Health Inequalities – What can EU do to support work done at local and regional level

SALAR - 30, Square de Meeus - November 5th 2014

Draft Introduction

Good Morning Ladies and Gentlemen

Firstly may I congratulate the organisers, SALAR, Eurohealthnet and EUREGHA for organising this important seminar and I'd like to thank them for their kind invitation to participate.

This seminar is particularly appropriate given the EU's expanding influence on health, the common health-related challenges we face across our regions; and where our local and regional authorities have a front-line role in addressing health inequities.

And although there is a diversity of governance structures and health systems across Europe; local and regional authorities nonetheless, play key roles in providing public health services, in health promotion and disease prevention.

It is well established that a range of factors affect health; these health determinants include: access to and the availability of healthcare services; an individual's lifestyle, behaviour and their genetic make-up; as well as social, economic and environmental factors. These determinants extend well beyond the boundaries of public healthcare systems.

Therefore inequities cannot be reduced by the health sector acting alone. It requires the introduction and implementation of integrated strategies across the levels of governance – the ***Health in All Policies*** approach.

Policy in every sector of government can potentially affect health inequities. Reducing inequities will require commitment from the many relevant departments such as health, social protection, education, transport, energy and so on **and** from the different levels of governance as these offices are often competing for resources and are often compartmentalised in their outlook.

Instituting shared targets, joint accounting, joint review and reporting across functional areas could be extremely beneficial for example, with issues like the misuse of alcohol, which affects the budgets of health, policing, employment, social services, prisons, roads, emergency services and so on; never mind the impact on individuals, their families and the wider community.

Numerous functions and policies of local and regional authorities, such as in employment, housing, transport, land-use planning, the environment, education and public safety ensure that they are key actors in promoting public health and in reducing health inequities. In the CoR opinion, I underlined the need for a constant focus on reducing health inequities at all levels - at EU, national, regional and local levels.

However, it is often our local and regional authorities that are taking the lead in addressing inequities that exist within our cities and regions. This is essential, as differences exist as much within our cities and regions as between them. **Moreover, it is often the actors at a local level that have the best understanding of local needs and can bring about the best results.**

National-level strategies can inform the development of regional and local level strategies and vice-versa. However, it is often at the local level that the crucial cross-sectoral approaches can be developed and implemented in a targeted and efficient manner and the results demonstrated. And I very much look forward to the presentation from Vastra Yotaland in this regard.

I believe that it is a pre-condition that strong political and organisational leadership is needed to help drive and implement a cross-sectoral commitment to reduce health inequities and make a real difference in our communities.

Political commitment is essential to prioritise the issue; to encourage different sectors to work together towards a common goal and to ensure that efforts are sustained over the longer term.

While authorities within Member States are responsible for the organisation and delivery of health services, EU policies can greatly contribute to improving them.

In recent years, EU policy initiatives in the health domain have focused on the relationship between health, competitiveness and economic growth. If people live longer and healthier lives, this should benefit not only the individuals concerned but also result in more people remaining active within society for longer, putting less strain on healthcare systems and public budgets.

Given the EU's complementary role in health under the open method of coordination, EU actions are concentrated on protecting people from health threats and disease, consumer protection, promoting lifestyle choices, workplace safety and helping national authorities cooperate.

The 3rd Programme for *EU Action in the Field of Health* emphasises the link between health and economic prosperity. The programme foresees expenditure of almost €450 million over the seven-year period. While the increased provision, compared with the 2nd Health Programme is very welcome, given the tighter overall EU budget; this allocation for health is still tiny in the context of an overall EU budget of €960 billion.

This 3rd programme for Health in the EU is of course, complemented by Horizon 2020, the European Structural and Investment Funds and various other funding programmes that have the potential to impact on health.

Regional funding through the European Regional Development Fund (ERDF) over 2007–2013 allocated around €5 billion for health infrastructure projects, while the European Social Fund (ESF) provided investment for initiatives linked to active ageing, e-health, health promotion and training. In total, these investments by the ERDF and ESF on health-related expenditure represented **just 1.5%** of the EU's total cohesion funding over the period leaving much scope for expansion.

However, I am concerned at the stated lack of capacity of health systems to bring forward investments to address health inequities. For many practitioners, EU funding and the associated bureaucracy is seen as arcane and complex. It is critical that local and regional authorities and health systems are engaged in all phases of the European Structural and Investment Funds programming cycle to ensure that health receives due prioritisation.

