular to play an important role in combatting health inequalities.
- For the period of 2007–2013, approximately € 5 billion from the cohesion funds are available for the health care system. That equals 1.5 % of the total amount available.
- After 2013 the Commission would like to align cohesion policy more intensively to health care.

– **Improved data basis**

- There are currently no publicly available or comparable EU data or research results on health inequalities in the EU.
- The Commission intends to extend the data base on health inequalities in the EU and to have EU research oriented towards the subject.
- The Commission sees this as a “first step” (p. 4) towards effective action.
- Member States should aim to establish, in collaboration with the Commission, a common set of indicators to monitor health inequalities and to develop a methodology auditing the health situation in Member States.
- EU measures should be assessed as to their impact on health inequalities.

– **Commitment across society**

- Since health is affected by many factors, the Commission is of the opinion that it should be addressed in everyday life, at work, in schools and in leisure time.
- According to the Commission, the health care system should play a key role in
 - ensuring “equitable” access to health care and
 - supporting health professionals in acquiring further knowledge and training.
- Moreover, the Commission wishes to facilitate the exchange of good practice amongst Member States and “relevant stakeholders” (p. 6).

– **Meeting the needs of vulnerable groups**

- The Commission emphasises that actions “to address the gradient in health” (p. 8) should be specifically targeted at “vulnerable groups”. This applies in particular to the needs of people in poverty, disadvantaged migrant and ethnic minority groups, people with disabilities, elderly people and children living in poverty.
- For some groups the Commission believes that reduced access to adequate health care involves their fundamental rights. It refers to the European Charter of Fundamental Rights, the United Nations Charter on Rights of the Child and the UN Convention on the Rights of Persons with Disabilities.
- According to the Commission, cohesion policy should be “further developed” in order to support particularly vulnerable groups.
- The Commission wishes to launch initiatives in collaboration with Member States to raise “awareness” of the issue and to improve access to adequate health care for vulnerable groups.
- The question of how the Fundamental Rights Agency could collect information on the extent of health inequalities in vulnerable groups needs to be examined.

– **Developing the contribution of EU policies**

- The Commission criticises the fact that for over half of the Member States the reduction of health inequalities is not a political priority.
- The Commission further criticises a lack of “comprehensive inter-sectoral strategies” (p. 9).
- The EU could therefore assume responsibility for improving the coordination of policies and for promoting the exchange of best practices.
- The EU could support Member States in creating “equitable” access to “high quality health care” and to “prevention and promotion systems” (p. 9).
- Further attention should be placed on health inequalities among women within the context of promoting equal opportunity between men and women.
- According to the Commission, environmental and agricultural policies can also contribute to the reduction of health inequalities.

– **Progress report**

- The Commission sees tackling health inequalities as a long term process.
- A first progress report on the situation will be produced in 2012.

Statement on Subsidiarity

According to the Commission, EU action is needed for an EU-wide harmonisation of data collection and monitoring, since the EU is better placed than individual Member States to ensure available, reliable and comparable data. Furthermore, the Commission believes that for Member States to be able to invest in “key determinants of health inequalities” such as living conditions, training and employment services and healthcare, it is necessary to have financial support from the EU as part of cohesion policy. [SEC(2009) 1397, p. 4]

Policy Context

Through the Open Method of Coordination, which is applied to social protection and social inclusion policies, Member States have agreed on the aim to take action against health inequalities in the EU population [COM(2005) 706]. Within a White Paper the Commission presented its proposals for EU health policy for the period 2008–2013 [COM(2007) 630].

Since 2005, an EU expert group has been working on the causes of and options for tackling health inequalities. In the “European directory of good practices to reduce health inequalities”, successful measures of Member States were listed. On 8 June 2009, the Council stated the need for additional action on the health needs of migrants, Roma and vulnerable youth groups.

Options for Influencing the Political Process

Leading Directorate General:	DG Health and Consumers
Consultation procedure:	No consultation procedure planned.

ASSESSMENT

Economic Impact Assessment

Ordoliberal Assessment

Within a dynamic system, inequalities – created by pioneers – are inevitable and indispensable. The same applies to health: **health progress** in individual Member States or within an individual population group is **necessarily accompanied by increased inequalities in health. Health equality at a low statistical level is not at all desirable.** The demand for high health standards for everyone is inconsistent with a dynamically changing world.

The Commission creates the impression that its aim is essentially to eliminate all inequalities by refraining from drawing any clear boundaries between health inequalities that must be eliminated and those which must be accepted as they are. Within the White Paper “Together for Health: A Strategic Approach for the EU 2008–2013”, which was published prior to the Communication, it was still focussing on health inequalities that are “avoidable and unfair” [COM(2007) 630, p. 4]. In its present Communication, however, it now sees health inequalities as being in general “not inevitable” (p. 3). By stating that it wishes to address inequalities that are “unfair and unjust” in its accompanying working document (p. iv) and explicitly not in the Communication, the Commission does not resolve the above mentioned concerns.

