Central Denmark Region

Health for People in Vulnerable Situations

# New Approaches to Tackle Health and Inequality in the EU Social Pillar

DEFACTUM

# A Turning Point for Principle 16

The European Pillar of Social Rights (EPSR) sets out the European Union's vision for a fair and inclusive social model. Its Principle 16 establishes that everyone has the right to timely access to affordable, preventive, and curative healthcare of good quality. As the European Commission prepares a new Action Plan to strengthen the implementation of this principle, the European Health Forum Gastein (EHFG) 2025 session 'Health for People in Vulnerable Situations – New Approaches to Tackle Health and Inequality in the EU Social Pillar' provided a platform for dialogue between policymakers, researchers, and practitioners.

The session, organised by Aarhus University, DEFACTUM (Central Denmark Region), and EuroHealthNet, aimed to develop recommendations for the upcoming Action Plan by the European Commisison. Using an interactive 1-4-All format, participants identified priority actions to better capture and address the lived realities of social vulnerability in health systems across Europe.

# 1 The European Social Pillar and Principle 16

The European Pillar of Social Rights serves as the EU's overarching framework for fairness, social cohesion, and inclusion. Its 20 principles span equal opportunities, fair working conditions, and social protection. Principle 16 focuses specifically on health, underscoring that equitable access to healthcare is not merely a service issue but a fundamental social right.

Effective implementation must also recognise the intersectional nature of vulnerability; how overlapping factors such as gender, age, disability, ethnicity, and socioeconomic position compound disadvantage and shape access to care.

Implementing Principle 16 effectively requires connecting healthcare policy with the broader social determinants of health. This includes housing, education, employment, and environmental conditions that shape people's ability to lead healthy lives. The session highlighted that EU monitoring mechanisms such as the Social Scoreboard could be enhanced through complementary indicators that better capture multidimensional vulnerability and inequality.

# 2 Evidence and Policy Context: Insights from EuroHealthNet and CHAIN

The session opened with an introduction to the EuroHealthNet–CHAIN 2025 report 'Social Inequalities in Health in the EU'. The report documents persistent and, in some countries, widening health inequalities across Europe. It shows that people with lower incomes or educational levels face shorter life expectancy and more years in poor health. Mental health disparities mirror these patterns, with a strong social gradient evident across all Member States.

The report identifies structural drivers such as poverty, discrimination, and unequal access to housing, employment, and education. It calls for a whole-of-government approach, integrating proportionate universalism and long-term investment in public health and prevention. These insights provided a strong evidence base for the session's discussion on how Principle 16 can be implemented to achieve tangible results.

# 3 Session Highlights and Stakeholder Insights

## 3.1 Panel Contributions

Professor Thomas Maribo (Aarhus University / DEFACTUM) presented the Social Vulnerability Index, a tool capturing dimensions such as functional ability, education, social relations, and housing. He emphasised that vulnerability is dynamic, not a fixed label, and that policy responses must use data to enable inclusion rather than reinforce stigma.

Dr. Kristine Sørensen (Global Health Literacy Academy) stressed the central role of health literacy in enabling people to exercise their right to health, making health literacy a human rights concern. She recommended that the European Social Scoreboard integrate health-literacy indicators to monitor progress.

Freek Spinnewijn (Nobody Left Outside Network) reminded the audience that many marginalised communities, such as migrants and homeless people, remain invisible in national statistics, and a focus on persons in vulnerable situation shouldn't be on the expense of marginalised groups. He called for direct EU funding and participatory mechanisms that empower NGOs and community organisations.

Christina Modoran (DG SANTE) noted that the forthcoming Action Plan will link Principle 16 more closely to other social rights, recognising that health equity depends on coordinated policies across sectors. She invited regional actors to share good practices and data to support implementation.

Caroline Costongs (EuroHealthNet) concluded that this is a pivotal moment to rebuild the social contract around health equity, aligning EU funds such as ESF+, Cohesion Policy, and EU4Health behind integrated models for health and social services.

