HEALTH INEQUALITIES

A PUBLIC HEALTH CHALLENGE FOR EUROPEAN POLICY MAKERS

Briefing: December 2019

epha european public health alliance

About EPHA

EPHA is a change agent – Europe's leading NGO alliance advocating for better health. We are a dynamic member-led organisation, made up of public health civil society, patient groups, health professionals, and disease groups working together to improve health and strengthen the voice of public health in Europe. EPHA is a member of, among others, the Social Platform, the Health and Environment Alliance (HEAL), the Alliance to Save Our Antibiotics, the Transatlantic Consumer Dialogue (TACD).

About our work on health inequalities

EPHA stands against discrimination, and for inclusion and equal opportunities for all to live, work and age in sustainable, healthy environments.

Find out more about our work at *https://epha.org/health-inequalities-and-roma-health/*

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Executive summary

The conditions in which people are born, grow up, live and work, as well as the risks of developing illness or suffering injury, determine their individual health status. Living conditions, access to resources such as education, employment, housing, healthcare, prevention services, wealth, etc. as well as different levels of participation in society and control over life choices create health disparities between socio-economic groups. Factors such as poverty, social exclusion, environmental hazards, lifestyle, poor nutrition, food insecurity etc. influence an individual's access to healthcare resulting in ill health and lower life expectancy. This can easily turn into public health concerns, especially when it affects entire population groups and lead to their vulnerability in many key areas of their life, including health.

In fact, health disparities are an issue closely linked to social injustice and discrimination experienced by some population groups in various fields. The unemployed, the elderly, disabled persons; ethnic minorities, including Roma; undocumented migrants; prisoners; homeless people are just some of the groups more likely to face unequal access to healthcare and preventive services, making it impossible for people in these social categories to maintain good health. Levels of wealth in Europe have increased in the last decade but its distribution has proven to be unequal - 22,4% of the population of the European Union live in risk of poverty, reducing their capacity to afford medical care and maintain good health.[1] According to EU estimates, 24.9 % of Europe's children are at risk of economic deprivation, unequally affecting single parent households. For Roma children, the risk is two times higher compared to non-Roma making them extremely vulnerable to the effects of health inequalities in all areas of the life, including life expectancy.[2] People living in deprivation are more exposed to environmental hazards such as toxic air, pollution, radiation etc. compared to other socio-economic groups. They are also the most affected by harmful tobacco and alcohol consumption, as well as poor nutrition, food insecurity and non-communicable diseases - causing premature deaths of a half of million people within the EU each year[3] strengthening the correlation between social injustice and health inequalities.

Such discrepancies reveal the complexity of health inequalities that go beyond health policy itself. They cannot be resolved without addressing social, economic and environmental factors responsible for the specific vulnerability of certain population groups in a number of areas, including health. It becomes clear that improved access to healthcare is not enough for combatting health disparities and they will persist as long as social disparities exist in health, economic and environmental fields. Therefore, a stronger social policy promoting health equity and social justice will contribute to combat health inequalities through strengthened coordination and cooperation between all stakeholders in social, economic, environmental and other relevant policy areas. Health equity depends, then, on social fairness - one of the objectives of the European Commission for the next five years.[4]

1 https://ec.europa.eu/eurostat/statistics-explained/index.php/People_at_risk_of_poverty_or_social_exclusion

2 https://epha.org/wp-content/uploads/2019/02/closing-the-life-expectancy-gap-of-roma-in-europe-study.pdf

3 OECD/EU (2016) Health at a Glance: Europe 2016 – State of Health in the EU Cycle

4 https://ec.europa.eu/info/strategy/priorities-2019-2024_en

Introduction

Health inequalities are the result of the uneven distribution of social and environmental determinants creating significant disparities between different population groups. Such discrepancies do not depend only on access to medical care and preventive services - they are closely related to social and economic components such as education and housing, environmental hazards, living conditions, income, availability and affordability of services. These factors determine an individual's health and influence people's lives. They increase the risk of non-communicable diseases, which cause high levels of premature deaths in the EU, reduce quality of life and healthy life expectancy. In addition, such diseases contribute to the rise of social disparities in parallel with health inequalities due to the high cost of treatment, which is often not affordable for population groups facing poverty and social exclusion. As a result, certain socio-economic groups are disproportionally affected by health inequalities producing negative effects on their economic competitiveness and productivity that can make possible to combat poverty and improve health.

Health inequalities is an issue that influences not only individual's ability to access health services, but also how public health is itself delivered. In this regard, health disparities are a public health challenge that can be resolved through the application of appropriate policies and instruments in all key policy areas. Combatting health disparities is a fundamental step for achieving the European Commission's objectives in the area of environment within the European Green Deal and an economy "that works for people," promoting social justice and economic prosperity within the EU.

