Committee terms of reference

A commission for equity in health

Terms of reference 2015:60

Decision at a Government assembly on 4 June 2015

Summary

A committee of inquiry – a commission for equity in health – is to submit proposals that can help to reduce the health inequalities in society. The commission's primary focus will be health inequalities between socioeconomic groups in society. Gender differences in health shall be consistently recognised in the commissions work. The commission shall also take into account the strategic work for an ecologically, economically and socially sustainable development. This work shall take its cue from existing and scientifically based knowledge on the importance of different factors for public health, and on strategies and measures that help to reduce health inequalities. The commission shall also consider relevant results and experiences from similar initiatives at local and regional level in Sweden and other countries, as well as in the EU and other international cooperation. The basis for the commission's remit is the Government's goal to close the avoidable health gaps within a generation.

The commission shall keep the Government Offices (Ministry of Health and Social Affairs) continuously informed about its work. The final results of the commission's work shall be reported by 31 May 2017.

Background

Public health in Sweden is developing in a positive direction for the population as a whole. Most people can expect to live both a longer and healthier life than previous generations. From a health perspective, Sweden is a good country to live in. Positive health trends among the population are of fundamental importance to developments in society as a whole. Promoting health and preventing illness creates conditions for long-term sustainability.

However, good health is not evenly distributed among the population, which is largely linked to people living under different socioeconomic conditions. For example, the remaining average life expectancy at age 30 is five years less among both women and men with basic education as compared to women and men with tertiary education. Moreover, the gap has widened over the past decades. For example, among women who only have primary education, the remaining average life expectancy at age 30 has hardly risen at all over the last twenty years if compared to other groups.

Health inequalities between different socioeconomic groups are clear almost regardless of the health problem concerned. The risk of suffering a heart attack, for example, is higher among both women and men with primary education in all age groups. In addition, for women who only have compulsory school level education, the risk has increased in recent decades. Women who only have compulsory school level education are at greater risk than others of both falling ill to and dying from cancer. Also with regard to dental health, obesity and general health, the socioeconomic inequalities are apparent. The disparities are also apparent with regard to girls' and boys' health. Children who live in financially vulnerable families are, for example, at greater risk of being admitted to hospital for various reasons. The difference is particularly noticeable when it comes to admittances due to mental ill health. Children who live in less favourable socioeconomic conditions are also at greater risk of suffering from injuries caused by accidents. Exposure to various harmful environmental factors during

childhood may also be a contributor to differences in health among children.

The possibility to work during an entire working life also varies for different groups in the population. This has an effect on an individual's finances, particularly in retirement. There are also studies that show that sickness absence among parents has an impact on their children's sickness absence as adults.

Besides health inequalities between various socioeconomic groups, there are also health disparities that can be linked to factors such as gender, impairment and ethnicity (see more under 'Remit').

Changes in society, such as increasing migration, urbanisation and an ageing population, also bring special challenges to the efforts of achieving equitable health in the population.

Health inequalities are closely linked to people's position in society and opportunities for participation and influence, which are affected by e.g. education and income level, as well as labour market attachment. There is also a close link between health and welfare since good living conditions are a prerequisite for good public health.

Conditions in society – the focus of public health policy

The importance of conditions in society for public health trends in Sweden has been raised in the Government Bill 'Public Health Objectives' (Govt Bill 2002/03:35), which describes the fundamental direction of Swedish public health efforts. According to the Bill, public health efforts are to primarily focus on public health determinants, i.e. living conditions, environments, products and lifestyles that affect public health. By focusing on the determinants and how these develop, the results of political decisions can be followed up more effectively. Given that public health determinants can be found in a number of areas of society, public health policy has to be conducted cross-sectorally. The generational goal and the environmental quality objectives that have been adopted by the Riksdag are important for people's health.

Another basic principle of public health work is the equal value of all people. This means that every individual has the right to developbased on their personal circumstances. An individual's socioeconomic conditions affect both lifestyle and health. It is particularly important that public health is improved for the groups in the population that are most susceptible to ill health.

Initiative for equitable health

The significance of socioeconomic conditions for public health trends has also been highlighted at international level and in other countries. Both the World Health Organisation (WHO) and the European Union (EU) have been paying attention to social health inequalities for several years. In 2005, the WHO appointed an independent commission to work for a global mobilisation for equitable health – *the Commission on social determinants of health* – known as the Marmot Commission. The Commission, led by Sir Michael Marmot, presented its results in 2008 in the report entitled *Closing the gap in a generation.* The Commission gave three overarching recommendations for reducing health inequalities:

- improve the conditions of daily life,
- tackle the inequitable distribution of power, money and resources, and
- measure and understand the problem and evaluate the effects of different measures.

As a result of the work of the Marmot Commission, the WHO World Health Assembly of 2009 adopted a resolution stating that member countries should work to reduce inequalities in health through measures that affect the social determinants of health.

The WHO Regional Office for Europe has conducted a survey of health inequalities in the 53 member countries in the WHO European region. The results form the basis of the European region's overarching policy framework for health and

well-being, *Health 2020*, of which the promotion of social equality in health is one of the cornerstones.

The EU's overarching growth strategy, *Europe 2020*, stresses the importance of measures that focus on combating poverty and social exclusion and reducing health inequalities.

In 2009, the European Commission published a communication (COM(2009)567) on health inequalities. As a response to the communication, the European Parliament adopted the resolution *Reducing health inequalities* in 2011. The resolution urges Member States to continue their efforts to even out social and economic inequalities.

