

# What are regions in the EU doing to reduce health inequalities?

## Overview Report of Equity Action Regional Network Case Studies



**EQUITY***ACTION*

TOOLS • REGIONS • KNOWLEDGE • STAKEHOLDERS •



*This work is part of EQUITY ACTION which has received funding from the European Union, in the framework of the Health Programme. The sole responsibility for this work lies with the author*



## Acknowledgements

We would like to thank the partners of the Equity Action Regional Network from the following countries and regions for developing case studies with information on how health inequalities are being addressed in their regions. The full case studies and summaries of these as well as the background guidance documents that partners received are available on [www.health-inequalities.eu](http://www.health-inequalities.eu).

### BELGIUM

*Pol Gerits*, National Project Partner - Federal Public Service Health, Food Chain Safety and Environment  
*Sol Wallyn*, Flanders - Flemish Agency Care and Health  
*Annouk Billiet*, Wallonia - Walloon Observatory of Health  
*Peter Verduyck*, Brussels-Capital - Observatorium voor Gezondheid en Welzijn

### CZECH REPUBLIC

*Hana Janatova*, National Project Partner - National Institute of Public Health  
*Dana Strniskova*, Olomouc - Public Health Authority of the Olomouc Region

### ENGLAND

*Stephen Gunther*, National Project Partner - Department of Health UK  
*Justine Cawley*, London - NHS East London and the City  
*Jane Connor*, London - NHS East London and the City  
*Simon How*, East England - Department of Public Health  
*David Ritchie*, North West - North West Health Brussels Office

### FINLAND

*Niina Mustonen*, National Project Partner - National Institute of Health and Welfare  
*Tuulia Rotko*, National Project Partner - National Institute of Health and Welfare  
*Marita Pikkarainen*, Kainuu Region - Joint Authority of Kainuu Region  
*Ilpo Tapaninen*, Oulu Region - Council of Oulu Region |  
*Tytti Tuulos*, Northern Finland - Regional State Administrative Agency for Northern Finland

### GERMANY

*Caren Wiegand*, National Project Partner - BZgA  
*Antje Richter*, Lower Saxony - Landesvereinigung für Gesundheit & Akademie für Sozialmedizin Niedersachsen  
*Marcus Waechter*, Lower Saxony - Landesvereinigung für Gesundheit & Akademie für Sozialmedizin Niedersachsen  
*Petra Hofrichter*, Hamburg - Hamburgische Arbeitsgemeinschaft für Gesundheitsförderung e.V. (HAG)  
*Wiebke Sannemann*, Hamburg - Hamburgische Arbeitsgemeinschaft für Gesundheitsförderung e.V. (HAG)

### GREECE

*John Yfantopoulos*, National Project Partner - EKKE  
*Kyriaki Nikolaidou*, Kefallonia Region - MUNICIPALITY OF KEFALLONIA



## ITALY

*Michele Marra*, Regional Project Partner, Piemonte - Servizio di Epidemiologia sociale - ASLTO3

*Carla Cogo*, Regional Project Partner, Veneto – Registro Tumori del Veneto

*Valentina Barletta*, Tuscany - Health Agency of Tuscany Region

*Manuele Falcone*, Tuscany - Health Agency of Tuscany Region

*Andrea Ranzi*, Emilia Romagna – Environmental Health Reference Center

*Nicola Caranci*, Emilia Romagna – Regional Health and Social Agency

## LATVIA

*Gunta Rozentale*, National Project Partner - National Health Service

*Eliņa Zarina*, Saldus Region - Biznesa Konsultantu Grupa, Ltd.

*Alina Dudele*, Valmiera municipality - Biznesa Konsultantu Grupa, Ltd.

## POLAND

*Bożena Moskalewicz*, National Project Partner - National Institute of Public Health, National Institute of Hygiene

*Krystyna Zuk*, Lubuskie - Lubuskie Voivodship

*Małgorzata Krasowska*, Marczyk Lubuskie - Lubuskie Voivodship

*Edyta Kolano*, Lubelskie - Lubelskie Voivodship

## SCOTLAND

*Jo-Anne Valentine*, Fife - NHS Fife

*Fiona Mackay*, NHS Greater Glasgow & Clyde

## SWEDEN

*Åse Enkvist*, Regional Project Partner, Västra Götaland - Public health Department

*Lars Paulsson*, Regional Project Partner, Västra Götaland - Public health Department

## WALES

*Gila Gingell*, National Project Partner - Welsh Government

*Nicola John*, Cwm Taf - Cwm Taf Health Board

*Gill Richardson*, Aneurin Bevan - Aneurin Bevan Health Board

*Jane Layzell*, Aneurin Bevan - Public Health Wales

*Marcus Longley*, Welsh Institute for Health and Social Care, University of Glamorgan

*Amy Simpson*, Welsh Institute for Health and Social Care, University of Glamorgan

Authors: Ingrid Stegeman and Yoline Kuipers (EuroHealthNet)

December 2012



## Table of Contents

1.	Introduction	5
2.	National governance leading to regional policies to reduce health inequalities	7
3.	Regional initiatives	11
4.	Examples of practice	12
5.	Tools, evidence and evaluation	14
6.	Conclusions	17



## 1. Introduction

This report provides an overview analysis of case studies by 24 regions from 12 EU Member States involved in the Joint Equity Action Regional Network that submitted information on whether and how they are addressing health inequalities.

