The story of DETERMINE

Mobilising Action for Health Equity in the EU

Final Report of the DETERMINE Consortium

BZgA Bundeszentrale für gesundheitliche Aufklärung
EuroHealthNet the European network for public health, health promotion and disease prevention
IPH
IUHPE International Union for Health Promotion and Education www.iuhpe.org
National Social Marketing Centre
National Institute of Public Health SZÜ

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This final report of DETERMINE (2007 – 2010) is written by Ingrid Stegeman, Caroline Costongs and Clive Needle from EuroHealthNet on behalf of the DETERMINE Consortium (see annex).

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The Story of DETERMINE

Our main messages

The DETERMINE Consortium highlights the following key messages on what is needed to advance work on addressing the social determinants of health and reducing health inequities:

Please see Annex 1 for the full version of these messages

1. Health systems[1] in EU Member States should ensure that reducing health inequities by addressing their underlying determinants is at the forefront of the policy agenda.

2. Health inequities are a population-based issue. Social position is directly correlated with health, resulting in a 'health gradient' that affects all groups of society. This needs to be widely understood by policy makers and practitioners within and beyond health systems across the EU.

3. The EU and its Member States should focus on gathering data on health inequities that is understandable, comparable and actionable.

4. Health systems within EU Member States should give greater priority to improving engagement with other policy sectors, promoting 'health equity in all policies' approaches. This involves developing legislation, reorienting and developing the health workforce and increasing the resource base for health promotion.

5. The EU and its Member States should invest in and coordinate efforts to develop better regulatory practices to ensure the most efficient and effective use of public resources to improve health equity. This requires more systematic application of and involvement in impact assessments procedures and economic analysis, and investing more in policy research and evaluation.

6. The EU and its Member States have a role to enhance the ability of local level actors to address health inequities by raising awareness about the health gradient and to provide them with tools and mechanisms to work with other sectors and disadvantaged populations on a regular basis.

7. The EU and its Member States should continue to invest in promoting, exchanging, and building on knowledge in this field, thereby actively supporting efforts to build a stronger basis for cross-sectoral work, such as initiated by the DETERMINE partnership and others. This involves exchanging information, building capacities, and greater engagement of the media and the public.

The Consortium sincerely thanks all its partners and the services of the European Commission for their active participation and support during the project period.

The Story of DETERMINE

Why did we work on health inequities?

Health inequities persist within and between states in Europe. They refer not simply to health differences between the best and the worst off in our society, but to the systematic correlation between our health status and our socio-economic status. This 'health gradient' exists across societies, for almost all causes of illness and for mortality, and therefore concerns everyone.

This health gradient reflects that our health is intimately linked with the economic and social conditions in which we live. Political, economic and social forces create and undermine our personal health and well-being. While life expectancy has steadily improved in most EU Member States, those who are better off benefit more than those who are worse off, leading to a growing gap of health inequities between rich and poor. People further down the socio-economic ladder face twice the risk of serious illness or premature death than those at the top. This situation will most likely be exacerbated by the current economic crisis and is unjust and unacceptable.

Why should the EU and its Member States invest in greater health equity and in levelling up the health gradient?

The European Union's aim, set out in the EU Treaty of 2009 (Title 1 Article 3) is to "promote peace, its values and the well-being of its people". Concepts of 'health' and 'well-being' are closely correlated, including in the founding WHO Charter. The existence of health inequities means that the EU is not effective in achieving its aim to protect the well-being of a large proportion of its citizens.

European societies value the concept of 'equal opportunity'. The fact that the socio-economic status that we are born into is a strong determinant of our health, which is important to our ability to take up other chances, belies the notion that we all have equal opportunities.

Health inequities signal a loss of human potential. Investing in the reduction of health inequities would unlock the productive and creative potentials of a wide number of people that are currently suffering from illness, mental health problems, or dying prematurely.

The imperative is both moral and economic. The EU's priority approaches to economic development, set out in the Lisbon Strategy to 2010 and proposed in the Europe 2020 plans, contain health but not health equity indicators and measures, which DETERMINE has found to be inadequate.

Facts on Health Inequities

- Between EU Member States, there is a 13.2 year gap in life expectancy at birth for men, an 8.2 year gap for women, and a 5-fold difference in death rates of babies under one year of age.[2]
- In the Netherlands females and males with low educational status have a life expectancy that is 7 years lower than those with higher educational status, and live 18 years less in good health.[3]
- While a man in Estonia spends up to 71% of their life in good health, a man in Denmark can expect to live 90% of their life in good health.[4]
- In Scotland in 2006, men could, on average, expect 67.9 years of healthy life and women 69 years. In the most deprived 15% of areas in Scotland, men could only expect 57.3 years of healthy life and women 59 years.[5]
- The number of life years lost due to deaths that can be attributed to health inequities in the EU is approximately 11.4 million.[6]

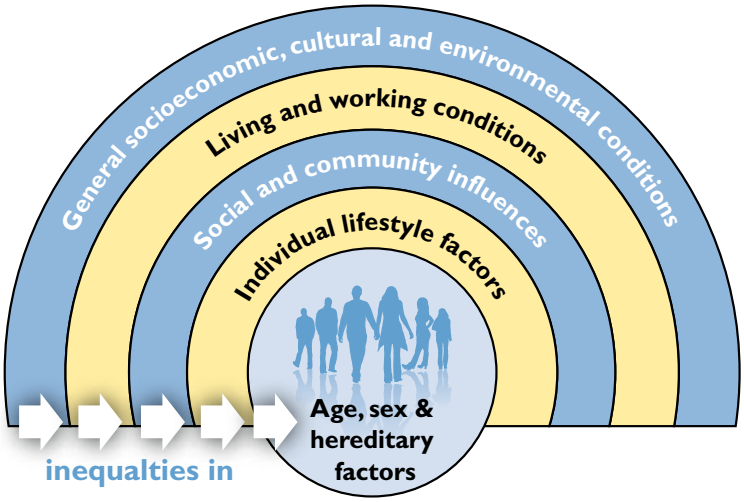
The DETERMINE Consortium

A major initiative to address the issue of health inequities in the EU has been the establishment of the DETERMINE Consortium, comprised of public health and health promotion institutes, governments, non-governmental organisations and academic organisations from 24 European countries. These bodies came together to assess what is being done to improve health equity in the EU and to identify and stimulate further collective action.

