Health Inequalities in Europe

On average people in Europe are living longer and in better health than ever before. However, many people are being left behind. Big differences remain between groups of people and countries.

LIFE EXPECTANCY AT BIRTH BETWEEN EU MEMBER STATES

HEALTHY LIFE YEARS or disability-free life years describe the number of years lived in a healthy state.

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AGE 65

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In general, the lower a person’s socio-economic status, the worse the health outcomes. This is the **social gradient in health**. It exists in all countries, but the steepness of the curve varies.

### SELF-PERCEIVED HEALTH IN THE EU\(^5,6\) (aged 16 or above)

The share of people that describe their health as ‘good’ or ‘very good’ increases with the level of education and income:

- **20% of the richest population**
  - GOOD OR VERY GOOD: 80.4%
  - FAIR: 15.7%
  - BAD OR VERY BAD: 3.9%

- **Average population over 16 in EU-28 in 2017**
  - GOOD OR VERY GOOD: 69.7%
  - FAIR: 22%
  - BAD OR VERY BAD: 8.3%

- **20% of the poorest population**
  - GOOD OR VERY GOOD: 61.2%
  - FAIR: 25.6%
  - BAD OR VERY BAD: 13.2%

Health outcomes and **health inequalities** are influenced by the social, economic, and environmental determinants of health - the conditions in which we are born, grow, live, work, and age.

![Health Inequalities](chart)

**HEALTH INEQUALITIES**

are the differences in health between different groups of people which are avoidable by reasonable means.

### Percentage of people that experience exposure to pollution

**Air**

- **EU-28**: 14% (15.6% in MALTA), 30.3% (32.5% in GERMANY), 23.2% (27.4% in LUXEMBOURG)

**Noise**

- **EU-28**: 17.9% (20.9% in MALTA), 26.2% (30.4% in GERMANY), 25.1% (32.4% in NETHERLANDS)

People living in socio-economically deprived areas are more likely to be exposed to higher levels of air pollution.\(^7\)
The WHO Health Equity Status Report indicates that 90% of health inequalities can be explained by financial insecurity, poor quality housing and neighbourhood environment, social exclusion, and lack of decent work and poor working conditions:

People with lower levels of education have a higher risk of suffering from certain illnesses than those with a high level of education:

- Depression: 3.12 times higher
- Diabetes: 2.36 times higher
- Obesity: 1.93 times higher

Health inequalities reduce economic and social productivity and lead to higher healthcare and welfare costs.

In the European Union, inequalities in health are estimated to cost €980 billion per year, or 9.4 percent of European GDP. A 50% reduction in gaps in life expectancy would provide monetized benefits to countries ranging from 0.3% to 4.3% of GDP.

Health inequalities:
- Reduce individual wellbeing, happiness and life satisfaction as well as people’s ability to contribute to society.
- Undermine economic growth and prosperity, a socially just transition to a sustainable economy, and the implementation of the SDGs agenda.
- Increase health and social care expenditures.
- Challenge European values of equality (incl gender), solidarity (incl. inter-generational), and justice.

A Call to Action to reduce health inequalities

Health is an enabler of social and economic participation in daily life, the ‘motor’ behind our economies, and a key determinant of a person’s wellbeing, happiness and life satisfaction. In EU surveys, people systematically value good health above all other aspects of their lives. They also consistently indicate being concerned about growing inequalities.

We must take action to ensure that good health is not simply a prerogative of the well-off, but of everyone. Health inequalities reveal that market economies are not delivering wellbeing in a fair and effective manner. Reducing health inequalities is possible, represents a good investment and has strong public support.
1. Make health equity a central indicator of sustainable development and of health system performance assessments. It is covered by UN Sustainable Development Goals (SDGs) 3 and 10 and is key to achieving many other SDGs.

2. Build capacities of professionals across the health sector to understand health inequalities in order to deliver appropriate, person-centred services and to work across sectors to improve the underlying determinants of health such as unemployment and social exclusion.

3. Engage in efforts to strengthen social protection systems and improve living conditions for all, implement the European Pillar of Social Rights, achieve the SDGs to make sure that no-one is left behind, and reduce inequalities in education.

4. Adopt measures that have been proven to prevent ill health. This includes smoke-free legislation and minimum unit pricing for alcohol, environmental measures (housing, transport) and address commercial determinants of health, by e.g. taxing unhealthy products and subsidising the production of fruits and vegetables.

5. Invest more in health promotion and disease prevention services, and in improving health and digital health literacy, with a focus on reaching those in greater need.

6. Invest in comparable data at local, regional and national level that can be used to measure and address health inequalities.

7. Develop capacities to analyse data, and to design and evaluate measures that can reduce health inequalities, to e.g. improve understanding of how to apply the principle of 'proportionate universalism' to policies.

8. Increase and use public funds (e.g. European Structural and Investment Funds, European Investment Bank loans) to develop the capacity of health professionals and administrators to address health inequalities, and to stimulate investments and collaboration across sectors (including private) in human and social capital and the determinants of health.

9. Engage in cross country dialogue on effective approaches to improve health equity, as is done in the Joint Action on Health Inequalities in Europe (JAHEE). Establish benchmarks and exchange good practice.

References can be found at www.eurohealthnet.eu
References

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