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HEALTH & CONSUMER PROTECTION DIRECTORATE-GENERAL

Public Health and Risk Assessment Directorate
Health Determinants Unit

EXPERT GROUP ON SOCIAL DETERMINANTS AND HEALTH INEQUALITIES

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Document: Report of the meeting of the Expert Group on Social Determinants and Health Inequalities – Brussels, 26-27 November 2007	
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Action: To note for next meeting	

Report of the Expert Group on Social Determinants and Health Inequalities, Luxembourg 26-27 November 2007

The fourth full meeting of the Expert Group on Social Determinants and Health Inequalities took place on 26-27 November 2007 in Luxembourg. The meeting was organized by the EU Public Health Executive Agency on behalf of the European Commission Directorate-General for Health and Consumer Protection (SANCO). There were 28 participants including representatives from 14 European Countries, OECD, WHO and invited experts. The meeting was chaired by Michael Hübel from the European Commission.

The group considered the following main topics: EU developments on social determinants and health inequalities; health and migration and the outcomes of the Portuguese Presidency; the role of education and culture polices in addressing social determinants of health; new EU projects on social determinants; country reports from Denmark and Netherlands, and the final report on obesity and socioeconomic groups in the EU.

EU developments on social determinants and health inequalities:

Equity in health forms an important part of the new EU Health Strategy adopted by the Commission in October 2007. Equity is one of the four underlying principles of the strategy and actions to reduce inequalities in health will be set out in a forthcoming Commission communication.

A new Community Health Programme (2008-2013) has been approved with EUR 321 million of funding. Health inequalities is included in the second of the 3 overarching objectives of the programme 'to promote health, including the reduction of health inequalities'.

The Commission has worked closely with the WHO Commission on social determinants (WHO CSD). During the last senior officials meeting between the Commission and WHO in October 2007, Sir Michael Marmot, chair of the WHO CSD presented the work of his commission. Work on taking forward the findings of the WHO Commission will be developed within the framework of the new health strategy which in addition to its emphasis on health inequalities also prioritises work on global health issues.

Health and Migration – Update from the Portuguese Presidency:

Health and Migration is a priority of the current Portuguese Presidency (July to December 2007). A major conference on the theme took place September 27-28 in Lisbon. Two reports from this conference provide detailed information on the topic. One provides an overview of the demographic situation regarding migration and describes the particular health needs of migrants. The second report collects together good practice.

These reports are available from the Presidency web site[12]
http://www.eu2007.min-saude.pt/PUE/en/conteudos/informacao/

[1] Report on good practices in health and migration. http://www.eu2007.min-saude.pt/PUE/en/conteudos/informacao/Report+Best+Practices.htm

[2] Report on health and migration. http://www.eu2007.min-saude.pt/PUE/en/conteudos/informacao/Relatório+Saúde+e+Migraçao.htm

Conclusions from the Presidency conference have informed the drafting of Council Conclusions on health and migration which are expected to be adopted at the next meeting of the Health Council.

Portugal has also been actively involved in the Council of Europe ministerial conference on health and migration which was held in Bratislava 21-23 November and in the preparations for the next World Health Assembly where discussions on migration and adoption of a resolution are expected.

Role of EU education and culture policies in addressing social determinants of health.

In addition to education and culture, the Directorate-General for Education and Culture (DG EAC) also has responsibility for policies on youth and on sport. Attention to social inclusion, solidarity, equal opportunities and the situation of disadvantaged groups is found within all these policies. There are also a number of areas where there is specific reference to health. The following examples were mentioned:

Education
The Communication on "Efficiency and equity in education and training systems" adopted in 2006 underlines the paradoxical role of education in inequalities and exclusion, since education contributes to reduce inequalities but often also to perpetuate exclusion. The Communication indicates fields to develop to improve the equity of the education systems like early childhood education, adequacy between education and work, training of teachers, vocational training, etc. To support MS in their effort to reduce early school leaving, the Commission coordinates a cluster of activities on "access and social inclusion in education", with specific attention to the issue of education of children of immigrant origin. In April 2008 the Commission will publish a Green paper on Education and migration, aimed at underlining the central role of education in integration policies.

The lifelong learning programme has an overall budget of around € 7 billion for 2007-2013. Three of the four sectoral programmes have an inclusion component:

- Comenius promotes greater inclusion in school education. It supports projects to reduce early school leaving and to promote integration of young people with fewer opportunities
- Leonardo da Vinci helps citizens to acquire skills, knowledge and qualifications through vocational training, with a focus on disadvantaged people
- Grundtvig focuses on all forms of non-vocational adult and continuing education, with a social integration goal (e.g. the European pilot project "second chance schools")

Culture
There is a strong link with social integration through the structural funds, which support many social inclusion projects with a cultural dimension. These projects concern mainly young people of disadvantaged areas. Promotion of inclusion and intergenerational and intercultural dialogue lie also at the heart of the European Year on Intercultural dialogue in 2008, which will have a major focus on young people.

