Health Equity Pilot Project (HEPP)

Summary of HEPP Coaching Workshop

Portugal 19 April 2018

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Report on the Health Equity Pilot Project Workshop - Lisbon, Portugal, 19 April 2018

1. Workshop objectives

The workshop had the following objectives:

- Sharing evidence of best practice - research case studies with regard to alcohol, nutrition and physical activity
- Considering the current position in Portugal with regard to key indicators and comparing these to other EU nations
- Fostering collaboration between the three different institutes/departments responsibility for these three policy areas
- Developing a shared understanding of what is understood by heath inequalities and its impact on health and healthy behaviours
- Considering what further actions might help progress this agenda.

2. Process

The workshop was co-produced in terms of content with the Deputy General Director of SICAD (General Directorate for Intervention on Addictive Behaviours and Dependencies), the Directorate-general of Health (National Physical Activity Promotion Program and National Healthy Eating Promotion Program) and HEPP. It brought together the two strands of nutrition and physical activity and alcohol from a health inequalities perspective for the first time.

The agreed workshop methodology was to:

- Establish the importance to the two entities by opening addresses from the Deputy Director of the Portuguese Directorate-general of Health, and the General Director of SICAD
- Set the context for the workshop in terms of the ECs commitment to addressing health inequalities and the Health Equity Pilot Project
- Establish that the workshop was interactive and not didactic
- Identify that while the workshop was not a decision making forum, that it was seeking to identify potential actions to take forward to address health inequalities
- Elaborate the principles and concepts of socio-economic health inequalities as developed in the Commission on the Social Determinants of Health
- Identify what is known about health related inequalities in the behaviours under review (nutrition, physical activity and alcohol consumption) and what was being done from a health inequalities perspective

- Identify the context for action on behaviour related health inequalities in Portugal.
- Identify opportunities and barriers to action on health inequalities (with a focus on behaviours)
- Share the evidence base for effective action to address health inequalities resulting from poor diet and nutrition, low physical activity, and harmful alcohol consumption.
- Consider potential future actions

The programme is attached as annex 1

The participants list is attached as annex 2

The evaluation is attached as annex 3.

3. The context of Health Inequalities in Portugal

This was bringing together nutrition and physical activity work for the first time, and represented an opportunity for key public health specialists and stakeholders to consider how health inequalities could be addressed. The meeting included leads on nutrition, physical activity and alcohol policy as well as people responsible for coordinating the public health plan, sports sector, workforce development, representatives of pharmacies and medical doctors.

While public health is well developed with excellent examples of inter-ministerial collaboration on nutrition, physical activity and alcohol, all of which include to a greater or lesser extent a focus on socio-economic inequalities, there does not appear to be a specific unit tasked with monitoring or addressing health inequalities. Strategies are based on internationally suggested approaches, principally from the World Health Organization, and then tailored and developed to a high degree from the local context.

Nutrition appears to use a lens of food insecurity as one lens for analysis which provides a useful indicator of the impact of poverty on nutrition and health. That lens, while principally focused on the bottom quintile, seems to indicate that the protective factors of the Mediterranean diet are likely to diminish as the diet becomes less accessible and more expensive.

The physical activity policy recognises that a physical activity strategy which doesn't exacerbate inequalities has the following characteristics:

- An emphasis on the 'upstream' determinants of health rather than 'downstream' (individual determinants) programmatic responses

- A focus on creating high-quality physical environments, emphasising the regeneration of deprived communities, and the development of infrastructure that prioritises walking and cycling over motorised transport

- Universal school-based interventions that take a 'whole school approach' to improving the health and well-being of students
- Workplace interventions in areas of greatest need and among employers of people from lower socio-economic groups
- Counselling in primary care, with an emphasis on people from lower socio-economic groups and deprived communities

4. What does the data tell us about health inequalities in Portugal?

There are clear social inequalities in the consumption and harm related to diet and nutrition. The prevalence of obesity, diabetes and hyper-tension are all associated with educational level (lower education having higher prevalence), so for example those with less than 4 years of education have 38.5% obesity as against 13.2% for those with more than 12 years of education. Conversely higher education is associated with higher consumption of both fruit and vegetables. It would also appear that the Mediterranean diet is declining among the poor, perhaps because of the rising cost of maintaining such a diet.