As is the case for EU Member States, regions in these Member States differ widely. Equity Action Partners involved in the regional work-strand were asked to identify one to three regions in their countries to participate in the Regional Network. The administrative units that qualify as regions can differ per country. For the purposes of the Equity Action, for example, England, Wales and Scotland are considered countries with their own 'regions', since the latter two have devolved powers in the area of health. Great variations also exist in the populations of the regions represented in the Network. The regions of Kainuu and North Ostrobothnia in Finland for example have populations of almost 86,000 and 380,000, respectively, while the region of Lower Saxony in Germany has almost eight million inhabitants. Most of the regions in the Equity Action Network have populations falling within these extremes and ranging from approximately one to one and a half million inhabitants (e.g. Brussels region in Belgium, or Västra Götaland region in Sweden) to around 4.5 million (e.g. Piemonte and Veneto regions in Italy). The demographic characteristics of the regions can be very different, some being largely urban, with high population densities, and others largely rural, with low population densities. In addition, some regions have relatively low levels of socio-economic deprivation *vis-à-vis* other regions in the country, while others have high levels of deprivation; some have a high percentage of young people, while others have a high percentage of older people. While it is generally very difficult to compare levels of health inequalities within regions, almost all regions taking part in the Regional Network have indicated that health inequalities exist within their borders, with some of the case studies providing specific data on this.

Political structures in EU Member States, and therefore the specific competencies of regions can also be very different. Some EU Member States have strong centralised administrations, while others, such as Germany and Sweden have regional governments with a high level of autonomy in policy areas affecting key social determinants of health, such as social policy and public health, making them central in efforts to reduce health inequalities. Other Member States are structured on the basis of national and municipal government, with little in between. Public health in England is transitioning towards such a model, as competencies in this area are currently being shifted from the regional level to municipal governments. While many governments have a traditional three-tier government structure (national, regional and municipal), variations exist here, too. Finland has, for example, recently established a supra-regional administrative level with competencies in, amongst other areas, public health. In addition to the traditional three-tier structure, Belgium is also divided into three 'cultural' communities that are also responsible for certain policy areas.

Despite such differences, most regions have significant influence on wider determinants of health and health inequalities, particularly since regional governments are more likely to have a better insight into the specific needs of their populations and are better able to develop integrated policy



responses to address these needs. Regional governments can also influence policy development and implementation by local level authorities, which also have legislative and budgetary means to influence key social determinants of health inequalities. An objective of the Joint Equity Action has therefore been to capture and share experiences on what different regions in the EU are doing to reduce health inequalities, with the aim of informing and inspiring further regional and local-level action.

The case study reports show that inequality in health is on the agenda of many regions, though the breadth of action being taken to address this issue differs widely, with some reporting explicit comprehensive strategies and approaches, and others only reporting *ad hoc* initiatives. Some regions reported no explicit action at all. In most cases, the extent to which action is being taken at regional level is directly related to the extent to which health inequalities is prioritised at national level, although there are some exceptions. The text below outlines some of the measures that are being taken by regions that are part of the Joint Equity Action Regional network, focusing more on those initiatives that reflect an explicit and comprehensive approach to reducing health inequalities. It also highlights some of the tools, including Impact Assessment tools, which were mentioned in case study reports that are contributing to the reduction of health inequalities in regional settings. This report serves as an overview and only covers some of the information included in the full case study reports. For more details on any of the information presented in this report, please consult the relevant case study reports and summaries at [www.health-inequalities.eu](http://www.health-inequalities.eu).



## 2. National governance leading to regional policies to reduce health inequalities

The case studies from the United Kingdom (England, Scotland and Wales) as well as Finland describe comprehensive national strategies, mandated by central government, which stimulate regional strategies to address health inequalities. These case studies reflect cross-sectoral approaches to addressing health inequalities, both at national and regional level.

Scotland appears to have one of the most comprehensive, cross-sectoral approaches to reduce health inequalities, as the issue is reflected in government policies and programmes at national, regional and local levels. The structure for this is established by the government's National Performance Framework, which has five strategic objectives and aims to ensure that policies are developed and implemented in an integrated manner. These objectives are for a Scotland that is: wealthier and fairer, smarter, healthier, safer and stronger, and greener. The National Performance framework sets out 16 national outcomes, one of which is to "have tackled the significant inequalities in Scottish society", - including health inequalities. The *'Equally Well'* policy document focusses in particular on the issue of health inequalities and identifies priorities and principles that are key to reducing health inequalities. The government has selected local test sites to implement and assess innovative approaches, reflecting these priorities and principles at local level. Learning from the local test sites could then be more generally and widely applied across Scotland. An evaluation of the tests sites was published in 2011.

