EU EXPERT GROUP ON SOCIAL DETERMINANTS OF HEALTH AND HEALTH INEQUALITIES: 12-13 OCTOBER 2010.

Present: The meeting was chaired by Michael Hübel – Head of Unit for Health Determinants, DG SANCO.

Introduction

Health inequalities are issues which remain very much on the agenda during this time of financial difficulty. In addition to the focus on traditional themes there is an increasing attention being paid to health inequalities as part of the discussion on the future of health systems in Europe. The informal Council in Madrid in April 2010, attended by Margaret Chan and Sir Michael Marmot included detailed discussion on health inequalities and health systems. The issue is also part of the debate on Europe 2020. The Europe2020 document itself mentions the need to reduce health inequalities as part of achieving the objective of inclusive growth and the topic is now becoming integrated into the flagship initiatives taking forward through Europe 2020. These include a new initiative on active and healthy ageing which is being led by the Commissioner for Health in Partnership with the Commissioner for the Information Society.

Brief updates from Members.

UK. In the UK significant reorganisations are taking place in the health care system in England following the election of a new administration in June 2010. There will be a change in the focus on priority areas known as spearheads. Some changes in the health inequalities policies of England can be expected in future and further details on this are awaited.

OECD – recently hosted a health ministerial meeting on the topic of heath priorities when money is tight. Health Inequalities and the Social Determinants of Health underlay much of the discussion. There are a number of publications on the meeting available on the OECD web site. Work is in progress on a publication on health in Europe being carried out in collaboration with SANCO and drawing on the ECHI indicators. It will include sections on access to care and unmet care needs, geographic distribution of physicians and specialists. Further information could be provided for a future meeting of the group.

Slovakia. Equity considerations have been mentioned in the policy pronouncements of the new government appointed in June. Further detail on future public health policy is awaited. Considerable work has taken place with community workers in deprived communities and this experience could be shared with the group at a future meeting.

Sweden has had change in government with public health issues moving to the ministry of social affairs. A review of the implications of the report of the WHO Commission on Social Determinants of Health for Swedish health policy has been carried out. (see separate item in this report and presentation).

Norway has passed a new public health law which clarifies municipal responsibilities on public health. There is an ongoing reform process intended to shift the emphasis of the health system towards prevention. There is a strong underlying focus on health inequalities which is a high priority for the government.

Finland is preparing an assessment of the situation regarding implementation of the national action plan to reduce health inequalities. The situation assessment will be completed before the end of the current Government's term in 2010. Negotiations between WHO and The National Institute for Health and Welfare has been started in order to found a new Collaborating Centre on Social Determinants of Health at THL.

EuroHealthNet is leading part of the review of public health capacity currently being carried out as part of the EU Health Programme. Work is underway on HI with a number of DGs. EuroHealthNet is also working on the healthy ageing initiative. Work on the Determine project has recently been completed. Some of this is being taken forward in the new Gradient project. A new activity will be carried out on sustainable lifestyles. There is active collaboration with other organizations including with regions and with other stakeholder groups including EPC. Further details could be provided to the group at its next meeting.

Italy. A report on health inequalities is being produced and a number of significant policy initiatives have been made. Deprivation will be included as a criterion for resource allocation for health care. A network is being created of centres on information systems and capacity building. Action is being developed on ways to address health inequalities through both prevention and non health care policies. A national health prevention plan has recently been approved which has little emphasis on the needs of different social groups. Further information could be provided at a future meeting.

Greece. There is concern that the economic crisis could exacerbate health inequalities. Some work on documenting the situation has been carried out which was reported on at a previous meeting.

Latvia has recently appointed a new government and is taking forward the Public health strategy 2011 -2017.

WHO is carrying out a health divide review which is informing the renewal of the WHO Health Policy for Europe - see separate section.

Turkey reported that it is prioritising the reduction of health inequalities in its public health policy and would be willing to report in more detail at a future meeting.

Hungary has a number of ongoing activities which are reported on later in this report. An immediate issue is the red mud flood which is a major ecological catastrophe.

Belgium is hosting three major events under its presidency relating to social determinants of health and health inequalities. It has also carried out a population health survey. Addressing health inequalities is an important element in the management plan of the ministry of public health and a task force and an inter cabinet working group on the issue is currently being established. Further details are given later in this report.

