European Commission

Health Equity Pilot Project (HEPP)

Coaching Workshop Report

Health

Contents

Summary Report

This report synthesises the learning from the six workshops carried out as part of the Health Equity Pilot Project (HEPP), to enable countries to engage with the learning from HEPP and consider what actions it would be useful for them to take to better address inequalities in nutrition and physical activity, and alcohol behaviours and outcomes.

Each country had its own specific area of focus within those broad headings, and it was clear that the position of public health and the extent to which socio-economic health inequalities was a priority varied substantially. That said, there were some common themes.

The HEPP project had agreed to work with countries with a range of significant health inequality issues related to behaviours, and at the same time to ensure a good geographic spread.

The process of engagement was deliberative, and enabled the co-production of the agenda, which meant that the work stayed within the framework of the HEPP project and at the same time was responsive to the actual interests and situations of the Member States in which we worked.

The facilitation enabled sharing of knowledge and ideas in a trusted space, and ensured that everyone had an opportunity to feed in their ideas. Where appropriate group work enabled more detailed discussion to take place.

The recommendations are:

1. Further workshops would be appreciated by the six involved Member States and would help further build practical engagement between Member State teams and the European Commission.

2. Having an agreed narrative on health inequalities within Public Health departments is important both to enable engagement with the wider government narrative, and to drive engagement with other government departments.

3. Where possible cross-government working groups and platforms to enable discussion on the role of different Ministries in addressing inequalities seem to be particularly beneficial. It is worth considering if it is possible to establish such structures to facilitate regular exchange.

4. It is useful for Member States to focus on differences in healthy life years rather than just life expectancy, not least to engage with other government departments including social protection and finance.
5. Member States should be encouraged to develop surveys and collect data at national and sub-national level which would enable the monitoring and better understanding of differences across the

population in risk factors, their socio-economic distribution and associated health outcomes.

6. Public Health departments should engage with research institutions to help establish a policy focused research agenda on the specific factors driving health inequalities in their country or local area.

7. At the least, research into the impact of public health policies or interventions should be encouraged to report on the distributional impact or at least make available research data in a format that would enable such an analysis.

8. Member States should consider if it is possible to make an economic case for addressing inequalities in health related behaviours or risk factors.

9. It is useful to set the narrative on health inequalities within the wider narrative of globalisation so that those global influences can be considered.

10. It is important to consider the impact of the social determinants of health on health inequalities both directly and as they impact on behaviours.

11. It is helpful to expressly consider the impact of the marketing of products with potentially harmful health consequences to lower income groups.

12. National governments and EU need to consider what actions are required at EU level, at Member State level and what is best implanted at local level.

13. Health promotion campaigns are probably best considered as mechanisms to prepare the ground for, or raise awareness of, policy changes that will impact positively on health inequalities, rather than as vehicles for personal behaviour change.

14. One clear request from countries was for the EU institutions to give an indicative figure to what proportion of the budget should be spent on public health functions and promotion so that where public health is weak it could look to EU guidance to bolster the need for increased prominence and action.

15. It would be helpful to increase the comparability of EU data on health inequalities, so that countries can better identify how well they are doing in addressing health inequalities and the direction of travel, a first step to which would be to explore what a basic data set on health inequalities would be and the extent to which it could be incorporated into existing EU statistical instruments.

16. The case studies were found to be useful in practice, and further work identifying and reporting and sharing good practice using EC guidelines and templates would be helpful.

Further workshops were supported by the in-country workshop leads as they provide a valuable opportunity to engage with the evidence and explore possible solutions with relevant departments, and organisations. While developing co-produced and non-didactic workshops takes time and engagement, the payoff is that the workshops are meeting a real need. The workshops do not need to be expensive and they will help to generate both knowledge and potential action. All the participating countries valued the opportunity afforded (see annex 1) to bring together those departments and stakeholders who they felt could move the agenda forward. In the HEPP workshops delivered, the opportunity for developing knowledge and exploring how to progress the health inequalities agenda was greatly appreciated as was reflected in the participant evaluation sheets, and in the comments received back from the workshop leads in country.

