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EU EXPERT GROUP ON SOCIAL DETERMINANTS AND HEALTH INEQUALITIES



Document: Draft Report of the meeting of the EU Expert Group on Social Determinants and Health Inequalities – Luxembourg 19-20 June 2012	
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Report: Meeting of the EU Expert Group on Social Determinants and Health inequalities

19-20 June 2012, Luxembourg

Day 1:

Tour de Table

Bulgaria

Bulgaria has adopted a national strategy for Roma integration with 6 major objectives. It has also adopted a national strategy for non-communicable diseases which has a particular focus on prevention throughout the life-course starting with children.

UK

It was reported that the health services reforms in England had passed into law through the 2012 Health and Social Care Act. The Act included the first-ever health inequalities duties. These duties applied to the Secretary of State, the NHS and other health service organizations, and related to health outcomes and access to services. They will come into force on 1 April 2013. The duties are likely to strengthen the focus on health inequalities, and a presentation on how these duties would work was offered to the next meeting of the group.

Sweden

Sweden will circulate a short report by email on ongoing activities and measures on how to tackle health inequalities. It has recently adopted a national strategy for Roma inclusion. The government is currently working on developing a monitoring mechanism for evaluating effects of the implementation of the strategy. SE could report on implementation of its Roma strategy at a future date.

A government inquiry on how public health including health services, social care services could be re-organized has recently reported. Twelve state agencies which previously did work with above mentioned issues will be considered for merging into 4 state agencies. The government has endorsed a strategy on enhancing health and wellbeing for people with various disabilities. The National Public Health Institute has been mandated to monitor the health of people with various disabilities. There is ongoing work on improving children and young people's health with a special focus on vulnerable groups, including young people from dysfunctional families and strengthening parents support. The Swedish Association of Local Authorities recently organized a national conference on how best to address health inequalities in the health care systems. Sir Michael Marmot was among keynote speaker and held a seminar on how to tackle health inequalities.

Netherlands

The Ministry of Health is preparing a discussion paper for local authorities to provide advice on addressing socioeconomic health inequalities. Issues include – what should be the 'norm', e.g. bringing the health of those with lower education to the same level as the health of higher educated. Secondly, what action should be taken within

groups. Thirdly, the balance between actions which address individuals and those which address groups. Work is also underway to support larger cities.

Italy

Is developing an agreement between the 20 regions and the state on 're-calibration' of services. There will be a report on health inequalities which is intended for December. Health inequalities have a high priority in the work of the Italian Centre of Disease Control for 2012-2013. In the 2012 funding for the national health plan there is a proposal for EUR 50million of projects to be funded on health inequalities which is currently awaiting a decision.

The EUROGBDSE project, which is funded under the EU health programme, is nearly finished. The project would like to consult members of the group on the project findings and the implications for policy.

Denmark

Social determinants of health and health inequalities are political priorities. The government is expected to identify national goals soon and these are expected to include a priority on health inequalities. Further details are provided in the presentation from Denmark below.

France

After recent elections, it is too early to say what new policies will be taken forward on health inequalities. There are a number of activities at the regional level. France could provide further information at a future meeting.

Germany

Germany has launched a national action plan on integration. It contains clearly defined targets on a broad range of issues – including education, social protection and employment. On health the main activities will be improvements in access to services including health services and health promotion and prevention.

Germany has created in 2001 a national cooperation network on health promotion for the socially disadvantaged, including sickness funds, regional and local associations and governmental bodies. This network endorsed recently recommendations for action on "Growing up healthily for all". The annual national conference on poverty and health was recently held, (March 2012) including a key note speech from Margaret Whitehead.

In the frame of the "Federal Act on Child protection" the federal governmental initiative „Network on Early prevention and family midwives“ has been implemented by the Federal Ministry of Family, Senior Citizens, Women and Youth. First established for 4 years (annually financed between 30 up to 51 Mio €). After 2016 a federal fund will be in place with an annual budget of 51 Mio €. Coordinator of the implementation of the Federal Initiative is the National Centre on Early Prevention based at the Federal Centre for Health Education (BZgA) and the German Youth Institute (DJI).