Food insecurity is an issue for about 19.3% of the population. Not surprisingly those who are food insecure are less likely to adhere to a Mediterranean diet, due both to cost and ease of access to produce. There may also be issues of the lack of time and skills for food preparation.

Food insecurity leads to diabetes, depression and lower quality of life and higher rates of disability. Those who are food insecure also have more difficulty using the health system.

5. Other Points

5.1 Making the case for action on health inequalities

Considering the years spent in ill-health of different sections of society is useful for making the economic case for reducing health inequalities.

5.2 Coordination

Looked at examples of cross government working, such as the Ministry of Gender Equality, where all ministries consider their role in addressing the issue. It might be useful to do the same in health inequality. This might for example include agriculture, families and so on. Families that eat together consume less – and it is a decision on whether there is time for a family lunch. Also welfare etc.

We need more data on health inequalities.

We need both a top down and a bottom up approach need to make links with e.g. primary health care, hospitals, those with long-term conditions, regional and local representatives, associations and community representatives. We need to consider both up-stream high-level measures as well as community focused measures.

Morbidity and mortality – CVD, Cancer – how does this relate to inequalities - we need research to show us the direction to take.

How are the existing commissions tested for health. Need join up between regional and local and policy – a mechanism to let that happen. Need to test and develop evidence.

Practice and policy

5.3 Alcohol focused work

The plans to address alcohol related harm are in line with the WHO Global strategy to reduce harmful use of alcohol, and the WHO European action plan to reduce the harmful use of alcohol 2012–2020, and the EU strategy to support Member States in reducing alcohol related harm (2006).

There are four pillars to the national plan for the reduction of addictive behaviours and dependencies these are:

1. National Coordination
2. Clear targets
3. A referencing network
4. A national alcohol and health forum

Portugal is amongst the heaviest per capita consumers of alcohol globally at more than 12.5 litres of alcohol per year for those above 15, in 2010. Though there has been a decline with current levels in 2014 showing about 9.9 litres of alcohol (and on a downward trend).

The national plan seeks both to reduce demand (taking a life course approach and identifying effective interventions) and also supply (production, availability, accessibility and marketing). It is led by the health ministry with an Inter-ministerial Council chaired by the Prime Minister, supported by a Technical Commission, and sub-committees. In addition the coordination links to a national alcohol and health forum which includes representatives of constitutional bodies and civil society and industry. The work is supported by

information and research, capacity building, and communication coordinated by SICAD.

There are 7 targets on prevention, morbidity and mortality, that are evaluated by 42 indicators, though not in terms of their distribution.

A reference network establishes what are considered to be low, moderate and high risk drinking patterns and consequently interventions appropriate to each risk. There is interest also in reducing the collateral damage from alcohol such as domestic violence, HIV incidence, and traffic accidents associated with alcohol consumption.

5.4 Nutrition interventions

Approaches include food and nutrition literacy, monitoring diet and nutrition, evaluating impact of interventions, providing food aid (and trying to improve what is offered so it is healthier), massive online courses 'Eat better, Spend Less', and EPODE. Against that work is the marketing e.g. of soft drinks on TV and in other media.

Improvements have been made in food baskets for those in food insecurity. Needed agreement with the Ministry responsible for social security to take this step.