Germany has established a national cooperation network on health inequalities including sickness funds, municipalities and other stakeholders which is being coordinated by the Federal Centre for Health Promotion (BZGA). There is ongoing work to extend the database on health promotion projects with the socially disadvantaged which now has over 2000 entries. The highly successful annual platform on poverty and health is being continued.

Activities on child health have expanded, like the "Governmental strategy on Child Health" and the "National Centre of Early Prevention" against child neglect and abuse, jointly run by BZgA and the German Youth Institute (DJI). Ongoing governmental reports on "Poverty and Health" and on "Children and Young people" have been published.

Estonia has been implementing the national health plan for 2 years. There is some progress despite the financial difficulties. Support is being given to municipalities to design their own health profiles and highlight local health inequalities.

Netherlands. There have been relatively few developments since the last report to the group which is partly due to changes in government. . Heath inequalities remain on the agenda with a focus on health disadvantage and low social economic groups.

Czech Republic has been developing work under the "innovation in public health strategy" since 2002. A report on the theme of health inequalities will be ready by the end of the year. There is also an initiative on health as part of exclusion targeting Roma areas.

Portugal has a number of ongoing initiatives on health inequalities including an emphasis on the health of migrants and ethnic minorities. Further information could be provided to the next meeting of the group.

Joint Action on Health Inequalities (C. Brookes)

The Joint Action is currently undergoing the final stages of discussions with the European Agency for Health and Consumers (EAHC). It has 23 associated partners from 15 EU Member States and 4 collaborative partners. The partners range from Ministries, to National Public Health Institutes, Research Institutes and not-for-profit organisations. The total budget is EUR 3.6 million, with an EU contribution of EUR 1.7 million over 3 years. The start date is early 2011.

Key points:
It is a joint action between the European Commission and Member State governments – which can delegate responsibility. The partners are obliged to keep their Ministries informed of developments. It represents a serious programme of work – which will only be of benefit if fully utilised and actively engaged with – including by the Expert Group. Member States should take opportunities offered by the Joint Action. Its mandatory work packages are: Coordination, Dissemination and Evaluation. The Joint Action has four main themes: 1. tools to improve the health equity focus in cross government policy making (DH/HAPI); 2. developing a regional/sub-national network; 3.developing an active scientific and technical network; 4. facilitating broad stakeholder engagement.

Tools to improve the health equity focus in cross-government policy making – DH/NHF-HAPI. This will develop understanding about the health equity approach and its' application in practice; review the current country situation, and literature on Health Impact Assessment with an equity focus (HIAef)/Health Equity Audit (HEA); develop a framework for carrying out a Health Impact Assessment with an equity focus; develop a framework for carrying out a Health Equity Audit of the impact of policy (in health field or outside) on health inequalities. Each country involved in the work package will carry out one HIAef/or HEA. It will review the process and define guidelines on HIAef and HEA.Two EU policies should be reviewed.

An overview will review what works for HIAef and HEA to actually make a difference in cross-government policy making; and what needs to happen for tools to be used in policy making.

The Joint Action will also support regional networking for needs assessment, case studies of experience, training workshops and disseminating knowledge of how to better use the structural funds at the regional level.

Another element of the Joint Action is the development of a scientific and technical network and activities with stakeholders.

World Health Organization: Renewal of the Health Policy for Europe and the review of the European Health Divide (Dr A. Tsouros)

The World Health Organization has always advocated for more equity in health and specific work has taken place within the framework of the WHO health for all policy since the 1980s. Important publications on Social Determinants of Health, the Physical Environment and Public Health Nursing were also published in 1998. In the last 5 years there has been a resurgence in attention being paid to this topic. However despite the growing importance attached to the social determinants of health and related initiatives at national level and across the WHO European Region, there remain large and avoidable differences in health opportunities and outcomes between and within Member States and between social groups and regions. The indications show that these are growing in some countries. Now the major worries are the huge disparities among Member States, especially between East and West. To address this problem it is clear that there is a need to reassess action on equity in health as part of the overall health policy for Europe and to put more focus on capacity building. These issues and others will be important concerns of the new European health policy which WHO EURO is currently developing. A first draft will be discussed with Member States in September 2011 with adoption planned for September 2012.

