

# Health Inequalities

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european public health alliance







# Health Inequalities

## A well-established socio-economic gradient of health

All across Europe, within and between countries, health inequalities persist and grow.

While the average life expectancy in the European Union has increased in the past decades, differences in life expectancy at birth between the lowest and highest socio-economic groups reaches ten years for men and six years for women in the EU<sup>1</sup> and varies significantly between EU countries. In other words, the health gains are not evenly distributed across countries, or even across socio-economic groups within the same country.

In addition, it is well recognised that differences in health status at a population level are closely linked to social determinants of health<sup>2</sup>. Social and environmental determinants of health are the conditions in which people are born, grow up, live, work and age. They will affect their opportunities to be healthy, their risks to develop illnesses or suffer injuries and their life expectancy.

Health inequalities - the unfair but avoidable differences in health status across different socio-economic groups in society - usually result from the uneven distribution of social and environmental determinants; the differential access to resources such as education, employment, housing, health services; different levels of participation in society and different levels of control over life.

Although wealth in Europe has increased in the last decade, its distribution has proven to become increasingly unequal and 80 million European citizens – that is about 16% of the population of the European Union - live in poverty, including one child out of five being born and growing up in economic and social deprivation<sup>3</sup>. Still, these numbers are likely to be even higher when accounting for parts of the population not existing in any official records.

## Poverty, social exclusion and discrimination are key factors in explaining poorer levels of health between groups and countries

There are dramatic differences in the health status of people living in Europe, between and within countries, which are closely linked with socio-economic status: in general, the lower the socioeconomic position, the worse the health status. The tendency is for life

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<sup>1</sup> COM 14848/09.

<sup>2</sup> Ibid.

<sup>3</sup> Bradshaw, J. (2000) 'Child poverty in comparative perspective'. In: Gordon, D. & Townsend, P. 'Breadline Europe: the measurement of poverty'. Bristol, *The Policy Press*.



expectancy to be shorter and for most diseases/injuries to be more common further down the social ladder in each society:

- **Life expectancy:** Between EU Member States, there is a five-fold difference in deaths of babies under one year of age, a 14-year gap in life expectancy at birth for men and an 8-year gap for women<sup>4</sup>. Differences in life expectancy at birth between the lowest and highest socio-economic groups reaches ten years for men and six years for women. Although women tend to live longer than men, they also spend a longer proportion of their life in ill-health<sup>5</sup>.
- **Unemployment or low education:** Relationships between poverty, unemployment, low education and poor mental and physical health are well documented. Not only does poor health prevent people from being economically active, there is also evidence that being unemployed or in financial difficulty increases the likelihood of becoming disabled, increases stress and leads to low levels of social inclusion, which is a risk factor for poor mental health and coronary heart disease<sup>6</sup> for example. Continuing anxiety, insecurity, low self-esteem, social isolation and lack of control over work and home life, have powerful effects on health<sup>7</sup>. Early retirement and exclusion from the labour force due to work-related stress and mental health problems, particularly depression, now account for an ever greater share of long term social welfare benefits, and indeed may even challenge their long term sustainability.<sup>9</sup> Low education is also a factor affecting poor health or lower life expectancy. In the Russian Federation, in 2001, the life expectancy of people with an elementary education degree was slightly over 50, while the life expectancy of people with a university degree was over 65.<sup>10</sup>
- **Poverty and exposure to environmental hazards:** Higher exposure to environmental hazards tends to follow a social deprivation gradient: people from lower socioeconomic groups are disproportionately more affected by environmental tobacco smoke, biological and chemical contamination, air pollution, sanitation and water scarcity, noise, road traffic and occupational injuries, workplace stress.<sup>11</sup> In Romania, 68.8% people in the lowest income group quarter report having no flush toilets, as compared to 11.2% of the highest quarter.<sup>12</sup> In England and Wales, children from families with the lowest occupational status (manual and low-skilled) have a 37.7 times higher death

<sup>4</sup> COM 14848/09.

<sup>5</sup> Ibid.