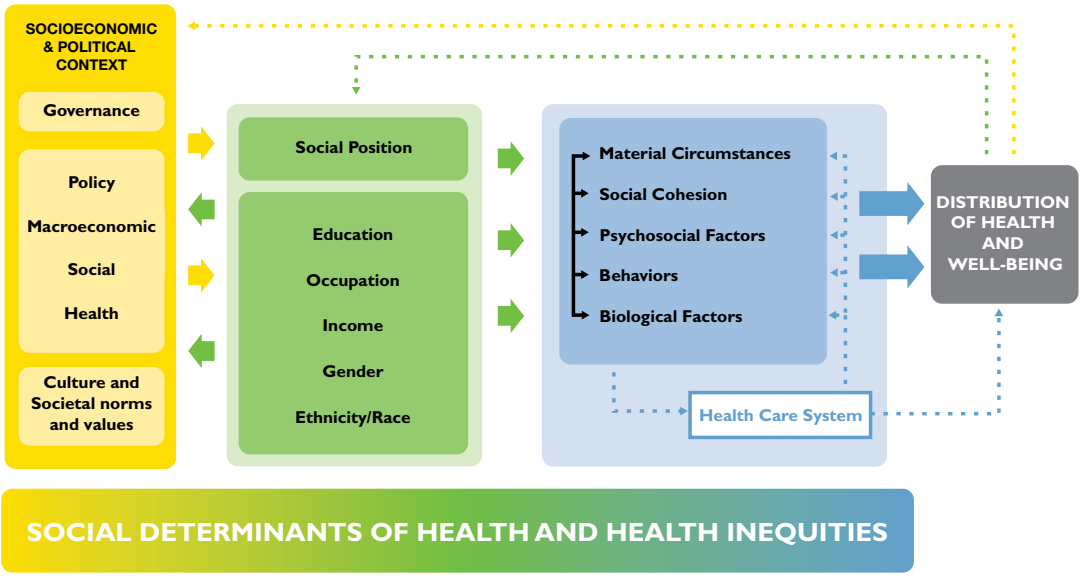
The work of the Consortium built on the momentum generated by the work of the WHO Commission on the Social Determinants of Health (2005-2008). The CSDH collected evidence on policies that improve health by addressing the social conditions in which people live and work. Amongst the goals of the CSDH was to build a sustainable global movement for action on health equity and the social determinants of health.[7] The Consortium also helps to take forward some of the actions outlined in the EC Communication on "Solidarity in Health, Reducing Health Inequalities in the EU".[8] By focussing on what can be done in the EU, DETERMINE aims to contribute to global learning in this area.

The conceptual basis we adopted

DETERMINE applied both Dahlgren and Whitehead's Wider Determinants of Health model as well as the WHO CSDH model as its conceptual basis.



Health Determinants Model[9]



Summary pathway and mechanisms of social determinants of health inequalities[10]

These two models make clear that there are many entry points, and no "quick fix" solutions to ensuring that everyone has equal chances at good health.[11] This can only be achieved by, in essence, assessing who is disadvantaged, when, where and why, how this is impacting their health, at what points along these models action can be taken to address this, and by taking the necessary measures.[12] This entails mobilising a wide range of actors to work together towards the common goal of achieving equity and reducing health inequities in particular.

DETERMINE in figures

Time frame: June 2007 – June 2010
Coordinator: EuroHealthNet
Contract holder: Czech National Institute of Public Health
Co-funder: DG SANCO under the EU Public Health Action Programme
Other Work Package leaders:
Finnish Centre for Health Promotion, German Federal Centre for Health Education (BZgA), Institute for Pubic Health in Ireland, Social Marketing Centre (England), International Union for Health Promotion and Education (IUHPE)

Countries involved: 24

Actions include:

- www.health-inequalities.eu
- DETERMINE film www.youtube.com/eurohealthhet
- 120 good practices in website database
- 4 Consortium Meetings in Lisbon, Ljubljana, and Prague and Brussels, plus a Capacity Building event in Paris
- 40 Consultations with Policy Makers
- 1 Action Summary in 14 languages
- 1 Interactive 'Menu of Capacity Building Actions'
- 4 Working documents
- 22 capacity building actions in 20 countries

Our approach

The DETERMINE Consortium took a three-pronged, interconnected approach to identifying and instigating concrete actions that can be taken in the EU to reduce health inequities.

This involved:

1. **Contributing to our understanding of the problem**
2. **Identifying and highlighting potential solutions**
3. **Stimulating action to ensure progress for health equity**

The following sections provide some key examples derived from the work of DETERMINE. This information is not intended to serve as a comprehensive account of the work of the Consortium, but is an overview of some of the main outcomes.

Further information about the DETERMINE project and its outcomes is available on The European Portal for Action on Health Equity (www.health-inequalities.eu) The portal provides information on policies and interventions to promote health equity in European countries and at the EU level, and links to all DETERMINE working documents, publications and other relevant background literature. It also contains a directory containing over 120 good practice examples from across Europe.

PART I:
Contributing to understanding the problem

While a lot is known about the existence of health inequities and the health gradient, less is known about the best approaches to address them. The DETERMINE Consortium investigated what is being done across Europe and at the EU institutional level to draw learning about the best approaches to tackle the social determinants of health and health inequities.

Consortium members looked at what kinds of policies, programmes, tools and mechanisms are currently being implemented to address the SDH and health inequities. They explored what politicians and policy makers in other sectors know about health inequities and their experience of working with the health sector.

The Consortium also looked into the economic dimension of addressing health inequities. Finally, Consortium members investigated what kinds of projects have been successful in the EU to improve the health of vulnerable groups.

A. What policies, programmes, tools and mechanisms are currently being applied across Europe?

A review of policies and mechanisms that are being implemented in 15 European countries[13] to address health inequities and the social determinants of health revealed that, although few countries in Europe have government policy which emphasises these issues, there is action taking place.

There are some examples where action is comprehensive, where governments have developed policies aimed at broad societal goals to indirectly or directly address the issue of health inequities.

Setting an example

➔ *The overall objectives of the **Scottish government** are for sustainable growth and opportunities in a Scotland that is "Wealthier & Fairer; Smarter; Healthier; Safer & Stronger and Greener." Five Director Generals have been charged with leading work on these objectives. 'Joint government' action to achieve these will address the underlying causes of health inequities in Scotland and are expected to lead to improved health equity across the population.*[14]

Setting an example

➔ ***One Wales** highlights the Welsh Assembly Government's ambition to transform Wales into a self-confident, prosperous, healthy nation and society, which is fair to all. Health and inequities in health are key to this and are fundamental considerations across policy areas. The statutory duty of the Welsh Assembly Government to consider sustainable development in all that it does can be seen as one way to include routine consideration of health inequities and their social determinants in all policies.*[15]

The Acheson report in the UK, an Independent Study into health inequities, commissioned by the government in 1997, exposed the limitations of individual initiatives within social justice and health inequities and the importance of joined-up action. In 2002, as part of the formal government –wide spending negotiations, the Department of Health and the Treasury led discussions between 18 departments to develop a Programme for Action. The Treasury's financial and political authority was instrumental in facilitating agreement between departments to combine expertise and resources behind government priorities.[16]

In other countries, health ministries are implementing comprehensive strategies that call for inter-sectoral collaboration to reduce health inequities. These strategies call for partnership or joint working with other sectors. The Swedish Public Health Policy (2003) is based on the recognition that actions that affect health are often the responsibility of other policy areas. Inter-sectoral collaboration is therefore at the forefront of this policy; it is also the focus of the Norwegian Strategy to Reduce Social Inequities in Health.

