Activities on health equity in Europe

Major challenges and best practice examples

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Knowledge Manager

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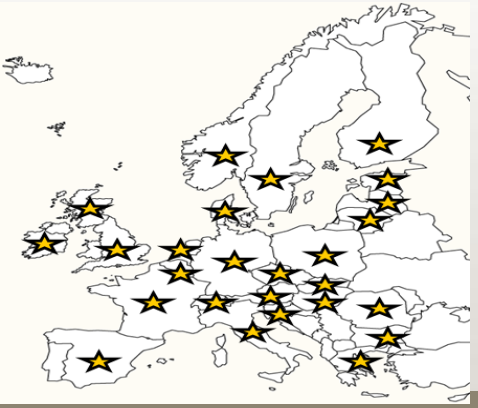
European Network of health promotion and disease prevention bodies

- 30 Members and 12 Partners in 26 Member States
- Reduction of health inequalities: focus/cross-cutting theme in all work
- Based in Brussels, 12 permanent staff
- Make the links between policy development at MS and EU level
- Coordinate or involved in a range of EU co-funded projects
- Develop a platform for action on social determinants of health
- Undertake and translate research into policy



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Activities of EuroHealthNet

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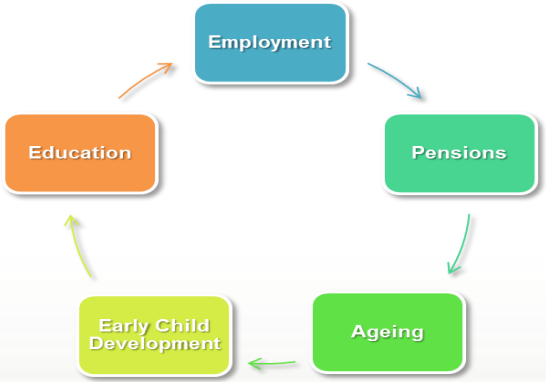
TOOLS • REGIONS • KNOWLEDGE • STAKEHOLDERS •

drivers
FOR HEALTH EQUITY

Crossing Bridges



Tackling the GRADIENT in health

SPREAD
Sustainable Lifestyles 2050

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Healthy Ageing

Report on Health Inequalities in the EU
(Tender n° EAHC/2010/Health/06)
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Equity Action (2011-2014)

Tools Health Impact Assessments
Health in All Policies

Regions
Case Studies
SF Review

Knowledge
Research &
Evidence

Stakeholders
Stakeholder engagement across sectors

Health inequalities situation in the EU (2011-2012)

Coordinated by UCL Institute of Health Equity

Report on Health Inequalities in the EU

(Tender n° EAHC/2010/Health/06)

- A critical review of recent literature on health inequalities in the EU
- A statistical analyses of:

  -Territorial inequalities;
  -Inequalities based on the social determinants of health
  -Interactions at individual level

- A report on EU level actions on Health Inequalities
- **A country-by-country assessment of policy responses to health inequalities**
- **Recommendations** on actions that should be taken at EU, national and sub-national levels

HAPI Health Action Partnership International

London Health Observatory

Durham University Wolfson Research Institute

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I. What can be done to reduce health inequalities – general approaches

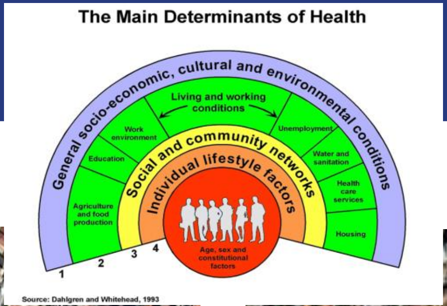
II. Overview of policy responses in EU MS to reduce HI

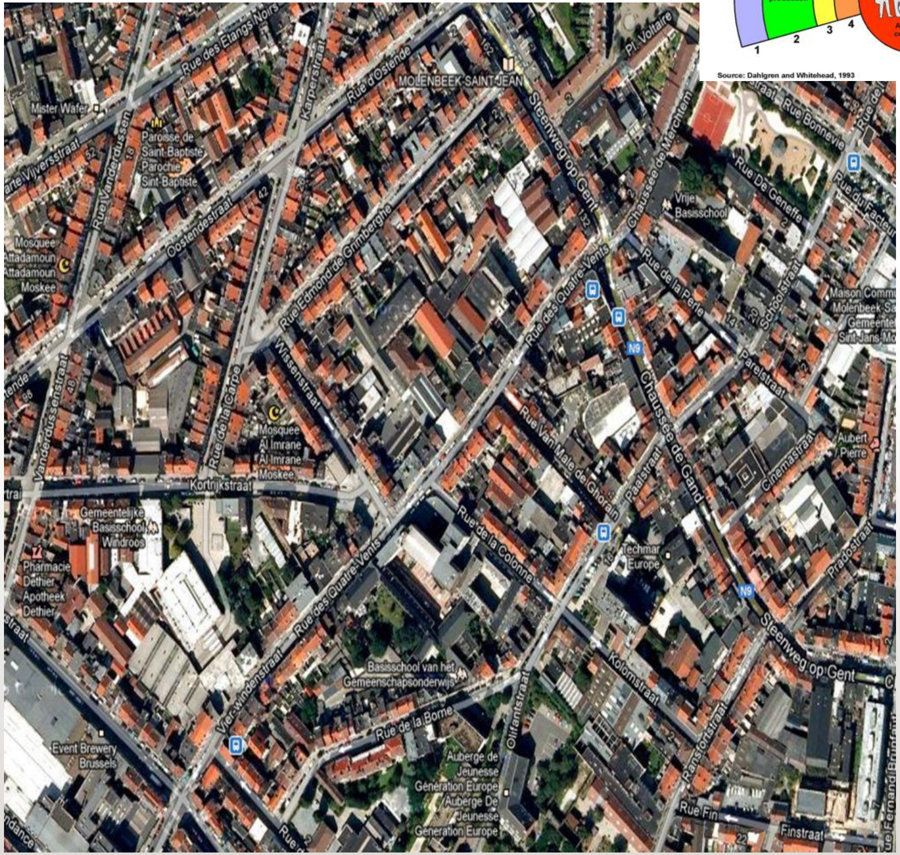
III. Good practice examples from some EU MS

