Health Equity Pilot Project (HEPP)

Summary of the HEPP Coaching Workshop

Slovenia, 11 June 2018

Contents

Report on the Health Equity Pilot Project Workshop – Ljubljana, Slovenia, 11 June 2018

1. Workshop Objective

The National Institute of Public Health for Slovenia (NIJZ) had indicated that they wished to develop their health inequalities thinking in relation to:

- Children and Young People
- Nutrition
- Physical Activity
- Alcohol
- Digital Marketing

2. Process

The workshop was co-produced in terms of content with the Senior Advisor, and the National Expert of the Slovenian National Institute of Public Health.

The agreed workshop methodology was to:

- Ensure that the significance of the workshop was recognised by inviting the Director General for Public Health from the Ministry of Health to open the workshop
- Set the context for the workshop in terms of the EC's commitment to addressing health inequalities and the Health Equity Pilot Project
- Establish that the workshop was interactive and not didactic
- Recognise 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 with a focus on digital marketing)
- Identify the context for action on behaviour-related health inequalities in Slovenia
- 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 workshop included representation from the following government departments:

- Ministry of Health
- Ministry of Education
- Ministry of Labour/Social Affairs
- National Institute of Public Health
- National Agency for Telecoms

as well as NGOs and representatives of municipalities.

The programme is attached as annex 1.

The participants list is attached as annex 2.

The participants' evaluation is attached as annex 3.

3. The Context of Health Inequalities in Slovenia

Slovenia is a relatively small country with a population of approximately 2m. The country has a legacy of good healthcare, education and social welfare support although there has been a greater emphasis on free market provision in health care since the end of the Yugoslav Republic.

The Slovenian National Institute of Public Health has a long history of collaborating with other countries - primarily through the direct contact with other National Institutes, with the World Health Organization and to some degree with the European Commission.

The Public Health team described a hierarchy of strategies, plans and reporting in Slovenia

1. Government of Slovenia: 2008-2013 Development strategy for Slovenia
2. National Institute of Public health: "Together for healthy society" 2016-25, under monitoring chapter the obligation for periodical monitoring of social determinants of health (SDH) (report every 4-5 years) Financial crisis in 2008-09: Inequalities in Health in Slovenia 2011 and in 2018
3. Ministry of Labour, Family and Social Affairs and Parliamentarian decision: Mandate for the regular reporting on social situation in Slovenia
4. Social Protection Institute: Social situation (position) in Slovenia, since 2013/14, annual reports

This means that public health leads are able to locate their priorities, at least in part, within a wider narrative of what constitutes a successful Slovenia.

It was clear that the Slovenian public health institute has a well-developed programme of action to address obesity and alcohol challenges. This does not mean that they would claim that they have resolved these issues, rather that they have a good knowledge of current need and are applying a variety of evidence informed approaches to address this.

The public health institute was concerned that a refreshed approach to nutrition (and this is also relevant to alcohol and gambling) is needed to include a more sophisticated approach from industry on this agenda, in particular the development of more sophisticated marketing tools to promote products, notably the greater use of non-traditional channels such as digital.

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

Slovenia has a well-developed set of indicators for analysing health inequalities within the population. These include differences between countries, peri-natal health, lifestyle-related health inequalities (diet, physical activity, obesity and overweight, alcohol consumption and smoking), self–assessment of health, and associated NCDs of CVD, diabetes, cancer and mental health. The alcohol harm paradox is present in Slovenia with lower educated groups experiencing more harm, yet consuming less than other groups.

Situation in Slovenia:

- Among men with the lowest education, the share of abstainers is almost 3 times higher than among men with the highest education, and more than 3 times higher among women with the lowest education.
- Population groups with particularly raised shares of hazardous drinkers* are:
    - men and women aged 15-17 years and 18-24 years,
    - men and women with elementary education or less,
    - men and women during education,
    - men from the lower SES,
    - men and women living without a partner.
- Comparison of directly alcohol-attributable mortality by education in both sexes shows a higher mortality rate for lower educated (statistically significant).

Suicide and accidental injuries are particularly high and follow a clear gradient (with higher suicides among lower educated groups). Unemployed people represent a particular sub-group where unhealthy behaviours cluster (especially higher obesity and smoking).

Slovenian public health also clearly acknowledges the importance of wider determinants in addressing health inequalities including:

- Employment and unemployment rates
- Minimum wages
- Education dropouts
- Social coverage expenses
- Health expenses
- Long term care expenses
- Income inequalities
- Share of inhabitants with minimum secondary education
- Poverty risk ratio
- Material deprivation

A 2nd report on the impact of the economic crisis on health was used to explore health inequalities using education as the principle marker.