<sup>6</sup> Bambra, C. & Eikemo, T. (2009) 'Welfare state regimes, unemployment and health: a comparative study of the relationship between unemployment and self-reported health in 23 European countries'. *J Epidemiol Community Health*, 63(2), pp. 92-8

<sup>7</sup> Brunner, E.J. (1997) 'Stress and the biology of inequality'. *British Medical Journal*, 314, pp. 1472-1476.

<sup>8</sup> Ferrie, J.E. et al. (2001) 'Employment status and health after privatisation in white collar civil servants: prospective cohort study'. *British Medical Journal*, 322, pp. 647-651.

<sup>9</sup> McDaid (Ed). (2008) 'Mental Health in Workplace Settings. Consensus paper.' Luxembourg, European Communities

<sup>10</sup> Murphy, M.; Bobak, M.; Nicholson, A.; Rose, R. and Marmot, M. (2006) 'The widening gap in mortality by educational level in the Russian Federation, 1980-2001'. *Am J Public Health*, 96, pp. 1293-1299

<sup>11</sup> WHO (2010) *Bonn expert meeting - Environment and health risks: a review on the influence and effects of social inequalities*. In: *Fifth Ministerial Conference on Environment and Health*. Parma, Italy, 10-12 March 2010. Copenhagen, WHO Regional Office for Europe.

<sup>12</sup> Eurofound (2008) *Second European Quality of Life Survey - First Findings*. Dublin, European Foundation for the Improvement of Living and Working Conditions.



rate due to exposure to smoke and fire than those from families with more favourable occupational status<sup>13</sup>.

- **Access to health services and primary healthcare:** Primary health care, including nursing care and social services are primary access points for the poor and the most vulnerable, and should be used not only to provide care and treatment but also to proactively pursue the goal of improving overall physical and mental health and well-being through tackling social determinants of health.<sup>14 15</sup> While the health sector can contribute significantly to achieving objectives aimed at reducing poverty and social exclusion, the sector might not be aware of its specific role. International research indicates that health care systems with strong primary health care are more effective and efficient.
- **Gender, poverty and health:** Relationships between gender, poverty and the health status are gathering more evidence: due to biological (sex) and socio-cultural (gender) differences, men and women are affected by poverty-related factors in different ways and their levels of sensitivity differ. Moreover, evidence shows that women (especially older women) are more likely to live in poverty and work longer for less (professional, house holding, informal carers) also when retired. Gender inequalities are very much reflected in differences in both exposure and vulnerability between men and women, whether related to work and employment, education, living conditions, access to health care (especially to sexual and reproductive health services), and health behaviour. It has been found that women may be more often exposed to chemicals, air pollution from cooking and home heating black smoke, while men tend to work in riskier workplaces and suffer more frequently from unintentional injuries.<sup>16</sup>
- **Roma community:** One of the most universally disadvantaged communities living in Europe are the Roma of which the great majority is found at the very bottom of the socio-economic spectrum: many studies have shown the health status of Roma communities to be far below the average for the country where they live (an average of 10 years less) - due to their higher exposure to the range of unfavourable factors that influence health.<sup>17 18</sup> In other words, poor health of the Roma population reflects their poor housing conditions, poor nutrition and health related behaviours, as well as discrimination, stigmatisation and barriers to accessing health and other services.<sup>19</sup> According to a case study in Hungary,<sup>20</sup> 15% of Roma settlements in Hungary are within 1 km of a waste dump, and another

<sup>13</sup> Edwards, P. et al. (2006) 'Deaths from injury in children and employment status in family: analysis of trends in class specific death rate'. *British Medical Journal*, 333, pp. 119-122.

<sup>14</sup> IRDES study - Part 1 *What role for health care system in health inequalities reduction policies? – Health inequalities determinants and the health care system role*. Available at: <http://www.irdes.fr/> (accessed 25 August 2010).

<sup>15</sup> European Health Management Association (2005) *The role of the health care sector in Tackling Poverty and Social Exclusion in Europe*.

<sup>16</sup> WHO (2010) *Social and gender inequalities in environment and health* In: *Fifth Ministerial Conference on Environment and Health*. Parma, Italy, 10-12 March 2010. Copenhagen, WHO Regional Office for Europe.