Taking into consideration the complexity of challenges that health inequalities represent for EU policy makers within the next five years, the present paper intends to analyse the social and environmental determinants causing health and social disparities within EU Member States focusing on some public health, social and environmental issues, without pretending to be exhaustive. It aims to propose solutions that can facilitate the adoption of a new policy approach tackling health inequalities in social, economic and environmental policies addressing the needs of socio-economic groups vulnerable to health disparities.

1. A well-established socio-economic gradient of health

1.1. Correlation between poverty, social exclusion and health inequalities between groups and countries

Major differences in terms of health status can be observed between European countries and socio-economic categories within countries proving the strong link between socio-economic situation and health status. People with low educational levels facing higher exposure to poverty and social exclusion are more likely to face difficulties in accessing healthcare and maintaining good health. As a consequence, they face a greater number of health risks, decreasing their life expectancy, compared to those who live in better conditions.[5]

1.1.1. Life expectancy

Despite the progress that has been made in longevity in the past decades due to improved living standards, healthcare education and decreased child mortality rates, notable contrasts can still be observed between Member States, regions and socio-economic groups within the European Union. With a ten years gap for men and six years for women[6] varying between EU countries, the health gains are not evenly distributed across populations. Life expectancy has increased an average three months per year across the EU, reaching 81 years in 2017[7] but it affects men and women differently (3.8 years and 2.6 years respectively)[8] leading to gender disparities. The gender gap in longevity varies between EU Member States, the largest difference was observed in Latvia (9.9 years) and the smallest in the Netherlands (3.2 years). Additional contrasts were noted between different European regions - Madrid recorded the highest female life expectancy, at 87.5 years while the lowest rate was observed in the French region of Mayotte, at 76.8 years and several regions in Bulgaria.[9] A Lifespan gap is also noted between some population groups, such as Roma communities, who experience high levels of unemployment and social exclusion. Disadvantaged communities and socially excluded groups living in poor conditions, have low income and employment opportunities which reduce their access to healthcare and their capacity to afford medical services, facing more barriers to maintain good health and achieve greater life expectancy. For example, life expectancy among Roma, one of the most vulnerable population groups in Europe in terms of wealth distribution, environmental hazards, living conditions etc., is ten years lower compared to non-Roma, showing the level of health inequalities faced by people experiencing social exclusion and poverty.

Deprivation is also a factor related to child mortality - another indicator for the quality of life and lifespan that also reflects health disparities across the EU. The highest rates were noted

5 https://www.oecd.org/els/soc/cope-divide-europe-2017-background-report.pdf

6 COM 14848/09.

7 https://www.oecd.org/els/soc/cope-divide-europe-2017-background-report.pdf

8 https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Population_structure_and_ageing#The_share_of_elderly_people_continues_to_increase

9 https://ec.europa.eu/eurostat/statistics-explained/index.php?title=Population_statistics_at_regional_level#Life_expectancy

for Malta, Romania (both 6.7 deaths per 1 000 live births) and Bulgaria (6.4 deaths), countries with high rate of poverty and social exclusion. The lowest child mortality rates were observed in Cyprus (1.3 deaths) and Finland (2.0 deaths) which can be explained by some social and economic factors, as well as the health policies and public health systems in these countries.[10]

1.1.2. Unemployment and low education

Relationships between unemployment, low education and poor health are the subject of numerous analytical studies and these issues are well documented. Strong relationships exist between unemployment and poor health, disability and vulnerability to diseases, requiring costly treatments across Europe.[11] People with lower educational level are more vulnerable to unemployment, often have harmful working conditions and lower purchasing power, preventing them from accessing good quality healthcare and preventive services. They live shorter lives compared to people with better economic opportunities and higher levels of education. This social group is more exposed to the risk of alcohol and tobacco consumption, obesity and overweight, all of which negatively impact individual health and well-being increasing the risk of premature death. According to EU estimates in 2017 more than a third of the population were at risk of poverty and social exclusion in Bulgaria (38.9 %), Romania (35.7 %) and Greece (34.8 %), notably diminishing their capacity to resist health hazards.[12]

Furthermore, poor health status prevents people from being economically active, decreases their quality of life and strengthens their likelihood of experiencing social exclusion. Poor physical and mental health diminishes individuals' competitiveness on the labour market and increases their vulnerability to long term unemployment and generational poverty. In addition, increased levels of stress caused by finding and keeping employment is one of the risk factors endangering an individual's health and employment status. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life, have powerful consequences on people's resistance to cardio-vascular and other non-communicable diseases - one of the main challenges for public health decision makers.[13][14] Job insecurity, early retirement and exclusion from the labour force due to work-related stress and health problems, particularly mental disorders now account for an ever-greater share of long-term social welfare benefit payments, and indeed may even challenge European cohesion and sustainability.[15]

1.1.3. Access to health services, primary healthcare and affordable medicines

Even if in most European countries, citizens have access to medical care, health disparities are persistent within regions and population groups. Capacity to afford medical care, medicines and transportation costs are particularly difficult for people on low incomes or people living in geographically isolated zones and rural areas. Lack of health professionals, specialists and specialised medical institutions further limits their access to healthcare services. Additionally,

