UNDERSTANDING THE DRIVERS OF HEALTH EQUITY: THE POWER OF POLITICAL PARTICIPATION

The WHO European Health Equity Status Report initiative
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Aaron Reeves and Johanna Hanefeld
ABSTRACT

The WHO European Health Equity Status Report, *Healthy, prosperous lives for all*, reveals the policy conditions responsible for the health gap in the WHO European Region. Underlying exactly how these policies impact differently on the health and well-being of women and men across social strata are governance systems and means by which the public is brought into decision-making that affects their lives and livelihoods. This policy brief presents evidence showing that political participation, representation, accountability and transparency are important preconditions for health equity. The theory of change underpinning the analysis is that: (i) inclusive political institutions give participatory space and weight to the voices of people whose lives are most deeply affected by health inequities, and thus more control in policy-making and implementation processes; and (ii) robust civil society organizations and press freedom lead to greater accountability and transparency in the political process.

Keywords

HEALTH INEQUITY
SOCIAL DETERMINANTS
POLITICAL PARTICIPATION
DRIVERS OF HEALTH EQUITY
## CONTENTS

- Acknowledgments vi
- Abbreviations vii
- Executive summary viii
- Introduction 1
- Participation and empowerment 3
  - Gender equity is good for everyone 3
  - Civil society and local government 6
- Accountability and transparency 9
  - Democracy and PR 9
  - Freedom of the press 12
- Putting it all together 14
- References 16
ACKNOWLEDGMENTS

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This report was developed as part of the WHO European Health Equity Status Report initiative (HESRI). The work is led by the WHO Venice Office and aims to bring forward innovations in methods, solutions and partnerships to accelerate progress for healthy prosperous lives for all in the WHO European Region.
# ABBREVIATIONS

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tr>
<td>CI</td>
<td>confidence interval</td>
</tr>
<tr>
<td>CSOs</td>
<td>civil society organizations</td>
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<tr>
<td>DALY</td>
<td>disability-adjusted life-year</td>
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<td>GDP</td>
<td>gross domestic product</td>
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<tr>
<td>HESRi</td>
<td>(WHO) European Health Equity Status Report initiative</td>
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<tr>
<td>PPP</td>
<td>purchasing power parity</td>
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<tr>
<td>PR</td>
<td>proportional representation</td>
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<td>SDGs</td>
<td>(United Nations) Sustainable Development Goals</td>
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EXECUTIVE SUMMARY

The WHO European Health Equity Status Report *Healthy, prosperous lives for all*, published in 2019, reveals the main policy conditions responsible for the health gap in the WHO European Region. Underlying exactly how these policies impact differently on the health and well-being of women and men across social strata are governance systems and means by which the public is brought into decision-making that affects their lives and livelihoods. This policy brief presents evidence showing that political participation, representation, accountability and transparency are important preconditions to achieving health equity, drawing on data from the Health Equity Status Report, the Varieties of Democracy dataset and the Quality of Government dataset.

The theory of change underpinning the analysis is that: (i) inclusive political institutions give participatory space and weight to the voices of people whose lives are most deeply affected by health inequities, and thus more control in the policy-making process and in implementing policies; and (ii) robust civil society organizations and press freedom lead to greater accountability and transparency in the political process. In some parts of the analysis, regional income differences are used as a proxy for socioeconomic inequalities as this was the most widely available indicator across the WHO European Region. Most comparisons were between men and women or between the top and bottom income quintiles by region\(^1\) (the richest and poorest groups in society).

The analysis identified the following as the main drivers of health equity.

**Local government:** this driver is closely correlated with health equity. The difference in life expectancy between the richest and poorest parts of a country are significantly reduced (by approximately two years) in societies with strong local government and where local government representatives are elected by local citizens (and are therefore more likely to listen to and respond to their concerns) compared with societies where this is not the case.

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\(^1\) That is, the upper and lower 20% of the population.
**Civil society organizations (CSOs):** the evidence showed that the gap in life expectancy between the richest and poorest parts of the country is likely to be smaller in societies where robust CSOs are encouraged to participate in the policy-making process.