<sup>17</sup> SEC (2008) 2172

<sup>18</sup> EPHA Briefing Paper on Roma and Health (2009). Available from [http://www.ephpa.org/IMG/pdf/EPHA\\_Briefing\\_Paper\\_Roma\\_Health.pdf](http://www.ephpa.org/IMG/pdf/EPHA_Briefing_Paper_Roma_Health.pdf) (accessed on 18 October 2010).

<sup>19</sup> European Monitoring Centre on Racism and Xenophobia (2003) *Breaking the barriers: Romani women and access to public health care*.

<sup>20</sup> Gyorgy, U. et al. (2005) 'Roma Colonies in Hungary – Medical Care of Children and Hygienic Conditions'. *Hungarian Medical Journal*, 146(15), pp. 691-699.

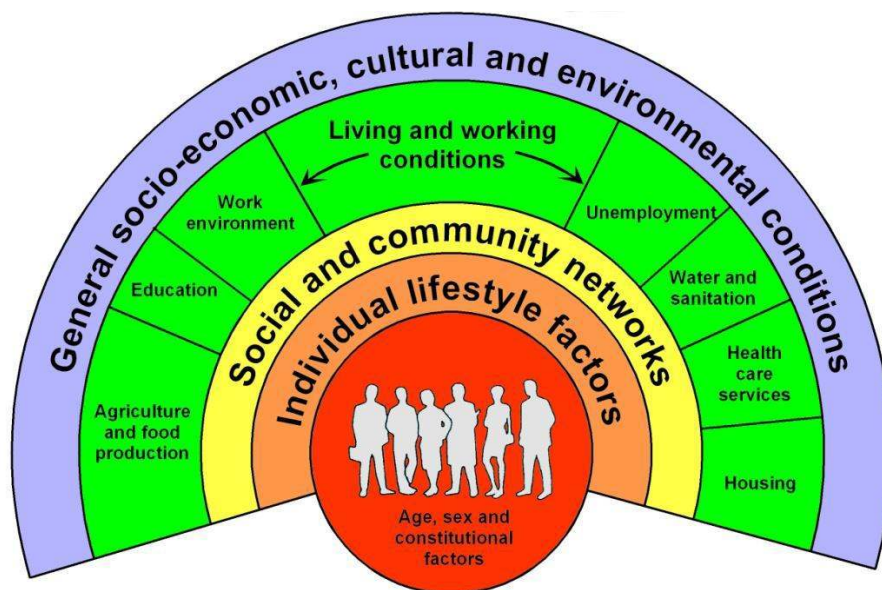


study reports Serbian Roma settlements having 2-3 times less frequent water supply and hygiene amenities.<sup>21</sup>

When addressing health equity, specific attention should therefore be dedicated to people living in poverty and people at risk: like children, the elderly, people suffering from mental ill health, homeless people, migrants, unemployed people, Roma, or people living with disabilities among others.

## What people eat, whether they drink or smoke is determined by their social conditions

As shown by the Dahlgren and Whitehead “rainbow”, lifestyle factors are determined by the social, environmental, living and working conditions. **In other words, being healthy (or not) is not an individual choice but primarily a result of the conditions in which people are born, grow up, live, work and age.**



Source: Dahlgren and Whitehead, 1991

- Tobacco harm and poverty.** There is a clear relationship between smoking and deprivation: The most recent Scottish Household Survey shows adult smoking rates varying from 12% in the least deprived fifth of the population to 41% in the most disadvantaged.<sup>22</sup> A Eurobarometer published in 2003 showed that the prevalence of smoking in 2002 was consistently higher among the unemployed (54%) and among manual workers (51%) in the EU15.<sup>23</sup> A large international study concluded that between half and two-thirds of the inequalities between high and

<sup>21</sup> Sepkowitz, KA. (2006) 'Health of the world's Roma population'. *Lancet*, 367(9524), pp. 1707-1708.