During the economic crisis Slovenia maintained relatively good health of citizens, in spite of low investments in the health system in comparison with other EU member states. Higher educated citizens of Slovenia live longer and in better health than lower educated citizens. The risk of suicide is four times higher in lower as against more highly educated men. Deaths from alcohol have risen from 2006-8, to 2012-14 across all education groups though there is no change in the inequality gap. Similarly obesity increased particularly for men, but no change was observed in the inequality gap.

The conclusions were:

- Inequalities in health in Slovenia are persisting as is evidenced by relevant indicators.
- In general, people with a low socioeconomic position have worse results.
- The health and use of health services is worse for unemployed than for employees.
- Even during the crisis, there are examples of good practices in dealing with health inequalities.
- Access to the health care system did not deteriorate during the crisis.

However, according to the Development Report 2016, Slovenia lost ground during the crisis in relation to average economic development of EU countries and experienced greater economic instability at a national and population level.

However, although the material position of the population in the crisis deteriorated, Slovenia’s well-developed social security systems, meant that relative to other member states it performed comparatively well on indicators focussed on social inclusion, inequality and accessibility to public services, and satisfaction with life remained relatively high among the population.

In the long run, most indicators of health have improved, while behavioural indicators have worsened.

The report itself (on the impact of the economic crisis on health) has been useful in galvanising the Ministry of Education, Labour, Family and Social Affairs, Development and Cohesion Policy, and Agriculture to consider actions they can take, as well as the Slovenian ombudsman's office, and for helping to shape priorities for future action.

It is interesting to note that the workshop discussion in Slovenia was one of the few that located some of the health inequalities challenges within a wider transnational context. Recognising that health inequalities are only partly able to be addressed within country, and acknowledging that globalisation, and the macro-economic climate impacts on health inequalities. The role of multinational companies and cross-border advertising is one example of that.

5. Other points

The workshop had allocated considerable time to focus on concerns and challenges with regard to digital marketing, particularly that targeted at children and young people.

5.1 Digital Marketing

The role of digital marketing is comparatively new and public health generally has not developed clear strategies to respond to it. It is further complicated because the range of channels that are used to promote unhealthy commodities (Facebook, Twitter, Instagram etc) are provided by organisations who have a global reach, for companies with a global marketing strategy. This is therefore an issue that cannot be addressed by individual member states.

The public health institute in Slovenia is directly involved in work with the WHO considering how best public health might respond to this agenda.

5.2 Tension between public health and economic growth

This issue highlights the tension between governments' ambitions to reduce inequality and promote wellbeing and their responsibilities to ensure a successful economy. The workshop recognised that this challenge was not just specific to member states but also existed with the European Union and its constituent parts.

For example, it was noted that Diageo now spend 90% of their marketing budget on social media advertising in various forms.

5.3 Inequalities in digital access and 'vulnerability'

While there is a digital divide with regard to access and use of social media this is much more pronounced at the older end of the age range. There is comparatively little difference in access at the younger end of the age scale. Given existing health inequalities in areas such as obesity among children and young people there was a concern that social media marketing would exacerbate this challenge unless more coherent action is taken. It was considered that there may be more marketing targeting vulnerable children, and it may be that they are both more susceptible to marketing, and potentially more exposed to marketing.

5.4 Understanding the digital world (and digital marketing)

One of the major challenges that was identified was the difficulty that public health departments face in knowing what was actually happening with regard to digital marketing. This is both at an individual level and a wider societal level.

- Individual Level - one of the attractions of digital marketing to corporations is that messages can be targeted to individuals and that this interaction is essentially private. There is however growing evidence of the amount of time that the general population and children and young people in particular give to interacting with digital communications on their phones, tablets computers etc.
- Population Level - at the moment member states lack the data to understand the scale and degree of interaction which is happening, while digital providers and the companies whose products they are advertising have this information.

5.5 Youth vulnerability to marketing

One of the challenges with regard to social media is that part of the way in which it is promoted and used is as a means to become part of wider virtual and real communities. It is recognised that this is an area that is particularly important to young people because at this stage of their personal development identity and connection are an important part of how people define themselves and develop as adults.

- young people are more likely to follow trend setters and influencers and adults may not be aware of who these are
- young people are more likely to be worried about being left out by others

Further, it was noted that young people are particularly vulnerable because as young adults they are still developing social skills and knowledge. This can mean that they are less sophisticated with regard to how they interact and engage in the real world and in their use of social media.

