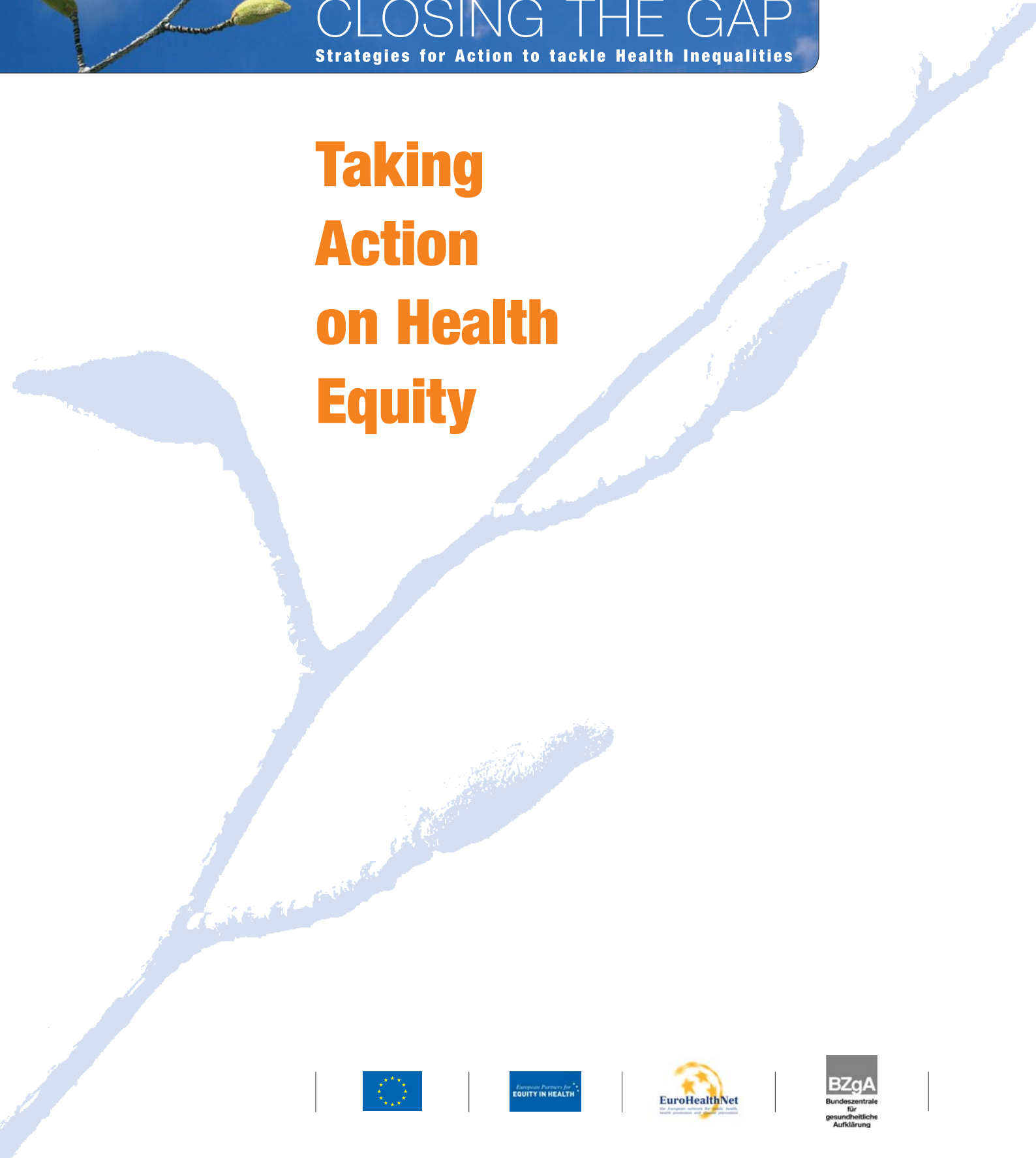




CLOSING THE GAP
Strategies for Action to tackle Health Inequalities

Taking Action on Health Equity





CLOSING THE GAP

Strategies for Action to tackle Health Inequalities

May 2007

*This publication has been written and compiled by:
Caroline Costongs (EuroHealthNet), Ingrid Stegeman (EuroHealthNet),
Sara Bensaude De Castro Freire (EuroHealthNet)
and Simone Weyers (BZgA).*

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FOREWORDS

Inequalities in health are a major challenge for public health in the European Union. Although the nature of health inequalities differs within EU member states, all face a health gap between the lowest and the highest socio-economic groups.

The Federal Centre for Health Education of Germany (BZgA) has been proud to be the lead partner in the Closing the Gap project. For the BZgA health inequalities are an important cross cutting issue which it seeks to address through a range of initiatives, either by specific activities on social inequalities, or by means of health education with special reference to social disadvantage, or through work with other sectors.

Networking is an important feature in our work, e.g. the national cooperation project 'health promotion in the socially disadvantaged' involves 16 regional networks in all German federal states and has created a database with more than 2800 projects (www.gesundheitliche-chancengleichheit.de).

BZgA has had the opportunity to coordinate, in collaboration with EuroHealthNet, the European project '**Closing the Gap: Strategies for Action to Tackle Health Inequalities in Europe**'. The aim of '**Closing the Gap**' is to develop a European knowledge base and infrastructure in order to implement and strengthen strategies and actions to reduce health inequalities.

The project has achieved a high level of engagement in European countries with 21 national public health and health promotion agencies from across Europe jointly working together.

This gave us the chance to exchange experiences and learn from each other. Joint concern and action can keep this issue visible on the public agenda, and international cooperation can improve professional and political action in counteracting the problem of health inequalities.

Dr. Elisabeth Pott,
Director, BZgA

EuroHealthNet has been delighted to co-operate with BZgA and other partners on 'Closing the Gap' and other network health promotion activities.

This work has been among the leading initiatives which, together with actions by various EU Presidencies, have raised awareness of the need to address health inequalities at all levels.

The active support of the EC Directorate General for Health and Consumer Protection has been crucial in this process. In turn EuroHealthNet hopes that the important outcomes – the Directory of Good Practices across Europe, the improved knowledge base and networking, and the resulting recommendations – will be taken up by the EU institutions as well as national and regional governments.

It is time to move from description of the problem to implementation of systematic and meaningful strategies and interventions to meet the real needs of European citizens. I am grateful to all who have worked on 'Closing the Gap' for their significant contributions in this respect, and commend the project outcomes and recommendations to all relevant policy makers and practitioners.

Clive Needle
Director, EuroHealthNet

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The Project Management Team

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1. Health Inequalities : a continuous challenge

The Member States of the European Union are amongst the countries in the world with the most developed economies and the highest levels of social protection. Even here, however, a person's level of health is strongly correlated with his or her socio-economic status. While most EU Member States show relative improvements in population health, the health status of those who are better off are in many cases improving at a faster rate than those that are less well off, leading to a widening 'health gap' between socio-economic groups. This means that all individuals do not, in practice, have an equal opportunity to enjoy their fundamental right to 'the highest attainable standard of health' possible¹.

Health inequalities is the generic term that is used to designate such variations and disparities in the health status of individuals and groups. Much evidence has been collected of social variations in health and life expectancy in all EU countries², with differences of four to six years in men and two to four years in women³. Differences in healthy life years are much higher, often in the area of 15 years.

Health inequalities exist not only within, but also between EU Member States. There is a 10 year difference between countries such as Sweden, Spain and Italy, which have the highest average life expectancy at birth (80 years) and Latvia, which has the lowest (70 years), Romania and Estonia (71 years). Rates of morbidity and mortality from e.g. heart disease, lung cancer, traffic accidents and injuries also vary considerably between EU Member States⁴. While factors such as genetic makeup and environmental and climate conditions may account for some of these variations, they can also be attributed largely to socio-economic conditions and policy choices.

Another pattern that is common to all EU Member States is that poor health is not only confined to those at the bottom of the social hierarchy: there is a '**social gradient**' of mortality and morbidity that affects all members of society: the further down the social ladder, the worse one's health. In other words, there are 'systematic differences in the health of groups and communities that occupy unequal positions in society.'⁵

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¹ Health 21 – the health policy framework for WHO's European Region, 1999
² Drever and Whitehead (1997); Marmot and Wilkinson (2005); Mackenbach and Bakker, (2002); Marmot and Bobak (2000) and Graham H (2004). Social determinants and their unequal distribution: clarifying policy understandings. *Milbank Quarterly*, 82, 101-24
³ Mackenbach JP (2006) Health Inequalities: European in Profile. London: UK Presidency of the EU.
⁴ EuroStat (2002-2003)
⁵ Graham H (2004). Social determinants and their unequal distribution: clarifying policy understandings. *Milbank Quarterly*, 82, 101-24

nge for Europe

The variations in morbidity and mortality rates across the EU and the health gradient attest that health differences are not simply the result of unhealthy behaviours by individual choice but that they are rather a result of a variety of social, economic and environmental factors that are often beyond an individual's control. Since these factors can be addressed and the inequities deriving from them reduced, they are avoidable, "unfair and unjust".⁶

As such, growing levels of health inequities defy the common values of social justice, solidarity and equality of opportunity that most EU Member States claim to share. Changing the slope of the health gradient, by focussing efforts on improving the health of those who are less well off, is an important way to secure these joint ideals.

But 'closing the health gap' is not only ethical; it also makes good economic sense. The cost of disease, disability and premature death puts an enormous economic burden on society and on the individual, while efforts to improve population health can lead to economic prosperity. It contributes to better health and better working lives, which helps employment, productivity and economic growth.

In the words of Markos Kyprianou, EU Commissioner for Health and Consumer Protection⁷: "We do not want health inequalities to widen further and threaten the social solidarity that we value so highly. We want our social model and economic model to deliver prosperity and a fair distribution of health"

Encouragingly, this conviction is becoming more widespread. Tackling health inequalities has been on the agenda of the WHO as well as on a number of EU Member States for over 20 years. In recent years it also became a part of public health strategies or programmes of almost all EU Member States as well as the EU itself. There is however considerable variation in the form and expressions of concern, in the public policy goals being set and in the range of measures being implemented in different countries.

Regardless of the amount of time that countries have been focussing on this issue, and the extent of action that is currently being taken, all EU Member States are still asking themselves the same common question; **what can effectively be done?**

⁶ Whitehead M and Dahlgren G (2006). *Levelling up: a discussion paper on concepts and principles for tackling social inequities in health*. Copenhagen, WHO Regional Office for Europe.
⁷ Speech at the Tackling Health Inequalities UK presidency Summit in London (2005).