Introduction

The following report is based on the six workshops carried out between January and July 2018. This report should therefore be read acknowledging that it is a partial view based on a limited selection of workshops. On the other hand the selection of countries was specifically aiming not to include those countries who are thought to lead on health inequalities but to work with a wider range of countries. We tried to identify countries in the north, south, east and west of the European in different stages of economic development.

Workshops were held in the following countries:

Estonia	26 February 2018
Romania	29 March 2018
Portugal	19 April 2018
Malta	9 May 2018
Slovenia	11 June 2018
Ireland	25 July 2018

Each of the workshops drew on the evidence from the HEPP scientific reviews and case studies, however these were used as the starting point for discussion on the specific interests of the countries and considering how to move the agenda forward.

Workshop Process

The HEPP team offered these workshops to Member States using intelligence it has gathered from the country profiles and with advice from the European Commission. The rationale for selection of Member State workshops was as follows:

- Broad geographic spread within the European Union.
- Those countries that are less often involved in public health initiatives on health inequalities
- High level of inequality in outcomes in relation to physical activity, alcohol consumption and nutrition.

The HEPP team worked with each national public health team to design the workshop to ensure that it is focused on key areas of concern in that country. For example, in some Member States there was greater concern about alcohol strategies and policies while others were more concerned about diet and physical activity. It was also important to align the workshop to each Member State's analysis of health inequality focusing principally on socio-economic differences and more deprived areas. The HEPP team developed a basic framework for the workshop which was adapted to reflect local priorities, government structures and capability.

The basic framework for the workshop was as follows:

- Ministerial introduction
- Country context - with regard to health inequality and prevalence of non-communicable diseases (NCD)
- Current strategies
- Presentation of evidence on addressing relevant inequalities in nutrition, physical activity and alcohol behaviours and outcomes from international experts
- Review and action planning

See annex 2 for the workshop process developed ahead of the workshops.

Workshop Facilitation

The workshop was delivered in partnership with local public health leaders.

HEPP developed the scope of the workshop in close consultation with the country leads. In addition the HEPP project used a needs assessment process to help to ensure that the coaching workshops meet the needs of the participants.

Training materials focusing on actions to address health inequalities in nutrition, physical activity and alcohol behaviours and outcomes from international experts were produced as appropriate for each workshop, and country leads were invited to share a situation analysis both in terms of population level data and research on health inequalities in relation to nutrition and physical activity and alcohol, and the policy and delivery framework which could be used for action.

Workshops included input from recognised experts who are part of the HEPP team. They included a mix of alcohol, nutrition and physical activity leads together with leads who focused on health inequalities.

The workshops were facilitated by a Professor with experience in running such workshops.

The facilitation encouraged a process of honest and active sharing and learning so that everyone in the room acknowledged that they had a role to play in shaping the potential outcomes. It was clear that the workshops could not be a decision making forum, however they provided a 'convening space' to bring together those individuals, Ministries and organisations who were well placed to address the relevant inequalities in behaviours or contribute to understanding the drivers of them.

The process included building knowledge of the situation in the morning (led by individuals within the countries) and the evidence for effective action led by the HEPP project team, while predominantly exploring opportunities for action, and consideration of effective strategies in the afternoon. The role of the facilitator was key in ensuring that the audience was engaged, respected, and

helped towards identifying learning coming out of the workshops. Each workshop was very different requiring a different inflection and different levels of formality versus informality for example.

The workshops concluded with a summary from the HEPP team and the country lead, and then completion of an anonymous participant evaluation form, an analysis of which was fed back to country lead.

The workshop report was then submitted to the European Commission and the country partner.