<sup>22</sup> Scottish Government (2009). *Scotland's People. Annual report: results for 2009. Scottish Household Survey.*

<sup>23</sup> *Special Eurobarometer 182*, November 2003,

[http://ec.europa.eu/health/ph\\_determinants/life\\_style/Tobacco/Documents/eb582\\_smoking\\_env\\_en.pdf](http://ec.europa.eu/health/ph_determinants/life_style/Tobacco/Documents/eb582_smoking_env_en.pdf)



low-income men in Europe are due to smoking<sup>24</sup>. Smoking drains poor and vulnerable people's incomes and is a huge contributing cause of ill health and premature death.

According to the WHO/Europe, smoking accounts for 12–20 years of life lost and up to 21% of deaths. In the WHO European Region smoking prevalence is estimated at around 28.6% with a large gender difference: 40% of males and 18.2% of females. On average, 24% of young people aged 15 years smoke every week.<sup>25</sup>

- Alcohol dependence and illicit drug use are also closely associated with social and economic disadvantage.<sup>26</sup> Differences in alcohol-related harm by socioeconomic status within given society tend to be more visible than the differences in alcohol consumption per se. Meaning that for a given amount of alcohol consumed, poorer members of the society are likely to experience disproportionately higher levels of alcohol attributable harm, this is particularly the case for men. Alcohol causes an estimated 90 extra deaths per 100,000 men and 60 extra deaths per 100,000 in the EU-12 as compared to the EU-15.<sup>27</sup> Not only does alcohol and drug dependence result in higher mortality and morbidity rates (accidents, injuries, suicides, violence), but due to harsh economic and social conditions related to ill-health of other than alcohol or drug origin, people are more likely to turn to increased use of such substances. Results of a study funded by the European Commission Public Health Program - Eurothine (Tackling Health Inequalities in Europe: an integrated approach) have confirmed that alcohol higher among lower educated men and women in all countries.<sup>28</sup>

The WHO European Region has the highest proportion in the world of total ill-health and premature death due to alcohol and illicit drugs, after tobacco and cardio-vascular diseases. Alcohol use is considered to be the third leading risk factor of premature death as measured in disability-adjusted life years (DALYs), after underweight and unsafe sex,<sup>29</sup> where alcohol is a contributing factor in itself to the latter. Alcohol consumption in the WHO European Region is double the world average, resulting in the fact that alcohol is responsible for 6.5% of all deaths (11% of male deaths and 1.8% of female deaths) and 11.6% of all the years lost to disability or premature death (disability-adjusted life years, or DALY) (17.3% for men and 4.4% for women).<sup>30</sup>

- **Nutrition and poverty:** Compared to the wealthiest groups, low income groups (such as young families, elderly people and the unemployed), eat less well, pay more for what they get in relative terms, and have worse access to healthy options.<sup>31-32</sup> Low income is associated with poor nutrition at all stages of life, from

<sup>24</sup> Jha, P.; Peto, R.; Zatonski, W.; Boreham, J.; Jarvis, M. and Lopez, A. (2006) 'Social inequalities in male mortality from smoking: indirect estimation from national death rates in England and Wales, Poland and North America'. *Lancet*, 368, pp. 367-70.

<sup>25</sup> WHO (2009) *Report on the Global Tobacco Epidemic: Implementing Smoke-free Environments*. Geneva: World Health Organisation.

<sup>26</sup> Wardle, J. et al. (1999) (eds.) 'Smoking, drinking, physical activity and screening uptake and health inequalities'. In : Gordon D et al., (eds.) 'Inequalities in health'. Bristol, *The Policy Press*, pp. 213-239.

<sup>27</sup> Anderson, P. & Baumberg, B. (2006) *Alcohol in Europe*. London: Institute of Alcohol Studies.

<sup>28</sup> Eurothine project website: <http://survey.erasmusmc.nl/eurothine/index.php?id+112,0,0,1,0,0>

<sup>29</sup> WHO (2009) *Global Health Risks: mortality and burden of disease attributable to selected major risks*. Geneva: World Health Organisation

<sup>30</sup> WHO Regional Office for Europe (2009) *Handbook for action to reduce alcohol-related harm*.