Setting an example:

The Norwegian National Strategy to Reduce Social Inequities in Health (2007) *aims to mainstream social inequity concerns and to promote the view that 'equity is good public health policy'. It continues the work set out in the White Paper Prescriptions for a Healthier Norway (2003) and the Challenge of the Gradient action plan (2005).*

While this strategy makes explicit reference to health in its title, it was nevertheless felt that an important factor facilitating collaboration during its development was to focus on the common goal amongst ministries of reducing inequities and not necessarily health inequities. In this way, some common ground was reached and interest grew in targeting the "causes of the causes" of inequities in different areas (health, labour and education).[17]

The action plan of the Finish Ministry of Social Affairs and Health is another example of a comprehensive strategy to reduce health inequities.

Setting an example

The Finnish National Action Plan to Reduce Health Inequalities 2008-2011 *provides proposals for the most important measures in welfare policies to tackle poverty, education, unemployment, working conditions and housing, as well as proposals for promotion of healthy habits and equitable use of health services. The Plan also focuses on developing the knowledge base.*

It was prepared and is being coordinated and led by a multisectoral permanent Advisory Board of Public Health, which consists of representatives from various Ministries, regional administrations, government research institutes, professional organisations and NGOs. A group of researchers involved in the 'TEROKA' project, which focused on consolidating the knowledge base of health inequities in Finland, played a significant role in getting the plan onto the political agenda and in the preparatory phases.

DETERMINE partners identified a variety of strategies developed and led by other (non health) ministries that can contribute to a reduction in health inequities. They relate to policy areas such as social affairs, education, employment, environment, urban and regional planning, neighbourhood renewal and housing –most of them focusing on poverty and social inclusion and improving core services in the most deprived areas. Greater involvement by health systems in these 'other' policies and programmes can help to ensure that they maximise their potential to reduce health inequities.

Setting an example

- ***The EU Open Method of Coordination (OMC)*** *process in the area of Social Protection (Social Inclusion, Pensions, and Health and long term care) encourages countries to establish objectives and develop integrated policy goals in these areas. The OMC is a potentially significant mechanism to initiate and strengthen collaboration between the social and health sector. The Commission publishes a yearly Report on Social Protection and Social Inclusion that reviews the main trends across the EU and at national level. While health inequities was not from the outset considered, this has changed in recent years, as it has become one of the focus areas .*[18] *It is likely this process will be reviewed in the coming year.*

It is important to note that policies and strategies do not necessarily lead to action. To do so, they must be implemented, which requires financial and human resources and mechanisms and tools to facilitate action. DETERMINE partners indicated that explicit financial resources earmarked for the goal of reducing health inequities, committees and offices bringing together different sectors and focussing on this goal, and processes such as inter-sectoral consultation are essential to action on health equity and social determinants of health.

In addition, policy and programmes developed in other sectors should be screened for their impact on health inequities on a more regular basis. Health Impact Assessment is in this context an important tool, although it is important to ensure that it screens for impacts on different socio-economic groups.

Setting an example

- ***Health Impact Assessment (HIA****) considers the potential impacts of policy implementation on the health of the population as well as specific population groups. It is not a statutory requirement anywhere in Europe, and government departments are not obliged to conduct them on a regular basis.*

- *In* ***Wales****, however, an Impact Assessment Support Unit, funded by the Welsh Assembly Government, has published a range of HIAs that deal with central and local government activity. Other Impact Assessment tools being applied across Europe and at EU level are a statutory requirement and may also focus on health and health inequities, such as Equality Impact Assessments in* ***Northern Ireland****.*

- *In* ***Scotland****, Inequities Impact Assessments are used for some policies in some areas of government, with plans to extend use for all policies under development.*

- *Strategic Environmental Assessments, which are required across EU Member States by EU Directive, incorporate health considerations, but not health inequities.*[19]

An overview on national level policies applied in European countries is available at www.health-inequalities.eu. The information includes cross governmental policies and strategies to address socio-economic determinants of health, driven by the health and other sectors.

B. Other policy-sectors' awareness of health inequities, and the current nature of collaboration between health and other policy sectors

Gaining a better understanding of what other policy sectors know about health and equity is critical in paving the way for further action on health inequities. To what extent do other sectors already work with health systems, and what are their views on strengthening collaboration?

DETERMINE partners consulted with politicians or policy makers from another sector at the national, regional and local level to assess their views on these themes. Amongst the findings of the 40 consultations undertaken by DETERMINE partners in 19 European countries[20] was that while collaboration between health and other sectors does take place, no examples were provided that this was initiated by the health sector.[21] This suggests that there is room for a more proactive approach, which could actively invite other partners to the discussion table at an early stage, while providing concrete support to other sectors by helping to achieve their aims and objectives.

In addition, collaboration between health and other sectors took place in areas such as the environment, social policy, workplace conditions, etc, where the link to health was most clear. It was less evident in areas like finance, justice and foreign affairs, which also impact on health, but via different pathways.

A number of those consulted felt that they would need government mandates to work inter-sectorally. They indicated that they would benefit from legislation on inter-sectoral cooperation and from national guidelines to ensure the consistency, effectiveness and sustainability of partnerships. There was also a strong feeling that common targets and a shared budget were important to ensure successful partnerships, although issues of accountability are at stake and more work must be done to determine how this can be achieved in practice.

Additional Findings:

- *Health inequities are understood in terms of differences between 'richest and poorest', but little awareness of the health gradient.*
- *Cooperation frequently happens on an ad-hoc basis at the local level. While less frequent, it seems better 'institutionalized' at the national level.*
- *Establishing a personal rapport of trust helps to initiate collaboration; personal relations and initiative are important.*
- *Inter-sectoral action works best when measurable policy objectives and win-win solutions can be identified for all sectors involved.*
- *A number of those consulted identified the need for greater exchange of knowledge, information and tools to advance inter-sectoral collaborations.*

C. The economic costs of health inequities

A key way of convincing politicians, policy makers and the broader public of the need to invest in the reduction of health inequities is to provide evidence of the economic rationale for doing so. This requires stronger proof that investing in the reduction of health inequities represents a more effective use of resources than paying the costs of ill health and lost productivity. The DETERMINE Consortium worked on identifying the economic arguments for addressing health inequities, as a key advocacy approach.[22]

It proved difficult to find strong evidence to form the basis of economic arguments, since this field is still relatively young. Unsurprisingly, only the few countries in Europe with government policies that emphasise health inequities and the social determinants of health also tend to include health outcomes in the economic evaluation of non-health policies.

Some of the challenges to undertaking economic analyses related to methodological difficulties, such as attributing health outcomes to interventions, measuring and valuing health outcomes and incorporating equity considerations. Others related to the overall costs of undertaking economic assessments. There can also be resistance to developing economic arguments for moral or ethical reasons: creating health should not be about saving money but about improving the quality of life for citizens.

The DETERMINE Consortium nevertheless found that efforts are being made to analyse in economic terms the impact on health and health inequities of a range of policies outside health care, and identified several examples.