Preliminary results of the German health interview and examination survey for adults (2008-2012) have recently been released by the Robert Koch Institute. The preliminary results show a significant rise in obesity (>5% for men) - particularly amongst those with a lower social status. On the other hand the results show also increase of physical activity. More information can be given upon request.

Slovak Republic

Slovakia has updated its national health promotion programme at the end of 2011. A new government began in spring 2012. Political priorities on health inequalities are currently being discussed. Further information could be given in the future.

Turkey

Turkey has restructured the Ministry of Health. Meeting the EU health acquis is an important objective. Turkey has established a Public Health Institute and an Institute of Health Promotion. These will include work on social determinants of health and health inequalities.

Greece

Greece has carried out some studies on impact of crises on health inequalities which show very high levels of inequality. Social capital is low at the moment with minimal trust in institutions. More information could be provided at a future meeting.

Tour de Table- updates from other participants

EuroHealthNet – is the project leader for 2 relevant projects which have recently been completed: the Gradient project funded under FP7 and Crossing Bridges- project on implementation methods of HiAP co- funded by SANCO.. From the Gradient outputs will include an app for smart phones.

HAPI (Health Action Partnership International): is involved in three areas of work:

1. Joint Action with Member States on equity in health
2. Part of the consortium conducting the EU review on Health Inequalities
3. Discussion on EU progress on impact of social protection on health.

Update on implement of the EU health inequalities strategy

Hana Horka, DG SANCO (C4 Health Determinants)

The basis of the policy framework is the Commission Communication on health inequalities of 2009. Since then there have been 2 sets of supporting Council Conclusions, a resolution of the European Parliament and a number of developments in key policy areas – including on Roma inclusion and cohesion.

The Commission proposal for structural funds for the next programming period includes a priority on reducing health inequalities. The Commission has recently adopted a report on National Roma Integration Strategies. Health is one of the 4 priorities for Roma inclusion. All Member States with Roma populations have developed national Roma inclusion strategies. Many of these address the priorities of health of children and women, prevention and the involvement of Roma in service delivery. However, few have developed adequate monitoring mechanisms and for many the resources envisaged are too low.

The FRA has published a [report](#) of its household survey done in 10 Member States – which will be extended to more MSs in futures. Key issues highlighted for Roma include poor housing, lack of medical insurance and low child vaccination.

Using EU structural funds to address health inequalities

Andor Urmos, DG REGIO

Around 80% of the structural funds will be spent on convergence regions (will be names, as less developed regions) in the next programming period. To improve access and reduce health inequalities there is a need to improve the identification of areas of poverty and this requires data at lower levels of aggregation than NUTS2 – so called micro regions. While not specifically mentioned in the structural funds regulations it would be useful if Member States could develop this level of data.

In the current period around 2% of structural funds have been allocated to health infrastructure. Hungary has allocated the most – around 5.3%. Overall around 60% of commitments have been implemented. Concerning the health infrastructure, the most relevant health investments were on e-health and hospital-centric developments. A key issue in many places has been a lack of coherent strategy which would ensure sustainability of health investments.

In the new programming period there is a wish to identify how investments lead to achieving overall Europe2020 targets. A recent review of the current programming period (HU, BG, SK), has been carried out which shows a lack of strategic investments. It also shows a lack of emphasis on improving access in territories which are poorly served or for social groups which have high health needs.

In the new programming period there will be 11 thematic objectives – one of which is on social inclusion and reducing poverty under which improving access to health services and reducing health inequalities are identified as priorities. There will be ex-ante conditionalities, which if not fulfilled may cause suspension of funding. Other priorities will be integrated programming – using all the funds. The key priority for the next programming period will therefore be integrated programming approach and focus on community – led developments. In general the Commission is looking for investments which reform health the health system, not merely improve infrastructure.

The Common Strategic Framework gives an overview of priorities for all funds and there are more detailed points under the individual funds. These include under the ESF improving access to affordable sustainable and high quality services, and under the ERDF priorities will include reducing in equalities in health status and improving community care. The rural development fund can provide support to health and social infrastructure.

