



# The equity action spectrum: taking a comprehensive approach

Guidance for addressing inequities in health







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## Abstract

This guidance aims to support European policy-makers to improve the design and implementation of policies to reduce inequities in health. It brings together current evidence on how to develop comprehensive policy action plans to identify and address social determinants of health inequities. While great improvements have been made in health across the WHO European Region, there are still striking contrasts in the standards of health enjoyed by different countries within the Region and by different population groups within these countries. Reducing health inequities and improving governance for health and health equity are key strategic objectives of Health 2020 – the European policy framework for health and well-being endorsed by the 53 Member States of the WHO European Region in 2012. This guide seeks to assist European policy-makers in contributing to achieving the objectives of Health 2020 in a practical way. It draws on key evidence, including from the WHO Regional Office for Europe's *Review of social determinants and the health divide in the WHO European Region*. It also provides a framework that policy-makers at national, regional and local levels can apply to their own unique context, in order to consider the processes by which inequities might occur, and to suggest policy interventions that may be helpful in addressing these factors.

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## Foreword

Overall population health indicators have improved across Europe over recent decades, yet that improvement has not been experienced equally everywhere, or by all. There are widespread inequities in health between and within societies, reflecting the different conditions in which people live. These health inequities offend against the human right to health and are unnecessary and unjust.

Health 2020 is a new value- and evidence-based health policy framework for Europe, supporting action across government and society to promote health and well-being, the reduction of health inequities and the pursuit of people-centred health systems. It was adopted at the 62nd session of the Regional Committee held in Malta in September 2012. Its commitment is to health and well-being as a vital human right, essential to human, social and economic development and a sustainable and equitable Europe. Health is a fundamental resource for the lives of people, families and communities.

To make this vision a reality we need to tackle the root causes of health inequities within and between countries. We know more about these now from the 2013 report of the European review of social determinants of health and the health divide, led by Professor Sir Michael Marmot and his team at the University College London Institute of Health Equity. Yet opportunities to be healthy are far from being equally distributed in our countries, and are closely linked to good upbringing and education, decent work, housing and income support throughout our life course. Today's disease burden is rooted in how we address these social factors that shape current patterns of ill health and lifestyles, and in the way our resources are distributed and utilized.

For these reasons I welcome the publication of this series of policy briefs, which describe practical actions to address health inequities, especially in relation to priority public health challenges facing Europe: tobacco, alcohol, obesity and injury. I hope this series will offer policy-makers and public health professionals the tools and guidance they need to implement the Health 2020 vision and the recommendations of the social determinants review. The policy briefs were prepared in collaboration with the European Union and I would like to express my gratitude for this support and for the recognition that the European Union and WHO both share this common commitment to addressing equity.

Achieving the promise of Health 2020 will depend on successful implementation of the relevant policies within countries. We can and must seize new opportunities to enhance the health and well-being of all. We have an opportunity to promote effective practices and policy innovations among those working to improve health outcomes. The present (often extreme) health inequities across our Region must be tackled and the health gap among and within our European Member States reduced.

**Zsuzsanna Jakab** WHO Regional Director for Europe





# Introduction

## Purpose of this guidance

This guidance aims to support European policy-makers to improve the design and implementation of policies to reduce inequities in health. It brings together current evidence on how to develop comprehensive policy action plans to identify and address social determinants of health inequities.

While great improvements have been made in health across the WHO European Region, there are still striking contrasts in the standards of health enjoyed by different countries within the Region and by different population groups within these countries.

The Region includes countries with some of the best health and narrowest health inequalities in the world. Health gains in these countries have come from sustained periods of improvements in living conditions, including the provision of comprehensive welfare systems, and high-quality education and health services.

Not all countries in the Region have enjoyed such gains, however, and differences in social and economic development are reflected in the health inequities that can be seen both between and within countries. Furthermore, there is evidence that even in the more affluent countries in the Region health inequities are increasing and the economic crisis since 2008 has exacerbated this trend.

## Using this guide

This guide provides a framework that policy-makers at national, regional and local levels can apply to their own unique context, in order to consider the processes by which inequities might occur, and to suggest policy interventions that may be helpful in addressing each of these factors. Additional resources are listed at the end of the guide to direct policy-makers to further evidence, promising practices and tools to support policy formulation and evaluation.

## New policy approaches for the European context

Reducing health inequities and improving governance for health and health equity are key strategic objectives of Health 2020 – the European policy framework for health and well-being endorsed by the 53 Member States of the WHO European Region in 2012. Health 2020 strongly emphasizes the need to strengthen population-based prevention and accelerate action across levels of government on the social determinants of health (SDH).

The European Commission adopted a communication entitled “Solidarity in health: reducing health inequalities in the EU” in 2009 (1) and the importance of addressing health inequalities is clearly stated in the European Union (EU) Health Strategy (2). The Second European Summit on Roma Inclusion in 2010 highlighted the significant health inequities experienced by Roma, and the subsequent EU Framework for National Roma Integration Strategies includes reducing the gap in health status between Roma and the rest of the population.

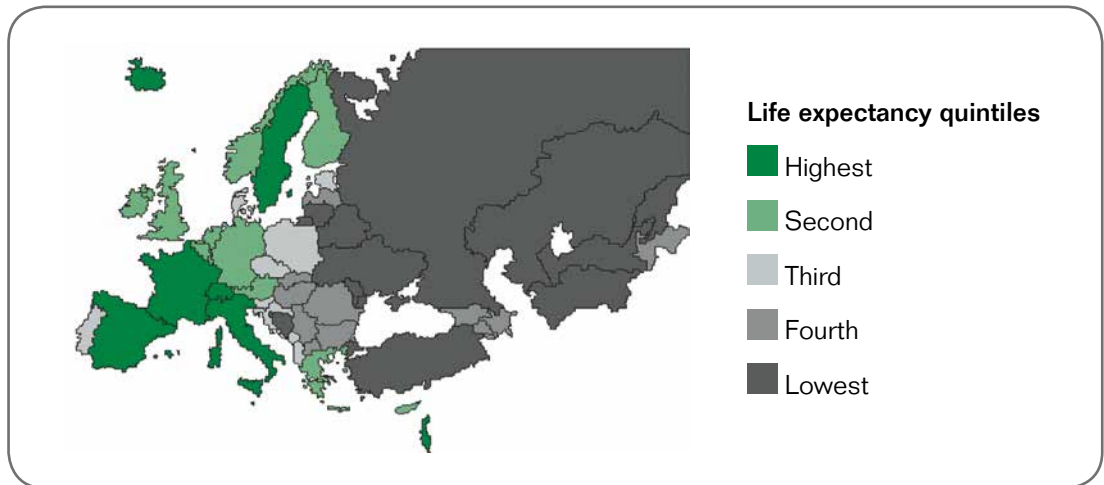
The 2013 *Review of social determinants and the health divide in the WHO European Region* (3) highlights the importance of the following issues.

