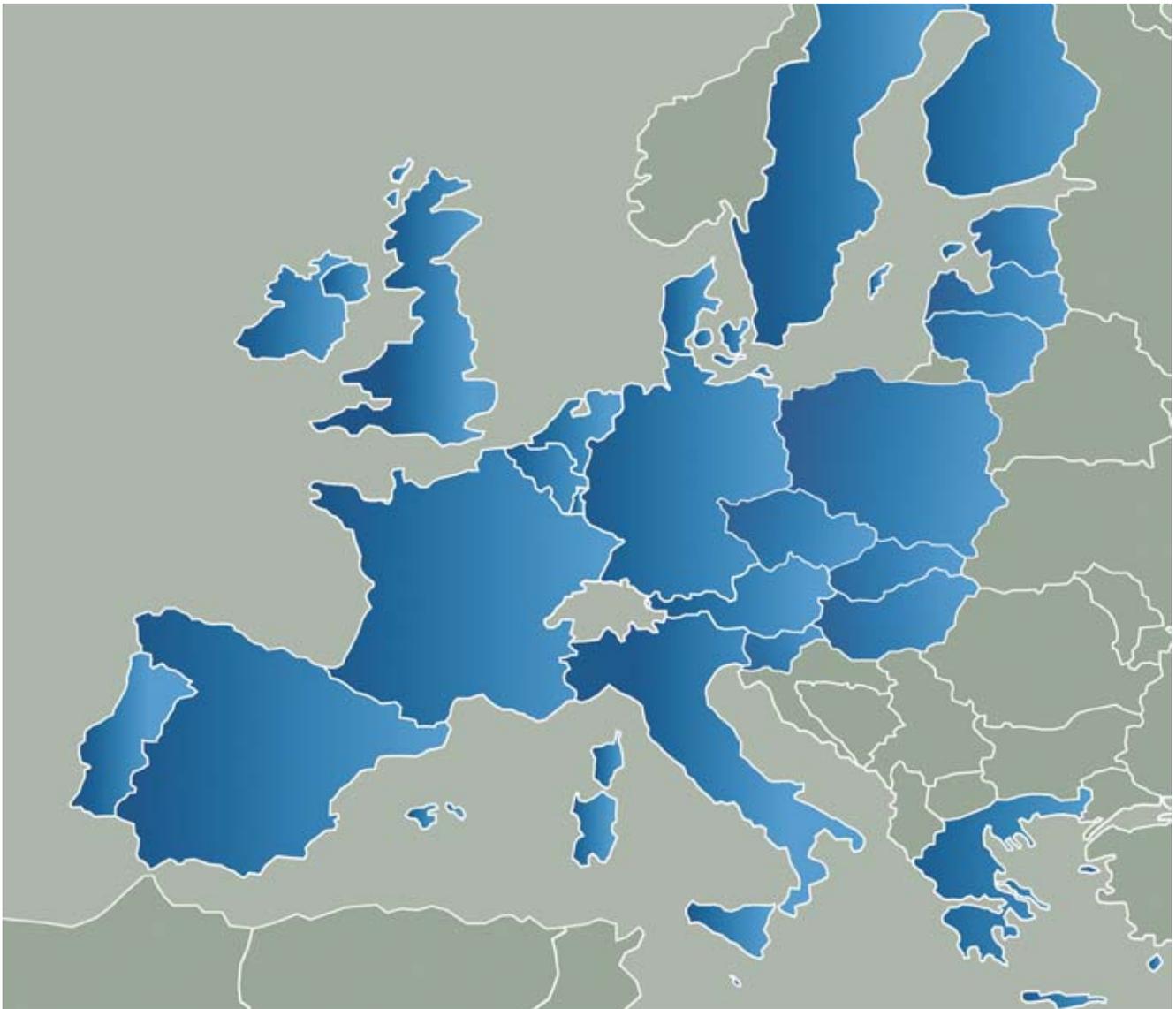


# Health Inequalities: a Challenge for Europe

Ken Judge, Stephen Platt,  
Caroline Costongs and Kasia Jurczak



An independent, expert report commissioned by the UK  
Presidency of the EU (February 2006)





# **Health Inequalities: a Challenge for Europe**

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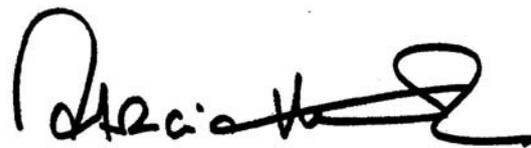
# Foreword

Tackling health inequalities is an international issue and was a key health theme for the UK Presidency of the European Union in 2005. Almost all important health problems, and major causes of premature death such as cardiovascular disease and cancer, are more common among people with lower levels of education, income and occupational status. The health gap in life expectancy is typically 5 years or more. Narrowing this health gap within countries, and making good health a reality for everyone, is essential if we are to create a Europe of social justice as well as prosperity.

As part of the Presidency the UK commissioned two new reports of which this is one. As a result of the growing recognition of the problem, many countries are responding by developing public policies in a wide variety of ways and the primary aim of this independent report<sup>1</sup> is to review national-level policies and strategies that either have been or are in the process of being developed to tackle health inequalities. It shows that strategies to reduce the health gap within member states are at different stages and that, while much progress has been achieved, many challenges still remain.

Member states can learn from each other about different approaches to reducing health inequalities through systematic sharing of evidence, and EU and international support to member states in developing effective strategies and programmes could add value.

We believe that this document, and a matching report “Health Inequalities: Europe in Profile”, will inform the work of the European Commission and agencies such as WHO and OECD. Both reports build on the interim versions launched at the UK Presidency Summit: “Tackling Health Inequalities-Governing For Health” in October 2005. In developing these reports we have received invaluable assistance from member states. We are grateful for this, and hope that the reports will be useful in developing policy and action on health inequalities, for example through the Commission’s Expert Working Group on Social Determinants of Health Inequalities.



Rt. Hon. Patricia Hewitt MP  
Secretary of State for Health, England

<sup>1</sup> The views expressed in the report are those of the authors and not necessarily those of the UK Government, other member states or the European Commission.

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# Executive summary

## Aims

Health inequalities are increasingly recognised as an important public-health issue throughout Europe. As a result of the growing recognition of the problem, many countries are responding by developing public policies in a wide variety of ways.

The primary aim of this independent report, which was commissioned by the UK Presidency of the EU, is to review national-level policies and strategies – that either have been or are in the process of being developed to tackle health inequalities – and to reflect on the challenges that lie ahead.

In doing so, it primarily focuses on socio-economic inequalities in health.

## Social and economic determinants

The report begins by reviewing the importance of the wider social determinants of health inequality and the challenges associated with integrating attempts to promote social justice and social inclusion and policies to reduce health inequalities.

The fight against poverty and social exclusion is crucial for tackling health inequalities. One of the reasons is that the size of the problem of health inequality is very much related to the numbers of people disadvantaged by different forms of social exclusion. There is a wealth of data showing how many of the wider social determinants associated with health outcomes are unequally distributed in all member states.

The fact that so much emphasis is being given to anti-poverty and social inclusion policies across the EU, therefore, is potentially good news in terms of reducing health inequality, provided that policy can be translated into meaningful and proportionate

action. In developing such policies it is important to note that, although policy entry points legitimately vary from country to country, there is great value in having a clear and measurable focus on health inequalities as part of wider concerns with social justice. Such an approach is not yet evident in many parts of Europe.

## Policy frameworks

The next section considers the overall framework within which national policies to reduce health inequality are being developed, paying particular attention to the role of the World Health Organization (WHO) and the European Union (EU).

There is considerable variation in the public policy goals and targets being set in different countries. Individual countries have chosen to respond to WHO recommendations and European Union initiatives in a wide variety of ways.

- Most countries subscribe to the equity principles and values articulated by the WHO and the EU.
- Most are explicitly concerned with the socio-economic dimension of health inequalities but several (such as Hungary) focus on ethnic differences.
- Some, such as Sweden, Denmark or Poland, emphasise their equity commitments in the context of broader public health strategies.
- Others, such as the Czech Republic or Latvia, choose to express their domestic commitment to the Health21 targets specified by the European Regional Office of the WHO.
- Countries such as Finland and the Netherlands have a single health inequality goal specified in quantitative terms.
- Whereas Ireland and the four constituent countries of the UK each have a number of more detailed quantitative targets.

- Some countries that do not have national targets do have examples at a regional or local level.
- Most countries with quantitative targets have set them in terms of reducing gaps between the poorest and the more affluent, but Scotland and Wales appear to be unique in terms of emphasising the importance of improving the position of the poorest groups per se.
- None of the countries considered have explicit goals or targets related to the gradient between socio-economic position and health status across the whole population.

## National approaches

There are three useful ways of distinguishing between the different approaches to health inequality currently in place in member states of the EU.

The first relates to those countries that have clear references to tackling health inequalities included in legislation. The second is whether or not explicit goals or principles to promote health equity are mentioned in national policy documents. The third is whether such objectives are associated with quantitative targets, by which we mean that they have identified a specific aspect of the problem of health inequality as a priority and made a commitment to reduce it by a specified amount by a particular date.

A number of EU countries have not formally articulated principles or goals to guide their actions at **the national policy level** in relation to promoting population health equity or reducing health inequalities. But the lack of national level policy statements does not necessarily mean that concerns about health inequalities are absent within a particular country.

## Responsibility for action

It is typically the Department (Ministry) of Health (or umbrella department in which Health is located) that is responsible for action to tackle health inequalities. In nearly all countries this responsibility is shared with other departments. However, there is a considerable variation in the extent to which there is a concerted effort to co-ordinate action on health inequalities between government departments and/or successful implementation of such action.

In one group of countries there is a general commitment across government to equality issues but no formal mechanism for co-ordinating implementation of policy on health inequalities across government departments. In a second group of countries co-ordinated national action on health inequalities, while evident, is less extensive or formalised than that found in a third group of countries. Co-ordinated and comprehensive national action on health inequalities is evident in a small number of countries in this final group.

## Action and implementation

Four main ways that action programmes to reduce health inequalities are being implemented have been identified. One group of countries has well-integrated and co-ordinated action plans. Countries in the second group have very clear concerns about, and some have commitments to, promoting health equity as part of more general public health policies. In a third group of countries it is possible to identify various actions to reduce health inequalities, but these are not necessarily related to a 'master plan'. Countries in the final group appear to lack any distinctive focus on health inequalities per se, but like other member states they have examples of action in relation to the social determinants of health at national and local levels.

One important implication of the review is that the more focused and integrated is the cross-government strategy for action, the greater is the probability that health outcomes will change in the desired direction. In addition, policies to reduce health inequalities are likely to be more successful when there is a clear action plan – that can be implemented and monitored – focused on specific targets within realistic timeframes.

## Monitoring and evaluation

There is little evidence to suggest the widespread adoption of systematic evidence-based approaches to policy making across all areas of government. Even in a specific area, such as health improvement or the reduction of health inequalities, we have been able to locate only a few relevant frameworks. Nevertheless, several European countries appear to have developed a method to measure progress towards achieving health inequalities targets. In one group of countries monitoring is limited or not fully comprehensive. In keeping with the detailed specification and quantification of their health inequalities targets, countries in the second group have established systematic frameworks for monitoring and evaluation. (In a third group of countries there is no specific tool to monitor progress because no health inequalities targets have been set.)

## Conclusions

This paper represents the first attempt to review and bring together in one place the experiences of those member states of the European Union that are in the process of developing national policies to tackle health inequalities. It shows that much progress has been achieved. But many challenges remain.

No EU member state has yet made a concerted effort to implement the most radical approach to

health inequalities, namely a reduction in the health gradient, whereby health is related to the position of social groups (and individuals within these groups) at every level within society. We suggest that EU member states should consider the potential advantages to society as a whole that might result from the adoption of this wider frame.

One of the many issues that needs further thought in the future relates to the value of targets in national policy-making related to health inequality. Answers are needed to questions such as:

- Is sufficient thought given by policy makers to the rationale for focusing targets on particular aspects of the problem of health inequality?
- Should EU countries be working towards a common understanding of what type of target should be measured (which implies also a common understanding of what is meant by ‘health inequalities’ and what should be the focus of remedial action)?
- Does the formulation of targets help or hinder the implementation of effective action to reduce health inequalities?

