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EXECUTIVE SUMMARY OF THE IMPACT ASSESSMENT

Accompanying the

COMMUNICATION FROM THE COMMISSION TO THE EUROPEAN PARLIAMENT, THE COUNCIL, THE EUROPEAN ECONOMIC AND SOCIAL COMMITTEE AND THE COMMITTEE OF THE REGIONS

Solidarity in health: Reducing health inequalities in the EU

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1. INTRODUCTION

This document summarises the impact assessment which considers policy options for an EU initiative "Solidarity in Health: Reducing Health Inequalities in the EU". The Commission identified the need for action in the EU Health Strategy[1] and announced an EU initiative on health inequalities in the 2008 Renewed Social Agenda[2]. This document incorporates comments from the Impact Assessment Board in relation to the objectives, the use of the terms inequalities and inequities, proportionality, subsidiarity and costs. The report commits only the Commission's services involved in its preparation and does not prejudge the final Commission decision.

Principle responsibility for addressing health inequalities rests with Member States, but EU policies can have an indirect impact on health and can help overcome current obstacles to action. The report appraises EU action to support and complement the efforts of Member States and stakeholders and to mobilise EU policies towards reducing health inequalities, in full respect of subsidiarity.

EU action should support improvements in the health of the whole population, but with emphasis on reducing avoidable and unfair gradients in health between social groups and EU regions – i.e. a 'levelling-up' approach.

A number of relevant actions are already taken at both the EU and national levels. Current actions are however limited by the level of awareness and priority given, lack of stakeholder involvement, gaps in information and knowledge, insufficient exchange of good practice and difficulties in creating an inter-sectoral policy approach. This document therefore considers measures to address these issues.

2. PROBLEM DEFINITION

There is currently an 8 year gap in life expectancy at birth for women between EU Member States and a 14-year gap for men. There are also large differences in death, disability and disease between Member States and EU regions. In some countries the health gap to the EU average and the best performers has widened in the last two decades.

There are large differences in health between social groups defined on the basis of income, occupation, educational level or ethnic group in all Member States[3]. People with lower education, income or occupation live shorter lives and spend more time in poorer health. Differences in life expectancy at birth between socio-economic groups range from 4 to 10 years for men and 2 to 6 years for women. This pattern is reflected in many measures of physical and mental health. In some countries the gap has widened in the last decades.

Inequalities in health are related to inequalities in social determinants of health including living conditions (housing, environment), health-related behaviour (diet, smoking, exercise),

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1 COM(2007) 630.
2 COM(2008) 412.
3 Health Status & Living Conditions. Monitoring Report prepared by the European Observatory on the Social Situation . European Commission 2008.

employment and working conditions, education, access to social protection including access to quality health care. A substantial proportion of health inequalities are avoidable and amenable to policies which can be influenced by EU policy.

Three areas are identified where weaknesses are observed which pose obstacles to taking effective action to address health inequalities. These are areas where the EU can support and complement Member States actions:

Lack of awareness and insufficient policy priority and commitment by Member States and other stakeholders

Absence of comparable and regular data, monitoring and reporting. Lack of knowledge on the determinants and the effective policies to implement

Insufficient concerted EU approach to health inequalities (lack of mainstreaming at the EU level)

Member States are implementing some policies but comprehensive strategies are lacking. Over half of the Member States do not place any policy emphasis on reducing health inequalities. In addition, policies lack evaluation and dissemination.

While robust evidence exists, more information is required on the effect (causality) and importance of some health determinants in order for Member States to implement effective action in relation to particular population groups and determinants. Comparable, routinely available EU wide data on health outcomes and determinants of health inequalities broken down by socio-economic group is also needed.

Lack of EU data and research knowledge is an obstacle to policy development. Better and shared evidence and a rationale for action can provide the commitment currently lacking from a range of stakeholders.

At EU level health inequalities have received higher policy priority and there are a number of EU policies which are having a positive impact. However, this is difficult to quantify and there has not been significant mainstreaming of health inequalities across all relevant EU policies.

