



Thematic session 4: Addressing the social determinants of health- Concept Paper



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determinants of health-
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1 Introduction

The VulnerABLE project is a two-year pilot initiative of the European Commission (DG SANTE), run by ICF, in partnership with EuroHealthNet, the UCL Institute of Health Equity, the European Public Health Alliance, Social Platform and GfK. The project aims to increase understanding of how best to improve the health of people living in vulnerable and isolated situations, identify and recommend evidence-based policy strategies, and raise awareness of the findings and support capacity-building within Member States.

The project involved a range of research activities, including a cross-national survey with 1,938 respondents belonging to potentially vulnerable groups¹ across 12 Member States; a literature, policy and data review of existing evidence on health needs and challenges of these groups; an inventory of good practices in addressing health challenges; expert focus groups and interviews with key stakeholders.

This paper has been prepared for the Dissemination Conference of the VulnerABLE project in November 2017. It brings together the key project findings on the topic of 'Addressing the social determinants of health: How can we remove socio-economic barriers to healthcare and make EU societies more inclusive?' as well as posing questions for the event.

2 Presentation of the theme

2.1 Social determinants of health – a conceptual framework

Health inequalities can be defined as 'differences in health status between individuals or groups, as measured by for example life expectancy, mortality or disease' that arise from 'avoidable differences in social, economic and environmental variables' (European Commission, 2009a).

Vulnerability is a social phenomenon, affected by multiple processes of exclusion that can lead to or result from health problems. Three notions shape the concept of vulnerability:

- 'Risk': vulnerability is a situation that anybody can experience at a point in their life and 'any individual may be at risk of physical, psychological and social health issues (Rogers, 1997).
- People's coping capacities with adverse situations (Zaidi, 2014).
- The outcome of this adverse situation on the individual's health: its impact 'in term of welfare loss' (Alwang et al, 2001).

The 'vulnerable populations conceptual model' (VPCM) identifies vulnerable populations as '*social groups who have increased morbidity and mortality risks, secondary to factors such as low socioeconomic status and the lack of environmental resources*' (Flaskerud and Winslow (1998); Nyamathi et al. (2007)). The VPCM illustrates the interactions between:

- Resource availability, determined by human capital; social status; social connection and environmental resources, at both individual and community level;

¹ The groups included in the project were: families who are in a vulnerable situation (e.g. lone parents with young children); having physical, mental or learning disabilities or poor mental health; the in-work poor; older people who are in a vulnerable situation; people with unstable housing situations (e.g. homelessness); prisoners (or ex-prisoners in vulnerable situation); persons living in rural/isolated areas in a vulnerable situation; long-term unemployed/inactive (not in education, training or employment); survivors of domestic violence.

- Relative risk, where risk factors may be behavioural or biological and refer to the differential vulnerability of specific groups to poor health; and
- Health status, including disease incidence, prevalence, mortality and morbidity rates in a community.

Different factors determine the risk of vulnerability: personal factors - inborn or acquired -, societal and environmental ones. The more personal resources and environmental resources a person has, the less likely that person is at risk of vulnerability.

With regards to the determinants of health, i.e. the factors that determine the health status of individuals and social groups in society, a number studies try to identify and describe them.

Authors distinguish between personal factors, and structural (social and environmental) ones. Personal factors are: early life conditions, quality of parenting, nutrition and exercise, psychological factors, substance abuse, education, place of birth, place of living². Structural factors are: belonging to a certain ethnic/social group, gender, social support, social exclusion, poverty, level of incomes, quality of work, unemployment³.

All health determinants interact to create a complex set of health dynamics. Solar and Irwin (2010) have developed a conceptual framework on social determinants of health; and is illustrated in 0.

The socioeconomic and political context - governance, macroeconomic policies, social policies, education, health and social protection policies, culture and societal values - determines the socioeconomic position, i.e. the position in which individuals find themselves depending on their occupation, education, income, gender, race/ethnicity, and other factors. The socioeconomic positioning impacts in turn on intermediary determinants - behavioural and biological factors, psychosocial factors and material circumstances. All factors mentioned above determine in the end the health status of individuals.