Although there are many legitimate entry points for policy initiatives to tackle health inequalities, it is important that those selected are supported by financial and political commitment. It is equally important that steps are taken to ensure that adequate capacity and infrastructure are put in place to allow policies to be implemented in a sustainable way.

One of the biggest challenges facing all member states is to assess the impact of their policies on health inequalities. Several developments are critical. One is the importance of assessing the potential impacts of non-health sector policies on health inequalities. Another is to recognise that monitoring of progress is crucial at all stages of the policy

process (development, specification, implementation, impact and, especially, review/learning).

Equally essential is the need for a more integrated approach to evaluation and implementation, using the most robust and sound methodologies and taking advantage of 'natural experiments'.

Evidence-based guidance derived from comparative national-level analyses is also required about the nature and significance of the relationships between poverty, income inequality and many other manifestations of social exclusion, on the one hand, and different manifestations of health inequality, on the other.

Action at the European level is needed in order to progress policy processes that might contribute to the reduction of health inequalities and to respond to the unique challenges facing an enlarged community of 25 member states. Facilitating effective action to reduce health inequalities will contribute to one of the EU's strategic objectives – promoting a more cohesive society – as outlined by the Lisbon Agenda.

EU member states should be encouraged to take advantage of every opportunity to learn from each other about the value of different policy approaches to reducing health inequalities through the systematic sharing of evidence (from pre-implementation appraisal to the assessment of policy impact). The European Union can play a major role in facilitating these exchanges, for example through the Expert Working Group on Social Determinants of Health Inequalities.

This is quite deliberately a largely descriptive report. In essence, it takes at face value what policy documents say about approaches to reducing health inequalities. Even in those countries that appear to be most well developed in policy terms, however,

there are big gaps between the documentation of concerted efforts to tackle health inequalities and evidence that any real and sustained impact is being achieved. What is now needed is an assessment of the appropriateness and effectiveness of policy responses in different countries that takes account of the scale of the problem of health inequalities that is being addressed.

# 1. Introduction

## 1.1 Aims

Health inequalities are increasingly recognised as an important public-health issue throughout Europe. The topic was chosen as one of the two main themes of the UK's Presidency of the EU in 2005 (the other being patient safety).

In a companion report to this one, Mackenbach (2006) reviews the most recent data and shows that the problem of health inequality is universal. For many common indicators of socio-economic position – such as employment and occupational status, income level or educational attainment – those in the poorest circumstances face higher risks of adverse health outcomes than those who are better off. The data that are available are not always produced in consistent ways and caution is needed in comparing one or more countries with others. Nevertheless, what is perhaps surprising about the nature of these risks is that they do not vary that much from country to country within the main geographical parts of the EU, although some potentially important differences between those countries in the East and elsewhere do appear to be emerging.

**The persistence of large health inequalities in all countries with available data, including countries with long-standing social, health care and other policies aimed at creating more equality in welfare, underscores the fact that these inequalities must be deeply rooted in the social stratification systems of modern societies (Mackenbach, 2006).**

As a result of the growing recognition of the problem, many countries are responding by developing public policies in a wide variety of ways.

The primary aim of this independent report, which was commissioned by the UK Presidency, is to

review national-level policies and strategies – that either have been or are in the process of being developed to tackle health inequalities – and to reflect on the challenges that lie ahead.

## 1.2 Outline

The substantive part of the report begins by reviewing the importance of the wider social determinants of health inequality and the challenges associated with integrating attempts to promote social justice and social inclusion and policies to reduce health inequalities.

The next section considers the overall framework within which national policies to reduce health inequality are being developed, paying particular attention to the role of the World Health Organization (WHO) and the European Union (EU). At the national level three main approaches to policy are identified. The first is distinguished by legislative commitments, the second focuses on general health equity concerns and goals, while the third emphasises the importance of quantitative targets.

Attention then turns to the different ways in which responsibilities for action and co-ordination are taken forward in EU member states before illustrating the four main ways that action programmes are being implemented.

- One group of countries has well-integrated and co-ordinated action plans.
- Countries in the second group have very clear concerns about, and some have commitments to, promoting health equity as part of more general public health policies.
- In a third group of countries it is possible to identify various actions to reduce health inequalities, but these are not necessarily related to a 'master plan'.

## 2. Social and economic determinants

The fight against poverty and social exclusion is crucial for tackling health inequalities. It is important to recognise, however, that the size of the problem of health inequality is not only about the differences in health outcomes between social groups that are so clearly demonstrated by Mackenbach (2006). It is also a function of the relative size of the population groups most at risk, in other words the numbers of people disadvantaged by different forms of social exclusion.

### 2.1 The scale of social inequalities

Eurostat and other agencies have produced a wealth of data showing how many of the wider social determinants associated with health outcomes are unequally distributed in all member states. A selection of statistics illustrating some of the variations between EU member states is shown in Table 1.

Some of the most striking differences shown in Table 1 are:

- The level of income inequality, as illustrated by the ratio of total income received by the richest 20 per cent to that received by the poorest 20 per cent, varied from around 3 to more than 6.
- The proportion of the population living in households in relative poverty varied from less than 10 per cent to about one-fifth.
- The proportion of children living in jobless households in 2004 varied from 2.6 per cent to 16.8 per cent.
- Long-term unemployment rates in 2003 varied from about 1 per cent to more than 10 per cent.
- The proportion of the population aged 25–64 with low levels of educational attainment in 2004 ranged from about 12 per cent to around 75 per cent.

It is not part of the purpose of this report to make judgements about the public policy responses in different European countries to the kinds of problems highlighted in Table 1. But the critical reader might want to take them into account in assessing the different approaches to tackling health inequalities being adopted across Europe, and which are described in the following pages.

### 2.2 Challenges in the European social context

At the European Councils in Lisbon and in Nice (2000), the member states of the European Union took and reinforced a major initiative by making the fight against poverty and social exclusion based on the provisions of the Amsterdam Treaty one of the central elements in the modernisation of the European social model. This initiative was made possible on the basis of Articles 136 and 137 of the Treaty.

The Lisbon strategy acknowledges the importance of poverty reduction and elimination of social exclusion as mechanisms necessary for the European Union to become the most competitive, knowledge-based economy. The common objectives to be pursued by the member states are:

- to facilitate participation in employment and access by all to resources, rights, goods and services;
- to prevent the risks of exclusion;
- to help the most vulnerable; and
- to mobilise all relevant bodies.

EuroHealthNet (2004) has produced a very useful background paper that provides more detail about the Lisbon strategy and its potential relevance for reducing health inequality.

As a result of the Lisbon process, and subsequent EU Council decisions, all 25 member states are committed to a process of preparing and submitting for review reports on *National Action Plans Against Poverty*

- Countries in the final group appear to lack any distinctive focus on health inequalities per se, but like other member states they have examples of action in relation to the social determinants of health at national and local levels.

Next, the report considers the ways in which the problem of health inequality and action to ameliorate the problem are monitored and evaluated. Finally, the concluding comments reflect on the main lessons and challenges arising from the review.

Before the main purposes of the report are addressed, however, it is important to consider two important issues: the concept of health inequality; and, the meaning of health inequality policy or strategy.

### 1.3 The concept of health inequality

It is important to acknowledge that “although the concepts of health inequality and health inequity are well established in the Anglophone academic discourse, translation of these terms to some other European languages can pose problems” (Jurczak, Costongs & Reemann, 2005, p. 24). Health inequality is most commonly referred to in the context of indicators of social position such as class, education and income, and the primary focus of this paper is on such social inequalities in health. But there are other important ways in which health inequalities manifest themselves, such as gender or ethnicity, for instance. There is also increasing recognition of the fact that social groups with poor health outcomes are often clustered in particular regions, localities and neighbourhoods. Furthermore, there is a strong association between living in disadvantaged geographical areas and the intergenerational transmission of poverty and deprivation.

It is important to consider all distinct social groups who suffer from different aspects of social exclusion that might impact on health inequality, and the environments in which they live, in considering appropriate policy responses. For the purposes of this paper, however, the main characteristic of health inequality to be highlighted is:

**The systematic and avoidable differences in health outcomes between social groups such that poorer and/or more disadvantaged people are more likely to have illnesses and disabilities and shorter lives than those who are more affluent.**

Another important point to remember is that it is not simply the poorest who experience less than optimum health; there is a gradient of risk across the whole population. It is helpful, therefore, to keep in mind Graham’s (2004, pp. 118, 120, 123) typology of classifications of health inequality, which distinguishes between the poor health of socio-economically disadvantaged people, health gaps between different groups and social gradients across whole populations. This is not simply a technical question. The choice of approach can influence perceptions of success or failure. The implication is that that policy makers should be clear about the rationale for focusing on particular aspects of health inequality, not least because different measures of health inequality can move in opposite directions (Donkin et al, 2002).

Regardless of which aspect of health inequality is the focus of concern, there is growing international recognition that health and well-being are the products of many factors and that a sophisticated understanding of the social determinants of health is essential for the development of public health policy. In thinking about policies to reduce health inequalities, however, what is of primary concern is the **distribution** of health determinants.

**... positive trends in health determinants can go hand-in-hand with widening inequalities in their social distribution ... distinguishing between the overall level and the social distribution of health determinants is essential for policy development. When health equity is the goal, the priority of a determinants-oriented strategy is to reduce inequalities in the major influences on people's health**  
(Graham & Kelly, 2004, p. 5).

## 1.4 What is a health inequality strategy?

One positive feature of the fact that health inequality is the product of many different factors is that governments have a wide range of choices about where to focus their efforts and how to describe their approach. However, it is not always clear what to count as a 'health inequality policy'. At least three different kinds of strategy can be identified that explicitly address concerns with health inequality. For example, some countries have broadly-based public policy strategies that are explicitly linked to the objective of **reducing specific aspects of health inequality**. Others have embedded a concern with **health equity** within more general sets of public health policies. On the other hand, some countries that are committed to **reducing inequalities in the distribution of important health determinants** make little or no reference to the impact that this might have on health inequality itself even though it could be substantial. Are these general social welfare policies to be described as 'health inequality policies'? We believe that the answer will often be 'yes'. What matters is the content of action to redistribute opportunities and resources and its relevance to the nature of health inequality in a particular context and not particularly how it is 'labelled'. A background paper prepared

for the WHO's Commission on Social Determinants of Health (SDH) (2005) makes the very important point that:

**Determinations about policy entry points and the content of recommended policies will vary with the specificities of national contexts. Successful health policy to address SDH cannot adopt a "one-size-fits-all" character. Different countries and jurisdictions find themselves at very different stages of readiness for action on SDH and of openness to more fundamental redistributive approaches. The particularities of national and local contexts will show which social determinants need to be addressed most urgently to improve population health, and which policy tools are most appropriate**  
(pp. 33–4).

This implies a need to adopt a broad perspective about what constitutes health inequality policy. The approach that we have adopted, therefore, is to try to identify both all references within EU member states to distinctive health inequality policies and health equity related references embedded within wider public health policies. In an attempt to do some justice to the huge variety of approaches being developed in relation to the wider social determinants of health and health inequality, that may not make explicit reference to health outcomes, attention is focused on one set of policies being developed in all 25 EU countries as a result of the Lisbon European Summit in 2000: the *National Action Plans Against Poverty and Social Exclusion*. In addition, we make extensive use of material<sup>1</sup> collected as part of a project jointly co-ordinated by EuroHealthNet and the German Federal Centre for Health Education (BZgA) and funded by the European Commission, "Closing the Gap: Strategies for action to tackle health inequalities in Europe (2004-2007)" (see Annex 2).