2. Closing the Gap : Strategies for Action

This three-year initiative (2004-2007) has aimed to address this question. **Closing the Gap** is a partnership of 21 national public health agencies and institutes from across Europe that are working together to develop a shared understanding of health inequalities and to determine how to reduce them. The project has been coordinated by EuroHealthNet and the German Federal Centre for Health Education (BZgA) and is co-funded by the European Commission under the EU Public Health Action Programme.

The partnership provided an excellent opportunity for relevant, accountable actors to gather and exchange information, experience and good practice in this area. Participating agencies started with a 'Situation Analysis' to assess how health inequality was currently being addressed in their countries, and jointly decided on the following four areas in which action was most needed:

- > Awareness Raising and Advocacy
- > Health in All Policies and Health Impact Assessment (HIA)
- > Support to the Regional and Local Level
- > Evidence and Evaluation

An internal policy tool-kit was developed among the partnership to give further guidance on potential strategies for action. Each participating agency then developed a 'Strategic Initiatives' Plan outlining some of the measures that they can realistically undertake to improve or complement strategies and actions that are already in place. This information was shared and discussed during the '**Health Equity Week**': 17 National Seminars that took place across Europe in mid February 2007. Several countries chose to embed their plans and seminars into existing political and professional developments. For other countries the plans and seminars provided a new opportunity to raise awareness and define action on health equity.

This publication provides a brief overview of the current **national situation** in each of the participating countries with respect to tackling health inequalities, and of the further actions planned for 2007 and beyond. The initial idea was to 'cluster' countries according to their level of experience in tackling health inequalities, and to develop Strategies for Action on the basis of common characteristics. During the course of the project process, however, it became evident that this would reinforce differences between groups of countries and undermine joint learning. Some general recommendations, which are based on an analysis of the information that has been gathered in the context of this initiative, are provided at the end of this publication. These recommendations have been designed to guide all actors that are seeking to reduce health inequalities.

While the national level is of course important to tackling health inequalities, the **European Union level** is also of key importance, since EU regulations and resources can have important implications at the national level. A task of **Closing the Gap** has been to highlight the role that the EU can play in reducing health inequalities at the national level or local level. A separate report will therefore present an overview of some key developments, and of what can be done at this level⁸.



to Tackle Health Inequalities in Europe

It is however at the **local level** where measures to address health inequalities take direct effect. Each participating agency therefore selected five good practice projects and programmes from their countries that are contributing to the reduction of health inequalities. The interventions mainly focus on targeting behavioural changes by improving mental health, nutrition, physical activity and substance abuse, although there are also a substantial number of projects that address the broader social-determinants of health, such as living and working conditions, education, health care services, unemployment and housing. This report highlights several examples of the various good practices that were collected.

The information provided in this publication is by no means comprehensive, but provides a sample of the wide range of information that was collected and developed during the course of this initiative. The full range of background documents and links can be found on **Closing the Gap's** main outcome, namely the **European Health Inequalities Portal (www.health-inequalities.eu)**. The Portal contains information from each country that was derived from their Situation Analysis, their Strategic Initiatives, and reports of their National Seminars. It also hosts the **European Directory of Good Practice** that includes over 90 good practices collected in the context of this initiative. Information on how current developments in the EU can affect levels of health inequalities in EU Member States as well as extensive links on health inequalities can also be found on the Portal.

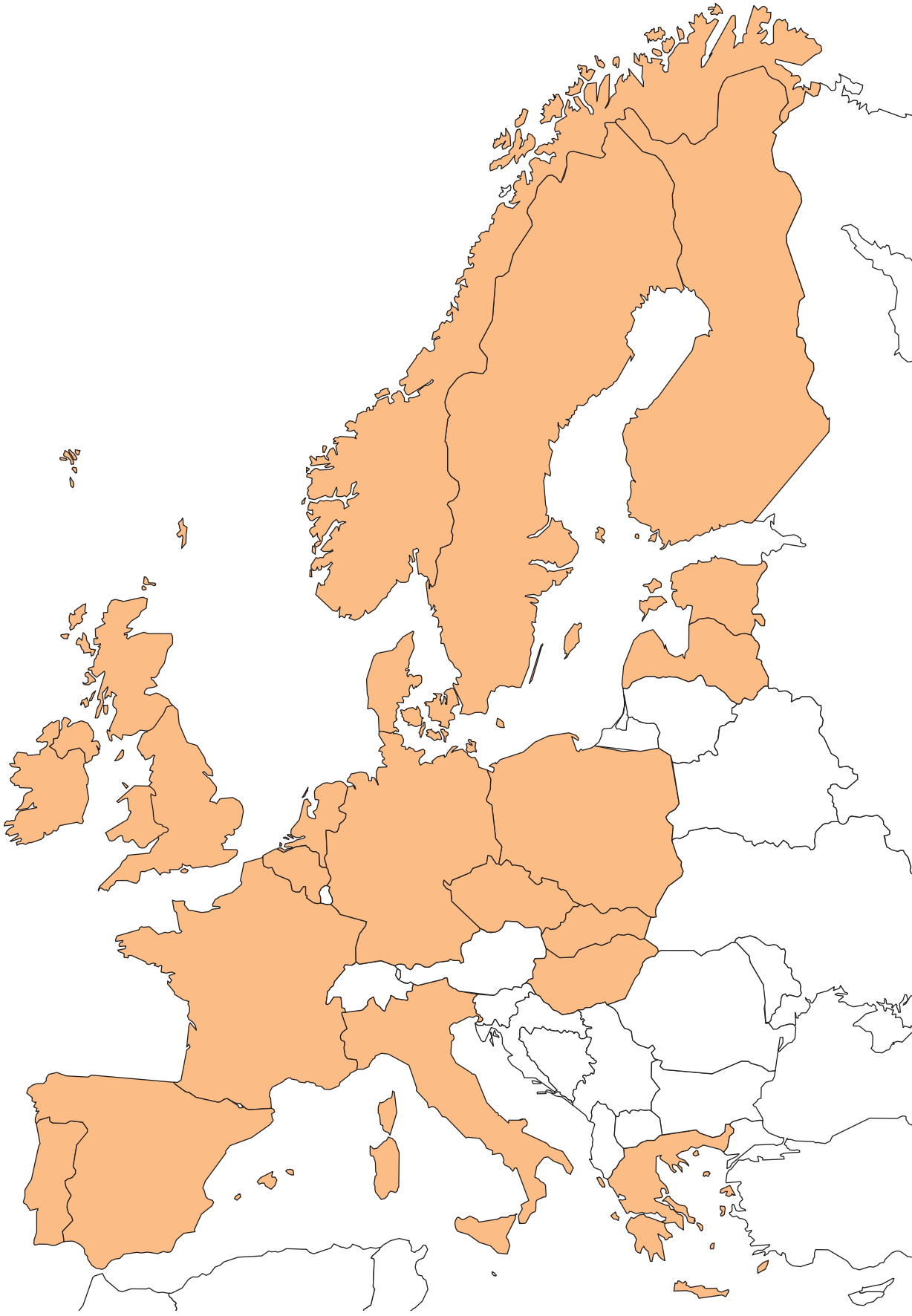
In their National Seminar report, a Swedish partner notes that:

“Closing the Gap demonstrates that it is possible to build and take advantage of a network between national institutions accountable for public health in Members States respectively, and mutually draw on national strengths that can be transferred and adapted into contexts in other countries, without imposing simple solutions”.

Exchanging knowledge and experience in order to stimulate further action was the primary aim of this initiative, and we hope that the following sections of this publication will inspire an even wider range of actors to take action and contribute to efforts to create equal opportunities for health for all in the EU⁹.

⁹ Please note that Norway (not EU, but EEA member) is among the participating countries.

II. CURRENT SITUATION AND STRATEGIES FOR ACTION IN EUROPE





Belgium



Despite its democratic health care system health in Belgium, as in other EU countries, is unequally distributed across socio-economic groups. Since mid 2006 the King Baudouin Foundation, in collaboration with the University of Gent and the Free University of Brussels (ULB), have been assessing the nature of health inequalities in Belgium and conducting an inventory of existing initiatives that could contribute to their reduction. They have also established a working group of key experts from Belgium to identify priority actions that could be taken to improve the existing situation.

During the second meeting the expert working group identified a wide range of measures that could contribute to a reduction of health inequalities in Belgium. These include the development of national body to bring together all relevant actors and information in this field and to bridge the gap between research and policy. Issues such as strengthening local level initiatives to improve the health of socially vulnerable groups by, e.g. improving access to primary care services, and inter-sectoral collaboration were also discussed. The working group will establish whether these or other measures should be considered 'priority actions' during the course of spring 2007.

The outcomes of this initiative will be presented to the new Federal government as well as to the regional and communal governments in the summer of 2007, with the aim of securing the political commitment that is necessary to take action on health inequalities in Belgium.

In January 2007, **Closing the Gap** presented at the first expert group meeting to provide an indication of the range of actions on health inequalities being taken in EU Member States.

The Flemish Institute for Health Promotion (VIG) has observer status in **Closing the Gap**, and is also taking part in the King Baudouin Foundation initiative on health inequalities.



Czech Republic



The Czech Republic has over the past 17 years been making the transition from a socialist to a democratic form of government. During this period, the emphasis has been especially on macro-economic issues, rather than on issues such as health inequalities, which were not regarded as a priority and therefore not monitored by government authorities.

The Czech Republic introduced a new Public Health Programme in 1993, which made reference to health inequalities, and only began to gather preliminary data to assess the situation regarding this issue around this time. The Czech National Public Health Programme supports from 65 to 110 health promotion projects every year, of which only a few address health inequalities.

The Czech National Institute of Public Health's (NIPH) efforts to take action on health inequalities will therefore focus on raising awareness and engaging politicians. The **Closing the Gap** National Seminar held in February 2007 provided an opportunity to do this. During this event, attended by 25 national experts, existing health inequalities policies and possible future actions were discussed. The NIPH plans to continue to raise awareness through meetings, seminars, pre and post graduate lectures, publications and NIPH web-pages.

The NIPH also considers it to be of critical importance to take forward action on health inequalities by generating a better understanding of the socio-economic determinants of health amongst relevant actors. The Third Medical Faculty and the Faculty of Philosophy, Department of Psychology of the Charles University in Prague have already begun to incorporate these topics into their pre and post graduate curricula and are offering these courses to other Czech and Moravian Universities. The NIPH has also decided to embed work on health inequalities and the psychosocial determinants of health into its priorities in public health projects, campaigns and consultation activities, in cooperation with Czech regional health institutes, universities, research institutes and related scientific societies and associations.