And I believe it is important that there is access to well-informed and well-promoted contact points within Member States to back-up online and other information sources such as Equity Action's excellent *Report on the Use of Structural Funds for Health Equity* and recent reports from WHO Europe and the European Commission.

On a wider aspect of EU policy, Europe 2020 the EU's strategy for jobs and smart, sustainable and inclusive growth, is based on five headline targets, measured by ten indicators which include the rate of employment, the rate of early school-leavers, 3rd level educational attainment and numbers at risk of poverty and social exclusion.

Europe 2020 has the potential to improve policy-making and the process of target setting, policy coordination and assessment is very welcome; however, progress to reaching EU and national targets is mixed. Moreover, given the 'top-down' nature of the process, there is a lack of awareness, never mind engagement by potential stakeholders.

Europe 2020 is implemented through National Reform Programmes to translate EU targets into national targets. The European Commission responds through annual Country Specific Recommendations – CSR's – essentially report cards on Member States progress. I note that in 2013, **eleven** Member States received a recommendation for reforms of their health systems in the CSR's.

In addition to issues around the reform of health systems, I believe that health equity and inequity should be addressed in <u>all</u> Country Specific Recommendations.

And more broadly, I believe that there should be a greater emphasis on social challenges and on equity within Europe 2020 and in the priorities of the newly installed Commission and I look forward to the work programme of the new Health Commissioner.

Europe 2020 is currently undergoing a mid-term review to be completed early next year and I would urge all interested parties to contribute to consultations. **Within Member States, I would like to see more structured engagement with potential stakeholders including local and regional authorities and public health actors.**

As Europe 2020 is proceeding, the impacts of the economic crisis across Europe continue to be felt. The impacts on public finances have been significant with public spending on health falling in many countries. With increasing numbers of public patients, health costs have increased, resulting in raised contributions from patients for treatments and prescriptions as well as increased general taxes.

With falling household incomes, reduced private health insurance coverage is increasing pressure on already-stretched public health care systems.

However, some countries have seen the crisis as an opportunity to introduce reforms to their health systems. I welcome the fact that the European Commission is assisting Member States by introducing initiatives to help them learn from best practices of other Member States and regions.

As exemplified with the foresight in hosting and organising this conference, health standards in Sweden and other Scandinavian countries are often seen as the benchmark on which other countries are judged. In Ireland, our per capita spending on healthcare is higher than that of Sweden and about 32% above the EU average, so it is not simply a question about the provision of resources.

EU programmes and policies as well as instruments such as the EGTC are synonymous with territorial and cross-border co-operation and this is a significant benefit of EU engagement by local and regional health administrations. In my own country for example, Health Ministers for the island of Ireland – from both Northern Ireland and the Republic – are planning to concentrate child heart surgery in Dublin and this cooperation should provide for the highest standards of care.

But in this era of euroscepticism and the prospect of a UK *in-out referendum*, we must not take such co-operation nor the benefits of EU membership for granted; rather, **we must redouble our efforts to ensure that the work of the EU is relevant and meaningful and that this, is clearly demonstrated to citizens.**

Finally, I would like to briefly mention the EU's wider international role which has the potential to impact on the delivery of health services locally.

Many are concerned that the current Trans Atlantic Trade and Investment Partnership – TTIP – has the potential to challenge our regulations on food safety, alcohol and tobacco promotion and the provision of public health services. There are concerns that global companies could in effect, sidestep European or national regulations, that impact on public health.

We must be mindful that while healthcare has major economic significance, that the common values underlying European healthcare systems - universality, access to good quality care, equity and solidarity should always override other concerns. ***I urge that the Health in All Policies approach must be seen to apply to all Directorates-General of the European Commission, and specifically in the TTIP negotiations.***

To conclude; there has been enormous work carried out in recent years in better understanding health inequities and in setting out how they can be addressed; particularly the work of Professor Marmot and his team; and that of WHO Europe and the European Commission. The Committee of the Regions has consistently called for the utmost level of cooperation between these two bodies.

Importantly, much of the future guidance to address inequities is based on the pioneering work of progressive health authorities in our regions - whose representatives you will now want to hear.

Ladies and gentlemen, thank you very much again for your invitation and for your attention. The organisers have set up two expert panels of practitioners and policymakers and it is now time to hear from them.