5.6 The scope of digital marketing

Passive marketing
Issues arising from the direct targeting of children and young people and potential actions that could be taken to reduce this.

Active marketing
A lot of digital marketing includes offers, games etc that build a relationship with the recipient.

Data Harvesting
It is clear that one of the attractions of social media to advertisers is their ability to develop a greater understanding of their customers at a population and individual level. This allows them to build relationships and target individuals more effectively.

5.7 Some of the strengths (or assets) in Slovenia

Despite the challenges and concerns raised above (5.6), the workshop noted some of the strengths that already exist within Slovenia that could be brought to bear on this issue, these include:

- A well-developed healthy schools network
- Good working relationships between the public health institute and a number of NGOs
- Supportive relationship with government
- Well-developed international links particularly with the WHO.

5.8 Some other actions which may be considered

There was an agreement that it was important to take a more coherent approach on this issue. While legislation is one avenue there are a range of other actions that are possible and not all of these involve social media directly.

Young Families
The importance of the first 1,000 days was recognised and actions to strengthen engagement with young families was seen as a priority.

The non-digital world
There was a view that governments and public health need to build on existing connections and relationships they have in the non-digital world and to use these connections to connect better with children and young people. Suggestions included:

- Training in how to engage with social media in an appropriate and aware way
- Providing alternatives to digital such as utilizing existing resources such as public buildings more effectively to offer alternatives to digital

- Considering making some spaces digital-free - for example schools in France now ban all phones and tablets during school hours.

5.9 WHO Regional Office for Europe

WHO is seeking to help countries to consider the extent of digital marketing and help to raise awareness of the problem. The current workshop is useful, as will be the European Public Health Conference in Ljubljana on 28 November this year. WHO is helping countries to map the digital eco-system – who has responsibility for what? They are testing some methods for monitoring which they think are going to be effective and intend to pilot test tools and protocols to help countries respond to the challenge of digital marketing of unhealthy commodities.

Ireland's use of data privacy may have been helpful, as it is illegal to process data on children under 18.

5.10 Evidence

The dilemma is that much of the marketing is creating brand affiliation and is not advertising. It is also cross-border which makes regulation more difficult.

There is no evidence from systematic reviews of the literature of the differential targeting, exposure, or impact of marketing in digital media. There are a limited number of studies suggesting greater exposure for lower income groups to digital marketing, and there is evidence of a relationship between exposure to marketing more broadly and consumption of unhealthy commodities.

Modelling work on TV advertising restrictions shows the greatest benefit for the most disadvantaged group. It is likely that the differences across the social gradient will be small but marginally more in the lower SES groups, while having an impact across all groups.

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

There was a consensus that more work needed to be done to scope this issue and develop plans and ideas for action.

1. One suggestion was to establish a small 'multi-sectoral group' to with a membership that might include public health experts, wider government, NGOs, municipalities and young people. The idea here was to create a light touch "friends group" of "motivated individuals". This group could explore the issue as widely as possible and to develop ideas for action.

2. An alternative suggestion was to establish a more formal 'steering committee' to involve different government ministries from agriculture through to social protection as well as experts in the field of information and technology, NGOs and the National Institute for Public Health.

There was some discussion about the strengths and weaknesses of these two groups:

1. Multi-sectoral group - sitting outside government but with representation - able to be more independent, less constrained by broader government sectional interests, better connected to front line services such as schools.

2. Steering group - able to influence and work across ministries, well placed to influence government policy development, arguably in a better position to have a more influential relationship with the regulator of telecommunications.

No decision was reached on these two options - it was noted that it may be appropriate to do both. Avoiding industry involvement in either group was considered to be important. There was a discussion also on ensuring that 'difficult' evidence is presented in a reasonable tone, recognising the difficulty and competing pressures faced by Ministries.

The invited participants for the workshop are in many ways the important actors in digital marketing, and have a better understanding as a result of the workshop.

The complex nature of this issue and its cross border nature means that it is important to include work with others outside of Slovenia including WHO and the EU.

In thinking about enforcement and regulation of digital marketing, NIJZ was encouraged to consider enforcement and monitoring and who and how this might be effectively done.

There is much still to be done to understand the scale and scope of the problem, how young people are engaged, by what platforms and on what devices in what context.

Slovenia is already working through the WHO considering what actions individual member state public health institutes can take. However it was felt that there will also be a need to develop stronger alliances with member states in the EU to consider what action they might expect the Commission to take, and what actions they themselves might take.

Other areas:

It is important to protect the strengths of public health that are a legacy of the previous regime.

There is good commonality of understanding of health inequalities and their causes through government departments and across many of the relevant institutions in Slovenia.