Other actions which may address diet and nutrition without exacerbating health inequalities include:

- Labelling to support the consumer (which would be least likely to exacerbate inequalities if the label was colour coded)
- A sugar tax, which is in place, and is likely to have greater impact on lower income groups both because they are more likely to consume high-sugar beverages, and because price elasticities are likely to be higher when disposable income is less
- Restrictions on marketing of junk food for children
- Improving the food offer in hospitals
- Addressing the composition of unhealthy products for children
- And a potential salt tax which might reduce salt in bread, biscuits and other high salt products from 1.4 per 100g to 1.2 or 1g per 100g.

5.5 Physical Activity focused work

In a similar way to alcohol, physical activity work draws its mandate from international strategies and programmes including the Sustainable Development Goals, and the WHO physical activity strategy for the WHO European Region 2016–2025. The broad approach is to improve the physical activity environment to reduce inequalities with a particular focus on social inclusion and gender inequality. The intention is therefore to promote universal access to

environments and facilities that support physical activity across social gradients, to improve the availability, affordability and acceptability of physical activity for the most vulnerable groups, and increase the availability of physical activity resources and recreation spaces to promote physical activity among residents, including in more deprived neighbourhoods.

The physical activity strategy establishes coordinating mechanisms, promotes alliances across society, has a focus on pregnancy and early childhood, promotes active travel, involves older people in opportunities and seeks to strengthen the monitoring and evidence base.

Reducing sedentary behaviour as a specific focus and increasing physical activity in schools and the work environment are seen as priorities.

The assessment of physical activity and sedentary behaviour levels was included in the health informatics system in the Portuguese Health System (SClinico), and is to be addressed in primary care consultations as a vital sign. Brief counselling tools were also developed and incorporated into the system. These tools were developed based on the best scientific evidence regarding the support of behavioural self-regulation and motivation. The training of health professionals to use this tools, and specific manuals are under development. A pilot test will also be conducted to assess the impact of physical activity advice and prescription at the health care system.

There is a newly established Inter-Sectoral Commission for Physical Activity Promotion, which was due to meet the day after the workshop, with the health sector as just one of the partners, alongside social inclusion, education, labour, sports and science and higher education.

6. Summary of learning and areas where action could be taken

6.1 Multi-Sectoral Commission on Heath Inequalities

The existence, composition and role of a Commission on Nutrition, the Interministerial Council on Alcohol, and a similar entity for physical activity were noted. It was suggested that, based on this model, a cross government commission on health inequalities would be helpful in developing a shared approach to this cross-cutting issue. This should include civil society, academic boards etc. It should be an obligation on all ministries to coordinate questions on health inequalities.

6.2 Developing a Shared Health Inequalities Data Set

There was an agreement that there is a need for a clearer focus on health inequalities across all three policy areas. Central to this is to develop a consistent narrative that is based on population data on health inequalities.

It was noted that without this it would be very difficult to develop a shared narrative, one that recognised that the populations most affected by health inequalities are affected by all areas of policy. There was also a recognition that a shared health inequality data set would help engage champions in other policy and service areas such as Employment, Health Services, Agriculture etc.

For example it was suggested that it would be helpful to have a health inequality data set that could be cross-referenced with key diseases conditions such as cardiac problems, diabetes etc.

6.3 Morbidity versus Life Expectancy

It was noted that there had been a shift in the discourse about health inequalities with a greater recognition of inequalities in the burden of disease (as opposed to morbidity) between population groups and the earlier impact on populations who experience health inequalities.

There was a recognition that it was important to be able to describe this and in particular to be able to demonstrate the cost that this had on the state both regard to earlier and longer use of heath and social welfare but also how this affected the capability of the workforce.

A focus on inequalities in healthy life years rather than just life expectancy may well gain more traction in the Finance Ministry and other Ministries.

6.4 Health Promotion - communication strategies

There was a recognition that Portugal could do more to utilise different media channels to promote healthy lifestyles. Ideas included dialogue with television channels about embedded health messages in soaps (not didactic but showing problems and solutions) which are more likely to impact on lower SES groups.

