The Impact of the Economic Crisis on Health inequalities

An AER Background paper

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“Health inequality is estimated to cost around 1.4% of GDP, prompting calls for investment in social and health services in an effort to boost the economy in the longer term”.

(Euractiv, 11/01/10)

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1. Health inequalities in Europe

What are health inequalities?

Health inequalities refer to **differences in the health status of individuals or groups**. One's health status depends essentially on the **social determinants of health**, that is to say the conditions in which one grows, learns, lives, works and ages[1].
Although some of these inequalities in health are unavoidable as they stem from biological variations or from specific personal choices, most health inequalities are the result of **unequal distribution of the social determinants of health across different social groups** (such as class, sex and race[2]).
These health inequalities are socially unjust and they can lead to considerable avoidable costs/fees for public health systems. Therefore, adequate health investments and social policies must exist in order to tackle growing inequalities facing people's health status in Europe:.

Health inequalities or health inequities?

The terms health inequalities and health inequities are both used when speaking about differences in people's health status. But health inequalities only state that the health status of people is not the same, whereas health inequities imply that these differences are caused by unjust and avoidable contextual factors.

Essential health indicators

To assess the differences within people's health status in Europe, we have to rely on parameters that are comparable across social groups as well as across regions and countries. The health indicators as for health inequalities with the most meaningful data available in Europe are:

- **Infant/premature mortality rate[3]:** Percentage of born children dying before the age of three;
- **Life expectancy at birth:** Number of years a person is expected to live at his/her birth;
- **Disease rate:** Percentage of people suffering from a disease (cardiovascular and cancer-related diseases are of particular interest when examining the most important health inequalities as they often lead to death);
- **Healthy life years:** Number of years a person is expected to live in "full" health
- **Health lifestyles:** for example, the number of cigarettes consumed per day, the consumption of alcohol per day or week, or the amount of physical exercise per day.

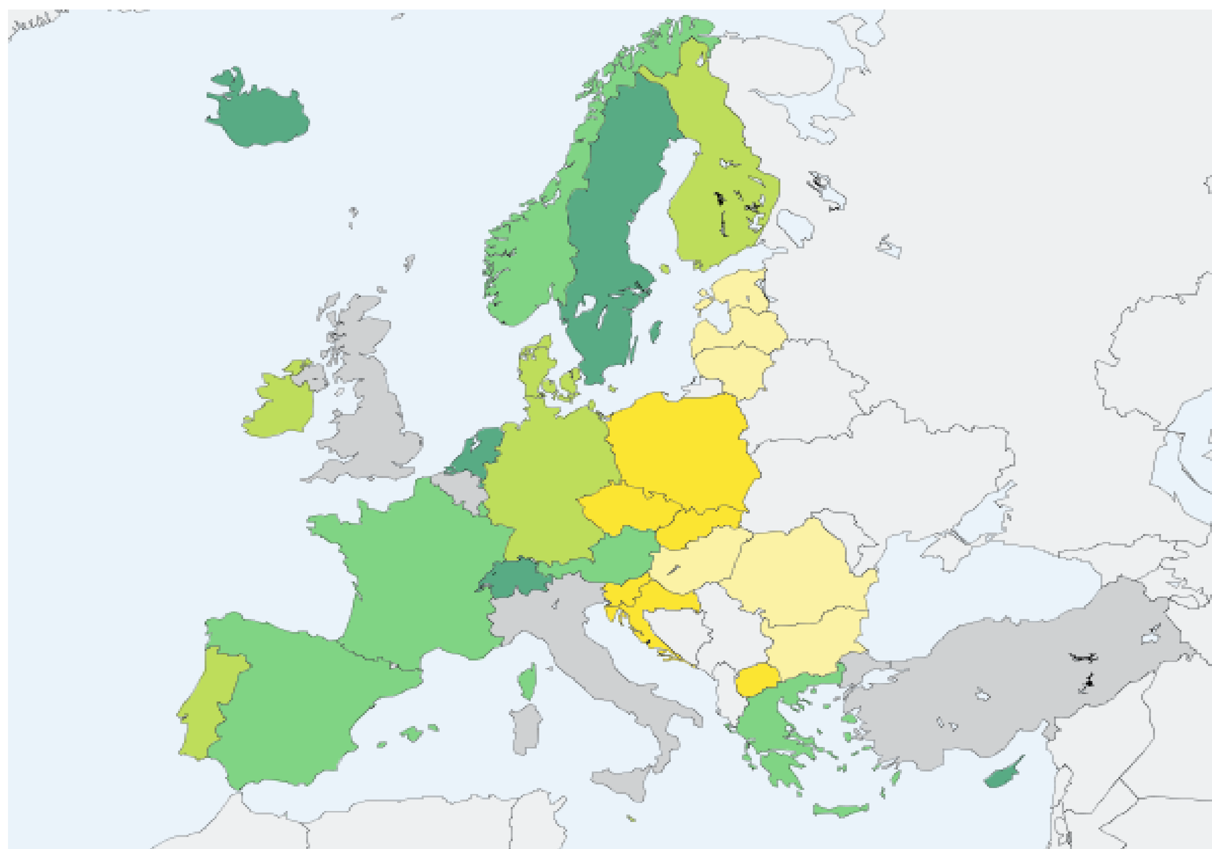
1.1 Health inequalities between European countries and regions

