Achieving health equity in the European region

See **Articles** page e529

For the **European Health Equity Status Report** see http://www.euro.who.int/en/publications/abstracts/health-equity-status-report-2019

For more on the **WHO Commission on Social Determinants of Health** see https://apps.who.int/iris/bitstream/handle/10665/43943/9789241563703_eng.pdf?sequence=1

On Sept 10, 2019, WHO published a report, *Healthy, prosperous lives for all: the European Health Equity Status Report*, which reviews progress and gaps in achieving health equity in the WHO European region and provides critical evidence to inform governments in designing their policies and foster action. Health equity implies that everyone should have a fair opportunity to attain their full health potential and that no one should be disadvantaged from achieving this potential—this report, unfortunately, reveals that progress towards health equity in many of the 53 countries of the WHO European region is stalling. Despite overall improvements in health and wellbeing in the European region over the past 15 years, these successes have not been distributed equally and strong inequities within countries persist.

Average life expectancy in the European region increased to 76·2 years for men and 82·0 years for women, but a clear socioeconomic gradient remains. Life expectancy at birth by education level, for example, shows huge variations within countries—with an average gap in life expectancy between lower and higher educated women of 3·9 years (range 2·3–7·4) and in men of 7·6 years (3·4–15·5). Some of the largest inequalities by education level were observed in Slovakia, Poland, Hungary, and Czechia. In this issue of *The Lancet Public Health*, Johan Mackenbach and colleagues present an analysis of the association between partial life expectancy and education level in 15 European countries, which further substantiates the WHO report. They report substantial gaps ranging from 2·3 years to 8·2 years in men and from 0·6 years to 4·5 years in women. Smoking, low income, and obesity were identified as major risk factors contributing to the observed inequalities in mortality, but Mackenbach and colleagues caution that these three risk factors should be considered as "entry points for policy" and conclude that "a substantial reduction of health inequalities in life expectancy requires policy actions on a broad range of health determinants".

Here, the *Health Equity Status Report* makes a valuable contribution. Building on the work from the WHO Commission on Social Determinants of Health—which provided evidence as to why health inequalities arise and of their fundamental drivers—the report identifies five critical factors and assigns to each a percentage reflecting its contribution to the overall burden of inequity. First, income security and social protection is estimated to account for 35% of health inequities. Second, living conditions are estimated to account for 29% of health inequities. Third, social and human capital (such as isolation, lack of control, trust in others, and low educational outcomes) account for 19% of health inequities. Fourth comes access to and quality of health care, which accounts for 10%. Finally, employment and working conditions are estimated to contribute to 7% of the overall burden of inequity.

Importantly, the *Health Equity Status Report* goes beyond ranking the relative importance of the different drivers of health inequity and offers governments avenues to tackle them by highlighting policy shortcomings. For example, while 29% of health inequities are linked to precarious living conditions, 53% of countries in the region have disinvested in housing and community services in the past 15 years. Child poverty is another staggering example. Although an estimated one in five children are living in relative poverty, the average country expenditure on social protection fell from 12·9% to 6·1% of gross domestic product (GDP), between 2000 and 2012.

The report's final and most important contribution is to estimate what it would take to reverse the tide of health inequity. The authors examine eight macroeconomic policies and identify six with clear potential to reduce inequities in limiting illness among adults over the short term (2–4 years): increasing expenditure on housing and community amenities, reducing income inequality, increasing social protection expenditure, reducing unemployment, increasing expenditure on labour market policies, and reducing out-of-pocket payments for health. Furthermore, the report estimates that a 50% reduction in health inequity could provide financial benefits to countries ranging from a 0·3% to a 4·3% increase in GDP—a figure that could help in convincing governments to reduce inequalities.

The WHO *Health Equity Status Report* offers a clear roadmap for countries towards achieving Sustainable Development Goal 10 on reducing inequalities and provides evidence for both the population wellbeing and economic cases for investing in health equity.

■ *The Lancet Public Health*