There is also a need for further research in the field. This will be undertaken through co-operation with other institutions and experts from medical schools, research institutes, regional health institutions, scientific committees, societies and associations.

The NIPH considers further involvement in European projects such as **Closing the Gap** as an important catalyst for action and change, since they lead to knowledge transfer and shared experiences.





Denmark



The issue of health inequalities has been on the agenda for over 20 years in Denmark. The current Public Health Programme, “Healthy throughout life” (2002-2010) aims, amongst other things, to “reduce social inequality in health to the extent possible above all by strengthening efforts to improve health for the most disadvantaged groups.”

While there is no specific strategy at the national level to address health inequalities, the national government looks at equity issues in many national policies, and puts aside resources to address the needs of the most disadvantaged groups of society.

Many of the concrete actions that can contribute to a reduction of health inequalities have recently been devolved to the regional and municipal level. Since 2007, regions have become responsible for the part of health services that concerns treatment as well as patient oriented prevention, while municipalities are responsible for citizen-oriented prevention and health promotion. This means municipalities are in charge of initiatives concerning, for example, housing, homeless and activity centers, school lunches, and special health promotion programmes for ethnic minorities. Good practice is exchanged through joint municipality organisations like the Local Government Denmark and the Danish Healthy Cities Network, which give the reduction of social inequality in health a high priority. Tackling social inequalities in health was, for example, a main theme at the 2007 health conference that was held by Local Government Denmark.

The National Board of Health supports local level activities in a number of ways. In 2006, a number of municipalities could apply for special funding that was allocated to projects for socially disadvantaged groups, e.g. recipients of cash assistance and unemployed skilled and unskilled workers. The National Board of Health will collect and disseminate information regarding ‘model projects’ across municipalities, to encourage the exchange of good practice.

Denmark is strong on the research and monitoring tools in the field of health inequalities, and the National Institute of Public Health has several research programmes that address this issue. The outcomes of these programmes may contribute to the possibility of developing a national strategy on this issue.

Numerous seminars have and will be taking place in Denmark to generate awareness, exchange information and stimulate further action on population health differences caused by socio-economic factors. **Closing the Gap** was, for example, presented and discussed during the Danish Healthy Cities Annual Conference that took place in March 2007, while a National Seminar on “Public Health in a Socio-Political Perspective” will take place in August 2007 and also take forward the **Closing the Gap** objectives.



England



England is one of the very few countries with a comprehensive stand-alone policy on reducing inequalities in health. After the election of a New Labour government in 1997 social justice emerged as a key political priority with an explicit emphasis on tackling health inequalities. The Independent Inquiry into Inequalities in Health (Acheson Report, 1998) provided a foundation for all subsequent work on health inequalities.

Its influence can be seen in the public health white paper *Saving Lives: Our Healthier Nation* (1999) and the *NHS Plan* (2000). The *NHS Plan* went further and announced the first-ever national health inequalities target on infant mortality and life expectancy.

A national consultation (2001) and a Treasury-led cross cutting review on health inequalities (*Summary of Cross Cutting Review*, 2002) explored how to deliver the target. They provided the basis for the national cross-government strategy on health inequalities, *Tackling Health Inequalities: A Programme for Action* (2003). Its aim was to help meet the target and achieve a long-term, sustainable reduction in health inequalities.

The *Programme for Action* was organised along four themes:

1. Supporting families, mothers and children – reflecting the high priority given to them in the Acheson report
2. Engaging communities and individuals – strengthening capacity to tackle local problems and pools of deprivation, alongside national programmes to address the needs of local communities and socially excluded groups
3. Preventing illness and providing effective treatment and care – by tobacco policies, improving primary care and tackling the big killers of coronary heart disease and cancer
4. Addressing the underlying determinants of health – emphasising the need for concerted action across government at national and local level.

It was underpinned by a number of key principles. These included mainstreaming, or ensuring that the needs of disadvantaged populations are reflected in the planning and delivery of public and other services.

Developments against the target and the themes of the national strategy are assessed annually in *Tackling Health Inequalities: Status Report on the Programme for Action* (2005), and *2006 Update of Headline Indicators* (2006).

The achievement of further progress towards the target has been the subject of individual reviews including *Review of the Health Inequalities Infant Mortality PSA Target* (2007). These reviews seek to identify the interventions that are most likely to help meet the target and ways of sharpening the local delivery of services to the target groups.

The public health white paper *Choosing Health* (2004) further promoted the health improvement and health inequalities agendas, including through spearhead local areas – those areas with the worst health and deprivation indices and covering around a quarter of the population. The spearhead strategy gives priority to reducing early deaths amongst adults aged 30-59.

In 2006, health inequalities were also identified as one of the top six priorities of the National Health Service (NHS). This will help raise the profile of the issue in the NHS and provide a continuing impetus for more effective partnership working and improved management performance and data collection.

A **Closing the Gap** reception was held in the Parliament buildings in London, 28 February 2007.





Estonia



Tervise Arengu Instituut
National Institute for Health Development

Despite recent positive changes in the life expectancy of the Estonian population, it is still considerably lower than in many other European countries and lower than the average in new member states.

The issue of health inequalities has recently received increased attention at the national level. In 2002 the first national survey analysing inequalities in health revealed that increasing gaps have emerged across different education levels, incomes, places of residence and nationalities.

In response to these findings, since 2004, all new national health strategies highlight the principle of equity. The reduction of inequalities is generally addressed through a focus on specific populations such as vulnerable groups or communities rather than the population as a whole.

The Ministry of Social Affairs is currently developing a national population health plan for 2008-2015 with five priorities amongst which 'to strengthen social cohesion and decrease health related inequalities'.

The National Institute for Health Development (NIHD) which is responsible for coordinating the implementation of all national health related strategies has elaborated a list of priority actions and activities for the institute and its partners to reduce social inequalities in health. These priorities are in line with the national public health priorities and planned activities and include the following:

- > To improve awareness of health inequalities (to develop evidence base, to strengthen expert knowledge and involve the media).
- > To develop and implement measures and programmes in order to reduce health related inequalities (to develop health promotion programmes targeting disadvantaged sections of the population, to guarantee access to effective health and preventive services for vulnerable groups and to develop a database on effective interventions).
- > To improve cooperation with other sectors (in which the health sectors will play a leadership role).
- > To promote regional development (and improve the capacity to plan and implement health promotion activities).

A **Closing the Gap** National Seminar took place in Estonia on 13 February 2007. Sixty participants, including representatives from the Ministry of Social Affairs and public health and health care experts, as well as representatives of municipal governments took part to discuss, amongst other things, the new Public Health Development Plan and its implementation.



Finland



Health inequalities have been addressed in the Finnish Health Policy programmes for the past 20 years. The last of the eight objectives in Finland's current Public Health Strategy (2001) is to "reduce inequality and increase the welfare and relative status of those population groups in the weakest position". The target is "to reduce mortality differentials by gender, education and occupation by 20% by 2015." Yet the document includes only a few detailed suggestions concerning the kinds of initiatives that need to be implemented to achieve this target.

Concerned about increasing levels of health inequalities in Finland, the Ministry of Social Affairs and Health has begun to take more effective action to achieve the 2015 target. The multi-sectoral national public health Committee (Advisory Board for Public Health) under the Ministry decided in 2005 to develop a national strategy and action plan to reduce health inequalities in Finland. The preparation began in the latter part of 2006.



The Action Plan is being built around the following seven strands:

1. Reinforcing the theme *Health in All Policies* (HiAP) and integrating health inequalities into it;
2. Strengthening work to reduce health inequalities in municipalities;
3. Alcohol and tobacco policies;
4. Enhancing equity in services;
5. Reducing health inequalities in children and young people and preventing social exclusion;
6. Reducing health inequalities in people of working age;
7. Developing monitoring systems for health inequalities between population groups.

A number of perspectives, such as paying attention to the impact of social and economic determinants, the prevention of social exclusion, the needs of specific vulnerable groups as well as the health gradient and gender difference will be taken into account in all of the strands.

The preparatory work has been undertaken by the Advisory Board for Public Health, as well as research institutions under the Ministry of Social Affairs and Health and the TEROKA project (*Reducing Socioeconomic Health Inequalities in Finland*).

A person responsible has been appointed for each strand to draw up a memorandum outlining the most important challenges, strategic objectives, proposals for actions, the timeframe in which they can be implemented and how they can be monitored. In each strand, hearings and meetings with larger groups of experts are being organised to collect ideas and experience from the field and research.

The preparation of the Action Plan will be completed by 2007. The Plan will cover mainly the next four-year government period, although the structural changes that may be necessary as well as the anticipated outcomes are expected to extend beyond this time. The proposal for the Action Plan will be presented to the Government, which will decide if the proposed actions require legislative measures and related funding.

The Finnish National Seminar, with approximately 490 participants, took place on 1 February 2007 and was one of the stages in this process. It also took forward the **Closing the Gap** objectives. Presentations covered a wide range of issues, from questioning the existing viability of the universal welfare state, to what municipalities and voluntary organisations can do to tackle health inequalities. The role of alcohol policy, the educational system, the food industry, and of partnership working were also discussed. A panel representing major parties in the Parliament discussed their views on reducing inequalities in health.

France



France does not have an explicit policy on health inequalities, although a number of actions are being taken to address this problem. The public and political debate on the subject of health inequalities in France tends to focus on social exclusion and difficulties in access to health care services rather than on socio-economic inequalities. A comprehensive programme against social exclusion was established in 1998, which included a section on health. This involved specific intervention programmes at the regional level (PRAPS) and measures to enable access to health care by reducing financial barriers (CMU) or physical or psychological obstacles (PASS in hospitals). In the context of urban policy, health promotion actions are taken and notably targeted at vulnerable neighbourhoods. Civic organisations in France have played a big role in raising awareness of and addressing social exclusion phenomena.

The new National Health Policy of 2004 includes a specific reference to health inequalities. Among the health priority challenges considered by the law, was the issue of “deprived populations and inequalities” and two objectives were set for public health policy from 2004 to 2008:

- > Objective 33: To reduce financial obstacles that prevent persons whose income slightly exceeds the threshold by also giving them right to the CMU to access healthcare.
- > Objective 34: To reduce disease and death inequalities, increasing life expectancy among low socio-economic groups.

