



European Charter for Health Equity

December 2010

Preamble

Whereas a country's progress cannot be measured or defined by economic growth on its own but by the fair distribution of health and well-being across all settings and regions, and within all population groups;

Whereas in contemporary societies people with higher socio-economic position lead healthier and longer lives as health of people is affected by the conditions in which they are born, grow, live, work, age and make use (or not) of the systems put in place to deal with illness as concluded by WHO Commission on Social Determinants of Health (1);

Whereas the evidence clearly indicates that the quality and distribution of these key determinants of health (2) are imbalanced and strongly linked to political, economic environmental and social structures across Europe and threatening the health of the most vulnerable population groups and people in vulnerable settings such as of hospitals, care houses and prisons;

Whereas between different Member States of the European Union there is already a 5-fold difference in deaths of infants under one year of age, a 14 year gap in life expectancy at birth for males and an 8 year gap for females, and these gaps are widening;

Whereas vulnerable and socially excluded groups in our societies such as some migrant or ethnic minorities have up to 10 years shorter life expectancies than the general population they live in;

Whereas both the biological concept of sex and the social construct of gender matter in health at all levels and impact differently on women and men's health, access to health and healthcare creating gender gaps in health status, health-related behaviour, access to prevention and treatment in such a way that life expectancy in all Member States of the European Union is shorter for men than women, and that women experience poorer quality of life during their life course;

Whereas there are important gender gaps in health policies, research and services, and in many cases women are more and differently affected by disadvantages, inequality and poverty;

Whereas both the European Commission (3) and the European Council (4) expressed concerns about such dramatic differences in health and life expectancy between and

within European countries and regions;

Whereas European societies value the concept of ‘equal opportunity’ and consider health inequalities as a loss of human productive and creative potential, and therefore have enshrined these values in the European Charter of Fundamental Rights (5) and the Lisbon Treaty (6) (7);

Whereas already existing legal and policy documents (8 - 16) state that addressing all social determinants of health and reducing health inequalities is a matter of fairness and social justice as it improves the health of those most exposed to health threatening conditions and already experiencing health inequalities – the poor, the marginalised, and those excluded from participation in various aspects of society by virtue of their living conditions or legal status;

Whereas a debate on reducing health inequalities requires a multi-sectoral approach with active participation from civil society, governmental and non-governmental organisations, and including non-health actors;

Whereas it has become clear that one of the strengths of the civil society organisations, is their diversity which enables them to represent the many different voices of society and even those frequently excluded from it;

We, the undersigned, express our concern that existing systematic differences in health – widespread, unfair and avoidable – impose a growing threat to all people living in Europe and have to be addressed in a concerted manner at all levels and by all relevant stakeholders. Putting right these inequities is a matter of social justice.

Article 1

The European Charter for Health Equity **reaffirms** the commitment to the values of well-being, solidarity, social justice, promotion of fundamental human rights and gender equity. Furthermore, it reaffirms the commitment to the principle enunciated in the constitution of the WHO that the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being.

Article 2

The **purpose** of the Charter is to call for action from the civil society to all relevant stakeholders and in particular decision makers, relevant governmental and civil society partner organisations, and other regulatory bodies, to protecting and promoting people’s health by acting on health inequalities between and within countries in Europe.

Article 3

This Charter has twin objectives: to increase awareness and motivate actions that will contribute to the improvement for health and well-being for all, and to reduce unfair and avoidable health inequalities. The achievement of these objectives requires a life course and gender perspective. Action to reduce health inequalities must start before birth and be followed and fostered through the further life of every child, adolescent, adult and elderly.

Signatories of the Charter fully support the conclusions of the Marmot Review (17) and call on actions to implement its priorities:

- **Early Child Development as the best start in life** – as virtually every aspect of human development is laid as early as during the pregnancy and in early childhood, this period has lifelong impact on many aspects of health and well-being continuing to adolescence and adulthood. Poor health of children being born and growing up in poverty is unacceptable, and we must act.
- **All our children, young people and adults to make the most of their potential and control their lives** – investment in early child development is crucial, but maintaining any early equality gains requires a sustained commitment to all children and adolescents through the years of education. Poverty during adolescence worsens opportunities for later good living standards, behaviours, employment and income.
- **Fair and full employment and good working conditions for all** – enjoying good employment is of protective nature for health. People enter the job market smoother and better equipped with relevant skills when solid physical and mental health foundation were laid in childhood and adolescence. Already at the start, impoverished health and lost opportunities usually put people in disadvantaged position. Unemployment poses threats to health and therefore increases health inequalities. Insecure, inflexible and poor quality employment deteriorates employees' physical and mental health.
- **A healthy standard of daily living for all** – health inequalities arise as opportunities for a healthy life are missed due to insufficient means to do so. Inadequate nutrition, physical activity, housing, social interactions, transport, medical care and hygiene due to poverty are all powerful enough to impose persistent and inherent health inequalities that pass on from generation to generation. It is unfair, avoidable and we must break this circle.
- **Our health rooted in healthy, cohesive and sustainable places and communities** - physical and social aspect of communities, enabling and promoting healthy behaviours, and sense of common ownership over community health, all make a contribution to social dimension of health. Communities equipped in open and green spaces, public transport, quality housing and energy use as well as healthy food supply sources benefit with regards to health and social perspectives. There is a potential in each community to create and sustain health of its people.
- **Our communities need cost-effective ill-health prevention balanced with disease-treatment** - not only is the availability of curative health care system, its accessibility, quality and affordability important for reducing health inequalities, gender biases and discrimination. Prevention in the context of the social determinants of health requires active and conscious involvement of a range of stakeholders – not necessarily from a health sector solely. By this means, ill-health prevention is vital to a lively and healthy community.