1 EuroHealthNet and BZgA. Situation Analysis Questionnaires. Brussels: EuroHealthNet, 2005

**Table 1**

Selected indicators of social cohesion

TOPIC	BE	CZ	DK	DE	EE	EL	ES	FR	IE	IT	CY	LV	LT	LU	HU	MT	NL	AT	PL	PT	SI	SK	FI	SE	UK
LOW EDUCATION <sup>1</sup>	36.4	11	17	16.5	11.1	45.9	55.1	34.9	37	53.1	34.4	16	13.3	38.4	24.9	77	32.4	20.4	16.6	74.7	20.7	13.4	22.4	17.1	29.6
EARLY LEAVERS <sup>2</sup>	12.8	6	10	12.8	11.8	15.3	29.8	13.7	12.1	23.5	15.1	18.1	11.8	17	11.8	48.2	15	9.2	6.3	40.4	4.3	4.9	8.3	9	16.7
JOBLESS KIDS <sup>3</sup>	13.2	9	5.7	10.3	9.6	4.5	6.3	9.6	11.8	7	2.6	7.2	6.5	3.1	13.2	8.9	7	5.6	na	4.3	3.8	12.8	5.7	na	16.8
LONG TERM UNEMPLOYMENT <sup>4</sup>	3.7	3.8	1.1	4.7	4.6	5.1	3.9	3.5	1.5	4.9	1.1	4.3	6.1	0.9	2.4	3.5	1	1.2	10.7	2.2	3.4	11.1	2.3	1	1.1
INCOME INEQUALITY <sup>5</sup>	4	3.4	3	4	6.1	5.7	5.5	3.9	4.5	4.8	4.1	5.5	4.9	3.8	3.1	4.6	4.1	3.5	4.7	6.5	3.1	5.4	3.7	3.4	5.4
POVERTY BEFORE TRANSFER <sup>6</sup>	23	18	29	22	25	23	23	26	30	22	18	24	24	23	17	20	22	22	31	24	17	28	29	17	26
POVERTY AFTER TRANSFER <sup>7</sup>	13	8	10	13	18	20	19	13	21	19	15	16	17	12	11	15	12	12	16	20	11	21	11	9	19

**Notes**

- persons with low educational attainment (% of population aged 25–64), 2004
- % of the total population aged 18–24 who have at most lower secondary education and not in further education or training, 2003
- % of children aged 0–17 living in jobless households, 2004
- long term unemployment rate, 2003, % of the labour force 15+
- the ratio of total income received by the 20% of the population with the highest income to that received by the 20% of the population with the lowest income, 2001 or nearest year
- the share of persons with an equivalised disposable income, before social transfers, below 60% of the national median equivalised disposable income after social transfers, 2001 or nearest year
- the share of persons with an equivalised disposable income, after social transfers, below 60% of the national median equivalised disposable income after social transfers, 2001 or nearest year

Source: Eurostat

([http://epp.eurostat.ec.eu.int/portal/page?\\_pageid=1996.45323734&\\_dad=portal&\\_schema=PORTAL&screen=welcomeref&open=/&product=STRIND\\_SOCOHE&depth=2](http://epp.eurostat.ec.eu.int/portal/page?_pageid=1996.45323734&_dad=portal&_schema=PORTAL&screen=welcomeref&open=/&product=STRIND_SOCOHE&depth=2))

**Key to individual countries:**

BE Belgium  
 CZ Czech Republic  
 DK Denmark  
 DE Germany  
 EE Estonia  
 EL Greece  
 ES Spain  
 FR France  
 IE Ireland  
 IT Italy  
 CY Cyprus  
 LV Latvia  
 LT Lithuania  
 LU Luxembourg  
 HU Hungary  
 MT Malta  
 NL Netherlands  
 AT Austria  
 PL Poland  
 PT Portugal  
 SI Slovenia  
 SK Slovakia  
 FI Finland  
 SE Sweden  
 UK United Kingdom

and Social Exclusion (NAPs/inclusion). The Joint Report on Social Protection and Social Inclusion (European Commission,

2005b) provides an excellent summary of the actions being taken in all 25 member states in this area. It

### **Lisbon challenges related to social inclusion**

#### **Increasing labour market participation**

Seen as the most important priority by most member states, this translates into expanding active labour market policies and ensuring a better linkage between social protection, lifelong learning and labour market reforms so that they are mutually reinforcing.

#### **Modernising social protection systems**

This means ensuring that sustainable social protection schemes are adequate and accessible to all and that benefits aimed at those who are able to work provide effective work incentives as well as enough security to allow people to adapt to change.

#### **Tackling disadvantages in education and training**

Emphasis is being laid on preventing early departure from formal education and training; facilitating the transition from school to work, in particular of school leavers with low qualifications; increasing access to education and training for disadvantaged groups and integrating them into mainstream provision; and promoting lifelong learning, including e-learning, for all. Many recognise the need to invest more, and more efficiently, in human capital at all ages.

#### **Eliminating child poverty**

This is seen a key step in combating the intergenerational inheritance of poverty. Particular focus is given to early intervention and early education in support of disadvantaged children; and enhancing income support and assistance to families and single parents. Several countries also put increasing emphasis on promoting the rights of the child as a basis for policy development.

#### **Ensuring decent accommodation**

In some member states attention is being given to improving housing standards; in others, to the need to address the lack of social housing for vulnerable groups. Several member states are developing more integrated approaches to tackling homelessness.

#### **Improving access to quality services**

This includes improving access to health and long-term care services, social services and transport, improving local environments, as well as investing in adequate infrastructure and harnessing the potential of new, accessible ICT for all.

#### **Overcoming discrimination and increasing the integration of people with disabilities, ethnic minorities and immigrants**

The fight against high levels of exclusion experienced by such groups involves a mixture of increasing access to mainline services and opportunities, enforcing legislation aimed at overcoming discrimination and developing targeted approaches. The difficulties faced by the Roma require special attention.

Source: European Commission, 2005b, pp. 6–7.

also identifies the seven key policy priorities emerging across the EU as a result of the Lisbon strategy, which are shown on page 15. It is likely that the further development and implementation of policies in response to these challenges can contribute significantly to reducing health inequalities.

## 2.3 Integrating health inequality and social justice

The importance of the Lisbon process is further emphasised in a comparative study of *Policies to reduce inequalities in health in 13 developed countries* (Crombie et al, 2005). It argues that as: “social justice/social inclusion policies deal with the underlying causes of poor health (low income and unemployment, housing and homelessness, and social exclusion) they are directly relevant to inequalities in health” (p. 3). The fact that so much emphasis is being given to anti-poverty and social inclusion policies across the EU, therefore, is potentially good news in terms of reducing health inequality, provided that policy can be translated into meaningful and proportionate action. On the other hand, Crombie et al (2005) also highlight an important and outstanding challenge facing policy makers.

**Unfortunately there is not always a strong link between inequalities policy and social justice policy. Thus the challenge facing policymakers is**

**to ensure that strategies to tackle the macroenvironmental factors feature in policy on inequalities in health and that health becomes a prominent issue in social justice policy. This could be best achieved by integrating the policies in these two areas** (p. 4).

There is a growing body of international debate about this issue and the WHO has highlighted the need for developing a thoughtful and integrated cross-governmental approach to tackling health inequalities. At a special session of the World Health Assembly in 2005, for example, England’s Chief Medical Officer, Sir Liam Donaldson, set out some of the main lessons learned in the UK about tackling inequalities in health outcomes using a social determinants approach (see box below).

The clear implication of these remarks is that, although policy entry points legitimately vary from country to country, there is great value in having a clear and measurable focus on health inequalities as part of wider concerns with social justice. Such an approach is not yet evident in many parts of Europe. Nevertheless, despite the fact that many of the policies that might impact on health inequalities are not well integrated in many EU countries, there is plenty of evidence of action and concern about the health divide, to which we now turn.

### Lessons from England

You need a plan and clear, measurable objectives.

You need belief ... Action needs to start with the belief that you can do something about it.

You need a cross-governmental plan to address health inequalities – including the finance ministry.

Although this work is not about health services alone, the health sector has an important leadership role to play.

‘Joined up government’ is terribly important, especially at the local level, where planning and funding mechanisms need to be brought into the picture. [www.who.int/social\\_determinants/advocacy/wha\\_csdh/en/](http://www.who.int/social_determinants/advocacy/wha_csdh/en/)

## 3. Tackling health inequalities: national frameworks

Across the European Union and beyond there is a growing recognition of the problems associated with health inequalities and an increasing number of governments are making firm commitments to reduce them. However, there is considerable variation in the form and nature of the expressions of concern and public policy goals and targets being set in different countries. Mackenbach, Bakker et al (2003) highlight the importance of such factors as:

- the availability of descriptive data about the nature and extent of health inequality;
- the presence or absence of political will;
- the state of economic development; and
- the role of international agencies.

Despite the very considerable variation in the way in which different EU member states have responded to health inequality, and the absence of anything like the Lisbon process in relation to this problem, the World Health Organization and the European Union have played an important role in providing a framework and principles to encourage action in many countries.

### 3.1 International organisations

One important context for thinking about health inequality policies in the EU, therefore, is the declaration of the World Health Assembly in 1998, which emphasised “the importance of reducing social and economic inequities in improving the health of the whole population”.

Building on a substantial amount of work dating back to the 1980s, the European Regional Office of the WHO subsequently spelled out the implications for Europe in its publication *Health21: the health for all policy framework for the WHO European Region* (1999). This document emphasised the need to pay attention to reducing differences in health status between member states and, of more importance for this paper, between social groups within countries. The policy framework set out a number of proposed targets for promoting health for all in the 21st century and the one shown below is particularly relevant.

The WHO Regional Office for Europe also published an important set of proposals produced by members of the *European Committee for Health Promotion Development* (ECHPD, 1998).

#### Health21 targets

By the year 2020, the health gap between socio-economic groups within countries should be reduced by at least one fourth in all member states, by substantially improving the level of health of disadvantaged groups. In particular:

- the gap in life expectancy between socio-economic groups should be reduced by at least 25%; the values for major indicators of morbidity, disability and mortality in groups across the socio-economic gradient should be more equitably distributed;
- socio-economic conditions that produce adverse health effects, notably differences in income, educational achievement and access to the labour market, should be substantially improved;
- the proportion of the population living in poverty should be greatly reduced;
- people having special needs as a result of their health, social or economic circumstances should be protected from exclusion and given easy access to appropriate care.

In recent years the European Union has also paid increasing attention to health inequalities. For example, the EU Health Strategy in 2000 highlighted the importance of health inequalities by drawing attention to the wide variations and inequalities in health status (both morbidity and mortality), with substantial evidence that poorer people, the disadvantaged, and socially excluded groups have significantly higher health risks and mortality (European Commission, 2000).

More recently, an overall objective of the Programme of Community Action in the Field of Public Health (2003–2008) (European Commission, 2002) is to reduce health inequalities by taking action *inter alia* by developing strategies and measures on socio-economic health determinants. The programme includes the development of methodologies for benchmarking and linking strategies to identify health inequalities, using data from the Community health information system. It also aims to promote health and prevent disease through addressing health determinants across all policies and activities.

Health inequality is also an important dimension of the new proposals for a “Health and Consumer Protection Strategy” and “Action Programme

2007–2013” (European Commission, 2005a), which notes the major **inequalities** within and between member states in life expectancy, health status and access to healthcare, which in turn lead to inequalities in growth and competitiveness. It stresses that meeting the challenges posed by health inequalities requires a range of cross-sector actions to address social and economic determinants of health.

Funding available from international organisations also often facilitates research and exchange of experience that leads to further development of the knowledge base. Although in some countries official publications on health inequalities are not available, sometimes research reports have been produced in the framework of international cooperation that can lay the foundation for further work at a national level. This has been the case in Estonia and the Czech Republic (with projects funded by the World Bank and the European Commission respectively).

Another indication of the way in which countries are choosing to work together to articulate concerns about health inequality can be seen in a joint communiqué agreed between the Health Ministers of Belgium, Germany, Portugal, Spain, Sweden and the United Kingdom. At their meeting in Stockholm on 28–29 August 2005 they discussed how to

#### **Joint statement**

“... The fundamental values of equity, universality and solidarity underpin health systems throughout Europe. All our systems, although they vary greatly in how they are organised, managed and financed, seek to provide equity of access to high quality, efficient and financially sustainable health care services to the entire population, based on need rather than the ability to pay. All systems are based on solidarity – between ill and healthy, between poor and rich, between young and old and between those who live in urban and rural areas.

“Inequalities in health, whether it derives from differences in education, income, living conditions or other health determinants must be addressed and the gap need to be narrowed if we are to succeed to maintain a just and prosperous society ...”

facilitate cross-border care for the benefit of their citizens within a European context, taking account of developments in the internal market, while preserving the fundamental values and principles which distinguish the European Social Model. A key part of their joint statement is shown on page 17.

## 3.2 National responses

Individual countries have chosen to respond to the WHO recommendations and European Union initiatives in a wide variety of ways. Some of the main differences of approach, identified from the “Situation Analysis” questionnaires, are highlighted below.