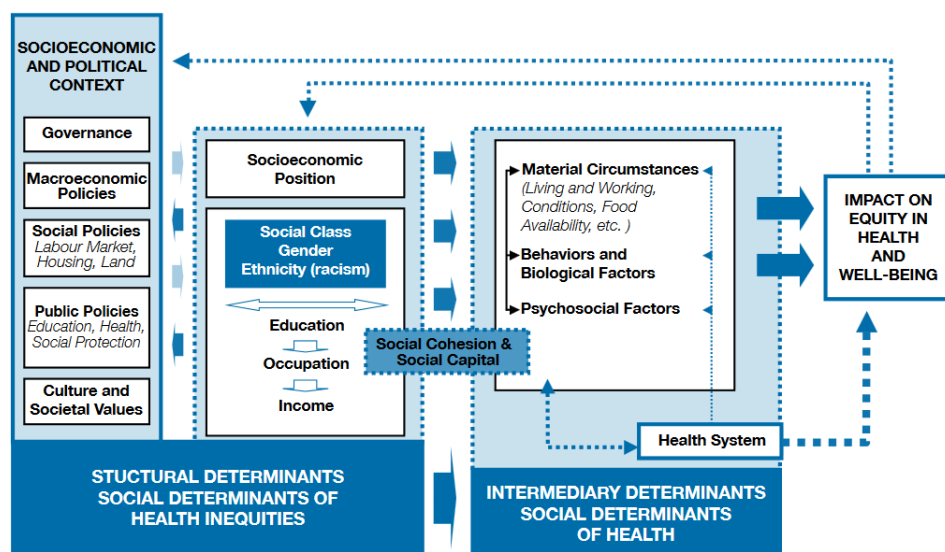
The context, structural elements and resultant socioeconomic position of individuals are defined as social determinants of health inequalities⁴.

² Early life conditions, education and place of living can also be considered as structural factors, given that they are influenced by public policies;

³ R. Wilkinson, M. Marmot, *Social Determinants of Health, The solid facts, 2nd Edition*, WHO Europe, 2003; M. Marmot, Social determinants of health inequalities, Lancet 2005;

⁴ Solar and Irwin (2010), A conceptual framework for action on the social determinants of health, WHO, 2010.

CSDH conceptual framework



Source: *Solar and Irwin (2010)*

The research carried out through the VulnerABLE project shows that social determinants of health play a major role in determining vulnerability in access to healthcare and on the health status of individuals; this is true for all target groups forming the objective of our study.

2.2 The impact of social determinants on health status and access to healthcare

Over the last decade population health indicators have improved across the European Union. However, widespread inequalities in health and access to health persist between and within Member States. This is clearly demonstrated by data collected at European and national level.

The European Commission study on 'Health inequalities in the EU' (2013a) found that general ill health and longstanding health problems are increasingly common as disadvantage worsens (social gradient of health inequalities). The steepest social gradients were found for the relationship between material deprivation and adverse health outcomes. The study also found that health inequalities exist between and within Member States and social groups, which are increasing in particular in Eastern Member States.

Data from Eurostat show that life expectancy varies among Member States, with countries like Bulgaria, Hungary, Estonia Latvia, Lithuania, Romania and Slovakia having the lowest life expectancy for men and women⁵. Differences between Member States have reduced over the last ten years, but they are still significant. In 2008 the difference between the Member States with lowest life expectancy and the highest one was 10 years; in 2014 this gap decreased to 8.8 years.

⁵ Eurostat (2016a), 'Life expectancy by age and sex.' Brussels: European Commission, available from: http://ec.europa.eu/eurostat/web/products-datasets/-/demo_mlexpec.

Dissimilarities exist between and within Member States also regarding healthy life years at birth. For instance Eurostat data from 2014 indicates that in countries such as Estonia, Latvian, Slovakia, Portugal, Austria and Finland healthy life years at birth were the lowest. The lowest data - from Latvia, Slovakia and Portugal - differed from the highest data - from Malta and Sweden - by 22 years for men and 19 years for women⁶.

