



EUROPE

Putting our own house in order: examples of health-system action on socially determined health inequalities



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Acronyms

BHC	Building Healthy Communities (Ireland)
CHP	community health partnerships (Italy)
CSDH	Commission on Social Determinants of Health
EU	European Union
HIA	health impact assessment
HSKN	Health Systems Knowledge Network
ISPI	Inequalities Sensitive Practice Initiative
MEKN	Measurement and Evidence Knowledge Network
MiMi	Mit Migranten für Migranten (With Migrants for Migrants, Germany)
NHS	National Health Service (United Kingdom)
NST	national support team (United Kingdom)
PSAs	public service agreements
SDH	social determinants of health
SDHI	socially determined health inequalities
SGB	Sozialgesetzbuch (social code book, Germany)
SNIPH	Swedish National Institute for Public Health
TB	tuberculosis


Executive summary

This publication is intended, firstly, to give policy advisers, policy entrepreneurs and those who work within health systems a better understanding of the key issues related to taking action on socially determined health inequalities (SDHI). In particular, it is aimed at those who work within a policy environment where there is a *will to take action* on these inequalities and who seek guidance on how to do so through supporting and informing action-oriented evidence and knowledge. This is the document's key audience.

It builds on existing global (e.g. the Commission on Social Determinants of Health) and European work in creating an evidence base for acting to counter SDHI. However, evaluations of interventions and policy responses on action to tackle SDHI are limited. At the same time, there is a growing demand by those involved in policy-making processes (policy advisers, entrepreneurs and advocates, those working in local and municipal authorities, among others) for knowledge on the options for acting on SDHI. This demand goes beyond documenting examples of action (health system or otherwise). It (a) makes the information available in a form that supports systematic uptake and application of the learning; and (b) unlocks key pieces of information about why the action worked, for whom and in what circumstances. In addition, the landscape of action on SDHI is changing and increasing investment is being made in better monitoring, measurement and evaluation of interventions to counter health inequalities.

This document seeks to advance this by showing how to systematically use and generate evidence-informed options for action from the knowledge contained in a selection of case studies. In a departure from how such studies are usually presented, they are used here as a source of data rather than as exemplars.

Secondly, this document contains a checklist of generic principles that can be put into practice or used to review existing examples of health-system actions and that can assist the key audience described above to design and develop their own policy response. The checklist is not intended to be followed unwaveringly like a prescription or a recipe. Health inequalities are a complex problem for which there is no simple solution and no single answer.



Instead, it is intended to stimulate new approaches and interpretations within an individual health-system context. Thus, the checklist can be used to interrogate, evaluate and better understand examples of action, so that these examples can be adapted and reshaped to achieve a better fit with prevailing circumstances of the particular health system.

Thirdly, the examples demonstrate that there is a wide scope of actual and potential actions that can be taken. These can be better explored as part of an approach where the health system is seen to be “putting its own house in order”.

In this sense, this document seeks to move beyond the standard debate on how much the health system can contribute in relation to other determinants. The additional need is to recognize that while it can help reduce inequalities rooted in other sectors, its *own* internal inconsistencies and weaknesses may contribute to those existing inequalities or even create new ones. What is really required is a response to *both*.

While the health system alone cannot significantly reduce health inequalities, it nevertheless has a vital role in achieving that goal. This is by acting to:

- (a) improve how we do our own business within the health system, which includes ensuring equity of access to health services and providing services that ameliorate and remedy the health disadvantages among sub-groups in the population and that are caused by social determinants such as poverty, poor living conditions and unemployment; and
- (b) improve our investment and approach to working with other sectors so that we are instrumental in developing collaborative, intersectoral solutions that create the conditions for health for all groups in the population.

The search for such solutions within the health system and across other sectors is continuing, and despite the many related difficulties identified in this publication, there are solid grounds for concluding that real progress is being made in tackling SDHI.


Key terms used in this publication

Health inequalities refers to *avoidable and unjust systematic differences in health status between different groups in a given society (inequities)* and not all inequalities. Health inequalities and not health inequities is used here because in some languages there is only one word for the two terms and the distinction is often lost in translation (1,2). However, where the terms inequity or inequities are used in this publication it is because the particular intervention or policy being described deliberately uses this term and is usually indicated by *. For example, the Health Promotion among the Navarre Ethnic Minorities Programme specifically refers to reducing *health inequities* (3).

Health systems refers to *the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health* (4). This is elaborated in more detail in the introduction and Box 1.

Policy advisers and entrepreneurs refers to those actors involved in the policy-making process within and outside of government agencies, and who are responsible for developing evidence-informed options for action and/or for advocacy purposes but who may not necessarily be the final decision-makers. They are part of the wider community often referred to as policy-makers. However, a distinction is made because policy advisers and entrepreneurs are likely to seek to use much more detailed and technical information in developing policy options for decision-makers to consider.

Social determinants of health refers to the social conditions, in which people are born, grow, live, work and age (5), that shape their health and disease exposures, vulnerabilities and outcomes. These social factors may include, but are not limited to: employment and working conditions, living environments, availability of and access to health and social protection services, education and social cohesion or connectedness. They also refer to the way in which social class, gender, age and ethnicity norms, values, and discrimination, are linked to other determinants of health to increase the vulnerabilities and risks that lead to health inequalities (1,2,5,6).



Wicked issues is a term that is used to describe “complex problems that often have no definitive shape, can evolve and mutate, elude clearly right and wrong solutions, and often have many causal levels” (7). Given the complexity of health inequalities and the challenges in identifying a single or ideal solution, sometimes health inequalities are described as “wicked issues”.

Chapter 1. Introduction

Socially determined health inequalities (SDHI) in the WHO European Region¹ have been increasing (8–12) and are likely to continue to do so without determined action to counter them. Left unchallenged, their negative consequences on vulnerable populations will also impose costs on society as a whole. They are caused by and relate to social determinants such as poverty, unemployment, unsafe working conditions and precarious work, gender norms and standards and level of education (2) as well as activity in the health system itself. While the health system alone cannot reduce health inequalities, it nevertheless has a vital role in achieving that goal, and as part of any overall approach to tackling SDHI. Therefore this publication aims to provide guidance to those who work in a policy environment on how to take action where the *will to take action* on these inequalities already exists.

1.1 Health inequalities are increasing between and within countries

No country in the WHO European Region, no matter how wealthy, is immune from SDHI (13). While there has been improvement in overall health status within the WHO European Region, it is not equally shared across populations either within countries or between countries. These inequalities lead to increased vulnerabilities in populations as well as increased differences in health behaviours and outcomes between population groups (whether measured by factors such as education, income, or employment). In turn these inequalities are reflected in both measures of life expectancy or mortality and quality of life (morbidity and self-rated health). There are costs to not acting, because ongoing inequalities will eventually undermine existing and overall health gains (14).

This is illustrated by a study of 22 European countries where mortality was found to be higher (15) among those with less education. The size of inequalities in mortality as a result of education varied greatly between countries. That is, the relative index of inequality for men *in countries that joined the European Union (EU) before 2004* is twice that among men with

¹ The WHO European Region encompasses 53 countries or Member States including the 27 countries within the European Union. For more information about which countries this includes please see the WHO Regional Office for Europe web site (<http://www.euro.who.int/en/home>). Examples were to be drawn from countries within and outside the European Union.

least education compared to men with most education. For three of the four countries that joined the EU in 2004, the relative index of inequality for men is four or higher (15). In terms of *differences within a country*, more recent findings from a study of selected EU Member States and Norway demonstrate a systematic relationship between educational level and mortality at any age – the lower the level of education, the lower the life expectancy. Furthermore, the differences in life expectancy among men based on educational level are larger than those for women (8).

1.2 Taking action: health systems are an important arena for action

The final report of the global Commission on Social Determinants of Health (CSDH) (12) made three overarching recommendations for guiding action to reduce health inequity within a generation.

1. Improve the conditions of daily life – the circumstances in which people are born, grow, live, work, and age.
2. Tackle the inequitable distribution of power, money, and resources – the structural drivers of those conditions of daily life – globally, nationally, and locally.
3. Measure the problem, evaluate action, expand the knowledge base, develop a workforce that is trained in the social determinants of health (SDH), and raise public awareness about the SDH (12).

The CSDH report clearly identifies health systems as a vital determinant of health and one of the arenas for action. The recommendations for health-system action focus on:

- building health-care systems based on principles of equity, disease prevention, and health promotion;
- ensuring that health-care system financing is equitable;
- building and strengthening the health workforce, and expanding capabilities to act on the SDH (12).

The subsequent resolution of the World Health Assembly (16) reflects that health systems have a vital role in tackling the social determinants for improved health equity and urges Member States to take a range of action including:

- developing and implementing goals and strategies to improve public health with a focus on health inequities;

- taking into account health equity in all national policies that address SDH, and considering developing and strengthening universal comprehensive social protection policies, including health promotion, disease prevention and health care, and promoting availability of and access to goods and services essential to health and well-being;
- ensuring dialogue and cooperation among relevant sectors with the aim of integrating a consideration of health into relevant public policies and enhancing intersectoral action;
- generating new, or making use of existing, methods and evidence, tailored to national contexts in order to address the social determinants and social gradients of health and health inequities; and
- developing, making use of, and if necessary, improving health information systems and research capacity in order to monitor and measure the health of national populations, with disaggregated data where national law and context permits so that health inequities can be detected and the impact of policies on health equity measured (16).

In this publication, health systems are defined in the broadest sense and include *all the activities whose primary purpose is to promote, restore, or maintain health* (4). This is consistent with the definition used by the CSDH and means that health-system actions on SDHI are about more than health care services alone. More recent definitions, as presented in Box 1, build on this and emphasize the importance of working intersectorally.

Box 1. Defining health systems

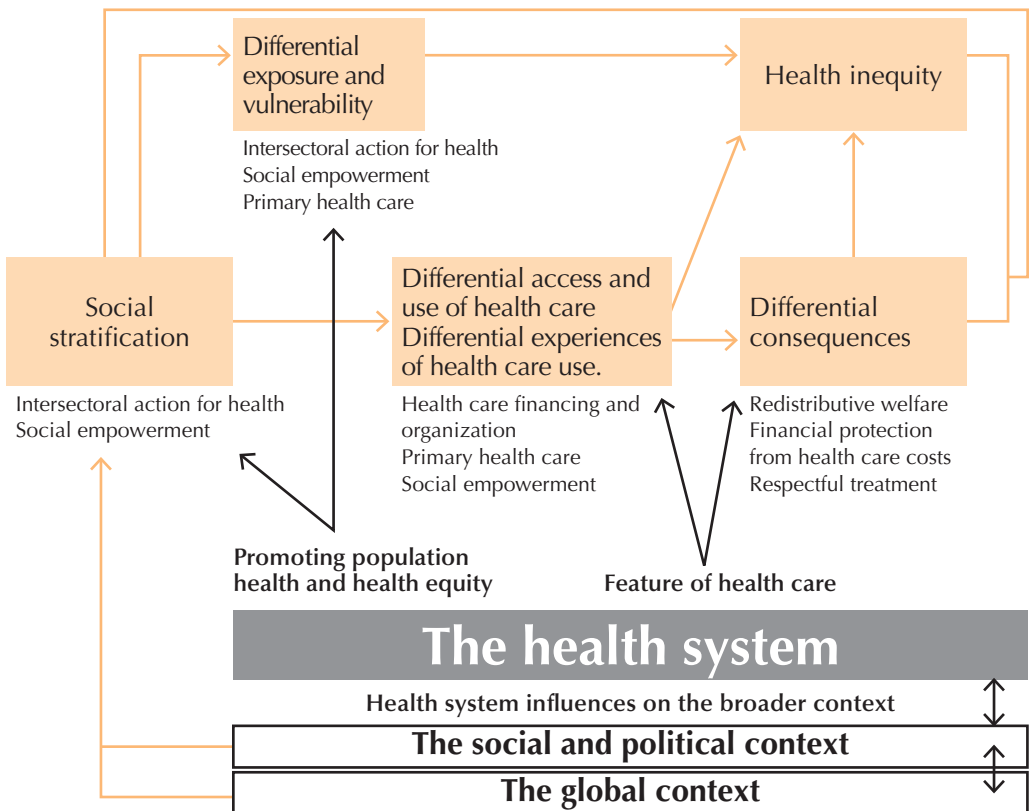
Health systems include *all the activities whose primary purpose is to promote, restore, or maintain health* (4):

A health system consists of all organizations, people and actions whose primary intent is to promote, restore or maintain health. This includes efforts to influence determinants of health as well as more direct health-improving activities ... It includes inter-sectoral action by health staff, for example, encouraging the ministry of education to promote female education, a well-known determinant of better health (17).

Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health (18).

Health systems are themselves both a determinant of health and socially determined. This means that they can be specifically designed so as to address directly and respond to the impact(s) of SDHI through the provision of health services; and to act directly on or in response to social determinants outside of the health sector (19). The Health Systems Knowledge Network (HSKN) identified four overarching features of health systems that have the potential to improve health equity: leveraging intersectoral action; engagement and participation of population groups and civil society; arrangements that aim at universal coverage; and revitalizing comprehensive primary health care (19). Fig. 1 presents different points of intervention for health-system action and how they relate to the four overarching features. The work of the HSKN demonstrated that there is great scope for health-system action to go beyond financing and/or the provision of health care services to other health-system functions, particularly the function of stewardship or governance.

Fig. 1. The pathways of positive potential for health systems: points of intervention



Source: Gilson et al. (19).

This does not mean that the health system alone is responsible for countering inequalities – a balance of actions within it and other sectors is required. However the health system can hardly call upon and expect other sectors to change and act on SDHI without acting to ensure that *its own house is in order*. Health systems can make an important contribution and have a vital role in achieving that goal.

Therefore this publication aims to demonstrate:

1. the important contribution that actions by the health system can make;
2. that the health system has a responsibility not to make existing social and health inequalities worse, through, for example, catastrophic out-of-pocket expenditure by patients that impoverishes them;
3. that it is not a case of “either or”, but rather that both health systems and whole-of-government actions by and with other sectors are needed; and
4. that there are some principles for good practice in developing and implementing the necessary health-system actions on SDHI.

The contribution and relevance of health-system efforts to address health inequalities will vary depending on the country context and specifically: the nature and extent of health inequalities within that country (relative and absolute); and the structure of the social and health protection systems. For example, in the United Kingdom, as part of the Marmot review of 2010, the delivery systems and mechanisms task group (20) was asked to review the role of health services in relation to health inequalities, particularly access to effective health services as a social determinant of population health; and inadequate access as a potential cause of health inequalities. One of the group’s recommendations is to maintain the universal health care system, while simultaneously improving the mechanisms for identifying and correcting inequalities in the delivery of services, and to develop further the capability of taking an SDH approach.

The National Health Service (NHS) provides an important foundation for action that needs to be maintained, and this highlights the importance of monitoring and evaluation of services to check that universal coverage is not being eroded (20). However, the circumstances of other countries within the WHO European Region are such that part of health-system actions on SDHI will include building universal coverage through more inclusive criteria for access to health services and/or by reducing out-of-pocket expenditure(s) associated with health service use, particularly user fees.

1.3 The price of not acting: the economic and social costs of health inequalities

Evidence suggests that the economic and social gains from acting to decrease health inequalities may be substantial. For example, a study of 15 EU countries (21) found that if these countries succeeded in reducing avoidable health inequities by 10%, the economic benefits would amount to:

- €14 billion through gains in health as a “capital good” that is an important component of production;
- €70 billion through gains in health as a “consumption good” that contributes directly to an individual’s happiness or satisfaction;
- €18 billion through reduced health-care costs; and
- €6 billion through reduced social security costs (21).

The same evidence also indicates that if no action is taken health inequalities will persist and increase and are likely to lead to rising costs to health and social services (21).

Furthermore, the current global economic downturn means that, unless action is taken, health inequalities are likely to increase within the Region. As well as further entrenching SDHI such as poverty and social exclusion, there is the potential for a loss of the health and development gains made in the past decades (14). Regular monitoring of public perceptions of the social impacts of the financial crisis indicated that views and experiences about the social impact varied across the 27 EU countries (22). This reflects the diversity of responses that are potentially required to counter new and emerging inequalities. For example, in relation to coping with the costs of various types of health care in the past six months, both the March and May 2010 surveys consistently had higher proportions of respondents from Bulgaria, Latvia, Lithuania, Portugal and Romania, who identified that the affordability of health and social care had worsened. However, among these countries, respondents from Latvia and Lithuania indicated in the May 2010 survey that health and social care affordability had showed some improvement (22).

This gives greater urgency to developing both an accurate picture of the causes of inequalities in the WHO European Region (within and between countries) and to identifying options for acting – what can be done and “what works”.

1.4 Wicked issues: health inequalities are complex

As indicated in many conceptual frameworks, the relationship between social determinants and health are complex. Health inequalities are a complex problem for which there is no one or simple solution. Because of this they can and have been described as “wicked issues”, that is, complicated problems that usually have no definitive form, are multicausal, liable to change and, for which there is usually no definitive solution or single solution (7). Given the increased awareness of the importance to act on SDHI and the evidence for acting, there is growing demand by those involved in policy-making processes (policy advisers, entrepreneurs and advocates, those working in local and municipal authorities, among others) for knowledge on the options for acting on SDHI. This demand goes beyond documenting examples of action (health system or otherwise), to making the information available in a form that supports systematic uptake and application of the learning, and to unlocking key pieces of information about why the action worked, for whom and in what circumstances. There is also a demand for greater specificity or accuracy about the potential outcomes and gains from undertaking such action.