- **Human rights** are central to the approach taken in European countries to improve SDH and health equity. All WHO European Region Member States have committed to protecting the right to health through their commitment to the WHO Constitution and most have also signed at least one convention on human rights. It is the responsibility of governments to ensure that all individuals have the resources they need to be as healthy as possible and to be able to live a life that they value.
- **Joint action** is also essential on social determinants, social cohesion and sustainable development. Many SDH lie outside of the direct influence of the health sector, which means that action to improve health equity requires collaboration and partnerships between the health sector and other sectors, including national and international organizations, national and local governments, and communities and vulnerable groups.
- **Protection of the gains already made** should be provided. Europe has led the world in developing fair and just systems that promote health. The economic crisis challenges us to protect the gains that we have made in developing equitable systems.

## Health inequities in Europe

Fig. 1 shows the extent to which health varies between the countries in the WHO European Region; that is, the so-called health divide. The gap in life expectancy between the highest and the lowest countries is 17 years for men and 12 years for women.

Fig. 1. Life expectancy in countries of the WHO European Region, 2010

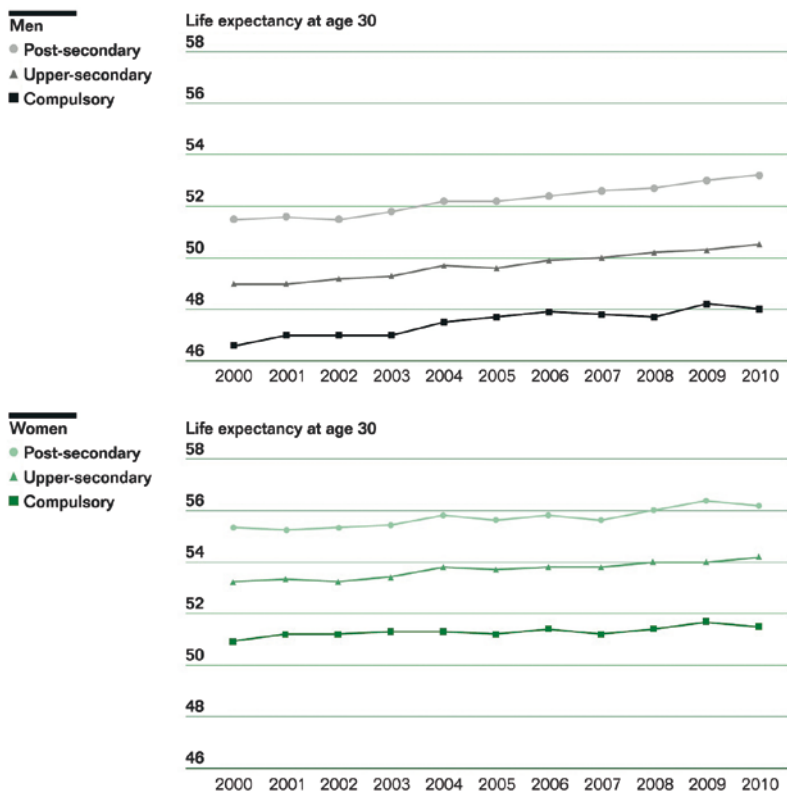


Source: WHO Regional Office for Europe (3).

Differences in health between socioeconomic groups within countries exist in all parts of the WHO European Region, including those countries in which overall levels of health are relatively high, such as Sweden (Fig. 2). This is known as the social gradient in health, whereby health outcomes improve as socioeconomic status improves, rather than a pattern of ill-health concentrated in the most disadvantaged groups while the rest of society enjoys relatively good health.

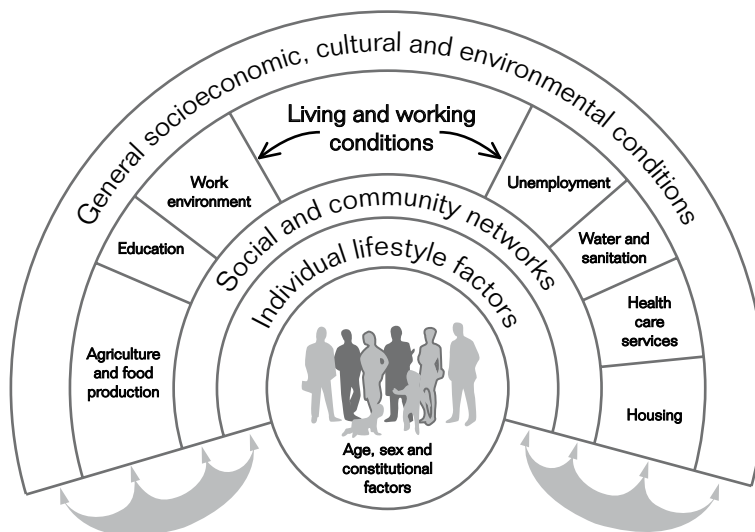
Health inequities are defined as systematic differences in health that can be avoided by appropriate policy intervention and that are therefore deemed to be unfair and unjust. To be able to devise effective action, we first need to understand the causes of these inequities in health. Health inequities are not solely related to access to health care services; there are many other determinants related to living and working conditions, as well as the overall macro-policies prevailing in a country or region (Fig. 3). Inequities in health are caused by the unequal distribution of these determinants of health, including power, income, goods and services, poor and unequal living conditions, and the differences in health-damaging behaviours that these wider determinants produce.

Fig. 2. Life expectancy at age 30 in Sweden, by educational level and sex, 2000–2010



Source: WHO Regional Office for Europe (3).

Fig. 3. The main determinants of health



Source: Dahlgren & Whitehead (4).

## Developing a comprehensive approach and action plan

The many SDH, spanning different policy sectors – along with the way they interact to produce health inequities – mean that a coordinated and multifaceted approach across sectors is needed to deal with these inequities.

