SOSTE

SEMINAR REPORT: Tackling health inequalities in a fast changing world

31 May 2017, 13:30-17:15

Helsinki

This conference is supported by the European Commission, through the EU Programme for Employment and Social Innovation (EaSI 2014-2020)

Agenda

13:30 Registration, networking and coffee

14:00 Welcome by co-chairs: Kristiina Kumpula Chair SOSTE Council and Caroline Costongs, Director EuroHealthNet

Session one "Health is a political choice"

Päivi Sillanaukee, Permanent Secretary at the Ministry of Social Affairs and Health - Successful co-operation within social and health sector will lead to people's best

Ana-Carla Pereira, Head of Unit Social Protection, European Commission DG Employment and Social Affairs – EU Pillar of Social Rights

Juhani Eskola, Director General of the National Institute for Health and Welfare (THL) – Finnish social and health services reform, barriers and success factors

Prof Clare Bambra, Institute of Health & Society, Newcastle University – role of social policies to reduce health inequalities

Examples from other countries (Mojca Gabrijelcic, National Institute of Health Slovenia, Elisabeth Bengtsson, Vasta Götaland, Sweden)

15:30 Coffee Break

15:50 **Session two "How to follow up with health and social integrated actions"**

Jussi Ahokas, Chief Economist of SOSTE - Welfare investments as means to improve wellbeing

Prof Olli Kangas, The Social Insurance Institution of Finland (Kela) – The Basic Income Experiment

Clive Needle, Senior Policy Advisor EuroHealthNet – New thinking in EU Social and Health policy

Examples from other countries (Eileen Scott, NHS Health Scotland UK and contributions from the floor)

17:10 Closing remarks and conclusions - Nicoline Tamsma, President EuroHealthNet

17:15 End of the seminar – closing by chairs

Presentations are available on the EuroHealthNet website

Background information

Europe is being confronted by demographic, economic, social, environmental, technological, political and cultural changes. Income and wealth inequalities have for example been rising since the 1970s. Today, the top 10% of households earn 31% of total income and own over 50% of total wealth. Forms of inequality and poverty are changing, whilst the number of people in the EU living at risk of poverty and social exclusion increased by 4.5 million between 2010 and 2014.

The world of work is also in transition. New forms of work are emerging and technological advances are reshaping the way we work. The norm of having one career with a single employer is ending; whilst 'gig' and 'platform' economies (people working without social security on an ad-hoc basis) are growing. Youth unemployment is still unacceptably high in the EU – averaging 20% with peaks of more than 40% in some countries. Fears about unstable work are palpable across society.

These changes have clear effects on physical and mental health, equity and well-being. The greatest impact falls on the most vulnerable people and those with lower levels of education, amplifying social and related health inequalities. The need to avoid widening health inequalities within and between Member States is clearer today than ever before. It makes good economic sense, as currently public spending on health care and long term care accounts already for 8.5% of GDP in the EU. It is expected that this will increase by 1-2% by 2060.

The implications for people are enormous, but the challenges can be addressed through cross-cutting and joint efforts, such as those outlined in the Agenda 2030 and Sustainable Development Goals, or via a potential new EU Pillar of Social Rights including the social determinants of health.

This Seminar was organised in order to explore how the health and social sectors can work more closely together to address these challenges and meet common objectives in terms of building a fair and socially sustainable society with health and wellbeing for all.

Caroline Costongs (Director EuroHealthNet) and Kristiina Kumpula (Chair SOSTE Council)

welcomed participants and established the aim of the Seminar- namely to explore some of the latest thinking and trends in health and social policy, and to hear about new approaches to promoting health and social equity. Constant, rapid change requires the public health and social sectors to be more attentive, responsible, dynamic and innovative than ever before, as reflected in EuroHealthNet's REJUVENATE framework on promoting health and well-being towards 2030. The chairs noted that the presentations and discussions were intended to provide food for thought and discussion on what health and social sector actors are doing and can do to address common societal challenges.

