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On 30 April 2011, the CPME Board adopted the "Health Inequalities – addition to CPME 2010/014 FINAL on the basis of CPME members' replies to questionnaire" (CPME 2011/019 EN)

Health Inequalties

This document consists of three sections. First a short introduction, then a section on actions for reducing health inequalities on both the CPME and the national medical association level. The third section gives the background for the actions.

Introduction

There are three major reasons for caring about health inequalities. The first is that avoidable health inequalities are simply and many would say immorally unfair. The second is that avoidable health inequalities often infringe an internationally acknowledged human right to health. The third is that health inequalities are economically costly- societies with smaller health disparities do better in economic terms than societies with wider health inequalities.

Action for reducing health inequalities

The well-being of and care for their patients is the prime concern and responsibility of physicians. Physicians apply their expertise to the best of their knowledge for the benefit of the sick and for the prevention of ill health. Research for new approaches and technologies to improve health, and contribution to policy making in clinical and public health are also important obligations for the medical profession.

In many countries physicians are confronted with violations of the right to health. People are unfairly discriminated against on the basis of gender, ethnicity, age, health status etc and vulnerable groups like immigrants without documents have very limited or no access to health care.

Health is a national responsibility, and the NMAs have the best knowledge of local challenges. CPME therefore suggest that European medical organisations should have two approaches to this issue:

1. Agreed action at the EU level
2. Agreed action by National Medical Associations (NMAs)

Action on the CPME level

The European Commission (CPME Info 197-2009) has announced that it will address health inequalities in EU by:

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Collaborating with national authorities, regions and other bodies
Assessing of the impact of EU policies on health inequalities to ensure that they help reduce them when possible
Regular statistics and reporting on the size of inequalities in the EU and on successful strategies to reduce them
Better information on EU funding to help national authorities and other bodies address the inequalities
(European Commission Communication Solidarity in Health: Reducing health inequalities in the EU)

In a response to the Consultation on European Commission Communication "Solidarity in Health" (CPME/AD/consultation/300309/082/EN) CPME suggested several measures to reduce inequalities in health. Some of these are not directly health-care related as for example education, social cohesion, fiscal and taxation policy etc. While the CPME supports action in these areas to reduce health inequalities, as an organisation for medical doctors, CPME would concentrate its lobby activities on health issues and give priority to these measures:

Improving the data and knowledge base and mechanism for measuring, monitoring, evaluation and reporting
Documentation of health inequalities is a first step to effective action. Better indicators and exchange of best practice can add value to the national policies to tackle health inequalities.

Improvement in infrastructure, especially water and housing
Clean water and appropriate housing have a positive effect on health. Polluted water causes serious health problems and homeless usually receive less health care than the rest of the population. They are usually not in an economical situation where they are able to pay for their health care. EU should use structural funds to help countries and regions to improve housing and distribution of potable water.

Improved maternal and child health care
Healthy children with good nutrition are more likely to stay healthy throughout their lives. Good child nutrition for all can also contribute to erase health inequalities.

Secure the right to health for disadvantaged people including illegal entrants and asylum seekers
In addition to the six policy recommendations made by Marmot as noted below CPME proposes emphasis on the right to health of the most disadvantaged and powerless within each society, of which their access to health care is an essential criterion. Physical, organisational and economical obstacles can often make it difficult for disabled and disadvantaged persons to receive the health care they are entitled to. Well educated people who are acquainted with their rights are more likely to receive health

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care than people with fewer resources. Health care should be delivered without adverse discrimination through integrated, accessible, accountable but of course also democratically acceptable and affordable systems.

Actions on the National Medical Association (NMA) level
Most NMAs are not in a position to take direct responsibility for implementing measures that reduce health inequalities and improve the health for disadvantaged groups. NMAs can, however, document disparities in health and access to health care services among groups of people. For example, the Norwegian Medical Association publishes annually a report on an actual health topic. As examples can be mentioned Health care for elderly, Health care for adolescents, Health care for drug abusers and Health care for immigrants from non-Western countries.

In a survey on health inequalities conducted by CPME and answered by 19 member states, many of the NMAs reported that social determinants have major influence on peoples' health. The major factors include income, work, housing, education, food, financial insecurity, access to green space etc. The health of children is key. The social determinants are often more important than differences in access to health care. The main reasons for health inequalities are the social gradients.

CPME recommends that National Medical Associations concentrate on

Contributing to the reduction of social gradients.
- By informing the health authorities about health inequalities, and stimulating research to identify areas where changes are needed. NMAs can inform health authorities and politicians and work to improve the situation for vulnerable groups as asylum seekers, immigrants, indigenous people, those in poverty and prisoners, etc.
- By working with other parts of civil society to make a significant contribution to the reduction of health inequalities, by developing partnerships with central and local governments, NGOs and other stakeholders.
- By informing and educating their members to raise their awareness of the influence of social determinants on health disparities.