There is a cross-ministerial consensus on the importance of addressing health inequalities, and of collecting relevant data.

Education is recognised as an asset in protecting health.

As in most countries there is no individual ultimately responsible for ensuring that health inequalities are addressed. It is a shared responsibility.

Arguments linking the need for a healthy working age population may make a focus on inequalities in healthy life years particularly relevant.

Annex 1: Programme HEPP Coaching Workshop

Programme
HEPP Coaching Workshop
11th June 2018

		Presenter	Indicative timings
Welcome	NIJZ Director Ministry of Health	Nina Pirnat, TBC Mojca Gobec, DG, MoH, TBC	9.30
Introduction	Introduction of participants Purpose of the workshop and the pilot project Tour de Table - expectations of day	Mark Gamsu, HEPP Host Chris Brookes, HEPP	9.35
Scene Setting	Main concepts of health inequalities Opportunity for questions	Mark Gamsu, HEPP Host Peter Goldblatt, IHE	10:00
Local Context	Slovenian legal and strategic framework - current policy context Key Slovene strategies - equity lens, and overview of Slovene monitoring framework for SDH and health inequalities Slovene health inequalities 2018 in figures Legislative context of digital marketing in areas of nutrition and alcohol	Mojca Gabrijelčič, NIJZ Sandra Radoš Krnel, NIJZ	10.30
WHO context	Update on WHO Europe expert meeting on monitoring of digital marketing, held in Moscow, 5th – 6th June 2018	Jo Jewell, WHO office for European Region	11.20
Coffee and PA Break			*11.30*
Who is responsible	**Group discussion – who is responsible?** Key actors (national, regional and local level, responsible sectors – their roles and activities, explicitly and implicitly linked plans and strategies	Mark Gamsu, HEPP Host All participants in small groups	11.45
Lunch	*Organized at NIJZ, all participants invited*		*12.30*

		Presenter	Indicative timings
What the evidence tells us	What the evidence tells us generally with regard to inequality, nutrition, alcohol and physical activity. Digital marketing and inequalities	Chris Brookes UKHF Jane Landon UKHF	13.15
What additional action should be taken at different levels and by which responsible actors?	Summary of morning discussions; definition of context, future developments, skills, capacity and knowledge needed	Mark Gamsu (HEPP host) All participants in small groups	13.45
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?	Mark Gamsu, Chris Brookes, HEPP Hosts All participants in small group discussions, followed by plenary	15.00
Coffee and PA break			*15.30*
Agree Key Actions/Next Steps	Group discussion on next steps	Mark Gamsu - HEPP Host All participants in small groups	15.45
Concluding Comments		TBC	16.15
Closure of the meeting	**Closure remarks**		16.25-16.30

Annex 2: Participants

Annex 3: Participants' Evaluation

Health Inequalities Workshop - Evaluation sheet - participants	**Q1: To what extent did the workshop meet your expectations?** 1 not at all, 5 being very well	**Q2: To what extent did the workshop meet the aim of increasing understanding of health inequalities in Slovenia?** 1 being not at all 5 being very well	**Q3: To what extent did the workshop meet the aim of increasing understanding of health inequalities generally and how to address them ?** 1 being not at all 5 being very well	**Q4: To what extent did the workshop allow you to begin to consider action to address digital marketing to children?** Please tick: 1 being not all 5 being very well	**Q5: How satisfied were you with the administration of the workshop?** Please tick: 1 being not all 5 being very well	**Q6: What advice would you offer to improve the workshop if it was held again?**	**Q7: Any other comments**
1	5	4	5	4	4		
2	5	5	5	5	4		
3	4	5	5	4	5	It was interesting - thank you!	
4	5	3	5	3	5		
5	4	4	4	3	4		
6	5	4	4	4	5	Evidence and advice should be more focused on country specifics.	

7	5	5	4	5	5		
8	5	4	5	5	4	Make introduction and scene setting shorter.	
9	5	4	5	5	3	More material given in advance not on the table. To prepare for the issue, topics.	
10	5	5	5	5	4: There were some technical issues during the video presentations.		
11	3: I didn't like that we rushed so much through the presentations, I think there should be few but more indepth.	3: As I said we really rushed through, the presentations, we only mentioned a few points, but I don't think I got a clear view.	4: There were more presentations, so I got more information.	5: I think we had a lot of time to discuss and share ideas, which is good, because you can get a new point of view.	5	Less presentation (by number), but more focused. I liked there were people from different sectors	
Average	4.6	4.18	4.6	4.36	4.36		