- Most countries subscribe to the equity principles and values articulated by the World Health Organization.
- Most are explicitly concerned with the socio-economic dimension of health inequalities but several (such as Hungary) focus on ethnic differences.
- Some – such as Denmark, Italy, Poland and Sweden – emphasise their equity commitments in the context of broader public health strategies.
- Others, such as the Czech Republic or Latvia, choose to express their domestic commitment to the Health21 targets specified by the European Regional Office of the WHO.
- Countries such as Finland and the Netherlands have a single health inequality goal specified in quantitative terms.
- Whereas Ireland and the four constituent countries of the UK each have a number of more detailed quantitative targets.
- Some countries – such as Italy and Spain – that do not have national targets do have examples at a regional or local level.

- Most countries that have quantitative targets set them in terms of reducing gaps between the poorest and the more affluent, but Scotland and Wales appear to be unique in terms of emphasising the importance of improving the position of the poorest groups per se.
- None of the countries considered have explicit goals or targets related to the gradient between socio-economic position and health status across the whole population.

As far as we are able to tell at this stage, a number of EU countries have not formally articulated principles or goals to guide their actions at **the national policy level** in relation to promoting population health equity or reducing health inequalities. We should note, however, that it is distinctly possible that the information available to us is incomplete and any future editions of this report would aim to make good such omissions.

It is important to emphasise, however, that the absence of national-level policy statements does not mean that concerns about health inequalities are absent within a particular country. In Estonia, the President of the Republic highlighted the problem of health inequality in his New Year speeches in 2003 and 2004. In the case of Spain, for example, the national Health Ministry arranged for *Health21* (WHO, 1999) to be translated into Spanish and distributed to all regional health departments.

It is also the case that, even in countries where there is relatively little evidence of national policy, there may be important regional or local initiatives. For example, at least three regions in Spain include explicit references to health inequalities in their plans; one of these – the Basque country – has adopted specific quantitative targets:

- To reduce social differences in mortality from diseases of the circulatory system by 25% from a baseline of 39% in 2002 to a target of 30% by 2010.
- To reduce social differences in mortality from cardiovascular diseases by 25% from a baseline of 45% in 2002 to a target of 34% by 2010.

Similarly, most if not all countries have clear commitments to promote health **care** equity, even if statements about health inequality do not appear to exist. For example, one of the main features of the mission statement of the Ministry of Health in Cyprus ([www.moh.gov.cy/moh/moh.nsf/mission\\_en](http://www.moh.gov.cy/moh/moh.nsf/mission_en)) emphasises the importance of: “the provision of equal opportunities for health care to all citizens, irrespective of socio-economic status and place of residence”.

## 4. Types of approaches of EU member states

There are three useful ways of distinguishing between the different approaches to health inequality currently in place in member states of the EU. The first relates to those countries that have clear references to tackling health inequalities included in legislation. The second is whether or not explicit goals or principles to promote health equity are articulated in national policy documents. The third is whether such objectives are associated with quantitative targets, by which we mean that that they have identified a specific aspect of the problem of health inequality as a priority and made a commitment to reduce it by a specified amount by a particular date.

### 4.1 Legislative commitments

Some countries have passed laws that make specific references to health inequalities. One of the most recent to do this is Greece, which passed a law concerning the “organization and operation of public health services” in June 2005.

#### Greece

Articles 1 and 2 define public health as being an investment in the protection and improvement of human capital and state that it refers to the total organized activities of the state and society, which are scientifically based and aim at the prevention of disease, protection and promotion of the health of the population, increase in life expectancy and improvement in the quality of life. Public health is characterised as being intersectoral and interlinked with health development and health impact assessment.

Article 2 includes the statement that:

**Activities related to the social care and the special needs of vulnerable groups of the population, who live in disadvantaged social conditions such as poverty, unemployment, old age, social exclusion, no income, and the attempts to ameliorate socioeconomic inequalities in health, are included in the wider concept of public health.**

Article 3 sets out the main activities of public health and includes a specific reference to:

**The protection of the health needs of vulnerable groups of the population.**

Chapter 3 describes how policies and strategies for public health are to be developed and Article 6 in this section says that they will be developed on the basis of the following criteria: “effectiveness, efficiency and **equality**”.

The prerequisites for policy development are listed in Article 6 and point 5 highlights the importance of:

**Access to health services, removal of inequalities, meeting the needs of poor and vulnerable groups and the promotion of healthy lifestyles.**

## Germany

The system of Statutory Sickness Funds in Germany is based on the principle of solidarity between those at the upper and those at the lower end of the income spectrum, between the sick and the healthy, and between large and small families. Furthermore, the public health services (Öffentliche Gesundheitsdienste) complement the services provided by the statutory sickness funds, and serve to benefit those in disadvantaged situations.

Since 2000, the paragraph on health promotion and prevention in the German health care law states that these services should contribute to the reduction of health inequalities. Based on this paragraph, some Statutory Sickness Funds have started new programmes for the promotion of health promotion and prevention specifically addressing the lower socio-economic groups.

The German Federal Ministry of Health and Social Security has “equity in health” as one of five central topics involved in the process of agreeing national health targets ([www.gesundheitsziele.de](http://www.gesundheitsziele.de)).

The conference “Poverty and Health”, which has been held in Berlin annually since 1995, has established itself as the largest event nationwide in this area. Every year about 1,000 representatives from intervention projects, health policy and research meet in order to discuss the potential for reducing health inequalities. The conference is co-sponsored by the Federal Centre for Health Education (BZgA) and by some Statutory Sickness Funds.

[http://www.gesundheitberlin.de/index.php4?request=themen&topic\\_id=138](http://www.gesundheitberlin.de/index.php4?request=themen&topic_id=138)

A new internet platform on health inequalities has been established by the Federal Centre for Health Education (2005). The platform makes it possible to produce a comprehensive overview, constantly updated, of the initiatives aimed at health promotion for socially disadvantaged people, and to make this information available free of charge to everybody. More information at <http://www.gesundheitliche-chancengleichheit.de>.

An extensive expert opinion has been written by the Sachverständigenrat zur Begutachtung der Entwicklung im Gesundheitswesen (Advisory Council on the Assessment of Developments in the Health Care System), established by and reporting to the German Federal Ministry of Health, which facilitated a detailed discussion on health inequalities in the April 2005 report for the first time.

The federal government has also published reports on poverty and wealth in Germany. The first report (Coordination and Quality in the Health Care System; [www.svr-gesundheit.de](http://www.svr-gesundheit.de)) came out in 2001 and the second in spring 2005.

Germany provides another example of a country with specific legislative commitments related to health inequalities. Some details together with other examples of national policy initiatives are illustrated above.

## 4.2 General goals

For another group of countries, including Denmark, France, Hungary, Italy, Norway, Poland, the Slovak Republic and Sweden, clear documentary evidence of policy commitment to health equity can be found, which is expressed in a variety of ways but does not include commitments to quantitative targets.

Hungary is rather unusual in having a particular focus on ethnic, as well as socio-economic, inequalities. It has a general commitment to reduce the gap in life expectancy between the Roma population and the Hungarian average, which is estimated to be 10 years. “A fundamental tenet” of the National Programme for Health (2003) “is to reduce inequalities and create opportunities”.

A number of countries have general commitments to promote equity in health. For example, in Sweden, it is very evident from the speeches of ministers and from general public health documents that the problem of health inequalities is well understood, and the principle of health equity is embedded in policy thinking.

### Sweden

In the statement of government policy by the Prime Minister, Mr Göran Persson, to the Swedish Riksdag on 14 September 2004, he said:

**I want Sweden to be a country of security and welfare for all, not just for some ... But in our country there are still differences in health and access to education that cannot be explained by anything other than social background ... A hundred years of fighting the class society have not eradicated the differences.**

[www.sweden.gov.se/content/1/c6/02/97/25/f13dc79e.pdf](http://www.sweden.gov.se/content/1/c6/02/97/25/f13dc79e.pdf)

Nevertheless, the prevailing philosophy of action in Sweden is based on the belief that a very strong and historic commitment to universal social welfare and health services is the best way to make progress. This is emphasised by the Ministry of Health and Social Affairs in an overall description of its work and responsibilities:

**The objective of the Government’s public health policy is to create societal conditions to ensure good health, on equal terms, for the entire population. This is set out in the Public Health Objectives Bill adopted by the Riksdag in April 2003. The Bill focuses on all the factors in society that affect our physical and mental health, such as living conditions and lifestyle habits, the state of the environment or the products we consume ... The Government emphasises that public health work should incorporate a gender and class perspective. Irrespective of gender, class, sexual orientation, ethnic background or disability, people should have access to the same conditions for good health.**

[www.sweden.gov.se/sb/d/2028/a/48089;jsessionid=a4sFgaSxlpLc](http://www.sweden.gov.se/sb/d/2028/a/48089;jsessionid=a4sFgaSxlpLc)

All the Swedish Public Health Reports (1987, 1991, 1994, 1997, 2001) have presented data on social inequalities in health. In addition to the analysis of differences by socio-economic group, sex and geographical location, the Reports have also focused on vulnerable groups, such as immigrants, single parents and their children. The Swedish Public Health Report of 2005 is not yet available in English, but the 2001 Report is published as a supplement to the *Scandinavian Journal of Public Health* (Health in Sweden – The National Public Health Report 2001, supplement 58, 2001)

In Denmark, the most recently published policy document (*Healthy throughout life in Denmark*, 2002) reiterates earlier policy announcements that make clear that “reducing social inequality in health” is one of the key objectives of public health policy.

**The Government will continue to maintain the perspective of equity in health. Society must take responsibility for the most disadvantaged and vulnerable population groups. The Government therefore emphasises the need for special attention and efforts in relation to several high-risk groups in *Healthy throughout life* ... The Government believes that social equity in health is one of the fundamental values of a welfare society, including for efforts to promote health** ([www.folkesundhed.dk/ref.aspx?id=190](http://www.folkesundhed.dk/ref.aspx?id=190)).

Danish policy makers have identified social differences in relation to four key areas – mortality, quality of life, smoking and very limiting chronic illness – as warranting special attention in terms of monitoring trends in health inequalities.

Norway is another of the Nordic countries worth mentioning, despite it not being a member of the EU, because of its long-term commitment to social solidarity in general and social equity in particular. In a recent report to Parliament, the Ministry of Health announced that one of two primary public health objectives was a “reduction in health disparities between social classes, ethnic groups and the sexes” (2003). Interestingly, this represents quite a marked change of direction for Norwegian health policy.

**Public health policy in Norway has been more concerned with average factors than with diversity in the state of health of the population ... To reach groups of the population who do not meet the average criteria, it is important to be aware of what characterises their situation and what constitutes ‘their’ problems. The Government therefore wishes to place a sharper focus on the differences in health problems.**

**A strategy to improve public health should pay particular attention to improving the health of groups whose health is below average for the population as a whole. This will mean gearing our policy more specifically to the parts of the population where both the challenges and the possibilities (prevention potential) are greatest. At the same time, we must consider the effects the policies of several sectors can have on the living conditions and possibilities of the most disadvantaged** (Ministry of Health, 2003, p. 20).

The Ministry of Health and Social Welfare in Poland published its National Health Programme 1996–2005 in 1996 (<http://www.medstat.waw.pl/nhp/>). This specifies the overall strategic goal as “improving the health status of the population and enhancing the health-related quality of life” with one of the three sets of underpinning activities being “reducing inequalities in health and access to health services”. Interestingly, in the discussion of inequalities in health, reference is made to potentially avoidable differences in health outcomes by gender and area of residence – differentiating between urban and rural as well as region – as well as by social status. Furthermore, Poland has a specific target aimed at “preventing premature births, low birth weight and reduction of related negative health effects”, which is to be achieved through improvements in nutrition for pregnant women living in poverty.

In Italy, the 2003–5 National Health Plan (2003) acknowledges the role of social disadvantage as a determinant of poor health. However, specific objectives associated with reducing inequalities appear to be restricted to more marginalised groups such as drug misusers and immigrants.

Finally, in this group of countries, France has two general objectives linked to reducing health inequalities. The first is to reduce avoidable mortality and morbidity, and the second is to reduce health disparities between regions.

### 4.3 Quantitative targets

On the basis of information available at present, at least seven EU countries have quantitative health inequalities targets. These countries seem to fall into three distinct groups.

