The European Platform on Health and Social Equity (PHASE) is an advocacy and action-oriented body for EuroHealthNet participants and a wider range of partners from relevant fields in public, private, and voluntary sectors willing and able to work on addressing the wider determinants of health. PHASE aims to directly support and actively contribute to the EU policy framework for social investment and innovation by bringing new ideas to bear on areas of specific added value with regards to tackling social inequalities in health.

Our Policy Précis provide an easy-to-read analysis of a key policy area, outlining where progress can be made to address social and health inequities in Europe. The aim is to inform and help to improve international, national and local policies and practices within and beyond health systems, in order to promote better health and well-being for all.

This series of summaries is updated and expanded with full references online at www.eurohealthnet.eu

Why making the link matters

EU policy has responded to economic and societal changes, and health in Europe has improved in many respects. But these improvements have not been enjoyed throughout the population, and significant sections of people in Europe still struggle for their health and well-being. These people are far more likely to come from lower socio-economic groups. For example, “differences in life expectancy at age 30 between those in higher education and those with basic secondary education or less exceed 10 years in many Member States.”

Life expectancy gaps between high and low educational attainment (2010-2011)

Findings of the project on measuring life expectancy by socio-economic status group, V. Corsini, European Commission, Eurostat (2012)

The Review of Social Determinants and the Health Divide in the WHO European Region “has identified the clear existence of inequalities by educational status for total mortality, cancer, ischaemic heart disease, general morbidity, diabetes and suicide.” The Review notes that, “countries with higher levels of social inequality, such as inequality in income or the proportion of the population living in relative poverty, tend to have the highest prevalence of obesity in the population, especially among adolescents and among children. Obesity and overweight among children was also associated with the socio-economic status of their parents, especially their mothers.”

While work on specific risk factors and genetic, behavioural and environmental determinants are all important parts of the practical “jigsaw” puzzle of policies and practices that must be assembled to tackle inequities, unless underlying factors and causes are addressed they may fail or re-surface. In addition to building knowledge and evidence, the priority needs remain to:

> Improve the conditions in which people are born, grow, live, work and age;
> Empower significant changes in the balance of equitable access to wealth, power and resources

EuroHealthNet has worked on the link between social inclusion and equitable health for 3 years within the EU PROGRESS Programme. From 2014 – 17 it will develop that initiative in the EU EASI Programme. Health inequalities may be socially determined, when people’s socio-economic environment influences their choices, or leads them to adopt certain behaviours that affect their health. Health inequalities are also structurally determined, and occur when there are avoidable differences in access to resources, when people’s health is affected by factors over which they have limited autonomy. Social ‘gradients’ exist in access to resources, levels of participation and degrees of autonomy experienced in all European states. Policies are needed which will ‘level up’ the health gradient, lifting the health of everyone in society closer to the level of those with the best health.
Social inclusion approaches mean intergenerational solidarity and quality of life for all citizens, so that each individual views themselves, and is viewed by others, as a useful, respected, and equal participant in society. This resonates with the empowerment principles of health promotion as established in the Ottawa Charter. The social exclusion of an individual will have direct consequences for that person’s health. Contributing factors include poverty, unemployment (or being under-employed), a low level of education and skills, poor access to information, childcare and health facilities, location, poor living conditions, disability or poor health, as well as restricted social participation. Health policy should be informed by an understanding of how these factors are connected. But equally, policies related to all these social conditions should be informed by their anticipated impact on health.

Addressing social exclusion and promoting equitable health in integrated ways will contribute to national and EU objectives of smart, sustainable and inclusive growth as well as the objectives of the WHO Europe Health 2020 strategy.

The situation

The EU Gradient Project led by EuroHealthNet included evidence on the importance of social capital and inclusive communities as factors impacting on wellbeing of families and young people. There are many examples in which health promoters are engaged in tackling social exclusion as an integral part of work. Yet, health and social systems planning are often administratively separated. In many states, the resulting social needs and costs are identified as “burdens”. Taking an approach of integrated social investment in health nevertheless offers benefits for states, societies, citizens and children across social gradients.