3. OBJECTIVES

EU action regarding health inequalities aims to support and complement the actions of Member States and other stakeholders and to ensure that EU policies and activities provide a high level of health protection as set out in the Treaty. As far as possible, the health protection provided by EU policies should extend to all citizens irrespective of where they live or their social background. In fulfilling these aims EU action can make a contribution towards a reduction in health inequalities in the EU.

3.1. General Objectives

The general objective of this initiative is to support and complement the efforts of Member States and stakeholders and mobilise EU policies towards reducing health inequalities.

3.2. Specific Objectives

Specific objectives are to:

Raise awareness, promote information, best-practice exchange and policy coordination and advocate the tackling of health inequalities as a policy priority; both at Community and Member States level and by other stakeholders.

Improve data availability and the mechanisms to measure, monitor and report on inequalities in health across the EU and improve the knowledge base on the causes of health inequalities and the evidence base for action.

Develop the contribution of relevant EU policies towards reducing inequalities in health, including better support of Member States and stakeholders' efforts to tackle health inequalities and a specific focus on vulnerable groups and third countries.

4. ANALYSIS OF SUBSIDIARITY: IS AN EU ROLE JUSTIFIED?

Although the main responsibility for addressing health inequalities rests with Member States, the problem is of policy concern for the EU for a number of reasons.

Firstly, the pervasiveness and persistence of health inequalities suggests a discrepancy between the existing situation and some of the overarching goals of the EU such as strengthening of economic and social cohesion, ensuring equal opportunities, promoting the reduction of inequalities, and the promotion of equality between men and women and the solidarity among Member States (Art. 2 of the EU Treaty and Art. 2 of EC Treaty).

Secondly, high levels of poor health in sections of the EU population imply substantial opportunity costs for the Union and provide an economic reason for promoting action to address them. High levels of population health are important in the context of an ageing population to allow longer working lives and support higher productivity, competitiveness and employment levels. Avoidable ill-health also leads to large costs for health systems and puts unnecessary pressure on public budgets. Reducing unnecessary losses due to ill health and premature death can make a contribution to meeting the Lisbon goals and achieving Europe's full potential for prosperity.

There is a legal basis for action under several articles of the EC Treaty including: arts. 12 and 13 (on anti-discrimination), art. 125 (promoting employment and a skilled, trained and adaptable workforce), arts. 136 and 137 (improving living and working conditions and social protection and combating of exclusion), art. 152 (ensuring a high level of health protection of all Community policies), arts. 158 and 159 (strengthening economic and social cohesion). These articles form the basis for the Community to support and complement Member States' actions.

The necessity of EU action can be found: 1) in the need for EU-wide data collection and monitoring, as the EU is better placed then individual Member States to ensure reliable and comparable data and 2) in Cohesion policy through which the EU provides financial support to Member States, especially less well-off regions, that can be invested in key determinants of health inequalities such as living conditions, training and employment services, and healthcare (promotion, prevention and treatment). The EU can also provide added value by raising

awareness and reinforcing a focus on health inequalities, improving monitoring mechanisms, enhancing research and knowledge gathering, providing visibility of relevant actions through improving the sharing of experiences and good practices and capacity building, and improving the linkages between EU policies. These have been suggested in the consultation responses and in other research reviews.

5. POLICY OPTIONS

Three options are analysed to achieve the objectives. Option I is the continuation of current activities ("business as usual"). Option II "Current plus" builds on existing work which can be taken forward in a short time frame without further or fundamental changes to current Community instruments, and formulated in a Communication. Option III "Far Reaching" requires a longer time frame, involves changes in existing EU instruments, and includes a Council Recommendation. The options are cumulative (option III builds on option II which builds on option I - see table).