Recommendation

Further workshops were supported by the in-country workshop leads as they provide a valuable opportunity to engage with the evidence and explore possible solutions with relevant departments, and organisations. While developing co-produced and non-didactic workshops takes time and engagement, the payoff is that the workshops are meeting a real need. The workshops do not need to be expensive and help to generate both knowledge and potential action

Themes

Status of Public Health

In the countries with whom the HEPP project worked, the status given to public health, particularly focused on non-communicable diseases, varied hugely within wider government policy ranging from the peripheral to the central. The overlay of health inequalities on that then also varied. The variation in focus on public health might be related to the economic performance of different countries. In some countries with less robust economies, or which were particularly badly hit by the financial and economic crisis of 2008 the emphasis may be on economic renewal in the short to medium term, with little space for long term public health policies that are concerned with reducing health inequalities. In such cases, available funding is more likely to be used to fund health systems, and in particular to improve secondary care, which is more likely to prove politically acceptable. This is not however universally true. For example, Portugal, which was severely hit by the recession, appears to have a strong focus on public health and cross-government working.

There are also countries which have had less of a focus on health inequalities in recent years. These tend to be those countries where a focus on an equality agenda is reminiscent of the Soviet era in their histories, and also where differences in health status between different parts of the population are highly political.

Countries with stronger economies are in a position to take a longer term view and in a number of cases have a strategy which sets out a vision that aims to

be more inclusive and fair. Examples that we came across included Slovenia and Ireland. Here Public Health teams were able to link their agenda to broader government strategy and vision and set out how they might contribute to this. Further, in some countries the public health team had a clear senior political champion which gave them authority and leverage.

This ultimately led to a wide variation in terms of resourcing and prominence given to public health within overall government policy. Where links were made to national strategic goals, public health objectives were given more attention. In addition, the different histories and ways of describing and thinking about health inequalities has an additional impact on the degree to which the differences in the patterning of behaviours and related harms were given prominence and were included in public health and wider government policy discussions.

The countries with whom the HEPP project worked all indicated that having time to reflect with colleagues from other Ministries and sections of society (civil society, research, business) on inequalities in behaviours (nutrition, physical activity and alcohol consumption), enabled a chance to explore and consider the profile of the agenda which would not have been possible otherwise. The workshops, which do not need to be costly, had a strong convening and catalyst function, and being coproduced were focused on issues of relevance to both the HEPP project and the country partners.

Recommendations

- One clear request from countries was for the EU institutions to give an indicative figure to what proportion of the budget should be spent on public health functions and promotion so that where public health is weak it could look to EU guidance to bolster the need for increased prominence and action.

- Further workshops would be appreciated by Member States both those previously engaged and new ones, and would help further build both knowledge and action.

Governance

In our discussions in the coaching workshops it was clear that one of the biggest challenges faced by Public Health Ministries is identifying effective tactics to promote evidence based policies to reduce inequalities related to risky behaviours.

This area is complex and difficult. For example:

- Public Health Institutes and Ministries are seeking to make progress in an area of policy that can bring it into potential conflict with other priorities and policy areas such as economic development or into potential conflict with particular industries such as alcohol or 'junk' food.

- It is the case that the health inequalities agenda is at best a second order priority compared to other concerns that governments may have. Further, it is a long term agenda and its outcomes appear relatively intangible and therefore unlikely to show immediately visible results when compared to building a new hospital or creating 1,000 new jobs.

- In particular awareness across the population of the social gradient in health and its causes is very limited, or dismissed as 'the way it is' or too difficult to address.

- The long term nature of this work, the multi-causality of issues such as obesity and diabetes, and the difficulties in gathering data can lead to accusations from advocates of a neo-liberal approach to markets and regulation that public health is being overly prescriptive and interfering inappropriately without just cause.

- Health inequalities are particularly difficult because of the value judgements that can easily be made about people on lower incomes, whereby poorer people are blamed for making worse choices, rather than being considered more vulnerable to the pressures that lead to unhealthy behaviours, and poorer health status.

- On the other hand the HEPP project found that economics is having a direct impact for example on food choices, so that a Mediterranean diet is increasingly beyond the reach of much of the population of Portugal, or access to vegetables and fruit in Romania. The policy response to poor diet due to low income is of course complex.