Other data show the impact of social determinants on health status and access to healthcare, such as Eurostat data on the proportion of people with long-standing illnesses or health problems by income quintile (population subgroups with different levels of incomes) demonstrate that people with the highest income levels have significantly lower rates of long standing illnesses. On the contrary, the two groups with the lowest incomes have the highest rates of long-standing illnesses⁷.

Other data (Eurostat 2016) show that users consider cost of treatment as one of the main barriers to health. Self-reported unmet healthcare needs which occur due to the cost of treatment are also twice as prevalent among Europeans in the first income quintile (i.e. the least wealthy in society) than among the European population as a whole. Unmet needs due to treatment costs are also over eight times as prevalent among people in the first quintile (the lowest income group) as among people in the fifth quintile (the highest income group). Lastly, data from Eurostat show that unmet health needs among unemployed people have been consistently higher than unmet needs among employed people in Europe in the period 2008-2014⁸.

3 Key findings from the project

The work carried out through the project, mainly: the literature review, the survey carried out with target group members from 12 Member States and the Focus Group meetings with experts, largely confirm the data presented in Section 2⁹.

3.1 How social determinants affect health in all target groups

The survey carried out in 12 Member States¹⁰ showed that social determinants have an impact on health access and the health status of individuals and communities.

⁶ Eurostat (2016b), 'Healthy life years and life expectancy at birth, by sex.' Brussels: European Commission, available from: <http://ec.europa.eu/eurostat/web/products-datasets/-/tsdph100> .

⁷ Eurostat (2016c), 'People having a long-standing illness or health problem, by sex, age and degree of urbanisation.' Brussels: European Commission, available from: http://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_19 .

⁸ Eurostat (2016e), 'Self-reported unmet needs for medical examination by sex, age, detailed reason and income quintile.' Brussels: European Commission, available from: http://ec.europa.eu/eurostat/data/database?node_code=hlth_silc_08 ; Eurostat (2016g), 'Self-reported unmet needs for medical examination by sex, age, detailed reason and degree of urbanisation.' Brussels: European Commission, available from: http://ec.europa.eu/eurostat/web/products-datasets/-/hlth_silc_21. VulnerABLE: Pilot project related to the development of evidence based strategies to improve the health of isolated and vulnerable persons (SANTE/2014/C4/034) - Scientific Report, September 2017;

⁹ See relevant the reports for further details on the results of this research: Literature review report, available from: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_literaturereview_en.pdf ; Pan-European survey report, available from: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_surveyreport_en.pdf ; Case study inventory, available from: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_casestudyinventory_en.pdf.

¹⁰ The survey was carried out by GfK, within 12 Member States (France, Germany, Greece, Italy, Lithuania, Netherlands, Poland, Romania, Slovakia, Spain, Sweden and the UK). A mix of offline Paper-Assisted Personal Interviews and online Computer-Assisted Web Interviewing was used. The survey was completed by 4.187 respondents, from all 9 identified target groups; the Pan-European survey report is available at this link: https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_surveyreport_en.pdf ;

First of all, in terms of barriers to health, survey respondents reported lack of money as the most common factor hindering access to healthcare (stated by 62% of respondents)¹¹.

Also, respondents in difficult financial situations self-reported their health status as poorer compared to wealthier respondents: 36% of those in a difficult financial situation reported bad health status compared to 15% of those in an easy financial situation.

The findings for the different target groups illustrate that lack of money played a greater role for the in-work poor (72%), people living in an unstable housing situation (71%), members of vulnerable families (68%) and long-term unemployed or inactive people (66%)¹².

In terms of access to healthcare services (to medical practitioners, dental examinations or treatments, and medication) while almost all target groups reported the costs of healthcare services as the most important barrier to healthcare access, the cost factor had an even greater impact for members of vulnerable families (39%-45%) persons living in rural and isolated areas (36%-40%), people living in unstable housing situations (33%-40%) and the in-work poor (31%-42%).

High costs were mentioned by the respondents as the main reason for not visiting medical practitioners, accessing dental examination/treatment or getting medication. The unaffordability of all three healthcare services was reported most often by: members of vulnerable families, persons living in isolated or rural areas, in-work poor and people with unstable housing.