Currently the new regulatory package is under discussion by the European Council. The EP will then discuss it and finalize the first reading by the end of 2012. In the meantime preliminary discussions are taking place with MSs on the basis of position papers for each Member State (The Commission will share the position Papers with MS by the end of summer 2012). Some MSs have already started their preparations.

Maria Jose Peiro, SANCO D1 (Unit: Health Strategy)

There are several dimensions -health, economic, social and territorial-, as well as structural challenges, calling for good investments in health. The EU health policy framework includes the EU Health Strategy, the Health Programme and the Health for Growth Programme, and key policy references including on health inequalities.

The new Cohesion Policy regulatory framework, currently under discussion at the Council, with EUR 336 billion (EC proposal) offers an excellent opportunity for direct and non-direct health investments. The Staff Working Document on the Common Strategic Framework - CSF (March 2012) provides a common set of thematic priorities, eligible actions and operational principles to the five cohesion and structural funds. There are two main areas outlined for investments under structural funds: reduction of health inequalities and improvement of access to healthcare; and developing innovative, efficient and sustainable health systems, with priorities scattered across the 11 CSF thematic objectives. The health-related ex-ante conditionality asks for a strategic policy framework, accompanied by a prioritised budgetary framework.

Member States (EPSCO Council), adopted in June 2011 Council Conclusions on Health Systems “Towards modern, responsive and sustainable health systems” which invited MS to initiate a Reflection Process on Health Systems (within Council Senior Level Working Party on Public Health - SLWP) to help them understand and improve efficiency of health systems and investments.

Within this Reflection Process, Working Group II “Success factors for the effective use of Structural Funds for health investments” is develop a joint policy report in 2012 and a practical tool box for 2013 for the use of Member States when programming investments in health under cohesion and structural funds.

The group is led by Hungary and includes the following MSs: BG, CZ, EL, LV, LT, PL, RO, SK, SI. The next meeting will take place on 2nd July in Brussels.

Ingrid Stegemann – EuroHealthNet – Report from the Joint Action on Regional Dimension.

The joint action has established a network of 25 regions in 12 Member States to identify how structural funds are currently being used and what lessons can be drawn for use of structural funds in the future. EuroHealthNet is also providing a help desk to support regions and Member States in this area to improve understanding of processes and engaging in political discussion on reducing health inequalities.

Jonathan Watson: New Project "HealthEquity2020".

The WHO booklet on the use of the structural funds for health identifies a number of areas of opportunity. These include investments in health services, vulnerable groups and getting health from other policies. However an [evaluation report](#) done in 2010 concluded that there was little evidence that many existing structural funds investments had actually reduced health inequalities. The key reasons for this were

the dominance of relatively small scale and short term investments. Another reason is rather superficial projects with lack of strategic and integrated approach. To make a difference in health inequalities there needs to be sustainable change. A big challenge is to move away from structural funds being used to address weaknesses and move towards systemic change that will capitalise on assets.

HealthEquity2020 will aim to help regions to develop effective policies to address health inequalities. It will take a broad approach to investments including improving living and working conditions and tackling health related behaviours as well as modernizing health systems. It will aim to link health investments to the overall economic development of regions. It will begin with 2 pilot regions - Pomurje in eastern Slovenia and Lodzki (PL) and then extend to 8 regions later. Prof. Mackenbach will produce a toolkit, which will be part of an 'action learning programme'. There is a budget to assist 'pathfinder regions' to participate. The project will also include a capacity building programme. The start up workshop will take place in Brussels in July 2012. The project will continue over the next 3 years. Partners especially from BG, RO and EST are welcome to participate.

Discussion and Summary:

The new regulatory package for the next programming period (2014- 2020) of the structural funds is currently being discussed in the Council. The criteria for assessing conditionalities in the health area are designed to support priorities for healthcare systems. These priorities have a basis among other on the [EU Health Strategy](#), Council [conclusions on Health systems](#), on [Closing the health gap](#) and in the EU Communication "[Solidarity in Health](#)". The intervention of structural funds in health should include investments that support reducing of the health inequalities complying with principles of sustainability and effectiveness.