It was clear from all of the coaching workshops that Public Health Ministries/Institutes had to be careful how they framed the challenge and how they engaged with stakeholders. In general some of the strategies they used that felt helpful included:

Industry/State

Most public health Ministries maintained a clear separation between industry and the state - being particularly cautious about the potential for conflicts of interest. This was not always the case, funding pressures led to at least one Ministry having an active collaboration with the food industry. In principal separating policy making from potentially health harming industry engagement is desirable as public health has a primary focus on population health and business is obliged to have a primary focus on creating profit.

Wider stakeholder engagement

In some of the workshops it was clear that Ministries had been successful in creating structures that had broad and active involvement within government across departments and Ministries. For example, Portugal was noticeably

effective in bringing together cross-government working groups. These working groups acknowledged the role that other Ministries had on nutrition and alcohol consumption, and Portugal were considering establishing a cross-government working group on health inequalities.

All the workshops the HEPP project conducted were good at bringing together different stakeholders, though the level of cross-government engagement varied enormously, largely based on the status accorded it by the government apparatus.

There was an active debate about the relative merits of creating structures that involved stakeholders such as municipalities and NGOs. The HEPP project heard views expressed that with an agenda as complex as this and with the potential for conflict of interest between different governments departments, transparency and the opportunity to question and challenge by outside agencies was important and might help strengthen the work of Public Health Ministries and political champions.

Recommendation

- Where possible, cross-government working groups and platforms to enable discussion on the role of different Ministries in addressing inequalities seem to be particularly beneficial. It is worth considering if it is possible to establish such structures to facilitate regular exchange on health inequalities.

Relationship between central government and local communities

National governments can take significant action in terms of regulation and legislation, however meaningful action also requires the active involvement of local stakeholders.

In Slovenia the HEPP project heard about growing concern about the way in which national and multi-national companies can target and influence the behaviour of the public (in particular children and young people) through social media.

While public health departments had supported the development of legislation to respond to this the workshop discussions in Slovenia and in Ireland in particular included considering ways in which governments could support the public to develop skills and knowledge in order to be more resilient to this form of marketing.

There was a recognition that initiatives such as healthy schools provide an opportunity to build on personal direct, trusted relationships with the public.

Supporting people to successfully change their behaviour with regard to alcohol, physical activity and nutrition requires an understanding of the

relationship between their environment and local cultures; further there is a need to develop trusted long-term relationships with the public. In this case specifically with communities and interest groups who may be marginalised or easily ignored.

There was a wide variation across the six workshops in terms of how robust and meaningful these relationships were. In some Member States local government is very weak with no independent means of raising revenue to develop services. Therefore part of the public health challenge was to develop alliances with other local services such as primary care, schools and NGOs.

In Romania, for example, local government is comparatively weak in rural areas not least because the opportunity to raise revenue is very limited. The Public Health Institute was working with local municipal leaders to develop stronger collaborations with primary care in particular as well as using international funding to support work with Romanian NGOs and working in partnership with international NGOs such as UNICEF.

Recommendation

- National governments and EU need to consider what actions are required at European level, at Member State level and what is best implanted at local level.

Health Promotion Campaigns

One of the discussions was on the role of health promotion campaigns, particularly as public health messages tended to be disproportionately acted upon by more educated or affluent groups in society. Several countries suggested the use of role models who might be more appealing to lower income groups or using utilizing programmes (e.g. 'soap operas') with a predominantly lower educated audience. There is no clear evidence of successful targeting of educational campaigns to impact on lower income groups, although market testing with different sections of society would no doubt decrease the extent to which educational campaigns impact more on higher educated groups.

However campaigns can have a positive impact in preparing the ground for, or re-enforcing messages about, government action on areas such as product reformulation. They are better used from a health inequalities perspective to help change the popular narrative than to seek to change individual behaviours.