1.5 More about this publication

1.5.1 Who is it for?

This publication and its web-based counterpart have been designed primarily for policy advisers and entrepreneurs involved in policy-making processes at national, subnational and local levels and working within the health system in the WHO European Region. Within this audience it has been designed for those who are interested in identifying options for action to confront SDHI and therefore it assumes a certain level of knowledge and understanding about the SDH and health inequalities. It is also aimed at those who work in a policy environment and are at a stage where there is a *will to take action* on these inequalities (23) and who want to know (for example) how to:

- tackle SDHI, and learn from some examples of actions that have been taken, including good practices;
- take action as part of an overall health-system strengthening effort to address SDHI including examples of actions;
- improve the health of vulnerable groups such as those living in poverty,

or who are homeless or vulnerable as a result of ethnic and other forms of discrimination;

- tackle the social gradient and reduce the gap between most and least advantaged or between different social groups; and/or
- put the findings and recommendations of the CSDH into practice in their countries.

It may also assist those who have difficulties in identifying options for acting (23).

Apart from the primary audiences described above, this material is also open to those working in sectors other than health.

1.5.2 How can it be used?

Policy advisers and entrepreneurs can use this publication to develop a picture or options on how to take effective action within their own context by supporting and feeding action-oriented evidence and knowledge. It sets out some principles to use in reviewing existing examples of health-system action (available on the web-based resource); and to assist in framing the design and development of their own policy response including the following.

- What can be done about SDHI? What might work?
- How do the apparently effective policies or interventions work?
- What works for whom in what circumstances?
- Which factors may moderate the impact of this policy?
- Will intervention or policy X work in this context (24,25)?

As previously observed, there is growing demand for examples of best practice initiatives which have been properly evaluated and documented as making a difference to health inequalities. But few of these actually exist (11–13,26). Therefore there is a need for better and more specific evidence. In this publication, the examples have been used as available evidence to derive a checklist of generic principles that can be put into practice or used to review existing examples of health-system action on SDHI and that can assist the key audience to design and develop their own policy response. Once again, there is no simple solution to health inequalities. The checklist is thus intended to be used to stimulate new approaches and interpretations within an individual health-system context. It can be used to examine, evaluate and present relevant knowledge from examples of action in a way that is compelling for decision-makers.

Chapter 2. How the checklist was developed

2.1 Developing the evidence base for action on determinants of health

The increased need and demand from countries for more specific knowledge on what action(s) can be taken to reduce SDHI is driven by emerging evidence about their magnitude and trends and action that can be taken to tackle them. There is also growing recognition of the relationship between health and development, and how ongoing health inequalities affect future economic and social development. The evidence base for measurement and action on SDHI has advanced considerably in the last decade. However, the Measurement and Evidence Knowledge Network (MEKN) of the CSDH identified six problems which make developing the evidence base on the SDH potentially difficult:

- lack of precision in specifying causal pathways;
- conflation of causes of health improvement with causes of health inequities;
- lack of clarity about health gradients and health gaps;
- inadequacies in descriptions of axes of social differentiation in populations;
- the impact of context on interpreting evidence and on the concepts used to gather evidence; and
- problems of getting knowledge into action (6).

It also made the case for methodological diversity in building the evidence base for action on SDH to ensure that all relevant knowledge can be collected, and learning from practice in a systematic way:

... much can be gleaned from the tacit knowledge of practitioners about how things work by supporting them to document the processes that lead to effective delivery of social interventions (6:70).

2.2 A joint action by the EU and WHO

A response to this increasing demand was a joint initiative between the WHO Regional Office for Europe and the European Commission Directorate-General for Health and Consumers (2006WHO03) on inequalities in

health-system performance and their social determinants in Europe. The two objectives were: (a) mapping health inequalities in the EU and selected neighbouring countries based on a range of Eurostat datasets, available on a regional level (<http://194.255.1.165/Project2006WHO03/>); and (b) development of examples of practical current and past examples of effective policy solutions across Europe, including contextual information to enable uptake in different settings.

Two products are being developed to meet the second objective:

- this publication, which is based on a synthesis and analysis of examples of health-system action (policy, programmes, projects and/or practices) on SDHI and from which a checklist of principles for good practice has been derived; and
- a web-based resource (<http://194.255.1.165/Project2006WHO03/>) that gives access to the examples of health-system action reviewed as part of this work in relation to the principles for good practice and access to detailed materials about these examples (including peer reviewed and published case studies).

This work called for the identification, analysis and synthesis of examples of health-system action that address SDHI, to be undertaken within the framework of the CSDH (12). It draws from countries within the WHO European Region including a focus on countries in the EU. The emphasis in the joint action was to collect *examples of good practice* and develop a web-based resource that could be widely disseminated to EU policy-makers and national and subnational authorities, as part of strengthening the evidence base on what works to tackle SDHI.

The issue of health inequalities and social determinants, however, has been on the agenda of the EU for over 20 years. In 2000, the following core values were adopted by the heads of states of all EU countries as forming the basis of all health systems:

- universality (services for all)
- equity (in access)
- solidarity (in funding)
- quality (27).


These values were restated by health ministers in 2006. Health inequalities have also been the focus of past EU presidencies including the 2000 Presidency of the EU by Portugal, which emphasized the role of health determinants in influencing health, and more recently the Spanish Presidency of the EU which focused on monitoring SDH and the reduction of health inequalities (27). This recent Presidency advanced the issue of measurement of health inequalities considerably and invited Member States to: (a) take the appropriate measures to optimize existing national data sources with a special emphasis on obtaining information related to SDH; and (b) take steps to improve the data needed to properly evaluate and monitor policies with a health impact with a view to orienting such policies towards equity in health where appropriate (28).

Finally, there has been investment in similar initiatives with a view to strengthening knowledge, capacity and exchange of good practices including the DETERMINE and Eurothine projects. The Eurothine project recommended the establishment of a databank and a clearing-house for Europe of equity initiatives (13).

In 2006, an EU expert group on social determinants and health inequalities was established; it provides a forum for exchange of information and good practices between Member States on SDH and health inequalities. Members of this expert group have been involved in the development of this publication and the underlying work on examples of health-system action.

2.3 Collecting examples of good practice: moving from the specific to the generic

As an initial step, consultations were held with stakeholders (academics, policy advisers, practitioners and deputy ministers). These consultations highlighted two key issues: defining what is meant by “good” practice; and the use and quantity of case studies and examples as a way of enabling those working with policy-makers and practitioners to take action. On the first issue, stakeholders indicated that identifying 30 country examples and ensuring “good” practice would be challenging. Further discussions about the criteria and ways of assessing practice also highlighted that there might be only limited guidance on what constituted “good” and that ideas on good practice might be better derived from looking across the range of examples of health-system action in this area.



On the development of examples of action or case studies, the issue of concern was not the case studies themselves, but unlocking the relevant information contained in them. Stakeholders noted that they could produce an example using a different (case study) format, but they considered this of little benefit and questioned the assumption that policy-relevant information is and can be easily derived from single or grouped case studies.

Current approaches to generating and using case studies do not lend themselves well to development of normative guidance or patterns of evidence. In particular knowledge of what works and in what circumstances. This includes using case studies differently, and moving from deriving key lessons from single case studies or grouping single examples around a theme to better syntheses of examples of equity actions to generate more specific information about patterns and the implications of these patterns (29) for guidance (6). While case examples are useful in providing indications of what actions might be taken, how they are produced and presented to policy advisers makes the difference.

It was agreed that the publication would benefit from using a theoretical approach such as grounded theory to structure the synthesis of several examples. This was to enable movement from the specific details (case study as exemplar) to the generic. An example would be: what can be said as a general rule about taking action on SDHI by using the case studies as a source of data on specific aspects of taking action.

2.4 Examples of health-system actions for synthesis

In the consultative process, inclusion criteria were defined for the types of examples to be included. These criteria include:

- a health-system focus: i.e. the health system is the key proponent or one of the main stakeholders in initiating and implementing the action;
- action at national, subnational or local level;
- a focus on SDH, preferably with a clearly defined equity objective; and

- inclusion of information on context for development of the action, capacity building, funding and resource mechanisms, implementation, and monitoring and evaluation.

In the initial consultation process, 13 examples of existing actions were identified.

An initial synthesis of the examples was undertaken. It focused on only 10 of the 13 examples because they included enough relevant information for analysis within the theme of health-system actions on SDHI. The methodology and approach used to inform this initial synthesis are described elsewhere (30,31).

The original case studies or descriptions of the health-system actions were used – of the 10 examples, eight were peer-reviewed and published case studies. The remaining two were a peer-reviewed article about the action, and a detailed overview of the action. This initial synthesis yielded important common themes across the examples that were tested with stakeholders (some original and some new) in another meeting, and from this a set of themes that might form the basis for principles for good practice was derived.

A further six examples were identified, and/or developed, as case examples for inclusion in the synthesis for this publication, bringing the total to 16. The peer-reviewed article was excluded in this second analysis. Of the 15 remaining examples, 12 were from peer-reviewed and published case studies and the remaining three were prepared as new case studies for inclusion in the web-based resource. These examples have been and/or are currently being peer reviewed.

In addition, another three to four examples are being developed for inclusion in the web-based resource. Table 1 outlines the key features of the 15 case studies presented in this publication including the level and type of health-system action. Details of the original sources for each case study including the purpose for which they were originally produced are outlined in Annex 1.

Table 1. Overview of the 15 examples and level of policy action

National	
1. Germany – Law 20 on prevention (32)	This describes the implementation of Law 20 (social code book no. 5) with its focus on (workplace) health promotion, primary prevention, self-help and reducing social inequalities in opportunities to be healthy. It also describes how this Law had been put into practice by the German social health insurance system by using examples of initiatives for unemployed and elderly as well as workplace health promotion.
2. Ireland – Building Healthy Communities programme (33)	This programme was a three-year demonstration initiative conducted in 2003–2006. The two-phase programme was developed by the Combat Poverty Agency with the aim of supporting disadvantaged communities, both geographical and sectoral, and tackling poverty and health inequalities. The second phase included: (a) the piloting of new approaches to community development through the funding of 10 community development and health projects with a focus on providing services for vulnerable groups and/or facilitating and improving their access to services; and (b) a range of programme support activities to capture the key lessons from this work for transference into policy guidance.
3. Netherlands – a health for all approach to public health (34)	This describes the development of policies to target health inequity in the Netherlands over 20 years – from 1985 when the Government first adopted WHO Health for All policy targets up to 2006. In the interim period two major government-sponsored research programmes paved the way for development of a specific equity objective and a series of policies and programmes designed to reduce health inequalities.
4. Norway – national strategy to reduce social inequalities in health (35, 36)	This strategy was outlined in report no. 20 to the Storting (Norwegian parliament) and together with two other reports (see pp.30–31) these reports form the Norwegian Government's <i>comprehensive policy</i> for reduction of social inequalities, promoting inclusion and combating poverty. Report no. 20 lays down the guidelines for the Government and ministries' efforts to reduce social inequalities in health over the next 10 years.
5. Poland – improving equity of access to health care (37)	This describes five solutions that were introduced into the Polish health system beginning in 1999 in order to ensure equity of access to care for the country's most disadvantaged and vulnerable groups. 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.
6. Sweden – public health policy (38)	This refers to the National Public Health Bill of 2002 which sets out 11 policy objective domains with the overall goal "to create societal conditions that will ensure good health for the entire population". It uses an intersectoral structure for objectives and targets and allows the Government to adopt applicable intermediate targets to work towards. It represents a strategy for informing and structuring public health action in Sweden.
7. United Kingdom – England – a systematic approach to achieving the inequalities target for infant mortality (39)	This illustrates how health inequalities in infant mortality are being tackled in England using a systematic approach of reviewing the evidence, setting targets, monitoring progress and promoting good practice within a comprehensive, cross-government health inequalities strategy. It specifically focuses on the actions taken after the 2007 target review found widening inequalities, which include: development of a good practice implementation plan; and the establishment of an infant mortality national support team (NST).
Subnational	
8. Germany – With Migrants for Migrants – intercultural health in Germany (MiMi) (40)	The MiMi programme aims to level unequal long-term health opportunities by making the health system more accessible to immigrants, increasing their health literacy and empowering them through a participatory process, thus promoting their individual responsibility for health and awareness of health issues. This is achieved through culturally sensitive interventions in health promotion and prevention, together with the provision (in migrants' native languages) of information about healthy living, how to deal with the German health system and how to make use of its services.

9. Italy, Padua (Veneto region) – High Council for Immigration (41)

The High Professional Immigration Body is the main organization that provides social and health care services for documented and undocumented immigrants in Padua and is a part of Local Health and Social Authority No. 16. It is the result of a collaboration of institutional and non-institutional bodies that – with different contributions – have implemented a coordinated system of plans and activities. Services created specifically for foreigners are: the Listening Centre, which provides information and health and social orientation services; a multi-ethnic unit for obstetrics and gynaecology; a unit for dermatology; and units for community paediatrics.

10. Italy (Tuscany region) – Community Health Partnership (42)

Community health partnerships (CHPs) are an initiative by the regional government of Tuscany, consisting of public consortia made up of municipal and local health units. Initially introduced as pilot programmes following constitutional reform (Law 3 of 2001), the CHPs are now mandatory under regional laws 40 and 41 of 2005, the Regional Health Plan and the Regional Integrated Social Service Plan. The partnerships provide a structure for intersectoral work with the overall objective of strengthening the integration of health and social services at local level. This approach is being implemented as part of a wider objective to realize the right to health through a strong health and social services system.

11. United Kingdom – Scotland (NHS Lothian) – A whole systems approach to reducing health inequalities (43)

In late 2006 the Board of NHS Lothian approved a *whole systems approach* across the health service in the way that business is done to address health inequalities. The approach being implemented focuses on three main strategies: (1) ensuring mainstream services are accessible to all; (2) putting in place specific initiatives to support disadvantaged groups to access health services; and (3) partnership work to address determinants of health inequalities more directly and include working with other sectors.

12. Slovenia (Pomurje region) – Programme MURA (44)

Programme MURA is a subnational programme that began in the early 2000s from the implementation of the investment for health concept in Slovenia. It aims to integrate health into the regional development programme in the Pomurje region, which at the time was the most disadvantaged region in the country in terms of health and socioeconomic indicators. Intersectoral collaboration plays an important role in the success of the Programme. Regional health inequalities are tackled through specific initiatives and activities designed to address educational and employment opportunities and to improve the economic and environmental sustainability of the region, such as eco-tourism.

13. Spain – Health Promotion among Navarre Ethnic Minorities programme (3)

This programme aims to reduce health inequities by improving the health of the Roma community. The approach used is assets-based: people from within the Roma community are trained as mediators and then act as peer educators and as a liaison between the community and the central health, social and education services. The mediator plays a key role in documenting the health history of families in the health implementation zone and drawing up a health plan in cooperation with the appropriate service providers.

Local**14. Austria – neunerHAUSARZT – demand-oriented health services for the homeless (45)**

Overall neunerHAUSARZT aims to safeguard and improve homeless people's access to standard primary level health services. After 18 months as a pilot, the project became a permanent initiative, with the Vienna District Health Insurance Fund and the Viennese Social Fund agreeing to cover 100% of the costs. Today, it provides health care at 11 (out of 24) Viennese hostels for the homeless, accommodating 1202 people. Physicians working in the programme liaise with a range of other health and social care professionals to ensure a holistic approach in the delivery of health services to homeless people.

15. Romania – a community approach to controlling tuberculosis (46)

This project has successfully improved tuberculosis-related knowledge, thus enabling prompter detection of tuberculosis (TB) cases and improved completion of treatment within Roma communities in Romania. As well as improving people's knowledge, the project sought to reduce the stigma associated with TB and improve detection rates and adherence to treatment. The campaign was based on the use of qualified peer health educators from within the Roma community. All the health services promoted during the project were offered within the Romanian public health system, through the national TB control programme.

2.5 Using case studies as data: a pragmatic approach in the face of alternatives

The timeframe for joint action and the willingness of key stakeholders to develop existing examples of health-system action on SDHI using a new format, limited the choice of approaches to analysing the information. In addition, there was a very clear brief to develop examples for action using a case study format. Within the time allocated for the work, existing available data were used as much as possible. The initial synthesis of the 10 examples proved that significant information could be derived. In addition, the number of case studies in this field has increased tremendously in the last eight to ten years particularly through the work of the CSDH knowledge networks (e.g. HSKN produced 20 case studies) (19) and European and EU projects in the field. See for example the good practice directory at the DETERMINE web site (<http://www.health-inequalities.eu/>) or the case studies developed as part of the HealthQuest project on quality and equality of access to health care (47). One advantage of this for policy advisers is that case studies can provide a source of readily available information and data. This is important in a time- and resource-constrained environment.

It is recognized, however, that alternative approaches to synthesizing and deriving key themes for health-system action on SDHI exist, specifically systematic reviews. Systematic reviews use a specific search strategy with inclusion criteria to identify and collate original studies that meet their criteria. The results are combined or “pooled” in a way that is intended to limit bias and random error (48). A systematic review is often a significant undertaking. One systematic review undertaken to generate evidence on the impact of wider public health interventions that affect the SDH and health inequalities included a focus on access to health and social care but found only four reviews in the “access to healthcare” domain (49). Given the parameters of the project (time, a collection of examples for a web-based resource, and resources), however, it was decided to make better use of the existing available data in case studies.