Particular attention needs to be given to the needs of people living in poverty and disadvantaged migrants and ethnic minorities group such as the Roma. To support Member States in reducing health inequalities among the Roma population, the Commission has recently adopted a [report on National Roma Integration Strategies](#) (NRIS). Health is one of the 4 priorities for Roma inclusion. The Commission will review annually the implementation of NRIS under the framework of the [Europe 2020 Strategy](#).

Anne Scott: Report on health inequalities situation

There is some evidence that inequalities between countries have been decreasing over the last decade particularly for infant and child mortality. For life expectancy at birth in the EU in 2010 the gap between the highest and the lowest was 11.7 years for males (Malta and Italy have the highest life expectancy, Lithuania the lowest) and 7.9 years for females (corresponding ratios: 1.17 and 1.10). The Gini coefficient is an overall measure of inequality. It takes into account all the countries, weighted by their population size - 1 is total inequality and 0 is total equality. Using the Gini coefficient as a measure of inequality shows a decline in inequalities in male life expectancy at birth of -3.5% from 2000 to 2010. The major part of this decrease is due to a decline in inequalities in the under 14 age group while some age groups have seen a rise.

Inequalities between regions are higher than inequalities between countries. Between regions there has been an increase in inequality in life expectancy at birth for males and little change for females.

Inequalities between regions within countries are only possible to calculate for countries with 4 regions or more. There has been an increase in inequalities between regions within countries for infant mortality for some countries and a decrease for others. The same picture emerges for life expectancy at age 50. Between 2002-04 and 2007-09, Romania experienced the biggest declines in inter-regional inequalities for both indicators – a decrease of about 30% for inequalities in infant mortality and a drop of almost 40 % in inequalities in life expectancy for men at 50. The same two indicators also reveal substantial reductions in inter-regional inequalities in the Netherlands. In contrast, there were large increases in inter-regional inequalities in, for example, infant mortality in Belgium and male life expectancy at 50 in Poland.

Regarding inequalities between social groups these analyses were mostly presented at the December 2011 meeting. The 2010 EU-SILC microdata suggest a slope index of inequality of 12 percentage points for differences in poor or very poor general health among men by level of education. Similar inequalities are observed for income and for women for the same two indicators of socio-economic status.

Comments:

In the discussion a query was raised about whether Gini was the best indicator and whether the trends would be better illustrated by other indicators (such as Theil's index or Atkinson's index). It was also remarked that the most recent regional data was from 2009 and this did not include the changes that may have occurred recently. It was remarked that in Greece the NUTS3 analysis showed a different picture.

Regarding the increase in inequalities for males 15-24 it is possible that one contribution is the large difference in success rates in addressing accident rates for this group between parts of Europe. Another contributor may be differences in treating malignancy.

Caroline Costongs , Policy Response on health inequalities

A total of 274 policy responses were received and analyzed by EuroHealthNet. Although there are good examples of initiatives at national and regional levels, the level of policy response across European countries is highly variable and the majority of countries do not have national-level strategies in place for tackling health inequalities. Only 12% of policies submitted as part of this study were national or regional-level policies with an explicit focus on health inequalities.

The three biggest “other” Policy Categories are “anti-poverty & social inclusion” (13%), “government programme (such as coalition agreements or national reform programmes)” (13%) and “children/youth/family” (10%). In terms of cross-sectoral cooperation, social affairs, education, employment and environment are sectors that are involved most frequently in policies submitted.

Since 2006 there is a positive development demonstrating that knowledge about 'health in all policy' approaches is becoming widespread which should be further encouraged. Most health inequalities strategies still focus on 'vulnerable groups' while few of the universal policies submitted clearly demonstrate a proportionate "levelling-up" component. There is a clear gap between policy making and the actual implementation of policies. In some countries this 'implementation gap' appears to be wider than in others, which is enforced by the current crisis. In addition, most strategies and policies are still not sufficiently monitored or evaluated.