Commitment to act

We, the undersigned, commit ourselves to using this Charter as a basis to transform our shared values into action with an objective to catalyse implementation of the above commitments on health equity. We have a responsibility and have a role to enhance the ability of all stakeholders to improve health equity. Therefore we commit ourselves to:

- **Promote** the shared values of solidarity, equity, gender equality, sustainability and participation through mainstreaming health equity in our policies and other actions to ensure due attention is paid to the needs of the poor and other vulnerable groups and to support a societal development that maximises individual and community potential;
- **Invest** in actions that promote and support health equity, social, gender and environmental determinants of health, and guarantee that such pro-health initiatives are coherent and integrated with effective and measurable evidence-based interventions that are responsive to people's needs, preferences and expectations;
- **Foster** and build capacity and cross-country learning and cooperation between all relevant stakeholders in development and implementation of policies that have positive impact on social determinants of health.

Health Equity: call for action

We, signatories of the Charter, call on public decision makers to:

- increase expenditure allocated to the early years, skills development and family support across the social gradient;
- invest in healthy and sustainable communities and places which fully integrate the planning, transport, housing environment and health systems;
- ensure standard of living that enables and fosters health and well-being across the life course;
- ensure adequate social protection systems as a basic citizen's right to protect the most vulnerable groups in society from falling into poverty, social exclusion and homelessness in the first place as well as a consequence of disease or injury;
- promote labour market participation and social cohesion;
- develop and implement standards for minimum income for healthy living;
- develop greater quality employment across the social gradient;
- prioritise investment in ill-health/injury prevention and health promotion across all sectors and with active and meaningful participation of all stakeholders;
- set up systematic monitoring schemes and performance assessments to ensure the implementation of policies supporting integrated care:
- work collaboratively across sectors to achieve a health in all policies approach to decision making:
- adopt, implement and enforce evidence-based measures targeted to poorer individuals, families and communities.

Launched in
Brussels, December 2010

Corrected in March 2011

Undersigned:

End notes:

- (1) WHO Commission on Social Determinants of Health Report: Closing the gap in a generation: Health equity through action on the social determinants of health. Geneva: World Health Organisation, 2008.
- (2) Key determinants of health: physical environments, social environments, income and social status, child development, education and literacy, employment and working conditions, life skills, health systems, genetics, gender and culture.
- (3) 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. COM(2009) 567 final.
- (4) Council Conclusions on Equity and Health in All Policies: Solidarity in health. 8 June 2010.
- (5) The Charter of Fundamental Rights of the EU and in particular art. 35 stating that “everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices.”
- (6) Under art. 168 of the Treaty on the Functioning of the European Union, “Union action is to complement national policies and be directed towards improving public health; it is also to encourage cooperation between the Member States in the field of public health and, if necessary, to lend support to their action.”
- (7) Under art. 9 of the Treaty, “Union shall take into account requirements linked to the promotion of a high level of employment, the guarantee of adequate social protection, the fight against social exclusion, and a high level of education, training and protection of human health.”
- (8) Council Conclusions on Health in All Policies. 16167/06
- (9) Council Conclusions on Common Values and Principles in EU Health Systems. 10173/06
- (10) Council Resolution on Action on Health Determinants. 29 June 2000.
- (11) WHA Resolution on Reducing health inequalities through action on the social determinants of health. WHA62.14.
- (12) WHA Resolution on monitoring of the achievements of the health-related Millennium Development Goals. WHA61.18.
- (13) Open Method of Coordination for Social Protection and Social Inclusion. COM(2005) 706.
- (14) Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee, and the Committee of the Regions on Telemedicine for the benefit of patients, healthcare systems and society. COM(2008) 689.
- (15) Communication from the Commission to the European Parliament and the Council on Patients safety, including the prevention and control of healthcare-associated infections. COM(2008) 836.
- (16) Council of the EU on Sustainable Development Strategy. 10117/06.
- (17) Fair Society. Healthy Lives. Strategic Review of Health Inequalities in England post 2010. The Marmot Review Team, February 2010.