2.6 Case studies: their potential and limitations

The MEKN (6) identified the importance of methodological diversity in developing an evidence base for action on SDHI, noting the need to choose approaches for generating evidence in way that is “fit for purpose”. This implies that those involved in developing policy options for action on SDHI

need to: draw on more than one type of evidence, beyond the evidence generated by more traditional methods such as clinical trials; and that no particular type of evidence should be privileged over another. It is important, however, to use a systematic approach in generating and/or reviewing the available sources of evidence. This includes unpublished knowledge and/or tacit knowledge (knowledge that is implied or unknown), in particular that created through implementation and learning from practice. Case studies are one mechanism for ensuring that tacit knowledge is systematically collected (6) and for generating evidence from practice about what does or does not work in taking action on SDHI.

A good case study should provide insight. A case study is usually the intensive study of a single case (in this instance a programme, policy, etc.) for the purposes of generating insight (50) into a particular issue. It is designed to tell a specific story (including the story of “best practices”) and, by its nature, uses narrative or rhetorical tools that can lead to the information in the case study being treated as testimony rather than evidence. In addition, the knowledge contained within the case study is often viewed as the exemplar or prototype for action, rather than how the knowledge could be generalized for action in other contexts. This issue was identified in the consultations with key stakeholders. Another potential limitation of case studies is that the examples that form the basis of them are selectively rather than randomly generated.

However, case studies are more easily undertaken and made available than some of the more traditional forms of evidence generation. There is a wealth of case studies to draw on within this field as a result of activity in the past eight to ten years. Therefore they form an important available source of existing knowledge from which policy advisers and entrepreneurs can draw. Responding to the challenges identified through the consultation with stakeholders, this study has tried to move beyond some of the limitations of case studies to demonstrate how the knowledge emanating from them can be systematically collected and presented in order to generate evidence informed options for action.

2.7 Systematically recording information from the examples: the template

A template was developed for capturing key criteria to profile examples on the web-based resource and based on the initial synthesis. It includes four sections to demonstrate four different ways of presenting (lenses) or

looking at health-system action on SDHI and to record this systematically in relation to each example.

1. *The first focuses on the end point of reducing health inequalities.* What is the goal that the action is trying to reach and what are the implications for monitoring progress towards that goal? This uses Hilary Graham's typology of the main approaches for tackling inequalities in health (51) to assess whether the action was attempting to remedy health disadvantage, narrow the gap between disadvantaged and more privileged groups, or address the whole social gradient in health.
2. *Focusing on the principal functions of a health system,* as reflected in the WHO Regional Office for Europe's health-system strengthening framework (52), attempts to see where the balance of actions lies across the four functions of service delivery, financing, creating resources and stewardship/governance. What health-system stewardship means in practice is not always well understood and breaking the concept of stewardship/governance down into its subfunctions is difficult. Using the examples helps to present a clearer and less theoretical picture of what health-system stewardship for health equity means.
3. *Focusing on the social determinants of the observed health inequalities* asks what are the different ways in which health systems could influence social determinants of health inequalities and what is the focus of the actions in practice. This uses a framework developed in collaboration between the WHO Regional Office for Europe's Office for Investment for Health and Development and Margaret Whitehead and colleagues (20,53) to assess where the actual thrust of the action in these examples is aimed. These range from: (a) addressing inequalities in access to health services that lead, contribute to or exacerbate inequalities in health status; (b) preventing or ameliorating health damage caused by wider determinants outside the health system; (c) acting with other sectors to influence wider social determinants outside the health system; and (d) making a direct attack on the social determinants of health inequalities, such as tackling low income and unemployment through exploiting the health system's ability to create jobs. In the template categories (c) and (d) are merged into one category of direct action and stewardship on the social determinants.
4. *Focusing on the necessary processes and preconditions for a health system to tackle health inequalities* uses a framework developed by the HSKN to assess whether the action addresses any of the four


overarching processes that health systems need to engage in to promote health equity: (a) leveraging intersectoral action; (b) engaging and encouraging participation of population groups and civil society; (c) making arrangements that aim at universal coverage; and (d) revitalizing comprehensive primary health care (19).

Though the four lenses are independent of each other, they also overlap. They should not be used to assess or benchmark examples presented in the web-based resource. The four lenses are used here to provide a focus on the specificity of the examples reviewed. Of the four, only the first – the categories for better describing the equity objective of an action by Graham (51) – is presented in detail in this publication. This is because of its relationship to the second principle for action in the checklist – what is the equity objective that the action was designed to address? However, more detailed analyses of each of the four lenses in relation to the examples are being developed and will be the subject of future publications.

In addition, the examples were selected because of their focus on action on SDHI. This means that the case studies will reflect and emphasise the health inequalities dimension of the action rather than particular features of the health system which might already be in place and are fundamental for action to occur (see section 3.7).

The following section uses the examples to highlight where one or more of the good practice principles is addressed but no assessment is made of the quality of the practice(s) *per se*. This is for the reasons identified previously – lack of agreed criteria and approach to systematically assessing action in this area. Also, the tools for evaluating actions to address SDHI are not well developed or sensitive enough at this stage to be able to attribute a specific change in health inequalities to one particular policy or aspect of it. However, using the principles for better extraction of knowledge for action and uptake in a way that is systematic may ultimately facilitate a change.

The principles form a checklist that can be used to *do-confirm* rather than *read-do* (54). The latter checklist is like a recipe – the tasks can be carried out as they are checked off. However, it is not possible to follow a recipe in developing solutions to counter SDHI. Therefore, what is meant by the *do-confirm* checklist is to: (a) check that the information collected from each example adequately addresses or answers each of the principles, after it has been collated; and/or (b) to review proposed options for health-system action on SDHI prior to implementation,



in order to check that the options adequately addresses each of the principles (54).

This is not to imply that ticking off each of the principles means that practitioners will get it right – this is not the ultimate goal. Nor does it contradict the fact that health inequalities are a complex issue and there is no simple solution or single response. Policy (particularly health and social) responses involve a degree of uncertainty and complexity, and therefore raise issues that, while they seem obvious (e.g. Was the problem correctly defined?), are important enough to include in a checklist, so that they are not overlooked. The following principles are thus proposed as a checklist. The aim is to ensure that one does not forget to take the obvious but core steps (54) in creating an evidence-informed foundation for development of health-system actions on SDHI.

Chapter 3. A checklist of key principles for reviewing examples of practice

... much can be gleaned from the tacit knowledge of practitioners about how things work by supporting them to document the processes that lead to effective delivery of social interventions (6:70).

Some principles are unique to this field and others are more general and apply to all good practice in programme or policy design – coherence and programme logic. What does generic good practice look like in the design of health equity actions – coherence and programme logic for equity? Through the original synthesis several principles that apply to good practice for all policy and programme design have been identified (e.g. clarity of objective, etc.) – *generic principles*. These principles may appear to be obvious but are included for three reasons. The first is to demonstrate the issues in the application of the basics of good practice in the field of the SDH and health inequalities. The second is to highlight potential gaps in some of the case studies: i.e. the principles may have been applied, but are not mentioned in the original case study. The third is because sometimes these principles have been overlooked or not applied despite the best intentions of policy advisers and practitioners. As indicated previously, the case studies are used as explanatory examples to highlight the key issues of specific principles and no assessment is made about the quality of the practice or how the principle was implemented.

In addition, the following principles (see sections 3.1–3.8) do not explore in detail the mechanisms and processes that lead to the development of the health-system action described. This would be the subject of another publication. Moreover, this type of analysis has been undertaken through a series of policy learning case studies about action on health inequalities with some countries in the WHO European Region, such as the case study from Norway by Strand et al. (55). In addition, the following checklist does not imply that the mechanisms and process(es) for developing policy responses to SDHI or any other policy issue are linear – it is recognized that they are multi-faceted, non-linear and opportunistic (35).

3.1 Is health equity really the objective of the action?

Often actions to address the SDH are understood as being directed towards equity, when there may be no intent to address the distribution of health

opportunities and impacts. This does not alter the need to assess whether some population groups are disproportionately affected (positively or negatively) by the action. In some cases, population-based initiatives on SDH that do not consider distribution of impact may unintentionally make inequalities worse by improving the health and opportunities for health of those who are already advantaged at a faster rate than those who have health disadvantages (56). Tackling the SDH and tackling the social determinants of equity are not the same things (51,57). An assessment of examples of actions means distinguishing whether the action (be it policy, programme, project or practice) was intended to improve health equity or reduce health inequalities or simply to improve overall population health by tackling those social determinants that contribute to it.

Likewise a focus on “vulnerability” or vulnerable groups is often equated with a commitment to equity. However, it is important to define and understand what is meant by vulnerability, which can be defined in terms of age groups, sex or life stages such as a focus on children, the transition to school, and the transition to retirement and to older age. In all of these examples the potential vulnerability is physiological and does not equate to an equity focus unless it is cross-linked with social determinants and circumstances (58).

Equity is mentioned in seven of the 15 examples reviewed in the synthesis but how it is then translated into practice may differ slightly different from the stated intent or objective. The absence of a specific or defined equity goal in seven of the examples is due to the fact that several predate the system for categorizing and differentiating equity objectives as proposed by Graham (51). However, this is changing and examples now often include a more explicit statement of the intended outcomes with regard to health equity.

The lack of an explicit equity commitment does not mean that the intention is absent but that stating it may have been seen as unnecessary. For example, the traditional approach to health policy-making in Sweden is to use universal, population health strategies to achieve health for all groups: “to create societal conditions to ensure good health, on equal terms for the entire population” (38). Therefore the Swedish public health legislation has an equity focus that is more often implicit than explicit but is also underpinned by an unstated assumption that part of public health activity should be to “improve the (health) most for the groups that have the worst health status (38).” This focus is consistent with:

Health in equity obviously reflects other inequalities in the society: different levels of power and influence, economic differences,

inequalities in education and housing. Interventions that influence health in equity are hence very difficult to distinguish from general social welfare policy (38:324).

In contrast, the whole-of-government approach in Norway is explicit about equity, *levelling up* across all social groups using a mainly universal, population-based approach to tackle social determinants such as education and employment conditions (36). This reflects increasing awareness and application of more clearly defined equity objectives rather than the assumption that improving the SDH and improving health equity or reducing health inequalities always means the same thing (for example, see Box 2). Even where the equity objective is clearly stated, the translation into practice may not be consistent with the stated objective. A recent review of national-level approaches to tackling the SDH and equity both separately and as part of public health approaches (56) highlighted a potential flexibility in the interpretation and application of both SDH and an equity objective across all countries.

Box 2. Programme MURA: improving opportunities for health through direct action on the SDH (44,59)

Programme MURA is a subnational programme developed in the early 2000s out of the implementation of the investment-for-health concept in Slovenia. Its goals are:

1. to improve the health and quality of life for the people in the Pomurje region through the identification, development, implementation and strengthening of best practices in the field of socioeconomic and environmental development, and
2. to ensure that an understanding of health underpins the development potential of the region and vice versa: that is, development as the basis for better health.

The Programme seeks to integrate health into the regional development programme in the Pomurje region, which when the initiative began was one of the most disadvantaged regions in Slovenia in terms of health and socioeconomic indicators. Intersectoral collaboration plays an important role in the success of the Programme. Regional inequalities in health outcomes are tackled through specific initiatives and activities designed to address educational and employment opportunities and to improve the economic and environmental sustainability of the region, such as eco-tourism, together with an intensive health promotion campaign to improve the population's lifestyle focused on the rural population and vulnerable groups. It is an important example of where the **primary motivation was not health equity, but tackling the social determinants** as part of regional development in order to reduce the differences in economic and development opportunities between Pomurje and other regions in Slovenia.

3.2 Moving beyond generic commitment to reduce health inequity to more specific objectives

Following on from the first generic principle, in order to be able to assess whether an action is making a difference to health inequalities, it is important to have some agreed and consistent way of framing the objective, so that it is more than aspirational and can be measured. A good-practice principle in this regard is whether **the equity objective can be easily identified because it has been clearly stated**. Graham's equity categorization (51,56) provides a useful way of framing the equity objective and looking across examples. The categories are:

- a. remedying health disadvantage;
- b. gap;
- c. gradient;
- d. a combination of two or all three of the above (51,56).

Therefore the questions are: (i) whether the example is actually intended to address inequalities or just social determinants generally without regard to social or geographical differences; and (ii) whether the equity objective is clearly stated. Examples of each of the categories include:

- a. *remedying health disadvantage* – to reduce health inequities by improving the health of the Roma community (3);
- b. *reducing the gap* between two groups – to increase the healthy life expectancy of the lowest socioeconomic groups in the population at a faster rate than the healthy life expectancy of the highest socioeconomic group (34);
- c. *levelling up across the gradient* – “to reduce social inequalities in health by levelling up” (36). Reducing health gradients provides a comprehensive policy goal of equalizing health chances across socioeconomic groups **including remedying health disadvantage and narrowing health gaps**. However the emphasis here is that to reduce the socioeconomic gradient, health in other socioeconomic groups also needs to improve at a faster rate than in the highest socioeconomic groups (60).
- d. *remedying health disadvantage and gap* - “starting with children under one year, by 2010 to reduce by at least 10% the gap in mortality between routine and manual groups and the population as a whole (39)”.

Table 2 provides an overview of the breakdown of the different equity objectives for each of the 15 health-system actions and in relation to the

intended level of policy reach and impact – national, subnational and/or local. Most national initiatives are being delivered at subnational and local levels. Nevertheless, the policy or action is still intended to have national reach and impact, because such initiatives remain part of an overall and national approach. It is important to differentiate the level of intended reach and impact of the examples for the purposes of transferability. Where the example did not include an explicit statement of equity intent (for reasons outlined previously), it was initially classified as “not specified”. The examples are not a representative sample but are presented to highlight or explain a particular feature of equity action, e.g. what levelling up across the gradient looks like.

Table 2. Health-system actions by equity categorization and level of policy intent

Level of policy intent	National	Subnational	Local
Category			
Not specified (not matched)	Sweden, national public health policy with a focus on determinants and creating opportunities for health (38)	Slovenia, Pomurje region, Investment for Health and Development in Pomurje, Programme MURA (59)	
Not specified (in practice reflects remedying health disadvantage)	Germany, legislating for primary prevention and health promotion with a focus on addressing social inequalities of opportunity (61)	Italy (Veneto region), integration of social and health services for immigrants, the case of the High Professional Immigration Body, Padua (62)	Austria (Vienna), programme <i>neunerHAUSARZT</i> : demand-oriented health services for the homeless (63)
	Poland, legislating to improve equity of access to health care (64)	Italy (Tuscany region), the Community Health Partnership of the north-western zone of Florence (65)	
		Germany, With Migrants for Migrants (MiMi) programme (66)	

Level of policy intent	National	Subnational	Local
Category			
Remediating health disadvantage	Ireland, community funding programme, phase 2 – national level programme delivered at subnational and local levels (67)	Spain, Health Promotion among Navarre Ethnic Minorities programme (68)	Romania, a community approach to controlling TB (69)
Gradient	Norway, national strategy to reduce social inequalities in health (70)		
Combination	<p>Netherlands, approaches to public health and their focus on reducing socioeconomic inequalities in health:</p> <ul style="list-style-type: none"> reducing the gap in healthy life expectancy and remediating health disadvantage (34) <p>United Kingdom (England), a structured approach to achieving the inequalities target for infant mortality:</p> <ul style="list-style-type: none"> reducing the gap and remediating health disadvantage (39) 	<p>Scotland (NHS Lothian), a whole systems approach:</p> <ul style="list-style-type: none"> remediating health disadvantage and a gradient focus through universal, targeted and “distributional” services - the gradient across quintiles (43) 	

Of the eight examples that were initially identified as “not specified”, six were actions that in practice could be seen as seeking to remedy health disadvantage. This was because they focused firstly on improving the health of a specific population group (immigrants, the poor and/or the homeless). Secondly they aimed to improve access to health and social services

through increased opportunities. They also tried to decrease barriers. In the case of introduction of Law 20 on prevention in Germany, the equity focus was left relatively open and not expressed in terms of these categorizations or with any specificity that would enable measurement of the potential equity objective:

Health insurance should provide services of primary prevention and health promotion to increase the health status of the overall population, and in particular to reduce socially-caused inequality of health opportunities (32).

In practice, Law 20 has been implemented through a series of projects that focus on promoting the health of specific population groups (e.g. workplace health promotion), and/or remedying health disadvantage (unemployed, older people living in disadvantaged suburbs) (61). Box 3 outlines another example of remedying health disadvantage in practice.

Box 3. Remedying health disadvantage among the homeless: the neunerHAUSARZT programme (45,63)

The overall aim of the programme is to safeguard and improve homeless people's access to standard/primary level health services. It is implemented by an incorporated, non-profit-making association, to establish and manage housing for homeless people according to their needs. The equity objective of the programme is not specifically stated but in practice the programme specifically targets a clearly defined segment of the population (the homeless) and so is understood as remedying health disadvantage. The programme addresses access to health services and the provision of appropriate and acceptable services to remedy health disadvantage experienced by a specific group. It is user-friendly, not bureaucratic, and acceptable to the target group because no appointments are needed, waiting times are appropriate and it takes into account their special needs. The homeless are accepted as they are, thus avoiding discrimination and stigma.