Recommendation

- Health promotion campaigns are probably best considered as mechanisms to prepare the ground for, or raise awareness of, policy changes that will impact positively on health inequalities, rather than as vehicles for personal behaviour change.

Longevity

Where the public health function has had stability and longevity it has developed relationships and 'social capital' or trustful relationships. This is very important in terms of addressing public health challenges which are by their nature long term, complex and difficult.

Telling the story

1. Conceptualising Health Inequalities

Only one country told the story of health inequalities in a way which fully acknowledged the impact of transnational and international forces on health inequalities. At the very least the marketing and internet sales of 'potentially' health harming products requires international action, while the production of high-volume goods in lower wage countries has implications for the labour market and ultimately on job opportunities in the European Union. Migration was also largely ignored in the framing of inequalities, adding as it does a further layer of complexity to the understanding of health inequalities.

A number of countries did however frame their understanding of health inequalities in terms of the various levels of influence, and recognised that the patterning of behaviours was also influenced by, inter alia, the patterning of jobs, income, tax and social protection/social welfare payments.

The commercial influences on health behaviours and their patterning was also potentially over-looked. Counter-acting the potentially health harming aspects of some industries was often not clearly articulated, however where it was the unequal distribution of resources between the public sector and commercial interests were noted. There is little evidence of differential impact of health harming industries e.g. through marketing of unhealthy products to lower income groups, or the differential impact of marketing on different sections of society.

Health inequalities is a complex topic. It is therefore particularly important that Public Health teams are able to tell the story of health inequalities in a way that is clear and understandable and engages key stakeholders such as politicians and officers in other departments. It is particularly important that politicians and senior civil servants are provided with a narrative that they can use to champion this agenda. This indeed was the main take home for one of the countries the HEPP project worked in.

In most of the countries that HEPP held workshops in, it did not feel as though there was a sufficiently clear understanding of what is meant by the term 'health inequalities' and data was used inconsistently to describe the scale and impact of health inequalities.

Some Member States had used 'deep dive' approaches - focusing on a particular geographic community to capture information - compensating for the lack of a systematic country wide approach.

Recommendations

- Having an agreed narrative on health inequalities within Public Health departments is important both to enable engagement with the wider government narrative, and to drive engagement with other government departments.

- It is useful to set the narrative on health inequalities within the wider narrative of globalization so that those global influences can be considered.

- It is important to consider the impact of the social determinants of health on health inequalities both directly and as they impact on behaviours.

- It is helpful to expressly consider the impact of the marketing of products with potentially harmful health consequences to lower income groups.

2. Data

While most countries still focus on life expectancy as the key indicator to be used when considering the challenge presented by inequality, morbidity data is increasingly being used. This is particularly powerful because it allows arguments to be made with regard to the impact of health inequalities on people's ability to contribute to the economy as well as arguments with regard to the effect of health inequality and morbidity on social welfare systems. One of the challenges here is that Member States that have comparatively undeveloped social welfare systems may be less affected by this. Similarly this is likely to have less traction among Member States that have weak economies with high levels of unemployment. Nonetheless having a healthy, fully productive workforce makes economic sense in most contexts. This applies both to individuals own health and reducing the burden of caring for sick children and elderly relatives.

To some degree developing a narrative with regard to morbidity is more difficult because gathering data on this (particularly multi-morbidity) is more complex than capturing mortality data.

Many countries had very limited data of the patterning of behaviours and outcomes in relation to behaviours. Data on the patterning of obesity were reasonably good, however having the data to understand the patterning of other inequalities was less common. In the case of alcohol this is at least in part because Europe-wide surveys (European School Survey Project on Alcohol

and Other Drugs[1] (ESPAD) and Health Behaviour in School-aged Children[2] (HBSC) focus on children and young adults.

Some countries have then relied in part on specific funding to enable good quality national surveys to take place, which means that the data responds to funders priorities and are not necessarily self-determined. Even where data are collected on socio-economic factors, there a frequently few resources found to analyse the causality of differences observed.