Sport
The White Paper on Sport (2007), highlights the role that sport can play for young people, people with disabilities and people from less privileged backgrounds. It points out that sport

can also facilitate the integration into society of migrants and persons of foreign origin as well as support inter-cultural dialogue. The Commission will take actions in this area to facilitate the exchange of information and good practice, in particular in relation to young people, with a focus on the grassroots level.

Youth
EU Youth Policies address the transition period teenage/adulthood, school/work, putting a strong emphasis on young people with fewer opportunities. The Framework for European cooperation in the field of youth comprises 3 strands: active citizenship, the European pact for youth and including a youth dimension in other policies.

The 'Youth in Action' programme has an overall budget of 885 million euros for the 7 years 2007-2013. Each year it involves 110 000 participants in around 10 000 projects. One focus of the programme is the inclusion of young people with fewer opportunities.

In September 2007 the Commission adopted a communication *Promoting young people's full participation in education, employment and society*. The Communication highlights the fact that good health is a requirement for building human capital and full participation. It underlines the influence of social circumstances on children's and young people's health. Lower socio-economic status and levels of education are associated with a higher incidence of mental and physical health problems. The Communication stresses the need of greater cross sectoral collaboration to address the social dimension of health and create tailored actions to promote children's and young people's health. It invites Member States to combat child poverty by promoting equal opportunities and to equip youth organisations and youth workers to deal with health issues.

New Projects

Equity in health

This is a collaborative project being carried out by WHO and cofunded by the European Commission. It began in March 2007 and involves the Venice and Copenhagen offices of WHO.

The two main components are:

1. Developing a Geographic Information System (GIS) & maps/atlas at regional (NUTS2 level) of
    - Structural determinants
    - Intermediary determinants
    - Health outcomes

2 Developing a range of resources to enable countries to take action (especially at HS level) to address socially determined health inequalities

The main objectives of the GIS are: to improve access to statistical indicators on social inequities in health and their determinants across countries and regions in Europe; to provide information support for equity oriented policies at national and regional levels and to facilitate monitoring of equity aspects of policies (health and other sectors).
The project will also produce:

- A collection of best practices of Health Systems action to tackle socially determined health inequalities - Publication and website
- policy briefings – publications on poverty and health, vulnerable groups, gender equity and others
- know-how and development for senior policy-makers, including training, building on work on best practice.

DETERMINE

Determine (2007 – 2010) is an EU Consortium for action on Socio-economic Determinants for Health. The contract holder is the National Institute for Public Health in Czech Republic and it is being coordinated by EuroHealthNet. There are 30 main partner organisations from 21 EU Member States and 26 collaborating partners (WHO, OECD, 6 Ministries, 7 European networks). The main outcomes expected are:

- mapping exercise on intersectoral actions on socio-economic determinants
- 3 annual reports analyzing action taken
- Innovative actions in the field of social marketing for health
- Pilot projects and policy maker surveys
- Capacity building and awareness raising activities in all participating EU Member States
- Policy recommendation and a final event in 2010
- Further development of www.health-inequalities.eu

HEALTHY STADIA

This project commenced 1st July 2007. It has partners in UK, Netherlands, Italy, Spain, Finland, Poland, Latvia, Sweden and Greece as well as 36 collaborative partners. It is coordinated from Liverpool. There are still openings for further collaborative partners.

The main objectives are to demonstrate the potential impact that sports stadiums can have on community health; to apply a healthy settings approach to sports stadiums and to recruit as many European stadia as possible to promote health. The project will build on a concept developed by the North West Region of England involving Liverpool football club and other prominent stadiums. Main outputs will be:

- document on current good practice at stadia in promoting good health,
- recommendations for sports stadia to become health promoting,
- a healthy stadia toolkit
- an international healthy stadia conference
- a healthy stadia network across participating European countries

PROMO

The aims of PROMO are to identify and disseminate best practice in promoting mental health in socially marginalised people who have manifest mental health problems. The project will review relevant policies and legislation and assess practice in terms of a) service models b) overall approaches of care. The main target groups are: long-term unemployed; homeless,

prostitutes, illegal immigrants, asylum seekers and refugees, travellers. The project will aim to identify best practice, to disseminate findings and make policy recommendations

Healthy Regions

Healthy regions is a consortium involving South Denmark DK (main partner), Schleswig-Holstein DE, Bruxelles BE, Veneto IT, South West UK, Östergotland SE. Collaborative partners are selected from within these regions. The main aim of the project is to develop a European concept for "Healthy Regions" based on both a theoretical concept and action generated within the participating regions. It will create a European Website at www.healthyregions.eu and produce policy recommendations, guidelines, methodologies, a pilot project catalogue and good practice examples. The project will build on related initiatives such as the regions for health project coordinated by WHO Europe.