It was noted that while there continues to be a 'digital divide' with regard to access to some social media, in Portugal access to mobile phone technology is fairly universal and it was suggested greater use could be made of SMS texting.

6.5 National to local, and top down to bottom up

Several comments noted the need to have an approach that was both top down and bottom up, and that provided linkages between the national, regional and local. There was a recognition that a bureaucratic hierarchical approach was not effective.

6.6 Relationships with local partners - Healthy Settings

It was felt that more could be done with local partners, specifically work in schools, opening schools up to local communities and using these as community centres for local people.

Suggestions were made with regard to some form of accreditation for private sector companies with regard to how they contributed to the welfare of their staff in relation to physical activity and nutrition.

6.7 Workforce Capability

"In Portugal an alcoholic patient is someone who drinks more than his doctor" *Traditional Portuguese joke*

There was a agreement that it was important to develop a coherent and systematic strategy to ensure that there was a clear understanding among key stakeholders about the impact of health inequalities and of its relationship to the three 'behaviours' that were being considered. This capability issue should include further work to ensure that front line clinicians (in primary care and hospitals) had a clear understanding and skills to deliver appropriate interventions such as brief interventions.

Examples of such stakeholders included:

- Policy makers
- Politicians
- Clinicians - including medical students and other allied health professionals

6.8 Alcohol

The industry representative questioned whether there was enough evidence to identify minimum unit pricing (MUP) as useful in addressing alcohol harm. HEPP responded that the modelling indicated that MUP particularly benefited those most at risk of harmful drinking and was effective in addressing the social gradient of alcohol related harm. In addition the industry representative expressed concerns about the additional costs that might be faced by industry through taxation and through having to produce different labels for home consumption and export. The Portuguese public health leads indicated that

industry needed to start playing its part, and that voluntary labelling of calories on alcohol would be helpful, in their estimation.

This seemed to be an area where further consideration of actions would be helpful. It was noted that it would be important to learn from the Scottish experience of MUP, particularly as the Scottish whisky industry has a large export market. Evaluations of the broad impact of the Scottish ‘experiment’ on consumers, businesses should be considered - when they are produced.

Despite these concerns there were also ideas with regard to considering how to ensure that non-alcoholic drinks are more readily available than alcohol particularly at events where children are present. For example that soft drinks should be available at a cheaper price than alcoholic drinks in the estimation of Portuguese workshop participants.

6.9 Role of Academic Sector

There was a view that it would be very helpful to have more systematic involvement of the academic sector in Portugal with an ongoing programme of research on heath inequalities.

6.10 Final feedback from policy leads

This was an immensely useful workshop. It was an agenda we wanted to get into, and it was good also to hear the reflections of our colleagues. We need to more systematically address this issue and engage with health directors and others to gain their support.

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Annex 1 - Programme

PROGRAMME

HEPP Coaching Workshop

LISBON - 19th April 2018		PRESENTERS
09H30 Welcome	Senior Ministry Officials	**Graça Freitas** Director of the Portuguese General Directorate of Health **João Goulão** General Director (General Directorate for Intervention on Addictive Behaviours and Dependencies)
09H45 Introduction	Introduction including who is here by institution Purpose of the workshop and the pilot project Tour de Table - expectations of day	**Mark Gamsu** - HEPP Host **Chris Brookes** - HEPP
10H15 Scene Setting	Introduction Main concepts of health inequalities Opportunity for questions	**Mark Gamsu** - HEPP Host **Peter Goldblatt** - IHE
10H45	COFFEE	BREAK
11H00 Local Context	Portuguese legal and strategic framework - current policy context including key action plans that this workshop can take into account or influence Three short inputs which might cover areas such as measurement issues (understanding the problem), policy issues, and possibly implementation issues: • Inequality and nutrition • Inequality and physical activity • Inequality and alcohol	**Manuel Cardoso** – Deputy General Director SICAD and RARHA Executive Coordinator **Pedro Graça** - Coordinator of the Priority Program of Nutrition of the General Directorate of Health **Pedro Teixeira** - Coordinator of the Priority Program of Physical Activity of the General Directorate of Health
12H00 Who is responsible	Group discussion – who is responsible? • Describe the key actors who are responsible for this issue at a national, regional and local level. • Which departments have a role to play and what is their current activity? • Which plans and strategies explicitly and implicitly address this agenda? - To include - Health, Finance, Economic Development, Education, Social Welfare, Employment	**Mark Gamsu** - HEPP Host Small table discussion followed by plenary feedback
13H00	LUNCH	*Opportunity for workshop planning team to touch base and discuss afternoon session*
13H45 What the evidence tells us.	*HEPP host to explain that focus will be on Nutrition Physical Activity and Alcohol inequalities - behaviours harms and interventions* Overview of evidence-based approaches to reduce health inequalities - focussing on nutrition, physical activity and alcohol	**Chris Brookes** - UKHF