IV. EU-level actions

V. Applying EU Structural Funds to reduce HI

I. General approaches


The Main Determinants of Health
General socio-economic, cultural and environmental conditions
Living and working conditions
Work environment
Education
Agriculture and food production
Unemployment
Water and sanitation
Health care services
Housing
Social and community networks
Individual lifestyle factors
Age, sex and constitutional factors
1
2
3
4
Source: Dahlgren and Whitehead, 1993


Rue des Etangs Noirs
Rue d'Ostende
MOLENBEEK SAINT-JEAN
Mister Wafer
Paroisse de Saint-Baptiste
Parochie Sint-Baptiste
Oostendestraat
Rue Edmond de Grimberghe
Karperstraat
Steenweg op Gent
Chaussée de Merchtem
Pl. Voltaire
Rue Bonnevie
Rue De Geneffe
Vrije Basisschool
Rue des Quatre-Vents
Rue de la Perle
Schoolstraat
Mosquee Attadamoun
Attadamoun Moskee
Wissenstraat
Rue de la Cape
Mosquee Al Imrane
Al Imrane Moskee
Kortrijkstraat
Rue Van Male de Ghorain
Chaussée de Gand
Parelstraat
Cinemastraat
Aubert Pierre
Gemeentelijke Basisschool Windroos
Pharmacie Dethier
Apotheek Dethier
Rue de la Colonne
Techmar Europe
Rue des Quatre-Vents
Vierwindenstraat
Basisschool van het Gemeenschapsonderwijs
Rue de la Borne
Olifantstraat
Kolomstraat
Steenweg op Gent
Ransfortstraat
Event Brewery Brussels
Auberge de Jeunesse Generation Europe
Rue Fin
Finstraat
N9

*“Heath is a universal aspiration and a basic human need. The **development of society**, rich or poor, **can be judged by the quality of its population’s health, how fairly health is distributed** across the social spectrum, and the degree of protection provided from disadvantage as a result of ill-health.”*

Michael Marmot, 2010

Some key messages on action to reduce HI

- Can not be achieved by the health sector alone: Requires a **comprehensive approach**, led/supported by executive level, to mobilize and coordinate work of all relevant sectors, applying relevant tools (joint progress reports, accountability for equity)
- Key role of the health sector **to create a strong case** for why improving equity is important for other government goals
- Requires **upstream action** (on **causes** of health inequalities) and **downstream action** (to address **consequences** of health inequalities)
- Calls for **universal measures** (education, health promotion) and **targeted measures** (ensure access & assistance to those who need it most)
- Calls for **long** and **short term approaches**

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Identify key entry points

With a view to the **life-course**, identify and focus on:

- **Key determinants that affect social position and health** (e.g. early childhood conditions, education outcomes)
- **Determinants of illness affected by social position** (e.g. income, long-term unemployment, physical environment, work environment)
- **Determinants generating unequal consequences of illness**

  (e.g. access to healthcare)