The seventh of these examples is the Programme MURA in Slovenia. While it has no specific health equity goal, its focus is similar to that of the Swedish public health legislation – to tackle and improve the wider socioeconomic determinants within the Pomurje region of Slovenia, so as to improve the regional disparities between health indicators of population within Pomurje and the populations in other regions of the country. Rather than remedying health disadvantage per se, the focus has been on tackling SDH such as access to higher education and school retention, fair employment

and better health literacy, and their impact on opportunities to be healthy within the region (44,59).

Programme MURA could be understood as an example whose equity objective is reducing the gap between this region and the rest of the country. In addition, while the initial objective was to tackle SDH as part of improved regional development, the policy context for the Programme has evolved in such a way that increased attention to health inequalities and health equity is now an explicit goal. In 2005, the Pomurje region developed a regional strategy and action plan to tackle health inequalities (71). The objectives of this strategy have been integrated into the regional development programme for the period 2007–2013. In 2009, the Ministry of Health placed health equity higher and more explicitly on the political agenda with the intention of preparing a national strategy or common framework to tackle this issue. The National Institute of Public Health made health equity and the SDH priority areas in the strategic plan for 2010–2015, and systematic analysis and monitoring of health inequalities and the SDH are under discussion by the key national institutions (44,59).

Sweden provides the eighth example. Here, the equity objective is not explicit in the government bill and therefore “not specified”. However, the intent is “to create the societal conditions to ensure good health, on equal terms, for the entire population” and there is a statement about the importance of remedying health disadvantage for specific population groups (38). The policy was updated in 2008, adding greater elements of individual choice and responsibility and to include a focus on subgroups within the population such as children, young people and the elderly, particularly on initiatives aimed at strengthening and supporting parents, increasing suicide prevention efforts, promoting healthy eating habits and physical activity and reducing the use of tobacco (72).

In the 2008 case study of the Swedish national public health policy, the equity objective was categorized as focusing on health gaps between different groups (73). By contrast, Vallgarda (74) categorizes the Swedish policy as having a focus on the social gradient and remedying health disadvantage. However, the policy remains categorized as “not specified” because there is no stated equity objective and it is not possible to tell from the original case study alone whether in practice there is deliberate action either to decrease gaps between groups or to level up the health of different social groups at a faster rate across the social gradient (56). It therefore has not been categorized as meeting either of these equity objectives.

The case studies from Sweden and Slovenia highlight a challenge in applying the categorization because the focus of both objectives was clearly and specifically on creating the social conditions for good health across the population. Put another way, both approaches sought to reduce the number of people in the population exposed to unfavourable SDH such as high levels of poverty. The focus of both approaches is upstream on factors, such as employment and increasing opportunities for employment, rather than placing the emphasis on further developing the social safety net. While there is no explicit statement about equity, both approaches are underpinned by a concern for the distribution of opportunities for all groups in the population to be as healthy as possible. In practice, however, it is not easy to tell from either example whether there has been a deliberative effort to improve the health of the lowest socioeconomic groups at a faster rate (Sweden) or to improve the health the people living in the Pomurje region at a faster rate than that of the general population (Slovenia). Both, however, are important examples of action that can be taken in this area. They highlight the lack of a defined equity objective, which makes measurement with regard to health inequalities potentially a challenge. In the case of Programme MURA, the recent developments highlight how the evolution of the programme however has led to improved health equity as a more explicit goal.

Three of the examples given in this document had a stated focus on remedying health disadvantage – two were focused on improving the health of Roma communities (Spain and Romania) (68,69). The third, Phase Two of the Irish Building Healthy Communities (BHC) programme was designed to improve the health of disadvantaged populations. In practice, projects funded by the BHC programme focused on population groups that were geographically disadvantaged (remote locations) or through disability or being Travellers (67). In terms of being able to measure impact or achievement of the equity objective, both the Spanish and Romanian initiatives included measurement of health status before and after the introduction of the initiatives. In addition, both these initiatives had a strong focus on community engagement and participation, including the training of peer health educators for working in and with Roma communities (3,46,68,69).

None of the examples reviewed had reducing the gap between groups as its primary or only objective. In England, the infant mortality target was aimed at improving the health of disadvantaged mothers and infants in

the target group and **closing the gap** between this routine and manual group and the whole of the population. Thus, closing the gap appears to be the primary outcome of action (39). However, related initiatives, such as the Family Nurse Partnership, have a sharper focus on socially-excluded groups that mostly are not covered by the target. The target focus has, in practice, also been widened in terms of policy and delivery to encompass all disadvantaged groups. Based on this, the example of the structured approach to achieving the infant mortalities target in England, is classified as a combination of closing the gap and remedying health disadvantage (39).

The Norwegian national strategy to reduce social inequalities in health (36) along with the Reports to the Storting on employment, welfare and inclusion and early intervention for lifelong learning (75,76) form part of the Norwegian Government's comprehensive policy for reduction of social inequities, inclusion and combating poverty. The national strategy sets out the guidelines for the Government and ministries' efforts to reduce social inequalities in health over the next 10 years (36) (see Box 4). This is the only example among those reviewed (and currently within the WHO European Region) that has tackling the social gradient through levelling up as its specific and primary aim:

We must therefore continue to build on the Nordic tradition of general welfare schemes and at the same time implement special measures to help the people with the most problems (36:7).

The national strategy reflects an evidence-informed approach, through use of health intelligence that demonstrated that social inequalities in health affect all groups in the Norwegian population (35,77).

In practice, the Norwegian approach includes a combination of all three objectives whereby they note the need for measures to remedy health disadvantage. This is consistent with Graham's categorization (51) whereby a gradient approach provides a comprehensive policy goal of equalizing health chances across socioeconomic groups including remedying health disadvantage and narrowing health gaps (Box 4). There needs to be deliberate action to reduce the socioeconomic gradient by improving the health of the lowest socioeconomic groups at a faster rate.

This is one of the first national policies with the specific equity objective of tackling the social gradient (36,56).

Box 4. Four priority areas for action: the Norwegian approach (36)

There are four priority areas for reducing SDHI and their objectives.

- 1. Reduce social inequalities that contribute to inequalities in health through:**
 - a. reduced economic inequalities
 - b. safe childhood conditions and equal development opportunities
 - c. inclusive working life and healthy working environments.
- 2. Reduce social inequalities in health behaviour and use of the health services through:**
 - a. reduced social inequalities in health behaviour
 - b. equitable health and care services.
- 3. Targeted initiatives to promote social inclusion through:**
 - a. better living conditions for the most disadvantaged people.
- 4. Develop knowledge and cross-sectoral tools through:**
 - a. systematic overview of developments
 - b. all sectors of society assume responsibility
 - c. increase knowledge about causes and effective measures.

Two of the examples (Netherlands and England – infant mortality rate target) (34,39) reflect, in stated intent and practice, a combination of the equity objectives of remedying health disadvantage and reducing the health gap – usually between the disadvantaged group and the rest of the population. The example from the Netherlands draws largely from a case study of approaches to public health over more than 20 years and with a focus on equity and social determinants (34). In 2001, the Netherlands Government adopted a goal of raising the healthy life expectancy of the lowest socioeconomic groups by 2020 by at least 25% of the current difference in healthy life expectancy (about three years). This goal was informed by ten years of investment in two national research programmes on socioeconomic health differences (see principle 3.3). In addition to this, the Government's adopted policy agenda was to begin new initiatives in the four fields recommended as part of the ten-year research programme, namely interventions and policies targeting:

- socioeconomic disadvantage;
- health-related selection;

- factors mediating the effect of socioeconomic disadvantage on health; and
- the accessibility and quality of health care services (34).

However, no specific policy instruments were introduced to enable implementation of the policy goal. Within four years the focus shifted to remedying health disadvantage, with responsibility for addressing health arrears moved to municipalities, and a focus on vulnerable groups was introduced. In 2003, this goal was used by the Netherlands Court of Auditors to call the Government to account, and in 2006 the Ministry of Health was also summoned to state more clearly in the coming budget what actions would be taken to achieve the goal (34). Current (2010) health-system efforts to address health inequalities in the Netherlands focus on improving prevention and health promotion efforts for vulnerable groups. The Government is planning to incorporate a number of preventive initiatives into the standard health insurance coverage or basket of services. In addition, it is seeking to build improved cooperation within the health system between the health and curative sectors (78).

The example from NHS Lothian is classified as a **combination** as it focuses on both remedying health disadvantage and having a focus on the gradient. NHS Lothian recognizes that it is also about the gradient, not only about the most disadvantaged, but also about universal, targeted and “distributional” services. For example, those undertaking equity audits regularly look for the gradient across quintiles (43). It is not clear, however, whether the whole systems approach means that the health of the lowest socioeconomic groups is improving at a faster rate than other groups within the region and/or the population. This again highlights a flexibility of interpretation (56).

3.3 The problem and the solution: have the conceptual framework and causal pathways been clearly articulated?

Understanding and mapping the causal pathways between SDH and health equity have improved considerably in the last 20 years. This is reflected in the number and sophistication of conceptual frameworks to explain the relationships between different social determinants, health outcomes and sometimes their distribution. CSDH’s conceptual

framework is one of the most recent, and incorporates a strong focus on the distribution of power and resources within society (12). This conceptual framework was advanced by the HSKN (see Fig. 1) to include:

- (a) the identification of **five key entry points or levels for action** – social stratification, differential exposure, differential vulnerability, differential access, use and experiences of health care and differential consequences; and
- (b) **potential points of intervention** to improve health equity – leveraging intersectoral action for health, primary health care, social empowerment and universal coverage (19).

While conceptual frameworks are important, they provide only a starting point for defining the problem and setting the parameters for action once the causal pathways are agreed. The HSKN framework also builds on a simpler and more generic conceptual framework, developed by Diderichson, Evans & Whitehead (79), which uses the five key entry points and seeks to identify the key social determinants and their distribution within a specific setting. For example, gender norms and standards are usually an important social stratifier. However, gender will be a more significant social determinant of SDHI in some settings than in others.

The key principle in reviewing the examples is to identify whether the problem and its causes have been clearly stated, and whether the health-system action (or solution) seem to match the stated causes. Does the solution match the problem definition? Is the problem that the action was designed to address clearly articulated? Does the description of the example show why such action was necessary, and what the causes or causal pathways of the problem are? Without this information it is difficult to assess whether the action is in fact a “good” practice, because while it may be well-designed, the problem has been poorly defined and the two do not match. It may also be that the problem is well-defined but there is a mismatch between the level at which the action is delivered and the stated objective. Box 5 presents how a health profile was developed to inform action on SDH in the Tuscany region.

Box 5. Developing a health profile for integrated health and social service provision (65)

The Community Health Partnership of the north-western zone of Florence, in Tuscany, Italy, is one of several community health partnerships (CHPs) that are part of an initiative by the regional government of Tuscany. The CHPs consist of public consortia made up of municipal and local health units. They provide a structure for intersectoral work with the overall objective of strengthening the integration of health and social services at local level. This approach is being implemented as part of the wider objective to realize the right to health through a strong health and social services system. A health profile was developed as the first assessment of needs produced by the CHP of the north-western zone of Florence. This profile enabled the partners to identify priority areas and population groups for action, and to develop data that can be used to compare and evaluate the expected outcomes from implementing the CHP. Policy-makers may find the health profile methodology of interest if they are considering how to measure and assess the best way to take action on the SDH. It is an example of how better health intelligence has been used to improve access to services by immigrants and to provide new or additional health and social services for them to improve their health.

3.3.1 *Articulating the problem and solution(s)*

The case study from the Netherlands (34) is an important example of this principle in practice. During the 1990s, the Ministry of Health, Welfare and Sports invested in generating increased knowledge (health intelligence) about health inequalities. The initial five-year knowledge generation programme focused on establishing the size and nature of socioeconomic differences in health and their determinants in the Netherlands. As part of this, a large follow-up and longitudinal study was initiated to identify the causes of socioeconomic inequalities in health (the GLOBE study). The next five-year programme focused on the development and evaluation of interventions and policies to reduce socioeconomic inequalities in health using quasi-experimental design. The results were used to inform the development of the quantitative target adopted by the Government: raising the healthy life expectancy of the lowest socioeconomic groups by 2020 by at least 25% of the current difference in healthy life expectancy (about three years). It was also used to inform the Government's policy agenda (see section 3.2) including interventions and policies targeting the accessibility and quality of health care services (34).

The development of the Swedish Public Health Policy with its intersectoral approach to creating the conditions for good health was preceded by over three years' work to draw up national goals for public health (Box 6).

Box 6. A clear problem statement and solution: the Swedish case study (80:28)

“Research has shown that most of today’s diseases and health problems are caused by several interrelated factors. In other words, there is seldom one single factor sufficient to cause an individual to be ill. Furthermore, exposure to the same risk factor is often a contributory cause of several different disease and injuries. Public health work can most effectively be carried out, therefore, by focusing on so-called health determinants, i.e. the living conditions, environments, products and lifestyles that influence public health, rather than on individual diseases. Tackling the causes of ill health or developing good health factors will clarify the political nature of public health work. Society will have a common responsibility.”

A National Public Health Committee was established in 1997 and given the task to develop national goals that “... act as guidance for initiatives to promote public health, prevent illness, reduce risks to health and prevent premature and avoidable disability, ill-health and death.” (81:1) The Committee included members from a broad range of backgrounds ranging from politicians to experts in public health and public health practitioners, academia and non-government and consumer representative organizations. It produced two interim reports, 19 scientific reports and ten discussion documents before arriving at the final proposal for public health goals (81).

The extended summary of the Public Health Objective Bill (Govt. Bill 2002/03:35) (80) includes a statement of the evidence and key public health challenges facing Sweden. This includes both the epidemiological evidence and an analysis of key trends. In terms of inequalities, mortality was decreasing in almost every socioeconomic group, apart from blue collar women, but there had been no overall decrease in inequalities in the past 20 years. Health inequalities were described as being another major challenge for public health in Sweden. Key trends reviewed included: demographic trends such as birth rate and family size; working life in relation to globalization, technical development and economic conditions; welfare; environmental factors; lifestyle, including communicable diseases; and trends in health and medical care. Comparisons were made with Europe and across different social groups based on education, family structure, receipt of welfare benefits and/or vulnerable groups (e.g. substance abusers) (80).

In 2003, Sweden adopted a national and intersectoral public health policy that was innovative for its focus on the determinants of health. The policy was updated by the new government in 2008 (72). The 11 objective domains of the Policy address the most important determinants of Swedish health and as reflected in the evidence base as presented in the extended summary and Box 6 (72,80):

1. participation and influence in society
2. economic and social prerequisites
3. conditions during childhood and adolescence
4. health in working life
5. environments and products
6. health-promoting health services
7. protection against communicable diseases
8. sexuality and reproductive health
9. physical activity
10. eating habits and food
11. tobacco, alcohol, illicit drugs, doping and gambling.

3.3.2 Problematisation: who defines the issues?

Work on reviewing national approaches to health inequalities using the Graham categorization (74) highlighted the importance of the process of problematisation. This refers to the usually political process by which issues related to health inequalities are defined and made accessible to policy action. Box 7 gives a brief insight into the definition of the problem and areas for action in the case of the High Professional Immigration Body in Padua, Italy. This is different from defining the problem and causal pathways in that problematisation involves analysis of the stakeholders and politics involved in defining a problem. Blackman et al. (7), in their analysis of the target and performance management approaches in three different countries, note that it is not possible to make claims about what works when the way that issues and problems are defined differs significantly either between or perhaps within countries.

In an early case study on the development of the Norwegian approach, Torgersen et al. (35) noted that:

In a rational view of policy making it may be believed that issues reach the policy agenda by recognition of problems. From a normative perspective governments should, in the public interest, search for problems and rationally assess problems, solutions,

actors, timing, context and implications. The problem of social inequalities in health had been recognised by scientists for quite a long time without automatically triggering any comprehensive policy response (35:17; 82).

Box 7. The High Professional Immigration Body, Padua, Italy (62)

The High Professional Immigration Body of the Local Health and Social Authority in the municipality of Padua, Veneto region of Italy aims to improve the integration of health and social services through both inter- and intrasectoral action. It is the main organization that provides social and health care services for documented and undocumented immigrants in Padua and is a part of Local Health and Social Authority No. 16. In Veneto, as elsewhere in Italy, immigrants with regular residence permits tend mainly to use the emergency services and, to a lesser degree, specialist services. The **impetus for the initiative** came when a senior paediatrician noticed changes in the demographic characteristics of patients seeking health and social services, with a significantly high number of undocumented migrants and large number of cases of social isolation among them. **Thus it was deemed imperative to increase** the immigrants' uptake of preventive health services, as well as to pay attention to the integration of their social, mental and physical well-being. The involvement of other institutions was a priority if these issues were to be addressed, because their material resources and knowledge were needed to develop an efficient response.

This process of defining and owning the problem is fundamental to understanding how the stated equity objective is developed and then what happens in practice. In addition, problematization defines who is responsible for acting.