In the region of Fife, the main policy document is the Community Plan for 2011-2020, which aims for three high-level outcomes: reducing inequalities, increasing employment and tackling climate change. Since it began in 1999, strategic partnerships have been formed to lead on five key areas (economy, education and skills, environment, community safety and *health and well-being*.) The Fife *Health and Well-Being Alliance* was established to lead work on improving health and well-being and reducing health inequalities in Fife and to ensure that organisations work together and genuinely engage communities in doing this. It has a three year strategy, or *Health and Well-Being Plan* (2011 -2014, 3<sup>rd</sup> one) which has the overarching aim of reducing health inequalities. The Plan calls for work across three themes: supporting healthier lifestyles for individuals and families; creating and sustaining healthier places and communities; and changing the way organisations work. The Health and Well-Being Alliance also links with other partnerships addressing the wider determinants of health such as the Fife Housing Partnership and the Children in Fife Partnership. Funds from three areas (Fairer Scotland Fund, Health Improvement Fund, Choose Life Funding) are brought together for small projects which take forward some of the priorities of the Health and Well-Being Plan, amounting to approximately one million pounds. However, by far the largest resources to reduce health inequalities exist within mainstream services and their budgets across community planning partners and organisations. Fife is also a local test site in Scotland to implement and assess innovative approaches to reduce health inequalities that focus mainly on antisocial behaviour in relation to alcohol and underage drinking within a specific neighbourhood.



The Welsh Assembly government has, since it gained more devolved powers in 1999, also placed a strong emphasis on health inequalities. A **Strategy Action Plan to Reduce Inequalities in Health**, called **“Fairer Health Outcomes for All”** was published in March 2011. It sets out the vision and underlying principles to improve healthy life expectancy and to close the gap between each quintile of deprivation. Regions in Wales are required to design policies and initiatives to reduce health inequalities that are in line with national level policies. Many other policies at national and regional level also explicitly and implicitly address health inequalities. ‘Community First’ is a specific example of a community regeneration programme, raised in the Welsh regional case studies, that aims to involve many different actors and sectors to improve overall conditions and thereby reduce health inequalities in the most deprived parts of the country.

The case study from the Aneurin Bevan region in Wales states that awareness among politicians about health inequalities varies. While understanding of the relationship between the wider determinants of health and health inequalities has increased in all areas over recent years, local governments are at different stages of maturity in addressing inequalities. Since 2003, regional Health Boards and local governments have been required to co-operate to develop various local partnerships and strategic plans aimed at improving health and well-being. These plans are expected to reflect local priorities and issues. The Welsh Government sets performance targets that Health Boards must meet, some of which may be relevant to health equity. The Aneurin Bevan Health Board recently set up an internal **Public Health Committee**, which will focus on health improvement and health equity based on a local Public Health Strategic Framework. In the region of Cwm Taf’s health inequalities is a key local priority within all local strategies and action plans including the **Health, Social Care & Wellbeing (HSCWB) Strategies**, which are statutory plans developed in partnership by the local authorities and Cwm Taf Local Health Board, together with partners including the third sector, private sectors and Public Health Wales.

England has a long history of addressing the issue of health inequalities in comprehensive, cross-sectoral manner. The current national context for tackling health inequalities is set out in the Coalition Government’s national policy paper **“Healthy Lives, Healthy People”** (2011). This was informed by the Marmot Review **“Fair Society Healthy Lives”** (2009) and illustrates the link between poverty and health inequalities and the importance of the wider determinants of health. In England, the national government sets the themes for health and health improvement policy, whilst regional and local government put these into practice. All regions in England are required to develop a **Health Inequalities Strategy**. Local level authorities are then required to develop **Joint Strategic Needs Assessment (JSNA)** which focuses on its geographical area’s particular needs as defined by the local authority’s priorities which should include the needs of the local population, and makes recommendations for local policy and practice. This approach aims to marry the strategic drivers from national government with the local needs of the population.

Finland is the only other country represented by the Joint Equity Action Regional Network outside of the UK which follows the model whereby national government sets the strategic drivers around health and health equity and monitors actions and outcomes, but leaves it up to the regional and local levels to develop and implement actions that address the specific needs of the localities,





based on analyses of local data. One of the goals of the Finnish 2015 Public Health programme (Ministry of Social Affairs and Health 2001) is to reduce health inequalities and to increase the number of healthy life years. The Ministry of Social Affairs and Health requires Regional State Administrative Agencies to draw up plans that outline how they aim to promote health. Since the Primary Health Care Act of 2006 emphasised the importance of promoting the health and well-being of the least well-off population and on reducing inequalities, this has become the focus of the regional plans.