The **first group**, comprising the Czech Republic, Latvia and Lithuania, broadly follow the WHO recommendations. In the case of the Czech Republic this appears to mean the straightforward adoption of Target 2 in *Health21*. Latvia makes a similar commitment, but the public health strategy published by the Ministry of Welfare goes several steps further.

By the year 2010, the gaps among health indices between socio-economic groups in Latvia should be reduced by at least a quarter by substantially improving the level of health of disadvantaged groups (Cabinet Ministers of Latvia, 1995). In particular:

- The values for major indicators of morbidity, disability and mortality should be more equitably distributed across socio-economic groups.

- People having special needs as a result of their health, social or economic circumstances should be protected from exclusion and given easier access to educational, health, social and other necessary services.
- The proportion of poor people should be significantly reduced.

Following the adoption of a National Health Programme by the Lithuanian Parliament in 1998, which included the WHO inequalities target, the next step was to develop a set of socio-economic indicators for a range of health care outcomes, such as mortality, life expectancy, low birth weight and health behaviours and risks, so that a regular programme of monitoring could be introduced (Padaiga, 2002).

Countries in the **second group** have one or two general quantitative targets. In the Netherlands the aim is to bridge the gap of health inequalities by extending the healthy life expectancy of the lower social income groups by 25% of the current difference (=3 years) in 2020. There is also a good deal of concern about health inequality at the local level in the Netherlands.

In 2002, for example, research reviewing the health policy documents produced by the 480 municipalities showed that:

- 56.5% mentioned health inequality as a policy target.
- 51.4% mentioned low income groups as target groups.
- 27% mentioned homeless people as a target group.
- 21.6% mentioned the inhabitants of deprived neighbourhoods as a target group.

In Finland, which has had commitments to health inequality targets since 1986, the aim is to reduce mortality differences between the genders, groups

with different educational backgrounds, and different vocational groups by 20 per cent by 2015.

The **third group** of countries, which covers Ireland and the UK, has a wider range of targets.

In Ireland, *Quality and fairness: a health system for you* (Department of Health and Children, 2001) and the *National Action Plan against Poverty and Social Exclusion* are the key frameworks that underpin the central policy for reducing health inequalities. The key targets are:

- Reduce the gap in premature mortality between the lowest and highest socio-economic groups by at least 10% for circulatory diseases, cancers and injuries and poisoning by 2007.

- Reduce the gap in low birth weight rates between children from the lowest and highest socio-economic groups by 10% from the 2001 level, by 2007.
- The gap in life expectancy between the Traveller Community and the whole population will be reduced by at least 10% by 2007.

In terms of setting, monitoring and reviewing health inequality targets, the example of England is noteworthy. The English Department of Health has published its first substantial report about the changing focus and impact of policies in this area in recent years (Department of Health, 2005).

### **England**

As part of a cross-government review of public expenditure priorities in 2004 the Westminster government reaffirmed its strong commitment to reduce health inequalities by 10% by 2010 as measured by infant mortality and life expectancy at birth. It also identified a Spearhead group, which covers the 70 local authority areas with the worst health and deprivation indicators, as a focus for action. The 2004 Spending Review highlighted the relevance of health inequalities in a new health improvement target to “substantially reduce mortality rates by 2010:

- from heart disease, stroke and related diseases by at least 40% in people under 75, with at least a 40% reduction in the inequalities gap between the fifth of areas with the worst health and deprivation indicators and the population as a whole;
- from cancer by at least 20% in people under 75, with a reduction in the inequalities gap of at least 6% between the fifth of areas with the worst health and deprivation indicators and the population as a whole”.

It reiterated existing targets to tackle the underlying determinants of ill health and health inequalities by:

- reducing adult smoking rates to 21% or less by 2010, with a reduction in prevalence among routine and manual groups to 26% or less;
- reducing the under-18 conception rate by 50% by 2010 as part of a broader strategy to improve sexual health;

and set a new target for:

- halting the year-on-year rise in obesity among children under 11 by 2010 in the context of a broader strategy to tackle obesity in the population as a whole.

### **Northern Ireland**

Health and well-being are largely determined by the social, economic, physical and cultural environment. Health policy has so far tended to concentrate on the treatment of ill health rather than on its prevention.

**This strategy seeks to shift that emphasis by taking action to tackle the factors which adversely affect health and perpetuate health inequalities.**

The overarching aims of this strategy are “to improve the health status of all our people, and to reduce inequalities in health”, and it includes a large number of general objectives and specific targets. The most important objectives in terms of reducing health inequality include one:

- To reduce inequalities in health between geographic areas, socio-economic and minority groups.

Examples of specific targets, which relate to this objective, are:

- To halve the gap in life expectancy between those living in the fifth most deprived electoral wards and the average life expectancy here for both men and women between 2000 and 2010.
- To reduce the gap in the proportion of people with a long-standing illness between those in the lowest and highest socio-economic groups by a fifth between 2000 and 2010.

In other parts of the UK there are also well-developed health inequality targets, but Northern Ireland, Scotland and Wales have all gone in slightly different directions to England. Northern Ireland, like Norway, has made an explicit commitment to change direction in its strategy document *Investing for Health* (2002).

Scotland has taken a different approach to almost all other countries in that it has chosen to adopt targets that focus on improving the position of the disadvantaged without specific reference to other groups, rather than attempt to close the gap between rich and poor in some way, as most other countries with quantitative targets are trying to do. It has been decided that targets for reducing health inequality should focus on increasing the *rate of improvement* across a range of indicators for the most deprived communities by 15% by 2008, based on an assessment of recent trends (Scottish Executive, 2004).

In Wales, a broad framework for health gain targets and indicators, that provide the focus and direction for improving health and reducing health inequalities, was announced at the beginning of 2005 in a report by the Chief Medical Officer (Welsh Assembly Government, 2005). Unusually, rather like Scotland, two of these targets do not focus explicitly on ‘closing the gap’ but emphasise relatively faster improvements for the most deprived groups. The other three targets are not inequality targets as such but there is a marked social gradient in the prevalence of the problem in question.

# 5. Responsibility for action

## 5.1 The challenge of mainstreaming policies to tackle health inequalities

The problem of generating and sustaining ‘cross-cutting’ action on (‘mainstreaming’) health inequalities in national public policy is well known but rarely acknowledged. Across the European Union it is typically the Department (Ministry) of Health (or umbrella department in which Health is located) that is responsible for action to tackle the issue. In nearly all countries this responsibility is shared with other departments. However, there is a considerable variation in the extent to which there is a concerted effort to co-ordinate action on health inequalities between government departments and/or successful implementation of such action.

## 5.2 General commitment to cross-government co-ordination

In one group of countries (e.g. Estonia, Italy, the Netherlands and the Slovak Republic) there is a general commitment across government to equality issues but no formal mechanism for co-ordinating implementation of policy on health inequalities across government departments. Of course, even where it is not obvious that co-ordinating mechanisms exist at the national level, it is possible

to identify many examples of multi-sectoral action at the local level or regional level. An example from Estonia (shown below) illustrates this point.

## 5.3 Co-ordinated action evident but not comprehensive

In a second group of countries co-ordinated national action on health inequalities, while evident, is less extensive or formalised than that found in other countries.

- In Hungary there is an inter-Ministerial committee for the Roma.
- In Lithuania, a consensus conference to consider the midterm evaluation of the national health programme, held in the Parliament in October 2005, embraced commitments by 6 Ministers (Health, Environment, Economy, Social Affairs & Labour, Education & Science, and Transport) to a close partnership for health.
- In Spain, the Ministry of Employment and Social Affairs is responsible for the national plan for social inclusion (where health inequalities policy is ‘located’). Implementation of the plan involves several other departments (Foreign Affairs, Justice, Treasury, Interior, Public Works, Education, Culture and Sport), which meet three times a year as a high-level inter-Ministerial commission.

### **Estonia: School Milk and Free Hot Meal Programmes**

In 2001 the Ministry of Agriculture, in co-operation with the Ministry of Social Affairs and local governments, started the School Milk Programme. The main objective of the Programme is to promote milk drinking and healthy nutrition among school children. In 2002, the Milk Programme was followed by the Free Hot Meal Programme, which was also targeted at grades 1–4. This was only available to pupils from families living in disadvantaged economic circumstances. However, many children from poor families were not eligible for the free lunch. Consequently the scheme was revised and currently all students in grades 1–4 receive a free lunch.

- In Germany there is topic-related collaboration but no regular co-ordination between policy units. There are, however, Cabinet plans to enhance co-operation, leading to a more integrated prevention strategy. On a lower level, co-ordination occurs within the framework of a nation-wide collaboration between health insurance funds, charities, health associations and public agencies to promote the health of socially disadvantaged people.
- In Denmark, the multi-sectoral *Healthy Throughout Life* programme is owned by 12 different ministries, in recognition of the cross-cutting nature of the national public health function.
- In Poland, there is collaboration between the ministries responsible for action on health inequalities; health policy directions are set in the Prime Minister's Economic Council.

## 5.4 Advanced co-ordination mechanisms

Co-ordinated and comprehensive national action on health inequalities is evident in a small number of countries.

### Ireland

In Ireland, the Department of the Taoiseach (Prime Minister), through the Cabinet Committee on Social Inclusion and an associated Senior Officials Group, has the overarching co-ordination role. While the Department of Health and Children has lead responsibility for addressing health inequalities at policy level, the Health Service Executive is responsible for management and delivery of services. Both levels seek to influence the policies and programmes of other departments and agencies whose activities have an impact on population health. The Office for Social Inclusion of the Department of Social and Family Affairs has overall responsibility for co-ordinating the National Anti-

Poverty Strategy (NAPS) (and the associated National Action Plan Against Poverty and Social Inclusion) across all relevant departments.

### Northern Ireland

The Northern Ireland *Investing for Health* strategy contains a framework for action to improve health and well-being and reduce health inequalities by partnership working among departments, public and voluntary bodies, local communities, district councils and social partners. The strategy was developed by a cross-departmental group of senior officials from all government departments and chaired by the Minister for Health, Social Services and Public Safety. At national level, the inter-departmental Ministerial Group continues to meet to manage cross-departmental action and monitor progress in other areas. At local level, a strategic partnership has been established in each of the four health and social services board areas.

### England

The group responsible for influencing and co-ordinating action on health inequalities in England is the Health Inequalities Unit (HIU) in the Department of Health. The HIU is a small team with a cross-government focus. Rather than taking the policy lead on all health inequalities issues, the HIU makes links and connections between a wide range of bodies and initiatives to ensure that a health inequalities perspective is incorporated into their work. The national health inequalities strategy described in the *Programme for Action* set out the arrangements for governance and co-ordination. A Cabinet sub-committee shares responsibility for health inequalities across government. There is also a cross-government Programme Board chaired by the Chief Medical Officer to oversee the implementation of the strategy. The Board is supported by a series of external reference groups to assist delivery on the ground. A newly established board dealing with

targets oversees co-ordination within the Department of Health. Regular senior official level meetings with other Units take place. Located in the Office of the Deputy Prime Minister (ODPM), the Social Exclusion Unit, with its focus on vulnerable, deprived and excluded individuals and groups, and the Neighbourhood Renewal Unit, responsible for oversight of neighbourhood renewal programmes, also have a major role to play. Regulatory Impact Assessment includes assessment of impact of policies on health inequalities and is mandatory at Central Government level.

### **Scotland**

The Directorate of Health Improvement within the Scottish Executive Health Department facilitates cross-cutting work in all departments. The Directorate is charged with establishing a cross-cutting approach to health improvement, resulting in work across boundaries, linking the different agendas that impact on health. NHS Health Scotland, the country's national health improvement organisation, supports organisations and individuals to take action to improve health and reduce health inequalities.

### **Wales**

Co-ordination between Welsh National Assembly groups (eg education and training, social justice and regeneration) takes place at different levels and through a variety of mechanisms, eg ministerial committees, strategies and programmes. The whole of the Cabinet has public health responsibilities, which encourages joined-up policy making. Health Challenge Wales also provides a national focus for a co-ordinated and sustained effort to improve health and reduce health inequalities.