As noted earlier, the question of problematization is not addressed in detail in this publication, largely due to limited information about this process in the case studies used. However this process is described in more detail in a recent policy-learning case study of the Norwegian policy approach (55). It found the following key factors were important in defining the problem in Norway and the eventual policy response:

- a. country-specific research on the prevalence and causes of health inequity and on related policy interventions;
- b. creation of an arena in which experts or communities of specialists and practitioners can interact and generate common ground, capacity and receptivity for tackling complex issues;
- c. clear and consistent framing of the problem and the possible policy options;

- d. creation of a strong team or network of policy entrepreneurs to communicate the problem and bridge the equity goals of the health and other sectors towards the achievement of the broader governmental agendas; and
- e. basing of the process for developing the national strategy on existing structures including linkage and coherence with other national strategies and policy approaches (55:2–3).

3.4 Evaluation of impact on inequalities

Has the health-system action been evaluated for its impact on health inequalities? In an environment where one wants to know with increasing specificity what works and how, it is necessary to check whether the health-system action has made a difference to health inequalities and/or how it has been evaluated. There are many dimensions to evaluation. These dimensions assume greater relevance at different stages of the work. The choice of what and how to evaluate, e.g. what is measured or assessed, depends on the change theory being applied (6) and the assumptions made about why and how the action would make a difference to SDHI.

Of the 15 examples reviewed for this publication, fewer than half had evaluated the actual health impacts, rather than or in addition to implementation of the action itself. While, as noted previously, the case studies are only explanatory examples and not a representative sample, the limited information available about the impact of the action on health inequalities is not unusual. Measurement or evaluation of the impact of actions to address health inequalities is hindered by a range of factors, including conceptual dilemmas, biased reporting, statistical fallacy and implementation failure (83). However, this is changing with an increasing focus on performance management of health inequalities. Key examples of countries that are focusing on evaluation of inequalities action include England, Norway, Scotland and Slovenia. There is a real and increasing commitment to measurement and follow up on specific targets. This is about moving away from seeing the targets as only aspirational, to looking at how implementation is taking place, using information from monitoring to improve actions at local and national levels. This offers a better chance of achieving the stated targets or goals. Some of the more specific issues to consider when reviewing the evaluation of the examples are presented below.

3.4.1 *Being able to describe a difference: having data on “before” and “after”*

In **Romania**, baseline health data on a brief health promotion intervention to improve uptake of diagnosis and treatment services for TB among a limited number of Roma communities enabled both process and impact evaluation to be undertaken. Prior to implementation, a baseline survey was conducted to gather information on knowledge and attitudes to TB, and to identify potential sites for the intervention. The preparatory work not only provided baseline data but also helped to gain the trust of the Roma community, which is essential to the effective implementation of such interventions.


The baseline data made it possible to measure the impact of the campaign by comparing one group who were exposed to the awareness-raising, education and information campaign on TB, and one group who were not. The evaluation found that, where knowledge of the treatment and transmission of TB was concerned, those who had been exposed to the health education and awareness campaign were better informed than the group who had not been so exposed. They were more likely to act in ways to reduce the transmission of TB to others and to seek treatment from available TB services (42,69).

3.4.2 *Comprehensive approaches to evaluation*

In **Spain**, the Health Promotion among Navarre Ethnic Minorities programme, established in 1987, is one of the examples reviewed where there has been an evaluation of both implementation and the impact of the programme on health (Box 8). The programme has been evaluated at different levels including process and impact evaluation and outcomes. The Public Health Institute is responsible for evaluating the programme (3,68).

Box 8. Health Promotion among Navarre Ethnic Minorities programme (3)

This programme aims to reduce health inequities* by improving the health of the Roma community. It was initiated by the Saint Lucia Foundation Patronage (a nongovernmental organization) and its management was subsequently taken over by the Public Health Institute of Navarre. The approach used is assets-based: people from within the Roma community are trained as mediators and then act as peer educators and as a liaison between the community and the central health, social and education services.



In terms of process and impact evaluation, the ongoing training of the peer educators/mediators is regularly evaluated. Data on specific indicators are obtained through collaboration between mediators and primary health care professionals. As part of the programme, a health census of the Roma community is carried out manually by mediators in their health zones and contains very detailed information on the health of families. This information is analysed by health professionals and used to determine health needs. Specific records are also collated on school attendance. The census provides important information for the development of appropriate action, as well as baseline data for monitoring and assessment of changes in health status and needs (3,68).

A complete evaluation of the programme (covering 1987–2006) highlights some lessons for the future. It has been successful in creating a real concern about health in Roma communities, and health services are increasingly responding to their health needs. To start, the focus tended to be on children's and women's health but, as a result of the health census and family histories, new issues are coming to the fore. Efforts are now required to standardize the monitoring system across the different zones, and to pay particular attention to Roma perceptions of health when prevention programmes are designed. A related and complementary policy development is the publication on Roma community and health (84). This report includes the first results of the Roma national survey on health and makes proposals and recommendations for reducing health inequities (3,68).

While no specific health targets have been set for the programme, evaluation has shown that positive results have been achieved in primary health care, women's health, health education and school attendance. For example, 80% of children have been vaccinated against childhood diseases; 70% of adolescents have been vaccinated against hepatitis B; and 39.7% of children attend the dental prevention programme (3,68).

An external evaluation of the Building Healthier Communities Programme in **Ireland** was commissioned in 2008 (85) (Box 9). The aims of the evaluation were: (a) to assess whether the Programme's aims and objectives had been achieved; (b) to identify its strengths and weaknesses; (c) to capture the main practice and policy learning on community development approaches; and (d) to identify opportunities for mainstreaming elements of the Programme (69,85).

Box 9. The Building Healthy Communities Programme: Ireland (67)

The Programme was undertaken in two phases commencing in 2003, and developed by the Combat Poverty Agency to support disadvantaged communities, both geographical and sectoral, and to tackle poverty and health inequalities. It provided resources and technical support to community development and health projects. Phase 2 included: (a) the piloting of new approaches to community development through the funding of 10 community development and health projects with a focus on providing services for vulnerable groups, and/or facilitating and improving their access to services; and (b) a range of programme support activities to capture the key lessons from this work for transference into policy guidance.

The evaluation found that the Programme had helped to increase the capacity for more effective participation by groups. It also helped to build effective relationships between projects and national and local government organizations; enabled the development of effective community development approaches to health inequalities and poverty; increased the opportunities for networking and for reflecting on and sharing good practice; and strengthened both the role of the community health worker and the collective voice among community health projects (67,84).

3.4.3 Beyond the generic to the specific: using targets to assess impact on health inequalities

While health inequalities can be defined as “wicked problems” – that is, they do not lend themselves to single or simple solutions – this need not impede greater efforts to measure the impact of actions on SDHI (7). There is extensive debate about how targets are set, then measured (83) and interpreted. Vallagarda (74), for example, found that one national-level programme had remedying health disadvantage as its focus, but the indicators for assessing changes as a result of the programme measured the distribution of health across the social gradient. However, improved knowledge about what the data and results mean is leading to changes in the way in which actions on health inequalities are being monitored and evaluated (74).

An important example in this regard is the action taken in England to recognize that progress in achieving the infant mortality target by 2010 was not on track. Despite limitations with the methodological basis of the target itself (83), a dedicated review was undertaken in 2006 and the results of the review were made public in February 2007. The review provided a better

understanding of what was required to help meet the target in terms of the local delivery challenges and the interventions most likely to help meet the target (39). It made five recommendations for rapid implementation to assist local authorities in reaching the target:

- develop and promote action that will help deliver the target through activities such as promotion of examples of good practice and ensuring dissemination of these examples;
- promote coordinated delivery of services to the target group with the published guidance for implementing the Government's maternity commitments;
- encourage ownership of the target at local level through effective performance management;
- raise awareness of the target and what it means through improved communication; and
- improve data quality and strengthening the evidence base including commissioning research to improve the evidence base (39).

The review resulted in the development of a good-practice guide for implementation including seven evidence-based interventions that will contribute to reducing the gap and help local authorities to meet the target (86). The approach used in England by the Department of Health's Health Inequalities Unit represents an important principle of good practice (39). The findings from the review of overall progress in implementation of the national cross-government programme for health inequalities gave insights into how implementation of the related programmes could be strengthened to improve the chances of achieving the infant mortality target on health inequalities (83).

One of the oft-debated issues with targets is what is measured and how representative it is of the issue. A project that looked at the difference that the approach of each part of the United Kingdom (England, Scotland and Wales) to applying targets and performance management had made in tackling health inequalities found that it was not possible to say with any certainty "what works" because the targets and policy priorities were often not comparable (7). The expert group that informed the Ministerial Task Force on Health Inequalities in Scotland suggested that three measurement approaches be used to give a comprehensive picture of inequalities across the population in relation to the headline indicators for coronary heart disease, cancer, alcohol and all-cause mortality (87). The three dimensions proposed were:

1. a relative index of inequality to measure the steepness of the inequalities gradient;
2. an absolute range to measure the size of the gap between the most deprived and least deprived groups; and
3. the scale of the problem including the underlying size and past trends (87).

3.4.4 Investment in measurement and monitoring for evaluation

Sweden made a significant investment in developing a system for monitoring of its intersectoral public health policy. Since 2004, the Swedish National Institute for Public Health (SNIPH) with the help of several Swedish authorities has monitored progress of the policy. This has been done through two mechanisms. First, a public health policy report aims to provide an account of the measures implemented by central agencies, county councils and municipalities to influence public health and identify future directions for action (“proposals”) (88). Second, a national public health survey shows the state of the population’s health and follows up changes over time. It is an ongoing collaboration between the Institute and county councils and regions in Sweden (conducted annually from 2004 to 2009 with the latest results available in English). The survey results are presented nationally and at regional level. The national data are cross-linked with sex, age, employment, level of education, country of birth and economic situation (64,89).

SNIPH pursued a detailed process of dialogue and consultation to develop a system with indicators for monitoring of the implementation of the new public health policy. For example, consultations were held with 45 central state agencies on a SNIPH proposal for indicators for the 11 domains of objectives described earlier. Furthermore, a dialogue was established with central state agencies and county administrative boards over two years, to identify their roles in the field of public health and report on the measures they are taking to achieve the overarching goal of the public health policy (90). To support implementation at the local level the SNIPH compiled basic public health statistics for local authorities to assist with planning and monitoring of their public health work (88).

The first public health policy report was released in 2005 and included 36 principal indicators and 47 subindicators (related to 42 determinants of

the 11 objective domains). This report provided an important snapshot of implementation as well as of public health in the 11 domains by gender, life-course (children, young people and older people) and inequalities. It identified nearly 400 proposals for development for the public health policy which were reduced to 42 priority proposals (88). In relation to health inequalities, it was noted that health inequalities would impact on the achievement of the overarching goal of creating the right conditions for good health for the population and:

... should be rectified first and foremost by employing general measures. Health impacts should be assessed to a greater degree, especially the effects of measures on different socioeconomic groups and people of a different sex and origin (88:11).

The first policy report also recommended continued stepwise implementation of the policy with cross-sectoral collaboration at national level and ongoing investment in building capacity. The public health policy report using the 2009 data is available (72). Of the case studies reviewed, England (infant mortality target) (39) and Norway have also made significant investments in their reporting systems (91). In addition the Scottish Government as part of its national strategy on health inequalities, *Equally Well* (92), has made significant investment in a system for monitoring and evaluation of the strategy. The implementation plan includes a commitment to develop an evaluation framework that builds on the implementation plan and enables the analysis of medium-term outcomes (92).

3.4.5 The challenge of attribution: how do we know that it worked because of the action?

One of the key challenges for evaluating the health inequalities impact of actions lies with attribution. Given the complexity of health inequalities and their causes, it is rarely easy to attribute impact to a specific policy, programme or intervention. In its first annual public health policy report, the Norwegian Directorate of Health (91) observes that the measurement of trends in avoidable deaths is a useful method for an overall assessment of the quality and availability of services (a core priority of the national strategy). However, the report also notes that “Striking a balance between simplification and precision is demanding, especially where access to data is limited. This report is also a first attempt to show the trend in and distribution of key health determinants – and it is by no means exhaustive; the reporting has to be continually improved” (91:9). This is particularly

the case with measurement of intersectoral and systemic action on health inequalities.

The challenge may also have its roots in some of the issues described in the principles outlined previously, including: How were the problem, the solution and equity objective defined? What systems and mechanisms were put in place to measure impact and impact of what? What was the theory of change: i.e., the conceptual framework of cause and effect (6)? Are all of these factors aligned and consistent? Are they all explicitly stated somewhere in order for such an assessment to take place?

Recent work on health-system strengthening makes the case that often evaluations of health-system interventions focus on individual interventions or actions or the individual functions (e.g. health-system financing) rather than the system as a dynamic whole and/or the intervention as part of system (93). This may also explain some of the challenges inherent in attribution. Box 10 presents some key attributes of a more systems-oriented approach to evaluation.

Box 10. Skills of a systems-thinking approach (93:43)

1. *Dynamic thinking* is about framing a problem in terms of patterns over time rather than particular events.
2. *Systems-as-cause thinking* is about looking at those who manage the policies and workings of the system.
3. *Forest or big picture thinking* is about understanding the context of relationships in order to know something (see sections 3.5 and 3.7).
4. *Operational thinking* is about concentrating on causality and understanding how a behaviour or change is generated.
5. *Loop thinking* is about understanding causality as an ongoing process that has a feedback effect to influencing causes.

Norway and England have both sought a better understanding of the overall impact of their approaches to health inequalities, including investment in reporting and monitoring systems and processes of review. In **England** this took the form of regular status reports (2005, 2006 and 2007) on the 2003 strategy in the programme of action and further updates (2008 and 2009) on the national target. The status reports included monitoring

of the target, as well as wider determinants (94–96). In addition to this the review of health inequalities post 2010 in England (Marmot review) (97) was established to propose the most effective strategies for reducing health inequalities in England from 2010 and reported in February 2010. The Marmot review was initiated “... amid widespread concern that health inequalities in England persist, despite ... a plethora of policies and actions designed to narrow health gaps” (97:7).

In **Norway**, the Directorate for Health is responsible for coordinating the design and development of indicators as part of the reporting system and in close collaboration with relevant ministries, directorates and professionals. An intersectoral review and reporting system has been established to provide a systematic and regularly updated overview of developments in achieving the policy directions. Based on this system and starting in 2009, an annual policy review is published (55,70). Each annual report includes the main national initiatives and strategies, goals for reducing inequalities and comments on the trend for each indicator (91). The report is then used as a basis for annual reporting in the national budget through joint reports in the Ministry of Health and Care Services’ budget proposition (91).

While developing the strategy, the Government decided not to use quantitative targets, given the longer-term nature of social policy interventions and the challenge of attribution to a specific intervention or programme. Instead, the annual public health policy report presents trends using a set of indicators for the intervention areas of income, childhood conditions/education, work and working environment, health behaviour, health services and social inclusion. These indicators are aligned with the objectives of the strategy which in turn are based on the policy priorities identified in the intervention map (55:36–37). This map can be understood as a conceptual framework or representation of the theory of change that underpins the Norwegian approach to tackling social inequalities. The first report, in 2009, identifies trends that are regarded as being matters of serious concern. For example, school retention rates or prevention of students leaving school before completing secondary education is identified as potentially “one of the greatest public health challenges we face” (91:6). For the moment, however, the challenge of specificity and attribution remains.

3.5 Policy consistency and/or coherence

Assessing an example of action for policy consistency and/or coherence is important in order to:

- enable uptake, integration and sustainability of any inequalities action with existing policies and programmes (within the health system and in other sectors); and
- determine whether there are other policies and programmes (within the health system and in other sectors) that may be counterproductive to achievement of the equity objective of the proposed action on SDHI.

So how consistent is the proposed initiative or action with other government mandates? Are there existing systems and structures to enable integration of the proposed initiative within a wider policy approach to health and/or reducing inequalities in health? For example, in the United Kingdom the NHS is underpinned by the principle of equity of access based on need, not ability to pay, and this informs all health-system policies and programmes. In addition, in **England**, a whole-of-government approach is in place to reduce health inequalities and has enjoyed strong political support as a priority for government over the last 10 years (98). Health inequalities were reaffirmed as a priority by the new United Kingdom coalition Government formed in May 2010 as part of its commitment to promote fairness and social justice, including the introduction of a new duty of the NHS to tackle health inequalities (99).

In terms of policy coherence, tackling health inequalities has been at the centre of a web of government priorities to address social justice through the 30 public service agreements (PSAs) covering the whole-of-government activity. Seven national PSAs relate directly to health and inequalities in infant mortality, including issues like child poverty. Local action is driven by the *Implementation Plan for Reducing Health Inequalities in Infant Mortality* (86), a good-practice guide for achievement of the infant mortality target and narrowing the (infant mortality) gap, and the work of the infant mortality national support team. There is consistency between national objectives, local good practice and existing policy mandates and governance mechanisms for implementation and monitoring (e.g. NHS Operating Framework 2008/09 – Vital Signs and the new performance framework for local authorities and local authority partnerships: single set of national indicators) (39). Although the formal PSA structure has been discontinued by the new coalition government, the focus on health

outcomes, local action and an integrated, cross-government approach – including on issues such as child poverty – is already part of its approach in tackling health inequalities (39).