**A National Action Plan for Reducing Health Inequalities (2008 -2011)** has also been developed to achieve the national goal of reducing health inequalities. **The project for reducing socio-economic health inequalities in Finland (TEROKA)** played an important role in the development and implementation of this National Action Plan. In a first stage (2004-6), the TEROKA project collected information on national health inequalities and applied this to raise public awareness. The project then focused on co-operation with the Kainuua and North Ostrobothnia regions and the city of Turku, which served as tests sites to identify how health inequalities can be addressed in practice (2006-2008). This included the development of two comprehensive reports on health inequalities in the two regions, as well as guidelines on how these should be addressed<sup>1</sup>. It also included the establishment of multi-sectoral **Health and Well-Being groups** at the supra-regional as well as at the regional and municipal level. These groups brought together all actors responsible for promoting health and well-being at these different levels. They were given the statutory task of processing and considering information on socio-economic differences in health and, on the basis of this information, engaging in cross-sectoral co-operation for health. The role of the Health and Well-Being group at the supra-national (State Authority) level is to advise and supervise the work of the regional and municipal level groups and to facilitate exchange of experience and learning on how to improve well-being amongst the least well-off and reduce health inequalities.

In Italy, there are no comprehensive national or regional-level strategies relating to health inequalities, but recent developments suggest that this may change. The Italian State-Regions Conference is a body where the State and Regions discuss and negotiate which level is responsible for managing what in the field of e.g. health care. In March 2012, the Conference's Health Commission established an **interregional working group on social determinants of health** that has been tasked with developing recommendations in this area as well as a comprehensive strategy to reduce health inequalities in Italian regions.

---

<sup>1</sup> See following abstracts in English:

*Socioeconomic health inequalities and their reduction in Kainuu*

[http://www.ktl.fi/attachments/suomi/julkaisut/julkaisusarja\\_b/2008/2008b27.pdf](http://www.ktl.fi/attachments/suomi/julkaisut/julkaisusarja_b/2008/2008b27.pdf). *Socioeconomic health inequalities in Northern Ostrobothnia*

<http://www.thl.fi/thl-client/pdfs/c9991933-db64-47f4-87e5-989edc0853f3>



### **Data and Monitoring**

Only a few regions indicate that they systematically measure health inequalities. Unsurprisingly, the EU Member States and regions with comprehensive action on health inequalities are also those that appear to have comparatively good data relating to this. They also have innovative data collection and dissemination approaches, as illustrated in the examples below drawn from the case studies.

- In England, the **Health Inequalities Intervention Tool** provides information on life expectancy by local authority, and enables the comparison between the gap in life expectancy of the general population and of those living within the most deprived quintile of each local authority. The tool is able to estimate the effect of certain interventions on the life expectancy of defined populations.
- In the North West region of England **innovative methodologies to track health inequalities** have been introduced using **near real-time mortality data**. The Office for National Statistics (ONS) provides real time mortality data at local authority level on provisional deaths counts in most recent months.
- East of England Region's Public Health Observatory uses a "**Fingertips tool**" that presents data relating to key indicators to measure health inequalities.
- Scotland has a tradition of collecting, analysing and making available a range of information to understand health inequalities and has established long-term indicators of health inequalities that are updated annually. The region of Fife has developed the "**Know-Fife data set**" that provides information relating to health and health inequalities at neighborhood level to the public.
- In Finland, a **new Health Care Act** that entered into force on 1 May 2011 **requires local authorities to monitor the health of the population** in their municipalities by population group, including socio-economic groups. Local authorities are required to prepare a wellbeing report once in every electoral period.
- The case study from Greece reported that there were plans to establish a Health Inequalities Observatory using EU funds.

While data is important to instigate action on health inequalities, it will not, in and of itself, lead to action. In the region of Brussels, for example, data on health inequalities has been available since 1999, but this has not provided the impulse for strong co-ordinated action on the issue. The Finnish case studies also stress that data is not enough; it is a tool that must be actively used to generate discussion and action around the issue of health inequalities.



### 3. Regional initiatives

In other countries taking part in the Joint Equity Action Regional Network, national governments may mention health inequalities in their Public Health and other policy documents, but they are not taking actions to encourage co-ordinated actions at national or regional level. Some regions in these countries are nevertheless taking their own initiatives in this field.