Sweden has played an active role in the processes in the UN, WHO and EU that have resulted in resolutions and Council conclusions etc. on social equality in health. Through these, the countries have made certain voluntary commitments to apply a cross-sectoral approach ('Health in All Policies') in work on the social determinants of public health and in efforts to prevent ill health. Internationally and in the EU, continuous development work is under way in this area.

In our neighbouring countries Norway, Denmark and Finland, analyses of the Marmot Commission's proposals have been conducted at national level. In the Norwegian Public Health Act, which entered into force in 2012, the levelling out of health inequalities is a fundamental aim. In Sweden, the Swedish National Institute of Public Health presented a report in 2010 about Swedish lessons learned from the work of the Marmot Commission.

In Sweden, cross-sectoral initiatives have been taken at regional and local level, for example, in Västra Götaland County Council and the municipal cooperation body Östsam Regional Federation Council, as well as in Malmö Municipality and Gothenburg Municipality. The Public Health Agency of Sweden and the Swedish Association of Local Authorities and Regions have taken the initiative together to create the *Social Sustainability Forum*, a forum for developing welfare in a socially sustainable way.

Remit

The commission for equitable health shall submit proposals that can help to reduce health inequalities in society. The commission's primary focus will be the inequalities in health between various socioeconomic groups in society. The basis for the commission's remit is the Government's goal to close the avoidable health gaps within a generation. The commission's proposals shall take into account strategic work for sustainable development from an ecological, economic and social perspective.

In its work, the commission shall also consider other health disparities in society, for example between people with impairments, LGBTQ people, people with foreign backgrounds, the Sami people, people belonging to national minorities and the rest of the population. The distribution of health based on different age groups should also be considered. Gender differences in health shall be consistently recognised in the commission's work. The commission shall also comment on gender differences in health that cannot be explained by differences between socioeconomic groups.

The commission shall consistently apply a cross-sectoral economic perspective when analysing both ill health and any intended proposals. It shall conduct its work on the basis of a broad public health policy perspective and consider factors in several areas that are important for the health of the population, including education, labour market and working life, leisure time, the environment, and health and medical care. The broad welfare policy perspective for public health work described in the Government Bill 'Public Health Objectives' (Govt Bill 2002/03:35) shall be a starting point for the commission's work, as is the cross-sectoral approach ('Health in All Policies') that was adopted in WHO resolutions and EU Council conclusions. This kind of approach will enable proposals to cover both environmental and social factors.

The commission shall consider the significance of both general measures and measures aimed at specific target groups in efforts to reduce health inequalities.

This work shall take its cue from existing and scientifically based knowledge on the importance of different factors for public health, and on strategies and measures that help to reduce health inequalities. If the commission identifies considerable knowledge gaps that require research outside the framework of the commission's remit, this should be highlighted in the commission's continuous reporting.

In its work and when formulating proposals, the commission shall consider relevant results and experience from similar initiatives at local and regional level in Sweden and other countries, as well as in the EU and other international cooperation. The commission shall also consider the commitments made by Sweden in the WHO and the EU.

The work shall result in proposals intended for the State, municipalities and county councils, and other relevant stakeholders in society. Using an outreach-oriented and inclusive approach, the commission shall work actively to ensure that the proposals presented have good prospects of gaining traction in various decision-making processes and gaining support among stakeholders in society who can help reduce health inequalities in society. As far as possible, the proposals shall cover various time perspectives: the short term (2–4 years), the medium term (8 years) and a generation (25–30 years).

Proposals for financing models that can help to reduce preventable health problems and that promote an efficient use of resources over time, and between sectors and responsible authorities, should be presented.

The commission shall also consider to what extent the current cross-sectoral structure for follow-up of all public health work is appropriate for the Government's goal to close the avoidable health gaps within a generation.

Impact assessments

The implications of the proposals are to be reported in accordance with Sections 14–15a of the Committees Ordinance

(1998:1474). Where proposals entail increased costs or reduced revenues for the public purse, financing proposals shall be presented.

Instructions on conducting and reporting on the remit

The commission's work shall be characterised by an outreach-oriented and inclusive approach. The commission shall appoint reference groups with representatives of political parties and relevant stakeholders in society. This includes, but is not limited to, non-profit organisations – including patient and consumer organisations – trade unions and professional associations, the sports movement, business organisations (including the food industry) and the research community. The commission shall consult stakeholders affected by its work, including government agencies and representatives of the local government sector. In addition, the commission shall consult representatives of local and regional initiatives for equitable health and promote synergies between similar initiatives at different levels. The commission shall organise regional conferences with the aim of collecting ideas, gaining support for proposals and raising the issue of everyone's responsibility to even out avoidable health inequalities. The commission shall participate in various ways in the public debate on issues affecting its remit.

In its work, the commission shall take into account other ongoing projects that are relevant to the issues laid out in the remit.

The commission shall keep the Government Offices (Ministry of Health and Social Affairs) continuously informed about its work and regularly present proposals and other results of its work.

The final results of the commission's work shall be reported by 31 May 2017. The report shall contain an overall assessment of which measures are necessary to achieve the Government's goal of closing the health gaps within a generation. The overall assessment is to also cover both the direct economic

consequences of the measures and their economic consequences for society.

(Ministry of Health and Social Affairs)