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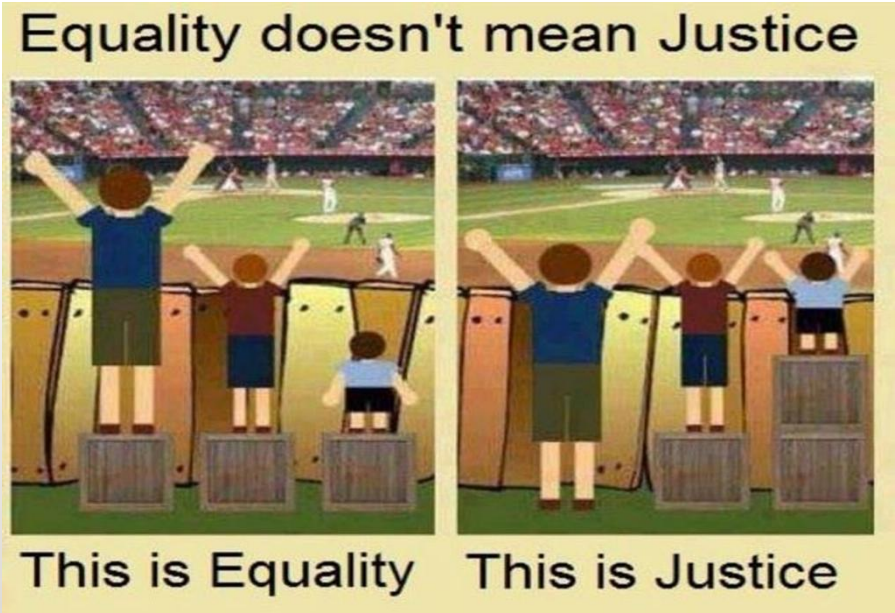
Take a step-wise approach

Ensure policy choices **do not make inequities worse**

Focus on addressing health consequences for the **most disadvantaged**

Reduce the gap between the most advantaged and the most disadvantaged

Seek to **flatten the gradient** across the whole population



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Ensure effective measures

- **Don’t assume what works on average, works for everyone** Different socioeconomic groups = different underlying mechanisms (It is **not** a matter of doing **more of the same** for disadvantaged groups)
- Rather than lack of knowledge, more important barriers for low income groups are **affordability, accessibility** and **practicality**
- Evidence suggests that **Fiscal policies** are most promising single intervention, but no type of intervention is **“equity proof”**
- **Involve local people and communities** as this improves the design and impact of policies for equity. Aim at an **assets based approach**

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Monitor!

Crucial:

- A **monitoring system** for health equity, and public reporting, that can drive political & public concern

- Can be comprehensive or simple: e.g. (*Fair society Healthy Lives,* 2010)
  - -life expectancy
  - -healthy life expectancy for men and women

  + three social determinants to capture the life course:
  - -early child development,
  - -people not in employment, education or training (NEET),
  - -an adult poverty measure

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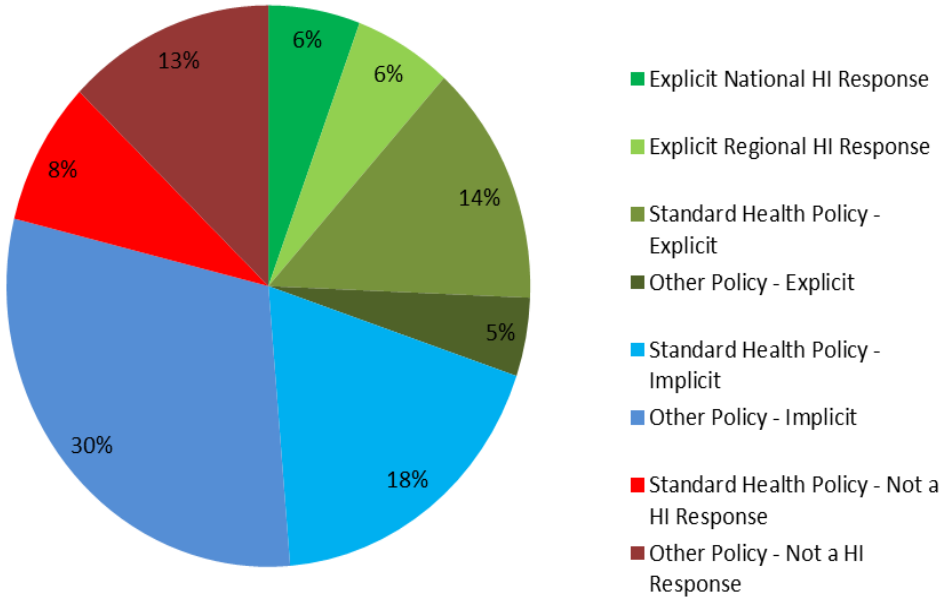
II. Overview of policy responses in EU MS to reduce HI

Country-by-country assessment of policy responses to HI

1. EuroHealthNet developed draft country profiles (key actors, key resources & policy docs) based on document analysis and extensive internet research
2. Called for information/validation: June - August 2011
3. Uploaded country profiles on www.health-inequalities.eu
4. Identified country experts (n=33)
5. Interviewed country experts, September, 2011
6. First analysis presented Nov 2011, mainly based on interviews.

Member State policy responses to HI (2011)

- The majority of policies in member states had no significant aims that explicitly referred to reducing health inequalities.
- Many included “implicit” action on the social determinants of health – in a way that would plausibly reduce health inequalities.
- **12% of policies were explicit national or regional HI responses.**
- **Only 14% of ‘standard health policies' had explicit aims to reduce HIs.**
- General focus on vulnerable groups; little attention to levelling up or proportionate universalism.
- Cross-sectoral co-operation with social affairs and employment, education, and environment.
- Many policies were not led by the health sector (‘other policies’). These included anti-poverty & social inclusion strategies, children/youth/ family policies, and cross-government programmes.