The few countries that do have overarching national health inequality strategies in place also have a more active response to health inequalities in other sector policies; this suggests that national-level leadership pays dividends. They also have proportionally greater policy focus on prenatal & maternal care, early child development, neighbourhood and community cohesion, vulnerable groups, housing, poverty & disadvantage and social inequalities.

Most countries make explicit mention of health inequalities in some of their policies but have no overarching national strategies in place. These countries have proportionally greater policy focus on access to health services, gender equality, immigrants and ethnic groups, discrimination and disability.

By contrast, a smaller minority of countries have no policies in place to tackle health inequalities. These countries have proportionally greater policy focus on health information systems, social and health insurance, clinical treatment, medication and medical equipment.

Further research is needed into policy implementation and impact analysis. Leadership at the EC level is required to (re)stimulate action and build capacity on tackling health inequalities in a targeted way.

Chris Brooks, Health Action Partnership

Chris Brooks tabled a report from a PROGRESS project "Expert Forum: Austerity, social protection and health, main issues, themes and futures scanning". The project would like input from the EU Expert Group Members in relation to production of a tool kit. The meeting on the development of the practical guide will take place on 26th and 27th November. Further information will be sent by email.

Mark Gamsu, Caroline Costongs, Stephen Gunter: Update on the Joint Action on Health Inequalities- WP4. (Website: <http://www.health-inequalities.eu/>)

A report from the Joint Action (JA) had been previously circulated. Mark Gamsu, the project coordinator introduced the action. Since the JA started there has been an increasing need to orientate work to addressing the economic crisis. One thing that has become apparent is the emphasis by many Member States on health systems – with little focus on health in other policies. There is a need for the JA to emphasise work on the social gradient as well as work on vulnerable groups. Work package 6 on scientific and technical transfer has identified a number of important gaps for further research. In order to strengthen the connection with MSs, Mark invited all EU MSs to participate in the work of JA, even if they are not official "partners".

The Equity Action [Newsletter](#) is accessible on website.

Stephen Gunter described work on tools to improve the health equity focus in cross government policy making.

Pol Gerits (BE) gave a presentation concerning the impact of the participation to the JA “equity action” on the work carried out in Belgium concerning health inequalities.

In discussion there was welcome for tools that the JA will produce. There was a theme about the development of activities on engaging with stakeholders. It is proposed that the next JA discussion will focus on Regions (WP5).

Day 2:

Country Reports

Latvia

Latvia adopted a new health strategy – ["Public health strategy for 2011-2017"](#). There is currently negative population growth and significant inequalities between social groups. The strategy includes 6 health priorities one of which is to ‘eliminate injustice in the field of health by implementing measures to ensure equal health possibilities to all inhabitants of Latvia’. The main elements of the strategy include health care reform. Changes in primary care include incentives for disease prevention. There has been a major reduction in hospital beds. A new disease prevention and control centre has been established. Reforms to the social safety net are also taking place which include covering copayments for health care for needy persons.

Spain

Spain is developing a national strategy on health equity at the moment. The strategy has 4 main actions: Information systems; tools for inter-sectoral work; a global plan for childhood and a plan for political visibility of the national strategy. It involves a training process for national, regional and local government public health staff and production of a methodological guide.

The methodological guide is about how to integrate a focus on social determinants of health and equity into health strategies and activities. It draws on work carried out in Chile. It includes a checklist for preliminary analysis – 5 steps for review and redesign.

Malta

Malta has carried out a number of analyses on health by education using SILC and other sources. As education is strongly associated with age, there is a need to statistically adjust for age in order to interpret the figures. The analysis reveals a strong tendency for those with university education to have lower rates for non communicable disease and certain cancers – except breast cancer, which is known not to be associated with education in other countries. Next steps are for a greater orientation to equity in the disease and risk factor specific strategies.

Malta is now developing an overarching health strategy, partly in response to the expected future ‘ex-ante conditionality’ requirements for use of the structural funds on health. Vulnerabilities and differences in disease rates for particular social

groups will be an important consideration. Malta will host the WHO EURO regional committee meeting in September and the EUPHA meeting in November 2012.