**Deliberative democracy:** the degree of deliberative democracy (whether a real discussion takes place that can genuinely impact on the policy-making process) was found to be correlated with health equity – the greater the degree of deliberative democracy, the lower the differences in life expectancy between the richest and poorest people in society.

**Proportional representation (PR):** the analysis found that countries with PR-based electoral systems had smaller differences in life expectancy between the richest and poorest parts compared with countries with other systems of determining political representation (such as first past the post) through making representation and giving a voice to minority and potentially marginalized groups more likely.

**Press freedom:** freedom of the press strengthens political accountability and transparency. A press that is free to uncover and criticize the actions of government is more likely to help citizens to hold governments to account. The gap in life expectancy between the richest and poorest people in society was found to be lower in countries with a low level of government censorship of the press, and lower yet where media corruption is low.

**Gender equity in politics:** a more surprising association was also found with gender equity in politics. In countries with greater representation of women and greater gender equity in politics, men’s health appears to improve, becoming more similar to the level of women’s health (which generally is better). Similar results were found using two measures: life expectancy, and disability-adjusted life-years (DALYs) owing to unsafe sanitation and air pollution. As well as being generally beneficial for women, gender equity also benefits male health.

Of course, many of these drivers will correlate; for example, greater freedom of the press and deliberative democracy are likely to go hand in hand. Each driver nevertheless had an independent association with health inequity, as measured by the difference in life expectancy between the top and bottom income quintiles.
Gender equality and the equal rights of women have been enshrined in law, including the Universal Declaration of Human Rights, and are essential to fostering freedom and security, the hallmarks of sustainable development. The findings in this report indicate that these forms of decision-making are normatively desirable, and that moving towards more inclusive political and consultative processes that give a greater voice to people traditionally marginalized or excluded by political systems could reduce health inequity.
INTRODUCTION

Over the last two decades, progress towards achieving health equity has been slower than expected, especially in the WHO European Region, despite the Region’s unprecedented level of commitment to addressing health inequities. Health inequities have even widened in some countries of the Region over this period. One of the great disappointments in the public health arena is that health inequities persist in high-income countries despite substantial improvement in living standards, the persistence of welfare states and concerted government efforts to reduce such disparities (1,2). This does not mean, however, that the persistence of health inequities is rooted in a lack of political will within the health community; nor does it imply that the evidence base is inadequate. The pathways to achieving health equity are well known and many political leaders acknowledge that the lottery of birth should not determine how long people live. Indeed, the commitment to reduce health inequities has been enshrined in the United Nations Sustainable Development Goals (SDGs): SDG 3 commits countries to ensuring healthy lives for all, while SDG 10 calls on signatories to reduce inequalities, including in health.

It nevertheless has been difficult for politicians to drive policy changes that would accelerate progress towards health equity. This is not a new problem: it has always been difficult to incorporate evidence into policy, particularly when it concerns public health (3,4). A large and well established body of evidence exists on cost-effective interventions that, if implemented, could avert premature deaths and reduce the disease burden, thus potentially reducing health inequities (5,6). So why, for example, are fewer than 15% of people worldwide covered by effective tobacco taxation policies (7), and why do countries lack bans on trans-fats (8)? Even where progress has been made, policies are sometimes reversed or implemented ineffectively, as with the Austrian smoking ban – although here the ban is being reinstated.

The WHO Health Equity Status Report initiative (HESRi) aims to identify the policy conditions responsible for the health gap in the Region and draws attention to the fact that public health is about policy, power and how the public are brought into decision-making (9–11). The document, Healthy, prosperous lives for all: the European Health Equity Status Report (12) therefore discusses a number of underlying drivers of progress towards ensuring healthy lives for
all related to social and political participation, empowerment, accountability and transparency. The direction and force of these drivers of health equity, however, do not always enhance health. For example, the participation of tobacco companies in policy discussions may actively undermine public health goals. Whether the drivers of health equity actually produce healthy lives for all depends on political institutions, that is, the rules governing who has voice in decision-making processes and thereby influences the “receptiveness of governments to different policy initiatives and the sustainability of different policies” (9). The drivers unavoidably are political in nature because they are focused on who has power and how policy is made.