Key stages are essential to build the necessary comprehensive approach, whether at national, regional or local levels. Such steps include:

1. securing political commitment and cooperation from many sectors;
2. assessing the extent of the problem, identifying gaps in information and considering the possible points of intervention for a strategy to implement the policy, along with the barriers to action at those points;
3. weighing up the best organizational arrangements and financial requirements and designating responsibility and resources for dealing with these;
4. drawing up action plans at all levels that specify what actions will be taken, by whom, what budget is to be allocated, and what output is expected.

In reality, this process is not simple or linear, and requires attention to be paid to the factors that enable the system to exist and/or function, summarized at the end of this policy brief in Table 1. A system of monitoring and evaluation is important to support all steps in this process, and that system needs to be able to measure inequities in health status, SDH, and service delivery, as well as identifying the differential impacts of policies and interventions.

### Securing political commitment and multisectoral cooperation

Political commitment is essential to substantiate actions, to encourage different sectors to work together towards a common goal and to ensure that efforts are sustained over the long term, as required. Ministries of health and the public health community have a key role to play to create and support a strong case for why improving equity and action on social determinants are priorities, not only for health but also for the attainment of other government/societal goals and aspirations. This can be achieved by:

- building and sustaining a strong case for health equity, connecting to broader governmental and societal goals (to stimulate debates in Parliament, at other levels of government, such as cabinet committees, and in the media);
- using joint assessment methods in partnership with other stakeholders within and outside of government, including local communities, to build support for and common understanding of problems and solutions to address inequities and improve health.

Policy in every sector of government can potentially affect health inequities. Although health may not be the explicit focus in many policy areas, unless the equity and health effects of policies and investments are considered, opportunities will be missed for

reducing inequities in health through action on social determinants. Strategies for strengthening joint action on health inequities (i) across sectoral portfolios and (ii) between local, regional and national governments include:

- implementing a formal cross-government framework (for example, a strategy), setting out explicit goals and policy actions of different sectors and levels of administration for reducing social inequities in health and development (and linked to ministerial portfolios and budgets nationally and locally);
- using existing or developing new legislation, regulation and memoranda of understanding to set and monitor the requirements of sectors across government in delivering agreed goals relating to equity and health;
- implementing joint accounting for results, including shared targets, joint review and reporting on progress;
- systematizing the use of structured impact assessments in order to better inform and evaluate policy and investment decisions on determinants of equity and health;
- introducing or scaling up financial and reward systems linked to team results, such as pooled and shared budgets;
- producing new or further strengthening existing guidance and support mechanisms which enable different stakeholders to implement necessary actions on social determinants and health equity. Information, evidence, guidance and training are important features of supportive systems that can facilitate action.

Box 1 details the requirements to secure commitment to and cooperation for an Action Plan for Health Equity, with the ultimate goal of reducing health inequities.

### **Box 1. Advice from Västra Götaland Region in Sweden on what is needed to secure commitment to and cooperation for an Action Plan for Health Equity**

- Set up a Commission, instigated by the Regional Council and reporting back to the Council, to draw up an action plan involving all the relevant council committees (public health, human rights, regional development committee, cultural affairs, health and medical care) and expert reference groups/regional networks.
- Develop decision forums and tools for facilitating the implementation of long-term initiatives; for example, tools for applying a social investment perspective to long-term measures.
- Make health equity a permanent area of policy responsibility in the Council.
- Ask the Commission's steering group to investigate ways in which the health equity policy area can be anchored at the highest decision-making level.
- Set up a permanent cross-sectoral working group, the main task of which is to coordinate measures for reducing inequities in health.
- Use "statements of intention" to demonstrate commitment and cooperation between the organizations that are responsible for carrying out different measures.
- Develop cooperation with actors at national and international levels.

Source: adapted from Region Västra Götaland (5).

## Assessing the problem and possible intervention points

Action plans need to be based on a thorough understanding of the unique set of circumstances in each country or district, which requires collection and review of available information on health inequities and their determinants, as well as the scope for action in a particular jurisdiction. This is best carried out as a joint diagnosis with other sectors and the community. The steps set out in the list below are essential to achieving this.

1. Set up an expert working group to provide an assessment from available information sources of the extent of the problem in a jurisdiction, including analysing health data at all levels by (at least) age, sex, and some measure of socioeconomic status or circumstances. Some countries may only have measures of the deprivation of an area, not data on each individual's socioeconomic circumstances, but that information can still provide valuable insights.
2. Assess the causes of health inequities, including asking the following questions.
  - Are there systematic differences in social and economic conditions that are contributing to health inequities? If so, which of these are amenable to action?
  - Are there systematic differences in living and working conditions that are contributing to health inequities? If so, which of these are amenable to action?
  - Are there systematic differences in health-related behaviours that are contributing to health inequities? If so, which of these are amenable to action?
  - Are there systematic differences in access to and quality of health services that are contributing to health inequities? If so, which of these are amenable to action?
  - Are there particular factors affecting certain population groups – minorities, people with disabilities, or other vulnerable groups – that are contributing to health inequities? If so, what are they and what can be done about them?
  - Are there factors affecting particular geographic areas that are contributing to health inequities? If so, what are they and what can be done about them?
3. Examine the collection of health information at all levels to see how it can be modified to record the most important socioeconomic variables (depending on which health inequities are identified as most significant in step 1). The list of additional tools, resources and examples at the end of this guide indicates where more detailed information can be found on how equity monitoring can be improved, even in basic health information systems.

Involving local people and communities improves the design and increases the impact of policies aimed at improving health and reducing social inequities. Specifically, emphasis should be placed on ensuring that the differential needs of marginalized and at-risk groups are recognized, and that they are involved in resource allocations as well as the design, monitoring and review of policies, services and interventions. There is often a lack of understanding of the social, cultural and economic lives of the resource-poor population when policies are being designed.

Practical ways to achieve this goal include:

- supporting local people and communities in order to build capacity to participate in local decision-making and develop solutions which inform policies and investments at local and national levels;
- strengthening the capacity of nongovernmental organizations (NGOs) and local authorities in their use of participatory planning methods which improve health and reduce social inequities;
- using tools and instruments to provide support at the local level in order to define local problems and solutions, informed by local data;
- public reporting on actions and progress in order to allow access to and debate on results and new challenges, by and with communities/third parties;
- making intelligence and data on health, equity and social determinants accessible within the public domain, both locally and nationally.

### **Deciding on optimum organizational and accountability arrangements**

Government has a crucial role to play in determining the conditions through which governance and implementation of action on the SDH and health inequity are achieved.