10 https://ec.europa.eu/eurostat/web/products-eurostat-news/-/DDN-20190719-1

11 https://www.oecd-ilibrary.org/sites/3c8385d0-en/1/2/2/index.html?itemId=/content/publication/3c8385d0-en&mimeType=text/html&_csp_=b34e17fcb01ce2b733f2804c894c2118&itemIGO=oecd&itemContentType=book

12 https://ec.europa.eu/eurostat/statistics-explained/index.php/People_at_risk_of_poverty_or_social_exclusion

13 Brunner, EJ. (1997) 'Stress and the biology of inequality'. British Medical Journal, 314, pp. 1472-1476.

14 Ferrie, JE. et al. (2001) 'Employment status and health after privatisation in white collar civil servants: prospective cohort study'. British Medical Journal, 322, pp. 647-651.

15 McDaid (Ed). (2008) 'Mental Health in Workplace Settings. Consensus paper.' Luxembourg, European Communities.

administrative barriers separate disadvantaged communities from the health system and increase their vulnerability in terms of access to medical care and preventive services. Therefore, primary health care, including hospitalization, nursing care and prevention becomes a challenge not only for people living in deprivation, but also for numerous other social groups. According to a recent report released by the Organisation for Economic Cooperation and Development (OECD), two in three people aged over 65 years suffer from "cardiovascular diseases, musculoskeletal disorders, cancer or diabetes[16]" – chronic diseases requiring costly treatment, while 17,6% of women and 13,2% of men over 65 live below the poverty line in Europe.[17] This situation is a major challenge for the social security system as 14.5 % of young people in the EU are unemployed and cannot make contributions.[18] Due to lack or poor medical coverage and financial resources, access to healthcare then becomes a struggle for vulnerable groups, including older people and unemployed young people, leaving them with weakened health and lower economic opportunities. This is particularly worrying for young Europeans who are more and more exposed to job insecurity and precarity, which has significant effects on their health status. Therefore, improving primary health care is a crucial factor in successfully addressing demographic change in Europe and population ageing in particular, but is also absolutely necessary for the achievement of social justice and ensure positive economic growth and prosperity in the EU.

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1.1.4. Gender and health

More evidence is being gathered on the relationship between gender and health status: due to biological (sex) and socio-cultural (gender) differences, health inequalities affect women and men differently. Historically, across Europe, the disparities in women's situation compared to men have resulted in numerous disadvantages in employment, working conditions, remuneration, housing, education, wealth and health. Today gender disparities are tackled by different social policies; however, despite the progress that has been achieved in Europe in the field of women's rights, women remain more exposed to severe injustice in terms of health, affecting their ability to access employment and social services. As a result, they are more likely to work longer for lower remuneration, receive lower pensions when retired and have more difficulties to afford healthcare, medicines and preventive services. Access to sexual and reproductive health services is another crucial area for women's health, increasing health inequalities between women and men. Availability, accessibility and affordability of family planning and reproductive health services is not assured in all Member States, limiting their access to contraception and preventive services and leading to additional obstacles for women to maintain good health, especially for those on low incomes.

Also, more vulnerable to domestic violence, women face higher levels of stress, depression and anxiety which can weaken their mental health and well-being, while men are more vulnerable to alcohol and drug addiction.[19] It has also been found that women's health may be worsened more often due to the effects of chemicals, air-pollution from cooking and black smoke from home heating, while men tend to work in more risky workplaces and experience unintentional injuries more frequently.[20]

16 https://www.oecd.org/health/health-systems/OECD-Policy-Brief-Primary-Health-Care-May-2019.pdf

17 http://appsso.eurostat.ec.europa.eu/nui/submitViewTableAction.do

18 https://ec.europa.eu/eurostat/statistics-explained/index.php/Unemployment_statistics#Recent_developments

19 https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf

20 WHO (2010) Social and gender inequalities in environment and health In: Fifth Ministerial Conference on Environ-

In general, men with lower social positions and educational levels working in the worst conditions suffer more often from disease, have poorer health status and live 10 years less compared to those with university degrees.[21] Women enjoy longer life expectancy than men but spend twelve years of their life in ill health and the gender gap is higher among those with lower levels of education, income and employment opportunities - another proof of the link between gender, social status and health.