The most striking difference in health between countries of wider Europe appears when comparing the life expectancy of men and women: we note a **18-year gap in men's life**

[1] WHO Commission on Social Determinants of Health: http://www.who.int/social_determinants/en/.
[2] There are other dimensions to describe health inequalities such as political power, cultural and social assets and honorific status.
[3] See WORLD HEALTH ORGANIZATION, GLOBAL HEALTH OBSERVATORY: http://apps.who.int/ghodata/.

expectancy between Ukraine with 62 years on the one side and Switzerland with 80 years of life expectancy on the other. As for women, the gap is lower but still considerable with **a 10-year difference between the countries with the highest and the lowest life expectancy**[4]. When focusing on the European Union, we note a difference of 13 years for men and of 9 years for women (see below).

Life expectancy at birth, by gender - [tps00025]; Males
(years) - 2008



Legend

66.29 - 69.97	69.97 - 75.53	75.53 - 77.63
77.63 - 78.4	78.4 - 79.99	N/A

Source: Eurostat.

There are also large differences between countries of wider Europe both in **infant mortality rates** (with a variation from 1,8 deaths per 1000 life births to 15 deaths) and in the **number of healthy life years** (from 51 healthy life years to 72 years)[5]. These disparities between

[4] See WORLD HEALTH ORGANIZATION, GLOBAL HEALTH OBSERVATORY: http://apps.who.int/ghodata/.
[5] See WORLD HEALTH ORGANIZATION, GLOBAL HEALTH OBSERVATORY:

countries are also reflected in the number of cases of cardiovascular and cancer-related diseases.

Looking at the data, we can make the following observations:

- European Union's member states generally show better results than the neighbouring countries (with the exception of Norway and Switzerland).
- Within the European Union there is a clear difference between west-east disparity: people from the Baltic states, Central and Eastern Europe both suffer from a lower life expectancy, live less years in good health and face both higher rates of diseases and higher rates of infant mortality.

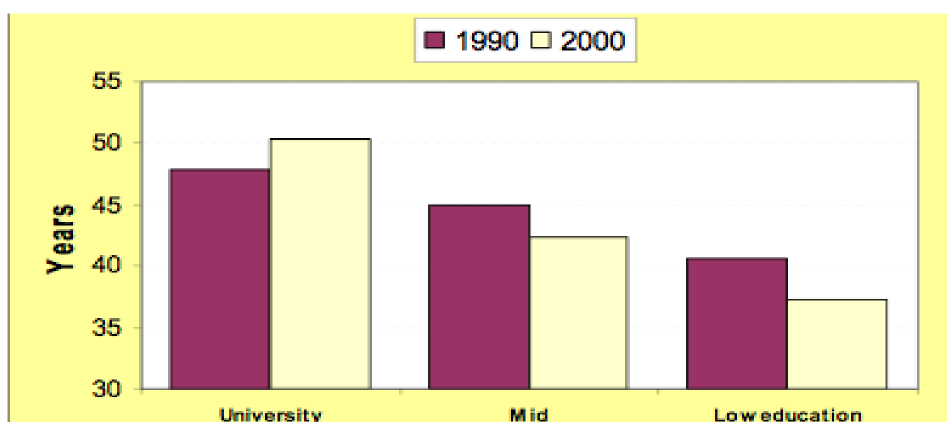
A possible explanation to these geographic disparities remain the economic differences that continue to exist, notably in terms of job quality, service quality, living conditions and levels of income.