At regional, national and subnational levels, there are several strategies to improve organizational and accountability arrangements for action on health equity, listed here.

- Use existing or develop new legislation, regulation and memoranda of understanding to set the requirements of stakeholders in delivering agreed goals on equity and health (and monitor implementation of these requirements).
- Strengthen the capacity and remit of existing statutory governance bodies to hold all stakeholders to account. These bodies should have access to competent, appropriately trained public health scientists, be required to report on findings and have the authority to propose remedial action.
- Enhance the role of government and Ministry of Health policy units to collect and make available data on health, disaggregated by social and economic factors.
- Implement health intelligence systems that draw on and use a range of data sources to inform analysis reporting and implementation of action on social determinants, including household surveys, censuses, vital registrations (births, deaths), institution-based data (individual, service or resource records) and case studies.
- Specify agreements with the private sector (industry/commerce) on their contribution to delivering equity targets.
- Scale up and strengthen programmes supporting political, civic and professional leadership of SDH and equity at local and national levels.



## Drawing up a strategy and action plan

After consideration of the problem, its causes and policy options, a decision on a policy to tackle health inequities needs to be followed up with a strategy for putting the policy into effect, including a concrete action plan. There are several important principles on which a health equity strategy must be based, as listed in Box 2.

### Box 2. Principles for action to address SDH and health inequities

- Design policies that act across the whole social gradient in health, as well as addressing the most disadvantaged; these policies should be universal but with focus and intensity proportionate to need.
- Strive to bring the health of everyone up to levels achieved by the most advantaged.
- Address SDH; namely, the conditions in which people are born, grow, live, work and age. Work collaboratively across sectors and with communities.
- Take a life course approach.
- Tackle the processes creating exclusion, rather than focusing simply on the characteristics of excluded groups.
- Develop actions based on the resilience, capabilities and strengths of individuals and communities.
- Build capacity for action in organizations and empower individuals and communities to engage in decision-making.
- Pay attention to sustainable development and the impact of policy on future generations.

Source: adapted from WHO Regional Office for Europe (3).

Several European countries have now drawn up national strategies aimed at reducing social inequities in health, and regions and cities within countries are also starting to do so, tailoring the strategies to their own specific circumstances. The Norwegian national strategy, published in 2007 (6), is perhaps the most comprehensive to date, in terms of covering both universal and selective measures and focusing on the whole causal chain: upstream, midstream and downstream. This is illustrated in the Norwegian intervention map in Box 3.

The Spanish national strategy on health equity (7), illustrated in Box 4, emphasizes developing information systems, tools and knowledge for intersectoral work. It selects childhood and youth as the priority area of focus for a global plan, and proposes to develop a plan to promote the political visibility of the national strategy, bearing in mind the need to secure sustained political commitment.

The strategy also pays attention to the need for training and capacity building among managers and practitioners charged with the task of implementing the strategy. Box 5 illustrates the Spanish training programme aimed at reorienting managers to take an SDH perspective.

**Box 3. Norwegian national strategy to reduce social inequalities in health, 2007**

The Norwegian strategy is an example of a comprehensive national strategy, covering both universal and selective measures and focusing on the whole causal chain: upstream, midstream and downstream.

**Norwegian intervention map**

	<b>Social reform (Upstream)</b>	<b>Risk reduction (Midstream)</b>	<b>Effect reduction (Downstream)</b>
<b>Universal measures</b>	Public system for education, taxes, labour market policies	Working/living environment, structural lifestyle measures	Universal health services
<b>Selective measures</b>	Benefits	Targeted lifestyle measures	Targeted health services

Source: Poulsson Torgersen, cited in Povall et al. (8).

**Priority areas and policy instruments set out in the Norwegian national strategy to reduce social inequalities in health**

<b>Priority area</b>	<b>Examples of policy instruments/action</b>
1. Reduce social inequalities that contribute to inequalities in health	Promote fair income distribution through the tax systems; create of safe childhood conditions through preschools, schools and children’s services; invest to promote an inclusive labour market and healthier working environments.
2. Reduce social inequalities in health behaviour and use of health services	Use pricing and tax policies to regulate availability of healthy goods and services; carry out health promotion activities in schools and at the workplace; undertake surveys to map access to health services; implement user fees and financing mechanisms as possible tools to alter any inequitable patterns of access to services.
3. Target initiatives to promote social inclusion	Increase budgets to focus on excluded groups and deprived geographical areas; improve access to labour markets and adult education.
4. Develop knowledge and cross-sectoral tools	Set up monitoring systems and develop appropriate indicators for social determinants; develop expertise in health impact assessments; introduce annual reports.  Ensure all sectors (health and care, environment, local government and regional development) collaborate to keep social inequalities in health central to planning and are responsible for reporting on their indicators each year at the time of the national budget.

Source: adapted from Norwegian Ministry of Health and Care Services (6).

#### **Box 4. Spanish strategy on health equity and SDH**

- a) To develop health equity information systems to guide public policies:
  1. use the Health Equity National Monitoring Network
  2. carry out health impact assessment in public policies
  3. report on health inequalities in Spain.
- b) To promote and develop knowledge and tools for intersectoral work – moving forward to the concept of health and equity in all policies:
  4. create intersectoral bodies
  5. include specific objectives in health plans
  6. introduce training in health equity for health sector professionals
  7. implement actions to raise awareness of the importance of health inequalities.
- c) To develop a global plan for childhood and youth health, which protects equal opportunities for all children's development, regardless of their parents' conditions:
  8. ensure the provision of global support to childhood.
- d) Develop a plan to ensure political visibility of the national strategy on health equity and SDH.

*Source:* adapted from the Spanish national strategy on health equity (7).

#### **Drawing up an action plan**

A strategy by itself is not sufficient: an action plan is required to make things happen and to help people work together towards the common goal. An action plan, be it for a city, a region or a country, needs to set out:

- the priorities for action and why;
- the actions to be taken and by whom;
- the resources to be allocated to the actions;
- the expected outcomes or targets to aim for and over which timescales;
- the management and coordination structures;
- the monitoring and evaluation system that will be set up to track progress and learn from mistakes;
- the timetable for reporting back to the public and politicians on progress.

Box 6 illustrates these points, based on the contents of the English Programme for Action on Tackling Health Inequalities drawn up in 2003, designed to meet health inequalities targets by 2010.