With regard to health inequalities, evidence from Eurostat data highlights differences in levels of access to healthcare between different population subgroups: persons with lower incomes, lower levels of educational attainment, those who were unemployed and people living in rural areas were more likely to have unmet needs for medical examination compared to the general population¹³.

The survey results showed similar results in terms of access to healthcare: vulnerable and isolated people often find it difficult to obtain the healthcare they need, due to their inability to afford necessary healthcare services. It was especially the case for people self-reporting bad health. It also emerged that satisfaction with health services is often lower for people who need healthcare the most¹⁴.

3.1.1 Impact of social determinants for different vulnerable groups

The project results show that social determinants have an impact on the health status of all vulnerable groups researched. The main impacts identified through the project work are discussed in the present section.

¹¹ Other factors where: lack of good housing conditions, work (or lack of work) concern about relationships, lack of experience, unhealthy diet, smoking, alcohol, drugs, stress, VulnerABLE: Pilot project related to the development of evidence based strategies to improve the health of isolated and vulnerable persons (SANTE/2014/C4/034) - Scientific Report, September 2017, Fig. 19, p.23;

¹² VulnerABLE: Pilot project related to the development of evidence based strategies to improve the health of isolated and vulnerable persons (SANTE/2014/C4/034) - Scientific Report, September 2017;

¹³ VulnerABLE: Pilot project related to the development of evidence based strategies to improve the health of isolated and vulnerable persons (SANTE/2014/C4/034) - Scientific Report, September 2017, p. 31;

¹⁴ VulnerABLE pilot project: Report of survey with people living in isolated and vulnerable situations, Pilot Project related to the development of evidence based strategies to improve the health of people living in isolated and vulnerable situations (SANTE/2014/C4/034), p. 6, available from:

https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_vulnerable_surveyreport_en.pdf ;

3.1.1.1 Older people

Survey results show that older people in vulnerable or isolated situations reported having greater difficulty accessing healthcare services than average. This was primarily due to the cost of healthcare, although difficulty understanding health information provided by doctors, nurses and other healthcare professionals was another barrier.

Literature review results show that the socioeconomic factors are identified as a key determinant of health and vulnerability in later life, with those experiencing greater disadvantage experiencing poorer health and wellbeing (Knesebeck et al., 2007; Siegrest, 2009). Education and wealth can have a direct and indirect impact on health.

Welfare arrangements in individual Member States can also have an impact on vulnerability and health, as older people become dependent on support from fixed incomes (such as pensions) and families as they are no longer of working age (Eikemo and Bambra, 2008).

Focus group findings showed that costs of healthcare represent a growing issue. While the financial burden of healthcare for the individual might not be perceived as overly heavy when entering old age, increases in healthcare needs and a decrease in independency can cause older people's financial security to quickly deteriorate, reducing their ability to cope with growing costs. This can escalate social exclusion and poverty, with further associated impacts on health.

3.1.1.2 Long term unemployed and inactive

Long-term unemployment and inactivity is associated with poverty and social exclusion. Households with higher levels of unemployment are more likely to experience poverty and social exclusion due to the lower levels of household income (Eurostat, 2015b).

The literature review results showed that participation in the labour market or exclusion from it has a significant impact on life chances, risks of material deprivation and wellbeing that may influence or determine people's health throughout the life-course. Levels of unemployment are more likely to affect those in lower socioeconomic positions, with lower levels of education (Donkin et al., 2014). Also, long-term unemployment and inactivity is associated with a range of poor health outcomes. These include the following: premature ageing, poor mental health, negative health behaviours, and low levels of self-reported health.

People experiencing long-term unemployment and economic inactivity are likely to experience barriers in accessing healthcare in relation to cost, particularly within Member States where access is reliant on in-work benefits or insurance coverage, or where there is a direct financial cost involved in accessing care, and there is no state provision or subsidy (Crepaldi et al., 2009).