The lack of data means that it is difficult to understand the patterning of behaviours, and where to intervene to address socio-economic health inequalities across the life course. It also makes the monitoring of policy and intervention impact particularly difficult to gauge.

If data is sparse at national level on the distribution of impact, it is virtually none existent at sub-national level or local level.

Recommendations

- It is useful for Member States to focus on differences in healthy life years rather than just life expectancy, not least to engage with other government departments including social protection, and finance.

- Member States should be encouraged to develop surveys at national and sub-national level which would enable the monitoring and better understanding of differences across the population in risk factors, their socio-economic distribution and associated health outcomes.

- It would be helpful to increase the comparability of EU data on health inequalities, so that countries can better identify how well they are doing in addressing health inequalities and the direction of travel, a first step to which would be to explore what a basic data set on health inequalities would be and the extent to which it could be incorporated into existing EU statistical instruments.

3. Research and Modelling the Economic Impact of behaviours

It was noticeable from the workshops that there was very little policy-focused research to help policy-makers to identify what would work in their country. It is interesting, that in bringing together stakeholders those who might help to create the evidence base from both the perspective of commissioning research and in terms of carrying out research, were singularly absent. One notable

[1] http://www.espad.org/
[2] http://www.hbsc.org/

exception was in Estonia, where evidence of inequality in access to care was presented, possibly reflecting the dearth of data on inequalities in risk factors and health outcomes.

On several occasions it was noted that being able to quantify the costs to the economy and/or the health service of inequalities would focus attention on them. This is unlikely until the data on inequalities is routinely collected and could be modelled with appropriate data.

Recommendations

- Public Health departments should engage with research institutions to help establish a policy focused research agenda on the specific factors driving health inequalities in their country or local area.

- At the least, research into the impact of public health policies or interventions should be encouraged to report on their distributional impact (e.g. differences in impact between lower and higher SES groups), or at least make available research data in a format that would enable such an analysis.

- Member States should consider if it is possible to make an economic case for addressing inequalities in health related behaviours or risk factors.

- The case studies were found to be useful in practice, and further work identifying and reporting and sharing good practice using EC guidelines and templates would be helpful.

Particularity

One of the challenges for European-wide projects is that it is difficult to recommend policies which will work across all Member States. So for example price increases and in particular Minimum Unit Price (MUP) are effective in reducing the harmful consumption of alcohol and through modelling have been shown to have the greatest impact on lower income groups. However in countries where home production or illicit production of alcohol is high, price increases and MUP may be less effective and drive more people to illicit alcohol or home production instead.

Annex 1: Value to countries

In response to the question: Did you find the workshop useful? If so in what way was it useful?

Ireland stated:
The workshop was a very useful exercise for us, as it provided an opportunity for further engagement with key stakeholders (both from within government and with NGOs) around the key policy area of childhood obesity and the associated health inequality issues, to enhance understanding of the issues, as well as promote understanding of the approaches to implementation and policy alignment.

The external facilitation, and overarching context from the international evidence base, had a particular value in moving the national dialogue forward to focus more on supporting implementation, rather than overly focusing discussions on 'problem description'.

We were also delighted to have the opportunity to engage with the Amsterdam programme which we had been aware of. As a result of the workshop, the Amsterdam programme has been invited by our Department of Children and Youth Affairs to a national conference on children and local action in October.

Slovenia stated:
We were very satisfied with the workshop. We have further increased the understanding the inequalities issues related to nutrition and alcohol and other factors. For us it was mainly important because of the digital related risk factors.

Romania stated:
It was on opportunity to:

- bring together many stakeholders; MoH, UNICEF, WHO, ROMA AGENCY
- exchange experience on different in-country interventions
- present further opportunities
- start a collaboration with WHO euro on that topic

Malta stated:
Despite keeping within the intended themes the workshop in Malta managed to address specific issues such as physical activity, obesity and alcohol consumption. This was particularly useful for the audience.

Portugal stated:
We found the workshop very useful considering we had time to look at the Inequalities area in a more concrete and extended way, as we had together professionals from different areas discussing the theme.