The INPES (Institut National de Prévention et d'Éducation pour la Santé) has made the reduction of health inequalities a main focus of all its prevention and health promotion activities and is in the process of incorporating action on health inequalities across its different programmes. The Institute has recently developed an action plan initiated by **Closing the Gap** to contribute to the reduction of health inequalities in France. The action plan includes the following seven main strategic objectives:

1. *To shape a shared framework about reducing health inequalities* (intended for the Institute's programme teams).
2. *To provide technical support to the Institute's programme teams.*
3. *To support local actors in implementing quality actions.* The INPES is creating a good practice database to tackle health inequalities, which will be based on and adapted from the European Good Practice Directory. This project is a partnership between the Ministry of Health and three regions. The good practice database was presented to the different regions of France in the context of the **Closing the Gap** National Seminar on health inequalities that took place on 14 February 2007 and was jointly organised by the Institute and the Ministry of Health. Additional activities will include an analysis and the development of assessment tools, more research of intervention criteria to reduce health inequalities and the production of an “Action Guidebook” to tackle health inequalities.

4. *To develop knowledge on health inequalities.* Partnerships will be developed with universities, research centres etc. and by capitalising existing evidence on health inequalities. In 2007 the Institute has launched a research call for projects.
5. *To formalise a communication strategy for the Institute,* and to adapt the Institute's language and communication in order to widen the target reached by mass media preventions campaigns.
6. *To develop an intervention focus on early childhood development*
7. *To continue international cooperation.* In the spring of 2008, the Institute will organise the first international French speaking health promotion conference on strategies for action to tackle health inequalities.





Germany



Welfare services in Germany are highly devolved to the Lander (regional) level. This includes health promotion and public health, and many actions related to tackling health inequalities. Health care legislation and insurance systems are however a national level competency.

Health inequalities are receiving a growing amount of attention at the national level. The Ministry of Health has since 2000 been reforming the Health Services, to make prevention a fourth pillar of the German Health System (in addition to therapy, rehabilitation and care). These activities will focus primarily on socially disadvantaged groups. In addition, under a new German Social Law, statutory sickness funds (health insurances) are also obliged to invest in primary prevention and are recognising socially disadvantaged people as an important target group.

At the governmental level, an expert working group on 'Poverty and Health' was created in order to establish recommendations on health services provision for migrants and the homeless. The conference 'Poverty and Health', which has been held in Berlin annually since 1995, has established itself as the largest nationwide event in this area. These different measures and initiatives could improve the health status of disadvantaged population groups, and lead to a reduction of health inequalities.

In 2001 BZgA initiated a national cooperation project entitled 'Health Promotion for Disadvantaged people'. The following are amongst a range of activities and actions that will be taken during the course of 2007 to build on this initiative and to reduce health inequalities:

- The Internet platform www.gesundheitliche-chancengleichheit.de including an online directory with 2800 projects is an important tool within the cooperation project. It also contains actual information on all modules, research, dates and events, materials, publications, links, cooperation partners etc. An important task is to keep this directory up to date.
- Forty-two organisations from different sectors have recently formed a coalition of interest, and developed a common declaration on health inequalities, in order to raise awareness about this topic. More cooperation partners will be sought.
- Regional networks have been established in all 16 federal states in order to support structures at the regional and local level. These networks will receive permanent funding, so that they can continue to implement actions that can contribute to the reduction of health inequalities.
- The actors involved in the cooperation project will discuss the key issue of evidence and evaluation and the good practice approach. To date, some 40 good practices have been identified. The aim is to identify more exemplary projects and initiatives that meet the assessment criteria and can be exhibited. Furthermore, general strategies and recommendations will be deduced from the individual projects.

On the 13th of February 2007 the Federal Centre for Health Education (BZgA) organized a **Closing the Gap** National Seminar on health inequalities, bringing together 100 high level multi-sector representatives from policy, practice and science. This event stressed the link between national and European initiatives.





Greece



Greece is characterized by a welfare state with social market economy. Although recent growth performance is considered to be good, unemployment rates and income inequality are relatively quite high. The health care system remains largely centralized perpetuating the gap in service provision quality between the rural and urban areas. Additionally, as it is observed in other Mediterranean countries, the welfare system and social economy are underdeveloped and the family has to play an important role as service provider.

Public health policy-making lacks a distinctive focus on health inequalities. However, it has developed some programmes directed towards social determinants of health at the national and local level. Recent policy and legislative articles on social justice and social inclusion have included general references to health inequalities. Additionally the current public health policy aims to integrate specific vulnerable groups. Nevertheless it lacks specific objectives, quantitative targets and timeframes. Generally speaking, little policy attention is paid to the importance of multi -sectoral public health strategies and no formal cross -sectoral coordination mechanisms are in place. No systematic and comprehensive evaluation of public health programmes or policies is carried out.

One of the difficulties encountered in developing and monitoring strategies to reduce inequalities is the limited data available on the issue. Until recently no systematic research had been conducted on health inequalities in Greece. The Institute of Social and Preventive Medicine (ISPM) in collaboration with the Center for Health Services Research of the University of Athens launched during 2006 the first large scale study on evidence on health inequalities in Greece (HELLAS HEALTH I). The study will be repeated every two years and will offer an insight on progress made on the reduction of health inequalities, using a wide range of socio-economic and cultural indexes. The **Closing the Gap** National Seminar conducted in Athens by the ISPM during February 2007 attracted a lot of attention by the press. Additional awareness activities have been planned for 2007 and 2008 by the Institute in an effort to prioritise the issue on the political agenda.



Hungary



Reducing inequities in health has been a declared, well-articulated aim and basic value of the Hungarian health policy for the last 25 years. However, the trends in morbidity and mortality show partly increasing health inequities and deepening levels of poverty.

At the governmental level, the main political approaches for tackling social and economic determinants of health and reducing inequities in health are as follows:

- > The Public Health Strategy articulates equity as an explicit basic value in a horizontal approach and includes also some specific target programmes for people in deprived situations.
- > Strategies in social and educational policy with an explicit focus on health (e.g. Roma Decade, School Health Programme, Programme Against Child Poverty)
- > Strategies linking health and development (e.g. Structural Funds, National Development Framework).

In parallel, efficient initiatives and interventions are carried out at the regional and local levels within the community (e.g. local Roma programmes).

Partly due to the complexity of the challenge but also due to the lack of appropriate financial and human resources, the implementation of strategies remains generally limited. The inadequate critical mass of experts with both social policy and a health promotion background, in particular at the local level, is one amongst many challenges.

Since mid 2006 Hungary has a newly elected government that is committed to implement a clearly needed, comprehensive reform of the health care system. As a consequence, the main focus of health policy is currently on health care reform and less attention is given to health promotion and health inequalities.

The National Institute for Health Development in Budapest has a special department and target programmes for reducing inequities in health. In November 2006 the Institute organised and hosted a countrywide conference with more than 100 participants on the issue of inequities in health. This initiative was followed by the organisation of seminars and methodological publications.

In 2007, in the context of **Closing the Gap**, health inequalities will be discussed in different events including a conference on the socio economic determinants of health and some regional workshops attended by health promotion stakeholders.

The Republic of Ireland and Northern Ireland



The Republic of Ireland and Northern Ireland have recently experienced an economic boom, but also experience some of the highest income inequalities and relative poverty rates in the EU. The link between health and poverty has, since 2000, been clearly accepted by policymakers and tackling health inequalities is now embedded in national policy. Both countries have made commitments to tackle health inequalities in policy documents, and proposed targets for this purpose. For example, the Republic of Ireland has committed to reducing the health gap between the lowest and highest socio-economic groups by at least 10% by 2007 in respect of premature mortality and the occurrence of low birthweight babies.

Policy on health inequalities in the Republic of Ireland is structured within the framework of the National Anti-Poverty Strategy and the allied National Action Plans for Social Inclusion. This work is done on the basis of cross-sectoral collaboration. The Department of Health and Children convenes and administers the Working Group on the National Anti-Poverty Strategy and Health.

Similarly, in Northern Ireland, tackling health inequalities is a core component of the Government Strategy against Poverty and Social Inclusion “lifetime opportunities” and the Investing for Health Strategy.

The Institute of Public Health in Ireland was established to achieve co-operation for public health and a central focus of all its work is tackling health inequalities across the island of Ireland.

Amongst the priority actions that were highlighted in the Irish Strategic Initiative is the need to optimize the use of existing statistical information on health inequalities and to improve this information. The importance of providing support for national and local level efforts to evaluate projects and initiatives that can contribute to the reduction of health inequalities and to bring together and disseminate this information, in order to stimulate learning and the exchange of good practice, was highlighted. It was noted that adequately monitoring policies and programmes that can directly or indirectly lead to the reduction of health inequalities require the selection of proper indicators.

The Ireland and Northern Ireland Population Health Observatory (INISPHO) and the All-Ireland Electronic Health Library (AleHL) have been established within the Institute of Public Health. The observatory provides a central online resource for information on tackling health inequalities. The Institute of Public Health is currently preparing an all-island publication entitled ‘The Social Determinants of Health – The Irish context’, which will provide evidence on the impact that key social determinants have on the health of Irish people.

Another important priority that was identified is the need to develop mechanisms to incorporate evidence-based proposals to tackle health inequalities into national health policies by liaising with the relevant government departments. A key tool in this task is the mainstreaming of Health Impact Assessment (HIA) into the policy-making process.

It was noted that a greater ‘health-inequalities’ focus cannot be achieved without developing expertise in this area, and trained people who can raise awareness and advocate from within and beyond their sector. In this regard, the Institute of Public Health places an emphasis on capacity building. For example, the Institute’s ‘Leadership for Building a Healthy Society’ programme has developed a public health advocacy toolkit. This supports the development of meaningful partnerships to tackle health inequalities across a range of sectors, including further research to develop methods of measuring the impact of partnerships on inequalities in health. Awareness and learning is also promoted through events such as conferences and seminars that provide opportunities for learning, networking and sharing information amongst multidisciplinary audiences.

The priority actions for the Republic of Ireland and Northern Ireland draw on the conclusions of recent national conferences that focused on the issue of health inequalities. This includes the **Closing the Gap** National Seminar that took place on 14 February, 2007.



Italy



Italy is an example of a Mediterranean welfare state where, traditionally, informal care provision plays an important role. The extension of universal health care coverage to the whole population is a key characteristic of the Italian health care system. The National Health Service in Italy is decentralised with regions responsible for delivery of the service provision. However the situation across the 20 regions is very heterogeneous. Responsibility for health promotion rests at the local level.

The focus on health inequalities is variable depending on the political climate. The 1998-2000 National Health Plan called for a population-based approach to the reduction of health inequalities. The following National Health Plan (2003 - 2005) focused solely on disadvantaged groups, rather than the difference between all social groups.