1.1.5. Disadvantaged communities and socially excluded groups

When addressing health inequalities, specific attention should be dedicated not only to social determinants of health such as income, social status, education or gender but also to additional factors related to violations of an individual's human rights and the levels of discrimination they face. Some socio-economic groups struggle to access healthcare and preventive services, as a result of discrimination and prejudice. Homeless people, refugees, old persons, people with disabilities, LGBTI, prisoners, undocumented migrants[22] as well as stateless children, ethnic minorities, including Roma among others are disproportionally affected by health inequalities. At the same time, the poor health of disadvantaged groups limits their capacity to find a job, housing or benefit from education and training opportunities. As a consequence, they live in worst housing conditions, suffer more from pollution, poor nutrition and poor mental and physical health, further deepening the health inequalities they face. Additionally, ill health diminishes the individual's capacity to escape the cycle of poverty and improve their social status and contribute to the economic growth of society. Roma, one of the most disadvantaged communities in Europe, perfectly illustrates this correlation. They live at the very edge of the socio-economic spectrum and their health is far below average compared to non-Roma living in the same countries. The resulting health inequalities which Roma face is due to their higher exposure to the range of unfavourable factors that influence health, but also the discrimination in different fields they face which prevent them from maintaining good health.[23]

Discrimination in its different forms is one of the main reasons for the increasing vulnerability of certain socio-economic groups and provokes a growing divide in access to healthcare and preventive services. This complex issue can be resolved through the adoption of an inclusive and multi-sectorial approach which looks beyond health and allows different social policies to be combined addressing the main factors causing health inequalities from birth.

1.1.6. Early childhood development

The first three years of a child's life are vital for its health and well-being. This period is characterised by intensive physical growth and mental development requiring adequate nutrition, adapted healthcare services, physical activity and brain stimulation to ensure the best start in life and prevent the health inequalities which children can face. This is also a critical phase where poverty and malnutrition have devastating effects on an individual's health and mental development, and should be tackled as soon as possible by guaranteeing access to healthcare, affordable medicines, vaccination and preventive services for every child regardless of social

ment and Health. Parma, Italy, 10-12 March 2010. Copenhagen, WHO Regional Office for Europe.

21 https://ec.europa.eu/health/sites/health/files/state/docs/2018_healthatglance_rep_en.pdf

22 Improving healthcare access for marginalised people, Nobody left outside Initiative, October 2019

23 https://epha.org/wp-content/uploads/2019/02/closing-the-life-expectancy-gap-of-roma-in-europe-study.pdf

status, gender etc. Greater protection of children's rights will have a strategic impact on their physical and mental development; will create opportunities to develop their full potential and live successful social and professional lives. Furthermore, preventing health disparities from an early age will contribute to tackling gender inequalities and combating social injustices faced by many population groups.

This is particularly relevant for children from disadvantaged communities and socially excluded groups who are more vulnerable to health inequalities compared to children with better social status. Long term unemployment, generational poverty, social exclusion, discrimination in numerous areas including health, lead to poor access to medical care and preventive services for pregnant mothers, their babies and children decreasing drastically the opportunities for optimal physical and mental development. Poor living conditions and poor access to activities which can stimulate a child's development also has significant impact on child health, and further contributes to an increase in the risk of poverty, social exclusion and health inequity.

Therefore, eradicating child poverty is an essential factor for ensuring the best conditions for early childhood development and combatting health inequalities in society. In this regard, the European Child Guarantee[24] proposed by the European Commission can be a response to the social injustice, including poverty and social isolation, faced by European children, but also can provide stronger guarantees for all children to access the health services needed for the proper physical and psychological development of Europe's future generation.

1.1.7. Financial costs of poor health

The consequences of poor health for individuals and society represents a significant economic challenge for healthcare systems in European countries regardless of the level of economic development. According to the World Bank and the OECD, there are still patients who do not have access to appropriate and evidence-based care, leading to increased financial costs, time and energy needed for further treatment of diseases.[25] Affordability and access to good quality medical care poses more challenges to people living below the poverty line, increasing their exposure to health risks. They face different difficulties in access to medical care; availability of prevention services; proper nutrition and physical activity leading to poorer health status compared to other socio-economic groups. As a result, a person with weakened health will be less productive and more vulnerable to long term unemployment, poverty and social exclusion and will have lower capacity to make a commitment to the social and economic growth of the European Union.

Secondly, poor physical and mental health decreases the individual's capacity to contribute to the social security system - a major issue in the context of population ageing in many EU countries. For this reason, preventing health inequalities becomes a public health, economic and demographic imperative. Investing in health systems and especially in access to good quality medical care for disadvantaged communities and socially excluded groups will contribute to the global positive change in Europe and the realisation of the United Nations' Sustainable Development Goals, improving health and well-being, and not only eradicating "a wide range of diseases," but also strengthening the economic prosperity of the EU and society more generally.

24 https://ec.europa.eu/social/main.jsp?catId=1428&langId=en

25 https://apps.who.int/iris/bitstream/handle/10665/272465/9789241513906-eng.pdf

2. Social and environmental determinants of health inequalities

Health inequalities are a complex issue caused by social, environmental and economic conditions that influence an individual's health status. In other words, being healthy (or not) is not an individual choice but primarily a result of the living, working and social environment in which people are born, grow and live.