This policy brief combines data from the HESRi Health Equity Dataset with other measures of political institutions that capture aspects of social participation, accountability and empowerment, such as the Varieties of Democracy dataset and the Quality of Government dataset. By combining these data, an assessment can be made of whether ensuring “responsive, inclusive, participatory and representative decision-making at all levels” (SDG target 16.7) of society contributes toward achieving progress in health equity. This approach recognizes that although health inequities are pervasive and durable, the extent of these inequities is not uniform across countries (13,14). This study therefore explored whether the political drivers of health equity could explain some of the cross-country variations in health inequities observed over time (15) and which are the most important. In some parts of the analysis, regional income differences are used as a proxy for socioeconomic inequalities as this was the most widely available indicator across the WHO European Region. Most comparisons were between men and women or between the top and bottom income quintiles by region (the richest and poorest groups in society).

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2 That is, the upper and lower 20% of the population.
Social (or political) participation occurs when people are able to be involved in and influence decisions that affect their lives, including their health (16). Participation in decision-making has important consequences for health outcomes because those who have power are under no obligation to heed the viewpoints of those who do not or cannot make their voices heard, even in democracies (17). When people vote, politicians listen (18). Whenever people write letters, strike, donate or lobby, politicians pay attention (4,19).

The problem, however, is that sometimes political institutions and other governance mechanisms can exclude those with the greatest health disadvantages from participating (10). This is because political institutions shape who has the right to speak and the conditions under which their voices are heard (20). Policy decisions may even influence whether communities and individuals are capable of participating in the political process. Social participation goes beyond mere involvement: it is not just a type of communication or a form of consultation (16). Genuine social participation necessarily involves the capacity to influence the outcome of decision-making processes. This analysis found evidence that the size of some measures of health inequity across countries may be attributable to the rules governing who has voice in decision-making processes.

**Gender equity is good for everyone**

The study began with an analysis of measures that empower women and foster equal participation between the sexes. Countries that have created greater gender equity were compared with those that have not, focusing particularly on gender equity in political terms. For example, countries have a higher degree of political equity when: (i) they have instituted fundamental civil liberties for women; (ii) women can and do participate in CSOs; and (iii) women hold formal political positions, such as having a seat in a national parliament.

In some respects, women have better health than men, but there are dimensions in which women are worse off. Women are more likely to be the victims of domestic abuse, are more likely to report
longstanding limiting conditions and experience worse self-rated health. One area where men experience a higher disease burden (represented by DALYs) is due to unsafe sanitation and air pollution (Fig. 1). Analysis of the HESRi Health Equity Dataset showed that men lost 1715.22 DALYs (age-standardized rate per 100,000 population) owing to air pollution while women lost only 894.45 DALYs (age-standardized rate per 100,000 population). The gender gap was far smaller for DALYs lost owing to unsafe sanitation, but men still had a higher disease burden. The size of the gap varied considerably across countries, however: in some countries it was very wide, while in others it was almost zero.

Crucially, the cross-country variation correlates with the degree of gender equity (21). In countries where women had more involvement in parliament and CSOs, the level of gender inequity in DALYs caused by unsafe sanitation and air pollution was lower. The reason for this is not that women experienced poorer health, but rather that men’s health had improved – the differences had levelled up.

**Fig. 1.** Difference in the number of DALYs lost to unsafe sanitation and air pollution between men and women across 48 countries of the WHO European Region

Notes: solid line: regression estimate of the difference in DALYs lost between men and women; dashed lines: 95% confidence interval (CI). The source for the degree of gender equality in politics was the Varieties of Democracy project dataset, in which data were collected through survey questions directed to country experts (21).

Similar associations were found for other measures of health inequity, including differences in disease burden and life expectancy between men and women. Women usually live longer than men
but, again, the size of the gap varies across countries. The gap in life expectancy also correlated with the degree of political equity between men and women. That is, when women had more political empowerment, both men and women were found to live longer, but the benefit was greater for men.

A deeper analysis of the data showed that one possible driver of this association is the proportion of women holding formal political positions (with a parliamentary seat (Fig. 2)) (22). This association is far from being deterministic – there is, for example, a number of countries where health inequity between men and women is low but which have not achieved high levels of gender equality. It nevertheless is striking that no countries with a large proportion of women in parliament had a high level of gender inequity in health, even after accounting for gross domestic product (GDP) per capita and the political regime.