Setting an example

- *In **Scotland**, the report of the Ministerial Task Force on Health Inequities, 'Equally Well', states that "a reduction of health inequities, by improving the health of the most deprived, is likely to result in a reduction of the costs to the National Health Service (NHS) and society as a whole. If 40% of all short journeys were switched from car to bicycle, it would result in an estimated saving of at least £2 billion per year due to reduced mortality*

- *In **Norway**, the benefits of walking and cycling are estimated to outweigh costs by a factor of 4.5:1. Investing in early childhood can generate a 2-7 to 1 return on every euro invested. In 2004, productivity losses due to ill health cost an estimated 141 billion euro.[23]*

This work can help to contribute to the argument that investing in health equity through action on the social determinants of health is more cost effective than paying for the consequences of health inequities.

D. 'Innovative' approaches to improving the health of vulnerable populations

Reducing health inequities means levelling up: improving the health of the more vulnerable at a faster rate than the rest of the population. One of the DETERMINE work-strands investigated projects and practice that aim to improve the health of the less well off.[24]

A number of DETERMINE partners identified 'innovative approaches' in their countries, which were defined as: "those interventions which practice new solutions for certain problems and challenges through the application of new ideas, techniques and methods". One of the findings was that what is considered 'innovative' in one country may be common practice in another.

Setting an example

➔ *Truck drivers typically have difficulties accessing acute medical services due to working conditions. As a result, many rely on self-medication with adverse effects on their fitness to drive and road safety. Preventive measures, such as check ups, are also rarely taken, resulting in higher risks of musculoskeletal, cardiovascular and cancer related diseases.* ***The Doc Stop project in German****, provides quick access to medical services for European truck drivers by partnering with 290 German motorway service areas. Addresses of medical specialists are deposited in registered motorway service areas and transportation to nearby doctors is provided. Doctors located within 4 km of the highway give preferential consultations to truck drivers. The service is available to those with health insurance with European coverage.*

DETERMINE also selected and provided funding to three small scale pilot projects with promising approaches, such as social marketing, to improve the health of disadvantaged groups.

These focused on:

- **Improving the health of overweight men with little or no education at workplaces in the Municipality of Guldborgsund, Denmark;**
- **Planning healthy and sustainable housing amongst a segregated Roma community living in Debrecen, Hungary;**
- **Enabling homeless to help themselves and improving their access to health services as well as the publics' awareness and perceptions, through a wide range of initiatives, in Slovenia.**

The process of choosing, monitoring and evaluating the three pilot projects generated a broad range of information about effective elements of projects involved with the wider determinants of health. Common to almost all the projects was that they understood the challenges people faced in their everyday lives, were citizen-centred, adopted participatory approaches in defining the project aims and harnessed the human and physical "assets" within communities. Empowering people and communities to address their own needs improved the sustainability of the projects.

Setting an example

*The **Opre Roma Association, ('Rise up Roma')** is based in **Debrecen in Hungary**. On the basis of a consultation, the Association identified housing as the most pressing problem that the Roma community living in Debrecen faced. The project therefore sought to improve the living conditions of people living in slum housing.*

Community members were engaged in the development of housing plans to present to a housing charity with the aim of relocating and building sustainable and secure housing. In addition, they received training in household management skills such as understanding the financial consequences of energy usage. They were also taken on field trips to explore environmental issues about energy use and pollution. An unexpected but positive outcome of the project was that it brought Roma and non Roma groups together that were previously mistrustful of one another.

*The **Manuel Merino Health Care Centre**, located in Alcalá de Henarés, Madrid, Spain, developed a programme with the participation of young people to address common problems that youth living in deprived areas face. The underlying principle is that young people themselves are best able to identify how to resolve their problems and to support one another in this process. The project brought together professionals from different fields, while the adolescents engaged in unique activities such as the development of a blog - http://adolescentes.blogia.com/ ,a radio broadcast and educational materials.*

A number of effective approaches were based entirely or in part on public/private partnerships, which can help to maximise available resources. These refer to "voluntary and collaborative relationships between various parties, both state and non-state, in which all participants agree to work together to achieve a common purpose or undertake a specific task and to share risks, responsibilities, resources, competencies and benefits."[25]

Setting an example

***Business in the Community** is a business led and funded non-profit organisation based in the UK that engages with the community to improve well being. 850 companies are members, while 3,000 companies are engaged in programmes and campaigns, as well as 100 partner organisations internationally. BiTC campaigns, coordinates programmes, issues awards, benchmarks and develops publications.*

Specific examples of how businesses engage with the community:

- *football clubs taking forward health awareness programmes*
- *banks helping people start small businesses or develop existing businesses*
- *'business-brokers' bringing public/private actors together to work as part of a collective plan to improve conditions in deprived neighbourhoods.*

http://www.bitc.org.uk

Setting an example

➔ ***The Holiday Participation Centre*** *is a service of Tourism Flanders & Brussels (Belgium) that was founded in May 2001. It works with private and public donors to enable low income families and other people who are usually unable to go on day trips or holidays, to do so.*

The Centre collaborates with the tourism industry to organise day trips, group holidays and individual holidays. The Centre has also developed partnerships with 950 other local organisations, such as welfare centres, volunteer organisations working on poverty and social exclusion, social services, family guidance services, and neighbourhood centres. Those benefitting from these services reported improved mental health and well-being well after the city trip or holiday. http://www.holidayparticipation.be

The outcomes of one of the DETERMINE pilot projects highlights some of the perils of private-public partnerships. Caution must be exercised to ensure that the private sector keeps the best interest of the target groups at the forefront:

Setting an example?

➔ ***The Guldborgsund project*** *managed by the public health department of the Municipality of Guldborgsund, Denmark, looked to use a public-private partnership with local employers to improve the health of obese, inactive men with little or no education. The Municipality of Guldborgsund built relationships with two private organisations. The Municipality worked with the companies to develop and implement plans to tackle problems identified relating to diet, tobacco, alcohol intake and physical activity.*

During the course of the project, however, the number of employees in a private company was reduced by around 250 as a result of the economic crisis of 2008. Evidence suggests that those who were laid-off tended to be those employees with lower qualifications or had more serious health problems. There was little evidence that the project had provision for maintaining relationships with those made redundant. Such an approach is likely to increase inequities.

"Innovative" approaches like the examples above that focus in particular on improving the health of vulnerable groups are important to reducing health gaps across different sectors of society. But an important caveat when identifying projects and programmes that can effectively address health equity is that they are seldom evaluated. As a result there is no strong body of evidence of effective practice. There is therefore a need to improve evaluation of policies and programmes that address health inequities in order to build a stronger evidence base of what works.

More detailed information on the pilot projects and another 114 good practice examples from across Europe can be found at www.health-inequalities.eu.

PART II:
Highlighting potential solutions

The work that the DETERMINE Consortium undertook to gain a better understanding of what is being done in Europe to address health inequities generated insight into important entry points to address the issue. It is evident that while awareness about health inequities has, in recent years, been growing, a great deal still needs to be done to mobilise coordinated action. The primary responsibility for this lies with health systems, which must advocate for action and stimulate other policy areas to engage by providing guidance on what can effectively be done.