1.2 Health inequalities within regions and countries

Health inequalities do not only exist between European countries. In all European countries, including those with long-standing social and healthcare policies, health inequalities persist within populations. Not all countries are affected to the same extent: health inequalities are rather large in countries with poor health outcomes (see above), often the result of small health expenditure[6].

The levels of education, occupation and income prove to be a decisive factor when it comes to measuring people's health status across Europe as in the rest of the world:

- The life expectancy of people with the lower socio-economic position is **4 to 10 years for men and 2 to 6 years for women** below this of people with the highest socioeconomic position.



Life expectancy according to educational background in the years 1990 and 2000. Source: Euphix.

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http://apps.who.int/ghodata/.

[6] There is a tendency for member states reporting lower life expectancy to report the lowest health expenditure per capita and as a percentage of GDP. Source: European Commission.

- People with lower education and income spend the majority of their lives in poorer health conditions. Indeed, they tend to suffer more from all kinds of health problems like cardiovascular diseases or injuries at work and have a higher premature death risk[7].
- People with lower education and income also report poorer self-perceived health than those with higher socio-economic position[8]:

TIME / GEO	2008
European Union 27	3.0
Belgium	2.8
Bulgaria	4.9
Czech Republic	4.7
Denmark	2.9
Germany	2.8
Estonia	5.7
Ireland	0.6
Greece	3.8
Spain	3.1
France	1.8
Italy	3.2
Cyprus	3.6
Latvia	8.9
Lithuania	5.7
Luxembourg	2.2
Hungary	5.7
Malta	0.6
Netherlands	2.5
Austria	3.6
Poland	3.3
Portugal	8.7
Romania	1.9
Slovenia	5.7
Slovakia	7.9
Finland	2.2
Sweden	2.0
United Kingdom	1.9
Iceland	2.3
Norway	2.5

TIME / GEO	2008
European Union (E...	0.8
Belgium	0.4
Bulgaria	0.7
Czech Republic	0.7
Denmark	0.5
Germany	0.8
Estonia	0.2
Ireland	0.3
Greece	1.3
Spain	0.6
France	0.4
Italy	1.3
Cyprus	0.2
Latvia	0.7
Lithuania	1.0
Luxembourg	0.2
Hungary	3.0
Malta	0.0
Netherlands	0.2
Austria	1.0
Poland	1.4
Portugal	1.7
Romania	0.6
Slovenia	0.6
Slovakia	1.5
Finland	0.5
Sweden	0.5
United Kingdom	0.3
Iceland	0.9
Norway	0.2

Self reported unmet need for medical examination or treatment, by income quintile; at left below 20% of median equivalised income, at right above 80% of median equivalised income. Source: Eurostat.

- These statistics show a social gradient in health across all socioeconomic groups. Vulnerable groups like homeless people, migrants, people with disabilities and long-term unemployed people but also the young and the elderly are particularly affected as they often fall in the group of people with the lower socio-economic backgrounds.

[7] British Whitehall Longitudinal Study: 1,6 times higher risk of death for those with the lowest socioeconomic position than those from the highest.

[8] COMMISSION OF THE EUROPEAN COMMUNITIES: Background document for press pack – launch of a Commission communication. Solidarity in health: Reducing health inequalities in the EU, Brussels October 2009, p. 13.

After this overview regarding the extent of health inequalities, we will examine more closely how inequalities arise and develop in Europe in the following chapter. Furthermore, we will examine possible policy actions to counter such rising health inequities[9].

