President, Commissioner, Ministers, thank you for asking me to contribute to your debate. Over the next few minutes I will share some EU-wide evidence on health inequalities, and some options for intervention.

This session has a special emphasis on diet and physical activity. 86% of deaths in the EU are caused by chronic diseases, for which diet and activity are key determinants. But 7% of deaths in the EU are caused by infectious diseases. And if we look at the wider burden of infectious diseases – including working days lost due to illness, treatment costs, disabilities caused – then their importance rises still further. Over the past few years, ECDC has done a lot of work to build up the EU-wide evidence base on infectious diseases. In doing this, we have found that social determinants play an important role in many of the epidemics we see in Europe.

My key message to you today is therefore that targeted interventions against infectious diseases is a cost effective way to reduce health inequalities.

Map of average life expectancy in the Netherlands

In the Netherlands, the country I know best, healthy life years vary by more than 7 years across different regions. There is a definite link here to social determinants. For example, take a look at the region of Utrecht here. In the very pleasant, affluent suburbs around Utrecht–life expectancy is among the highest in the Netherlands. If you look at inner city Utrecht – which has a range of social challenges – you see a rather low life expectancy.
I realise that we live in difficult times. The economic crisis is likely to have a negative impact on health inequalities, and I am afraid that in most countries it will also mean less money is available for public health.

So, the good news is that I will show you three examples where social determinants play a role, and where Member States could make a difference by cost-effective targeted actions.

**Three examples of social determinants of infectious diseases**

The three examples I will look at are:

1) Tuberculosis in vulnerable groups
2) Human papillomavirus (HPV) vaccination of at risk populations
3) Routine vaccination for measles in vulnerable groups

I will start with tuberculosis, which has long been called a disease of poverty.

### 1. Tuberculosis in vulnerable groups

1) Inequality gradient of tuberculosis in the EU

If you look to the right of the graph above you will see the richer countries. It is clear from this graph that the richer the country, the lower the TB prevalence rate. You can see that having a low level of national wealth correlates with a higher prevalence of TB.

But this is not the end of the story.
1) Inequality gradient of tuberculosis in the EU


If you take into account the TB cases that were foreign born in 2008, about a quarter of all reported TB cases in the EU were in people of foreign origin – notably Africa and Asia. As a matter of fact, the richer the EU country is the higher the proportion of foreign-born TB cases. So in these richer EU countries, interventions targeting TB among foreign-born populations will be an effective way both to reduce inequalities, and to further reduce TB.

2. Human papillomavirus (HPV) vaccination of at risk populations

2) Socio-economic indicators and cervical cancer


Cervical cancer rates are higher in less prosperous countries. The Human Development Index (HDI) is a comparative measure of life expectancy, literacy, education and standards of living for countries worldwide. In countries with lower HDI indexes, cervical cancer is higher than in richer countries. Women in the low HDI countries are not only more at risk, they also benefit less from prevention measures, as you can observe in the next graph.
HPV vaccination programs, against viruses that cause cervical cancer, are not implemented in the countries with a low HDI - the red dots. Even if cervical cancer screening programmes exist in these countries, women in socially vulnerable groups are less likely to access them. As a result, cervical cancer rates are higher in these groups. Implementing HPV vaccination programs in the countries with a low HDI, and then specifically targeting vulnerable groups, would reduce health inequalities.

3. Routine vaccination for measles in vulnerable groups

3) Epidemiological curve of measles outbreak, 2009-2010

The last example I will show is an outbreak in measles in an EU country. We are seeing more and more such outbreaks across the EU. Measles is a serious disease. About 30% of people who get it will need to be hospitalised. Some of these will suffer brain damage or long term sensory impairment: a few will die. Vaccine coverage against measles is too low across all sections of the population in many EU countries. But it tends to be particularly low in some poorer, and more marginalised populations.
Increasing vaccine coverage will bring health benefits to the whole of society. If we can achieve 95% vaccine coverage across the EU, we can eliminate measles. Efforts aimed at marginalised groups with low vaccine coverage are needed to achieve this. These efforts will also reduce health inequalities.

**Conclusion**
Madame President, to conclude: all of these interventions against infectious diseases – and many more – can reduce health inequalities. If any ministers are interested in pursuing these ideas, ECDC can offer knowledge, evidence and technical support to help them implement cost effective interventions.

**Summary**
Current financial crisis: call to action since health inequality is likely to worsen
Europe can really make a difference
1. Address underlying economic, social and environmental determinants of vulnerability to infectious diseases
2. Strengthen childhood vaccination programmes for vulnerable groups
3. Target prevention of serious respiratory infection in children (including housing quality, exposure to tobacco smoke)
4. Targeting of all vulnerable groups in relation to other relevant diseases - HIV, hepatitis B and C.
ECDC can provide added value to Member States using evidence-based data on how to implement interventions