Some regions have health plans that prioritise health inequalities (Umbria, Piemonte, Lazio, Marche, Toscana and Emilia Romagna). To what extent these plans are being implemented in practice is, however, uncertain. The independent province of Trento has established a working group to address the problem of health inequalities.

An Italian **Closing the Gap** National Seminar took place on 2 April 2007. Forty-two public health and health promotion specialists and some policy makers took part to learn more about and discuss the situation with respect to socio-economic health differences in Italy and to determine what measures could be taken to improve the situation. It was proposed that each Italian region set up a working group on health inequalities, and establish a network to link these groups. The work undertaken at the regional level could then be fed back to, for example, the national level discussions around the Italian National Action Plan on Social Inclusion.



Latvia



Latvia is a society in transition with substantial socio economic inequalities in the population.

Although there is no national comprehensive document or policy in place to address health inequalities, the principle of equality is enshrined in the Latvian constitution. There are different policy planning documents which provide actions for reducing health inequalities in Latvia:

- > Public Health Strategy (PHS) (2001)
- > Action plan for the implementation of the PHS (2004 – 2010)
- > National Action Plan for reduction of poverty and social exclusion (2004 – 2006)
- > National report on the social protection and inclusion strategy for the years 2006 – 2008

Additionally, in the context of the WHO Health for All Strategy the Latvian Public Health Strategy, has adopted equity and solidarity as one of its primary targets. The public health strategy of 2001 has for example the target of achieving 25 % reduction in life expectancy between socio-economic groups by 2010. The issue of regional inequalities in access to health care services has mostly attracted public attention.

Although political awareness on health inequalities remains limited and there is no data available on the differences in health status between different socioeconomic groups, an inter- sectoral coordination commission of Public Health was established in 2006. The commission aims to facilitate the involvement of other sectors in public health, particularly with the aim of reducing health inequalities.

On the March 2, 2007, the Health Promotion State Agency (HPSA) organised a national **Closing the Gap** seminar on health inequalities bringing together policy makers from different sectors. During the seminar, participants discussed and identified possible actions that can contribute to the reduction of health inequalities. Among these are the need to raise awareness between policy makers about the importance of reducing health inequalities, the identification and dissemination of good practice in this area, the development of an action plan to improve the health determinants amongst socio economically vulnerable groups and the need to improve cooperation and to coordinate the work of the Ministry of Health and the Ministry of Welfare.





The Netherlands



The issue of health inequalities has been on and off the political agenda in the Netherlands since the end of the 1980s and gained visibility thanks to the establishment of two investigative Commissions initiated by the Ministry of Health as a part of a Programme Committee on Socioeconomic Health Difference. The government in 2001 has set the target of bridging health inequalities by extending the healthy life capacity of the lower income groups by 25% of the current difference (3 years) by 2020.

Action to achieve this target has taken place primarily at the local level, since health promotion in the Netherlands is basically a responsibility of the 475 Dutch municipalities. Reducing health inequalities is mentioned as a local policy target in 2003 in over half of the municipalities, which have developed different initiatives to achieve their goals.

While there is currently no general national strategy in place in the Netherlands to reduce health inequalities, there is a strategy that aims to reduce health differences in large cities. The recent change of government (February 2007) however represents an opportunity to generate greater commitment and action at the national level also, since the new Coalition Agreement includes the goal of reducing differences in lifespan on the basis of social economic background. This Agreement specifies that this can be achieved by focusing efforts on 'problem-areas'.

Participants at the **Closing the Gap** Seminar in the Netherlands that took place in February 2007 agreed to petition the government to take action. The wide group of stakeholders, including representatives of municipalities, health care funds, local health authorities, as well as various Health Funds (e.g. Heart, Diabetes and Mental Health Fund) and representatives of the Minister of Public Health, Welfare and Sport used the Seminar as an opportunity to establish a broad coalition that will aim to stimulate the government to take further measures in this field. The 21 Health Funds also spoke of their ambition for greater cooperation to reduce health inequalities and their willingness to invest in this.

The Seminar participants have drawn up a Manifesto that has been presented to the Minister of Public Health, Welfare and Sport. The Manifesto calls on the Ministry to establish an Action Plan at the national level, and proposed the following 5 strategies:

1. Strengthen the neighbourhood based approach to health inequalities, and make health the core theme in the neighbourhood approach in the Coalition Agreement.
2. Invest in educational policies for disadvantaged groups and in poverty reduction
3. Ensure good physical education programmes in elementary schools.
4. Make prevention and the promotion of healthier lifestyles a part of basic-packages in health insurances (e.g. exercising by prescription, immigrant health consultants and support in anti-smoking efforts.)
5. Minimise the availability of unhealthy products through laws and regulations.

The priority areas established in the 2006 national prevention policy (obesity, diabetes, depression, smoking and alcohol abuse) can be regarded as departure points for an inter-sectoral approach to reach and involve those whose health is adversely affected by social and economic conditions.

A clear and concise overview (manual) of available and effective interventions that focus on disadvantaged groups will also be developed for municipalities and health services.



Norway

Even though Norway is a comprehensive welfare state, social differences have been increasing and there is a social gradient in life expectancy and disease. Until recently social inequalities in health were not explicitly addressed as the focus lay on poverty reduction amongst vulnerable groups. In 2003 a Government White Paper on Public Health was released, in which the reduction of social inequalities in health was established as one of the overall objectives. The White Paper was followed up by an Action Plan entitled '*The Challenge of the Gradient*', which was developed by an expert group in 2005.

A new government White Paper on Social Inequalities in Health was released in February 2007. One of the main points of the White paper is that "Equity is good public health policy." This implies a view on public health policies that aims at a more equal distribution of positive factors that influence health. The White paper presents a ten years perspective for developing a national cross-sectoral strategy to reduce health inequities, covering four areas:

1. to reduce social inequalities that contribute to health differences
2. to reduce social inequalities in health behaviour and use of health services
3. to target efforts for social inclusion
4. to develop increased knowledge and tools for cross sectoral collaboration and planning.

It also outlines strategies for action such as:

- > Reducing inequalities in income
- > Securing equal opportunities for development for all children, regardless of their socio-economic situation
- > Developing an inclusive work life
- > Improving living conditions for vulnerable groups

The main objective for the implementation of the White paper is to develop strategies that run across all sectors of society. In the implementation of the strategies, the following tools are suggested:

- > Health impact assessments
- > Develop relevant tools to include socio economic status in regional and local planning
- > Develop partnerships for health between regions, local governments and NGOs.

The concept of '*partnership*' is a central strategy of the Norwegian public health policy. This strategy aims at developing a holistic approach to health related issues by creating partnerships across administrative levels and sectors (i.e. at the national, regional and local level and also involving the public sector and NGOs).

The implementation of the suggested policies and strategies were discussed during the national **Closing the Gap** Seminar on health inequalities, which took place on the 8th of March 2007 and brought together policy makers involved in health inequalities related issues.



Poland



The Polish health care system has in recent years undergone considerable reforms, that have focused to a great extent on restructuring of the health services' provision and its funding mechanisms, with more attention now being given to public health and health promotion.

Health inequalities are a relatively new subject on the political agenda. There is a substantial body of evidence in the epidemiological literature pointing to the fact that inequalities exist. However there is no specific policy document on the subject.

The previous National Health Programme (1996 - 2005) recognised the existence of health inequalities with regards to gender, urban/rural settings and disparities between regions as well as socio-economic groups. The new National Health Programme (2006-2015) puts more emphasis on health inequalities. Its overall goal is to improve health and quality of life for the population, while its first operational objective is to decrease territorial and social health inequalities. No strategy has however been developed yet to achieve this.

Amongst specific initiatives from the Ministry of Health to reduce health inequalities is the Public Health Act, which includes a special section on health inequalities. In addition, the training and teaching programmes developed for health workers now include health inequalities as a subject matter.

There are a number of policy documents in Poland that are highly relevant to the reduction of health inequalities. The most significant of these is the National Development Plan (NDP 2007-2013). Some priorities in the NDP that are important to health inequalities include: reduction of social exclusion, building social capital, support for families and children and better access to education. It is to be seen how these policies will be operationalised.

The Polish Strategy for Social Policy, which is an integral part of the NDP, can be instrumental in reducing health inequalities. The aim of the Social Policy Strategy is to establish an integrated system of the state policy designed to guarantee all citizens equal access to social rights,

to provide support to families and to support at-risk- groups and individuals, while ensuring the principles of participation and democracy.

An inter-sectoral team of specialists will be appointed that will be responsible for the Social Policy Strategy. This will include a public health and a social policy consultant. Priorities will be established across all intervention activities, and tools will be developed to monitor and evaluate the intervention process.

The Polish National **Closing the Gap** Seminar took place from 14-16 February 2007. The Seminar was a first step in raising awareness, knowledge and skills related to inter-disciplinary working amongst people working at the local and regional level on programmes to improve the quality of life of socially disadvantaged groups.

206 representatives of the health sector, all levels of public administration, the social sector and NGO's attended. Further Seminars and events are planned to continue to build resources in this area.



Portugal



Life expectancy has been increasing in Portugal over the last two decades, and healthy life expectancy has also followed the same path. Recent surveys however, have highlighted important differences in health by social groups.

The National Health Plan 2004-2010 defines strategic guidelines with a view to creating conditions to tackle health inequalities and with that purpose different actions are being taken at both the national and local level.

The goals of the National Health Plan include:

- To achieve health gains by raising standard of health and by reducing the burden of disease;
- To use the necessary tools and equip the health system for innovation and re-orientation of the health care system;
- To ensure the right mechanisms by securing adequate resources, promoting inter-sectoral dialogue, adapting the legal framework and creating the mechanisms that will enable to follow-up and update measures to be implemented.

Additionally, the new Public Health Programme will focus on low socio-economic groups and emphasize partnership working.

At the local level, many interventions are contributing to the reduction of health inequalities, with a specific focus on vulnerable groups such as prisoners, migrants and low-income sections of the population and settings such as schools and work places.



Scotland



Scotland is part of the United Kingdom but health policy is a devolved function and is the responsibility of the Scottish Executive. Scotland therefore has its own specific approach to issues of health inequalities which are viewed in the context of social justice issues.

A Government White paper from 1999 set the framework for current public health and health improvement policy in Scotland, recognising that all action in this area should be underpinned by the need to reduce health inequalities. It was followed by two White papers (2003) that highlighted the need for the NHS to work in partnership with others, such as local authorities and communities to tackle the wider determinants of health and to narrow the health gap. Scotland has strong data on the issue of health inequalities.

NHS Health Scotland, the country's national health improvement organisation, supports organisations and individuals to take action to improve health and reduce health inequalities. It also supports the development of 'healthy public policy'.