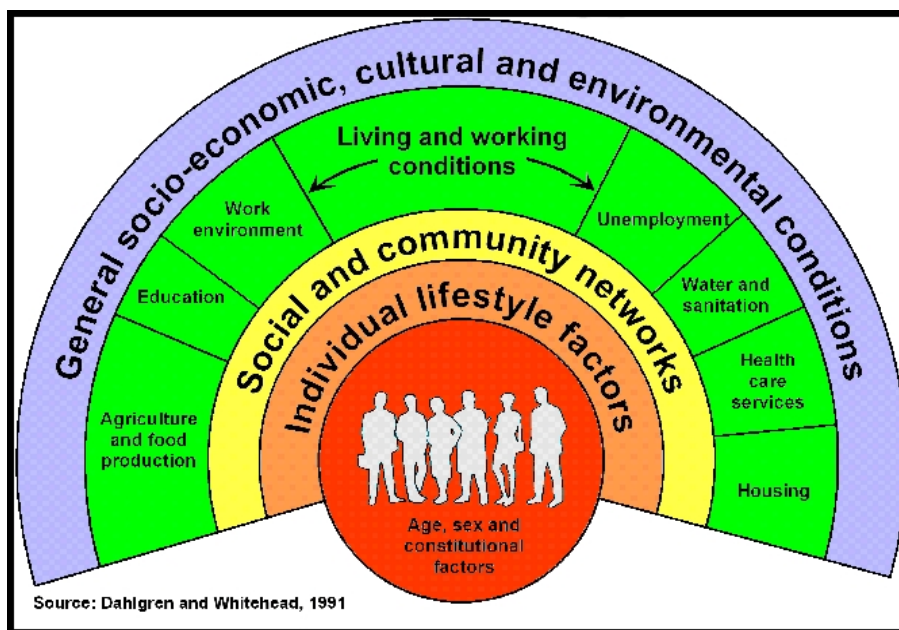
2. Social determinants of health

Health inequalities in Europe are not the result of coincidences but are caused by a wide range of social contextual factors in people's lives:

The model below shows that cultural and environmental factors, working and living conditions, are predominant affecting people's overall health status.

Health is also influenced by individual health-related behaviours and lifestyles, for example the choice to smoke or not to smoke.

These set of social conditions must to be analysed at great depth, taking into account the **time dimension:** "Some factors operate over long periods: e.g. poor conditions in childhood can affect health later in life."[10]



Source: Dahlgren and Whitehead, 1991.

[9] The following chapter is particularly inspired by the recommendations of Michael Marmot as made in WILKISON, Richard/MARMOT, Michael (ed.): Social determinants: The solid facts. Word Health Organization, Copenhagen 2003 and MARMOT, Michael: Strategic review of health inequalities in England post 2010, London 2010 (available at: http://www.marmotreview.org/english-review-of-hi).

[10] COMMISSION OF THE EUROPEAN COMMUNITIES: Background document for press pack – launch of a Commission communication. Solidarity in health: Reducing health inequalities in the EU, Brussels October 2009, p. 16.

2.1 Daily life conditions can determine people's health

Environmental conditions

Health inequities are created through variations in the safety, hygiene and healthiness degree of people's environment (e.g. transportation means, water and sanitation systems). In certain places for example, people have to deal with a degree of pollution that can heavily alter their health negatively. National and regional policies can have a greater influence over these environmental circumstances, for example by favouring public transportations instead of conducting policies that increase car dependence or by taking into account the impact of waste, water, fuel and industry policies on health when designing them. Consequently, tackling such health inequities can often mean tackling climate change at the same time.

Working conditions

The working environment has to fulfil a certain number of safety or ergonomic standards in order to maintain a healthy workforce. Unfortunately, the standards at work still remain highly dependable on the occupational status and are often linked to the level of income, which means that people with a lower socio-economic position are more likely to be at risk from work-related injuries.

Psychosocial factors derived from people's daily working conditions determine people's health to a great extent, too. Thus, it is essential that people feel appreciated and useful within their work environment. Inadequate rewards affect health as does stress due to high pressures and high work demands. Health is also negatively affected when "people have little opportunity to use their skills and low decision-making authority"[11]. An important aspect of health at work is the security people feel when entering the work force. If one feels his employment is insecure, be it due to the type of contract, or persisting economic fluctuations, as a result, this may influence one's cardiovascular and immune system. Seasonal workers and young people are particularly at risk as they suffer more from temporary employment.

However, "in general having a job is better for health than having no job"[12]. Indeed, unemployed people have to face financial problems, they often feel excluded from society and they tend to suffer particularly from mental illnesses and unhealthy diets.

Public authorities can contribute towards improving health in the workplace by encouraging the respect of appropriate rewards, requiring a healthy infrastructure at the workplace and by offering life-long learning opportunities.

Besides, decisions-making strategies aimed at preventing unemployment and job insecurities, we must ensure that sufficient and adequate training measures, are exercised in order for those out of work to be rid of health risks, while facing unemployment.

[11] WILKISON, Richard/MARMOT, Michael (ed.): Social determinants: The solid facts. Word Health Organization, Copenhagen 2003, p. 18.
[12] WILKISON/MARMOT, p. 18.

Housing conditions

Regarding housing conditions, people should be protected from noise and cold, have access to a bright environment and to running water. People also have to feel safe in order to live in good health. It is the duty of politicians to develop urban planning strategies and zoning laws that ensure a good health for all citizens, furthermore to alleviate potential barriers to access feasible housing, particularly paying attention to excluded or vulnerable groups such as homeless people. Improving house-building standards is also a way to fight against health inequities: this is also the occasion to tackle simultaneously climate change and health inequalities. Economic incentives can particularly support the building of healthy and sustainable housing.