5.1. Option I: Business as usual

In Option I, work to support the reduction of health inequalities continues under the social OMC and the Health Strategy. Equity in health is a guiding principle of the Health Strategy and reducing inequities in access to health care and health outcomes is a common objective under the social OMC. Through the exchange of experience, the EU assists Member States to translate this objective into national strategies. Mechanisms include National Strategy Reports and the Joint Report on Social Protection and Social Inclusion, peer reviews and Social Protection Committee meetings, as well as meetings of the EU Expert Group on Social Determinants of Health and Health Inequalities and the Council Working Party on Public Health at Senior Level. There is financial support through PROGRESS and the Health Programme 2008-2013. Likewise, Cohesion Policy, the Common Agriculture Policy and the Agricultural and rural Development funds support some activities regarding key determinants of health. Other EU actions would continue though not focusing on health inequalities.

5.2. Option II: Current plus

In Option II, the Commission adopts a Communication raising awareness on health inequalities and highlighting their economic, political and ethical magnitude. Option II confirms the reduction of health inequalities as a policy priority, increases dialogue with stakeholders and strives towards a better use of existing information and exchange mechanisms and existing financial support. It supports actions to build knowledge for effective action and strives to improve the measurement system on health inequalities between Member States, EU Regions and social groups. It encourages a first reflection by relevant policy areas on their potential for action in this field (as proposed by some national authorities in the consultation). It announces a number of specific actions aiming to strengthen activities, without requiring significant new policy development. It remains the responsibility of Member States to develop concrete policies.

5.3. Option III: Far reaching.

In Option III the Commission proposes in addition: a Council recommendation on health inequalities; targets to reduce health inequalities across the EU as a whole; a high level inter-institutional advisory committee; a review of a number of policy areas to include the

reduction of health inequalities as an explicit priority whereby resources would be reallocated or added accordingly for the period beyond 2013; a review of community measures contributing to ensuring access to basic needs for health (health care, shelter, food, water education); and an larger international initiative to address global health inequalities.

6. ANALYSIS OF IMPACTS

This is a non-legislative initiative aiming to strengthen action to support and complement the efforts of Member States and other stakeholders to reduce health inequalities. Actions proposed in options I, II and III imply: 1) increasing efforts to improve co-ordination and facilitation of the issues at EU level and 2) increasing efforts to raise awareness among Member States and other stakeholders of the importance to consider health and social issues notably in the present economic crisis. The extent to which the activities assist action by Member States and other stakeholders to reduce health inequalities is the main determinant of the impact of the proposals.

6.1. Social Impacts

The actions in the three options are expected to have positive social impacts and none is expected to have a negative social impact. Compared to Option I, Options II and III are likely to have a greater positive social impact

An important issue is that the present economic crisis can increase health inequalities through a deterioration of some determinants of health. Option II and III, through stronger awareness raising activities could help to ensure that, at a time of prioritisation, Member States do not neglect this policy area and incur negative future economic and social consequences.

6.2. Economic impacts

Indirect economic costs of large health inequalities are potentially considerable. They cannot be estimated with precision. One study has estimated the potential economic gain from bringing the health of the whole population up to the level of those with higher education to be between 1.2% and 9% of GDP.

It is difficult to identify the costs of actions to improve data availability and comparability, notably by socio-economic status.

Overall, progress on the determinants of health and health inequalities would likely have a positive economic impact. In the long run gains in health and reductions in loss of healthy life years may be cost neutral or of overall economic benefit.

7. APPRAISAL OF THE OPTIONS

All three options would help to achieve the general objectives with Option III likely to have the largest effect. However, Option III involves additional costs and faces some implementation barriers. Based on feasibility (notably the ability to act in relation to the current crisis) and the costs involved Option II is the preferred Option. Option II can be seen as a stepping stone to further EU level work on health inequalities and fully respects the principle of subsidiarity.

8. MONITORING AND EVALUATION

Actions assessed include proposals to improve information, monitoring and reporting on progress on health inequalities and their determinants which can be used for monitoring and evaluation. The Commission will also use expert support for regular analyses of EU policy developments through the European Observatory on the Social Situation and the Observatory on Health Systems and Policies. An additional monitoring mechanism is a Commission report in 2012 on the implementation of this initiative and the progress it has had on addressing health inequalities, with further reports envisaged.

Option I *– Business as usual*	**Option II** *– Current plus*	**Option III** *– Far reaching*