"The role of the health sector is important in acting as a catalyst by raising health and health inequalities agenda" (Policy maker from an Environment Ministry)

"The biggest obstacle is getting politicians to see the problem and to find solutions. One has to break down the issue so that decision makers feel comfortable with the discussion and feel that they can play a role in solving the problem" (Local politician)

Raising awareness of the problem and strengthening the role of the health sector are vital to scale up efforts for progress. It is also important to ensure top-level government mandates for action and to involve those who are less well off in efforts to improve their own health, through participatory approaches.

A. Awareness Raising and Advocacy

At the basis of effective action on health equity lies the need to raise awareness of the issue in such a way that practitioners, politicians, policy makers and the public are moved to action – the so-called "nutcracker effect " set out so well in the report of the WHO Commission on Social Determinants of Health.

Cartoon by Simon Kneebone, published by Fran Baum (2007), IIJHP&E,XIV, 2, 90-95. Reproduced with permission.

This requires understandable and comparable data that highlights the problem of health inequities in a manner that can be communicated and translated for these different groups.

Setting an example

- *A national survey conducted in 2002 in **Estonia** revealed that increasing gaps in health inequalities had emerged across different education levels, incomes, places of residence and nationalities. In response to these findings, since 2004, all new national health strategies include the principle of equity.*

- *Similarly, a **Spanish** research report on Social Inequities in health, life styles and health services utilization in the Autonomous Regions 1993-2003 had important implications for policy making.*

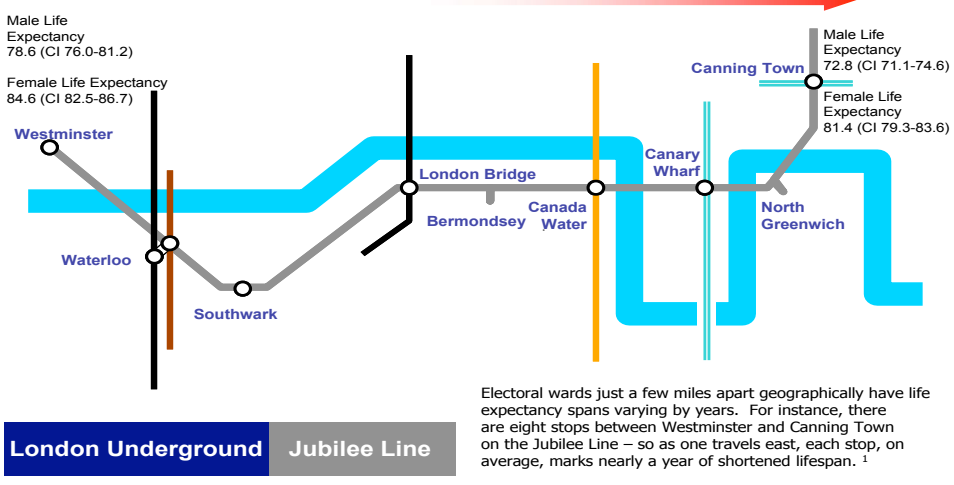
- *In **Finland**, municipalities are highly autonomous and can determine how policies are implemented in practice at the local level. The national government has made it mandatory that all municipalities monitor population health by different population groups. Although some small municipalities find this requirement difficult to fulfil, it draws attention to health differences.*

Many countries do not have good data on health inequities. DETERMINE concludes that the EU and Member States should ensure that improved data, stratified by socio economic indicators and including data on health determinants, is collected on a regular basis and that it is comparable across localities.[26] This data should include a wide range of 'intelligence' sources that can provide a more holistic understanding of the complex nature of SDH, such as data from transport, culture, tourism and from other agencies such as the policy, the business sector and the media.

In and of itself, however, good data is not enough. To effectively raise awareness, it must be presented in clear and compelling ways that can be easily understood by policy makers, civil servants and the general public.

Differences in Life Expectancy within a small area in London

Travelling east from Westminster, each tube stop represents nearly one year of life expectancy lost –Data revised to 2002-06



Electoral wards just a few miles apart geographically have life expectancy spans varying by years. For instance, there are eight stops between Westminster and Canning Town on the Jubilee Line – so as one travels east, each stop, on average, marks nearly a year of shortened lifespan. [1]

[1] Source: Analysis by London Health Observatory using Office for National Statistics data revised for 2002-06. Diagram produced by Department of Health

Needle C, Beulque C and Williams M, Poster and advertisement for The Parliament magazine, www.equitychannel.net 2009

"Policy decisions are usually determined by financial considerations … to make policy decisions 'health centred' would need an alternative use of available resources"
(Policy maker from the Justice Ministry.)

Further work must also go into raising awareness about the economic benefits of health equity to society. This can generate the support of the highest levels of government, including the finance ministry, which is a crucial actor to get on board.

Advocacy and awareness raising means that public health and health promotion professionals and relevant actors must strengthen ties with the media.

Setting an example

*Despite the good quality of health care in Belgium, the country faces high levels of health inequities. Since 2006, the **King Baudouin Foundation** has taken steps to address this, by bringing together a diverse working group of experts in health and welfare.*

The expert group's initial objective was to ensure that political groups put the issue of inequities in health at the top of their agenda, in the wake of national elections. The working group produced a report with policy recommendations. An important aspect of the approach was collaboration with journalists to ensure that the issue of health inequities received regular media attention. General articles explaining the phenomenon were written for the major French and Flemish newspapers, as well as articles outlining different political parties' positions on the issue.[27]

B. Leadership from the health sector

Raising awareness is but a first step, and can only be achieved and generate change if health systems display the leadership to improve health equity by building capacities to enable professionals to advocate successfully.

Setting an example

➔ ***NHS Health Scotland*** *engages in awareness raising and advocacy through its capacity building and leadership programmes. It for example provides a training course on 'Improving Health –Developing Effective Practice'. It has also developed and implemented other programmes to train people to act as leaders and advocates for health improvement across organisations, rather than just at the top level.*[28]

The analysis undertaken by DETERMINE partners reveal that in some cases there is leadership across government to addressing health inequities, and comprehensive action is being taken. Most countries in Europe do not, however, have elaborate strategies in place. They may, for example, mention the reduction of health inequities in their national health strategies, but apply few financial and human resources to achieve this aim.

The kind of action that public health and health promotion policy makers can take depends upon the political circumstances in their countries. In the words of a DETERMINE partner from Finland, it is important to "be pragmatic about getting health inequities on the political agenda. Opportunities to do so depend on local conditions and context."

In recent years, there has been international leadership on the issue, as evidenced by the work of the WHO Commission on the Social Determinants of Health and by the recent EC Communication on Health Inequities. Public health and health promotion professionals and decision makers can build on such international initiatives to advance national efforts to achieve greater health equity.