Food

Access to food is a fundamental and mandatory requisite towards fruitful and prosperous health. A deprivation of food or a lack of food diversity, particularly the lack of fresh food such as vegetables and fruit can cause malnutrition. It is the role of public authorities to guarantee that fresh food is affordable for all through adequate regulatory dispositions and agricultural policies. Furthermore, public authorities should promote the health education of their citizens and raise their awareness on what healthy food is.

Healthy lifestyles

People determine their health to a high extent themselves. “Some studies show that individual health behaviour can explain from 25% to 35% of differences in people’s health.”[13] An addictive personality to alcohol or cigarettes and, little exercise, results in increased health risks. Health reports illustrate that people with lower educational backgrounds and income tend to make unhealthier choices. However, these individual choices can also be influenced by contextual factors. Similarly, national and regional authorities can help individuals to make healthy choices by promoting healthy lifestyles and by establishing restrictive measures on the use of drugs such as: prohibitions laws against alcohol and cigarettes. Pro-active objectives such as, raising taxes, raising the minimum legal consumption age, and banning smoking from public places, establishes precedent of dissuasive measures identified by the regions as efficient.[14]

Education

Education has proven to be one of the most important factors influencing health as it determines human potential from early stages in life. An in-depth health education can help spark

[13] COMMISSION OF THE EUROPEAN COMMUNITIES: Background document for press pack – launch of a Commission communication. Solidarity in health: Reducing health inequalities in the EU, Brussels October 2009, p. 17.
[14] AER Social Policy and Public Health Committee, Conclusions of the AER Conference “What does alcohol do to your region? And what can you do about it?”, May 2010. http://www.aer.eu/fileadmin/user_upload/Commissions/HealthSocial/EventsAndMeetings/2010/Barcelona/Working_documents/Adopted_documents/Alcohol-Conclusions-12-May-2010.pdf

consciousness, making people aware of the consequences of their health choices. Therefore, public authorities have to guarantee a barrier-free access to education for all, regardless of people's socio-economic position. At the same time, the social gradient in educational outcomes has to be reduced. Progress has to be made as for hindering school drop-outs. Education policies also have to ensure that health is taken into account in the creation of educational programmes.

2.2 Health systems as a determinant of people's health

The contribution to health inequalities from the health system itself has only been recognised in recent years. "Availability (infrastructure, equipment and health professionals), access and quality of healthcare are key factors determining health and health inequalities as they influence the likelihood of overcoming morbidity and avoiding mortality."[15]

In some countries, health systems, even if egalitarian societies, otherwise, exclude people without health insurance coverage such as migrants or homeless people- without providing adequate access to proper healthcare services.

By establishing costs that must be met by people themselves or advanced "out of the pocket", the health system tends to create a social gradient of health. People with low incomes are often not able to manage such costs.

Furthermore, health systems "may respond differently to the same disease depending on patients' social characteristics"[16].

Finally, one also has to consider the territorial aspect of healthcare services. The health system itself produces health inequities by providing services unequally to its citizens: for example urban dwellers find healthcare services close to their homes whereas rural inhabitants sometimes have to accept large distances to access healthcare services.

Healthcare services have to be designed in a way that ensures the provision of a treatment to every patient without discrimination. When it comes to the promotion of healthier lifestyles, the same information should be delivered to every citizen and not only to citizens who already have access to knowledge and resources, which stress the importance of living in a healthy way.

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[15] COMMISSION OF THE EUROPEAN COMMUNITIES: Background document for press pack – launch of a Commission communication. Solidarity in health: Reducing health inequalities in the EU, Brussels October 2009.

[16] COUFFINHAL, Agnes (et al): Policies for reducing inequalities in health, what role can the health system play? A European perspective, in: HEALTH ECONOMICS LETTER, 92, February 2005.