Scotland focuses its health improvement initiatives on the most disadvantaged, and its health strategies are therefore tightly related to social inclusion strategies. The Scottish Executive (government) has therefore integrated specific targets to reduce health inequalities within the current social inclusion policy: Specifically, it seeks to increase the rate of improvement across a range of indicators for the most deprived communities by 15%, by 2008.

The Executive's health improvement and social inclusion strategies have led to a number of specific programmes and projects that contribute to a reduction of health inequalities. These initiatives are part of Scotland's wider anti-poverty and community regeneration strategy, but also involves targeted actions within the National Health Service (NHS).

The 'Keep Well' initiative, for example, is targeting health improvement action and resources at five of the most disadvantaged areas in Scotland. These 'Community Health Partnerships' involve building capacity in primary care to deliver proactive, preventative care; and providing early interventions to prevent escalation of health care needs. Seven new Community Health Partnerships will be starting in 2007/2008

In addition, three National Health Demonstration Projects or flagship initiatives are currently being implemented in different parts of the country. These are projects that seek to improve child health ('Starting Well'), inform young people's attitudes to sexual activity ('Healthy Respect') and prevent coronary heart disease ('Have a Heart Paisley'). The purpose of these community-based demonstration projects is to act as testing grounds for action in order to inform national policy and practice.

Scotland also has 47 Healthy Living Centres, which are area-based initiatives designed to address poor health, health inequalities and social exclusion by delivering improved services in the most disadvantaged areas.

A Health Scotland National Seminar, in the context of Closing the Gap took place on 15 February 2007. A number of policy makers and practitioners with responsibility for reducing health inequalities took part. The main aims of the Seminar were to convey the extent of health inequalities in Scotland as well as the national policy response and the wide range of national regional and local initiatives designed to address this problem, and to reflect on evidence and effectiveness.



Slovak Republic

Tackling health inequalities is one of the priorities of the current State Health Policy.

The National Health Policy (2000) identifies tackling health inequalities as a number one priority, and also indicates the importance of cross sectional work. In the National Health Promotion Programme (adopted in 2005) it is stated that Health Impact Assessment (HIA) should be implemented as an important tool to tackle health inequalities.

There is, however, a lack of data on health inequalities and no comprehensive strategies to put the above-mentioned policies into action. During the Slovakian **Closing the Gap** National Seminar, held on 22 February 2007, a lack of political interest to put this issue high on the agenda was identified as the main obstacle for action. This, in turn, is largely due to a lack of capacity to take this issue forward.

A wide range of actions were proposed during the Slovakian Seminar to tackle health inequalities. The lack of relevant information calls for more research on how best to measure health inequalities, on what kinds of policies and programmes can be implemented to address them, and on how best to monitor the effects of these actions on levels of inequalities. The need to engage the Ministry of Health, and to build capacities was also highlighted.

Another important measure is to make use of the existing infrastructure at the regional level to implement a health inequalities strategy. It is very important to increase awareness amongst decision makers at the municipal level and to encourage more inter-sectoral collaboration.

Greater investment in the development and implementation of health promotion programmes that focus on disadvantaged and vulnerable groups, and the use of health impact assessment, is also needed.



Spain



The Spanish welfare system is rather traditional and state-centered, and families still play an important role as service providers. Spain is also a country with vast regional differences. The Spanish health system was decentralized between 1981 and 2002, and health is now a responsibility of each of 17 autonomous communities. There are considerable differences in equity levels within and between regions.

In 1993, the Ministry of Health set up a Scientific Commission to study social inequalities in health in Spain, which resulted in a national report on this subject that was published in 1996. The report did not generate much response at the national level at the time.

More recently however, health inequalities have received increased attention at the national level. In 2006, the 'Quality Plan for the National Health System' included the promotion of equality as one of its six major areas of action. This will be achieved by implementing best practice and by analysing health policies and proposing actions to reduce inequalities, with emphasis on gender inequalities.

Additionally, in 2007, the issue of health inequalities will be addressed in different key national events such as the Health Promotion group of the Inter-territorial Council of the national health system or the national meeting for the Working Group on Vulnerable Groups.

Most interventions implemented by the administration or NGOs in the country still focus on the excluded populations, such as Roma population. Little research has been undertaken using a population based approach.

Some Spanish regions have been much more active implementing comprehensive policies to tackle health inequalities. Three regions (the Basque Country, Navarra and Madrid) have Regional Health Plans that devote a chapter to tackling health inequalities, including relevant targets. In the Basque region, e.g. targets were set to reduce the social inequalities in mortality resulting from cardiovascular and circulatory system diseases.



Sweden



In December 2002 the Swedish Government adopted a Public Health Objective Bill, which aims to improve public health and reduce the differences in health among various population groups. The Bill, which was adopted by the Swedish Parliament in April 2003 is based on the following 11 areas covering the most important determinants of health:

1. participation and influence in society
2. economic and social security
3. secure and favourable conditions during childhood and adolescence
4. healthier working life
5. healthy and safe environments and products
6. health and medical care that more actively promotes good health
7. effective protection against communicable diseases
8. safe sexuality and good reproductive health
9. increased physical activity
10. good eating habits and safe food
11. reduced use of tobacco and alcohol, a society free from illicit drugs and doping and a reduction in the harmful effects of excessive gambling.

Political responsibility for implementing the policy is divided among different sectors and different levels in society (municipalities, county councils and government authorities). During the last decade, most welfare services have been decentralised to the municipalities, which raise their own taxes to fund welfare activities. The Swedish National Institute of Public Health (SNIPH) is responsible for supporting and monitoring the overall implementation of the national public health policy.

A first evaluation of the Public Health Objective Bill indicates that the Swedish welfare model seems to have a positive impact on both the general health of the population and on inequalities between different social groups. A first set of indicators to evaluate the effectiveness of the new approach was presented in the '2005 Public Health Policy Report'. The evaluation revealed, however, that it is not yet clear how well it addresses the needs of specific groups. The SNIPH has therefore identified the need to develop more 'equity-sensitive' indicators on health determinants that will demonstrate the effect of the policies on different subgroups as an important next step in efforts to tackle health inequalities. This will take place in collaboration with Statistics Sweden, the National Board of Welfare and Health and Stockholm Centre for Health Equity Studies (CHES).

Additionally, the Institute has identified the need to bring together and fill in the knowledge gaps about how to decrease inequalities in Sweden. The SNIPH would like the new government to assign it to work in collaboration with the Swedish Council for Working Life and Social Research to describe the effects of different strategies to reduce differences in relation to the socioeconomic position, gender and ethnic origin. This could serve as a basis to develop an action plan to diminish social differences in health in collaboration with concerned authorities, organisations and research institutes.

140 decision-makers at the municipal and county levels as well as representatives from the Swedish Ministry of Health and Social Affairs participated in the Swedish **Closing the Gap** National Seminar that took place at the end of February 2007. The Seminar outcomes reinforced that a universal approach to reducing health inequalities is more effective than a targeted approach, and that general health and the level of health inequalities seems to be closely connected with conditions of economic growth and efficiency of municipal services. These conclusions were based in part on an in-depth look at conditions in Växjö, a municipality in Sweden with no socioeconomic differences in avoidable deaths.



Wales



The focus on inequalities in health started in 1998 (Better Health, Better Wales) and has grown considerably in profile and importance, which has led to investment in more action since then. Wales has established a broad framework of health gain targets and indicators, that like Scotland, do not focus explicitly on 'closing the gap' but emphasise relatively faster improvements for the most deprived groups.

One of the latest developments is Health Challenge Wales, which is Wales' national focus for improving health and reducing health inequalities. This initiative markets good health to the public as a means of achieving an even more co-ordinated and sustained effort to prevent ill health. It involves the public, organisations and all parts of government and has the support of all political parties.

Various public health initiatives have a health-equity focus: Wales's recent nutrition strategy, Food and Well Being, has the subtitle: Reducing inequalities through a nutrition strategy for Wales. Since 2001, the "Inequalities in Health Fund" has supported over 60 projects in disadvantaged communities. All the projects have involved local action to address inequalities in health. All the projects have concentrated on action to prevent Coronary Heart Disease, or helping people who have heart disease. An interim report Inequalities in Health Fund – making a difference was published in February 2006 and summarises progress and achievements. The report and further information about the Inequalities in Health Fund and the projects can be found at www.cmo.wales.gov.uk and www.cmo.cymru.gov.uk.

On the 27th of February 2007 in the context of **Closing the Gap**, the Wales Centre for Health (WCH) organised a conference on health inequalities. This event, attended by 160 policy makers and local actors, aimed to explore the different European approaches to tackling health inequalities, discuss the draft Welsh strategy for action and influence the development of a public health strategy. Different thematic workshops were organised enabling participants to discuss challenges and identify possible actions further contributing to the reduction of health inequalities. In May 2007, the main seminar conclusions will be presented to the Chief Medical Officer who is leading on developing a new Public Health Strategy for Wales. Some of the seminar recommendations are presented here:

1. Evidence and evaluation of health inequalities:

- Obtaining accurate data and information (and notably to develop a guide on how to use health inequalities).
- Building the evidence base to implement targets in Wales as a performance management mechanism. (Setting targets would be beneficial in order to monitor, but these are often complex and difficult to determine).

2. Health in All policy Areas and Health Impact Assessment:

- Use existing opportunities for strengthening intersectoral collaboration at both the national and local level such as the development of the Public Health Strategy for Wales, which will involve close collaboration with stakeholders and partners.
- Designate a leader post in all key organisations to 'champion' HIPA.
- HIA should be made statutory, as it will not be otherwise used.

3. Support at the local level:

In order to develop a partnership model at the local level, priorities for actions have been identified among which: Awareness raising to reduce health inequalities, Communicating effectively, Targeting difficult to reach groups effectively, Closing the gap in health literacy and overcoming the challenge providing health information through the digital divide.



III. EXAMPLES OF GOOD PRACTICES

The following are some examples of initiatives that are being taken at the local level in different EU Member States to contribute to the reduction of health inequalities. Full details of these as well as over 90 good practices collected in the context of Closing the Gap are available at: www.health-inequalities.eu

Supervision by the youth practitioner of pupils with absence because of illness (The Netherlands)



Short description:

Supervision by the youth practitioner of pupils with school absence due to illness in order to decrease non-attendance or early school departure.