**Fig. 2.** Difference in life expectancy between women and men against the proportion of parliamentary seats held by women across 51 countries of the WHO European Region

![Graph showing the relationship between life expectancy and the proportion of parliamentary seats held by women](image)

*Note: the source for the proportion of national parliamentary seats held by women was the Quality of Government dataset (22).*

This relationship was then modelled more formally by exploring whether, after accounting for GDP per capita and time, increases in the proportion of women in parliament is associated with female life expectancy, male life expectancy and the difference between them (Table 1). Once again, life expectancy for both men and women is higher in countries that have more female politicians, with some
suggestion that women’s health does not benefit more than men’s health. In other words, gender equality benefits women, but it also benefits men.

Table 1. Increase in the proportion of women in parliament improves life expectancy for both men and women

<table>
<thead>
<tr>
<th>Covariates</th>
<th>Female life expectancy at birth (logged)</th>
<th>Male life expectancy at birth (logged)</th>
<th>Difference between male and female life expectancy at birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>10-unit increase in the degree of gender equality</td>
<td>0.00049** (0.00013)</td>
<td>0.00071** (0.00019)</td>
<td>−0.00022* (0.000092)</td>
</tr>
<tr>
<td>$100 increase in GDP per capita, PPP (constant 2011 international $)</td>
<td>0.00018** (0.000032)</td>
<td>0.00027** (0.000043)</td>
<td>−0.000090** (0.000019)</td>
</tr>
<tr>
<td>Constant</td>
<td>4.30** (0.0069)</td>
<td>4.18** (0.0098)</td>
<td>0.12** (0.0044)</td>
</tr>
</tbody>
</table>

Observations | 926 | 926 | 926
R²           | 0.80 | 0.79 | 0.54

PPP: purchasing power parity.
* p < 0.05; ** p < 0.01 (estimated using a linear regression model).
Note: standard errors are in parentheses and are clustered at country level. The model also adjusts for time.

Civil society and local government

Empowering communities is achieved not only through including previously excluded groups, but also by creating governance structures that give people power in decision-making processes (16). This can be achieved in two ways: (i) by governments working directly with CSOs and communities to create and implement policy; and (ii) by ensuring that local governments are elected and given meaningful decision-making powers rather than being governed by leaders who are appointed by a higher-level body.

Governance structures are underpinned by political institutions that determine how governments and other social organizations interact, how they relate to citizens and how decisions are made (16). CSOs are crucial vectors through which the needs and concerns
of citizens are communicated to government. They can also highlight certain issues and ensure people’s rights are recognized and upheld. As social participation costs time and money, CSOs have an important role in enabling the views of citizens to be represented even when they do not have the capability to be directly involved in every decision-making process. CSOs and other forms of social participation, however, can only work when space has been created for discussion. Venues for political participation that have been created through both formal and informal mechanisms can ensure CSOs and other stakeholders are able to inform policy.

Of course, even when participatory spaces have been created, there is no guarantee that decision-makers will listen. This is especially true at local level, where social participation is most likely, rather than at national level (because of the challenges in reaching time-strapped civil servants and politicians). Local politicians appointed by a higher-level body nevertheless are far less likely to listen to the needs and concerns of people in their community. If elected politicians have no power, high levels of social participation will have little influence on decision-making. In short, if social participation is a driver of health equity, countries with active CSOs and genuinely responsive local government might be expected to have smaller health inequities than those lacking these forms of social participation.

The analysis confirmed these expectations (Fig. 3). The gap in life expectancy between the richest and poorest parts of the country was smaller in countries with more robust and genuinely participatory CSOs ($\beta = -0.44$, 95% CI: $-0.12 - -0.75$, $p = 0.007$) and in countries where local governments have real decision-making powers and are elected by local citizens ($\beta = -1.97$, 95% CI: $-1.47 - -2.46$, $p < 0.001$), although the association with civil society participation was smaller.
Fig. 3. Difference in life expectancy between the richest and poorest population groups according to the strength of civil society participation and elected local governments across 34 countries of the WHO European Region

Note: the source of measures of civil society participation and elected local government was the Varieties of Democracy project, in which data were collected through survey questions directed to country experts (21). Fewer countries are included in this analysis because of missing data on the health variables.
ACCOUNTABILITY AND TRANSPARENCY

Accountability has a central role in ensuring progress towards health equity because it establishes who is responsible for identifying and removing barriers to health equity. Accountability is created when institutions make the people with these responsibilities answerable to those affected by their decisions. Transparency is a crucial dimension of accountability because information is necessary to determine whether the responsible people are actually carrying out their duties.