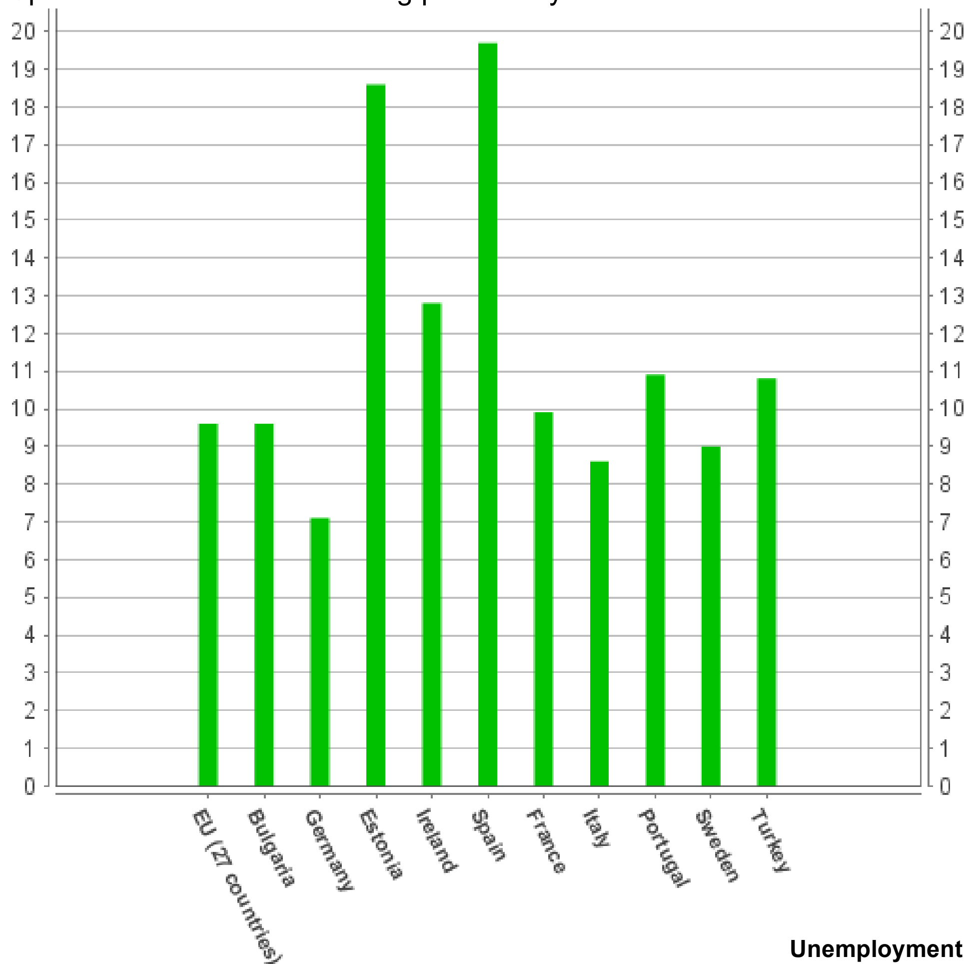
3. Economic crisis and public health

3.1.The current crisis

The current crisis is the worst economic recession since the Second World War[17] and has had a devastating impact on people's lives.

In reaction to this unprecedented crisis, public authorities have become engaged in economic recovery and bank support programmes while the governments' incomes are decreasing owing to declines in production and commodity prices. As a consequence, austerity plans covering all kind of policies have been applied throughout Europe since 2010.

The economic downturn following the financial crisis is characterised by a rise in unemployment and an increase in job flexibility: unemployment in the EU shifted from 7,1 % to 9,3%, with some countries like Spain or the Baltic states being particularly affected.



Unemployment rate 2010.
Source: Eurostat.

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[17] WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR EUROPE: Health in times of global economic crisis: Implications for the WHO European region. Regional Committee for Europe, fifty-ninth session, Copenhagen 14-17 September 2009, p. 1.

Furthermore, in some sectors employees are suffering from cuts in wages or reductions in working time leading this way to a lower income.

3.2 Consequences for people's health and health lifestyles

As stated in Chapter 2, the most important factors of people's health status are the conditions in which they live and work. An important increase in unemployment can lead to an augmentation of mental diseases[18]. As living standards are decreasing, a number of people cannot afford adequate living conditions and therefore cannot meet the bare minimum of proper living standards or sanitary needs. The population hardest hit by the economic crisis have been the poor by reason of being the most susceptible to economic fluctuations: In 2008, 16 % of the EU-population had already been at risk of poverty[19].

The consequences of a decrease in revenue are important:

- Food becomes unaffordable. The consumption of fresh food decreases. People fall back on cheaper diets that are rich in salt, sugar and fat.[20]
- Due to governmental choices or the devaluation of currencies, imported pharmaceuticals become more expensive and therefore less affordable for people with low income.
- Health services become less affordable too: in certain European countries, we note that medical use is decreasing, as are the private expenditure on health.