Session one: Health is a Political Choice

The theme of session one 'Health is a Political Choice' was explored from a variety of perspectives, as presenters focused on the aims and challenges of the health and social service reforms in Finland, EU level approaches and variations in health outcomes across political systems, and examples of how the health, social and other sectors are collaborating to address common challenges.

Paivi Sillanaukee - permanent secretary of the Ministry of Social Affairs and Health

said that in Finland, the health and social sectors are recognised as key players with an important role in helping to ensure economic growth and global security. This means that the health sector must understand and use the language of the other sectors, to ensure that they can take part in these discussions. She outlined the health and social service reforms that Finland, like many other EU Member States, is currently undertaking which involve decentralising responsibility for the implementation of these services to the county level. The aim is to strengthen the role of primary care, integrate health measures, social care, education, and employment, and to develop more personalised models of care while at the same time promoting the health of the population as a whole. Ms. Sillanaukee stated that Finland aims to be a forerunner in the use of new technologies and digitalisation to provide services in new and more effective and efficient ways. Ms. Sillanaukee ended by stressing the need for more integrated approaches, not as an end in itself, but as a means to solve common problems. She indicated her positive surprise that the EC seems to be putting the Social Pillar and SDG high on their agenda and noted that sharing good practice across the EU is important to address common challenges in a fast changing world.

Ana-Carla Pereira, Head of Unit Social Protection, EC DG Employment and Social Affairs

began by stressing that a Social Europe is a political choice for the Junker Commission, and congratulated EuroHealthNet on its briefing on the Social Pillar. The EU Social Pillar aims to support fair and well-functioning labour markets and welfare systems in the EU and to ensure that these systems are adapted to respond to modern day challenges. She noted that since the economic crises, levels of unmet need in the EU have grown, but that every person in the EU regardless of the work, should have access to social protection. Ms. Pereira explained that the Social Pillar includes 20 principles or political aims/objectives in relation to rights to social and health services that EU Member States commit to upholding. It is hoped that the European Council and the European Parliament will endorse a joint proclamation in support of the pillar. The hope is that the European Parliament will sign the Joint Proclamation by December 2017, so that it can serve as a basis for future EU-level work on social protection, pensions, disability, education, etc. The European Council now has to enter into the details of the debate, which means that discussions around the Social Pillar are becoming more difficult, since some Member States fear that some responsibilities in this area will be transfered to the EU. Ms. Pereira also explained the social scoreboard, which is a set of very limited indicators to generate visibility for social issues, to show what EU can do for upward convergence, and to show progress in EU Member States in relation to the 20 principles. There is a public consultation on EU Action in this area, which could, depending on the feedback received, become a legislative proposal on social protection issues- one of the areas of the social pillar.

Juhani Eskola Director General of the Finish National Institute for Health and Welfare (THL)

provided further information on the social and health service reform taking place in Finland, the biggest in the public system in the past 250 years, which has been under development for more than ten years. He explained that the reform is needed to address the growing needs and costs of an ageing population, and to reduce health inequalities. He noted that the 300 municipalities across Finland vary in size, and in the resources and ability they have to deliver health and social services. Another aim of the reform is to provide customers with more freedom of choice, and to cut the growth in health care costs from 2.4% to 0.9% between 2019-2029. Mr. Eskola noted that 10% of the population account for 80% of social and health care costs. Integration of care for these people is particularly important, since it can help to reduce costs. Mr. Eskola cautioned however that achieving integration is very complex. The aims of the reform may be achieved since it promotes economies of scale, which can strengthen the capacity of organisations to reduce health inequalities. But it is

questionable whether all counties have the competencies to deliver; information management systems will take time to develop and there are no guarantees that the savings target can be met.

Professor Clare Bambra, Institute of Health and Society at Newcastle University

presented on the outcomes of HiNEWS research project on Health Inequalities in European Welfare State, which focused on the role of social policies to reduce health inequalities. The project analysed responses from the European Social Survey, which included an additional 20 questions on social determinants of health (SDH). Twenty three EU Member States participated in the survey, which for the first time provided the information necessary to give a comparable view of health inequalities across the EU.