Democracy and PR

The type of electoral system in place can influence the degree of accountability (23). For example, democracies establish processes and mechanisms through which politicians become answerable to their citizens. Democratic institutions primarily are concerned with translating the interests of individuals and groups into policies to ensure citizens can fulfil their conception of a good life. As Sen famously argued, “no famine has ever taken place in the history of the world in a functioning democracy” because democratic governments “have to win elections and face public criticism, and have strong incentive to undertake measures to avert famines and other catastrophes” (24). Similarly, in his 1848 report on a typhus epidemic in Silesia, the pathologist Rudolf Virchow called for “full and unlimited democracy” to stop others from “silently [dying] of starvation” (9).

Where political institutions systematically exclude some groups from decision-making, the health of the excluded groups is likely to suffer because their concerns may be overlooked. This can happen even when those in power might be sympathetic to the policy preferences of underrepresented groups. Put simply, political institutions influence who has a voice, and this may affect health: inclusive political institutions can incentivize politicians to implement universal health coverage, expand social protection or allow the least well-off to capture a greater share of economic growth, all of which could improve well-being.

Across the WHO European Region, inequalities in life expectancy between the richest and poorest parts of a country were lower in
contexts that had established deliberative democracies (that is, had put in place processes that respect public reasoning focused on the common good) than in those with less deliberative democracies (Fig. 4) (21). Of course, democracy can be measured in multiple ways and similar results are found even when using an alternative measure of democracy taken from the World Bank Political Indicators. In countries with robust democracies, the gap in life expectancy at birth between rich and poor regions was 2.86 years less than in autocracies (adjusted for GDP per capita and whether the country was formerly part of the Soviet Union).

Democracies are not uniform and can be organized in quite different ways, leading to more or less accountability to marginalized groups. A primary distinction is between majoritarian and PR systems. Majoritarian electoral systems give political power for a given period of time to the party with the most votes. Although there are differences, majoritarian and plurality voting (which encompasses first-past-the-post systems) are often examined together because each grants power to the politicians with the most votes and thereby minimizes the influence of citizens who voted for the other candidates. In contrast, the proportion of parliamentary seats in PR systems equals the proportion of the vote, meaning a political party that wins 30% of the votes gets 30% of the parliamentary seats. Small parties and minority groups have more influence in the PR system because their politicians get into parliament, whereas in majoritarian electoral systems they can easily be blocked. As an example, in one country with a first-past-the-post system, a political party that won 12.6% of the vote gained only 0.2% of the parliamentary seats.

Differences between political systems are a concern for political scientists and can also affect economic and social outcomes. Compared with majoritarian electoral systems, PR–based systems tend to implement policies that reduce economic inequity, raise levels of satisfaction with the democracy and increase the turn-out rate at elections and other democratic events. These differences occur because the political coalitions forged in majoritarian electoral systems tend to be quite different from those in PR–based electoral systems. In PR–based systems, parties become far more concerned about the interests of less-affluent people in their societies and their decisive voters tend to be poorer than those in majoritarian systems. In other words, electoral systems shift the processes and mechanisms of accountability.
A comparison between countries with PR–based systems and those with other types of electoral systems showed that the level of inequity in life expectancy between the richest and poorest parts of a country was smaller in those with a PR electoral system (Fig. 5). This result suggests that creating electoral accountability through the system of democracy could be an important driver of health equity.