Social engagement occurs through structures in society such as work, school, sports or arts, community organisations or via informal contacts, friendships and partners. But poverty and exclusion affects how one can engage with society. The 2013 EU Review of social developments highlighted how taking up a job helps people to get out of poverty in only half of cases. We know, not least from the EU PROGRESS project reports on work and worklessness that being unemployed is bad for health and that some work is better than none, but good quality working conditions, healthy living wages and equitable rights at work contribute to physical and psychological wellbeing, a proven cost-effective public and private investment.

But beyond that, absolute and relative poverty need to be sustainably addressed in all states, as the WHO Europe Report on Poverty and health established. The social benefits are well known and are being developed in the context of the EU Flagship commitment poverty reduction targets as part of its EU 2020 strategy. EuroHealthNet is playing an active role in the European Platform against Poverty and Social Exclusion and in partnership with other stakeholder organisations because the evidence is clear that tackling exclusion in all its forms brings health and wellbeing gains as well as economic and social advantages.

The vicious circle can be tackled. A parent living in poverty may be unable to pay for child care that would allow them to work, study or socialize, or even the books or IT that are shown to significantly improve life chances and wellbeing. Poorer nutrition and less easy or available healthy decisions can increase vulnerability to illness or disability. Even in affluent areas there is real isolation and exclusion. A rural area without transport links means less access to services. A homeless person lacks even the basic security of somewhere safe to sleep.

The precariousness of life in poverty contributes to feelings of powerlessness, stress, and even distress. People living in one of the most deprived areas of one of the most affluent states in Europe, for example are almost twice as likely to exhibit levels of psychological distress and are eight times more likely to be admitted to a psychiatric unit with an alcohol-related diagnosis. Residents of poor areas report feeling angry and hurt by the stigmatization of their community, as well as receiving poorer...
quality service from both the public and private sectors because of where they live. In summary, autonomy and social participation are so important to health that, “their lack lead to deterioration in health.” There are strong associations between being poor, being out of work, having low educational qualifications and the risk of developing a long-term health problem or impairment.

Such a complex web of disadvantage in so many different aspects of life requires coordinated action, not only across government departments but a whole of society approach. There are massive potential gains in health for all including socially excluded people if services are delivered out of a shared strategy, with service providers having a broad understanding of how those in poverty are affected. Any such gains represent potential cost effective improvements in health services, reduced dependence on the state, and a more dynamic, integrated society. In short, efforts to reduce health inequalities are an investment in the prosperity of Europe.

Setting an example

Shared Housing Schemes

Networks all over Europe have facilitated shared housing schemes where live-in house-sharers provide support for an at-risk disabled or elderly homeowner. The schemes carefully match young people who would otherwise struggle to afford accommodation with older or disabled people who may otherwise be isolated. Lonely people face an increased risk of obesity, high blood pressure and dementia.

http://homeshare.org/

Rural Food Co-operatives

Originally funded under the Welsh Government’s Food and Well Being Strategy, the Community Food Co-operative Programme is delivered by a social enterprise, The Rural Regeneration Unit (RRU). The RRU has a network of more than 300 Community Food Co-operatives operating sustainably, approximately a third of which are in schools, being run by children, parents and teachers. Pupils with profound disabilities benefit from a simulated work experience in helping to run the co-op. And customers benefit from locally sourced, affordable fresh fruit and vegetables.

http://ruralregeneration.org.uk/

Roma Inclusion

Development and Education Centres operate in some of the poorest municipalities of Serbia, supported by NGOs, UNICEF and local municipalities. The centres offer children classes taught by specially trained teachers, as well as a wider programme of skills and training relevant to young people. As well as providing services to the children, the centres’ overall goal is to empower the Roma community so that they would be willing to participate in planning local services.