Setting an example

➔ *In* ***France****, building on the momentum generated by the outcomes of the CSDH Recommendations and international initiatives like DETERMINE, the Ministry of Health commissioned a High Council to investigate the issue of health inequities in France. The National Institute of Health Education (INPES) also developed guidelines for the newly establishing regional authorities on how to incorporate action on health inequities in their work. These outcomes were presented at a high level Ministerial Conference.*

Successful approaches in a country or region can help to promote leadership in other countries or regions. In Slovenia, action at the regional level put the issue of health inequities on the agenda at the national level:

Setting an example

➔ ***The Health Promotion Strategy and Action Plan for Tackling Health Inequities in Pomurje*** *is a regional strategy that was developed in 2005 as a response to the poor social, economic and health rankings in this region of Slovenia. There are now several health promotion projects and interventions throughout the region. These include healthy lifestyle promotion, employment initiatives, small enterprise development, and promoting the accessibility of nutritious food.*

On the basis of the experiences gained in this region, the Ministry of Health prioritized the development of a national strategy to deal with health inequities. The Institute of Public Health Murska Sobota was asked help prepare the national strategy in 2007, and to help prepare other regional development plans in 2010.

Even where it is difficult to get high-level political support for the issue of health inequities, there is still a great deal that the health sector can do. Organisations and professionals can introduce a greater 'equity' perspective in their work and include action on the social determinants of health. They can be more proactive in approaching other policy sectors and using the existing entry points and mechanisms that are available to them (e.g. inter-departmental consultations) to ensure that initiatives in other policy sectors do not exacerbate but rather reduce health inequities.

This means that they must ensure that they understand the objectives, targets and aims of other policy areas such as education, climate change, migration, sustainable development etc in order to develop joint working. In addition, the health sector can improve its understanding of policy cycles and engage in policy processes to ensure that health equity is incorporated into measures taken by relevant other sectors.

C. Achieving mandates for cross sectoral work.

Part I showed that politicians and policy makers feel that cross-sectoral work is more likely to succeed if there are top-level government mandates, legislation and guidelines that call for this. Through leadership and advocacy work, the health sector must strive to achieve such legislation, to ensure commitment and accountability from other sectors also. This can then lead to the consistent implementation of tools and mechanisms, such as impact assessments that include a focus on health inequalities, and economic assessments, that are vital to efforts to the reduction of health inequities.

Setting an example

➔ *The* ***Secretariat General*** *is one of the Directorates-General (DGs) and specialised services which make up the* ***European Commission****. Its role is to ensure the overall coherence of the Commission's work, by establishing its broad objectives and setting out yearly work plans The Secretariat General places great emphasis on integrated policy making and on undertaking Impact Assessments of new policy initiatives. These Impact Assessments should consider the economic, environmental*

and social impacts, the latter of which includes considerations relating to health and equity.

While impacts on health and different social groups should be assessed, a scan of recent EU impact assessments that are undertaken as part of DETERMINE's work identified that is seldom prioritised and done, unless the policy relates to this directly, due to the wide range of other impacts for consideration.

D. Participatory Approaches

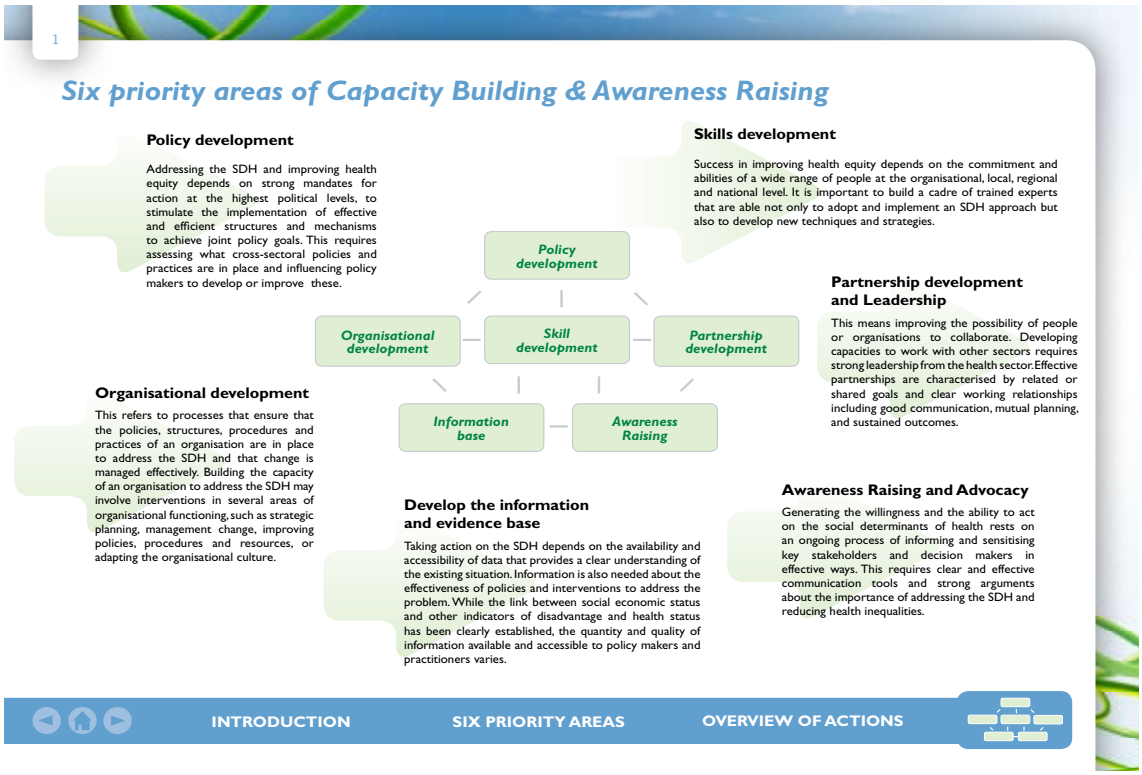
Finally, improving the health of those who are comparatively less well off can best be achieved through the active participation of those most affected or "users", organised via civil society. DETERMINE work on "innovative approaches" reinforced that this means enabling people in those groups who are most affected by health inequities to initiate action, by designing projects programmes based around their stated needs, that evolve and become sustainable through their involvement and empowerment.

Approaches to address the health of vulnerable groups are most likely to be effective if they are flexible and developed on the basis of the evolving needs of the target groups, rather than being rigidly 'topic' oriented. The diagram below[29] highlights the different elements observed in projects that followed this approach:

The diagram shows that focusing on individuals' and communities' strengths, rather than 'problems' and encouraging people to take an active role in the programmes that concern them is key to improving the health and well being of vulnerable groups.

PART III:
stimulating action and greater engagement

A third aim of DETERMINE was to stimulate action on the social determinants of health and health equity in Europe. DETERMINE partners had the opportunity to assess their capacity building needs and existing opportunities and to choose and develop one action of choice to advance the social determinants of health and health inequities in their countries. They received guidance through an interactive "Menu for Capacity Building and Awareness Raising Actions" (the Menu) that was developed as part of DETERMINE.[30]



The actions undertaken were diverse and based on the nature of their organisations, their national contexts and their level of experience in addressing the social determinants of health and health inequities. The examples can serve as an inspiration, since they demonstrate what kinds of actions are possible, even when faced with limited resources, to address the social determinants of health.