Source: Database of 274 Policies, with two-stage evaluation scheme. Supplementary information through interviews and expert feedback.

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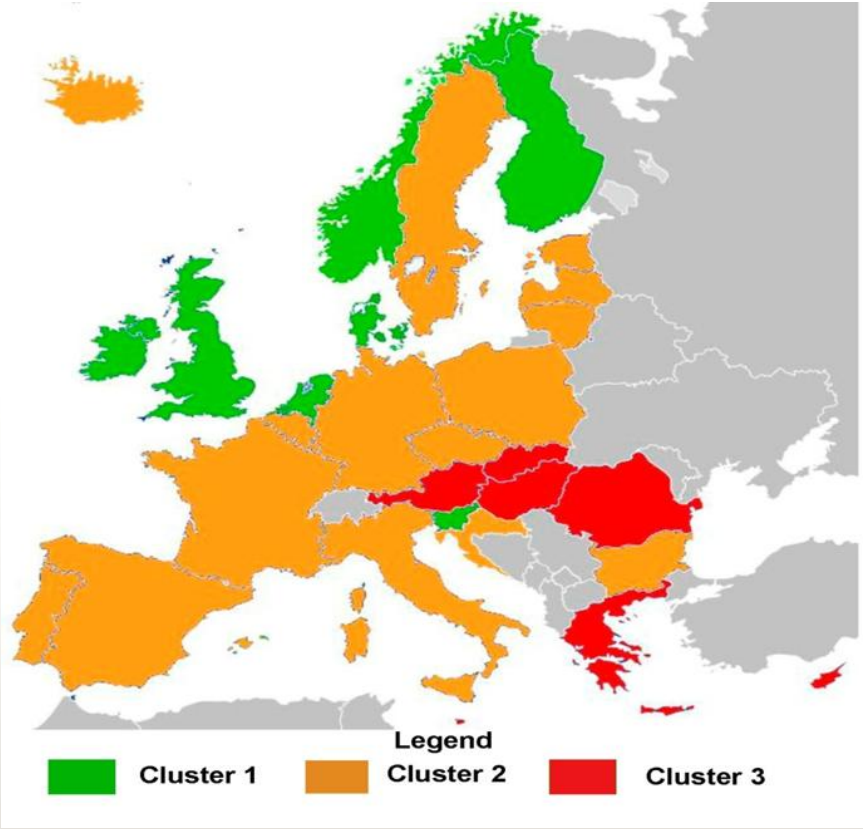
Country clusters by level of policy response



- **Cluster 1**: ***Relatively positive and active response to health inequalities*****.** At least one national response to HIs or comprehensive regional HI policy responses.

- **Cluster 2**: ***Variable response to health inequalities*****.** No explicit national policy on HIs, but at least one explicit regional response or a number of other policies with some focus on health inequalities.

- **Cluster 3**: ***Relatively undeveloped response to health inequalities*****.** No focused national or regional responses to health inequalities, no explicit health inequality reduction targets (though there may be targeted actions on the social determinants of health).

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Widening of policy response between member states since 2006

Level of policy response	Countries by Cluster Group
Intensification of policy response	Cluster 1: Denmark, Finland, Norway, United Kingdom* Cluster 2: Estonia, Latvia, Spain*, Iceland*
Same level of policy response	Cluster 2: Belgium, France, Germany, Italy, Poland, Sweden Cluster 3: Lithuania*
Decrease in intensity of the policy response	Cluster 1: Ireland, Netherlands Cluster 2: Czech Republic Cluster 3: Cyprus, Greece, Hungary

* Countries where on-going changes to policies (mentioned elsewhere within this report) may affect assessment.

Note: Some countries were not included in the analysis performed in 2006 and are therefore omitted from this table (Austria, Bulgaria, Croatia, Luxembourg, Malta, Portugal, Romania, Slovakia, and Slovenia).

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Member state policy responses: Headline messages

- **Different starting points and 'traditions' for tackling HIs**; variable political attention within countries over time. Aversion to the term 'inequalities' hampers action in some countries and in some political groups.
- **International action** (WHO, EU) is widely seen to have **galvanised action**.
- Perception among experts of a serious and large policy **implementation gap**.
- **Lack of data** (in some countries), limited analysis of existing data **and systematic monitoring** (in many other countries).
- Generalised **decentralisation** of responsibility for health to regional or local levels.
- The **economic and social crisis** has the potential to **exacerbate** existing health inequalities. However, it has concurrently reduced political attention that had been focused on the issue before the crisis, making action even more urgent.
- Widening of the policy response between countries since 2006 points towards a **potential entrenchment** of health inequalities across the European Union as a whole.

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III. Good practice examples from some EU MS

England

- Independent Inquiry into Inequalities in Health (**Acheson Report, 1998**)
- Reducing Health Inequalities, an action report (1999)

- ***Tackling Health Inequalities, A Programme for Action (2003-2010)***
  - Two overall targets: narrowing the gap in life expectancy and differences in infant mortality across social classes by 10%:
  - 12 headline indicators (targets for intermediate outcomes, linked to e.g. access to primary care, child poverty, education, diet, smoking)
  - 82 Departmental Commitments (specific actions, e.g. poverty reduction efforts, Sure Start scheme, many of which targeted deprived areas, low SES groups)
- **But: targets not achieved:**
  - Right entry points?
  - Effective polices (evidence-based)?
  - Scale?