Interestingly, although the degree and type of democracy (PR–based versus other electoral systems) influenced the degree of inequity in life expectancy, no association was found between inequity in self-rated health and income quintile. Although the type of electoral system does not seem to be associated with all forms of health inequity, greater democracy does seem to lead to longer lives, especially for the poorest.
Fig. 5. Difference in life expectancy between the richest and poorest population groups according to the presence or absence of a PR-based electoral system across 34 countries of the WHO European Region

Note: data on the type of electoral system (PR or not) were collected in the Quality of Government dataset (22). Fewer countries are included in this analysis because of missing data on the health variables.

Freedom of the press

Another determining factor of accountability and transparency is the degree of press freedom. In some countries, the government tries to influence the press, thus changing how the decisions and actions of politicians are represented in the media. This may be achieved either directly (through formal threats, for instance) or indirectly (such as through withdrawing financial support). In both cases, the press is hindered from performing one of its most important functions: to uncover and report on the actions of governments.

Of course, governments are not the only powerful actors that attempt to influence press coverage. Large corporations and, in some contexts, religions may also attempt to alter how their organizations are discussed by the media. Wider health inequities might be expected in countries where freedom of the press is threatened or where the media is willing to accept bribes to change their news coverage: citizens will be far less well informed about the actions of government (and other actors) and may not have the necessary information to hold politicians to account for their decisions.
Two measures were used to examine whether the degree of press freedom is associated with health inequity: (i) a specific measure of whether the government tries to influence media coverage (Fig. 6a); and (ii) a more general measure of the degree of media corruption (Fig. 6b).

Both analyses found that regional inequity in life expectancy was lower in countries with a greater level of press freedom, especially when using the measure of media corruption (Fig. 6b).

**Fig. 6a.** Difference in life expectancy between the richest and poorest population groups according to the degree of press freedom across 34 countries of the WHO European Region: government censorship effort

**Fig. 6b.** Difference in life expectancy between the richest and poorest population groups according to the degree of press freedom across 34 countries of the WHO European Region: media corruption

Notes: the degree of government censorship (Fig. 6a) and degree of media corruption (Fig. 6b) are composite measures for the degree of press freedom constructed from the responses given by country experts to a panel of survey questions collected in the Varieties of Democracy project (21). Fewer countries are included in this analysis because of missing data on the health variables. The results in these graphs are modelled estimates taken from a multilevel regression model with random intercepts which adjusts for GDP and whether a country was formally a communist regime or not.
PUTTING IT ALL TOGETHER

Many of the measures of political institutions are likely to correlate. For example, countries with a more deliberative democracy are also likely to have greater press freedom. An implication of this is that the association between press freedom and health inequity may result from differences in democracy and not from factors related to the press at all.

To address this possibility, a final model was used. The model incorporated the following measures of political institutions: freedom of the press, whether a country is a democracy, the effectiveness and autonomy of local government, whether a country has a PR-based electoral system and the proportion of women in parliament, along with measures of whether a country was a post-communist country and the level of economic development (GDP per capita, adjusted for purchasing power parity) (Fig. 7).

Fig. 7. Effect of political institutions on the difference in life expectancy in the richest and poorest population groups across 34 countries of the WHO European Region

PPP: purchasing power parity.
Notes: an increase of one unit in the independent variables of these models represents two standard deviations for each specific measure. This created a comparable metric across binary and continuous variables and allowed comparison of the size of the associations between these various measures. Fewer countries are included in this analysis because of missing data on the health variables. The political institutions data used in this analysis come from the Varieties of Democracy project (21) and the Quality of Government dataset (22).
Combining all of these measures gave the same results: after accounting for all of the other variables, democracies still had smaller regional inequities in life expectancy compared with autocracies. The type of democracy was also important, however. Countries with effective, autonomous local governments and those with PR-based electoral systems had lower regional inequity in life expectancy than the others. In addition, those with more female members of parliament had lower regional inequity in life expectancy. The only caveat is that while freedom of the press still negatively correlated with lower inequity in life expectancy by income, the 95% CI of this estimate slightly overlapped with zero. The overall result, however, was consistent: political institutions that empower communities and create accountability reduce the inequity in life expectancy.

For further details of the methodology, please contact the authors, Aaron Reeves (aaron.reeves@spi.ox.ac.uk) and Johanna Hanefeld (jhanefeld@gmail.com).


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3 All weblinks were accessed on 8 September 2020.


The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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