WHO Europe is carrying out detailed work on social determinants and the European health divide. Sir Michael Marmot is leading this work. The first phase was a paper for a technical discussion held in the margins of the WHO Regional Committee in September 2010. A more detailed report is in preparation which will be an important input to the renewal of the European Health for All Strategy. Specific pieces of work are being commissioned from centres around Europe. This work is being taken forward in cooperation with the Commission.

(Dr P. Goldblatt – University College London)

This presentation focussed on the report of "Phase 1" of the work on the European Health Divide which was provided to participants and the WHO EURO regional committee in Moscow in September 2010. There are major health inequalities within and between countries in the WHO European Region. Evidence shows that these inequalities should be mostly avoidable by reasonable means. Action is needed, because of the significant human and economic costs. Unless urgent action is taken, these gaps between and within countries will increase. This actions must be both systematic and sustained and is critical in responding to the global economic crisis, allocating resources and developing a new health policy for the

region. The lower a person's social position, the worse his or her health is. Everyone except those at the very top experience some degree of inequality in health. Inequality in health arises from inequalities in the social determinants of health: social policies and programmes, economic arrangements and the quality of governance.

Regional action on health inequalities (G. Fesus – Commission Directorate General for Regional Policy)

Investment in health is a crosscutting issue which in addition to having a public health rationale also has economic, social and territorial rationales. Cohesion policy instruments can support a number of types of investment which contribute to health: direct investments, indirect investments and investment with potential health gain. Types of investment for health in the current programming period 2007-2013 include health infrastructure, research, innovation and ICT. Building economic capacity, training, housing, water, sanitation and other infrastructure investments can also indirectly contribute to health improvements.
Cohesion policy and health in the period post-2013 will be linked to Europe 2020 priorities including amongst others the European Platform against Poverty and the Innovation Union. Following the presentation of the budget review paper in October, the Commission will present the 5th Cohesion Report on 10 November which will provide the main orientations for the future cohesion policy. Further emphasis will be put on improving socioeconomic conditions; cross border cooperation, conditionality, measurable and verifiable indicators, and integrated urban development.

Innovation in development policy in Hungary: programme for least developed micro-regions (F. Janza)

This project addresses the 33 least developed micro regions in Hungary. In autumn 2007 the Government defined the most deprived micro-regions on the basis of economic, social and infrastructure indicators and it decide to develop them through a multisectoral programme. The resources are Hungary Development Programme and the New Hungary Rural Development Programme.
The common characteristics of the micro-regions are category NUTS IV, 10 % of national population, mainly rural, peripheral and mostly with Roma people. There are huge differences between the regions. However most of the regions have low education, high child mortality, bad health situation, dangerous indebtedness, high migration, scarce public safety and discrimination, and a high unemployment rate. All of these factors first of all affect vulnerable groups as Roma, children and young people and older people.
The programme is funding every micro-region and every social group, with particular emphasise on the Roma population. A key objective is to stimulate the economy, and create employment. But there are also important actions on housing, health and education.

Health Inequality: towards a comprehensive approach Flanders (S. Wallyn)
Evidence from health surveys confirms that even in prosperous EU regions like Flanders, people's social position systematically affects their health.
The Flemish Agency for Care and Health develops and implements the health policy of the Flemish community. It is part of the Flemish Ministry for Welfare, Public Health and Family.

- There are legislative acts that consider tackling health inequalities: Preventive health care Parliamentary Act (integrated policy development with specific focuses on vulnerable groups);

- Primary Care – Parliamentary Act, 3 March 2004 (instalment of a dialogue platform for care providers)

Although policy makers at different levels are aware of the need to address inequalities, there has been little progress on closing the health gap. This is largely due to the complexity of the problem: the social determinants of health require a cross-sectoral approach, not only at (inter)national level, but also at regional and local level.
Regional policy offers an excellent framework for developing an integrated and comprehensive approach to address the social determinants of health. The Flemish authorities will organise on 8 and 9 November 2010 in Genk a two-day international conference "Reducing health inequalities from a regional perspective - what works, what does not?". Regions are also participating to the Joint Action which will involve the European Network of Regional and Local Health Authorities EUREGHA. The Veneto region will specifically coordinate this participation.