In Sweden, for example, the overall objective of the National Public Health Policy (2004) is to “create the social conditions for good health on equal terms for the entire population” (thereby targeting all political areas). In recent years however, the national government has placed emphasis on individual responsibility to improve health-related behaviour rather than on the underlying structural factors that may contribute to poor health. The regions and municipalities in Sweden have a high level of self-determination and are governed by officials who are directly elected every four years. The region of Västra Götaland has, accordingly, developed an overriding policy document setting out the long term strategy of the region, entitled ***Vision Västra Götaland – A Good Life***. It involves municipalities, the voluntary sector, colleges/universities as well as trade and industry. One of the Vision’s five focus areas is “good health”. The region’s public health policy guides the work in this area and contains six challenges, the first one of which is creating the conditions for equal and equitable living conditions. In the 2011 budget, the Regional Council therefore commissioned the Regional Executive Board to prepare an **Action Plan for Health Equity** throughout Västra Götaland. Different parties such as municipalities, employment agencies and trade union confederations and organisations like the County Council and NGOs have been invited to participate in the development of the Action Plan. The action plan focusses on childhood conditions, work participation and ageing with quality of life with the two cross-cutting themes life-long learning and good living habits. Those involved are currently taking part in a process of identifying what kinds of measures they can take that can contribute to the reduction of health inequalities, and how these can be achieved. The Public Health Committee has responsibility for co-ordinating the development of the Action Plan, and must report to the Regional Executive Board by the turn of the year 2012/2013.

Similar to the situation in Sweden, while Public Health Policy documents in Italy and Belgium make reference to health inequalities, there are currently no comprehensive national or regional-level strategies and no pressure from the national level to take action on the issue. As in Sweden, there are however regions that have a high level of autonomy when it comes to health and social policy and have or would like to take action themselves. The region of Piedmont in Italy, for example, passed a law that charged local health units with establishing levels of health inequalities in their populations and with analysing the health needs of the population. Local health units were also charged with supporting municipal mayors to develop and implement local policies (also those external to the health sector) that would improve general health and reduce health inequalities. However, the law is not considered a ‘success’ since it has proven difficult to engage those sectors that can contribute to making an impact.



According to the case study reports from the three Belgian regions (Flanders, Brussels, Wallonia) neither the federal level nor any of the regions currently take a systematic approach to addressing health inequalities, although integrated approaches do exist that aim to reduce poverty and social exclusion. Nevertheless, the Flemish case study report does highlight a conference on 'Reducing health inequalities from a regional perspective: what works, what doesn't work?' which took place in the context of the Belgian Presidency of the EU (Nov 2011). This included a 'Flemish afternoon' that enabled stakeholders to discuss the situation in Flanders. The authors of the report believe the outcomes of the Conference can serve to inspire future work on health inequalities in Flanders. The Flemish report states that Flanders - and particularly its Agency for Care and Health (VAZG) - would like to improve co-operation in policy planning between the regional and local levels to ensure that health inequalities become more of a cross-cutting policy theme in as well as outside of health. This would, amongst other things, contribute to the achievement of the Flemish health targets (which do not explicitly include health inequalities.) By 2014, all municipalities and cities in Flanders must become more transparent *vis-à-vis* other levels of government regarding priorities and how they will be achieved. This can provide an opportunity to ensure that municipalities and cities take health and health inequalities into consideration in a more systematic fashion when setting these priorities.

## 4. Examples of practice

Some case studies from regions mentioned above with comprehensive approaches to reducing health inequalities focus on specific practices taking place within these frameworks that can help achieve broader national and regional targets. These mostly centre on initiatives to ensure access and prevent and promote the health of socially vulnerable groups. The case study from the Aneurin Bevan region in Wales for example focuses on practices that aim to improve Heart Health and reduce obesity amongst at-risk groups, and to prevent smoking amongst young people. The practice in the East of England aims to ensure that the National Health Services smoking services are targeted at the most deprived fifth of the population, where the prevalence of smoking is known to be the highest, so that the proportion of those giving up smoking in the most deprived areas is comparable with those living in less deprived areas. The initiative has led to insights into what is most likely to succeed in targeting this segment of the population, and also resulted in improved data collection and monitoring systems.

The practice from the North West of England, Drink Wise North West (DWNW), aims to reduce alcohol-related hospital admissions by 5 per cent in two years. This is a significant challenge, given that these have increased by 73 per cent over the past seven years, and are thereby contributing to widening health and inequalities in the region. This aim is being achieved through a Large Scale Change (LSC) approach. This requires all those that are part of the project team, involving key stakeholders from the public sector services including NHS, social care and housing as well as local authorities, the police, and the voluntary sector to organise themselves very differently. The LSC model draws on the best international practice from the private, public and voluntary sector, and



uses tools and techniques which support creating and maintaining momentum by framing and engaging people and partnership to deliver ‘lots and lots’ of pragmatic changes in systems, process and behaviours in an emergent way. No steering groups were set up – instead the team committed to fortnightly hour-long telephone conferences and worked on plans of varying length (e.g. 30/60/90 days) rather than producing a detailed one- or five-year strategy. An evaluation of project implementation was carried out in September 2011 and reported positive results, with 24 Primary Care Trusts across the North West region at varying stages of implementation. The expectation is that the project will continue to gain momentum as it is an “invest to save model”, which is attractive in the current economic context.