14H45 What additional action should be taken at different levels and by which responsible actors?	*HEPP host to summarise discussion so far - we have been through a process of analysis - make an appropriate contextual statement - need to work within Portuguese policy context* *Group discussion – future actions* *Think 1,3,10 year timescales - what would you expect to see happening that was different?* *For example:* *- Quality of data to understand what is happening?* *- differential impact of policies under development being considered* *- Change in who is involved at different levels* *- improvements in skills, capacity and knowledge*	**Mark Gamsu** - HEPP Host **Manuel Cardoso** – Deputy General Director SICAD and RARHA Executive Coordinator **Pedro Graça** - Coordinator of the Priority Program of Nutrition of the General Directorate of Health **Pedro Teixeira** - Coordinator of the Priority Program of Physical Activity of the General Directorate of Health
15H45 Tactics to influence actors	Group discussion – tactics to influence main actors - who needs to be engaged to move forward over next 1.3 and 5 years and what needs to be done to make this happen?	HEPP Host with support from Portuguese host leads small group discussions with plenary
16H30 Agree Key Actions/Next Steps	Group discussion – next steps - HEPP host summarises - and then Portuguese team respond to discussions	**Mark Gamsu** - HEPP Host Portuguese hosts to collect feedback and respond
17H00 Concluding Comments	Senior Ministry Officials	
17H30	END	*Coffee available*

Annex 2 - Participant List

LISBON - 19th April 2018
HEPP Coaching Workshop

PRESENCE LIST

NAME	ORGANIZATION
Alexandra Almeida	Unidade de Alcoologia de Coimbra
Alexandra Pinto	Serviço de Intervenção de Comportamentos Aditivos e nas Dependências
Ana Cristina Garcia	Programa Nacional de Saúde
Ana Feijão	Unidade de Alcoologia de Coimbra
Ana Sofia Santos	Serviço de Intervenção de Comportamentos Aditivos e nas Dependências
Ana Vieira da Silva	Unidade de Alcoologia de Lisboa
Catarina Sena	Direção Geral da Saúde
Chris Brookes	UKHealthForum
Cristina Ribeiro	Direção Geral da Saúde
Fátima Mestre	Rede Portuguesa de Municípios Saudáveis
Fátima Quitério	Programa Nacional de Saúde
Filipa Alves da Costa	Ordem dos Farmacêuticos
Filomena Bordado	Confederação Nacional das Instituições de Solidariedade

LISBON - 19th April 2018
HEPP Coaching Workshop

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NAME	ORGANIZATION
Miguel Morais Vaz	Instituto da AutoRegulação Comercial
Patricia Pissarra	Serviço de Intervenção de Comportamentos Aditivos e nas Dependências
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Pedro Graça pedrograca@dgs.pt	Direção Geral da Saúde
Pedro Teixeira	Direção Geral da Saúde
Peter Goldbatt	UKHealthForum
Rita Silva	Rede Portuguesa de Municípios Saudáveis
Rosário Costa	Turismo de Portugal
Rui Tato Marinho	Faculdade de Medicina de Lisboa
Sara Moreira	Comissão para a Cidadania e Igualdade de Género
Sónia Figueiredo	Ordem dos Psicólogos