2.1. Environmental hazards

Health inequalities are a complex issue caused by social, environmental and economic conditions that influence an individual's health status.

In recent years a number of environmental factors linked to climate change have been identified as a reason for the worsened health status of individuals and social groups. Environmental determinants such as pollution, radiation and contamination increase exposure to health risks significantly. High levels of pollution in large European cities raises the risk of cardio-vascular and pulmonary diseases, to which some socio-economic groups such as older people are particularly vulnerable. Notable contrasts can be observed between Western and Eastern European countries, facing the highest rates of death caused by air pollution in the European region.[26] Rapid industrialisation, construction and unsustainable urbanisation in ex-communist countries has led to high levels of air pollution creating unhealthy conditions for populations living in these countries.[27] Domestic heating systems with poor energy efficiency in Central and Eastern Europe also aggravate air quality. For instance, 33 out of the 50 most polluted European cities are concentrated in Poland. The situation in the Balkans is even worse - Tetovo and Skopje experience the highest pollution rate across the continent, Bulgaria is also one of the European countries with the highest rates of toxic air. Such pollution levels increase drastically the environmental and health hazards in those regions and represent a major challenge for the public health systems in these countries, especially due to the lack of resources to tackle the consequences on population health.

Air pollution is a major health concern not only for Eastern and Central European countries. This is the greatest environmental risk generating health hazards with serious impact on quality of life, life expectancy and individual productivity.[28] In addition, contaminated and toxic fields in proximity to living areas further aggravate the health status of the European population - a well-known phenomenon that tends to follow a social deprivation gradient. In fact, people from lower socio-economic groups are disproportionately affected by environmental pollution, tobacco smoke, sanitation and water scarcity, noise, road traffic and occupational injuries and stress which rises notably the more health inequalities they face.

2.2. Tobacco harm

According to World Health Organization (WHO) estimates, Europe is one of the regions with the highest rates of tobacco consumption: 28% of the EU population consume tobacco, which causes major health risks. It is responsible for 700,000 deaths every year in Europe and is one of the main

26 https://www.who.int/gho/publications/world_health_statistics/2017/en/

27 http://berkeleyearth.org/air-quality-real-time-map/

28 https://epha.org/wp-content/uploads/2018/07/Clean-air-briefing.pdf

Being healthy (or not) is not an individual choice, but primarily a result of the living, working and social environment in which people are born, grow and live.

reasons for premature death affecting 50% of smokers. Tobacco is one of the most "dangerous commercial determinants of health"[29] associated with numerous non-communicable diseases, including cardiac disease and cancer, increasing further the rate of premature death in Europe.

Furthermore, there are clear relationships between smoking and deprivation. Tobacco consumption tends to be more frequent among disadvantaged groups: homeless people, people suffering from mental health problems, but also those on low incomes, are more likely to start smoking from an early age and consume tobacco more often. In the EU, the highest rate of tobacco consumption was noted in Bulgaria (27,3%) - the poorest Member State - illustrating the connections between socio-economic factors and tobacco use. Daily smoking is higher among people with lower educational degrees for both men and women in most Eastern European countries, but significant differences between male and female tobacco consumption can be observed in Northern Europe correlating with their social status. Smoking is also widely practiced by young Europeans between 15 and 24, in particular those from lower socio-economic groups. In Europe 29% of young people are regular smokers, which increases the risk of non-communicable diseases for this social category.[30] Another contrast is observed between ethnic minorities and the majority population in many European countries. Socially excluded groups, such as Roma communities smoke more frequently. For instance, in Croatia, tobacco consumption is prevalent among almost every Roma. Higher tobacco use is observed among migrants living in Germany and Switzerland compared with the general population. Smoking during pregnancy is higher amongst ethnic communities in the Netherlands.[31]

Tobacco generates many unfavourable health factors worsening health and well-being, but it also has negative effects on an individual's financial status. It leads to considerable extra costs for consumers living below the poverty line and diminishes their ability to resist health hazards, poor mental health and more broadly, social exclusion and premature death. Furthermore, tobacco consumption leads to nicotine addiction which is also harmful for smokers' mental health, increasing levels of stress and anxiety. Recent research[32] shows people with conditions such as depression and schizophrenia are more vulnerable to tobacco use, often perceived as a self-medication against stress and anxiety. For instance, the UK Office for National Statistics estimates that 45% of those suffering from schizophrenia smoke more heavily compared with 15% of the general population in the UK.[33]

In other words, smoking threatens individual health, notably reducing resistance to non-communicable diseases, including cancer; harms mental health and provokes addictions whilst increasing the risk of poverty and social isolation. On a societal level, it strengthens social disparities and health inequalities, a major macro-economic challenge in the context of sustainable development and economic prosperity of the European Union.