Estonia stated:
Yes very much so! The workshop fed into the process of designing new Estonian National health Plan 2021-2030.

The propositions developed in the workshop were used as discussion points for the working groups of NHP and developing the indicators. Reducing health inequality has been chosen as one of the goals and horizontal dimension of NHP, the interventions are weighed from the aspect of inequality and the indicators measuring health inequality are proposed.

The results of the workshop also fed into the program „Local Development and Poverty Reduction" of Norway/EEA grants, contributing to the project on children's physical activity, more than 4 million euros are planned to be allocated to support children's physical activity during 2018-2021.
During the workshop, several propositions were offered in the field of mental health. The propositions are documented for the further discussions on several strategic documents-to-be in the field of mental health (the development plan of psychiatric care, the development plan of long-term care and possibly others)

<u>In response to the question: What advice would you offer if further workshops were funded by the EC on health inequalities either in your country or elsewhere?</u>

Ireland stated:
I think the overall approach taken in this pilot series was one that could be built on in getting the key messages from the evidence more widely understood to promote policy coherence and understanding of the inter-connectedness of cross-government policy areas. There would be huge value in sharing best practice/learning from implementation, across the different stages of the policy cycle, which would also help enhance a Europe wide approach and understanding, give a mandate to collaborative action in this area, and perhaps drive multi-state activity.

Slovenia stated:
We would recommend to identify, engage, and involve as many relevant stakeholders and rights holders in the processes as possible. It would be also very useful if there is very clear call for action, jointly prepared for. At present there are silos of actions in different lifestyle factors.

Romania stated:
It would be useful to present more good practice approaches from different countries.

Malta stated:
More involvement by the participants through working groups and a longer session. Maybe one and a half days?

Portugal stated:
The most important feature of this work is to make possible to work together professionals from different areas so the exchange can be enriched and it can allow future collaboration in this area in your country in a near future.

Estonia stated:
We would advise to concentrate on specific policy issues – alcohol, tobacco, nutrition, primary care, long-term care, welfare etc. – and try to understand, how the specific policies and measures either increase or decrease health inequalities.

In response to the question: How has the workshop changed what you have done or intend to do?

Ireland stated:
Probably the main outcome for us has been the idea that this workshop could be the beginning of a series looking at issues around the main health behaviours and determinants of health inequalities. The format and running of the workshop gained positive feedback from the participants, and we would be interested in aligning our taking forward of any such series with future EC workshops if that was feasible.

Slovenia stated:
In Slovenia, the workshop has complemented all our activities, due to your flexibility and adaptation to our needs which was highly appreciated.

Romania stated:
In our new project, an 8 Million Euro Norwegian grant, we have put more focus on the weak points identified in other projects. Also we planned to use the instruments developed in other projects presented there. So, it was a good start.

Malta stated:
Despite its evident relation to our project on Social Determinants of Health I believe that in the long term the knowledge gained will become useful in understanding the causes for the identified local Social Determinants of Health influencing Public Health.

Portugal stated:
For the first time we could work together in the health area with the physical activity people, the nutrition ones and the addictive behaviour area and the professionals realise that a lot has to be done in this collaboration towards talking inequalities.

Estonia stated:
The workshop fed into the process of designing new Estonian National Health Plan(NHP) 2021-2030.

The propositions developed in the workshop were used as discussion points for the working groups of NHP and developing the indicators. Reducing health

inequality has been chosen as on of the goals and horizontal dimension of NHP, the interventions are weighed from the aspect of inequality and the indicators measuring health inequality are proposed.

The results of the workshop also fed into the program „Local Development and Poverty Reduction" of Norway/EEA grants, contributing to the project on children's physical activity, more than 4 million euros are planned to be allocated to support children's physical activity during 2018-2021.

During the workshop, several propositions were offered in the field of mental health. The propositions are documented for the further discussions on several strategic documents-to-be in the field of mental health (the development plan of psychiatric care, the development plan of long-term care and possibly others).