<sup>31</sup> Pomerleau, J.; Knai, C.; Branca, F. et al.(2008) 'Review of the literature of obesity (and inequalities in obesity) in Europe and of its main determinants: nutrition and physical activity'.





lower rates of breast-feeding to higher intakes of saturated fatty acids and lower intakes of antioxidant nutrients. Moreover, there is increasing evidence that poor nutrition in childhood results in both short-term and long-term adverse consequences such as poorer immune status, higher caries rates and poorer cognitive function and learning ability.<sup>33</sup>

Recent trends in food consumption in Western Europe reveal that highly processed and fast foods are more readily accessible, whilst nutrient-dense foods such as fruit and vegetables have become relatively more expensive. In Central and Eastern Europe fruit and vegetables are still relatively cheaper than dairy, meat and processed food, hence more affordable and available but there has already been some move away from traditional regional diets, to a converging energy-dense, nutrient-poor diet where fruit and vegetable consumption has stagnated.

Obesity prevalence levels in adults and children have been increasing in virtually all Member States. Secular trends show that, apart from some countries in Eastern Europe, there has been a continuing and in some countries a widening gap between the levels of obesity prevalence among adults in higher and lower socio-economic groups, with those in the lower showing higher prevalence levels. Obesity- and overweight-related diseases are more common in poorer countries and populations. Evidence suggests that over 20% of the obesity found among men in Europe, and over 40% of the obesity found in women, is attributable to differences in socio-economic status. Raising levels of obesity and overweight among children in Europe are also associated with the lower socio-economic status of their parents, especially their mothers. Furthermore, cross-country comparisons show the prevalence of childhood overweight is linked to a Member State's degree of income inequality or relative poverty.<sup>34</sup>

Poverty-related poor diet, overweight and obesity contribute to a large proportion of non-communicable diseases, including cardiovascular diseases and cancer, the two main killers in the European Region. Excessive fat intake, low fruit and vegetable intake and an increasing problem of obesity not only shorten life expectancy, but also harm the quality of life.

There is also growing evidence of the link between poverty and cardio-vascular diseases (CVD). CVD are primarily caused by a non-nutritious diet, tobacco, physical inactivity and alcohol abuse. They directly impact on the prevalence of such conditions as obesity, type II diabetes<sup>35</sup> and hypertension.<sup>36</sup> Notably, non-communicable diseases (especially diet-related diseases such as cardiovascular diseases, cancer, and diabetes mellitus) cause 86% of deaths and 77% of the disease burden in the WHO European Region.

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<sup>32</sup> Andreyeva, T.; Long, MW. And Brownell KD. (2010) 'The Impact of Food Prices on Consumption: A Systematic Review of Research on the Price Elasticity of Demand for Food'. *American Journal of Public Health*, 100(2), pp. 216-222.

<sup>33</sup> Nelson, M. (2000) 'Childhood nutrition and poverty'. *Proceedings of the Nutrition Society*, 59, pp. 307-315.

<sup>34</sup> Robertson, A.; Lobstein, T. and Knai, C. (2007) 'Obesity and socio-economic groups in Europe: Evidence review and implications for action'. Available from [http://ec.europa.eu/health/ph\\_determinants/life\\_style/nutrition/documents/ev20081028\\_rep\\_en.pdf](http://ec.europa.eu/health/ph_determinants/life_style/nutrition/documents/ev20081028_rep_en.pdf) (accessed on 18 October 2010).

<sup>35</sup> Riste, L.; Khan, F. and Cruickshank, K. (2001) 'High prevalence of type 2 diabetes in all ethnic groups, including Europeans, in a British inner city: relative poverty, history, inactivity, or 21st century in Europe?' *Diabetes Care*, 24, pp. 1377-1383.

<sup>36</sup> De Gaudemanis, R.; Lang, T.; Chatellier, G.; Larabi, L.; Lauwers-Cances, V.; Maitre, A. and Diene, E. (2002) 'Socioeconomic inequalities in hypertension prevalence and care: the IHPAF study'. *Hypertension*, 39, pp. 1119-1125.