NAME	ORGANIZATION
Francisca Araújo	Federação Portuguesa de Futebol
Francisco Toscano Rico	Instituto da Vinha e do Vinho
Graça Vilar	Serviço de Intervenção de Comportamentos Aditivos e nas Dependências
Hugo Esteves	Associação Nacional dos Médicos de Saúde Pública
Hugo Vieira Pereira	Associação Portuguesa de Fisiologistas do Exercício
Joana Sousa	Ordem dos Nutricionistas
João Goulão	Serviço de Intervenção de Comportamentos Aditivos e nas Dependências
Jorge Barroso Dias	Sociedade Portuguesa de Medicina do Trabalho
José Carlos Reis	Associação de Academias e Ginásios de Portugal
José Miguel Vaz Ferreira	Ordem dos Enfermeiros
Manuel Cardoso	Serviço de Intervenção de Comportamentos Aditivos e nas Dependências
Maria Machado	Comité Olímpico de Portugal
Mark Gamsu	Leeds Beckett University
Marlene Silva	Faculdade de Motricidade Humana

Annex 3 – Evaluation

Health Inequalities Workshop - Evaluation sheet - participants	Q1: How useful did you find the materials sent out before the workshop?	Q2: To what extent did the workshop meet the aim of increasing understanding of health inequalities in Portugal?	Q3: To what extent did the workshop meet the aim of increasing understanding of health inequalities generally and how to address them?	Q4: To what extent did the workshop allow you to begin to plan for future collaborative action?	Q5: How satisfied were you the administration of the workshop?	Q6: What advice would you offer to improve the workshop if it was held again?	Q7: Any other comments
1	5	4	4	4	5	-	
2	5 Call attention to the very real issue of inequality (unmet need).	5 Good work for awareness	4 I would suggest to be more specific. More data	5 Think in themes from scientific work	5	-	Send a report of the meeting. Post on website, Inc pictures of the meeting
3	3	4	4	3	4	-	-

4	4	4	4	3	4	1. Share the slides at the beginning at the workshop 2. The materials Should be translated to improve the understanding of important information	Very good participants and diverse group of experts
5	5	4	4	5	-	-	-
6	5	5	5	5	5	Everything is great!	-
7	4	5	4	3	4	-	-
8	5	5	4	5	5	-	-
9	4	4	5	4	5	-	-
10	5	4	5	4	5	Send some materials with more advance. Give feedback from the questionnaires that were requested in advance.	-
11	5 Very well organised and led	4 An expert on the local topic itself would have been useful.	5	4 Not all representative stakeholders were present (for my area)	5 Perfect	Tobacco/ smoking cessation also involved?	More confidence in selecting stakeholders represented

12	5	4	5	4	5	You can create an online support to hold information and discussions about these issues	-
13	5 People engaged very well in discussions	5 It was very interesting and informative	4 Difficult to understand how to go ahead in future	4 At least to collaborate better	5	To extend the partners - more civil society	-
14	3 Interesting but too broad (group)and too long in terms of presentations to have any serious work developed	2 Most Portuguese data was not on inequalities (only internationally collected). The only thing new was to realise we had a department within the Ministry focussing on inequalities?	4 The most useful was the last presentation although it would have been good to have the evidence shown properly referenced (even if they are in the report)	4 Opportunity to meet people. It would be useful to have a contact list at the end	2	Less traditional teaching and more interaction. (this was not really a workshop)	-
15	5	5	5	5	5	-	-
16	5	3	4	4	5	-	-
17	5	3	4	4	5	-	-
Average	4.6	4.1	4.35	4.1	4.6	-	-