Focus Group experts also stated that poverty and poor health are inextricably linked. The causes of poor health are rooted in political, social and economic injustices/inequalities and poverty can be understood as both a cause and a consequence of poor health. Poverty increases the chances of poor health and poor health in turn traps people in poverty.

Another barrier identified by the focus group experts was the reduction of screening for diseases such as breast and prostate cancers, as well as the limited use of primary health care that force patients to present for treatment at late stages when serious conditions have already taken hold. Marginalized groups and vulnerable individuals lack the information, money or access to health services that would help them prevent and treat disease.

Literature review results also showed that low-paid and temporary employment is less likely to be accompanied by employment-related benefits, such as health insurance.

This may require them to pay for health care services upfront where employment-based insurance is required or universal healthcare not offered.

3.1.1.3 In-work poor

An UK study found through the literature review showed that there is association between employment grade (which is also reflective of pay) and the prevalence of a range of health outcomes (Whitehall study (1991)). Due to the nature of work that employers required of lower grade employees (e.g. low control and low satisfaction, as well as often low pay), these employees presented higher levels of respiratory and circulatory health conditions and were more likely to engage in risky health behaviours including, smoking, diet and exercise.

Another study found that people in insecure employment were more likely to report poor mental health (Vives et al. (2013)), and the more insecure a person's employment status, the more likely they were to report poor mental health.

Poor mental health was also significantly higher among workers with low educational attainment, low skilled workers, those who had been previously unemployed and female immigrant workers.

3.1.1.4 Disadvantaged families

With regard to the factors affecting access to healthcare, individuals from disadvantaged families, lack of financial resources was a determining factor in access to healthcare in 68% of respondents.

A cross-sectional study conducted across 26 European countries, investigating how European country-level economic disparity and housing conditions were related, found significant and positive correlations between income inequality and country level childhood injury mortality rates (Sengoegle et al., 2013). In addition, poverty is also a risk factor for adverse childhood experiences, which can lead to a range of health needs including respiratory, circulatory and oncological diseases; mental health problems; drug abuse; and, risky health behaviours (UCL IHE, 2015).

A report from the Royal College of Paediatrics and Child Health (2017) in the UK, found that children from deprived backgrounds have considerably worse health and wellbeing compared to children from non-deprived backgrounds. The findings also suggest there is a clear link between children growing up in low income households and the poor health management and the prevalence of special or additional education needs, likely to affect children in adult life.

Focus Group experts highlighted that the cost of treatment, and especially long-term treatment is considered as one of the main barriers to access healthcare for this group. Indeed, children and families from disadvantaged backgrounds face important problems when they have a disability and/or a long term disease, due to the cost of the treatment involved.

3.1.1.5 People living in rural areas

The socio-economic situation and level of rural development can also affect the health needs of rural communities. Focus Group experts pointed out that a lack of services in an area can fuel the outward migration of young. Similarly, a lack of public transport can make some patients (especially the elderly) more reliant on others to support/maintain their health. This situation can represent a vicious cycle, whereby gaps in key services (e.g. mental health services) can make some people leave the area and reinforces socio-economic deprivation there. In these cases, providing healthcare then becomes more expensive and time-consuming, as residents are more likely to have more issues.

3.1.1.6 Homeless

Data show that people living in unstable housing and/or being homeless are generally associated with low income and material welfare. As mentioned above, EU-27 residents with the lowest incomes (fifth quintile) have a significantly higher rate of long-standing illness or health problem than those with the highest incomes (first and second quintiles) (Eurostat, 2016C). They are also more likely to have unmet health needs and the most likely to report having unmet needs due to the cost of healthcare (2016e).

The findings of the VulnerABLE survey confirms these results, showing that low income played a greater role for people living in an unstable housing situation (71%). Similarly, high costs were often mentioned among this group as the main reason for not visiting medical practitioners, getting dental examination/treatment or getting medication people with unstable housing (40%).

In terms of health impact, roofless living conditions are often associated with the most severe risks to both physical and mental health. Literature on the health needs of this sub-group indicate that they are at increased risk of contracting communicable diseases (compared to the general population), including Tuberculosis and Hepatitis. They are also at greater risk of developing multiple morbidities, including respiratory and circulatory conditions; injury, poor oral health, feet problems, skin diseases and infection; serious mental health issues, as well as depression and personality disorders; and drug and alcohol dependence (Griffiths, 2002).