2.3. Alcohol dependence and illicit drugs

29 https://epha.org/tobacco-and-trade-an-unhealthy-and-harmful-marriage/

30 http://www.euro.who.int/__data/assets/pdf_file/0005/247640/tobacco-090514.pdf

31 http://www.euro.who.int/__data/assets/pdf_file/0005/247640/tobacco-090514.pdf

32 https://www.cambridge.org/core/services/aop-cambridge-core/content/view/AA82945360EC59FEC4331A7A567309C9/S0033291719002678a.pdf/evidence_for_causal_effects_of_lifetime_smoking_on_risk_for_depression_and_schizophrenia_a_mendelian_randomisation_study.pdf

33 https://www.ons.gov.uk/peoplepopulationandcommunity/healthandsocialcare/healthandlifeexpectancies/bulletins/adultsmokinghabitsingreatbritain/2018

The UN Agenda for the Sustainable Development Goals accords significant importance to public health and well-being. Alcohol consumption and dependence are identified as risk factors for the population but also is an obstacle for the achievement of the objectives of the UN Agenda2030, especially when it comes to the health status of certain socio-economic groups. Alcohol dependence and drug use not only harms individuals' health and well-being but also contributes to rising poverty and social isolation, as well as curbing social cohesion and sustainable development promoted by the UN Agenda2030. These two risk components are public health issues and are associated with social and economic vulnerability,[34] as it is for tobacco consumption.

Alcohol is responsible for 7% of the cases of ill health and premature deaths within the European Union and leads to non-communicable diseases such as liver cancer. From a global perspective, the WHO European Region has the highest proportion of alcohol consumption (21.2%) in the world and the highest rates of current drinking among 15–19-year-olds (43.8%), greatly contributing to the poor health experienced by many population groups. Alcohol use is considered to be the third leading risk factor of ill health and premature death as measured in disability-adjusted life years (DALYs), after underweight and unsafe sex. It is responsible for 10.1% of all deaths and 10.8% of all the years lost.[35]

Not only does alcohol and drug dependence result in higher mortality and morbidity rates (accidents, injuries, suicides, violence), but it also increases the vulnerability of those living in harsh economic and social conditions to such substances. Differences in alcohol-related harm by socio-economic status within given societal groups tend to be more visible than the differences in alcohol consumption per capita. This means that for a given amount of alcohol consumed, poorer members of the society are likely to experience disproportionately higher levels of alcohol attributable harm – especially for men.[36]

2.4. Nutrition and food insecurity

Proper nutrition has a vital role for physical development, and a person's social and professional activities. This is a topic that should be addressed from early childhood by adopting the necessary habits to maintain good health. At the same time nutrition and food insecurity are public health issues, often related to economic, environmental and agricultural concerns that should be addressed by policy makers.

Despite the notable progress made in Europe, some socio-economic groups are unequally affected by access to adequate nutrition in sufficient quantities and have a lower capacity to afford healthy nutrition. They are more vulnerable to obesity, diabetes, and cardio-vascular diseases which are prevalent among people with low incomes. Disadvantaged communities and socially excluded groups facing high rates of unemployment face more obstacles in affording nutritious food and learning good eating habits at an early age. Furthermore, living in poverty and social isolation increases their vulnerability to poor nutrition and food insecurity, depriving them of access to rich nutritional values and good quality food needed for maintaining good health status. Compared to the wealthiest groups, low income groups (such as young people, single parents, households, elderly and unemployed people), eat less well, pay more for the food they buy and have worse access to healthy options and related

34 Wardle, J. et al. (1999) (eds.) 'Smoking, drinking, physical activity and screening uptake and health inequalities'. In : Gordon D et al., (eds.) 'Inequalities in health'. Bristol, The Policy Press, pp. 213-239.

35 https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf

36 https://www.thelancet.com/journals/lanpub/article/PIIS2468-2667(17)30078-6/fulltext?elsca1=tlxpr#seccestitle150

services.[37][38] Low income is associated with poor nutrition at all stages of life, from lower rates of breast-feeding to higher intakes of saturated fatty acids. Moreover, there is increasing evidence that poor nutrition in childhood results in both short-term and long-term adverse consequences such as poorer immune status, poor dental hygiene and poorer cognitive function and learning ability, which further aggravate the health inequalities experienced by some population groups.[39]

Figures show that 8% of Europeans are at risk of food insecurity due to the lack of sufficient food[40], as well as poverty, limiting their purchasing power and capacity to afford food. This issue has particular consequences on children's development, as they need good quality food in sufficient quantities for their physical and mental development. A survey produced by the European Fundamental Rights Agency showed that approximately 90% of Roma children in nine Member States are living in deep poverty and experiencing hunger, while Europe is one of the richest regions of the world. These children experiencing social injustice have lower opportunities to succeed in education, employment, secure higher incomes in adulthood and maintain good physical and mental health.