### **Sweden**

Sweden is perhaps an important special case. Sweden's *National Public Health Strategy* is intended to "make an improved public health a central goal for the entire Swedish government policy". It is anticipated that all public authorities at all levels will be guided by the goals including social welfare, transport and the environment. The main purpose of the new strategy is to reduce inequalities in health by influencing all areas of policy making and action. The absence of a co-ordinating unit to focus on health inequality is consistent with this broad social welfare model. A National Executive for Public Health Issues (established in 2003) brings together the Minister for Public Health and Social Services and directors-general from 17 government authorities, with representatives from other ministries, in order to promote co-ordination at national, regional and local levels.

## 6. Action and implementation

### 6.1 No single right way to reduce health inequalities

There is increasing understanding of the multiple pathways through which social, environmental and behavioural risks and behaviours interact. However, as a result of the lack of unambiguous evidence to guide policy making, the many risks associated with health inequality and the importance of local context in the form of history, culture and values, there are many legitimate policy entry points that countries concerned about the health divide can adopt to guide their actions.

**The available evidence on the effectiveness of policies and interventions to reduce socioeconomic inequalities in health is very limited ... There seem to be many entry points, but for only some of these have policies and interventions been devised, only some of them have been evaluated, and not all of the results have been made available to policy-makers around Europe** (Mackenbach & Bakker, 2002, p. 342).

We simply cannot say for certain that there is a single right way to reduce health inequalities. The content of action will and almost certainly should vary from place to place. Nevertheless, we can say something about the process of action. The more focused and integrated is the cross-government strategy for action, the greater is the probability that health outcomes will change in the desired direction. In addition, policies to reduce health inequalities are likely to be more successful when there is a clear action plan – that can be implemented and monitored – focused on specific targets within realistic timeframes.

### 6.2 Variation in the scope of national action plans to reduce health inequalities

Reflecting on developments in the 1980s and 1990s, Whitehead identified “a whole spectrum of readiness and receptivity to the subject of social inequalities in health” across the countries of Europe, from denial/indifference at one extreme to a co-ordinated and comprehensive response at the other (Whitehead, 1998, p. 469). The pace of policy development in relation to health inequalities has been rapid since the late 1990s. Drawing on Whitehead’s analysis, however, we can identify **four** groups of countries according to the presence and scope of action plans to reduce health inequalities.

**Group A: countries that lack any distinctive focus on health inequalities per se, but, in common with other member states, have taken action on the social determinants of health inequalities at national and local levels.**

**Group B: countries where it is possible to identify various actions to reduce health inequalities, but in which these are not necessarily related to a ‘master plan’.**

**Group C: countries with very clear concerns about, and in some cases commitment to, promoting health equity as part of more general public health policies.**

**Group D: countries with well integrated and co-ordinated action plans.**

The broad characteristics of each group, with some illustrative examples of the content of the policy response, are outlined below. A selection of 3 out of 52 good practices across Europe can be found at Annex 1. (See Stegeman and Costongs, 2004.)

### **Group A: action directed towards social determinants of health inequalities**

Countries in this group implement various actions related to the social determinants of health inequalities, but there is no evidence of an explicit policy to reduce health inequalities. Selected examples of relevant actions within this group are presented below.

#### **Cyprus**

The effectiveness of social policy in Cyprus relies on the co-ordinated efforts of the public, voluntary and private sectors. The Pancyprrian Welfare Council (PWC) has a leading role in the activation and effective integration to the total social effort of the voluntary sector and NGOs, as the co-ordinator of voluntary organisations, as a point of focus for public discussion about social problems and in mobilising voluntary organisations.

#### **Greece**

The Ministry of Health's Network of Social Support Services is operating within the context of supporting employment and interlinking social support and employment networks. Its implementation agencies are municipal authorities offering services either promoting employment or assisting direct beneficiaries. Generally, these services are aimed at combating poverty and social exclusion.

### **Group B: limited actions to reduce health inequalities**

Countries in this group are undertaking various actions to reduce health inequalities, but these are not linked to a national integrated plan to achieve that goal.

#### **Belgium (Flanders)**

“Kind en Gezin: working with family supporters”, an outreach project supported by the Flemish government, involves “experienced experts” accessing families who are living in poverty and at risk of

social exclusion. People who have experienced poverty are trained to become family supporters, advising the target group on the issues of health and family issues in a culturally acceptable way.

#### **France**

The Regional Programme of Access to Prevention and Care (PRAPS) facilitates co-operation between different actors, such as civil society, public services, medical professionals, insurance groups, hospitals and other professional groups working together to improve access to prevention and care for the most vulnerable groups. Each of the 26 participating regions prepares customised plans based on prior needs assessment. Implementation of the plans has to take account of local planning and other aspects of policies impacting on health inequalities, such as employment and housing.

#### **Germany**

The BZgA (*Bundeszentrale für gesundheitliche Aufklärung* – Federal Centre for Health Education) undertakes innovative health education and health promotion initiatives, particularly in social hot spots. These efforts take place in co-operation with the Federal programme “Die Soziale Stadt” (The Social Town), in which 250 municipalities have already enrolled. This programme aims to secure sustained improvement in the life situation of the affected residents of disadvantaged neighbourhoods.

In an effort to strengthen the measures and projects undertaken in the field of health promotion for socially disadvantaged persons, the BZgA has been documenting all activities in Germany in a continuously updated database which is accessible on the internet ([www.datenbank-gesundheitsprojekte.de](http://www.datenbank-gesundheitsprojekte.de)). At present, best practice projects are being selected from this pool. To support the implementation of such measures, health promotion networks for socially disadvantaged persons – so-called regional hubs – were created in

the Federal Laender at the BZgA's initiative, in which the BZgA, NGOs, health insurance funds and welfare associations have teamed up to support projects benefiting socially vulnerable groups.

### **Poland**

Polish 400 Cities Project (2003-2005) is an example of a multi-centre research project that aims at prevention of stroke and myocardial infarction among small town and village residents in Poland. People living in these locations are traditionally of lower socio-economic background and constitute the primary risk group.

The project covers 418 Polish towns with a population of less than 8,000 and in the neighbouring villages. The plans are that the programme will reach about 2.5 million people, of which at least 150,000 will undergo screening tests. Should any significant disorders be detected, a follow-up with in-depth diagnostic procedures will be run for newly detected cases. Traditional prevention programmes are supported by advanced social marketing techniques.

Apart from the medical intervention there will be educational seminars provided for the local leaders (local authorities, NGOs, Church and private business.).

The project has been based on the epidemiological data collected by NATPOL PLUS from Poland's Chief Statistical Office (GUS) ([www.400miast.pl](http://www.400miast.pl)).

### **Group C: promoting equity as part of general public health policy**

In this group of countries there is no specific health inequalities action plan; however, there is a recognition of the issue in a general public health action plan/strategy, with or without an accompanying commitment to take remedial action.

### **The Netherlands**

*Living longer in good health*, the Dutch White Paper on public health (Ministry of Health Welfare and Sport, 2003), makes the case for investment in prevention, particularly in relation to three 'spearhead' themes of smoking, obesity and diabetes. An action plan and a target for each spearhead is promised. Examples of the actions that the Cabinet intends to employ in achieving the targets for each spearhead include: more emphatic reminders to the public of the dangerous effects of unhealthy lifestyles; consultation with municipalities, which have a legal responsibility in the area of prevention, to adapt the spearheads (more fully) to local health policies; reminders to businesses of their social responsibility for public health; incentives for health insurers to identify health risks resulting from unhealthy lifestyles in a timely manner with their patients; and support for the development of "healthy schools". There is little evidence of an explicit equity perspective in the action plans.

### **Finland**

Finland's current public health programme (*Government Resolution on the Health 2015 Public Health Programme*) continues the government's long-standing commitment to reduce inequality and increase the welfare and relative status of the most disadvantaged population groups (Ministry of Social Affairs and Health, 2001). However, there is no separate strategy for reducing health inequalities; rather, the Programme suggests that this aim can be achieved by implementing strategies to meet the other public health targets (relating, *inter alia*, to improving child health, reducing accidental and violent deaths among adult young men, and improving working and functional capacity among people of working age and workplace conditions).

### **Denmark**

The foundation of the current public health strategy in Denmark is the programme *Healthy throughout life; the targets and strategies for the public health policy of the*

government of Denmark 2002–2010, which aims to increase life expectancy, improve quality of life and reduce social inequality in health (Government of Denmark, 2002). The Programme highlights several initiatives which are intended to improve population health overall, but does not present specific plans targeted at the reduction of health inequalities.

### Hungary

Hungary's *National Programme for the Decade of Health* refers to the reduction of inequality and increase in solidarity as a fundamental underpinning value. Future planned actions include the reduction of social exclusion and improvement of living conditions of marginalised groups. An outstanding example is provided in the box below.

#### Hungary

The *National Programme for the Decade of Health* refers to the reduction of inequality and increase in solidarity as a fundamental underpinning value. Planned actions include the reduction of social exclusion and improvement of living conditions and social mobility of marginalised groups and the design and implementation of projects to assist their lasting integration. In 2004, the government devised a model programme to promote the full social integration of the Roma national minorities in affected settlements by improving their quality of life, housing conditions and access to educational, social and health care services. The programme, which is being implemented in 2005/2006, will entail mobilisation into integrated residential areas in some cases and the rehabilitation of the residential environment in others.

### Group D: integrated plan for reducing health inequalities

Three key characteristics of action plans in this group of countries should be highlighted.

1. Reducing the health inequalities gap or improving health outcomes for the most disadvantaged

(although not reducing the gradient) is considered to be a central aim of public policy for which the government as a whole must take responsibility. There is a concerted effort to create 'ownership' of health inequalities targets in all major departments (in addition to Health) through a multi-sectoral and cross-departmental framework for action.

#### Northern Ireland

*Investing for Health (IfH)* (Department of Health, Social Services and Public Safety, 2002) places particular emphasis on policies designed to promote inter-sectoral working, recognising that the statutory sector cannot by itself achieve the desired improvements in health but needs to work together with non-statutory, community and voluntary groups. Cross-departmental strategies and action plans have been, or are being, produced in a range of areas, including drugs and alcohol misuse, food and nutrition, home accident prevention, mental health promotion, physical activity, sexual health, tobacco and teenage parenthood.

#### England

The report of the *Independent Inquiry into Health Inequalities* (1998), chaired by Sir Donald Acheson, paved the way for action on a broad front on health inequalities. The publication of the report, together with the announcement of a national health inequalities target (2001) and a Treasury-led cross cutting review of health inequalities (2002), resulted in the development of a national strategy. *Tackling health inequalities: a programme for action* was launched as part of the wider national drive for improving social justice (Department of Health, 2003). Backed by twelve government departments and agencies, the Programme lays the foundation for meeting the government's targets to reduce the health gaps in infant mortality and life expectancy by 2010.

2. Action plans are underpinned by a clearly articulated and pragmatic strategy for reducing

health inequalities and structured around a priority list of delivery themes.

### **Scotland**

*Towards a Healthier Scotland* (The Scottish Office, 1999) proposes action to tackle health inequalities at three levels: life circumstances, including unemployment, poverty and poor housing; health-related lifestyles, eg cigarette smoking, excessive alcohol consumption and unhealthy eating; and priority health topics, including coronary heart disease and stroke, cancer and mental health. The White Paper lists action points on the health topics and also proposes health demonstration projects (on child health, screening for colorectal cancer, heart disease prevention and sexual health promotion) which were subsequently funded and implemented. *Improving Health in Scotland: the Challenge* (Scottish Executive, 2003) sets out a work programme for advancing the health improvement agenda. The document gives 44 action points to be taken forward by various agencies, including the Scottish Executive, local NHS systems, local authorities and the voluntary sector.

### **Ireland**

*Quality and fairness: a health system for you* (Department of Health and Children, 2001) proposes seven action points to address health inequalities. The first is to implement a programme of actions to achieve the National Anti-Poverty Strategy (NAPS) and Health Targets. The five key themes of the NAPS, established in 1997, are: income inadequacy, unemployment, educational disadvantage, rural poverty and disadvantaged urban areas. The Government's review of the NAPS *Building an Inclusive Society* (2002) added targets in additional areas, such as health and housing. Other proposed actions in *Quality and fairness: a health system for you* include implementing initiatives to eliminate barriers to the achievement of healthier lifestyles among disadvantaged/vulnerable groups.