- **Mental Health and poverty:** Evidence shows clear bidirectional links between mental health and poverty.<sup>37</sup> People experiencing poverty are particularly vulnerable towards developing mental health problems. Conversely people with existing mental health problems are more likely to experience poverty.

The current financial and economic crisis has a considerable effect on the mental health and well-being of the population. Due to financial hardship and uncertainties about the future, especially depressions, anxiety-disorders and burn-out are more and more commonplace. When users of mental health services are asked about the major issues that concern them in their daily lives, personal finances are consistently identified as a major source of difficulty and distress. One in three people with a serious mental health condition are thought to be in debt. Concerns and anxieties regarding finance constitute a significant stress factor,<sup>38</sup> which is exacerbated in times of recession.

Pressure on those people who still have work is growing. A Eurobarometer survey<sup>39</sup> revealed that in certain countries up to 65% of the employees are anxious about their job security. Mental disorders are increasing in the working environment. Most common diseases are depression, burn-out feelings, but also heart rhythm disturbances, stomach problems etc. People often escape their reality by misusing alcohol and drugs.

According to a recent Eurobarometer survey on Mental Health,<sup>40</sup> released in October 2010, it is the poorest in society who are suffering the most with mental health problems. It is those who are the most financially stretched and those at the lower end of the social scale (it is quite possible that these are often the same people) who are seeking help for a psychological or emotional problem and who are taking antidepressants more than others. Those at the bottom of the socio-demographic scale are also more likely to be absent from work and tend to feel undervalued in the workplace.

In other words, **the growing number of non-communicable diseases will primarily affect people with a more deprived socio-economic background.**

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<sup>37</sup> WHO (2007) *Breaking the vicious cycle of mental ill-health & poverty*. Geneva: World Health Organisation.

<sup>38</sup> Jenkins, R.; Bhugra, D.; Bebbington, P. et al (2008) 'Debt, income and mental disorder in the general population.' *Psychol Med*, 38(10), pp. 1485-93.

<sup>39</sup> *Special Eurobarometer 261*, July 2009, [http://ec.europa.eu/public\\_opinion/archives/ebs/ebs\\_316\\_sum\\_en.pdf](http://ec.europa.eu/public_opinion/archives/ebs/ebs_316_sum_en.pdf)

<sup>40</sup> *Special Eurobarometer 345*, October 2010, [http://ec.europa.eu/health/mental\\_health/docs/ebs\\_345\\_en.pdf](http://ec.europa.eu/health/mental_health/docs/ebs_345_en.pdf)



## Tackling health inequalities goes beyond the health sector

Traditionally, the health sector has been looked upon to deal with concerns about health and disease. However, the main levers of health lie outside of the health sector.<sup>41</sup> In schools, workplaces and other institutions, the quality of the social environment and material security are often as important to health as the physical environment. Neither health professionals nor health policy-makers are able to tackle health inequalities without the support and cooperation of their colleagues in the fields of housing, town planning, transport, social services, education, employment, environment and others.

For instance, the use of healthy public transport with less driving, more walking and cycling, promote health and well-being of all social groups. They provide exercise, reduce fatal and non-fatal accidents, increase social contact, reduce air pollution and promote equal opportunities.<sup>42</sup> Recently, the WHO has launched a public campaign **“1000 Cities, 1000 Lives to highlight urban planning as a crucial link to building a healthy 21st century”**. Urban settings have a direct impact on the health of people living there, with a disproportionate impact on the poor. There is evidence that rapid, unplanned urbanization can have negative consequences for the health and safety of people.<sup>43</sup> Lacking of good public transport infrastructure, services and good networks for cycling and walking triggers a rapid transition to a more affluent lifestyle, and increased car or motorcycle use. This leads to enormous increases in traffic, traffic-related pollution, noise exposure, injury risks to pedestrians, cyclists and motorists, and a reduction in physical activity.