The case study region of North Ostrobothnia in Finland looks at approaches to address underlying determinants of health inequalities and provides information on, amongst other things, the MOPO project. This project identifies young men at risk of social exclusion through military service call-up examinations, and provides them with services to help them engage socially and in the labour force through on-site or virtual (e.g. social media sites) guidance counselling as well as the provision of physical activity training sessions.

In Germany, there is no governmental strategy at national level to tackle health inequalities, although there are federal-level policies and action plans where health inequalities are explicitly mentioned or can be regarded as an implicit objective. It is very difficult to obtain data on health inequalities across Germany, since data cannot be collected and correlated at the individual level e.g. on the basis of attestations on the causes of death (e.g. health-related data matched to socio-economic data). But data from the national cohort study, the socio economic panel, are available, as well data on morbidity and risk behavior in the frame of the national health reporting of the Robert-Koch-Institute. It is also possible to correlate health and socio-economic data at the more generalised community level. As the case studies from the Hamburg and Lower Saxony region reveal, the data that is available suggests increasing levels of social inequalities. Such trends have stimulated actors from different sectors e.g. the health, city development and environment and education sectors to work together to improve the situation.

The case studies from Hamburg and Lower Saxony in this respect describe comprehensive programmes that are being implemented to coordinate initiatives to promote health and reduce health inequalities at regional and municipal level. Lurup is for example a heterogeneous district located in the Western part of Hamburg with poor social conditions. Here, a Health Promotion Centre has been set up to provide relevant organisations with advice and support, also relating to the financing and planning of projects, on health promotion for socially disadvantaged groups. The Centre is jointly managed by the Hamburg Office for Health and Consumer Protection and the Techniker health insurance company (TK). “Lenzgesund” (Lenz-health) is another programme being implemented in the socially disadvantaged Lenz housing estate. The programme aims to coordinate the activities of all actors and institutions involved in the provision of pre and post natal health care in the area as well as other health promotion and prevention activities linked to e.g. immunisations, dental care, nutrition and exercise.



In the Lower Saxony region, the Association for Health Promotion and Academy for Social Medicine (LVG & AFS) is one of the organisations active in efforts to reduce health inequalities in the region. In 2008 the LVG & AFS for example established a department that focusses on “Migration and Health”. The department aims to improve the health of migrants in the region through e.g. the establishment of an internet platform, cultural competence trainings for medical professionals and the provision of information, advice and support to institutions wishing to become more migrant friendly.

Many of the case studies report on more *ad hoc* initiatives to ensure health-care or prevent ill health and promote good health amongst (vulnerable) populations, as examples of what their regions are doing to address health inequalities. While national government in Poland aims to adopt a social determinants approach to improving health and reducing health inequalities, the regional case study reports from the regions of Lubuskie and Opolskie suggest that this is not being translated into practice at regional level. The reports focus on health promotion and prevention activities such as cancer screening programmes, provision of dental care to children and young people, school nutrition programmes as well as the development of playgrounds.

The case studies from Veneto and Tuscany also highlight healthcare related initiatives (cancer screenings services and the implementation of a chronic care model, respectively) to improve health. The Case Studies from the Latvian regions of Saldus and Valmiera focus on the implementation of the Social Security Network Strategy, which aims to ensure that people with very few resources can get access to health care. The Wallonian (Belgium) regional case study also focuses on a programme to help people in unstable situations re-integrate into the mainstream health system. The Olomouc region in the Czech Republic, which is according to the case study report “one of the most equal countries in the EU” and where there is subsequently very little action on health inequalities at national and regional level, describes health promotion programmes to improve awareness of HIV Aids and reduce back problems amongst school children. The case study from the region of Kafallonia in Greece outlines a programme that provides homecare services to elderly people at risk of social exclusion.

## 5. Tools, evidence and evaluation

Mention is made across the case studies of specific tools that national and regional governments are applying that can contribute to a reduction of health inequalities. These relate to: health impact assessment; evaluation; databases with good practice and evidence; networks and information on the cost/benefits of health inequalities.

### **Health Impact Assessment**

Perhaps the most important of these tools are those which aims to assess the potential impact of policy measures on health inequalities and socio-economic gradients in health prior to implementation (*ex-ante* HIIA), or those that measure the impact of policies or measures after



implementation. The Fife case study indicates that Health Inequalities Impact Assessment tools are also being developed at national level. Fife applies Integrated Impact Assessments (IIA) as part of efforts to improve local policy and practice, and this is well supported through training and facilitation. However, the report states that Equality Impact Assessments tend to be used more frequently, due to the legislative requirements around them.