For the moment, it is still difficult to assess the full impact of the crisis on health inequities because there is only little data available. However, the long-term consequences for people and their health as indicated above show that they rather tend to increase health inequities, depending on the economic situation of a given region.

3.3 Consequences for the health system

While people's health is clearly affected by the economic crisis, most health systems are not capable of counterbalancing these affects.

In various countries, public expenditure on health falls because there are cuts in the general budget or because the allocated share dedicated to health is reduced in times of crisis:

[18] http://oecdinsights.org/2010/01/12/employment-and-the-crisis/.
[19] EUROSTAT: http://epp.eurostat.ec.europa.eu/portal/page/portal/eurostat/home/.
[20] http://www.globalcrisisnews.com/health/food-becoming-unaffordable-due-to-crisis/id=756/.

especially in most countries of Central and Eastern Europe whereby they announced downward revisions of their health budget in 2009[21].

As a consequence, capital investments are often postponed or switched to other areas; furthermore, the observed cuts in healthcare staff, results in lower healthcare quality and services.

Instead of counterbalancing the crisis' impact on citizens, numerous public authorities tend to put additional pressure on them. For instance, Croatia is "planning increases in user charges for pharmaceuticals"[22].

Health systems are not all reacting to the economic crisis by cutting into the health budget. As the European Commission explains it in its background document about health inequalities, the current economic crisis can also motivate countries to review their policy mix on health determinants.

It is important to consider the actions of public authorities to protect their citizens' health from the crisis' impact. For example, in 2009, Germany has chosen to lend subsidies to the social security system to counterbalance the decreasing revenues[23]. In Italy, an economic plan has been developed to support vulnerable groups[24]. Unfortunately, such examples of good will remain dim in Europe. The overall, impact on people's health will only become evident once enough data is collected; however it remains clear that this crisis has tended to enlarge health inequalities, rather than a focus on preventing them.

4. What can regions do to tackle the problem of increased health inequalities due to the economic crisis?

Health is wealth

When dealing with the problem of increased health inequalities in the context of the economic crisis, politicians have to bear in mind the financial costs that these inequalities represent for society. The loss of years of life and of active life caused by deaths and illnesses have a significant impact on the economy. Money can be saved through disease prevention and awareness campaigns. This is a strong incentive for politicians to base their policies on the principle of "health is wealth", as does the European Health Strategy. Beside the fact that living in good health is a fundamental right for everyone, this approach enables to measure and

[21] WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR EUROPE: Health in times of global economic crisis: Implications for the WHO European region. Regional Committee for Europe, Fifty-ninth session, Copenhagen 14-17 September 2009, p 23.

[22] WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR EUROPE, p. 25.

[23] WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR EUROPE, p 25.

[24] WORLD HEALTH ORGANIZATION, REGIONAL OFFICE FOR EUROPE, p. 22.

quantify health, which is a convincing argument for policy makers additionally in times of crisis. Even if it seems politically quite difficult, it is strongly recommended to consider the long-term benefits when developing health policies.

Health in all policies: Health should be a priority for every policy department

The principle "Health is wealth" is an important argument to ensure that health remains a political priority even in time of economic stagnation. The AER declaration on health inequalities precisely underlines the "importance of keeping health at the top of the political agenda at all levels of governments, as an unhealthy workforce has negative impacts on economy"[25].
As we note in Chapter 2, "most effective actions to reduce health inequalities will come through action within the social determinants of health"[26]. Therefore, regions should not only advocate for maintaining the health budget at a level that enables public authorities to address increased health inequalities, but this budget should also enable them to lobby for the consideration of health in the policies of other relevant departments.
Synergies between policy departments are indeed crucial to ensure coherence and efficiency. However, these synergies should not justify cuts on the health budget. As for regions with no financial autonomy, they should advocate for the maintenance of the health budget.

- *Assessment of health policies within the health department*

The health department should assess its own policies. The crisis should indeed be perceived as an opportunity for conducting a complete evaluation of new strategies and programmes. This can be a way to upgrade the current methods to more innovative approaches and solutions. The following recommendations are of particular importance:

- *Maintain a high level of employment in the health sector*

Even if budget cuts are unavoidable in the health department, the quality of healthcare should not be affected, which is the case when there are reductions in the healthcare staff.