Europe is also the place where highly processed and fast foods, high in fats, salts and sugars, are more readily accessible, whilst nutrient-dense food such as fruits and vegetables have become relatively more expensive, which strengthens the correlation between socio-economic factors, risk of over-weight and obesity and poorer health, especially among children. Obesity and over-weight are serious public health issues affecting more than half of the European population, increasing the risk of diseases requiring significant financial and social investment. Risk of obesity is higher for people with lower educational levels, perhaps because of the lack of sufficient resources to afford nutrient-dense food, low levels of awareness about eating healthily and poor nutrition habits.

Poverty-related poor diets, overweight and obesity contribute to a large proportion of non-communicable diseases, including cardiovascular diseases and cancer, the two main causes for premature deaths in the WHO European Region.

Therefore, poverty-related poor diets, overweight and obesity contribute to a large proportion of non-communicable diseases, including cardiovascular diseases and cancer, the two main causes for premature deaths in the WHO European Region. Many young people and children experience obesity, endangering their health status, shortening life expectancy, but also harming their quality of life and affecting their productivity. Combatting poor nutrition, then, goes hand by hand with preventing poverty and social exclusion and thus, eliminating food insecurity and malnutrition. It will also provide favourable conditions for improving the health status of the European population, especially for vulnerable groups; and will facilitate the development of circular economy that "works for people", tackling agriculture, environment and health issues.[41]

2.5. Mental Health

Poor mental health is a societal issue, requiring adequate preventive measures combined with strong efforts to address the social and economic components which exacerbate mental health risks. In fact, poverty, unemployment, social exclusion, alcohol consumption, drug use, poor nutrition and

37 Pomerleau, J.; Knai, C.; Branca, F. et al.(2008) 'Review of the literature of obesity (and inequalities in obesity) in Europe and of its main determinants: nutrition and physical activity'.

38 Andreyeva, T.; Long, MW. And Brownell KD. (2010) 'The Impact of Food Prices on Consumption: A Systematic Review of Research on the Price Elasticity of Demand for Food'. American Journal of Public Health, 100(2), pp. 216-222.

39 Nelson, M. (2000) 'Childhood nutrition and poverty'. Proceedings of the Nutrition Society, 59, pp. 307–315.

40 The state of food insecurity and nutrition in the world, joint report WHO, UNICEF, Food and agriculture organisation of the UN, International fund for agriculture development, World Food Programme, 2019

41 https://ec.europa.eu/info/strategy/priorities-2019-2024_en#documents

food insecurity may lead to mental health problems causing premature deaths. In many cases, it is the poorest in society who experience poor mental health more frequently. They are also the most exposed to non-communicable diseases due to stress, anxiety and mental disorders. Conversely people with existing mental health problems are more likely to experience poverty and have the lowest capacity to afford appropriate services and medical treatment.

Treating mental health issues is crucial step to achieve positive results in different policy areas, including economy, which aim to strengthen sustainable development and social fairness in Europe. First, poor mental health aggravates the risk of deprivation and social isolation and diminishes an individual's ability to contribute to the achievement of Europe's social and economic objectives. Secondly, mental health treatment is costly and raises issues related to affordability and accessibility, especially for certain socio-economic groups living below the poverty line. Despite the lack of official data, it is clear that individuals with low incomes have more difficulties in affording treatment and obtaining physiological support, especially when most of the European countries have low coverage of mental healthcare, which prevent people who live in deprivation to access relevant services. Availability of such services is another challenge for people having mental health issues, as more often such services are offered in the private sector.

At the same time poverty and lack of sufficient financial resources are a major source of distress and anxiety, creating a vicious circle of deprivation and poor mental health. Financial hardship and uncertainties about the future, especially depression, anxiety-disorders and burn-out are more and more commonplace among the European population, including young people, increasing the burden on health systems. Estimates show that 800 billion euros are spent per year on mental health issues and neurological disorders, almost half is caused by loss of productivity, followed by healthcare costs (37%) and social service costs (23%).[42] Stigma and discrimination in accessing mental health services, employment and housing additionally worsen individuals' health status, especially for those who have already experienced mental health issues. Job insecurity is another source of poor mental health conditions such as stress and anxiety, in particular for young people, women and those from disadvantaged communities, further increasing their vulnerability to unemployment; but also to health inequalities as it increases the risk of mental health issues, heart rhythm disturbances, stomach problems etc., which rarely enjoy sufficient attention from policy makers.

2.6. Digital health

Digital technology provides a wide range of online tools that can influence individual's health status and facilitate their access to different healthcare services. Digital transformation could be a way to promote access to preventive services and help people to adopt healthy behaviour, including nutrition and physical activity. It can be used to raise awareness about the harmful effects of tobacco and alcohol consumption; the consequences of air pollution and risk of chronic diseases caused by environmental hazards. In this regard digital health may be an instrument for reducing health inequalities faced by certain socio-economic groups and disadvantaged communities in particular.