**Box 5. Reorienting managers to take an SDH perspective: Spain**

The Spanish Ministry of Health, Social Services and Equality developed a training programme to raise awareness of SDH and health equity, to develop and strengthen capacity to assess the health equity impacts of health strategies and programmes, and to promote health in all policies. This training was offered to senior managers in the Ministry of Health, Social Services and Equality, regional health departments and at other key administrative levels in areas considered critical to the reduction of health inequities. The purpose was to “further re-orientate the health sector towards reducing health inequities, including moving towards universal health coverage that is accessible, affordable, and good quality for all” (9, p. 3).

The training involved:

- building theoretical understanding of health equity, SDH and programme evaluation cycles;
- building methodological capacity to carry out health equity impact assessments of public health programmes;
- producing a guide that brings together the methodology, background resources and experience of the training (10).

Three key lessons were learned from the use of this training in Spain.

1. It is helpful to take an approach that combines learning and action through a combination of teaching, self-directed learning, exercises, and group discussion and support – these lead to progressive learning about the SDH and health equity.
2. It is useful to make the working groups interdisciplinary and intersectoral and to encourage social participation – these are the ideal conditions for health equity reviews.
3. The process received a high level of political commitment, which facilitated the whole process and can help to ensure that a long-term and cross-cutting approach to equity is taken.

The authors note that even without this high-level support, training programmes like this may help to raise awareness of health equity and SDH, and to generate a critical mass of support that can lead to the reorientation of health policies away from the biomedical model and towards an SDH focus.

Source: Merino et al. (9) and the Spanish Ministry of Health, Social Services and Equity (10).

**Box 6. Example of specifications in an action plan to tackle health inequalities, England, 2003**

***Addressing the underlying determinants of health***

**Problem:** Child poverty

**Action and target:** Reduce the number of children in low-income households by a quarter by 2004/2005 from 1998/1999 as a contribution to the broader target of halving child poverty by 2010 and eradicating it by 2020

**Responsibility:** Treasury and Department of Work and Pensions

**Spend:** £1.5 billion (child tax credit).

**Problem:** Inadequate access to good-quality housing and environment for disadvantaged groups

**Action and target:** Improve the quality of social housing and raise 370 000 homes above the “decent homes standard” by 2006

**Responsibility:** Office of the Deputy Prime Minister

**Spend:** £2 billion investment over the next three years.

**Problem:** Disadvantaged people pushed into poverty/suffering from cold as a result of the cost of heating houses

**Action and target:** Reduce so-called fuel poverty by improving the energy efficiency of homes for 800 000 vulnerable households through the Warm Front programme by 2004

**Responsibility:** Department of Environment, Food and Rural Affairs

**Spend:** £152 million over the period 2003–2004.

***Monitoring***

Monitoring and performance management systems were set up for all elements in the plan, including: targets and milestones; national and local indicators of progress; performance management; review and reporting back on progress to Parliament and the public every two years.

*Source:* adapted from United Kingdom Department of Health (11, 12).



## A spectrum of activities – combining universal with selective actions

Reducing health inequities requires a combination of universal and targeted approaches. Because we are dealing with a gradient in health across the social spectrum, targeting high-risk groups is not sufficient to deal with the problem. Health inequities encompass the whole of society, so a universal approach is needed because it includes everybody, is not stigmatizing and often has the greatest impact on those that are worst off in society. One of the key principles of reducing health inequities is that we should try to level up the health of those that are worst off to that of the better off, which means improving their health faster than those who already have better health. Achieving a faster improvement in the health of the worst-off individuals may require additional effort, over and above the universal approach. This is where selective or targeted measures come in. An effective strategy to reduce health inequities would combine universal measures with selective measures that give extra support to groups suffering the greatest disadvantage and therefore with the greatest needs. The extra effort would thus be matched to the additional need in disadvantaged groups – sometimes referred to as proportionate universalism. In other words, for action on health inequities, it is not a case of choosing **either** universal **or** targeted, but combining both together in an effective strategy (Box 7).

### Box 7. Proportionate universalism in English smoking cessation clinics

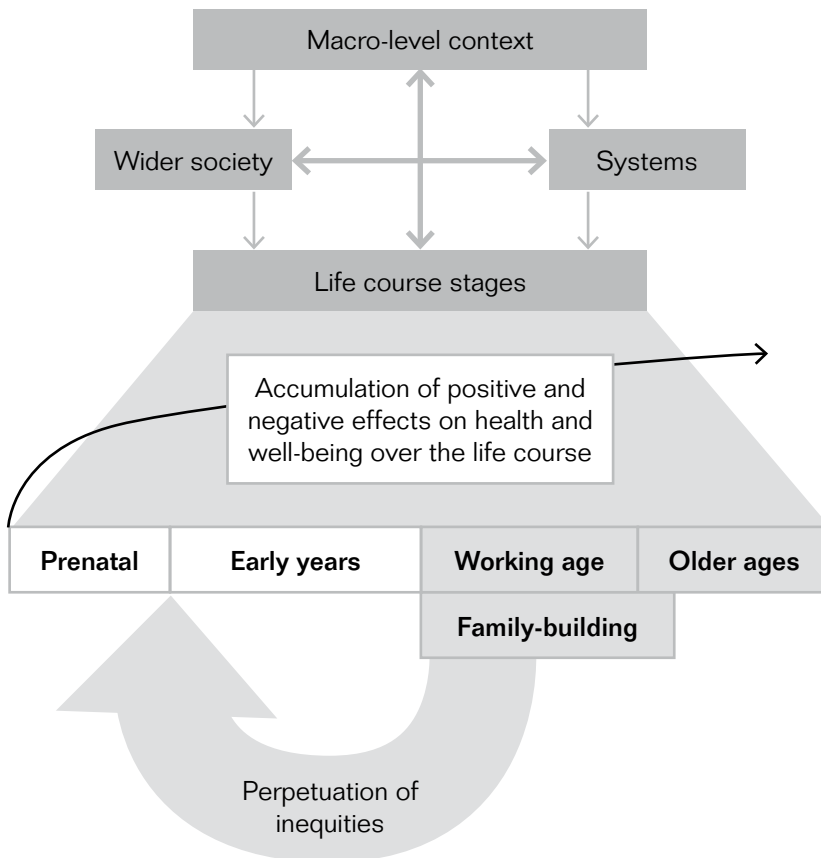
A practical example of proportionate universalism is the English National Health Service (NHS) initiative on smoking cessation clinics. As part of the national tobacco control strategy in 1999, free smoking cessation clinics were set up by the NHS throughout the country in primary care settings, open to all (and therefore universal). In 2003, however, as part of the national Programme for Action for tackling health inequalities, the Primary Care Trusts that administered the scheme were instructed to put additional effort (extra targeting) into covering disadvantaged areas, which had the highest smoking rates and lowest cessation success rates. A national evaluation in 2005 of the extent to which services were reaching and offering support to disadvantaged smokers found evidence of positive discrimination in all areas: services were effectively reaching a higher proportion of smokers living in the most deprived areas compared with more affluent areas.