### **England**

There are four delivery themes in the *Programme of Action*:

1. Supporting families, mothers and children (to help break the cycle of deprivation and disadvantage through the generations).
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 coronary heart disease and cancer).
4. Addressing the underlying determinants of health (emphasising the need for concerted effort across Government at national and local level).

3. There is recognition of the importance of action at regional/local (as well as national) level.

Although many commitments can only be addressed by the government (eg influencing structural determinants of health inequalities, such as the unequal distribution of income and wealth), delivery of more specific services and interventions are more likely to be in the hands of local providers (statutory bodies, community groups, NGOs).

#### **Northern Ireland**

At local level, a strategic partnership has been established in each of the four health and social services board areas. All four partnerships have produced their first health improvement plans (HIPs), setting out how they aim to address the identified health and well-being needs of their local populations.

#### **Ireland**

The health sector participates in two programmes (under the remit of the Department of Community, Rural and Gaeltacht Affairs) which target urban and rural areas of disadvantage: RAPID (Revitalising Areas through Planning, Investment and Development) prioritises resources into disadvantaged areas in cities and towns; CLÁR (Ceanntair Laganna Ard-Riachtanais – Gaelic for disadvantaged areas) targets rural disadvantaged areas.

#### **England**

The *Programme for Action* encompasses local solutions for local health inequality problems, given that local planners, frontline staff and communities know best what their problems are, and how to deal with them. Leadership and social enterprise will be important to the success of the programme and help unlock the potential within communities to regenerate areas. A key role in tackling health inequalities locally will be played by the Local Strategic Partnership (LSP), a multi-agency body which aims to bring together at a local level the different parts of the public, private, community and voluntary sectors.

## 7. Monitoring and evaluation

### 7.1 Different approaches to monitoring and evaluating policies to reduce health inequalities

While all European governments might subscribe to the principles of pre-implementation appraisal, implementation, evaluation and post-implementation review, there is little evidence to suggest the widespread adoption of systematic evidence-based approaches to policy making across all areas of government. Even in a specific area, such as health improvement or the reduction of health inequalities, we have been able to locate only a few relevant frameworks. Nevertheless, several European countries appear to have developed some type of system or tool in order to measure progress towards achieving health inequalities targets. In one group of countries monitoring is limited or not fully comprehensive. In keeping with the detailed specification and quantification of their health inequalities targets, countries in the second group have established systematic frameworks for monitoring and evaluation. (In a third group of countries there is no specific tool to monitor progress because no health inequalities targets have been set.)

### 7.2 Less comprehensive systems of monitoring

#### Finland

Monitoring of the implementation of the Finnish public health programme and the attainment of targets, including that relating to health inequalities, is promised in the government resolution. A separate budget is earmarked for implementation of the public health programme, including “monitoring and assessment”. The quadrennial Social and Health Report will undertake comprehensive monitoring “covering various sectors and levels of government”.

The Finnish response to the “Situation Analysis” questionnaire notes that “indicators have been developed to follow the attainment of the target to reduce health inequalities”. “The greatest need for follow-up information concerns (1) the local level (municipalities) and (2) healthy life expectancy.”

#### Denmark

Denmark has a long tradition of monitoring inequality in health with the following components:

- Register linkage (a special prevention register links socio-economic registers to health-related registers such as mortality, cancer, hospitalisation, health insurance etc).
- National Health interview surveys (latest in 2005), which include data on living conditions, social issues and socio-economic conditions.
- Local health profiles.
- Research.

The current public health policy, *Healthy throughout life*, includes an indicator programme that is intended to ensure regular monitoring of trends in population health. Indicators have been developed in relation to risk factors, target groups, settings for health promotion, as well as key indicators for health promotion by the public sector. There are specific indicators relating to social inequalities in mortality, self-rated health, smoking and very limiting chronic illness.

#### Germany

National Health and Morbidity Surveys (conducted in 1998 for population aged 19–79 and 2006 for population aged 0–18) provide data on the health status of the German population and permit comparisons by age, gender, social status and other characteristics. Furthermore, several reports on social variations in health and related factors have been launched by the health monitoring organisations.

### **Latvia**

An evaluation report on public health strategy is prepared by the Public Health State Agency for the Department of Health. This report summarises the evaluation papers of 44 different institutions.

### **Netherlands**

Under the authority of the Ministry of Health, the National Institute for Public Health and the Environment (RIVM) has developed a health inequalities monitoring system. The first set of data from this system is expected in 2006. RIVM also provides an overview of health inequalities data in the Dutch Public Health Status and Forecasts publications, produced approximately every four years (1993, 1997, 2002 and 2006 (forthcoming)).

### **Poland**

Continuous monitoring of the implementation of the National Health Programme, including equal access to health protection, is conducted by the National Institute of Hygiene, under the auspices of the Ministry of Health.

### **Spain**

The Health Ministry regularly publishes data on a basket of health indicators which are tracked in countries across the WHO European Region. However, the information on health inequalities appears to be confined to a comparison of Spain's progress against other countries rather than differences between social groups within Spain. Sources of data on health inequalities can be found in the national health survey (eg healthy status by social class, education, geographical area).

## **7.3 Comprehensive frameworks**

### **Ireland**

In Ireland the *Report of the Working Group on the National Anti-Poverty Strategy (NAPS) and Health* proposed a monitoring framework to assess progress on health inequality targets. The framework has four key elements: an indicators programme, a research programme, a monitoring system, and a review/revision process. The research subgroup of the Working Group on NAPS and Health is advising on the development of approaches to monitoring targets. The Irish Office for Social Inclusion produces an annual report on the National Action Plan Against Poverty and Social Inclusion, which details findings on progress towards NAPS health inequality targets (as reported by the Department of Health and Children).

### **Northern Ireland**

Northern Ireland's Inequalities Monitoring System comprises a basket of indicators which are monitored over time to assess area differences in morbidity and utilisation of and access to health and social care services in Northern Ireland.

### **England**

England has established various systems and tools to measure progress towards achieving health inequalities targets. Twelve national headline indicators set out in the *Programme for Action* have been developed to support the 2010 PSA health inequalities target ("by 2010 to reduce inequalities in health outcomes by 10 per cent as measured by infant mortality and life expectancy at birth"). These indicators provide a broad summary of the areas to be monitored and reflect data already collected. Additional measures support action and monitor progress at local government (local authority) and Primary Care

Trust (PCT) level. Health Equity Audit should help organisations address inequalities in access to services and in health outcomes.

### **Wales**

For each of the health inequalities targets identified in Wales, an ongoing monitoring target has been specified, eg to monitor age- and sex-standardised CHD mortality at local and national levels. The Welsh Health Survey, managed by the National Assembly for Wales, is a key tool which produces local health area data.

### **Scotland**

In Scotland the NHS Performance Assessment Framework includes indicators for health improvement and health inequalities, based on existing targets, against which progress is measured each year. A self-assessment instrument which helps Health Boards assess their development as public health organisations has been developed with partners.

## **7.4 Evaluation of national programmes and actions to tackle health inequalities**

Of the 19 countries (counting the UK as four countries for this purpose) returning “Situation Analysis” questionnaires, that we have used as source material for this paper, all but two reported that their national programmes and actions to tackle health inequalities are evaluated to some degree. Examples of relevant evaluation reports include:

- child poverty and school feeding programmes (Estonia);
- regional programmes of access to prevention and treatment (PRAPS) (France);
- a federal programme (Die Soziale Stadt) aimed at counteracting the widening socio-spatial rifts in cities (Germany);

- geographical inequalities in mortality (Hungary);
- promoting family well-being through family support services; teenage parents support initiative (Ireland);
- monitoring of expected results of National Health Programme implementation (Poland);
- national policy for social exclusion (Spain);
- Health Action Zones; Sure Start (England);
- health demonstration projects (covering CHD, sexual health and the early years) (Scotland);
- equity training and advocacy grants programme; Inequalities in Health fund (Wales);
- “Status 2001: Public Health” (Denmark).

However, with few exceptions, there is little evidence that European governments have developed systematic and comprehensive evaluation of programmes or policies to tackle health inequalities. Even where some relevant activity is reported, the impact of findings on subsequent policy making is highly variable. In some countries the impact is non-existent or negligible. On the other hand, the evaluation of the Finnish Health for All programme by the WHO review group in the early 1990s contributed to a clearer focus on health inequalities policy in the subsequent (1993) programme. In Wales, evaluations are used to inform future action (including new or revised programmes); for example, the evaluation of the Equity Training and Advocacy Grants Programme identified areas that required change in future programmes. In Scotland an attempt to develop an over-arching strategy for evaluating the policy making process relating to health improvement and health inequalities is in progress. Despite these more encouraging examples, there would appear to be insufficient recognition that:

**Evaluation is a prerequisite for decisions as to whether a policy should be continued, expanded, adapted, or curtailed** (Round Table Report relating to the project on *Tackling Inequalities in Health Through Health Promotion*, ENPHA, 2001, p. 11).

## 8. Conclusion

This paper represents the first attempt to review and bring together in one place the experiences of those member states of the European Union that are in the process of developing national strategies to tackle health inequalities. It shows that much progress has been achieved. In this concluding section we go beyond the systematic description of policies to present some personal reflections about the many challenges that lie ahead.

### 8.1 Using the evidence base

Policy makers seeking to adopt an evidence-based approach to tackling health inequalities will be frustrated by the relative dearth of evaluation studies which might provide guidance about effective interventions. The experience of the Acheson Committee, which conducted an independent inquiry into health inequalities in Britain, and the Albeda Committee, which developed a programme to reduce health inequalities for the Dutch government, illustrates this point (Mackenbach 2003). Where evaluation studies have been conducted, access to results through conventional databases can be problematic as a result of inadequate identification or non-inclusion of such studies (Mackenbach 2003; Mackenbach and Bakker 2002). Nevertheless, governments do not have to wait until an increased research effort delivers more comprehensive evidence of effective actions and strategies. Citing examples from Sweden (Swedish National Committee for Public Health 2001), the Netherlands (Mackenbach and Stronks 2002) and the United Kingdom (Hunter and Killoran 2004 [updated reference]), Macintyre (2003) argues that governments:

“should encourage the systematic collation and dissemination of the best international evidence of effectiveness ... They should encourage research studies and routine statistics to be designed so that

differential effects on, or trends among, different socioeconomic groups can be detected.”

### 8.2 The importance of tackling the health gradient

Many EU countries seek to improve the health of the most socio-economically disadvantaged groups in society, most commonly through a social inclusion focus. Others are attempting to narrow the health gap between the most and least socio-economically advantaged. However, no EU member state has yet made a concerted effort to implement the most radical approach to health inequalities, namely a reduction in the health gradient, whereby health is related to the position of social groups (and individuals within these groups) at every level within society. Graham (2004) has argued that a focus on socio-economic differentials (the systematic relationship between socio-economic position and health), rather than on social disadvantages, “widens the frame of health inequality policy in three major ways”:

1. first, the search for the causes of health inequality points towards “systematic differences in life chances, living standards and lifestyles associated with people’s unequal positions in the socio-economic hierarchy”;
2. second, as a result, “tackling health inequalities becomes a population-wide goal”;
3. and, third, the policy goal becomes broader, namely “equalising health chances across socio-economic groups” (p. 125).

We suggest that EU member states should consider the potential advantages to society as a whole that might result from the adoption of this wider frame. While the risk of exacerbating health inequalities through a general health improvement approach is

well known, it is less widely appreciated that even a focus on more disadvantaged groups may not be sufficient to close the health gap or alter the slope of the health gradient.

### 8.3 The value of targets

One of the many issues that needs further thought in the future relates to the value of targets in national policy-making related to health inequality. Answers are needed to questions such as:

- Is sufficient thought given by policy makers to the rationale for focusing targets on particular aspects of the problem of health inequality?
- Should EU countries be working towards a common understanding of what type of target should be measured (which implies also a common understanding of what is meant by 'health inequalities' and what should be the focus of remedial action)?
- Does the formulation of targets help or hinder the implementation of effective action to reduce health inequalities?

One argument in favour of target setting for reducing health inequalities (as for any other area of health improvement) is that it focuses the minds of policy makers and practitioners and increases the likelihood of developing and implementing appropriate action plans. It is certainly most unlikely that targets will reduce the priority given to this policy area. On the other hand, unrealistic targets can be demotivating or can lead to perverse (even if unintended) consequences elsewhere in the health system.