Other policies and programmes can be potentially counter-productive and have an impact on the effectiveness of any proposed action to address SDHI, no matter how well-designed they are (78). Therefore as part of this process, it is also important to assess whether there are in fact other policies or actions (within and outside the health system) that are potentially inconsistent and work counter to the inequities initiative. For example, is there a strengthened commitment to primary health care and ensuring universal access to the health system, but an increase in patient contributions to primary-care services or pharmaceuticals and increased out of pocket expenditures to be borne by families? The NHS Lothian whole systems approach to tackling inequalities outlined in Box 11 is an example of policy coherence.

Box 11. NHS Lothian whole systems approach: several policy strands together (43)

The development of the whole system approach to tackling inequalities in NHS Lothian, Scotland preceded the development of a national strategy on health inequalities in Scotland in 2008. The approach was informed by a range of policy developments highlighting the need to address health and social inequalities. These included the 2004 update of *Closing the opportunity gap* (100) and health improvement strategies that emphasized improving life circumstances as part of health improvement strategies. In addition, the whole systems approach is consistent with legislative requirements to address specific inequalities and discrimination relating to race, gender and disability. *Fair for all* (101) provided guidance to NHS boards on ensuring equality of opportunity and non-discrimination in relation to race, gender, age, sex, sexual orientation and disability. The whole system approach sought to bring these different policy strands together. Finally NHS Lothian is one of the Equally Well test sites for collaborations between local public services aiming to reduce inequalities in the health and well-being of people who need those services and established to support implementation of the national strategy on inequalities (2008).

3.6 Use of existing structures for development and delivery of the initiative

Using existing structures for development and delivery of an initiative sends an important message that tackling health equity is part of “core

business” of the relevant agencies. The **Norwegian** National Strategy to Reduce Social Inequalities in Health, for example, is being implemented through reorientation of existing initiatives and budget allocations through the national budget, and is not a separate action plan with separate budget allocations. This is because a separate pool of funding for action in this area would potentially have undermined the basic tenets of the national approach: that reducing SDHI is the business of government and a range of sectors including health; and should be done through reorientation of existing policies and their means of implementation (e.g. annual budgets) (35).

This is important to the longer-term sustainability of any of the actions, and in order to mainstream some of the actions to reduce health inequalities. Most of the examples reviewed were designed to use existing structures for the development and/or delivery of the action and the emphasis lay in doing things differently. For example, see the With Migrants for Migrants programme in Germany as outlined in Box 12.

Box 12. With Migrants for Migrants: working within the existing system (66)

The programme With Migrants for Migrants – intercultural health in Germany (MiMi) aims to level unequal long-term health opportunities by making the health system more accessible to immigrants, increasing their health literacy and empowering them through a participatory process, thus promoting their individual responsibility for health and awareness of health issues. It is an example of how a culturally sensitive intervention can be used to enhance the access of a specific population group to existing mainstream health services without the need for a new and/or targeted service. This is done through two key strategies: (a) improving migrants’ health literacy and knowledge so as to improve their access to existing health services; and (b) building the capacity of health service providers to be responsive to the particular needs of different migrant communities. MiMi started as a pilot initiative in four cities and is today delivered in 48 cities with continuing support (financial and in kind) from an expanded range of partners.

This is not to imply that additional funding and/or resources will not be required to “kick-start” or enable reorientation of existing efforts. Several of the examples of health-system actions used funding in this way. They include the Programme MURA for investment for health and development in Slovenia; the community-based approach to TB control in Romania; and the community funding initiative in Ireland.

The project in **Romania** focused specifically on the development and implementation of a national health education strategy for TB control in order to improve knowledge about available treatment and diagnosis services and thereby remove an important barrier to take-up of these mainstream health services. Implementation of the initiative has not necessarily involved major change (resources or system) and it is demonstrably sustainable. The Ministry of Health is now responsible for the funding and administration of this targeted health promotion approach, thus moving the project towards greater sustainability (39,42).

In Romania, some small additional funding was used to “kick-start” as part of an overall approach for integration of health equity into the wider health system and its existing structures (39,42). This is integral to achieving sustained change for greater health equity and enabling mainstreaming of a health equity focus as part of core business.

In contrast, the next principle highlights the importance of maintaining some existing policies, programmes, practices and/or principles as fundamental to the action.

3.7 The importance of context and the existing foundation for action

The template for capturing the examples on the web-based resource includes a section on health-system context. It seeks to present basic information about the health system including its financing and structure. In addition, one of the lenses in the case study template outlines four features of health systems with potential for promoting health equity. Universal coverage is one of these.

Section 3.6 notes that the emphasis is on using existing structures but doing business differently. Here, it is about ensuring that certain policies, practices and principles that are fundamental to action on SDHI remain in place: for example, universal access to health care. This principle in action was emphasized recently in the report by Whitehead et al. (20) as part of the task group on delivery systems and mechanisms for reducing inequalities in both social determinants and health outcomes. The task group reiterated the need to maintain an equitable NHS that confronts inequalities in service delivery as part of its business. The main principles of the NHS, which then underpin all policies and programmes, are:

- equitable financing of the system through general taxation;
- universal entitlement;
- free at point of use;
- comprehensive range (primary, secondary, prevention and promotion, mental and physical health care, chronic and acute care);
- geographic comprehensiveness for spread of services, based on strong primary health care, and selection on the basis of need for health care not ability to pay; and
- encouragement of a non-exploitative ethos (20:13).

It is important to emphasize these principles because this publication and the examples in the web-based resource focus on health-system action to counter SDHI. This means that it is easy to overlook key features that need to be in place for the action on health inequalities to take place. Of the examples reviewed, that from Poland is the only one in which the action on SDHI focuses solely on strengthening universal coverage through legislative changes and improved stewardship (see Box 13).

Box 13. Poland: improving equity of access to health care (64)

In 1995, action was taken to develop mandatory universal health insurance. This case study describes the five principles that were introduced into the health system from 1999 onwards to ensure equity of access to care for the most disadvantaged and vulnerable groups:

1. mandatory universal health insurance for all eligible people (1999);
2. voluntary insurance within the mandatory system;
3. free access to financed health services for uninsured poor people;
4. prohibition of treatment of private patients by public health care providers; and
5. protection of access to dental health care services by insured poor people.

Previous measures to strengthen the health care system, while important for those living in poverty, had not adequately protected such people's right to equity in health and health care. The government recognized the social right to free access to health care services and took steps to find solutions to the problem of protecting this right.

The detail provided in the other 14 case studies does not necessarily emphasize the fundamental or essential feature(s) that need to be in place for the action to be implemented. From these 14, some of the others that include strengthening universal coverage as part of the overall action include:

- Health Promotion among Navarre Ethnic Minorities (Spain) (68);
- community control of TB (Romania) (69);
- improving health literacy and knowledge of health-system services and rights among migrants for improved access to care (MiMi, Germany) (66);
- both examples from Italy to improve access to mainstream services through better integration of health and social care services at the subnational level (62,65); and
- the approach to improving best practice in achieving the infant mortality target in England (39).

Those examples that emphasize presenting the “why” and “how” of direct action on the SDH (such as Norway, Slovenia, Sweden) also rely on a strong, comprehensive and universally accessible health system being in place. For instance, the objectives of the Swedish public health policy are largely focused on SDH and health promotion and prevention activities, but the health service is understood as an important public health determinant and its efficiency and equity of access to care are seen as fundamental to supporting the creation of good health on equal terms (38). Therefore, most if not all of the examples are drawn from countries that have provision for universal access to health care/coverage. The health-system action has thus been developed based on the assumption that universal coverage is in place and specific efforts are required, either to strengthen other critical features (intersectoral action, revitalizing primary health care and/or participation and engagement) or to strengthen how well universal coverage is being achieved in practice.

The health-system action in **Poland**, however, focuses on the fundamentals of the health system in order to improve equity of access to health care and protect access of those living in poverty in particular. The consolidation of previous regulation and legislation into one act in 1999 (to provide for mandatory, universal health insurance) set the foundation for protection of equal access to health care services for all Polish citizens. As a result, 98–99% of all Poles and other people living legally in Poland are covered by obligatory health insurance. For individuals who are unable to make contributions to the system, such as the unemployed without unemployment benefits, the State pays the contribution. Children and pregnant women (Polish citizens) are entitled to free treatment regardless of whether they are insured or not. Likewise pre-hospital emergency services are covered by the

State and free access is also available to everyone (regardless of citizenship) in the case of: alcohol or drug addiction, selected psychiatric treatment, selected infectious diseases (e.g. TB), prisoners, and refugees (37,64).

All five largely legislative measures (see Box 13) were put in place to enhance access to health care services in a non-stigmatizing way, reducing conditionality, for example, but removing the need to prove inability to pay for health insurance. They were also developed in response to ongoing monitoring of the system (required by legislation), which identified that the system could be strengthened to better ensure equity of access to care (64).

3.8 Existing capacity and mechanisms for building capacity

It is important to build on assets and capacity where they exist, but it cannot be assumed that capacity always exists to tackle inequity within the health system and particularly when reorientation is required. Capacity means more than training or good intentions – it is about building organizational and systems to act, to be responsive rather than reactive, and to sustain the approach. Neither can it be assumed that those who are expected to deliver the health-system action or intervention share the same values, or even a commitment to equity (102,103). Even where there is a commitment, the capacity to act effectively may be limited.

So was action designed with reference to the existing health capacity or capacity to act in a way that promotes the consideration of health equity? And if not, were mechanisms put in place to build capacity? Failure to consider capacity may result in, or contribute to, implementation failure. This is not because the action was not well designed, but because existing capacity and what was or is required to enhance or facilitate its introduction were not taken into account. The case study about Article 20 from Germany illustrates how policy-makers recognized at the outset the importance of building capacity for effective implementation (see Box 14). The web-based resource related to this document includes several examples of health-system actions to counter SDHI that focused on building capacity within the system. Of the examples reviewed, about half had a specific capacity-building component to enable implementation of the health-system action. This usually included a combination of sensitizing health professionals (at the primary care level) (Austria, Germany, Romania and Spain) (63,66,68,69) to the SDH and disadvantaged or vulnerable groups, together with training and

use of community-based peer health mediators (Spain, Romania, Germany) (66,68,69).

**Box 14. Generating knowledge for implementation:
the case of Article 20 in Germany (61)**

In 2000 the German Government amended Article 20 of the fifth Social Code Book (SGB V) to require health insurers to provide measures to improve the health status of the population in general and in particular to reduce socially caused inequalities in health opportunities. Previous experience had indicated that primary prevention and health promotion initiatives could inadvertently increase inequalities between groups by improving the health of some at a faster rate than others. For the implementation of this amendment, the health insurance funds and their umbrella organizations were able to make use of their own personnel in the field of prevention and (company) health promotion. However, the revision of the law, with its requirement to contribute to reducing socially conditioned inequality, also made it necessary to obtain expertise from outside the health insurance fund system (largely academic experts from a wide range of disciplines) to design interventions or train the insurance staff. This new area of activity represented unknown territory for the health insurance funds. After the amendment to Article 20, a group of experts was formed to develop guidance for health insurers on how to implement the measure, particularly to reduce socially caused health inequalities. This resulted in 13 recommendations for the design of projects to pilot health promotion and primary prevention initiatives. Since 2002 a number of model projects have been developed, implemented and evaluated. This is an important example for policy advisers of how to build capacity to enact a legislative commitment to reducing SDHI.

As part of programme *neunerHAUSARZT*, in **Austria** six physicians provide regular low-threshold health services at 11 (out of 24) hostels for homeless people in Vienna. These doctors are experts in social medicine, and some have worked with drug addicts or in social work concerned with individuals and their personal circumstances. However, the programme includes training young doctors in the field of social medicine to complement the team (45,63).

With the *MiMi* programme in **Germany**, capacity building takes place at three levels. The first is among the migrant community in terms of education about relevant health issues, the German health care system in general and how to access local health services. The second is through the training of mediators, where members of the migrant community are trained to teach other immigrants, particularly those who are at a socioeconomic disadvantage, about basic health issues and the German health system. It takes over 50 hours to obtain a teaching certificate, with follow-up sessions. At the same

time, there needs to be a greater degree of institutionalization of the social integration of immigrants. The third level, therefore, is the training of social and health/medical professionals. These professionals are trained in issues relating to immigration so that they can help the migrant community more effectively and display a greater awareness of challenges relating, for example, to culture and socioeconomic disadvantage that affect the migrant community (40,66).

The Health Promotion among Navarre Ethnic Minorities programme in **Spain** has made a significant investment in building capacity within the Roma community. The central actors in the programme are the mediators from the community, who are selected according to specific criteria deemed important for this role and extensively trained to liaise between the community and the health services. They also participate in coordination with local services and are a valuable resource. The programme increases mediators' opportunities for education, emphasizes and gives importance to their skills and assets, and strengthens their leadership abilities, all of which also have a positive impact on the community and the programme itself. In addition, it aims generally to value and strengthen the role of Roma women, who are educators and caretakers of children and the elderly, and primarily responsible for passing on Roma cultural norms. Improving their health thus has a multiplying effect, with benefits for other family members (3,68).

Training is adapted to the needs of the Roma communities. The mediators highlight areas where they need more information or education, as identified through the Roma associations, e.g. for outbreaks of communicable diseases or issues related to lifestyle, life transitions, chronic diseases and prevention. Staff from the relevant agencies meet once a year to incorporate additional items into the annual training programme (3,68). Finally a range of tools has been developed to support the programme, including a training package for cultural mediators and a local health census (see for example the handbook for working with Roma communities (104)).

In **Ireland**, the BHC Programme had as one of its specific objectives "to build the capacity of community health interests to draw out practice and policy lessons from their work" (33). It sought to establish an infrastructure whereby the projects could interact with each other and with external agencies. Having such an infrastructure led to increased opportunities for learning, training and sharing knowledge. The evaluation found that "strengthening the capacity of the community development sector and providing opportunities for the organizations involved to learn and grow" was one of the programme's main strengths (67).

Individual projects also provided training: for example, the Fettercairn Health

Initiative gave a group of local residents participatory rapid appraisal training. This helped to strengthen their understanding of health needs within their community and of how health service decisions are made locally. Funding from the Programme enabled the employment of community development workers for some projects, although it relied on volunteers. The evaluation found that this could cause difficulty in areas with high levels of deprivation and not enough development workers to maintain interest and develop capacity. The presence of a dedicated community health worker was considered to be extremely important for the success of the project (67,85).

In **Norway**, the Expert Group on Social Inequalities in Health, which was established to provide research-based advice to inform the development of the national strategy, also has an important and ongoing capacity-building mandate including working for a better understanding of social inequity in health in society and contributing to better communication between research communities, decision-makers and the population (55). In terms of capacity building, one of the four components of the national strategy is the development of cross-sectoral tools to enable the promotion of good health and reduction of social inequalities in health. To date, specific capacity-building initiatives have included the following.

- Regular internal seminars are held in the Directorate of Health on health equity with the purpose of disseminating and sharing the latest knowledge on specific social determinants, their impact on health and the distribution of impact. In 2009 two seminars were held – on education and health; and health services. In 2010, a further two seminars were held, on work and health and on social capital and health, and a third was planned on housing/accommodation and health.
- Professional support and advice were provided to counties and municipalities on health determinants, monitoring, health impact assessment (HIA) and use of other cross-sectoral tools for improved planning and public health development (55,70).

One of the examples that is being developed for the web-based resource but not included in this synthesis is the Inequalities Sensitive Practice Initiative (ISPI) from **Scotland** (105). It merits mention because it is an innovative approach to putting in place professional and systems capacity to counter SDHI. ISPI involves looking beyond delivery of services and resourcing to building the human capacity of all those involved in the health system or service to understand and be responsive to health inequalities. It provides a corporate approach to both strategic planning of multiagency services and the

actual system and human changes required to implement services aimed at reducing inequalities. This is not only about care and treatment services, but includes employment and procurement practices to ensure equity sensitivity, all underpinned by an evaluation process. ISPI was set up to be one of the tools that will help the NHS, and its partners in the delivery of integrated services, find out what will improve the effectiveness and efficiency of frontline practice and determine what type of planning and policy arrangements are required to facilitate and sustain those practice changes (105).

3.9 The checklist: bringing the principles together

The following checklist (see Box 15) is derived from the generic principles and provided for policy advisers and practitioners to use in reviewing examples on the web-based resource and other case studies, to assess their potential transferability to another policy context. The generic principles in turn were derived from reviewing the examples. The MEKN also identified a range of criteria derived from effective interventions, however, which it proposes could be used to assess examples of action on health inequalities to understand what made them successful, and from which to generate a learning-from-practice database (6). The MEKN criteria overlap to some extent with the principles outlined in this publication and from which the checklist is derived, for instance, how practitioners were trained and supported to deliver the intervention. The difference is that some of the MEKN criteria are addressed through the additional information recorded from examples using the template for the web-based resource, such as the policy context for development of the action (6:73).

As signalled earlier, the checklist is not intended to be followed unwaveringly, like a prescription or a recipe, because health inequalities are a complex problem for which there is no simple solution and no single answer. Instead, it is intended to stimulate new approaches and interpretations within an individual health system. It can be used to interrogate, evaluate and better understand examples of action, so that these examples can be adapted and reshaped to achieve a better fit with prevailing circumstances of the particular health system. The checklist is provided as a summary of the key *do-confirm* steps to follow through once policy advisers and entrepreneurs have reviewed a range of options for acting and/or decided on an option for acting.