A. Bringing partners together

Developing partnerships between health and other sectors, or improving the possibility of people or organisations to collaborate, to identify shared goals and develop clear working relationships is key to addressing health inequities. This is, however, more easily said than done, given partners' different core agendas, time and budgetary constraints.

Some countries therefore organised high level national conferences, to bring the social determinants of health and health inequities to the attention of the decision-makers, politicians and professionals, while promoting DETERMINE outcomes.

Setting an example

- *There are considerable health inequalities in **Hungary** and responsibility for health in other policy sectors needs to be improved. Therefore, **the National Institute for Health Development** identified awareness raising as a key step to promote health equity. Their intervention involved: (1) organising a national conference (in partnership with Friedrich Ebert Foundation) and (2) developing advocacy materials and the website of the Institute incorporating DETERMINE outcomes and national information and evidence. By bringing together professionals, experts and high-level politicians, the conference strengthened the possibility that health inequalities may be included in the political agenda. Participants unanimously agreed on the importance of ensuring that health is a government priority and identified essential steps to tackle health inequalities. The findings showed that "promoting health equity is a learning process for decision makers, policy makers and health professionals also". As strong data and evidence base are needed to support advocacy efforts, and strong arguments and motivations need to be identified to engage other sectors decision makers and politicians.*

- *In order to advance the issue of health equity in a sensitive political climate, the **National Institute of Public Health (Czech Republic)** organised a national conference which brought together knowledge, data and practice and targeted professionals and policy makers from different sectors. Future activities comprise: a) intersectoral collaboration at national level under the umbrella of the Ministry of Health b) targeted actions on smoking and obesity in collaboration with WHO Venice Office, Czech Office and Ministry of Health and NIPH; c) an intersectoral seminar which will build on DETERMINE outputs and results. DETERMINE itself has proven "a very important tool for taking forward SDH and health inequalities from vague terms to actions".*

Other partners organised regional level workshops that brought together different actors, such as public health authorities and nongovernmental organizations to raise awareness and increase knowledge about health inequities and the social determinants of health, and to highlight common objectives.

Setting an example

- *In the context of political and organizational changes at national level, the **Regional Institute of Public Health (Romania/Iasi)** decided that the best entry point for action was at the local level. They organised a workshop to bring together local stakeholders and to raise awareness about the issue. The workshop set the ground for future action and partnerships between local authorities and nongovernmental organisations.*

Germany focussed on building partnerships across sectors and levels, by bringing together various actors working with socially disadvantaged groups.

Setting an example

- *The **Federal Centre for Health Education (BZgA Germany)** together with the **Federal Institute for Occupational Safety and Health (BAuA Germany)** organized a workshop bringing together experts and stakeholders from different sectors and different levels (national, regional and local) to identify the opportunities and challenges of intersectoral collaboration to address social inequities in health. BZgA will continue the activity beyond DETERMINE by incorporating the findings of the workshop into a manual on "Intersectoral Action", as part of a comprehensive toolbox for program managers at the local level.*

A second conference is planned in 2010, to facilitate further discussions and exchange between larger groups of experts and stakeholders. This conference will be the start of further activities in Germany to strengthen the involvement of stakeholder across sectors to tackle health inequalities.

B. Strengthening local level action

The local level is, in many countries, gaining more responsibility for the implementation of national public health policies, including those relating to health inequities. A number of actions therefore focused on identifying and promoting good practice examples of interventions undertaken by local municipalities.

In Sweden the good practice examples will be used mainly to stimulate and improve action at the municipal level, while in Denmark they will be used to inform a cross-sectoral group that was established at the national level to advance action. The action by Norway focused on strengthening capacity to implement HIA at the municipal level.

Setting an example

➔ *The **Swedish National Institute of Public Health's** action focused on identifying good practice examples at municipal level to address the social determinants of health and health inequities and on ensuring the findings' dissemination and transferability to stimulate further action in other localities. 19 'progressive' municipalities were identified that had clear objectives and programmes for action on health inequalities. Representatives of eight of these municipalities were interviewed with the aim of pinpointing successful policies, infrastructures and actions to address the social determinants and health and health inequities.*

Among key factors to ensure successful actions were active political governance and the appointment of a public health or sustainable development strategist function placed centrally at a high level in the organization to ensure coordinated action at the municipal level. The good practice actions identified focused on children and young people, education, job opportunities, health at work, environment, sexual health, physical activity, diet and food, tobacco, alcohol and drugs, and improving health and quality of life for the elderly.

Action at the local level is greatly facilitated by effective tools and resources that municipal governments and different sectors can apply to address health inequalities. A small group of DETERMINE partners focused on identifying a 'stock' of tools and guidelines that are transferrable and can be applied internationally.

Tools were chosen on the basis of the criteria that they were easy to use at the local level, results oriented and that they required little contextual adaptation. This stock includes for example: a Public Engagement Toolkit and Guides to Health Impact Assessment of Transport initiatives and Housing improvements. Available at www.health-inequalities.eu

C. Skill development and training

It is important to build a cadre of trained experts that are aware of the issue and that can adopt and implement action on the social determinants of health and develop new techniques and strategies. The actions of a number of DETERMINE partners therefore focused on designing learning modules on the SDH and health inequities, using DETERMINE outcomes and other existing resources. These modules were designed for professionals and decision makers within the health sector, as well as those working

in other sectors, at the national, regional and local level.

A number of partners will continue their work and aim to draw up a training module on health inequities and the social determinants of health that can be delivered across Europe.

Setting an example

- *In the context of a well-established system of competencies and qualification requirements for public health professionals, the **Wales Centre for Health** focused on developing a training module on health inequities and the social determinants that can be validated and accredited for education purposes and provided within a "public health foundation course" for public health practitioners. The module can also be used as a "stand alone" unit to be included in a variety of appropriate settings and courses.*

- *The priorities within the National Health Program in **Poland** (2007-2015) refer mainly to the improvement of general population health situation (mortality and morbidity indicators), and the reduction of territorial and social health inequalities. The **National Institute of Public Health -Hygiene (NIPH-NIH)** aimed to increase knowledge and awareness by incorporating training sessions on health inequalities and the social determinants of health in existing courses of epidemiology and public health. Moreover, the topic of health inequalities and the social determinants of health will be included in the research plan of the NIPH-NIH for 2010.*

D. Further plans to increase organisational capacity

Through involvement in DETERMINE, many partners took significant steps to addressing the social determinants of health and health inequalities. Sustainable progress on these issues however requires that these initial steps lead to further action. Belgium and Slovenia applied DETERMINE outcomes and tools to catalyze more ambitious plans for actions.

Setting an example

- ***The Flemish Institute of Health Promotion and disease prevention (ViGeZ)** developed a Capacity Building and Awareness Raising Action Plan to address social determinants of health and improve health equity (2010-2015).*

The plan will be incorporated in the renewed strategic plan of the ViGeZ Institute 2010 -2015, and was developed to take forward the principle of 'health in all policies' in the region. It comprises five main areas of intervention: Awareness Raising and Advocacy, Skills development, Policy development and Advocacy, Development of the information and evidence base and Organizational development. DETERMINE outcomes will be used to develop all of these actions.