Impact on Efficiency and Individual Freedom of Choice

The fact that not all Member States see the reduction of inequalities as a priority must not be regarded as a problem, as the Commission obviously does. It can also be interpreted as an expression of different political preferences. A de facto general EU competence should not be concluded from the fact that health depends on many factors, which are in turn influenced by EU policies. At first glance, **nothing is to be said against the exchange of best practices between Member States** and an improvement of data on health inequalities. Member States with the same issues can thus learn from each other and adapt successful solution strategies. However, it must be avoided that Member States be put under pressure to take action that does not correspond to their own preferences and scarcity conditions.

Impact on Growth and Employment

Within the framework of cohesion policy, supporting economic development should be a priority. It lies in the responsibility of Member States to decide whether or not and how they wish to use improved economic conditions for their health policy. Health policy can have a positive impact on economic growth by increasing the productivity of employees or by reducing the overall health expenditures through preventive measures. However, that does not apply categorically to measures tackling health inequalities. Besides, the financial dependence of Member States on the EU could – contrary to the goals of cohesion policy – be consolidated.

Impact on Europe as a Business Location

Unproblematic.

Legal Assessment

Legislative Competence

Even the Commission itself states correctly (p. 5) that the main responsibility for addressing health policy rests with Member States. However, the EU is entitled to support and complement national measures. Moreover, the Commission may launch initiatives for the coordination of the Member States' health policies, provided such initiatives are targeted at the definition of guidelines and indicators, the exchange of best practices or at regular monitoring and evaluation (Art. 168 TFEU; ex-Art. 152 TEC).

The other competence requirements mentioned by the Commission [SEC(2009) 1396, p.25 and 108; SEC(2009) 1397, p. 4] are also in principle appropriate as a legal basis for the proposed EU actions:

- promoting the qualification, training and adaptability of the workforce (Art. 145 TFEU; ex-Art. 125 TEC),
- improving living and working conditions, social protection and combatting social exclusion (Art. 151 and 153 TFEU; ex-Art. 136 and 137 TEC),
- strengthening economic, social and territorial cohesion (Art. 174, 175 TFEU; ex-Art. 158, 159 TEC) and
- protecting the anti-discrimination principle (Art. 18 and 19 TFEU; ex-Art. 12 and 13 TEC).

However, in specifying the concrete EU measures on that basis, attention must be paid that the main focus of these entitlements is not put on health policy. In addition, **EU action may – as the Commission itself emphasises** [SEC(2009) 1397, p. 3] – **only “support and complement the actions of Member States”.** **Otherwise there is a risk of undermining the primary competence of Member States in health policy.**

There is also the threat of a gradual erosion in the EU's system of allocating competences caused by those actions which, not backed by the TFEU, are to be developed at EU level and voluntarily introduced by Member States **through the Open Method of Coordination**. Since here the principle of conferral of competences [Art. 5 (1) TFEU] does not apply, EU action must not be based on an EU competence. Although from a formal legal point of view **such a procedure** does not infringe the TFEU due to the “voluntary self-commitment” of participating Member States, it is still **politically highly questionable due to its circumventing the EU's delimitation of competences and the de facto pressure to act.**

Subsidiarity

Not cogent is the Commission's claim that the financial support provided through the EU framework of cohesion policy is “necessary” in terms of the principle of subsidiarity [SEC(2009) 1397, p. 4]. It is incumbent on Member States to decide whether or not their own budgets will be invested in “key determinants of health inequalities” such as health care provision. The Commission does not explain why Member States are incapable of doing so.

Proportionality

Since the actions' depth of intervention is currently not foreseeable, a final evaluation of their proportionality cannot be given.

Compatibility with EU Law

Not foreseeable.

Compatibility with German Law

Not foreseeable.

Alternative Action

–

Possible Future EU Action

–

Conclusion

The Commission does not explain which form of health inequalities it actually wishes to combat and which not. Instead, it creates the impression of being against any form of health inequality. This is not appropriate in view of the different baseline conditions in Member States. The Member States themselves should decide on their priorities in health policy and not be pushed to act according to priorities set by the Commission. Cohesion policy should serve to improve economic development. Actions to combat health inequalities, however, are not principally meant to support growth. The strengthened use of the Open Method of Coordination threatens to cause a gradual erosion of the allocation of competences in the EU. The only positive outcome of the Communication is that the data base on the extent and causes of health inequalities is to be extended and the exchange of best practices between Member States is to be improved.