Draw the attention of governments to international conventions or charters that secure the right to health
By ratifying international human rights treaties that affirm the right to health, a state agrees to be accountable to the international community, as well as to the citizens, for the fulfilment of its obligations. A role of the NMAs could be to follow up their governments and hold them accountable for fulfilling their obligations.

Lobbying their health authorities for better health care particularly for disadvantaged groups
The preamble to the WHO constitution of 1946 declares that "the enjoyment of highest attainable standard of health is one of the fundamental rights of every human being

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without distinction of race, religion, political belief, economic or social condition". NMAs should continually monitor how the health care systems in their country function especially regarding health care for vulnerable people.

It is important that Member States can learn from one another. CPME will facilitate the sharing of information and successful examples between Member States.

Concerning the role of the NMAs, the CPME would like to draw attention to the six policy recommendations for reducing health inequalities recently made in Sir Michael Marmot's UK report on health inequalities[1].

These are:

> *"Give every child the best start in life: increase the proportion of overall expenditure allocated to the early years and ensure it is focused progressively across the [health inequalities] gradient*
>
> *Enable all children, young people, and adults to maximise their capabilities and have control over their lives: reduce the social gradient in skills and qualifications*
>
> *Create fair employment and good work for all: improve quality of jobs across the social gradient*
>
> *Ensure a healthy standard of living for all: reduce the social gradient through progressive taxation and other fiscal policies*
>
> *Create and develop healthy and sustainable places and communities*
>
> *Strengthen the role and effect of the prevention of ill health: prioritise investment across government to reduce the social gradient."*

Background

Summary of European Commission Communication Solidarity in Health: Reducing health inequalities in the EU" (CPME Info 197-2009)
The report "European Commission Communication Solidarity in Health: Reducing health inequalities in the EU" describes gaps in health between and within countries in the EU. Figures for 2007 show that life expectancy at birth varies between EU countries with around 8 years for women and over 14 years for men. Huge differences also exist between social groups. People with a lower level of education, a lower occupational

[1] Marmot M. Strategic review of health inequalities in England post 2010. Marmot review final report. University College London. www.ucl.ac.uk/gheg/marmotreview/Documents

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class or with a lower level of income tend to die at a younger age and have a higher prevalence of most types of health problems.

While the principal responsibility for health policy rests with the Member States, not all of them have the same resources to address the different causes of health inequalities. The European Commission has therefore announced a series of actions to help Member States and other actors to tackle this gap:

Improving the data and knowledge base and mechanism for measuring, monitoring, evaluation and reporting
Documentation of health inequalities is a first step to effective action. It will be necessary to have knowledge on what works and what does not work in improving health particularly for disadvantaged people.

Building commitment across society
Improving people's health can not be left to the health sector alone. The health sector must cooperate with government, local authorities, NGOs and other stakeholders representing areas like education, environment, employment, social protection etc. Reducing health inequalities means having an impact on the health of people in their everyday lives, at work, at school, etc.

Meeting the needs of vulnerable groups
The Commission writes that particular attention needs to be given to the needs of people in poverty, disadvantaged, migrant and ethnic minority groups, people with disabilities, elderly people and children living in poverty. Several international documents specify the right to health and medical treatment, children's right to health and persons with disabilities' right to access to health services.

Developing the contribution of EU policies
While there is agreement on the principle of reducing health inequalities, the level of awareness and the extent to which action is being taken varies substantially. Over half of the EU Member States do not have reducing health inequalities on their policy agenda and if strategies are implemented they often lack evaluation. The EU has a role to improve the coordination of policies and promote the sharing of best practice.

EU is also committed to supporting other countries (3rd countries) in health and related fields. Experiences with working with health inequalities within EU can be useful when assisting countries outside EU to cope with their health problems,

International treaties
Article 12 in the UN Convention on Economic, Social and Cultural Rights lays down the right of everyone to the enjoyment of the highest attainable standard of physical and

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mental health. This article promises all people equal access to health care and health-related services (e.g., clean drinking water), within the limits of a State's capacity.

General Comment No. 14 to article 12 gives s detailed description of the obligations of States to secure the Right to Health, as well as criteria for monitoring this right. General Comment No. 14 strengthens the basic principle that the accessibility, availability and affordability of health care of good quality is inalienable rights for all. Absence of available, accessible and affordable health care and underlying preconditions of health is thus not an absence of service, but a violation of a basic human right. The Comment lists core obligations the countries that have ratified the Covenant must fulfil. The UN Committee that monitors the implementation of the right to health also considers the role of health professional associations and other non-governmental organizations in relation to the States' obligations to the Covenant.

Also the European Charter of Fundamental Rights specifies the right to access to preventive health care and to benefit from medical treatment. The UN Charter of the Rights of the Child gives the child access to health care that goes beyond adult's rights. For example children of immigrants without documents have the same right to health care as children with legal stay in the country.

In support of the basic human right to health the World Health Organisation's Commission on Social Determinants of Health emphasises that 'social injustice is killing people on a grand scale' and that reducing health inequalities will be a major life saver.

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