Denmark

The Danish presidency has prioritised 3 areas: innovation, (smart health, better lives) chronic diseases and antimicrobial resistance. While these have not explicitly considered social inequalities in health this issue has been referred to particularly under chronic diseases where for most diseases there is a social gradient.

Denmark has carried out a review of determinants and policies on health inequalities. There is a strong link between annual income and life expectancy in Denmark. The gap has increased over the last 2 decades. A similar but less powerful relationship exists for gaps in education. The analysis identifies 3 main types of determinants - early determinants that affect social position and health, determinants of illness affected by social position, and determinants generating unequal consequences of illness. For example there is a relationship between poor cognitive development and overweight at age 7 by maternal occupation with more than double the prevalence of overweight in manual workers than in students or those in non manual jobs.

Denmark has confirmed the importance of home visiting for addressing these issues in early life, and aims to conserve these services during current budgetary pressures. A review has been carried out of legislation in all sectors which affect health equity with a particular focus on local government – which has a major responsibility for health and social services. A guidance report and film for municipalities and a number of prevention packages have also been produced. At the same time the equity focus on national health strategies on health related behaviours and on health services will also be strengthened.

Jesus Alvarez – EMPL Health and Safety Strategy

[The current EU health and safety at work strategy \(2007-2012\)](#) has, as a main objective, to reduce accidents at work by 25%. Other important aspects related to health are: to improve rehabilitation, to address health related behaviour through education and workplace health promotion, and to encourage development of the national strategies for health at work .

Social partners at EU level concluded Framework Agreements on stress, harassment and violence at work.. Currently there is an evaluation of the current EU strategy. Final results will be available probably around the end of the year. Preliminary indications suggest that many stakeholders consider that the major emphasis on accidents in the strategy may have created an imbalance with respect to action on broader health issues.. A second finding is that coordination between the health and safety strategy and other policies – such as tobacco and mental health is working well. Though this is a theme, which needs to be continually improved – for example in relation to environment and the REACH regulation, transport, agriculture, fisheries and public procurement.

Regarding a future strategy (2013- 2020) no decision has yet been taken. The possibility of a broad consultation on possible future priorities is being considered to follow the evaluation. Additional emphasis on health could include psycho-social risks, musculoskeletal disorders, ageing at work. Other aspects for further consideration are the particular needs of small and microenterprises.

Julia Flintrop – European Agency for Safety and Health at Work
(<http://osha.europa.eu/en/front-page>)

The agency's work includes campaigns, data collection and dissemination of good practice. The current campaign is on leadership and work involvement. The agency risk observatory is carrying out a telephone survey of European enterprises on their safety and health policies. An important activity is the collection and dissemination of good practices.

Workplace health promotion (WHP) is one of the priorities of the Community OSH strategy 2007-2012. Workplace health promotion involves working practices, worker involvement and support for health. It does not replace risk management- which is a first priority. The agency has a long term project on developing WHP. It has an expert working group with MSs, social partners, the Commission and international organisations. Current priorities are motivation, partnership and networking, environmental tobacco smoke (ETS) and work life balance and well-being. The agency has produced several fact sheets and case study collections. The estimated return on investment for WHP is EUR2.5-5 for every Euro spent.

Discussion and Next steps:

The two day meeting highlighted a great deal of work being carried out in Member States to address health inequalities. The ongoing and future impacts of the economic crisis are an increasingly important theme. Looking to the future the decision making taking place over the next 18 months on health systems sustainability in the context of fiscal consolidation and on the future use of the structural funds will be crucial for health equity. The forthcoming report on health inequalities in the EU expected for publication in December 2012 should provide useful information to inform policy decisions.

Topics for discussion at future meetings could include a focus on the local level, national strategies for Roma inclusion (SE), and health and the crisis with focus on psychosocial impacts of the crises.

Date for the next meeting will be circulated.

All presentations are available on:

http://ec.europa.eu/health/social_determinants/events/ev_20120619_en.htm