A number of partners indicated that the more *ad hoc* use of impact assessments that differentiate across population groups is on the rise. The case study from Kainuu, Finland, for example, indicates that the HIA+ procedure, or *ex ante* evaluation, is applied in the region, making it possible to take the health inequalities angle into account at the decision-making preparation stage. The case study from the region of London also reported on what could be considered an *ex ante* evaluation of how to ensure that the legacy of the London Olympic games, which took place in East and South-East London, continue to serve as a catalyst to revitalise this relatively more deprived part of London. There is no guarantee that effects of the investments made in the area during the Olympic Games will be sustained in ways that can also lead to a reduction of health inequalities in the area. NHS Public Health specialists and local government planning policy officers therefore reviewed the best evidence to develop a report on “Healthy Urban Planning in Practice for the Olympic Legacy Masterplan Framework”, which was published in 2011. A set of recommendations were developed as a result of this review, on integrating health and well-being assessments into the Legacy Masterplan Framework planning application.

The case study reports from the Emilia Romagna region and the Veneto region also on focus on *post-facto* Health Impact Assessments. In the Emilia Romagna region this was of a waste incinerator site, and its impact on different socio-economic groups in the area, while in the Veneto region this was on the uptake of publicly provided cancer screening tests. Such assessments can determine whether population groups with low socio-economic status are particularly vulnerable to certain risks, and/or whether certain interventions are effectively reaching them – and can thereby contribute to a reduction in health inequalities. The Flemish case study report focuses on the Song Scan Instrument that was commissioned by the regional Agency for Care and Health. It was used to assess a campaign to raise awareness about prevention of hearing disability with younger people due to the exposure to high noise levels at e.g. concerts. The tool was like a *post-facto* HIA in that it aimed to capture differentials in impacts of the campaign across socio-economic groups. Some of the interviewees claimed that the Song Scan was not practical enough to be mainstreamed, although it did raise awareness and instigate reflection about the differential effect of this measure across the social gradient.

### **Evaluation**

In addition to a more systematic application of assessments that take into account the potential or actual impact of specific measures on health across different population groups, another way to assess whether interventions are effective in reducing health inequalities is by ensuring that they are evaluated. In many countries, it may for a range of reasons (data availability, time) be very difficult to assess whether specific initiatives contribute to a reduction in health inequalities. As the



case study from the region of Brussels, which focusses on “a realist evaluation of projects that aim to reduce health inequalities amongst young adults”, innovative evaluation methods also make it possible to get a good idea of the effectiveness of projects and how they can be improved.

### **Databases with good practice and evidence**

A number of case studies also raise the importance of sharing information regarding what works to reduce health inequalities, in order to maintain and inspire action. Some case studies mention databases, such as the Health Equity database in Wales that capture some of the most recent initiatives in Wales that focus on health inequalities. In Germany too, a comprehensive internet portal on tackling health inequalities, which includes a database of good practice projects was established as part of the nation-wide "Cooperation Network on Health Equity" (see below) ([www.gesundheitliche-chancengleichheit.de](http://www.gesundheitliche-chancengleichheit.de)). The Flemish case study also mentions a database on inter-sectoral approaches for health (VIGEZ), which does not exclusively focus on tackling health inequalities, but it is useable for this purpose (<http://www.gezondeinspiratie.be>). This case study indicates that it would be useful to develop a handbook for the local level on tackling health inequalities. The comprehensive publications published in the Kanuu and North Ostrobothnia regions Finland, as part of the TEROKA project, serve as good examples of this (see Footnote 1).

The Finnish case studies also mention the TEAviisari service, which measures activity in health promotion (THL 2012) and supports the planning and evaluation of health promotion measures. The tool can be used to analyse differences between municipalities in regions and to compare regional results with those of other similar regions.

### **Networks**

Another initiative mentioned in some case studies in order to exchange knowledge and learning about how to reduce health inequalities at regional and municipal level is the formation of networks within countries. In Sweden, the Swedish Association of Local Authorities and Regions (SALAR) is co-ordinating a network on “Joint Action for Social Sustainability – Reduce Differences in Health”, which brings together 21 parties from regions, county councils and municipalities.

As mentioned earlier in this report, in Italy too, the Health Commission of the Conference of the Italian Regions committed to “setting up a technical working group made up of representatives of the Regions and of the Ministry of Health in order to respond to the 2009 Communication from the Commission “Solidarity in Health: Reducing Health Inequalities in the EU”. An interregional working group has been set up that is co-ordinated by the Piemonte Region.

In Germany, a federal “Cooperation Network on Health Equity” initiated in 2003 and mainly funded by the Federal Centre for Health Education (BZgA). Lower Saxony Regional Centre and the Hamburg Association for Health Promotion are part the Cooperation Network, which serves as a platform that brings together more than 50 partner organisations and stakeholders committed to tackling health inequalities.