Box 15. The checklist

1. Is it about action on SDH with the objective of reducing health inequalities? Or does it focus only on tackling the SDH without regard to distribution of impact, i.e. health inequalities?
2. Is the equity objective clearly defined?
3. Do the equity objective and actions match the problem or issue they are designed to address?
 - Is it easy to see what the problem was including the causal pathways?
 - Is there information about how the problem and solution were defined and developed, including who was involved?
4. Has the action been evaluated for its impact on health inequalities?
 - Did the evaluation approach have a model of attribution?
 - Were the assumptions about the links between the issue or problem and solution made clear?
 - Were the indicators or targets and measures for monitoring them relevant or consistent?
 - Was the theory of change that informed the solution made clear?
5. Is the action consistent with the broader policy context? For example, is the social protection system also designed to promote universal coverage? Is there enough information about the broader policy context to be able to assess this?
6. Is there enough information about the health (and/or social) system context to identify essential or fundamental features that need to be in place to support the action?
7. Were additional human, financial and other resources required for implementation of the action, or was it done by redirecting existing resources?
 - How was this done – by introduction of a new funding formula for allocation of resources with an emphasis on equity, for example?
 - Is there a system for monitoring progress?
 - Is there any evidence that this has made a difference to practices within the health system?
8. What investment was made in building capacity to act and to implement the health-system action? Is there any evidence that this has made a difference to practices within the health system?

Chapter 4. Conclusion


The overall objective of this publication and the web-based resource is to identify, collect and review health-system actions on SDHI to assist policy advisers and entrepreneurs to identify knowledge about “what works”. Three issues came to the fore in undertaking this work.

- Overall challenges that exist in this field relate to the monitoring, measurement and assessment of action on health inequalities. These relate in turn to lack of agreed systematic approaches as well as the seemingly intractable nature of health inequalities as an issue or problem.
- Case studies as a source of evidence on “what works” are potentially limited, given that a case study is essentially an individual and rhetorical device designed to tell a story about an intervention, rather than to present data that might contribute to a compelling evidence base. Key concerns were raised about the ability to draw general or generic lessons from case studies in order to be able to transfer this learning to other contexts, as well as how case studies are developed and whether policy-makers do or do not use them.
- There is the question of what is meant by “health systems” and the extent to which health-system action makes a difference to SDHI, given that health is largely created in sectors other than health. It seemed difficult to advance the debate beyond this question.

First, the bad news – it is difficult to say with 100% certainty “what works” because individual context (country, socio-political, etc.) is important and the motivations in each instance where policy advisers are looking to take action will be different (7).

However, the good news is that the landscape of action on SDHI is changing and investment is increasing in better monitoring, measurement and evaluation of interventions to counter health inequalities. Section 3.4 of this publication presents some of this changing approach, as well as key issues to consider in measuring and assessing “what works”. This means that one can move beyond the current position of not knowing with any certainty “what works” to a position where one has a much better idea and is improving at measuring the impact and different dimensions of these interventions.

Second and related to the first issue, the aim was to use case studies or



examples of action differently, to move from the underlying story for each example to extracting data that could be useful to policy advisers and entrepreneurs in developing evidence-informed actions. For example, what health-system stewardship means in practice is not always well understood (106). The examples given help to present a clearer and less theoretical picture of what health-system stewardship for health equity means. This approach enabled a checklist that can be used as a guide for reviewing examples of action and generating options – but as a guide, rather than a prescription or recipe for generating options. It is yet to be fully tested, so policy advisers are encouraged to use it in reviewing examples both on the web-based resource and other databases or collections of similar examples (e.g. DETERMINE or HealthQuest).

Another dimension of the approach has been to present the case studies or examples from four different perspectives or lenses. These are four possible ways to look at the issue, and data from the four lenses cannot be compared to each other within an example. The use of the lenses reflects that policy advisers or entrepreneurs in different contexts are likely to be asked about action on SDHI in different ways. Only one of the four lenses has been presented in any detail in this publication: one that focuses on the end point or objective of reducing SDHI, in sections 3.1 and 3.2. The fourth lens – which focuses on the necessary processes and pre-conditions for a health system to tackle health inequalities such as leveraging intersectoral action and making arrangements that aim at universal coverage – is not presented in any detail. However, it contains important information in relation to principles 3.5 and 3.7, specifically universal coverage as a fundamental to the health-system actions described in this publication, even where equity of access to care is not the primary focus of the action.

Third, the case studies presented in the web-based resource and this publication were not generated randomly, but designed to serve as explanatory examples of key issues and principles for taking action. However, the case studies have generated a wealth of data and they do demonstrate the existing and potential scope of health-system action to counter SDHI.

The approach to generating data from the case studies has enabled the presentation of health-system action in its broadest context and the demonstration of how this action on SDHI means more than health care and/or access to health care. The examples also demonstrate that, provided there is a will to do so, there is considerable scope for the health system to

put and continue putting its own house in order by both:

- acting to improve how the health system does its business with regard to health inequalities, which implies improved intrasectoral action; and
- improving the health system's investment and approach to intersectoral action on SDHI so that it is "... instrumental in developing cross-sectoral solutions that are conducive to sound conditions in which to grow and live" (91:4).

The search for such solutions within the health system and across other sectors is continuing and despite the limitations identified in this publication, there are solid grounds for concluding that health systems in the WHO European Region are making real progress in tackling SDHI.

References

1. Whitehead M, Dahlgren G. *Concepts and principles for tackling social inequities in health: Levelling up Part 1*. Copenhagen, WHO Regional Office for Europe, 2007 (http://www.euro.who.int/__data/assets/pdf_file/0010/74737/E89383.pdf, accessed 9 May 2010).
2. *The European health report 2009: health and health systems*. Copenhagen, WHO Regional Office for Europe, 2009 (http://www.euro.who.int/__data/assets/pdf_file/0009/82386/E93103.pdf, accessed 17 September 2010).
3. Perez Jarauta M, Goya Arive MA, Merino Merino B. Spain: Health Promotion among Navarre Ethnic Minorities programme. In: *Poverty and social exclusion in the European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010:178–187 (http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf, accessed 17 September 2010).
4. *The world health report 2000. Health systems: improving performance*. Geneva, World Health Organization, 2000 (<http://www.who.int/whr/2000/en/>, accessed 9 May 2010).
5. Tarlov A. Social determinants of health: the sociobiological translation. In: Blane D, Brunner E, Wilkinson R, eds. *Health and social organization*. London, Routledge, 1996:71–93.
6. Kelly M et al. *The social determinants of health: Developing an evidence base for political action. Final Report to World Health Organization Commission on the Social Determinants of Health from Measurement and Evidence Knowledge Network*. Geneva, World Health Organization, 2007 (http://www.who.int/social_determinants/resources/mekn_final_report_102007.pdf, accessed 17 September 2010).
7. Blackman T et al. Wicked comparisons: reflections on cross-national research about health inequalities in the UK. *Evaluation*, 2010, 16(1):43–57.
8. Corsini V. *Population and social conditions: highly educated men and women likely to live longer. Life expectancy by educational attainment*. Luxembourg, Eurostat, 2010 (http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-10-024/EN/KS-SF-10-024-EN.PDF, accessed 17 September 2010).
9. *Fair society, healthy lives. The Marmot review executive summary*. London, The Marmot Review, 2010 (<http://www.marmotreview.org/AssetLibrary/pdfs/Reports/FairSocietyHealthyLivesExecSummary.pdf>, accessed 17 September 2010).
10. *Solidarity in health: Reducing health inequalities in the EU. Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions*. Brussels, European Commission, 2009 (<http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2009:0567:FIN:EN:PDF>, accessed 17 September 2010).
11. *Solidarity in health: Reducing health inequalities in the EU. Background document for Press Pack - Launch of Commission Communication*. Brussels, European Commission, 2009 (http://ec.europa.eu/health/archive/ph_determinants/socio_economics/documents/com2009_background_en.pdf, accessed 17 September 2010).
12. *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*. Geneva, World Health Organization, 2008 (http://www.who.int/social_determinants/thecommission/finalreport/en/index.html, accessed 17 September 2010).

13. Mackenbach JP et al. Strategies to reduce socio-economic inequities in health in Europe: lessons from the Eurothine Project. In: Kunst AE et al., eds. *Tackling Health Inequities in Europe: An Integrated Approach EUROTHINE. Final Report*. Rotterdam, University Medical Centre, 2007:587–603.
14. *The economic crisis and its humanitarian impact on Europe*. Geneva, International Federation of Red Cross and Red Crescent Societies, 2009 (http://www.redcross-eu.net/A/uploaded/666_Economic_crisis.pdf, accessed 17 September 2010).
15. Mackenbach J et al. Socioeconomic inequalities in health in 22 European countries. *New England Journal of Medicine*, 358:2468–2481.
16. *World Health Assembly resolution WHA62.14 on reducing inequalities through action on the social determinants of health*. Geneva, World Health Organization, 2009 (http://apps.who.int/gb/ebwha/pdf_files/A62/A62_R14-en.pdf, accessed 12 July 2010).
17. *Everybody's business: strengthening health systems to improve health outcomes: WHO's framework for action*. Geneva, World Health Organization, 2007.
18. *The Tallinn Charter: "Health Systems for Health and Wealth"*. Copenhagen, WHO Regional Office for Europe, 2008 (<http://www.euro.who.int/document/E91438.pdf>, accessed 12 July 2010).
19. Gilson L et al. *Challenging inequity through health systems. Final Report of the Knowledge Network on Health Systems, WHO Commission on Social Determinants of Health*. Johannesburg, Equinet, CHP, LSHTM, 2007 (http://www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf, accessed 12 July 2010).
20. Whitehead M et al. *Delivery systems and mechanisms for reducing inequalities in both social determinants and health outcomes. Final report of Task Group 7 to Marmot Review of Inequalities in Health in England*. London, Marmot Review, 2009.
21. Mackenbach JP, Meerding WJ, Kunst AE. *Economic implications of socio-economic inequalities in health in the European Union*. Brussels, Health & Consumer Protection Directorate-General, European Communities, 2007.
22. *Monitoring the social impact of the crisis: public perceptions in the European Union. Wave 4*. Brussels, European Commission, 2010.
23. Whitehead M. Diffusion of ideas on social inequalities in health: a European perspective. *The Milbank Quarterly*, 1998, 76(3):469–492.
24. Pope C, Mays N, Popay J. *Synthesising qualitative and quantitative health research*. Buckingham, Open University Press, 2007.
25. Bonnefoy J et al. *Constructing the evidence base on the social determinants of health: a guide*. London, National Institute for Health and Clinical Excellence with Facultad de Medicina, University del Desarrollo, 2007 (http://www.who.int/social_determinants/knowledge_networks/add_documents/mekn_final_guide_112007.pdf, accessed 12 July 2010).
26. Masseria C. Health inequality. Why is it important and can we actually measure it? *Eurohealth*, 2009, 15(3):4–6.
27. *Moving forward equity in health: monitoring social determinants of health and the reduction of health inequalities. An independent expert report commissioned through the Spanish Presidency of the EU*. Madrid, Ministry of Health and Social Policy of Spain, 2010 (<http://www.msps.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/>

- PresidenciaUE_2010/conferenciaExpertos/docs/haciaLaEquidadEnSalud_en.pdf, accessed 12 July 2010).
28. Council conclusions on Equity and Health in all Policies: Solidarity in Health. Brussels, European Union, 2010 (http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lisa/114994.pdf, accessed 12 July 2010).
 29. Pawson R. *Evidence-based policy. A realist perspective*. London, Sage, 2009.
 30. Dixon-Woods M et al. *Integrative approaches to qualitative and quantitative evidence*. London, Health Development Agency, 2004.
 31. Britten N et al. Using meta ethnography to synthesise qualitative research: a worked example. *Journal of Health Services Research Policy*, 2002, 7(4).
 32. Pruessmann JF. *Promoting health and reducing socially caused inequalities in health opportunities: Health insurance sector in Germany*. Essen, WHO Collaborating Centre for Health Inequities in Insurance-based Health Systems, 2010.
 33. Houlihan E. Ireland: Building Healthy Communities Programme. In: *Poverty and social exclusion in the WHO European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010:74–85 (http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf, accessed 17 September 2010).
 34. Droomers M et al. The Netherlands. In: Hogstedt C et al., eds. *Health for all? A critical analysis of public health policies in eight European countries*. Ostersund, Swedish National Institute of Public Health, 2008 (http://www.fhi.se/PageFiles/4171/R200821_Health_for_all_komp0809.pdf, accessed 12 July 2010).
 35. Torgersen T, Giaever O, Stigen OT. *Developing an intersectoral national strategy to reduce social inequalities in health. The Norwegian case*. Geneva, Commission on Social Determinants of Health, 2007.
 36. *National strategy to reduce social inequalities in health. Report No. 20 (2006–2007) to the Storting*. Oslo, Norwegian Ministry of Health and Care Services, 2007 (http://ec.europa.eu/health/ph_determinants/socio_economics/documents/norway_rd01_en.pdf, accessed 12 July 2010).
 37. Marek M. Poland: poverty and health. In: *Poverty and social exclusion in the WHO European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010:124–135 (http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf, accessed 12 July 2010).
 38. Backhans M, Moberg H. Sweden. In: Hogstedt C et al., eds. *Health for all? A critical analysis of public health policies in eight European countries*. Ostersund, Swedish National Institute of Public Health, 2008 (http://www.fhi.se/PageFiles/4171/R200821_Health_for_all_komp0809.pdf, accessed 12 July 2010).
 39. Chakrabarti S, Earwicker R, Simpson S. *Tackling health and inequalities in infant mortality in England: a systematic approach*. Copenhagen, WHO Regional Office for Europe, 2010.
 40. Salman R, Weyers S. Germany: With migrants for migrants. In: *Poverty and social exclusion in the WHO European region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010:52–63 (http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf, accessed 12 July 2010).
 41. Naldoni S. Italy (Tuscany Region): the Community Health Partnership of the north-west zone

- of Florence. In: *Poverty and social exclusion in the European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010:86–94 (http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf, accessed 12 July 2010).
42. Barzon G et al. Italy (Veneto Region): integration of social and health services for immigrants - the case of Padova. In: *Poverty and social exclusion in the WHO European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010:95–103 (http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf, accessed 12 July 2010).
 43. Harrington P, Douglas M, Simpson S. *A whole systems approach to addressing health inequalities in NHS Lothian*. Copenhagen, WHO Regional Office for Europe, 2010.
 44. Buzeti T, Maucec Zakotnik J. *Investment for Health and Development in Slovenia. Programme MURA*. Murska Sobota, Centre for Health and Development Murska Sobota, 2008 (http://www.eu2008.si/si/News_and_Documents/Fact/March/0310_publikacija.pdf, accessed 12 July 2010).
 45. Fuchs M, Reidl C, Schmied G. Austria: NeunerHAUSARZT – demand-oriented health care services for the homeless. In: *Poverty and social exclusion in the WHO European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010:6–15 (http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf, accessed 12 July 2010).
 46. Berger D et al. Romania: controlling TB among the Roma - a community approach. In: *Poverty and social exclusion in the WHO European Region: health systems respond*. Copenhagen, WHO Regional Office for Europe, 2010:147–155 (http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf, accessed 12 July 2010).
 47. *Quality in and equality of access to healthcare services*. Brussels, European Communities, 2008 (http://ec.europa.eu/employment_social/spsi/docs/social_inclusion/2008/healthquest_en.pdf, accessed 12 July 2010).
 48. Cochrane Musculoskeletal Group. What is a systematic review? [web site]. Toronto, Arthritis Society of Canada (NFP), 2010 (<http://www.cochranemsk.org/cochrane/review/default.asp?s=1>, accessed 12 July 2010).
 49. Bambra C et al. *Tackling the wider social determinants of health inequalities: evidence from systematic reviews*. York, Public Health Research Consortium, 2008 (<http://www.york.ac.uk/phrc/D2-06%20Final%20Report.pdf>, accessed 12 July 2010).
 50. Gerring J. *Case study research: principles and practices*. New York, Cambridge University Press, 2007.
 51. Graham H. Tackling inequalities in health in England: remedying health disadvantages, narrowing health gaps or reducing health gradients? *Journal of Social Policy*, 2004, 33(1):115–131.
 52. *Strengthened health systems save lives. An insight into WHO's European Health Systems' Strategy*. Copenhagen, WHO Regional Office for Europe, 2005.
 53. Ziglio E et al. *Health systems confront poverty*. Copenhagen, WHO Regional Office for Europe, 2003 (http://www.euro.who.int/__data/assets/pdf_file/0011/74783/e80225.pdf, accessed 12 July 2010).
 54. Gawande A. *The checklist manifesto. How to get things right*. London, Profile Books, 2010.
 55. Strand M et al. *Setting the political agenda to tackle health inequality in Norway*. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/__data/assets/pdf_

- file/0014/110228/E93431.pdf, accessed 12 July 2010).
56. Graham H. Health inequalities, social determinants and public health policy. *Policy & Politics*, 2009, 37(4):463–479.
 57. Graham H, Kelly M. *Health inequalities: concepts, frameworks and policy*. London, Health Development Agency, 2004 (http://dds-dispositivoglobal.ops.org.ar/cursos/cursosport/Textos%20Completos/health%20inequalities_concepts,%20framework%20and%20policy.pdf, accessed 12 July 2010).
 58. *Social and gender inequalities in environment and health*. Copenhagen, WHO Regional Office for Europe, 2010 (http://www.euro.who.int/__data/assets/pdf_file/0010/76519/Parma_EH_Conf_pb1.pdf, accessed 12 July 2010).
 59. Vieth H, Simpson S, Buzeti T. *Programme MURA*. Copenhagen, WHO Regional Office for Europe, 2010.
 60. Ziglio E, Simpson S. Determinantes sociales y desigualdades en la salud [Social determinants and inequalities in health]. *Eidon*, 2010, 32:44–53.
 61. Pruessmann JF, Simpson S. *Social determinants of health and socially conditioned health inequalities: activities of the statutory health insurance sector in Germany*. Copenhagen, WHO Regional Office for Europe, 2010.
 62. Vieth H, Simpson S. *Italy, Veneto: The high professional immigration body, Padova - improving integration of health and social services*. Copenhagen, WHO Regional Office for Europe, 2010.
 63. Harrington P, Simpson S. *Austria: NeunerHAUSARZT – demand-oriented health care services for the homeless*. Copenhagen, WHO Regional Office for Europe, 2010.
 64. Vieth H, Simpson S. *Poland: increasing equity of access to health care*. Copenhagen, WHO Regional Office for Europe, 2010.
 65. Harrington P, Simpson S. *Italy, Tuscany: a community health partnership to facilitate intersectoral action and strengthen the integration of health and social services at the local level*. Copenhagen, WHO Regional Office for Europe, 2010.
 66. Vieth H, Simpson S. *Germany: With Migrants for Migrants*. Copenhagen, WHO Regional Office for Europe, 2010.
 67. Harrington P. *Ireland: Building Healthy Communities Programme*. Copenhagen, WHO Regional Office for Europe, 2010.
 68. Harrington P, Simpson S. *Spain: Health Promotion among Navarre Ethnic Minorities*. Copenhagen, WHO Regional Office for Europe, 2010.
 69. Harrington P, Simpson S. *Romania: A community approach to TB control*. Copenhagen, WHO Regional Office for Europe, 2010.
 70. Simpson S et al. *A national strategy to reduce social inequalities in health: tackling the social gradient*. Copenhagen, WHO Regional Office for Europe, 2010.
 71. Belovic B, et al. *Strategija za krepitev zdravja in akcijski na&rdot;rt za zmanjševanje neenakosti v zdravju v pomurski regiji [Health promotion strategy and action plan for tackling social inequalities in health in the Pomurje region]*. Murska Sobota, Zavod za zdravstveno varstvo Murska Sobota [Institute of Public Health Murska Sobota], 2005.