### 8.4 The value of monitoring

Monitoring of progress is crucial at all stages of the policy process (development, specification, implementation, impact and, especially,

review/learning). This is not merely a technical, or compliance, issue. EU member countries pursuing reductions in health inequalities and seeking to meet the objectives of the Lisbon strategy are simultaneously having to adapt and adjust to global influences beyond their control, which frequently tend towards the exacerbation of social (and therefore health) inequalities. As a result, even state-of-the-art health inequalities policy could be derailed. Monitoring will help to identify these countervailing forces and improve opportunities for fine-tuning or making more fundamental changes to policies for reducing health inequalities.

### 8.5 The importance of rigorous evaluation of policies to reduce health inequalities

One of the biggest challenges facing all member states is to assess the impact of their policies on health inequalities. Given that good-quality evidence to guide policy is in very short supply, it is important that opportunities to add to the knowledge base are not neglected. There is a growing number of studies of local projects and useful attempts are being made to produce digests of good practice based upon them. However, it is also the case that many public health professionals are failing to conduct sufficiently rigorous evaluation of their activities. At regional and national levels, well designed evaluative studies of major interventions (programmes and policies) to reduce health inequalities are increasing but are still far from being conducted as a matter of routine. In this regard, we make a plea for a more integrated approach to evaluation and implementation, using the most robust and sound methodologies and taking advantage of 'natural experiments'.

**Wanless and others have suggested that the gaps may be partially filled by exploiting the opportunities offered by “natural experiments”, such as changes in employment opportunities, housing provision, or cigarette pricing. Natural experiments have an important contribution to make within the health inequalities agenda (Petticrew et al, 2005).**

However, we also stress the importance of pre-implementation appraisal (for instance, by means of health equity impact assessment) where the potential impacts of non-health sector policies on health inequalities can be estimated. This would help to avoid the adoption of policies that are likely to increase health inequalities (even if they lead to an overall improvement in population health).

## **8.6 Need for comparative analyses of policy interventions to reduce health inequalities**

At a European level there is a pressing need for comparative national-level analyses of the relationship between socio-economic circumstances, public policies and observed patterns of health inequality. As new and more consistent data are collected by many more EU member states and others it should be increasingly possible to produce clearer recommendations for policy makers about the possible health inequality consequences of different policy options. Evidence-based guidance is required about the nature and significance of the relationships between poverty, income inequality and many other manifestations of social exclusion, on the one hand, and different manifestations of health inequality, on the other. In comparing health inequality across the EU, therefore, it is important not only to examine the absolute or relative risks

associated with social position for particular health outcomes but also the nature of the distribution of people between different sets of social circumstances.

## **8.7 Financial and political commitment**

Although there are many legitimate entry points for policy initiatives to tackle health inequalities it is important that recognition of the problem is supported by financial and political commitment. Effective implementation is the key to making progress and it is essential that the resources made available are commensurate with the goals that are being pursued.

## **8.8 The importance of capacity building**

A supportive structure is required for implementation of political plans in a sustainable manner. Institutes in charge of public health implementation at national and regional levels need to recognise the importance of the health inequalities issue, and also have the capacity to implement relevant policies. The same applies to other stakeholders, such as local authorities and providers of health care services and medical professionals, as well as representatives of civil society.

## **8.9 The need for international co-operation**

Action at the European level is needed in order to progress policy processes that might contribute to the reduction of health inequalities and to respond to the unique challenges facing an enlarged community of 25 member states. Facilitating effective action to reduce health inequalities will contribute to one of the EU’s strategic objectives –

promoting a more cohesive society – as outlined by the Lisbon Agenda.

EU member states should take advantage of every opportunity to learn from each other about the value of different policy approaches to reducing health inequalities through the systematic sharing of evidence (from pre-implementation appraisal to the assessment of policy impact). The European Union can play a major role in facilitating these exchanges, for example through the Expert Working Group on Social Determinants of Health Inequalities. There is also much to be gained by greater co-operation between the EU and other international bodies, such as the World Health Organization (including the Commission on Social Determinants of Health) and the Organisation for Economic Co-operation and Development.

## 8.10 From policy to impact

This is quite deliberately a largely descriptive report. In essence, it takes at face value what policy documents say about approaches to reducing health inequalities. Nevertheless, the reader should note that expressions of public policy concern or a statement of policy intent must not be mistaken for evidence of successful impact, however important they may be as a starting point for purposeful action.

Statements of policy intent on their own are not enough. Unfortunately, there are grounds for believing that many countries will fail to get beyond the setting of high-level and largely aspirational goals. This tendency is exacerbated by the dearth of convincing evidence about the most cost-effective ways that public policy can make significant inroads into reducing health inequalities. It is not surprising that faced with this situation many well-meaning attempts to reduce health inequalities may lead to failure (Ormerod, 2005). Intractable social problems

are just that. They are remarkably resistant to efforts to alleviate them.

This report represents an attempt to describe what has been observed. But that does not mean that all of the policies and actions we have identified are necessarily effective. Even in those countries that appear to be most well developed in policy terms, there are big gaps between the documentation of concerted efforts to tackle health inequalities and evidence that any real and sustained impact is being achieved. What is now needed is an assessment of the appropriateness of policy responses in different countries that takes account of the scale of the problem of health inequalities that is being addressed.

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# Annex 1: Examples of local action that might impact on health inequalities

## 1. Health Nutrition of Pregnant Czech and Romany Women

The project aimed at improving the health of pregnant Czech and Romany women and their children by encouraging improvements in their diet during and following pregnancy, and educating physicians, nurses and the pregnant women about the importance of good nutrition.

Promoting sound nutritional habits, particularly for pregnant women who have specific nutritional requirements – protein, iron, calcium, folic acid and zinc – is a health promotion priority in the Czech Republic. The particular project, informed by the World Health Organization’s “Nutrition Action Plan”, provided information on good nutrition and individual consultations to 650 pregnant Czech and Romany women. This included pre/post surveys of nutritional habits and the provision of recommendations on the consumption of fruit and vegetables and low-fat products etc, taking account of the cultural and social circumstances of the pregnant women. Participants also received a brochure on nutrition for pregnant women and a book of recipes, published in the Czech and Romany languages.

The project, carried out during 2004, was co-ordinated by the Medical Faculty of the Masaryk University in Brno and received funding from the Czech National Health Programme. It involved training health professionals, as well as developing and publishing the information materials. Gynaecologists contacted pregnant women who participated in the consultations. The women’s nutritional intake was assessed, and was further assessed six weeks later following the intervention,

and the difference statistically evaluated. Lectures and activities were also organised to help support Romany women.

## 2. Aurora Project, Italy

The Aurora Project in the Veneto area began in 1990 to take care of drug-addicted mothers and their children in a protected ‘family’ structured residential environment. The multi-disciplinary intervention aims to solve the mother’s drug dependency, give parenting help and provide education and support in obtaining or maintaining employment.

The multi-disciplinary team includes educators, community workers, psychologist-psychotherapists and psychiatrists. Each mother has a therapy plan, agreed in liaison with the drug prevention services, family advisory service and social services and other relevant agencies. This will involve individual and group psychotherapy, and support with the mother/child relationship, plus recreational activities for the children and training. The length of stay in the residencies varies, but is usually around two years depending on the individuals concerned and their economic position and social links with the area.

The project is funded by the Local Health Units and area municipalities, and as well as rehabilitating mothers and their families, it has renewed approaches to the problem of drug-addicted mothers, and has caused the juvenile court to revise its policies and consider better use of rehabilitation services.

### **3. Housing Programme for People with Mental Problems, Malta**

The Housing Programme offers accommodation to people with mental health problems, with the aim of improving the quality of their lives, enabling them to live independently and to reintegrate into the community.

The government provides the accommodation, and the rent is paid through the person's disability allowance or pension. The accommodation allows for three or four occupants, who are supervised by social workers. They are grouped according to their personal needs and characters and are encouraged to support and empower each other.

The project provides an alternative to living in mental health institutions for people with mental health problems. It also helps the person concerned learn practical life skills, and provides professionals with the opportunity to care for people in an environment more like home than an institution. In addition it gives the local community the chance to see that people with mental health problems can be fully integrated into society and be accepted.

Source: I. Stegeman and C. Costongs, *Promoting Social Inclusion and Tackling Health Inequalities in Europe: An overview of good practice from the health field*, EuroHealthNet, Brussels, Belgium, 2004.

## Annex 2

Respondents to the “Situation Analysis Questionnaires” (2005) in the context of the project “Closing the Health Gap: Strategies for Action to tackle health inequalities in Europe” (2004–2007),

co-ordinated by EuroHealthNet and the Federal Centre of Health Education in Germany (BZgA), co-funded by the European Commission DG SANCO (EC Grant Number 2003318).

**Czech Republic:** National Institute of Public Health (NIPH)

**Denmark:** National Institute of Public Health (NIPH)

**England:** National Institute of Health and Clinical Excellence (NIHCE)

**Estonia:** National Institute for Health Development (NIHD)

**Finland:** National Research and Development Centre for Welfare and Health (STAKES)

**France:** National Institute of Health Education and Disease Prevention (INPES)

**Germany:** Federal Centre for Health Education (BZgA)

**Greece:** Institute of Social and Preventive Medicine (ISPM)

**Hungary:** National Institute for Health Development (NIHD)

**Ireland:** Institute of Public Health in Ireland, IRL & IRL-NI/UK

**Italy:** Experimental Centre for Health Education (CSESI)

**Latvia:** Health Promotion State Agency

**The Netherlands:** Netherlands Institute for Health Promotion and Disease Prevention (NIGZ)

**Norway:** Research Centre for Health Promotion (HEMIL)

**Poland:** Polish Society of Health Education

**Portugal:** Ministry of Health

**Scotland:** NHS Health Scotland

**Slovakia:** Trnava University: Faculty of Healthcare and Social Work

**Spain:** Ministry of Health and Consumer Protection, Directorate of Public Health

**Sweden:** National Institute of Public Health (NIPH)

**Switzerland:** Fondation Charlotte Olivier (Observer)

**Wales:** Wales Centre for Health

More detailed information on national-level policies, as well as on examples of local good practice to tackle health inequalities, will be available on the Health Inequalities portal:

**[www.health-inequalities.org](http://www.health-inequalities.org)**.

This is intended to be a comprehensive electronic information resource, and is one outcome of the “Closing the Gap” project.

### **Key steps in the project**

#### **Year 1: June 2004 – May 2005**

Finalising the Consensus Paper on the definition of health inequalities  
Setting up national focus groups and responding to the “Situation Analysis Questionnaire”  
Setting up the Health Inequalities Portal

#### **Year 2: June 2005 – May 2006**

Collection of good practice information to tackle health inequalities and feedback into an electronic database  
Presentation of case studies on how EU policies impact on health inequalities at the national level

#### **Year 3: June 2006 – May 2007**

Preparation of National Strategies for Action to Tackle Health Inequalities  
Organisation of National Seminars on Action to Tackle Health Inequalities  
Final Conference

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Although social inequalities in health exist in all societies worldwide, the degree of these inequalities varies spatially and notable differences exist within Europe. Research published using the European Social Survey (ESS) data has contributed substantially to the exploration of how social inequalities in health vary across European countries (Eikemo et al., 2008a; Eikemo et al., 2008b; Huijts, 2011; Van de Velde, Bracke, & Levecque, 2010). These studies rely on three main health outcomes (i.e., self-rated health, limiting longstanding illness, and depression), and a limited number of studies. Summary: Health inequalities are present in most European countries and evidence of widening inequalities is shown in a number of national and international studies. However, the measurement and monitoring of health inequalities over time and across countries is not straightforward since the choice of measure will influence the results. Numerous measurement tools have been developed for measuring health.

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10. Scanlan JP. ILGA-Europe highlights challenges for German Presidency. ILGA-Europe in association with the Irish EU Presidency hosts first ever EU conference on homophobic and transphobic bullying. ILGA-Europe is concerned with the cancellation of Kyiv Pride. The aim was to better understand the specific health inequalities experienced by LGBTI people and the barriers faced by health professionals when providing care to these groups. The countries involved were Belgium, Bulgaria, Italy, Lithuania, Poland and the UK. Although situations vary across Member States, the study's findings revealed the existence of health inequalities, barriers, and discrimination based on sexual orientation, gender identity, gender expression and sex characteristics of LGBTI people.