Hungary (J. Rezmuves)

Hungarian Presidency Priorities

The overarching health theme of the Hungarian Presidency will be "Patients and Professionals Pathways in Europe", which highlights the cross border movements of patients' and health professionals' as well as the 'pathways' or processes that enable mobility.
Other major areas of interest include:

- Pharmaceuticals package, open debate on Information to Patients
- Childhood immunisation and its cross border aspects in pandemic preparedness
- Investing in healthcare systems of the future
- HR for health and migration issues
- E-Health
- Council conclusions on Mental Health Pact

Key events include the following:

There will be a Conference on Action in Prevention in May linked to health promotion and reducing inequalities.

The Informal Health Council on 4-5 April 2011 will consider the future of healthcare system, investing in health and workforce issues.

The June EPSCO Council will consider conclusions on this topic with an element on a possible third Programme of Community Action in the field of public health.

The Senior Level Working Party will take place on 17 March agenda.

Mental Health
The June EPSCO Council will consider conclusions on Mental Health.

Childhood Vaccination
An expert Conference on childhood vaccination is planned for 3-4 March.

eHealth
A Ministerial conference is planned on 11-12 May which will also address the broader theme of investment in health.

(E. Gabor)
There is a 7 year gap in life expectancy between rich and poor Hungarian regions. Action is based on the 2003 public health programme. Hungary, through the Hungarian National institute of Health Development has been participating in the Closing the Gap project, Determine project and the EU joint action. It is also involved in the Crossing Bridges Project (2011-2-12) on advancing the implementation of Health in All Policies approaches in Member States.
Within the Determine project work has taken place on developing healthy and sustainable homes for deprived areas including Roma populations in the area of Debrecen. Hungary has a legal framework with action on health inequalities which are in line with EU and WHO approaches. However it has experienced difficulties in sustaining long term action on health inequalities in common with many other new MS. It is keen to participate in EU level activities to improve knowledge transfer and to improve the use of EU funds.

Experience on the use of the structural funds has been that it frequently requires considerable administration to get the money. In many areas there is a lack of sufficient capacity to do this. For examples there are villages without internet access, few computers and few people who can administer and manage projects. Although there have been many examples of benefits from the use of structural funds there were some examples of unwanted effects. For example an evaluation in one small village showed that wellbeing went down after the investment. It was thought that one explanation could be due to a perception amongst the inhabitants, that the investment had benefited only certain people and not the community as a whole. There was therefore the need to design interventions to avoid this situation – particularly in rural areas there was a need for development plans which are comprehensive and benefit everyone. There is also a significant need for capacity building and community development. Work with professionals is needed to develop their abilities to understand engage with deprived communities. The economic crisis and the fragility of the economy is a reality that permeates thinking across all policy areas including of course health.

Belgium (P. Gerits : Action on reduction of HI in Belgium)

Belgium has a long tradition of research on health inequalities and has recently carried out a health survey. In 2001 there was a 7,5 year gap in life expectancy at age 25 between the highest educational group and the group with no educational degree for men and the gap was 6 years for women.

Between 1991 and 2001 there was an increase in life expectancy for all educational groups, but that increase was smaller for the lower educational groups in compared with the higher educational groups.

Between 1997 and 2004 there was an increase in good health for men and women and for all educational groups (except for the group “higher secondary”) for both men and women and the group “primary education” for women”. Overall there is a greater increase in health inequalities for healthy life years by educational level in women compared with men. The report confirms also that women with lower education spend much longer time with limitations.

Based on the results of the health survey of 2008 there is 2,7 times higher relative risk of bad health for low versus high education, 1.5 times higher relative risk of having a high blood pressure, 1.7 times relative risk of chronic conditions. There were similar trends for long term limitations, functional limitations and pain. For low psychological wellbeing, there was no evidence for a social gradient. But there was a gap between the lowest and highest educational level. Big educational differences were found for physical activity but not much for fruit and vegetable consumption. For Alcohol there was an inverse trend. Those with higher education use more.

In summary there is a clear social gradient for life expectancy, healthy life expectancy and for most of the lifestyles and other factors contributing to life expectancy. There has not been much change in the gap between educational groups in the period 1991 - 2004 though there have been overall improvements across the population.

Most of the actions until now focus on the increasing the accessibility and the affordability of healthcare and to tackle poverty. On health care access the improvement of accessibility and quality of health care is a main objective of current health care policy. Actions include emergency medical care for all, increased reimbursement for vulnerable groups, intercultural mediators for communication with migrants, maximum bills for those with serious illness, cross sector policy plans for combating poverty.