72. *Public health in Sweden*. Stockholm, Swedish National Institute of Public Health, 2010 (<http://www.fhi.se/PageFiles/8442/Public-health-in-Sweden.pdf>, accessed 12 July 2010).
73. Moberg H, Hogstedt C. Summary chapter. In: Hogstedt C et al., eds. *Health for all? A critical analysis of public health policies in eight European countries*. Ostersund, Swedish National Institute of Public Health, 2008 (http://www.fhi.se/PageFiles/4171/R200821_Health_for_all_komp0809.pdf, accessed 12 July 2010).
74. Vallgarda S. Social inequality in health: dichotomy or gradient? A comparative study of problematizations in national public health programs. *Health Policy*, 2008, (85):71–82.
75. *Report to the Storting No. 9 (2006-2007). Work, welfare and inclusion*. Oslo, Ministry of Labour, 2006 (<http://www.regjeringen.no/en/dep/aid/doc/regpubl/stmeld/20062007/Report-No-9-2006-2007-to-the-Storting.html?id=432894>, accessed 4 September 2010).
76. *Summary of Report No. 16 (2006-2007) to the Storting. Early intervention for lifelong learning*. Oslo, Norwegian Ministry of Education and Research, 2006 (<http://www.regjeringen.no/en/dep/kd/Documents/Bills-and-white-papers/Reports-to-the-Storting/2006-2007/Report-No-16-2006-2007-to-the-Storting.html?id=499227>, accessed 4 September 2010).
77. Dahl E. Health inequalities and health policy: the Norwegian case. *Norsk Epidemiologi*, 2002, 12(1):69–75.
78. Droomers M. Tackling health inequalities in the Netherlands. *Eurohealth*, 2009, 15(3):16–8 (<http://www2.lse.ac.uk/LSEHealthAndSocialCare/LSEHealth/pdf/eurohealth/VOL15no3/Eurohealthvol15n3-full.pdf>, accessed 12 July 2010).
79. Diderichson F, Evans T, Whitehead M. The social basis of disparities in health. In: Evans T et al., eds. *Challenging inequities in health*. New York, Oxford University Press, 2001.
80. Hogstedt C et al. The Swedish Public Health Policy and the National Institute of Public Health. *Scandinavian Journal of Public Health*, 2004, Sup.64:6–64.
81. Swedish National Committee for Public Health. Health on equal terms – national goals for public health. *Scandinavian Journal of Public Health*, 2001, Sup.57.
82. Hogwood B, Gunn L. *Policy analysis and the real world*. Oxford, Oxford University Press, 1984.
83. Bauld L, Day P, Judge K. Off target: a critical review of setting goals for reducing health inequalities in the UK. In: Kunst AE et al., eds. *Tackling health inequities in Europe: an integrated approach EUROTHINE, final report*. Rotterdam, University Medical Centre, 2007:567–585.
84. *Comunidad Gitana y Salud: Conclusiones, recomendaciones y propuestas [Roma community and health: conclusions, recommendations and proposals]*. Madrid, Ministry of Health and Consumer Affairs, FSG, 2008 (<http://www.msc.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/situacionComuGitanaEsp.pdf>, accessed 3 September 2010; in Spanish).
85. *Evaluation of the Building Healthy Communities Programme (Phase 2)*. Dublin, Combat Poverty Agency, 2008 (www.combatpoverty.ie/publications/EvaluationOfTheBuildingHealthyCommunitiesProgramme_2009.pdf, accessed 12 July 2010).
86. *Implementation Plan for Reducing Health Inequalities in Infant Mortality – a good practice guide*. London, Department of Health, 2007 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_081336.pdf, accessed 12 July 2010).

87. *Equally Well. Report of the Ministerial Task Force on Health Inequalities*. Edinburgh, The Scottish Government, 2008 (<http://www.scotland.gov.uk/Resource/Doc/226607/0061266.pdf>, accessed 12 July 2010).
88. Lundgren B. *The 2005 public health policy report. Summary*. Stockholm, Swedish National Institute of Public Health, 2005 (<http://www.fhi.se/PageFiles/4385/r200544fhprsummary0511.pdf>, accessed 12 July 2010).
89. Wadman C, Bostrom G, Karlsson AS. *Health on equal terms? Results from the 2006 Swedish National Public Health Survey*. Stockholm, Swedish National Institute of Public Health, 2008 (http://www.fhi.se/PageFiles/4351/A2008_1_health%20on%20equal%20terms.pdf, accessed 12 July 2010).
90. Lundgren B. Experiences from the Swedish determinants-based public health policy. *IUHPE - Promotion and Education*, 2008, XV(2):27–33.
91. *The Norwegian Directorate of Health's annual report on measures to reduce social inequities in health: Norwegian public health policy report 2009*. Oslo, Norwegian Directorate of Health, 2010 (http://www.helsedirektoratet.no/vp/multimedia/archive/00298/Norwegian_public_he_298769a.pdf, accessed 12 July 2010).
92. *Equally Well. Implementation Plan*. Edinburgh, The Scottish Government, 2008 (<http://www.scotland.gov.uk/Resource/Doc/254248/0075274.pdf>, accessed 12 July 2010).
93. de Savigny D, Adam T, eds. *Systems thinking for health systems strengthening*. Geneva, Alliance for Health Policy and Systems Research, WHO, 2009 (<http://www.who.int/alliance-hpsr/resources/9789241563895/en/index.html>, accessed 12 July 2010).
94. *Tackling health inequalities 2006-08 policy and data update for the 2010 national target*. London, The Stationery Office Limited, 2009 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/@sta/@perf/documents/digitalasset/dh_109468.pdf, accessed 12 July 2010).
95. *Tackling health inequalities 2005-07 policy and data update for the 2010 national target*. London, Department of Health, 2006 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_091415.pdf, accessed 12 July 2010).
96. *Tackling health inequalities: status report on the programme for action: 2006 update of headline indicators*. London, Department of Health, 2006 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_062897.pdf, accessed 12 July 2010).
97. *Overview of the review of health inequalities post 2010 in England (Marmot Review)*. London, Marmot Review, 2009 (<http://api.ning.com/files/PjJXqH9GZr4sTwPGRxAeu72ijtIQOKrG4IGKgfKN6QkVTVFLmRZd6Zb7VpmbUzdVqAS-U2gb68jWf8HK4lhY9XR4b8gnCs1Y/overview.doc>, accessed 12 July 2010).
98. *Tackling health inequalities: 10 years on. A review of developments in tackling health inequalities in England over the last 10 years*. London, Department of Health, 2009 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_098934.pdf, accessed 12 July 2010).
99. *Equity and excellence: liberating the NHS*. London, The Stationery Office Limited, 2010 (http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/@ps/documents/digitalasset/dh_117794.pdf, accessed 12 July 2010).

100. *Closing the opportunity gap. Scottish budget for 2003–2006*. Edinburgh, The Scottish Government, 2002 (<http://www.scotland.gov.uk/Resource/Doc/46997/0024934.pdf>, accessed 3 September 2010).
101. *Fair for all*. Edinburgh, Scottish Executive, 2002 (<http://www.sehd.scot.nhs.uk/publications/ffar/ffar1.pdf>, accessed 3 September 2010).
102. *Four steps towards equity. A tool for health promotion practice*. Sydney, Health Promotion Service, South East Health, 2003.
103. Furler J et al. Health inequalities, physician citizens and professional medical associations: an Australian case study. *BMC Medicine*, 2007, 5(23):doi:10.1186/1741-7015-5-23 (<http://www.biomedcentral.com/content/pdf/1741-7015-5-23.pdf>, accessed 12 July 2010).
104. *Handbook for action in the area of health services with the Roma community*. Madrid, Ministry of Health and Consumer Affairs, Fundación Secretariado Gitano, 2006 (<http://www.msc.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/docs/handbookHealthServices.pdf>, accessed 12 July 2010).
105. Krawczyk C et al. *Inequalities sensitive practice initiative in action in NHS Greater Glasgow Clyde*. Copenhagen, WHO Regional Office for Europe, 2010.
106. Alliance for Health Policy and Systems Research. *Neglected health systems research: governance and accountability*. Geneva, World Health Organization, 2008 (<http://infocooperation.org/hss/documents/s15874e/s15874e.pdf>, accessed 12 July 2010).

Annex 1. Original source of 15 examples

Title of example and country	Case study reference details
1. Programme NeunerHAUSARZT, Austria	Fuchs M, Reidl C, Schmied G (2010). Austria: NeunerHAUSARZT – demand-oriented health care services for the homeless.
2. With Migrants for Migrants, Germany	Salman R, Weyers S (2010). Germany: With Migrants for Migrants.
3. Building Healthy Communities programme, Ireland	Houlihan E (2010). Ireland: Building Healthy Communities Programme.
4. The Community Health Partnership of the north-western zone of Florence, Italy	Naldoni S (2010). Italy (Tuscany Region): The Community Health Partnership of the north-west zone of Florence.
5. The High Professional Immigration Body: integration of social and health services for immigrants – the case of Padua, Italy	Barzon G et al (2010). Italy (Veneto Region): integration of social and health services for immigrants – the case of Padova.
6. Solutions for protecting the access of people living in poverty to health care services in Poland	Marek M (2010). Poland: poverty and health.
7. Controlling TB among the Roma – a community approach, Romania	Berger D et al (2010). Romania: controlling TB among the Roma - a community approach.
8. Health Promotion among Navarre Ethnic Minorities, Spain	Perez Jarauta M, Goya Arive MA, Merino Merino B (2010). Spain: Health Promotion among Navarre Ethnic Minorities programme.
9. Sweden – National public health policy	Backhans M, Moberg H. Sweden. In: Hogstedt C et al., eds. <i>Health for all? A critical analysis of public health policies in eight European countries</i> . Ostersund, Swedish National Institute of Public Health, 2008 (http://www.fhi.se/PageFiles/4171/R200821_Health_for_all_komp0809.pdf , accessed 12 July 2010).
10. The Netherlands – A health for all approach to public health	Droomers M et al. The Netherlands. In: Hogstedt C et al., eds. <i>Health for all? A critical analysis of public health policies in eight European countries</i> . Ostersund, Swedish National Institute of Public Health, 2008 (http://www.fhi.se/PageFiles/4171/R200821_Health_for_all_komp0809.pdf , accessed 12 July 2010).
11. Social determinants of health and socially conditioned health inequalities: activities of the statutory health insurance sector in Germany	Pruessmann JF. <i>Promoting health and reducing socially caused inequalities in health opportunities: Health insurance sector in Germany</i> . Essen, WHO Collaborating Centre for Health Inequities in Insurance-based Health Systems, 2010.

Background	Peer reviewed
<p>Case studies 1–8 were taken from <i>Poverty and social exclusion in the European Region: health systems respond</i> (Copenhagen, WHO Regional Office for Europe, 2010)</p> <p>The case studies in this publication were developed in response to the call and follow-up to WHO Regional Committee for Europe resolution EUR/RC52/R7 on poverty and health in Europe and were developed in 2007 and 2008. The objective was to profile a programme or intervention to increase health-system performance for one or more of the following population groups:</p> <ul style="list-style-type: none"> • immigrants facing poverty and social exclusion; • under and unemployed persons; • children living in poverty; and • Roma exposed to poverty and social exclusion. 	<p>Yes – all eight case studies were peer reviewed.</p>
<p>These two examples will largely draw on the related country case studies in <i>Health for all? A critical analysis of public health policies in eight European countries</i> (Hogstedt C, Moberg H, Lundgren B, Backhans M, eds. Swedish National Institute of Public Health, Ostersund, 2008). They are otherwise known as the Equipop case studies.</p> <p>The objective of this collection of case studies, which began in 2003, was for scientific experts from eight different countries to write about public health policies in their respective countries with a special emphasis on the equity aspect with a focus on describing the activity up until 2006. The eight countries were: northern Europe (Denmark, Finland, Norway and Sweden); western (England and Netherlands); and southern (Spain and Italy).</p>	<p>Yes – all case studies were peer reviewed.</p>
<p>This is one of the examples that was developed for the web-based resource and so is a new “case study”. It draws largely on key policy documents developed by the Government.</p>	<p>Yes – the case study for this profile was reviewed by two independent experts.</p>

Title of example and country	Case study reference details
12. National strategy to reduce social inequalities in health, Norway	<p>Torgersen T, Giaever O, Stigen OT. <i>Developing an intersectoral national strategy to reduce social inequalities in health. The Norwegian case</i>. Geneva, Commission on Social Determinants of Health, 2007.</p> <p>and</p> <p><i>National strategy to reduce social inequalities in health. Report No. 20 (2006–2007) to the Storting</i>. Oslo, Norwegian Ministry of Health and Care Services, 2007 (http://ec.europa.eu/health/ph_determinants/socio_economics/documents/norway_rd01_en.pdf, accessed 12 July 2010).</p>
13. Programme MURA, Slovenia	<p>Buzeti T, Maucec Zakotnik J. <i>Investment for Health and Development in Slovenia. Programme MURA</i>. Murska Sobota, Centre for Health and Development Murska Sobota, 2008 (http://www.eu2008.si/si/News_and_Documents/Fact/March/0310_publikacija.pdf, accessed 12 July 2010).</p>
14. Tackling health and inequalities in infant mortality in England: a systematic approach, United Kingdom (England)	<p>Chakrabarti S, Earwicker R, Simpson S. <i>Tackling health inequalities in infant mortality in England: a systematic approach</i>. Copenhagen, WHO Regional Office for Europe, 2010.</p>
15. A whole systems approach to addressing health inequalities in NHS Lothian, United Kingdom (Scotland)	<p>Harrington P, Douglas M, Simpson S. <i>A whole systems approach to addressing health inequalities in NHS Lothian</i>. Copenhagen, WHO Regional Office for Europe, 2010.</p>

Background	Peer reviewed
<p>The first document is a case study developed as part of a global project in 2007 to review country experiences in intersectoral action for health. It resulted in the publication <i>Health equity through intersectoral action: an analysis of 18 country case studies</i>. Geneva, World Health Organization, Public Health Agency of Canada, 2008. The format for this and the other case studies included draws from a range of different social and political contexts, and where possible, examines intersectoral action addressing SDH toward the goal of health equity. The other document is the policy document for the Norwegian strategy.</p>	Yes
<p>This publication was developed to provide insights and lessons on how stewardship and governance of health (and development) can be realized in practice in the Slovenian and different country contexts.</p>	Yes
<p>This is one of the examples developed for the web-based resource and so is a new “case study”. It draws largely on key policy documents developed by the government including an implementation plan for reducing health inequalities in infant mortality: a good practice guide and the overall action plan for tackling inequalities in England, 2007.</p>	Yes – this profile was reviewed by three independent experts.
<p>This is one of the examples that was developed for the web-based resource and so is a new “case study”. It draws largely on key policy and strategy documents including the initial paper presented to and approved by the Board of NHS Lothian, outlining the approach to addressing health inequalities at a subnational level in 2006.</p>	Yes – this profile was reviewed by two independent experts





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