Country reports

Denmark

Recent research has thrown new light on the relationship between socio-economic factors and health in Denmark. For example one powerful analysis puts the effect of low educational attainment second only to smoking as a risk factor for premature death. Another shows that many negative factors are associated with each other – for example smoking and low physical activity and low educational level, low quality housing and poor social networks. Lower levels of motivation and empowerment are manifest in less advantaged groups. For example amongst those who are inactive and have the highest educational level nearly twice as many report being motivated to increase their physical activity as those with the lowest levels of education. A special health survey of the disadvantaged is currently being carried out in order to find out more about disadvantaged groups. The report is expected in 2008.

A new structure for health care and health promotion has been put in place in Denmark from 1 January 2007. Health care is the responsibility of the 5 regions. Health promotion and prevention outside of the hospitals is the responsibility of the 98 municipalities. Action to address health inequalities is being taken at both national and municipal levels. The national focus is on the most disadvantaged groups and particularly on tackling negative consequences on people's health of the existing social inequalities. This is a departure from the policies in the 1990s which focused on the inequalities gradient and on narrowing social inequalities. The National board of health is supporting model projects in the areas of lifestyle and health care services among socially disadvantaged groups

Netherlands

Health inequalities has been a policy concern in the Netherlands for the last 30 years. People from lower socio-economic groups die on average four years earlier than people from high socio-economic groups. Poorer people live in good health on average twelve years less than more wealthy people[3]. Chronic conditions occur more often in lower SEGs. These

[3] Opting for a healthier life: Public health policy in the Netherlands 2007-2010 http://www.minvws.nl/images/no-preventie-eng_tcm20-144198.pdf

differences are related to housing, working environments, living conditions lifestyle and quality of care (though less well educated visit the GP more often).

Following adoption by the Netherlands of the WHO Health for All policy in 1985 there was a commitment to act on health inequalities which involved extensive gathering of evidence and synthesis of research findings. In 1995 reduction of health inequalities was identified as a key policy goal and in 2001 the government adopted a target to raise the healthy life expectancy of the lowest socioeconomic group by at least 25% by 2020. Principle responsibility for action on public health and health promotion now rests with municipalities. Currently central government is reviewing its approach with a view to making its actions to achieve reductions in health inequalities clearer and more specific. This involves reviewing knowledge of ways to tackle health inequalities, considering improved mechanisms to involve relevant actors and the formulation of a new draft strategy.

Obesity and socio-economic inequalities

The aims of this work were to bring together information on the relationship between obesity and trends in obesity in relation to socio-economic groups in the European Population; to review evaluations of policy measures and interventions to tackle obesity which take into account variations in prevalence by socio-economic group; to make recommendations relevant to policies at European and national levels.

The review estimated that 26% of obesity in men and 44% in women could be attributable to inequalities in social status. In nearly all countries examined women in lower SEGs appear more likely to be obese than men.

Few controlled interventions targeted at lower SEGs were identified neither were there many studies where the effect of intervention on different SEGs had been measured. Where this had been done the results showed that in general lower SEGs show less response to health promotion programmes and higher drop-out rates. However most interventions were of short duration and failed to take account of ethnic and social diversity. Information alone is relatively ineffective and may increase inequalities though and exception to this is targeted support information on breastfeeding. The policy review indicated a lack of awareness of links between SES & obesity.

Conclusions:

- the health sector alone is unlikely to reduce the social gradient in obesity; cross-sectoral population-wide policies are needed; this should include improved availability and access to food and physical activity; welfare & social benefits; fiscal policies (subsidies and taxes); controls on marketing.

- there are significant gaps in our knowledge. Improved mechanisms for monitoring nutritional status are needed with measurement of height and weight. More research is needed on the differences in outcome between social groups from various interventions and policy initiatives.

- birth to two years is a key age for action which should target breastfeeding and the introduction of solid food.

- another priority for action is young women. A major effort is needed to try and reduce overweight and obesity in women before they get pregnant and to manage weight gain in pregnancy. This is because there is a tendency for obese women to have overweight babies which have a tendency to become overweight in later life.

The full report is currently being reviewed by the Commission and will be made available to the group in due course.

Work plan and other business

The group reviewed the work plan. Overall good progress has been made. The group has one more year of its initial mandate to run. Suggestions for future work include:

- a statement from the group with a report to the High Level Committee on Public Health
- input into the workplan for the Health Programme
- input into the future communication on health inequalities
- methods of measurement of health inequalities – including reviewing the outputs from the working party which has considered this topic and link to OECD work in this area.
- review EU policies on health inequalities relating to international development, environment and sustainable development (it would be helpful to have key documents prior to the meeting)
- consider how best to involve the group in the outcome of the WHO Commission on social determinants – eg by a specific meeting to consider this work. A conference is being planned to take place in the UK in 2008.
- countries interested in presenting in future include Belgium, Estonia, Cyprus, UK, Sweden.

Next Steps

- all participants were requested to complete and return the evaluation form.
- SANCO/PHEA intends to convene two meetings of the group to take place in Luxembourg in 2008.