Actions on health promotion include: intersectoral approach with other policies, including improvements in housing.

Health Inequalities is a key topic of the interministerial working group on health in Belgium and there are a number of significant developments.

The King Boudewijn Foundation has carried out a review and made recommendations. Future actions will address different policy levels and different sectors and will have a bigger focus on the social gradient. We will also participate on the Joint Action concerning health inequalities and we will start with a taskforce on health inequalities next year at federal level.

Sweden (P. Nylander / K. Melinder)

Sweden has an overall public health goal which is to create social conditions that will ensure good health on equal terms for the entire population. It has 11 national objective domains, covering all key areas. Following the WHO Commission on Social Determinants of Health, Sweden has carried out a review of what lessons can be learnt for Swedish health policy.

Key findings
Participation and influence – Increased engagement from civil society organisations but increased polarisation of those engaged. Recommendation: increased partnership between the public sector and civil society organisations.
Childhood – Mental wellbeing is decreasing and changes in inequality are uncertain. Recommendation: develop follow-up strategies for municipal efforts and school performance.
Physical Activity – Inequality has increased between urban and rural populations. Recommendation: increased active transport.
Tobacco – Reduced use overall but there is now greater social inequality in tobacco use. Recommendation: universal efforts, adjusted for geographic and social group circumstances.

The review produced a longer report, with several suggestions for action, and a cover letter to the Minister of public health in which the two Director Generals made three recommendations – the formation of an intersectoral committee, focus on early childhood, and a more heath promoting health care system.
In the longer report there were recommendations and discussions on proportionate universalism. Emphasis on sparsely populated areas and poor urban areas as well as vulnerable groups.
Next steps – SE public health policy report 1 November. Some regions will carry out their own reviews. SE now has Minister of social affairs with responsibility for public health issues. Awaiting public health policy report and considering next steps. Currently SE has some of the lowest HI in the EU and the best health. However there is evidence of increasing income inequalities.

Review of EU public health capacity

(C. Aluttis : Maastricht University)

(C. Chiotan : Eurohealthnet)

The aim of the project is to carry out a review the current public health capacity in EU Member States and to make recommendations for actions where EU support could provide assistance and added value to strengthen these capacities. The project has developed a public health capacity assessment tool which is being completed by key informants at country level. The data collected will be analysed and used to identify which are the main strengths, weaknesses, opportunities and threats for public health and health promotion in the EU. Policy dialogues will be organised to make recommendations for further action at national and EU level, and will involve key decision makers from the European Institutions and from the Member States.
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In discussion participants confirmed that this is a very important project. It would be important to include literature from languages other than English in the literature review and there will be a need to identify how to include material from countries which are not able to complete the full questionnaire process. A final report including main findings, suggestions and recommendations for future actions will be submitted to the European Commission in the first half of 2011.

Details of the project can be found on the internet at www.eurohealthnet.eu or at http://inthealth.eu/research/developing-public-health-capacity-in-the-eu/.
The tender is being executed by a consortium of organizations formed by Maastricht University, EuroHealthNet, EUPHA, IUHPE, ASPHER, and EHMA and is supported by WHO European Observatory on Health Systems and Policies and GEOMED.
For further information on the project, please contact Christoph Aluttis christoph.aluttis@inthealth.unimaas.nl or Cristina Chiotan c.chiotan@eurohealthnet.eu

Expert review and proposals for monitoring trends in health inequalities in the EU
(J. Yfantopoulos)

This presentation was a progress report on the work being carried out to advise the Commission on how to monitor trends in health inequalties. The presentation reviewed data

sources and possible indicators and made a number of proposals for how these could be used at EU level.

Recommendations included the following:

Data sources: Mortality, Labour Force Survey,
EU-SILC Supplemented by EHIS

Indicators: Some very user friendly indicators are required supplemented by more sophisticated measures.

- SILC – self perceived health and restricted activities by income group and educational level.
- Infant mortality and life expectancy by MS and Region

Gap analysis

- Absolute values for Gap Analysis
- Inter-Decile Ratios for Gap Analysis
- Gini indicator possibly supplemented by CI and Theil for Dispersion

Next steps

It was proposed that there should be 2 meetings in 2011 possibly in April and October. . SANCO agreed to supply provisional dates before the end of year. Post meeting note. Provisional dates are 5-6 April 2011, 4-5 October 2011.