### ***Economic costs of health inequalities and benefits of reducing them***

Another crucial tool mentioned in some case study reports to stimulate health as well as non-health actors to engage in efforts to reduce health inequalities is to identify the costs of health inequalities and to demonstrate the cost-benefits of taking action. In the East of England, for example, information supporting the economic argument for addressing health inequalities in smoking populations in the region was addressed in a report and modelling tool that was commissioned and used to inform work on smoking cessation within the region. The NHS Alcohol Challenge in the North West Region also led to the development of a business case called the 'Case for Change'. It focused on interventions that could be implemented to achieve the greatest gains. The business case showed that for every £1 of investment in the initiative would lead to savings of £3, with the potential to save the NHS £36 million in two years. The case study from Västra Götaland also indicates that the region commissioned a report on "Estimates of the social costs of socio-economic inequality in health". The report concludes that health inequalities in Västra Götaland per year "result in approximately 1,600 'premature' deaths, approximately 27,000 lost years of life, production losses equating to SEK 2.2 billion and a loss in health equating to SEK 13.9 billion."<sup>2</sup>

## 6. Conclusions

The case studies of the Joint Equity Action Regional Network provide examples of comprehensive action to address health inequalities, as well as *ad hoc* initiatives. It is clear from the case studies that making real inroads in reducing health inequalities requires commitment across governments and sectors, that must work together to change their approaches to ensure that policies and practices improve conditions for the more and most-deprived segments of the population, and don't exacerbate inequalities, including health inequalities. In some countries and regions, the challenge still lies in getting the issue of health inequalities onto the political agenda, in others it lies in getting all relevant actors on-board. Overall, the Joint Equity Action case study reports demonstrate that in many regions the issue is getting at least some attention, reflecting that there is potential for progress.

Yet it is also evident from the case studies that efforts to address health inequalities are mainly being led by public health/health promotion actors at the national and regional level, who must instigate collaboration with other sectors. The difficulty lies primarily in engaging those sectors and actors that can make 'hard' impact on the reduction of health inequalities, and in attributing changes in levels of health inequalities to any specific policies. A number of case studies reflect the challenges involved. In the region of Kainuu and North Ostrobothnia in Finland, the Health and Well-Being Groups established at local level did not initially incorporate the social sector, let alone

---

2

<http://www.vgregion.se/upload/Folkh%c3%a4lsa/j%c3%a4mlik%20h%c3%a4lsa/SlutrapportOj%c3%a4mlikhetkostnadeVGR.pdf>



other non-health sectors, limiting the potential impact of these groups. The case study from Cwm Taf region in Wales focusses on overcoming the difficulties in collaborations between the voluntary and statutory sectors, suggesting that there are similar challenges to address when different sectors work together. The Flemish case study report notes that: “including the social gradient in health in policy development depends mostly on the willingness of the areas outside the health sector”. It also states that inter-sectoral cooperation on the issue is difficult, since it entails financial and budgetary questions. This is verified by the case study on the development of the “Olympic Masterplan Framework” in the region of London, where there is little evidence that other relevant actors and sectors will act upon the findings of this report. The report from the Italian region of Piedmont, where a law was developed that charged local health authorities with carrying out local policies to improve general health and reduce health inequalities, is perhaps most explicit about the challenges that this poses. It states that the law has not proved to be very successful as “many local policies with a big impact on health and on health inequalities often tend to avoid dialogue and co-operation with social and equity-related issues”.

While it is easy to get discouraged by such examples, the positive note is that they represent evidence that action is being taken and that lessons are being learnt. It is crucial to build on the momentum generated by these actions and to persevere and build on these lessons as Wales is, for example, doing through the Community First regeneration programme. Rigorous evaluations of this large-scale national programme (with expenditures of 40 million Euros across Wales) led to the conclusion that it has led to some commendable outcomes, such as a better engagement of residents leading to better community planning processes. Yet the programme also received criticism that it was not achieving value for money, since it wasn't making 'hard' impacts on e.g. worklessness, health and educational attainment. As of April 2012, Community First has therefore been adapted into a 'Community Focused Programme' that is taking place in fewer and bigger areas, known as clusters. Community-supported actions will work alongside other programmes to narrow education, skills, economic and health equity gaps between the most deprived and the more affluent areas of Wales. The programme is being guided by a National Outcomes Framework and supported by a Delivery Plan. The aim is that it will thereby achieve the hard outcomes that are ultimately needed to reduce health inequalities in the cluster areas.

Embedding health inequalities in governance and policy structures and engaging and working alongside other 'hard' sectors to generate the changes required to address underlying determinants of health is certainly not an easy task. Identifying and expressing the outcomes and results of policies and initiatives that can reduce health inequalities is also very difficult. Yet these approaches are key to achieving reductions in health inequalities. There is much evidence to suggest that reducing health inequalities is in everybody's interest. The health community must continue to take responsibility for communicating this message as widely and effectively as possible in order to embed the issue in national, regional and local level governance and policy processes and to engage other actors and sectors. Sharing learning across regions and building on experiences such as those outlined in this report and reflected in the full case studies by members of the Joint Equity Action Regional Network is an important part of this process. As the case studies reveal,



initiatives are in place that can inspire further learning and action, and there is much potential for development and change.