## 3.2 Participant and Slido Feedback

### 3.2.1 Question one: What measures can be taken to address social vulnerability in health systems?

The first discussion question invited participants to reflect on how health systems can better identify and respond to people in socially vulnerable situations.
Across small-group discussions and Slido feedback, three broad themes emerged: **integration, proximity, and mindset**.

**Integration** meant breaking silos between health, social, housing, and employment services. Participants described how fragmented governance and short-term projects leave people moving between disconnected systems. They called for stronger coordination mechanisms, shared data, and joint funding streams between ministries and local authorities. Health systems should be designed to meet people where they are rather than expecting citizens to navigate institutional boundaries.

**Proximity** referred to the role of frontline professionals and community actors. Nurses, social workers, and general practitioners were seen as crucial in recognising vulnerability early and providing continuity of care. However, participants stressed that these roles require dedicated training, time, and recognition within health budgets. Partnerships with community health workers, NGOs, and local volunteers were cited as effective ways to bridge

gaps and build trust, but such partnerships must be fairly funded and not rely on unpaid labour.

Participants also underlined that vulnerability is rarely singular. People's health experiences are shaped by **intersecting identities,** such as gender, disability, ethnicity, sexual orientation, and migration background, which influence both exposure to risk and access to support. Recognising these intersections is essential to designing effective and equitable interventions under Principle 16.

Finally, participants emphasised a **mindset shift**. Social vulnerability should be understood as a *shared condition*, not a deficit of particular groups. This means changing the framing of vulnerability from "who they are" to "what systems do." Trust, empathy, and culturally sensitive communication were identified as key enablers of access. Several groups proposed national or regional campaigns to normalise help-seeking and highlight stories of inclusive care.

### 3.2.2 Question 2: What specific actions should be included in the EU Social Pillar Action Plan to effectively implement Principle 16 on the right to affordable and quality health care?

The second question focused on what DG SANTE and the European Commission should prioritise in the forthcoming Action Plan under the European Pillar of Social Rights. While the themes overlapped with the first discussion, participants moved from system design to **EU-level governance and accountability**.

Participants agreed that the Action Plan should:

- **Move from pilots to permanence.** Many Member States depend on temporary EU projects to fund local inclusion work. The Action Plan should promote longer funding cycles and earmark cohesion or ESF+ resources for structural reforms.

- **Introduce clearer definitions of "persons in a vulnerable situation."** This would help Member States align data collection and facilitate comparison across the EU while maintaining a rights-based, non-stigmatising language.

- **Develop guidance and peer-learning tools** to help national and regional authorities implement proportionate universalism; universal policies with intensity matched to need.

- **Support capacity-building** in health and social professions, embedding vulnerability, intersectionality, and communication training in EU competence frameworks.

- **Ensure participation and accountability.** Civil-society organisations should have formal channels to monitor the Action Plan's progress, and local communities should be able to feedback on implementation.

Participants also proposed that the Commission promote an EU-wide **Social Vulnerability Index** as part of the implementation of Principle 16, complementing the existing Social Scoreboard with metrics that capture social, functional, and environmental factors affecting health.

The contributions from both panelists and the session participants paint a picture of a wish for a cohesive and coherent approach that integrates all actors in cross-sectoral approaches, where social vulnerability is not a problem of "others". The contributions from the participants through slido also indicate the strong need to go beyond short-term pilot projects towards long-term, structural funding that can engage, build trust, and strengthen integrated social health systems.

# 4 Key Recommendations for the Action Plan

1. Institutionalise an integrated approach linking Principle 16 implementation to housing, education, employment, and environment policies. This integration includes permanent funding-mechanisms and joint accountability across sectors.

2. Adopt a European Social Vulnerability Index as part of the implementation of Principle 16 to complement the Social Scoreboard with multidimensional indicators developed through participatory and rights-based consultation with Member States and civil society.

3. Invest in health literacy, co-creation and intersectional practices to ensure meaningful participation of communities in service design.

4. Secure long-term funding for NGOs, municipalities, and social workers as central partners in delivering equitable care.

5. Promote non-stigmatising, rights-based, and intersectional policy and data frameworks to ensure that monitoring systems capture overlapping forms of disadvantage and empower rather than label individuals.