Implemented by:

Municipal Health Service West-Brabant

Summary of the Intervention:

The school reports all cases of pupil absences caused by illness to a youth physician. This happens in a structured fashion, based on certain non-attendance criteria and on the basis of a registration form. Subsequently, the pupil and/or his/her parents are invited for a talk with the youth practitioner. During the conversation with the pupil and/or the parents the youth practitioner tries to gain insight into the medical condition of the pupil. Besides attention for medical problems, the youth practitioner may identify behavioural problems, problems with other students or teachers, problems at home, mental health problems or motivational problems. The youth practitioner reports on the results of the conversations and provides advice to the pupils, parents and the school. If necessary the youth practitioner instigates measures to provide the pupil with further supervision and support e.g.: discuss the case with the social services or with the compulsory education officers. In this way efforts are made to improve the well being and thereby the future prospects of high risk pupils with a high non-attendance rate due to illness.

A full description is available at: www.health-inequalities.eu

Springboard Family Support (The Republic of Ireland)



Short description:

Springboard is an initiative of family support projects targeting vulnerable families which aims to improve the wellbeing of children and parents.

Implemented by:

Department of Health and Children / Health Service Executive

Summary of the Intervention:

Springboard is a family support initiative. Family support services aim to respond in a supportive manner where children's welfare is under threat and to prevent avoidable entry of children into the care system. In addition such services aspire to connect families with supportive networks in the community, promote parental competence and confidence and provide direct services to children. In 1998, the government launched an initial 15 family support projects and committed to the further development of the Springboard Initiative. Projects are involved in (1) individual work such as one-to-one sessions with clients to assess needs and offer advice, counseling and support, (2) group work and activities such as parenting, breakfast clubs, coffee mornings, homework and after-school activities, (3) family work such as counseling and therapy and accompanied visits to hospital, court, schools etc., (4) drop-in facilities for information and advice.

An evaluation of the initial support projects was conducted in 2001. This showed that the majority of families availing of the service were disadvantaged with high levels of debt problems, abuse, domestic violence and alcoholism. Around one quarter of all children attending Springboard services showed significant improvement in their school SDQ symptoms (disruptive behaviour, hyperactivity, difficulty in school etc.) but there was no detectable improvement in school attendance. The number of children deemed to be at risk of abuse or going into care was halved. 40% of parents described reduced stress levels and improved support networks while nearly one-quarter recorded improved parenting capacity. Meanwhile, 27 Springboard Projects are in operation nationally.

A full description is available at: www.health-inequalities.eu

Integral Plan for Public Health Improvement in Vallecas (Spain)



Short description:

Special plan for improving the health of residents in Vallecas: an experience in inter-institutional coordination and citizen participation.

Implemented by:

Institute of Public Health for Area 1. Directorate General of Public Health and Food. Board of Health and Consumption of the Madrid Community.

Summary of the Intervention:

In the year 2000 an agreement was reached between the government of the Madrid Community and the Residents' Associations in the region regarding a Plan to invest in different fields (education, health, youth, etc.) in the municipal districts of Puente and Villa de Vallecas, in Madrid for the period 2001-2005.

The "Integral Plan for Public Health Improvement in Vallecas" was initiated as part of the agreement, and allocated a sum of 1.8 million euros. The main aim was to reduce inequalities in health between residents of Vallecas with respect to other areas of Madrid. Three priority areas for action were established:

- > To improve the knowledge of the state of health of the population.
- > To strengthen and implement actions on prevention and health promotion.
- > To study and control environmental and dietary risk factors.

The methodology was based on integrated actions by means of teamwork, inter- and intra-institutional coordination and citizen participation in the implementation, development of activities as well as in budgetary management.

The main results obtained have been:

- > Increased knowledge with respect to demographic and epidemiological indicators, along with the needs and risks as perceived by the population.
- > Identification of and action on environmental and dietary risks.
- > Analysis and development of specific actions on health promotion targeted at the young.
- > Strengthening of actions involving volunteers, mutual help and others aimed at the vulnerable elderly.
- > Actions to publicize the plan.

A full description is available at:
www.health-inequalities.eu

I go to the 'U'! And You? (Germany)



Short description:

Kindergarten group contests to increase the use of early detection services U1 to U9.

Implemented by:

Federal Centre for Health Education (BzG)

Summary of the Intervention:

German health insurances have implemented a programme to stimulate the use of early detection services amongst children (U1 - U9). These services aim to evaluate the physical and psychological development of children and to detect illness and handicaps. While early detection services are frequented regularly by parents of children up to two years of age, uptake decreases when the children are three to five years old, above all amongst children from a low social economic or migrant background.

In order to help these groups, the Federal Centre for Health Education (BZgA) has developed a project entitled "I go to the U! And You?" in order to increase the use of early detection.

The intervention is carried out in socially disadvantaged areas and works on the basis of two principles: incentive and peer pressure.

The kindergarten plays an important role: parents are addressed through posters and flyers that raise awareness about the importance of early detection and the services available, and encourage them to examine their children's vaccination status. All children who frequent U7, U8 and U9 receive a respective "U-T-shirt". As soon as all children in a kindergarten have a t-shirt, a funny group photo is made and sent to the BZgA. All photos take part in a competition. The local actions are implemented regional networks.

These consist of pediatricians, kindergartens, youth welfare services, public health authorities and accommodation managers.

In a pilot phase, the project was successfully implemented in 10 communities

A full description is available at
www.health-inequalities.eu

The following presents key conclusions that can be drawn from an analysis of the ‘Strategic Initiatives’ or plans of action that were submitted by the countries participating in Closing the Gap, as well as their reports on the National Seminars. The conclusions also draw on the National Situation Analysis that was undertaken during the first year of the initiative¹⁰. In addition, it incorporates learning from the discussions at the four project meetings as well as the 90 good practices that were provided by the participating agencies.

We conclude that:

1. There is growing recognition of health inequalities in the EU Member States¹¹

Most countries subscribe to the equity principles and values articulated by the WHO and the EU, and express an intention to promote population health equity and to reduce health inequalities in their national-level policies and public health programmes. Nevertheless, the level of awareness and the extent to which real action is being taken across Member States to achieve the stated objectives varies. And despite increasing recognition of health inequalities, the gap in health status between the most affluent and the most disadvantaged has widened in recent years.

2. EU Member State approaches depend on the historical development and current structures of their socio-economic models, which affects their ability to take action and the nature of the actions that can be taken. Variations in social, economic and cultural contexts also means that population health profiles and priority areas differ, as do the structures in place and the amount and nature of the resources available to take forward action. Effective policies and approaches to tackle health inequalities will need to take into account those country specific circumstances and existing capacities. Effective policies and strategies will therefore be different from country to country.

3. Generally speaking, the nature of actions that are currently being taken by different countries can be divided into three categories: (1) Many countries have a number of projects and programmes that are directly or indirectly relevant to improving the health of vulnerable groups, and can thereby contribute to reducing health inequalities, although this is not their specific aim. (2) Others have established the reduction of health inequalities as the specific aim of initiatives that are being taken at the national or local levels, and have allocated resources towards this aim. (3) Only a few countries have established comprehensive, cross governmental strategies to address health inequalities.

4. There is a tendency in several EU Member States to devolve responsibility to reduce health inequalities to regional and local authorities. In several countries, welfare services, including health promotion, have been decentralised, which means that regional and local authorities are often in charge for developing and implementing action on health equity. National strategies therefore need

to complement regional and local level actions and to provide authorities and stakeholders at these levels with the support that they need to develop their capacities to address health inequalities in an effective and sustained manner.

5. It is increasingly recognised that health inequalities cannot be tackled by the health system alone, since the ‘causes of the causes’ – or the socio-economic determinants of health must be addressed. This means that reducing health inequalities can only be achieved in close cooperation with other policy areas. It therefore calls for the necessary structures and mechanisms to achieve inter-sectoral cooperation and cross government approaches at national as well as regional and local level.

6. The fact that health inequalities are the product of many different factors means that national, regional and local governments have a wide range of choices about where to focus their efforts. There is not a clear ‘health inequalities policy’ and no ‘single way’ or solution to tackling health inequalities. What is clear is that health inequalities is a deep-seated and complex problem and addressing it and flattening the health gradient will require sustained and systematic efforts on a wide range of fronts to target the needs of different socio-economic groups.

7. Successful strategies that countries are adopting involve both upstream (wider determinants – the underlying causes) and downstream approaches (measures to reduce the consequences of unhealthy circumstances). Upstream approaches involve efforts to address the macro socio-economic environment (e.g. efforts to ensure that national policies promote human development and reduce social inequalities). They also entail improving access to education, healthy working conditions, reducing unemployment, social and community inclusion policies. Mid- and more downstream measures ensure that lifestyle related programmes (tobacco control, alcohol misuse, nutrition, physical activity and mental health) as well as health care services address the more vulnerable or disadvantaged groups of society.

8. There is, however, still a strong need, at all levels, to monitor and evaluate the presented policies, programmes and initiatives in order to gain evidence of what works to really alter the slope of the health gradient.

¹⁰ which were also analysed in the report written by Judge, Platt, Costongs and Jurczak and commissioned by the UK Council Presidency Health Inequalities Summit in 2005.

¹¹ Norway is included in this analysis.

EU institutions, member states, regional and local governments and relevant stakeholders, including non governmental organisations, should act upon this learning by implementing priority strategies and measures within their separate and joint powers on the following basis:

We recommend that:

1. Improve visibility and gather data

Political and societal commitment is imperative to tackle health inequalities and can only be achieved if the problem becomes more visible to politicians and the public, for example by presenting strong data and evidence from independent sources.

In several EU countries there is an urgent need to improve national health information systems in order to make the problem of health inequalities more visible. More facts are required about the health gradient and related socio-economic indicators need to be part of the health information system.

In many EU Members States awareness and visibility regarding the issue of health inequalities is still limited and often lacking. In addition to conveying key figures, it is therefore also important to use clear and comprehensible language to raise awareness and understanding, generate interest and convince all relevant stakeholders about the need to address health inequalities.

2. Ensure equal uptake of prevention and health promotion measures

An important place to start raising awareness on health inequalities is within the health sector itself. This would entail the provision of equal access to quality health care services (which some countries are actively looking at), but also raising awareness among health professionals about the need to make their public health interventions equity sensitive, so that they effectively reach different socio-economic groups and generate change.

Too often national or regional programmes that aim to improve population health do not have a sufficient equity focus. Health prevention measures and health improvement strategies must be sensitive to the needs, characteristics and unequal circumstances faced by different socio-economic groups.

Incorporating a health inequality focus in public health strategies (equal access and equal outcome) is a necessary first step forward.

3. Involve key actors and encourage partnerships across policy areas

Health inequality is a multi factorial and complex issue; we need many partnerships across different levels and sectors and to work collaboratively to reduce them.