Annex 2: HEPP Country level coaching workshops

Reviewing and refreshing national strategies on non-communicable disease and Heath Inequalities

1. Overview

This paper describes the approach that the European Union funded Health Equality Pilot Project (HEPP) is taking to support EU Member States review their current policies and strategies with regard to health inequalities in nutrition, physical activity and alcohol behaviours and outcomes.

2. Background

One of the biggest health challenges facing the European Community is the growth in non-communicable disease caused by poor nutrition, low levels of physical activity and harmful alcohol consumption. We know that these factors disproportionately affect populations experiencing health inequalities. The Commission has responded with Joint Actions on Reducing Alcohol Related Harm, Nutrition and Physical Activity and Chronic Diseases, and a new Joint Action on Health Inequalities is planned. In addition the work complements the EU Action Plan on Childhood Obesity 2014-2020.

The HEPP project will use a series of systematic reviews and members state population case studies to provide the basis for a small number of Member States to hold a fully funded national workshop to review existing actions, local conditions and work with international experts to consider what further actions would help improve progress in this area.

The programme is offering one day workshops to 6 Member States between October 2017 and March 2018.

Public Health Ministries face significant challenges in developing powerful coherent action plans across Ministries. Some of the reasons for this include the need for Member States to focus on developing strong economic policy, the complexity of developing long term actions to address non-communicable disease and concerns about being seen to regulate the lifestyle choices of citizens.

3. W**orkshop objectives**

These workshops will provide a platform for public health leaders to invite members of key Ministries, NGOs and other stakeholders to consider how they might work together to develop a joint action plan to address health inequalities through action on nutrition and physical activity, and alcohol consumption and their determinants..

They are intended to help public health departments strengthen engagement across Ministries at Member State level.

4. Methodology

Selection of Members States

The HEPP team will offer these workshops to Member States using intelligence it has gathered from the country profiles and with advice from the European Commission. The rationale for selection of Member State workshops is as follows:

- Broad geographic spread within the European Union.
- Those countries that are less often involved in public health initiatives on health inequalities such as Malta, and Bulgaria.
- High level of inequality in outcomes in relation to physical activity, alcohol consumption and nutrition.

Workshop Design

The HEPP team will work with each Member State public health team to design the workshop to ensure that it is focused on key areas of concern in that country. For example, in some Member States there may be greater concern about alcohol strategies and policies while others may be more concerned about diet and physical activity. It will also be important to align the workshop to each Member State's analysis of health inequality. The HEPP team have developed a basic framework for the workshop which will be adapted to reflect local priorities, government structures and capability.

The basic framework for the workshop is as follows:

- Ministerial introduction
- Country context - with regard to health inequality and prevalence of NCD
- Current strategies
- Presentation of evidence on addressing relevant inequalities in nutrition, physical activity and alcohol behaviours and outcomes from international experts
- Review and Action planning

Workshop Delivery

The workshop will be delivered in partnership with local public health leaders. The intention is to deliver 2 one day workshops in the last three months of 2017 and the remaining 4 workshops in the first 2 months of 2018.

HEPP will develop a needs assessment process and framework to help to ensure that the coaching workshop meet the needs of the expert group.

Training materials focusing on actions to address health inequalities in nutrition, physical activity and alcohol behaviours and outcomes from international experts will be produced and shared with the EC.

Workshops will include input from recognised experts who are part of the HEPP team they will include a mix of alcohol, nutrition and physical activity leads together with Peter Goldblatt and Chris Brookes who will focus on health inequalities.

The workshops will be facilitated by Professor Mark Gamsu from Leeds Beckett University.

Learning

The first two workshops will be used to pilot the training materials and the approach.

The training materials will be revised in the light of the piloting for the remaining four workshops and agreed with EC.

The HEPP team will work with the local team to record key actions agreed. Actions and learning from all workshops will be brought together in a final report and shared with participating Member States so that ideas and learning can be shared.