The social determinants also have an impact of the health status of people with physical, mental and learning disabilities. It was found that people within this group are at greater risk of being exposed to poverty, poor housing conditions, unemployment, social disconnectedness and discrimination; this in turn increase the risk of poor health.

3.2 Addressing social determinants of health

Social determinants of health affect all vulnerable groups in EU societies. Reducing inequalities and creating more inclusive societies is the solution to address the root causes of health inequality. While many efforts have been made and policies are already in place, much more needs to be done at different levels of government. Private actors and NGOs should also take part in the response, together with public authorities.

Providing subsidies or a minimum income to vulnerable individuals who do not have sufficient financial resources would tackle the fundamental issue of not having the necessary means to access health services.

Promotion and health education measures that reach the most vulnerable would also be of paramount importance in ensuring that information on services and rights arrives to these individuals.

Universal access to health should be ensured to all vulnerable individuals, in all types of healthcare facilities, including specialised care. Quality and free of charge services should be guaranteed by the health system to all individuals in need. This is particularly challenging in countries where health systems are insurance based and where upfront payments or partial payments are required.

In order to guarantee an effective access to healthcare to all individuals, healthcare professionals have to be aware of the needs of vulnerable specific groups and to possess the necessary skills to deal with these necessities. Specific training should therefore be provided to them. Primary care centres services should be adapted to the needs of the most vulnerable; healthcare professionals should be able to identify vulnerable individuals without stigmatising them and respond adequately to their needs. Community-based care should be improved, in order to provide support as close as possible to the individual.

Further efforts to provide patient centred services should be made, considering the needs of patients already when developing and tailoring services. New technologies could be further used for this purpose, in particular for patients living in remote areas or not able to reach health facilities (like, for instance, people with disabilities and the elderly). Mobile health services could also be further employed.

Better collaboration should be ensured between social services and hospitals and other healthcare facilities. People with physical and mental disabilities should be properly assisted to reach health facilities, as well as accompanied when receiving the services. The same support should be provided to older people needing assistance to reach health services or having specific issues when accessing them. People with unstable housing situations need particular assistance; it was pointed out by many experts that often social centres hosting these individuals do not have adequate health services. The basic needs of these people can't often be granted, as not enough shelters are available and are not always adapted to their needs. Further collaborations could be developed also with non-governmental and private organisations that provide services to vulnerable groups, to better support people in need.

Social services should be guaranteed in general to individuals with specific needs, for instance guaranteeing access to social and recreational facilities, in order to promote integration in society and preventing isolation and vulnerability. For instance free of charge transport services to individuals who are not able to provide for themselves or cannot afford public transport would be very beneficial for vulnerable people.

Employment support schemes, as well as training, education and skills development activities should be provided to all individuals willing to re-integrate or better position in the labour market (unemployed, inactive, in-work poor). Many efforts have been made in this regard, but the needs of many are still to be met. Specific health support should be provided to these individuals as well, as they might suffer of specific health problems that often go undetected.

Recreational activities, psychological support and other types of basic services could be offered free of charge within the local communities to vulnerable individuals.

In order to create more inclusive societies and guarantee the participation of vulnerable individuals, different actors and levels of decision have to be engaged in the re-organisation of services. While this could appear as complex process, peer to peer learning and sharing information on good practices, could help find the best solutions.

A few examples of relevant best practices are provide in Table 1 below.