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England (2)

- **2010: *Fair Society, Healthy Lives*** (Marmot Review)
- Change of government (Conservative/Lib-Dem), **health system reform**, **Councils responsible for health**. New organisation, Public Health England, established to provide support
- **Health and Well Being Boards** at Council level
- Many **opportunities, but** coincided with **austerity** measures
- **Extensive monitoring** systems, allowing for regional comparisons
- 2 year after Marmot Review: slight improvements in relation to some key indicators, but health inequalities persist

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Scotland

- **National Performance Framework** – five strategic objectives:
  Wealthier and Fairer; Smarter; Healthier; Safer and Stronger; Greener
  + 16 national outcomes including **'to have tackled the significant inequalities** in Scottish Society', including HI

- ***Equally Well* (2008)** policy document sets out approach to tackle health and other inequalities in Scotland. (Reviewed in 2010)
  Focus on: early years, mental well-being, big killer diseases, alcohol
  By: improving environments, addressing intergenerational factors perpetuating HI; engaging at-risk groups in services;

- **8 local test sites** to implement and assess innovative approaches (e.g. healthy and sustainable neighborhoods, antisocial behaviour and underaged drinking, tobacco cessation.
  Mainstream, exchange experiences + roll out

- **Community Planning Partnerships** – health inequalities included in strategic objectives, strategic partnerships –Health and Well-being alliances

- **Resources –mainly mainstream services**

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Finland

- **National Action Plan to Reduce Health Inequalities (2008-2011**), closely linked to the Health 2015 Programme to reduce health inequalities and increase the number of healthy life-years.
  - Built on learning TEROKA project collected information + focused on cooperation with two regions that served as test sites

- **Target :** to reduce mortality differences between different socio-economic groups by 1/5

- **15 actions in 4 areas:** 1) welfare policies; 2)promoting healthy habits; 3)use of health and social services; developing the knowledge base and tools

- **Three key coordinating mechanisms:**
  - **Advisory Committee on Public Health**: Monitors population health and implementation of various activties across different sectors, + NGOs and other partners
  - **Three cross – sectoral policy programmes for health, under auspices of PM:** 1) health promotion; 2)employment, entrepreneurship and work environment; 3) well being of children, adolescents and families
  - Establishment of **Health and Well-Being Groups** at supra- regional, regional and municipal level. **Given the task of processing and considering information on HI and in engaging in cross-sectoral cooperation for health**

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Finland (2)

- Big emphasis in Finland on **monitoring and evaluation** of all policy documents

Outcomes:

- NAP on HI impacted on e.g. raising alcohol and tobacco taxes, contributed to health promotion amongst vocational students, development of healthier work environments and access to health needs of immigrant populations + raising awareness and keeping HI on agenda of national and local politics

But

- Remained a complementary plan in relation to a great number of other programmes and important SDH could not be addressed
- Fragmented nature and weak coordination of policy programmes
- Modest resources for implementation
- Short time span

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Denmark (1)

- **Danish "SDH Review"** (2011) to explore **why HI are increasing** in Denmark **despite universal healthcare coverage and relatively low levels of inequality** + suggest measures that could be taken to reverse this trend.

- In addition, **report** from Danish Health and Medicines authority **on integrating health in other sectors' work** & possible obstacles + review of other sectors' legislation

- **Findings**:
  -**actions on SDH turn into** individuals actions on **behavioral factors**
  -focus on **socially vulnerable groups**
  -**greater uptake universal services** amongst '**more resourceful' groups**
  -focus on **acute services**
  -**short term nature** of projects
  -**Lack of political buy-in**
  -**Difficulties in monitoring** and **lack of evidence of efficacy**

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Denmark (2)

- Report identifies **12 key determinants** relating to three main areas (addressing life-course): 1) ECD and schooling 2) socio-economic status 3)healthcare provision and access to services

  + measures (that can be monitored) to address key determinants

  – E.g. 1.1 Antenatal care comprising interventions that reach all women in early pregnancy
    1.5 Elimination of childhood poverty to prevent the long-term irreversible consequences that poverty has for children

Other initiatives

- **Support to municipalities** through **publication** on what they can do and **film** on setting inequality in the local political agenda
- Establishment of **national goals** – in process
- **Network for the health sector** – newly established

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Norway

- **"*The Challenge of the Gradient*" : Norwegian Strategy to reduce social inequalities in health** (2007-2017)
  - Initiated by Cabinet of Ministers. MoH Working Group + seven most relevant state secretaries involved in process of Strategy formation, + inter-ministerial body of officers to help implement
  - Nine 'stakeholder' workshops, involving 80+ representatives, held to help formulate Strategy

- Strategy **provides the framework and guidance + establishes responsibilities** in relation to e.g. annual budget, inter-ministerial cooperation on and policy instruments, implementation, also at regional level. **Applies and leverages existing structures, initiatives and resources.**

- **Monitoring** to cross-check policies and reporting and the development of indicators. **Annual PH Reports** to review key initiatives, targets and indicators. NIPH tasked with developing a monitoring system on HI (mortality and morbidity).