Source: Chesterman et al. (13).

### Priority issues in a comprehensive approach

The *Review of social determinants and the health divide in the WHO European Region* (3) highlights **three key issues for priority action** in any comprehensive approach to addressing inequities in health: (1) taking a life course approach, with special emphasis on giving every child a good start in life; (2) improving the conditions in which people live and work, with special emphasis on improvements for those suffering the worst conditions; and (3) building and sustaining more equitable health and social protection systems, which is more important than ever during economic downturns. These issues address the key aspects which contribute to the accumulation of health inequities (Fig. 4).

Fig. 4. Intervention points for a comprehensive approach to address inequities



Source: WHO Regional Office for Europe (3).

### 1. Taking a life-course perspective

Disadvantages can accumulate and interact across the life course, from before birth to old age. Increasing numbers of strategies, therefore, recommend action across the life course, specifically to address disadvantages in maternal health, childhood, working life and old age.

The highest priority is given to actions that ensure a good start in life for every child, including adequate social protection for young families and progress towards universal, high-quality, affordable early years education and childcare. The rationale for selecting early years education and development as a priority is that the transition into formal education is one of the critical periods in a child's life, which can have long-term consequences into adulthood and beyond. The poorer development and school readiness found among the children of less-privileged groups, for example, can lead to fewer qualifications, lesser jobs and lower incomes, as well as poorer chances of improving health. Investments in early childhood and social protection for young families may contribute to the levelling up of the social gradient in health. Box 8 illustrates the kinds of actions that one region in Sweden is taking to improve early-life conditions.



**Box 8. Action on early-life conditions: Västra Götaland Region, Sweden, 2013**

**Children and young people who have fewer socioeconomic resources are at a disadvantage in terms of favourable health development.**

Actions:

- Map the occurrence of and stimulate research into how the effects of poverty are reproduced between generations.
- Gather knowledge regarding methods for working in health-promoting arenas, such as preschools and family centres, in order to reach groups that are not currently being reached.
- Develop methods of parental support to reach groups of parents that are currently not being reached.
- Improve the social safety net that supports children at risk. For example, support the children of addicted parents, the children of parents with psychiatric illnesses, and undocumented children.
- Intensify preventive measures for children and young people to reduce the number of injuries and accidents, in particular those occurring in the home and in traffic.

**Children and young people who have fewer socioeconomic resources are at greater risk of leaving compulsory education without having achieved passing grades.**

Actions:

- Set up a regional development centre with the task of utilizing, developing, evaluating and disseminating methods focusing on, for example, improving the preconditions for children and young people who have recently immigrated to Sweden to enter and complete compulsory education as well as upper-secondary school.
- Develop a strategy for applying knowledge about the importance of preschool for social equality.
- Gather knowledge about the importance of preschool for stimulating the cognitive abilities of children, particularly those from homes with unfavourable socioeconomic circumstances.
- Check quality and implement methods for a positive effect on preventing school drop-outs and ensuring that students complete compulsory education with passing grades.

**Children and young people who have fewer socioeconomic resources have fewer opportunities to be active in their leisure time, to partake in cultural activities and to experience good living conditions.**

Actions:

- Develop social planning for safe and accessible physical environments, such as more cycle paths, safe and secure walkways, and more effective use of premises.
- Evaluate and implement methods that support the opportunities of children and young people to have healthy living habits; these methods should be open to all – particularly to those with lower socioeconomic status or fewer resources.
- Increase the opportunities of non-profit-making organizations to offer active leisure time activities, regardless of socioeconomic conditions, gender, functional impairment, and cultural and geographical differences.
- Develop new methods for preventive work concerning alcohol, tobacco, narcotics and other drugs and limit the accessibility of these substances.

Source: Region Västra Götaland (5).

## 2. Improving SDH related to living and working conditions

A priority in many comprehensive strategies is reducing inequities in SDH related to the conditions in which different groups within the population live and work. The way that the Pomurje region in Slovenia acted on this priority is outlined in Box 9; responding to the poorer employment, economic and health development of the region by drawing up a joint healthy regional development plan that was sustainable and made the most of the region's agriculture and tourism assets. This necessarily involved various sectors working together to come up with a common plan.

### Box 9. An example of regional development with a focus on health equity: Pomurje region, Slovenia

The Pomurje region is one of the poorer regions of Slovenia with lower educational attainment, employment and economic performance and higher dependency on welfare benefits. This is reflected in lower life expectancy for both men and women, with men living on average three years less and women 1.5 years less than the population of Slovenia as whole. Agriculture is the main economic activity in the region with more than half the households in Pomurje connected in some way with the agricultural industry.

The regional development strategy aimed to improve health in the region through joint action. The focus was on creating healthy communities, healthy food and healthy tourism, built on the foundation of creating a supportive environment for health. Key actions in each of these areas were set out, as described below.

**Healthy environment** focuses on supporting natural living and socioeconomic environments, with particular emphasis on improvements in terms of the provision of clean water and access to higher education.

**Healthy communities** encompasses health promotion in communities, preschools and schools, workplaces and amongst marginalized groups.

**Healthy food** includes recognizing the importance of agriculture to the region and the need to make sure it is sustainable, particularly in the context that many of the farms in Slovenia are small. A health impact assessment on the potential impact of the EU Common Agricultural Policy on local agriculture suggested that there was an opportunity to link the sustainability of these small farms with improving fruit and vegetable consumption, especially in schools. Encouraging the local farms to grow more fruit and vegetables made it possible to support local food supply chains.

**Healthy tourism** focuses on health spas, which are a source of income in the region. Supporting and linking these spas through cycle routes and footpaths led to economic improvements in the region and helped to promote ecological tourism.