Table 1. Promising practices from the project

Title	Lead organisation	Main aim and objective	Country	Target group
Action nutritionnelle dans une épicerie solidaire	A.N.D.E.S.- Association Nationale de Développement des Epiceries Solidaires,	Project aimed at setting up shops for vulnerable groups to access fresh fruit and vegetables, and gain employment.	France	Long-term unemployed and/or inactive
DIATROFI - Food aid and healthy	PROLEPSIS - Institute of Preventive Medicine	Programme delivering free school meals for children in deprived areas of Greece.	Greece	At risk children and families

Title	Lead organisation	Main aim and objective	Country	Target group
nutrition programme	Environmental and Occupational Health,			
Family centres	Swedish regions, municipalities and health providers	In 'family centres', universal access to healthcare is provided, as well as information and support (e.g. information for pregnant women, parenting counselling, training for unemployed parents and welfare guidance).	Sweden	Children and families from disadvantaged backgrounds
Healthy Ageing Supported by Internet and Community	Turtu University of Applied Sciences, Finland	Project to empower older people in Europe to take care of their own health both virtually and in peer groups. Besides helping older people on a person-to-person basis, this project also aims to make services more cost effective and increase their quality through cooperation between regional service providers, and policy recommendations regarding communal elderly services.	Transnational	Older people
Housing First	Local NGOs in different Member States; European Federation of National Organisations working with the Homeless - FEANTSA	Practice model to support homeless people in particularly difficult situations (people with mental illnesses, with problematic drug and alcohol abuse, with high support needs; people experiencing long term or repeated homelessness), providing access to permanent housing without any preconditions.	European	People with unstable housing conditions
«Let's Live Healthily» Part of Project Mura	Murska Sobota Institute of Public Health	Project piloted in Slovenia's Pomurje region, which is deprived compared to the rest of Slovenia and has a lower life expectancy. The aim is to promote healthy lifestyles among adults in rural communities through health promotion workshops.	Slovenia	People Living in Rural and Isolated Areas

Title	Lead organisation	Main aim and objective	Country	Target group
Mallu does the rounds	South Karelia Social and Health Care District	The Mallu bus was designed by the South Karelia Social and Health Care District (Eksote) to be an easy-to-use medical service for people in rural areas; health monitoring services, pharmacy tasks are provided and small operations are carried out. These services are delivered through an integrated mobile facility, a converted mobile caravan.	Finland	People Living in Rural and Isolated Areas
Multi-agency risk assessment conferences (MARACs), UK 2003–14	SafeLives charity (previously CAADA)	Meetings which bring together professionals from healthcare, social care and the third sector concerned with domestic abuse to identify and risk assess cases of domestic abuse.	UK	Survivors of domestic violence and intimate partner violence
Open.med Munich	Doctors of the World	Offers medical treatment to people without medical insurance, with the aim of improving the health of all individuals residing in Germany, including those without legal residence status.	Germany	In-work poor
Schutzengel	Guardian Angel GmbH	This project aims to improve access to services and quality of services to children from families in difficult social situations. It offers support and services to families, e.g. local midwifery and paediatric services, peers support meetings. Support is provided through family midwives, social workers and volunteers.	Germany	Children and families from disadvantaged backgrounds
SLaM 'Tree of Life' approach	South London and Maudsley NHS Foundation Trust	The project aims to promote the recovery approach in hospital wards and to better prepare patients for hospital discharge through developing more positive relationships between staff and service users. This is done through peer support training to staff and service users within psychiatric units, using the 'Tree of Life' model.	UK	People with physical, mental and learning disabilities or poor mental health

4 Thematic session overview

Addressing the social determinants of health: How can we remove socio-economic barriers to health outcomes and make EU societies more inclusive?

- Setting the scene: main themes and project results – **David Pattison, Lead Trainer- vulnerABLE Project team**
- Presentation of two good practices:
- *DIATROFI Programme- Yiannis Koutelidas, PROLEPSIS, Greece*
- *Housing First- Dalma Fabian, FEANTSA*
- Comments from **Giuseppe Costa, lead of the forthcoming Joint Action on Health Inequalities**
- Q&A session

5 Questions for the conference

1. What are the best strategies public authorities should put in place to:
 - Improve the socioeconomic position of individuals that are vulnerable?
 - Address the impact of social determinants of health and improve access to healthcare?
2. What are the most adapted levels of action and how should different decision makers interact with each other?
3. How should health and social services be modified to ensure that the needs of vulnerable groups in society are better met?
4. How can the EU support the Member States, public authorities and other relevant actors in this process?

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