However, digital health raises further issues related to accessibility and affordability, especially for people with low incomes or low levels of education. Lack of resources to afford electronic devices needed for accessing online services; availability and accessibility of training aiming to improve

42 https://ec.europa.eu/health/sites/health/files/mental_health/docs/ev_20161006_co02_en.pdf

digital literacy etc. may contribute to further exacerbate health inequalities between different socio-economic groups - a risk that has been highlighted by the European Commission in its recent report addressing the state of health in the European Union.[43] In fact the European Commission emphasizes the impact of social disparities between countries and regions in Europe on the capacity of public authorities to provide appropriate services, aiming to promote equal access to digital health, increase digital literacy and ensure the affordability of such services.

3. Tackling health inequalities goes beyond the health sector

Traditionally, the health sector has been looked on to deal with concerns about health and disease. However, the main levers of health lie outside of the health sector.[44] Evidence shows that health is a complex policy area crossing social, economic, agricultural and environmental sectors, which all should be taken into account in public health policy. Hence, policy makers, together with non-health policy and professional communities, including teachers, employers, local entrepreneurs, urban and rural planners, among others, should create a multi-sectorial framework to address health inequalities, examining, the wider determinants of health - in particular those which are poverty-related.

Health is a complex policy area crossing social, economic, agricultural and environmental sectors, which all should be taken into account in public health policy.

Policy makers and health professionals cannot tackle health inequalities without the support and the cooperation of their colleagues in the fields of housing, urbanisation, transport, social services, education, employment, environment and other policy areas. For instance, the use of healthy public transport which encourages less driving, and more walking and cycling, promotes the health and well-being of all social groups. Increased use of public transport or bicycles will contribute to reduce carbon emissions and prevent further air pollution, improving individual and public health and promoting equal opportunities.[45] Planned urbanization, sustainable transport and sufficient green space in cities may contribute to decreasing pollution rates; promote healthy habits, including physical activity[46] and facilitate access to education and employment. Good urban planning, including transport can be a tool for tackling social exclusion and spatial segregation which isolates entire population groups and increases their vulnerability to health inequalities.

This is an example of how actions in different policy areas can be combined to provide an instrument for fighting against health inequalities in parallel with social disparities. In other words, public health policy should be combined with the social outcomes of environmental policy, which ultimately can contribute to the realization of the EU goals aiming to transform Europe into a “climate-neutral continent,” also improving significantly Europe’s social cohesion and equity.

43 State of Health in the EU, Companion report, EC 2019

44 WHO Commission on Social Determinants of Health (2008) Closing the gap in a generation: Health equity through an action on the social determinants of health. Final Report. Geneva: World Health Organisation.

45 WHO Regional Office for Europe (1999) Charter on Transport, Environment and Health.

46 https://apps.who.int/gb/ebwha/pdf_files/WHA72/A72_15-en.pdf

All key policies, including climate, agriculture, economy, social policy etc. should include health perspectives in order to successfully reduce health inequalities and prevent such disparities in the future.

4. The Solution: Addressing health inequalities requires a multi-sectorial and inclusive approach

The European Commission has an ambitious plan for tackling climate change that requires efforts in the field of public health in parallel with environmental, agricultural, social and economic policy areas. In its priorities for the period 2019-2024, the European Commission accords a pivotal role to improving the economy, climate and democracy to positively affect the future of the European Union and its population. At the same time these three policy areas are strategic for combatting health inequalities and achieving social justice within the EU.

Increasing economic prosperity within the European Union requires measures for improving the health status of the European population but also mechanisms for guaranteeing equal access to health services, healthy nutrition and good quality of life. Such an approach will help to reduce social disparities among regions and population groups, as social injustice is one of the main factors responsible for health inequalities. Moreover, tackling health disparities as a short-term priority may positively impact the European economy and demographic change. In fact, poor health generates considerable financial costs and loss of economic productivity which prevent the achievement of the objectives for economic growth and prosperity within the EU. Social fairness and equal access to rights and services for all will significantly contribute to combatting health inequalities and facilitate the establishment of a socially responsible economy within the European Union.

Such positive outcomes are possible only if there is stronger cooperation between policy makers at European and national levels as well as between national governments, willing to improve public health systems and protect the European population from further social, environmental and economic upheaval, is established. There is an increasing necessity for coordinated actions across health and other related policy areas (e.g. social, economic, education, environment, justice), as well as the involvement of other non-governmental actors. Stakeholders, including policy makers and civil society must work together in order to reduce both health inequalities and social disparities by using a multi-sectorial approach that takes into account an individual's surroundings and social structures which subsequently influence both their own health status and public health as a whole.

Based on these principles, all key policies, including climate, agriculture, economy, social policy etc. should include health perspectives in order to successfully reduce health inequalities and prevent such disparities in the future. Closing the health gap becomes, then, a shared goal across all parts of government and by all stakeholders to address complex health challenges through integrated and inclusive policy responses. In other words, EU policy makers, national governments and public authorities must treat the main factors responsible for health inequalities by addressing the key determinants of health in more systemic and systematic manner.

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