Furthermore, many countries in the EU report that people with mental health problems face situations of isolation, loneliness and social exclusion due to transport problems. Urban transport being a major instrument to tackle social exclusion of people with mental health problems, lack or bad transport is excluding them further from society. Social aspects of transport should be a challenge for the policy makers.<sup>44</sup>

EPHA believes that the way the current European transport system works causes a bad urban environment and that urban planning would need to be made more sustainable by cycle- and walking-friendly planning and in order to benefit health of European citizens.

Hence, greater awareness of multi-factoral framework of health inequalities, wider determinants of health – in particular poverty-related - should be fostered by the health community amongst the non-health policy and professional communities, including teachers, employers, local entrepreneurs, urban and rural planners, and other sectors.

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<sup>41</sup> WHO Commission on Social Determinants of Health (2008) *Closing the gap in a generation: Health equity through an action on the social determinants of health. Final Report*. Geneva: World Health Organisation

<sup>42</sup> WHO Regional Office for Europe (1999) *Charter on Transport, Environment and Health*.

<sup>43</sup> WHO (2010) *Why urban health matters? 1000 Cities, 1000 Lives Campaign*. Launched at the World Health Day 2010.

<sup>44</sup> MHE's response to the European Commission Green Paper on Public Transport, March 2008. Available from [http://www.mhe-sme.org/assets/files/Consultation\\_Green%20Paper%20on%20urban%20mobility\\_contribution%20MH..pdf](http://www.mhe-sme.org/assets/files/Consultation_Green%20Paper%20on%20urban%20mobility_contribution%20MH..pdf) (accessed on 18 October 2010)



## The solution: tackling health inequalities requires a health in all policies approach

Many European Union policies and initiatives affect health and health systems across the European region. In general, politicians and decision makers are often not aware of such health effects. Evidence shows that important determinants of health frequently lie outside the health policy sector in environmental, agricultural, employment, education or transport areas. Nonetheless, the health sector can support other areas of governmental activity by actively assisting in analysis of health impact assessment and contributing to their policy development and goal attainment.

Health policy should address health inequalities by using a more “person-centred” approach that takes into account the individual’s surroundings and social structures that subsequently influence the health status of the individual. Only if the overall health policy and other policies that affect health (e.g. social, economic, education and justice) coordinate together, it is possible to reduce the disparities in this field. This cannot be achieved by fragmentary action.<sup>45</sup>

There is an increasing necessity for coordinated actions across various policy areas, as well as the involvement of other – nongovernmental or political - stakeholders.

Based on these principles, a new and innovative approach to cross-sectoral health and well-being achievement – referred to as “**Health in All Policies**” - has been developed. Health in all Policies (HiAP) means that closing the health gap becomes a shared goal across all parts of government and addresses complex health challenges through integrated policy responses. In other words, public authorities are able to address the key determinants of health in more systemic and systematic manner. Such an excellent guideline for moving towards shared governance for health and well-being is “**Adelaide Statement on Health in All Policies**” jointly developed by WHO and the government of South Australia in April 2010.<sup>46</sup>

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<sup>45</sup> MHE’s response to European Commission consultation on EU Action to reduce health inequalities, March 2009. Available from [http://www.mhe-sme.org/assets/files/MHE\\_RESPONSE\\_TO\\_EC\\_CONSULTATION\\_ON\\_HEALTH\\_INEQUALITIES\\_31%20March%202009.pdf](http://www.mhe-sme.org/assets/files/MHE_RESPONSE_TO_EC_CONSULTATION_ON_HEALTH_INEQUALITIES_31%20March%202009.pdf) (accessed on 18 October 2010)

<sup>46</sup> WHO and Government of South Australia (2010) *Adelaide Statement on Health in All Policies – moving towards a shared governance for health and wellbeing*. Geneva: World Health Organisation

## About EPHA

EPHA is a change agent – Europe's leading NGO advocating for better health. We are a dynamic member-led organisation, made up of public health NGOs, patient groups, health professionals, and disease groups working together to improve health and strengthen the voice of public health in Europe. EPHA is a member of, among others, the Social Platform, the Health and Environment Alliance (HEAL), the EU Civil Society Contact Group and the Better Regulation Watchdog.

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