The **2011 report showed progress** in several areas, including income distribution, kindergarten coverage, and health behavoiur amongst adolescents.

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Some common challenges

- Some of the most important SDH lie outside of the realm of Health and Social Policy sector. Elected governments must have the democratic **mandate to make the needed policy changes** to really address social determinants of health.
- Difficult to stay on course in the face of **austerity measures** and **budget cuts**.
- Need for **more focused policy efforts** based on careful alignment of targets, commitments and delivery of scale.
  Avoid getting lost in a jungle of programmes and fragmentary projects
- Need for **more research into the differential effects of policies,** and into the **effectiveness of policy measures**
- Continued efforts are needed to **develop strong models of inter-sectoral cooperation** and to define roles
- Difficulties around **monitoring** and **demonstrating progress**

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III. EU level Actions

EU level actions on Health Inequalities: the Commission Communication

Reports like *Europe in Profile* (Mackenbach, 2006) established that HI exist in all EU MS

EP Council Resolution

EU Health Strategy

Commission Communication, Solidarity in Health. Reducing health inequalities in the EU 2009

Series of Council Conclusions

WHO Commission on the SDH (2005-2008) identified Policies likely to have the greatest impact on HI


EUROPEAN COMMISSION

Brussels, September 2013
SWD(2013) 328 final

COMMISSION
STAFF WORKING DOCUMENT
Report on
health inequalities in the European Union

Sept 2013

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EU level actions on Health Inequalities

The EU Communication has helped give a strong focus on Health Inequalities.
There have been several levels of policy response:

- Overarching frameworks, such as **'Europe 2020'** focus on **education**, **employment**, **poverty** and **social inclusion**.
- Policies that **recognise their explicit role in addressing health inequalities** both within and outside public health (e.g. Social Investment Package, Environmental Action Programme)
- Policies focusing on **'at risk' and excluded groups** (e.g. Roma and Migrant Health)
- Policies focused on **lifestyle**, which are strongly socially patterned (e.g. tobacco, nutrition)
- Policies focused on a particular condition (e.g. European Pact for Mental Health)
- **Improving data sources** such as EU Survey of Income and Living Conditions as well as funding to improve baseline data (e.g. ECHI – European Community Health Indicators).
- and **funding to improve access to structural funds**

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EU level actions on Health Inequalities

Funding

Health Theme, **7th Framework Programme** for Research (17 current projects, further 7completed under earlier calls and programmes)

EU Public Health Programme (2008-13) included Health Inequalities as a key theme and funded several programmes (e.g. Equity Action: Joint Action on Health Inequalities)

Progress - EU programme for employment and social solidarity have had a specific call relating to health inequalities

Structural Funding - is accessible particularly for economically less developed regions through cohesion policy – with a focus on healthcare facilities.

European Social Fund also offers opportunities for action for excluded and vulnerable.

The Common Agricultural Policy has also provided support e.g. through School Fruit Scheme (though the inequalities aspects have not been evaluated)

It is unclear how much funding will be available

under future programmes….

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Applying Structural Funds to address Health Inequalities

EU Cohesion Policy

- The '**Regional Policy of the EU**'
- Objective: to reduce the significant gap between less-favoured regions and affluent ones in Europe
- Focus on Economic, Social & Territorial disparities

→ The Structural Funds are the financial mechanism to implement Cohesion policy

→ Renewed every 7 years (next period: 2014-2020)

Budget

325 billion euros

- 2014-2020 period
- > 1/3 of total EU budget
- 2nd largest EU financing mechanism

- Vote in Parliament on 18-21 Nov (after > year of negotiations)