The Ministry of Health was essential in bringing about this pilot programme and involvement in it required a high level of political commitment. The Ministry provided stewardship for the programme, while the Regional Development Agency was responsible for its implementation. The Regional Institute of Public Health brought many different organizations together to develop and implement the plan. This was the first time that different sectors had planned together, rather than separately. Regional targets were developed to complement national targets. Key factors for the success of this programme included:

- persistence and advocacy by the Ministry of Health
- availability of sustained resources during the programme's development

**Box 9. contd**

- ensuring that policies worked together, which helped to facilitate intersectoral working
- defining clear roles and responsibilities
- building capacity for health intelligence and leadership in public health
- sharing the learning with other regions.

Source: Buzeti & Zakotnik (14).

### **3. Building more equitable health care systems**

A third priority for a comprehensive approach is to tackle existing inequities in access to essential health services and to make progress in building a more equitable health system that ensures access for all sections of the population. A number of questions need to be answered to ensure this is achieved.

- Assessment of the current situation is necessary: are there systematic differences between different population groups in access to health services, treatment received, outcomes obtained or costs incurred that are contributing to health inequities?
- If so, which of these differences are amenable to action, what are the sticking points, and what realistic changes can be made to the system to make it more equitable?
- Introducing the changes comes next, followed by ensuring that the effects of the changes are monitored and reported back to politicians regularly, especially asking: what is the impact of this policy change on those that are worst off in society?

Box 10 gives examples from Poland and Kyrgyzstan of action to make health financing systems more equitable, in terms of financing, eligibility and coverage by the health system.

Forces are always acting to erode progress that has been made in building more equitable health and social protection systems; not least the current financial crisis, which has led to the implementation of austerity measures by many European governments.

The priorities for action in the short to medium term have been highlighted by the WHO Regional Office for Europe's *Review of social determinants and the health divide in the WHO European Region* (3), and include the need to:

- protect the level of spending on health systems and social protection in these times of recession;
- monitor the health and social consequences of austerity policies on different population groups in the country or region;
- feed back the findings of the monitoring exercise(s) into further economic and fiscal policy-making in order to prevent or ameliorate adverse effects on health.

## **Box 10. Equitable financing and eligibility: Kyrgyzstan and Poland**

### **Improving equity of the health financing system in Kyrgyzstan**

Kyrgyzstan's health care financing reforms in the late 1990s and 2000s were a response to financial pressures, reduced government spending on health, and rising informal out-of-pocket payments. The reforms were guided by the objective of having a single system for the entire population. This was supported by high-level political backing; continuous leadership in the health sector and extensive capacity building. A 1996 law introduced a new mandatory health insurance fund (MHIF) as a top-up to existing budget flows to health services, with a single information and accounting system for all patients, regardless of their insurance status. In 2001, a single-payer system was initiated, combining budget and insurance funds under the MHIF, organized in subnational regions and purchasing a "state-guaranteed benefits package" for all. In 2006, funding was centralized at national level, facilitating redistribution of resources between regions. Directing budget revenues to the MHIF meant that budgets went from directly subsidizing the supply of services to subsidizing the purchase of services on behalf of the entire population, with different sources of funds used in a complementary manner to create a unified, universal system. Equity in both utilization and financing was found to have improved. The proportion of patients making informal payments fell significantly for all categories of patient expenditures. However, substantial private user charges remain in place for services outside the basic benefits package, resulting in a high financial burden for the population (15).

### **Improving health insurance coverage for excluded groups in Poland**

Five new elements were introduced into the Polish health care system from 1999 onwards, to ensure equity of access to care for the country's most disadvantaged and vulnerable groups. These included: (1) mandatory, universal insurance of all eligible people, regardless of their socioeconomic status; (2) voluntary insurance for people not covered by the mandatory insurance; (3) free access to publicly financed health services for poor, uninsured people; (4) prohibiting treatment of private patients by public health care providers; and (5) protecting the access of insured poor people to dental health care services. Previous measures to strengthen the health care system – while important for those living in poverty – had proved insufficient to protect their right to equity in health and health care. Members of some excluded groups informed policy-makers that their rights were violated, and some groups were identified by health care providers, researchers or NGOs. All information on unintentional exclusions was analysed to identify neglected social groups so that they could be insured in a mandatory scheme. A legal act, introduced in 2004, provided an additional safety net to protect the very poor from exclusion (16).

*Source:* adapted from Loewenson and Whitehead's contribution to a "Resource guide on governance for social determinants of health and health inequities", prepared by the WHO Regional Office for Europe's European Office for Investment for Health and Development and discussed in Brown et al. (17).

## **Action for any starting point: "Do something, do more, do better"**

Countries in the WHO European Region are at a range of very different stages in their health, health equity and socioeconomic development. It is vital, however, that each country does what it can. The *Review of social determinants and the health divide in the WHO European Region* (3) recommends the following action points.

- **Do something.** For countries with few policies to address SDH it is important to take some action in the short term and plan for long-term strategies. Evidence suggests that even small improvements in social rights and social spending (in terms of legislation) can lead to improvements in health.
- **Do more.** Even countries in which some social protection policies are already in place can implement more initiatives to address SDH and health equity. This approach includes working towards ensuring that welfare systems – at a minimum – protect against financial loss due to ill health, unemployment, non-employment or low wages. Countries should work towards achieving a level of social protection that enables all individuals to reach the minimum standard for healthy living in that particular society.
- **Do better.** In the most affluent countries of Europe, with advanced social protection systems, there is scope to reverse the trend in rising inequities by strengthening the welfare system and implementing extra programmes to help the most vulnerable in society.

### Key messages

- Ministries of health and the public health community have a key role to play to create and support a strong case for why **improving equity is important for the attainment of other government/societal goals**, not only for health.
- **Action across multiple sectors** is essential. A number of strategies and tools exist for strengthening joint action on health inequities: (i) across sectoral portfolios; and (ii) between local, regional and national governments.
- **Involving local people** and communities improves the design and impact of policies aimed at improving health and reducing social inequities.
- It is important to develop the necessary legislation and regulations to strengthen **joint accountability for equity** across sectors.
- **Regular joint reviews of progress** should be carried out. These foster common understanding and sustain commitment to deliver shared results over time.
- Both **universal and targeted approaches** are required, including policies that act across the whole social gradient in health, and along with extra help for the most disadvantaged.
- It is critical to **assess the differential impacts of policies and interventions** on different social and geographical groups within society.
- A **monitoring system for health equity** – supported by targets and public reporting – is a core component of a comprehensive approach to addressing inequities, and can help build political and community concern.