The health sector (i.e. decision makers and professionals at national, regional and local level) has a crucial leadership role to play in involving other relevant actors. Other sectors often develop policies or strategies that are directly or indirectly relevant to reducing health inequalities. It is therefore the task of the health field to identify these policies and strategies, to liaise with the responsible actors and to argue for and ensure a health equity dimension. The support and commitment of senior management within the health sector is critical in order to make this inter-sectoral process of reducing health inequalities a success.

Examples are available from countries that have already established successful inter sectoral structures (committees, advisory boards, councils) that include policy-makers and civil servants from various governmental departments with the tasks to discuss health equity, formulate comprehensive multi sectoral strategies and/or monitor its cross-sectoral implementation.

The backing of financial departments is of particular importance to ensuring that adequate funds are available. All evidence regarding the benefits of greater investments in health, as well as optimal communication skills must be applied to convince and involve them.

Members of Parliament should be informed and involved to a greater degree, as part of the efforts to build and sustain political support. Political terms of office, as well as policy cycles, must also be taken into consideration. While many of the benefits of measures to reduce health inequalities may only become evident in the long term, it is important to gather and communicate the evidence of short term gains, since it can motivate sustainable political support.

Engagement with the private sector has not been mentioned often in country strategies, but is an increasingly interesting pathway to explore. Private sector businesses have a big impact in the provision of (un)healthy options to citizens and authorities should look at how to work jointly with the private sector in such a way as to reduce health inequalities.

At the local level, it is also important to mobilise all actors that have a direct influence on the lives and health of people in different circumstances, such as schools, primary health care, sport clubs, the voluntary sector, anti poverty NGO's, employers, the private sector, social services, child care support etc. Intermediaries in everyday environments are crucial to tackling health inequalities. National and regional strategies should mobilize a critical mass of intermediaries in order to bring about change.

4. Establish health-equity targets, also across sectors

While most European countries have general health policies that state that inequities in health shall be reduced, there are still very few examples of quantified equity targets that are backed by specific strategies, financial resources and performance management or monitoring systems.

Health equity targets should be developed taking into account the whole spectrum of the gradient and should be defined beyond the boundaries of the health sector and include joint targets that relate to other policy sectors. This particularly concerns joint targets in employment and social policies (healthy working conditions, anti-poverty and empowerment measures), education policy (early drop out for health related reasons), environmental and transport policies (urban planning). The joint target setting process will then automatically be one of a cross governmental nature.

5. Apply equity-sensitive Health Impact Assessments

A number of countries refer to the importance of Health Impact Assessments (HIA). HIA could be a useful tool to investigate and effectively advocate for health equity during a particularly defined policy process in a timely fashion.

HIA does not need to be a complicated process, and while it may require some initial investments, it could eventually be cost neutral and could perhaps even save money. It is important though to ensure that health impact assessments take a health equity focus. In addition, there should be a real readiness and possibility to change policy according to the HIA outcomes.

6. Develop capacities for implementation

In several countries there is still a gap between policy statements and what is happening in practice. This is partly due to the fact that there is insufficient capacity in place to implement those policies. Indeed, adequate financial resources, organisations, services and well-trained people at national, regional and local level are essential to ensure the development, implementation, evaluation and follow up of actions.

There is therefore an urgent need for sustained investments in the development of the organisational and professional capacity. It is necessary to develop infrastructures, which can address health inequalities, and ensure that information systems and coordinating instruments are available.

It is also important to guarantee that qualified health professionals are trained in health promotion methodologies, including the socio and economic determinants of health. Appropriate education in the field of health promotion, health in all policies and health inequalities must be available at university and post-graduate level. Training should also address communication skills and political knowledge, negotiating skills and the ability to work with different disciplines.

Developing capacities can only be achieved through the allocation of sufficient financial resources to enable the successful and sustainable implementation of measures that are comprehensive and coordinated enough to make an impact.

7. Support the local level and encourage local 'upstream' policies

The regional and local level is critical to the development and implementation of strategies that address the health gap. In several EU countries local governments even have the formal responsibility and the mandate to reduce health inequalities.

It is therefore important to encourage regional and municipal governments to prioritise a reduction in health inequalities in their public health plans and to take an inter-sectoral and 'upstream' approach. Local partnerships (e.g. NGO's, local businesses, voluntary sector) should be built and municipal services (e.g. health, social, education) should work together to develop those upstream actions.

Member States should develop the capacity of local level authorities to take up this responsibility and provide resources and knowledge support, link initiatives and maximise efficiency. In addition they could:

- > Encourage and provide technical support for the development of integrated strategies and programmes to reduce health inequalities (i.e. 'upstream' policies)
- > Provide an overview of existing good practices, cross-sectoral methodologies and tool-kits
- > Make available and adapt good practices from across Europe (such as on www.health-inequalities.eu) to local circumstances and languages
- > Support networking at the local level and facilitate an exchange of information among regional and municipal governments
- > Support the use of Health [Inequality] Impact Assessment (HIA) and the evaluation of relevant initiatives at the regional and municipal level
- > Contribute to human resources development; provide trainings, capacity building, apply for grants across sectors
- > Support local advocacy for health inequalities and use their collective experience for advocacy at the national level

Care must be taken to ensure that resources are allocated on the basis of need, so that poorer regions and municipalities do not have less to spend on actions to reduce health inequalities, thereby increasing the health gap.

8. Prioritise sustainable actions that address the gradient

Actions should involve a mix of up- and downstream measures; universal population approaches as well as additional targeted actions to disadvantaged groups, ideally linked to social inclusion and anti-poverty strategies.

Those actions should be prioritised that:

1. generate the greatest levels of inequalities (urgency);
2. lead to the greatest immediate health gains possible (notably amongst the more disadvantaged groups);

3. change the slope of the health gradient by addressing differences in health determinants across all socio-economic layers;
4. take a gender and life-course perspective, and in particular focus on children and adolescents.
5. are most cost-effective.

Specific actions that have proved effective in reaching and promoting the health of the lower socio-economic groups include the use of outreach workers and home visitors, intercultural mediators, self help groups, training and other low barrier approaches that engage and empower people. Several countries stressed the importance of equal opportunities during childhood and early interventions.

A common difficulty faced by many initiatives is that they are often based on short-term funding which endangers long-term impacts on the lives of the people involved. Local, regional and national governments should explore opportunities to scale up those actions that have the biggest impact on the lower socio-economic groups.

Sustainability of actions is critical if they are to have a lasting impact. This does not happen by itself, but requires careful planning.

9. Strengthen the evidence base and get it into practice

Too often policies and strategies are not being sufficiently monitored or evaluated in the different European countries. It is therefore important to ensure that policies and programmes that can contribute to a reduction of health inequalities are evaluated.

This should not be a 'black box' i.e. input-output evaluation. The evaluation should incorporate qualitative methodologies analysing the processes and mechanisms to explain why certain measures were effective or not effective. Evaluation should also include measurements of the extent to which policies or interventions reached vulnerable groups to a greater extent than those who are better off. This implies the development of equity sensitive indicators that provide a more accurate reflection of the differences between socio-economic groups across the gradient.

In this way, appropriate evaluation methodologies (what works for particular population groups and in what context) could also improve our understanding of the underlying mechanisms of emerging health inequalities.

More evaluation and better methodologies will only be effective, however, if the information gained is then disseminated amongst relevant, interested actors. Additional efforts should be undertaken in order to ensure mutual exchange among researchers, professionals and policy makers to learn from (un)successful initiatives and by taking up the lessons learned.

In this context, the cost-benefit-evaluation is another methodological challenge, which is to date underdeveloped.

10. Incorporate and build on EU processes

Initiatives taking place at the level of the European Union (EU) can reinforce national and regional level efforts. It is therefore important to establish parallels between EU level and EU Member State activities.

The European Commission's Open Method of Coordination (OMC) in the areas of Health and Long Term Care and Social Inclusion, can for instance help to stimulate and advance action on health inequalities within EU Member States. Common Objectives of this OMC include equal health outcomes and access to quality health services. Governments should link their health inequalities strategies to their National Action Plans on Social Protection. Public Health stakeholders need to become more involved.

The EU Structural Funds could, in particular amongst the 'new' EU Member States, be directed to fund health promotion measures that address disadvantaged people.

Comparable data on socio-economic variables and health could be made available via joint efforts from EU Member States and the European Commission.

The European Commission can also facilitate the process of sharing good practice and discuss transferability amongst EU Member States via the setting up of expert groups, platforms and networks. Several action programmes, in particular in the health and social policy

fields, have funds available for trans national exchange. In addition, the EC 7th Framework Research Programme includes opportunities for research on health inequalities interventions.

At the same time, it is important to ensure that rules and legislation deriving from the EC are consistent with EU values in the area of social justice, solidarity and equality and with the EU's Public Health strategic objectives and that they contribute to rather than undermine efforts to reduce health inequalities.

Taking action on health equity

Everybody has the right to, in the words of the World Health Organisation¹², the 'enjoyment of the highest attainable standard of physical and mental health'. Tackling health inequalities is a way of ensuring that everyone is empowered to make informed choices and has equal opportunities to achieve good health. Action in this area indicates that Europe and its Member States are committed to invest in the protection of this fundamental right.

The **Closing the Gap** partnership has not identified any 'quick fix' solutions to do this. Rather we recognise that health inequalities are a deeply rooted and multi causal issue, and reinforce that governments need to invest in a comprehensive package of sustainable policies and actions to tackle multiple deprivation and inequalities across socio-economic groups. However, we also conclude that we should not be inhibited by its long-term nature and see this as an important challenge for working together across Europe. **Closing the Gap** has proven to be a valuable initiative for cooperation in this area. We hope that in the future this cooperation will grow and lead to further joint actions for health equity.

CLOSING THE GAP

Strategies for Action to tackle Health Inequalities

BZgA

Bundeszentrale
für
gesundheitliche
Aufklärung

BZgA

Ostmerheimer Str. 220

D-51109 Köln

Germany

Tel: +49 (0)221 8992-0

Fax: +49 (0)221 8992-359

www.bzga.de

Helene Reemann

Dr. Simone Weyers

Dr. Monika Meyer-Nürnberg

Dr. Frank Lehmann



EuroHealthNet

the European network for public health,
health promotion and disease prevention

EuroHealthNet

6 Rue Philippe le Bon

B-1000, Brussels

Belgium

Tel: +32 (0)2 235 0320

Fax: +32 (0)2 235 0339

www.eurohealthnet.eu

Caroline Costongs

Ingrid Stegeman

Sara Bensaude De Castro Freire

Clive Needle



National Institute of
Public Health