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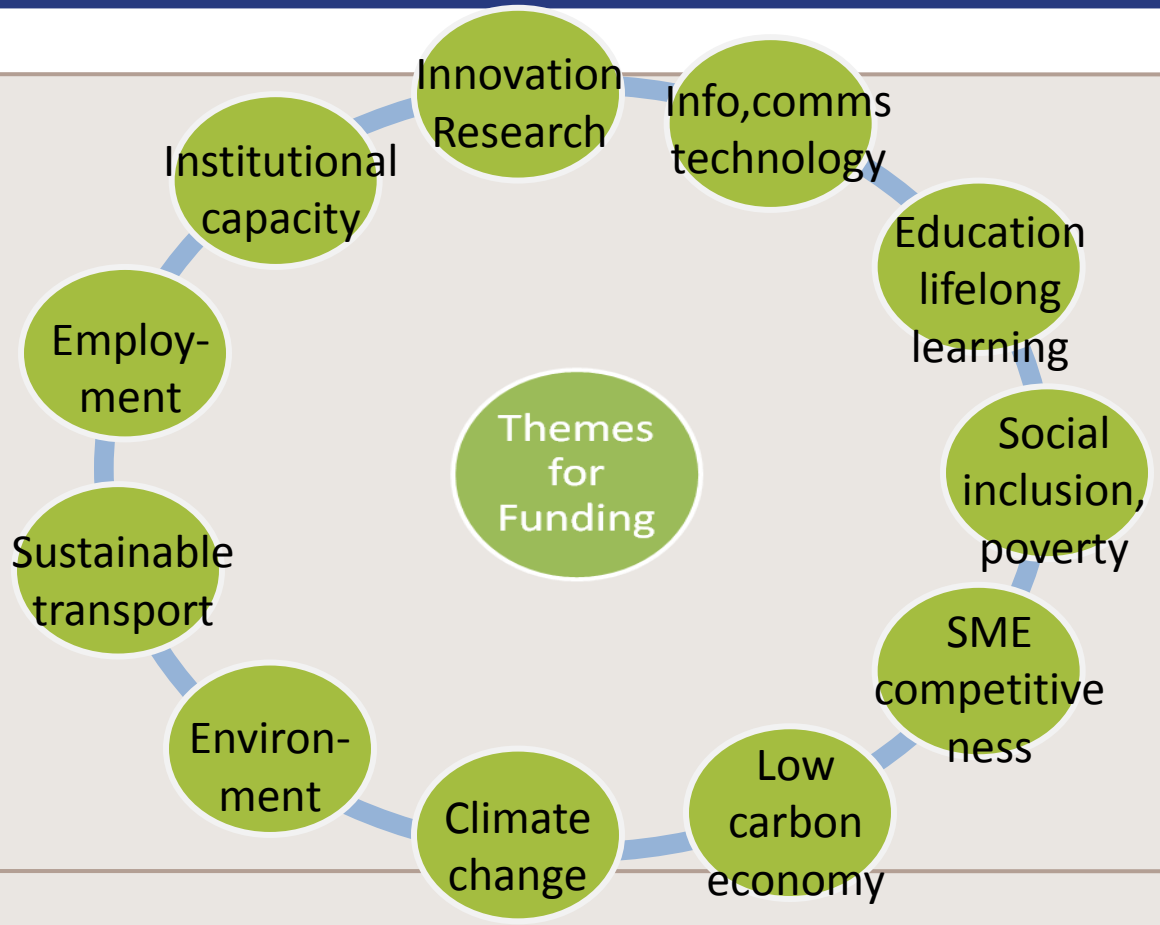
Funding Programmes

ERDF	• Economic change, regional development, enhanced competitiveness and territorial co-operation • Funding of 'hard projects'
ESF	• Enhancing access to employment and participation in the labour market, and reinforcing social inclusion • Funding of 'soft projects'
CF	• Environment and trans-European transport networks • MS with a GNI of less than 90% of the EU average
EAFRD	• Agriculture and Rural Development
EMFF	• Maritime and Fisheries

Thematic Priorities 2014-2020



Health is no longer explicit theme (was subsection during 2007-2013 period)

Direct health investments focus on health infrastructures, and eHealth

Indirect health investments need to be further developed!

Structural Funds Review

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10 SF Country Reports (10 MS)

Current Period

→ > 30 Examples of projects

→ Learning: opportunities, challenges

→ Preparing a project bid

Upcoming Period

→ State of play

→ Opportunities for action

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Two concrete examples (ERDF funds)

- **Italy:** POAT Salute: “Plan for Re-organisation and Capacity Building” of Southern Italy’s health-care systems
  - Strengthens capacities of the public administration to:
    - cope with social inequalities in health
    - evaluate interventions that take into account different SES groups
    - apply equity lens systematically in health programming
- **Finland**: Developing Well-Being in Northern Ostrobothnia
  - Take forward health equity related objectives in the Region’s Welfare Programme
  - Focused on getting HI written in strategies + engaging stakeholders to reduce health inequalities.
  - Has provided actors with a mandate to reduce HI

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Approaches and Examples identified

- Systematic approaches
  - Health (equity) as a selection / evaluation criteria
  - Health (equity) as a cross-cutting SF theme
  - Leveraging existing approaches

- Projects and Programmes
  - … Specifically focused on reducing health inequalities
  - … Addressing underlying determinants of health

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Conclusions (I)

The opportunities are there…

..but are (often) being lost

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Conclusions (II)

To address this, public health professionals should:

- **Be strategic**
- **Raise awareness** within PH sector (SF and objectives)
- **Raise profile of public health** within health care and other sectors (don't reinvent but partner-up)
- **Keep health equity on the political agenda**
- **Build capacity** to ensure that more SF contribute to greater health equity in the EU