- *Find new financial resources*

When finances are limited, it makes sense to review the funding resources and to provide information about additional possibilities. One of the objectives of AER Committee 2 is to support regions with its expertise in order to make the most of the money available. EU funding is one way through which the European Union can help to address health inequalities between

[25] Response by the AER "Social Policy & Public Health" Committee to the consultation of the European Commission, EU action to reduce health inequalities, p. 2.
[26] MARMOT, Michael: Strategic review of health inequalities in England post 2010, London 2010 (available at: http://www.marmotreview.org/english-review-of-hi), p. 86.

economically unequal regions. Regions, which can benefit from this support should use the opportunities offered by the European Structural Funds and the European Cohesion Fund.

- *Do better with less money!*

It is a key responsibility for regions to assess the efficiency of health policies. Indeed, activities and programmes may have to be reoriented and restructured after they are launched. Regions should therefore review their programmes and check whether the target groups, objectives, means and structures being implemented are in line with their priorities and the current economic situation. **New technologies** can particularly contribute to an increase of efficiency. Health policies should therefore include the development and implementation of new technologies in their strategies. "New technologies can help to improve the efficiency of healthcare delivery and to reduce health inequities"[27]. E-health for example has proven to open new perspectives for regional healthcare, which is of a significant importance for the elderly or people living in rural areas. At the same time, the development of e-health can both foster economic growth in a region and reduce costs of healthcare services, contributing to the improvement of the financial situation at the regional level.

- *Reflection on options to maintain and extend access on health*

An important step to improve citizens' health is to ensure that the most expensive services are available to everybody. This is especially true for preventive treatments that can avoid long-term illnesses. Investment in prevention of diseases should be considered as a key element of a successful strategy to tackle health inequalities. Even if it seems difficult in the context of the economic crisis, it might be necessary to think about alternative ways to expand the access to healthcare in order to reduce the prevailing gap between existing health inequalities from different socio-economic groups and backgrounds. Indeed, as mentioned above, the health system itself may reinforce existing inequalities.

- *Promote healthy lifestyles*

As mentioned above, individual health choices make up to 25% to 35% of differences in health. An important factor to reduce health inequalities is therefore the promotion of healthy lifestyles. Public authorities should develop programmes that guarantee the affordability of fresh food to everyone. Besides, pharmaceuticals should be made affordable to everyone, too. A reduction of

[27] Response by the AER "Social Policy & Public Health" Committee to the consultation of the European Commission, EU action to reduce health inequalities, p. 2.

"out-of-pocket", payments can also help to reduce health inequities as people with lower rewards may not always be able to advance the money.

- *Collect comparable data*

Through the research, it has become evident that there is a growing lack of available data. This means that most politicians in charge are not able to react adequately on health inequities because they are simply not aware of their impact. "Measurement and regular reporting of health inequalities indicators is therefore an essential and unavoidable first step"[28] to tackle health inequalities.

- *Take advantage of being close to your citizens!*

Regions are sometimes not aware that being very close to their citizens constitute their main strength compared to national authorities: through this proximity, they have a good knowledge of their local industry as a service commissioner, but they also have specific close tights to the voluntary sector etc. Regions definitively have to take advantage of this specificity:

- First of all, regions have to maintain a regular dialogue with their citizens to collect information on how the economic crisis has affected them and on what the subsequent problems are in order to be able to correct them immediately
- Regions can build partnerships with the private sector: the latter can for instance help implementing higher health standards at work or can contribute to the promotion health among their employees
- Regions can build partnerships with the voluntary sector: as underlines the European Commission by designating 2011 as the European Year of Volunteering, in the European Union "almost 100 million citizens of all ages invest their time, talents and money to make a positive contribution to their community"[29]. This contribution can help to tackle health inequities.
- Regions should also profit from the knowledge available in their territory in the domain of health inequalities: cooperation between the regional administration and universities has proven to be very fruitful for example as for collecting data on health inequalities[30]

[28] [28] COMMISSION OF THE EUROPEAN COMMUNITIES, p. 35.
[29] http://ec.europa.eu/citizenship/focus/focus840_en.htm.
[30] As AER Social Policy and Public Health Committee found out during a survey on the impact of the economic crisis on health among some member regions.

- *Exchange best practices*

Finally, we note that to get out of economic stagnation requires innovative solutions that are also efficient and coherent. One strategy to improve health and social policies is to exchange, data, knowledge, and information with other regions in order to learn about their approach. Some of the regions' experiences can then be replicated in one's territory or simply contribute to the development of new ideas. Believing in the importance of exchanging best practices, AER Committee Social Policy and Public Health is organising a conference on health inequalities to enable regions to share what they have identified as successful solutions to this complex set of problems.

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