Setting an example

- *For the **National Institute of Public Health in Slovenia** the guidelines, questions and findings of DETERMINE policy consultations helped to inform the preparation phase of WHO coordinated interviews with other sectors and the "Menu of Actions" (Menu) was used as a practical tool to identify priorities and to plan future work and interventions. DETERMINE outcomes were presented at three national workshops, to raise awareness and knowledge amongst experts and professionals.*

  A specific workshop organized under the DETERMINE capacity building strand aimed to gather knowledge about the social determinants of health and health equity that was used to identify future institutional priorities for awareness raising, partnership development and capacity building using the

framework presented in the "Menu".

A report summarizing the capacity building activities of the DETERMINE partners[31] and the 'Menu of Actions' can be downloaded at www.health-inequalities.eu.

Conclusions

The main aims of the DETERMINE Consortium were to advance action on health equity in the European Union, to show what can be done and to contribute to global learning. This report has illustrated how the Consortium approached this by contributing to our understanding of the problem, highlighting potential solutions and stimulating greater engagement and action.

The Consortium has made modest but concerted and distinct contributions to this field. Its core achievements include having

- **Firmly planted the concept that health equity must lie at the core of any efforts to improve population health amongst the wider DETERMINE Consortium and its partners.**
- **Raised awareness that health equity can only be improved if it becomes a concern of other sectors, and that health systems must take the lead in getting other sectors on board.**
- **Evolved on the basis that progress will not be achieved through concepts alone, and that action must be taken, however small the initial steps may be.**
- **Addressed the need for increased capacity to tackle health inequalities and address the social determinants of health by providing examples of how capacities can be built and of resources to do so.**
- **Facilitated an exchange of knowledge and experience amongst European countries, which is essential to move forward this agenda. The website: www.health-inequities.eu, which includes a 'directory of good practice', has and will continue to serve as a central resource in this process.**
- **Contributed to establishing Europe amongst the global leaders in efforts to ensure more equal opportunities for good health for all.**

ANNEX: Key Messages in full

1. Health systems[32] in EU Member States must ensure that reducing health inequities by addressing their underlying determinants is at the forefront of the policy agenda.

Life expectancy and quality of life has consistently improved in most EU Member States but better health has not reached everyone in the same way. DETERMINE supports further action on health equity on the basis that:

a. Socio-economic inequities in health and differences in the number of years lived in good health are widening in many countries, and may widen even more due to the economic crisis since 2008.

b. The work of the DETERMINE Consortium built on global evidence that "this unequal distribution of health damaging experiences is not in any sense a natural phenomenon but is the result of a toxic combination of poor social policies and programmes, unfair economic arrangements, and bad policies"[33]

c. DETERMINE outcomes demonstrate economic arguments that investing in health equity is more cost effective than paying the costs to society of this unnecessary mortality, morbidity and lost productivity.

2. There should be greater awareness that health inequities are a population-based issue. Social position, whether measured by class, income or education, is directly correlated with health, resulting in a 'health gradient' that affects all groups of society.

Improving the health of those who are worst off at a faster rate than those who are best off is critical to addressing the problem, but should be complemented by appropriate and comprehensive population wide measures at regional, national and EU level.

3. The EU and its Member States should focus on gathering data on health inequities that is understandable, comparable and actionable.

While there is a large amount of data that points to the existence of health inequities, the availability of this data is patchy within and between EU Member States and not easily comparable. The EU should identify what common data and methodology can be used to illustrate the social gradient for each health indicator, across countries and over time in all EU Member States. It should invest in training and tools to enable national institutes to collect, analyse and provide comparable quantitative and qualitative data in a coordinated manner, including data from a wide range of intelligence sources from other policy areas and agencies such as the police and the business sector.

4. EU Member States and their health systems should prioritise engaging with other policy sectors, promoting a 'health equity in all policies' approach.

This entails:

a. Developing legislation and/or national guidelines on cross government strategies to address health inequalities and the social determinants of health. National governments should also improve political coordination by e.g. setting up a steering group across ministries and establishing streamlined systems to manage and assess measures taken across different sectors and levels of government.

b. Developing and reorienting the skills of staff within the health sector, who have a focus on health inequities, and a specific remit to work with other sectors. This means ensuring that they are able to understand policy cycles and to engage with experts in other fields. The health sector must build capacity to better assume its role in approaching a number of policy areas and understanding their objectives, targets and aims, in order to develop joint working.

c. Including information about health inequities and the health gradient in the core training curricula of public health and health promotion professionals and medical students.

d. Increasing the sustainable funding base for health promotion and 'health equity in all policies' collaborative work, as currently less than 4% of national health expenditures are spent on these approaches, despite evidence of their cost-effectiveness.

5. The EU and its Member States should invest in and coordinate efforts to develop better regulation and ensure the most efficient and effective use of public resources to improve health equity.

This requires:

a. Strengthening and systematising impact assessment procedures to ensure that there is also a strong focus on health impacts and their distribution across social groups and making certain that the findings from these impact assessments are integrated into the final policy and its implementation process.

b. Undertaking economic analysis of policies and programmes that directly or indirectly affect health and ensuring greater consideration of the costs relating to health outcomes and the distribution of these outcomes (equity). Investing in the improvement of methodologies to undertake such analyses can strengthen the rational for action to reduce health inequities.

c. Investing in research, development and evaluation of policies and programmes that address the social determinants of health and health inequities and in improved methodologies to undertake such evaluations, in order to build a strong evidence base.

6. Enhance the ability of local level actors to address health inequalities by raising awareness about the health gradient and providing them with tools and mechanisms to work with other sectors and disadvantaged populations on a regular basis.

While the European and national level are crucial in establishing cross governmental policies for health equity, local level initiatives also have an important impact on people's day-to-day's lives. The EU and Member States should therefore invest in mobilizing policy makers and practitioners in health and other sectors at the local level to incorporate health equity into their work.

More efforts should be made to stimulate good practice which builds on a good understanding of the challenges that people face in their everyday lives. Projects should adopt citizen-centred, "bottom up", participatory approaches in defining the project aims and harness the human and physical "assets" within communities. Empowering people and communities to address their own needs will enhance the sustainability of local project work.

7. The EU and its Member States must continue to invest in promoting, exchanging, and building on knowledge in this field, thereby actively supporting efforts to build a stronger basis for cross-sectoral work, initiated by the DETERMINE partnership.

This involves:

a. Exchanging information on successful approaches, policies, mechanisms and tools across the EU.

b. Building capacities within the public health sector and beyond to engage in inter-sectoral work, including improved organisational structures, work force development and increased resources.

c. Greater engagement of the media and the public in the issue of health inequities. Targeted communication and increased action on advocacy for health equity throughout the EU is a crucial step in securing public – and thereby also political- commitment.

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