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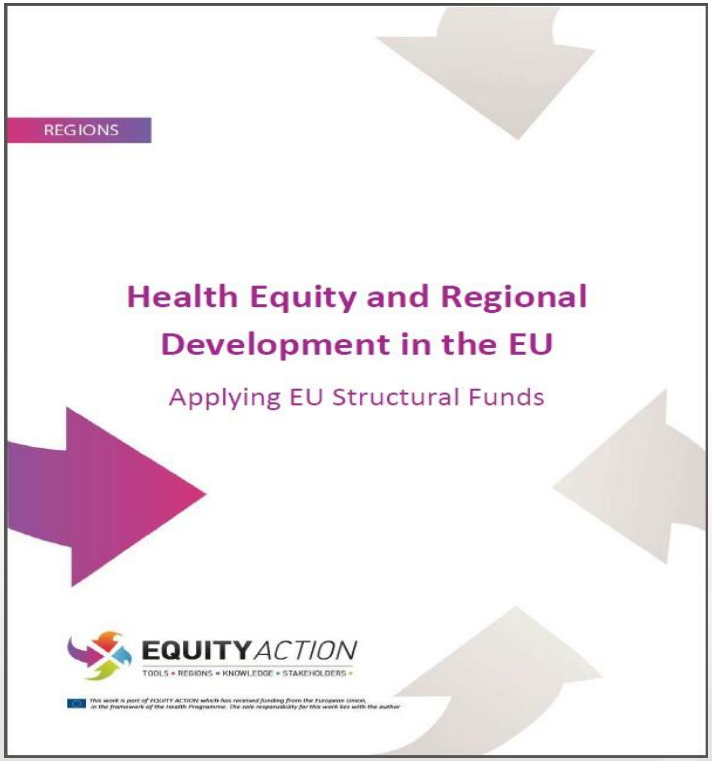
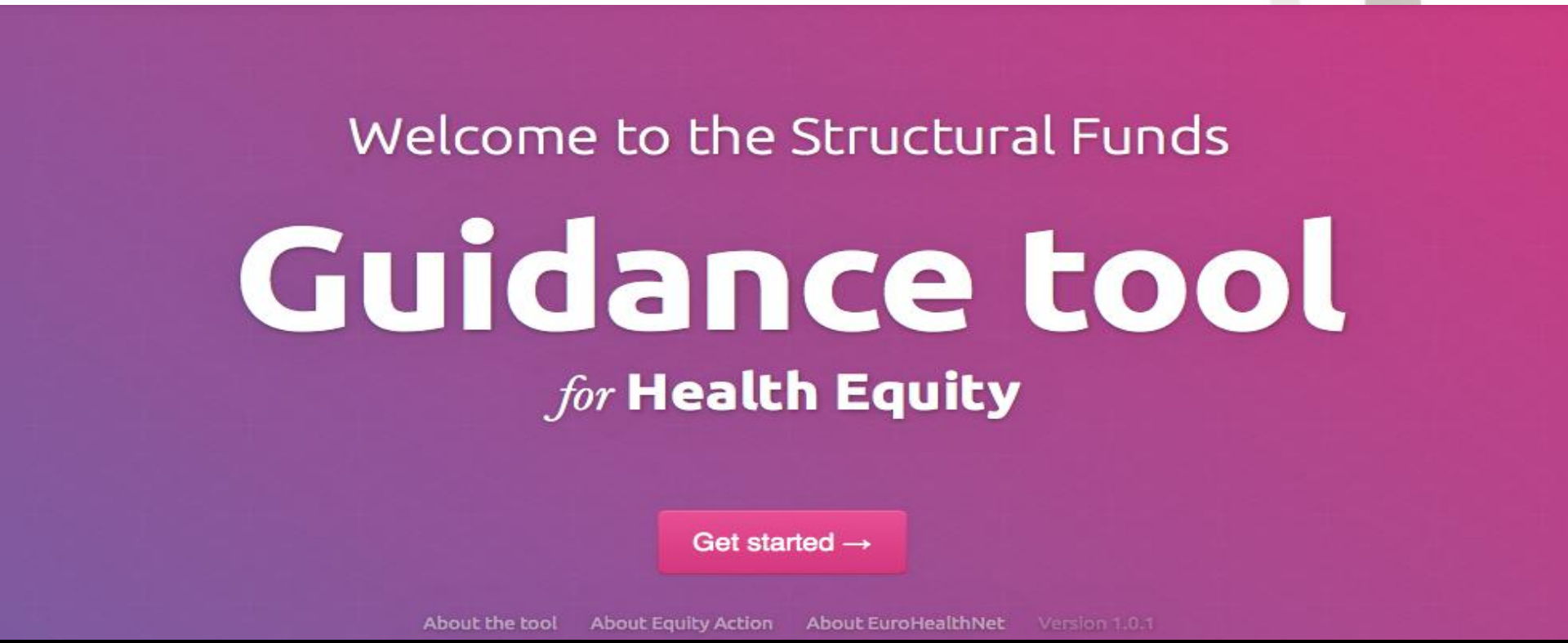
Tool 1: SF Analysis Report



www.health-inequalities.eu

Tool 3: SF Guidance Tool



www.fundsforhealth.eu

Tool 2: EA Final Conference

http://finalconference.equityaction.eu

Thank you!

Further information:
www.health-inequalities.eu

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