**Table 1. System components that support a comprehensive approach to reducing health inequities through action on SDH**

Domain	Systems characteristic	Exemplified by
<b>1. Political commitment</b>	Clear political commitment	Ministerial accountability for improving health equity and SDH Specific political roles on equity and SDH at national, regional and local levels Cross-government committee for equity/SDH Explicit budget for health equity and SDH Institutional and legislative framework for equity in health and development
<b>2. Intelligence</b>	Evidence and information on health inequities and SDH to: <ul style="list-style-type: none"> <li>inform policy and investment decisions</li> <li>monitor progress</li> <li>hold stakeholders to account</li> </ul>	Equity/SDH as a core work area and funding stream in research budgets Evidence on equity and SDH systematically reviewed and publicly reported Dedicated health intelligence and analysis services producing open access data Input, output and outcomes data published on health equity and SDH at local, national and European levels Agreed minimum datasets/reporting requirements for equity and SDH at national and local levels (This requires collection of data disaggregated by geographic region and social group, as a minimum.)
<b>3. Accountability structures and systems</b>	Legislative structures and systems enabling intersectoral action on equity and SDH at European, national and local levels Statutory governance boards capable of holding all stakeholders to account Legislative structures and systems: (i) enabling formation and action of NGOs and civil society groups as partners in action to reduce inequities; and (ii) monitoring progress	A legal framework placing a duty on all health and non-health stakeholders to collaborate and report on SDH/health inequity actions and outcomes Community health boards, established with explicit powers to review data/progress of policies, along with options/solutions for improving health equity, and to hold all stakeholders to account Statutory roles with a formal duty to reduce inequities through action on SDH; that is, empowered to publicly mandate action at European, national and local levels (e.g. public health minister, chair of parliamentary development committee, prime minister, ombudsman)
<b>4. Policy coherence across government sectors and levels</b>	Formal framework setting out stakeholders involved in action for improving equity in health Framework linked to ministerial portfolios and budgets, nationally and locally Government policy audited through health impact assessment and equity impact assessment Instruments which institutionalize collaboration across sectors and levels of government	Coherence of sectoral actions (national and local) on agreed targets for equity and SDH Equity outcomes explicitly defined for all sectors, nationally and locally Specific agreements with the private sector on their contribution to delivering equity targets Outcomes assessed and published by all ministries/directorates at all levels Impact assessments, which should be public domain documents, challengeable through accountability mechanisms Systems for joint accounting for results, including pooled budgets, shared targets, joint review and reporting on progress, and integrated intelligence systems

Table 1. contd

Domain	Systems characteristic	Exemplified by
<b>5. Involving local people</b>	<p>Commitment to participation of local people and subnational authorities in policy design and review</p> <p>Instruments and systems which secure community involvement in solutions</p> <p>Intelligence and data on health, equity and SDH made accessible within the public domain – locally, nationally and across Europe</p>	<p>Mechanisms, organizational design and capacity building to enable diversity of voices and perspectives from the community, at all levels in decision-making and solutions</p> <p>Tools and support at the local level to define local problems and solutions, informed by local data</p> <p>Public reporting of actions and progress to allow access to and debate on results and new challenges, by and with community/third parties</p>
<b>6. Institutional and human resource capacity</b>	<p>Capacity development, including:</p> <ul style="list-style-type: none"> <li>• development of competent and trained staff</li> <li>• institutional processes</li> </ul>	<p>Programmes supporting political, civic and professional leadership of SDH/health inequity action within different institutions</p> <p>Curriculum modules on equity and SDH for training professionals within and outside the health sector</p> <p>Formal protocols defining institutional arrangements and expectations related to SDH/health inequity in all sectors</p>
<b>7. Modernized public health</b>	<p>Review of public health training and practice</p>	<p>Revised descriptors and competences for national public health practice, to include skills required for equity and action on SDH</p> <p>New/updated training for public health professionals</p>
<b>8. Learning and innovation systems</b>	<p>Commitment to continuous improvement in understanding the efficacy of policies and interventions to reduce inequities</p> <p>Commitment to ongoing performance review/improvements in governing for equity in health, through action on SDH</p>	<p>Stronger learning transfer systems within and between countries, to accelerate uptake of promising policies and instruments</p> <p>Enriched capacity to tackle inequities in health through innovation programmes, live demonstration sites/exchanges, along with documented and disseminated learning</p>

Source: WHO Regional Office for Europe (17).





## Tools, resources and examples

### Actions to address health inequities and SDH

- **Review of social determinants and the health divide in the WHO European Region: final report** (3).
- **Report on health inequalities in the European Union** (18).
- **Closing the gap in a generation: health equity through action on the social determinants of health. Final report of the Commission on Social Determinants of Health** (19).
- **European strategies for tackling social inequities in health: levelling up part 2** (4).
- **A typology of actions to tackle social inequalities in health** (20).
- **Health 2020. A European policy framework and strategy for the 21st century** (21).
- **Resource of health system actions on socially determined health inequalities.** WHO Regional Office for Europe online database (22).
- **Action:SDH.** A global electronic discussion platform and clearing house of actions to improve health equity through addressing the SDH (23).
- **European Portal for Action on Health Inequalities.** An Equity Action partnership information resource on health equity and SDH in Europe, including a database of policy initiatives (24).

### Policy assessment tools

- **How can the health equity impact of universal policies be evaluated? Insights into approaches and next steps** (25).
- **Health inequalities impact assessment. An approach to fair and effective policy making. Guidance, tools and templates** (26).
- **Methodological guide to integrate equity into health strategies, programmes and activities** (10).
- **Tools and approaches for assessing and supporting public health action on the social determinants of health and health equity** (27).

### Data disaggregation and monitoring tools

- **Equity in Health project interactive atlases.** WHO Regional Office for Europe online resource (28).

- **Handbook on health inequality monitoring with a special focus on low- and middle-income countries** (29).
- **Moving forward equity in health: monitoring social determinants of health and the reduction of health inequalities** (30).

### **Governance for health equity**

- **Governance for health equity in the WHO European Region** (17).

### **Case studies**

- **Setting the political agenda to tackle health inequity in Norway** (31).
- **A whole-of-government approach to reducing health inequalities: the Scottish experience** (32).
- **Investment for health and development in Slovenia. Programme MURA** (14).

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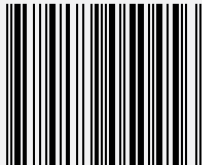
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