http://www.drustvenicentri.org/


Pathways to progress

Europe2020 is the EU’s ten-year economic growth strategy, and it sets a target of lifting at least 20 million people out of poverty and social exclusion, and of increasing employment of the population aged 20-64 to 75%. The number of people at risk of poverty or social exclusion is 115.7 million, or 23.4% of the EU population.21

Europe2020 explicitly connects the health of the European population with the success of Europe's economy. One of Europe2020's flagship initiatives is the European Platform Against Poverty, which calls for action to address social exclusion. The European Social Fund (ESF) is the EU's main tool to support employment through investing in human capital – more than 74 billion EUR from 2014. At least 20% of that will be spent on social inclusion. In February 2013, the European Commission launched its Social Investment Package, an attempt to mobilise member states, working with the voluntary and private sector, to equip society to prevent social risks from materialising. “The Social Investment Package aims to encourage member states to enable and enhance people’s capacities to participate in society and in the labour market. It argues for more efficient and effective use of economic resources in the task to ensure adequate and sustainable social protection, investing in people’s skills and capacities throughout the life course and ensuring that social protection systems respond to people’s needs at critical moments during their lives.”22

According to the EU Treaty, member states are still formally responsible for the organization of their social inclusion, health care, long-term care and pensions system. However, using the Open Method of Co-ordination in these areas (social OMC), member states collaborate at EU level to set common objectives, monitor progress and share best practice. The social OMC can be a catalyst for reform, potentially furthering the integration of economic, employment and social policies. Policy makers in a variety of policy areas increasingly cooperate with the Social OMC’s Social Protection Committee, and the intention is to increase mainstreaming of social inclusion and social protection. Crucially, those experiencing social exclusion should be involved in this process.23

Member states will also contribute to the New Fund for European Aid to the Most Deprived – 3.5 billion EUR for the most deprived of Europe’s citizens will be spent on food distribution, and meeting other basic needs. The Fund supports measures contributing to a healthy diet as, where appropriate, the choice of food products shall be based on principles of balanced nutrition and quality food, including fresh produce, and should contribute to a healthy diet of the end recipients.24

The Third European Quality of Life Survey From Europe2020 Foundation for the Improvement of Living and Working Conditions (Eurofound) specifically calls for equality considerations to be part of mainstream policies, not restricted only to the margins. It argues for multi-dimensional strategies addressing the social determinants of poor health, including poor-quality housing, poverty and low educational attainment, as well as the mental health needs of unemployed people. It also argues that the health of older people, unemployed people and people with a limiting disability or health condition, is at a disadvantage, and this demands specific healthcare policies and strategies.25

The World Health Organisation echoes these calls, urging policy makers to recognize that health inequities belong at the top of the social and economic agenda, and are not merely for the health agenda. Its Health 2020 policy framework and strategy26 asserts that addressing social inequities demands a minimum standard of healthy living for all, and empowerment, which includes the ability to participate in the decision-making process.27 If people do not have control over their lives, it follows that they lack the opportunity, and often the capacity, to take control of their own health.28

The DRIVERS project, co-ordinated by EuroHealthNet, has examined early childhood development, employment and working conditions, as well as income and social protection, seeking to construct a clear picture of what is already known about how these areas impact health. Preliminary conclusions provide food-for-thought for policy makers. Research has found that improving developmental outcomes during early childhood provides substantial and life-long benefits for children and their families. Additionally, stressful work as defined by high demand combined with low job-task control, and/or high effort spent and low reward received in terms of low wage, job insecurity and lack of recognition increases the risk of suffering from stress-related disorders (mainly depression and coronary heart disease). Furthermore, people confined to in-work poverty are particularly vulnerable to stressful work. Workplace health-promoting policies (including access to occupational health services) should be prioritised in such workplaces. The supply and quality of collective resources is likely to influence people’s ability to sustain their health and well-being. And the less people have, in terms of individual resources, the more important it is that they can draw on collective resources. More generous benefits are linked to better health, but only when a large proportion of the workforce is covered by the unemployment insurance.

Sources


Making the link: social inclusion and health equity


Rural Regeneration Unit (2014) http://ruralregeneration.org.uk/