Professor Bambra showed graphs revealing that in almost all countries, certain regions are doing worse or better than others, in terms of overall health as well as specific conditions like blood pressure, overweight or obesity, cancer, mental health and self-related poor health. The HiNEWS project is interested in describing these social and regional patters and why some countries do better than others. In the US, for example, the infant mortality rate is 2.5 times higher than Finland, and one third of the population is obese. The differences in overall health status and specific health conditions that exist between European countries and systems are more nuanced. The initial findings of the analysis are available in two articles, co-authored by Professor Bambara.

Mojca Gabrijelcic, National Institute of Health in Slovenia

gave a short overview of the 'Longevity Strategy' that has been developed and was the subject of a public consultation in May/June in Slovenia. The Strategy was developed to respond to the fact that the population in Slovenia is decreasing, and getting older. Those over 65 with lower levels of education have low levels of health, and can simply not be counted on to work more, although this will become an economic and political necessity. The Strategy is based on information collected and processes that took place in the context of the 'Active and Healthy Ageing in Slovenia'(AHA-SI) project, co-funded by the EC, that networked all relevant stakeholders and citizens and brought together decision makers from the Health and Social sectors. Instead of a linear approach to education, work/employment, retirement and leisure time, the Longevity Strategy suggests a more flexible and fluid model that integrates these

roles and activities over the life cycle and emphasises life-long learning, with longer work activity and more careers.

Elisabeth Bengsson from Vasta Gotaland, Sweden,

focused on a law that the Swedish government had just passed to increase physical activity levels in schools. The purpose of the law is to try to get all young people through school and to avoid school failures, since research indicates that just 20 minutes of physical activity substantially increases ability to concentrate and reading ability. Most boys and girls are currently physically active for less than one hour a day. Schools will have to fit the physical activity into their existing curricula so it may not be possible to achieve this through extra gym classes, but by applying more physical teaching methods like explaining maths by walking around. Ms. Bengsson noted that this was a good example of proportionate universalism, since the children and youth who are in need of more physical activity are those that benefit most.

Discussion Points:

The discussions following the presentations focused on the emphasis the Finnish health and social system reforms placed on 'freedom of choice' and how this related to the aim of reducing health inequalities. It was noted that the ability to exercise this freedom depends a great deal on health literacy, and questioned whether people in rural areas would really get freedom of choice. One participant raised evidence that suggests that increasing choice in health systems has negative consequences for health inequalities.

Mr Eskola (THL) agreed that this was the most heated part of the proposals. The idea is that there will be many providers that can more efficiently meet needs of different patient groups. The reforms are based on an extensive study, including visits to other countries (Nordic, UK, NL) to establish what works. Ms. Pereira noted that there need not be a trade-off between choice about equality, since it may be better to give those that currently have no choice more choice, and to enhance and diversify services at a low cost, so that people have access to them too.

A participant also noted that health promotion is generally considered the 'little brother' of health care and curative care, and funding for health promotion is generally the first to be cut in a climate of downsizing. Mr Eskola indicated that the health system reforms emphasise primary care, but that this could indeed be an issue in the implementation phase.

Session two ‘How to follow up with health and social integrated actions’

This session focused on new approaches to improve well-being, new forms of social security, and new thinking in relation to EU social and health policy.

Jussi Ahokas, Chief Economist at the Finish Federation for Social Affairs and Health (SOSTE),

presented work they are doing in the area of the welfare economy. This work is based on the premise that economic arguments are too dominant and that a greater emphasis should be placed on outcomes of investments in terms of health and wellbeing. Welfare investment can range from individual's behavior (encouragement to stop smoking) to major structural reforms (improving the performance of health and social systems). The potential benefits of such investments are only visible over the long term, making policy makers hesitant to enforce them. Foresight work on welfare economy and social return on investment evaluations are therefore useful tools to raise awareness and to convince politicians.

Professor Olli Kangas from the Social Insurance Institution of Finland (KELA)

also presented a new approach that could potentially improve health and wellbeing, namely the new Finnish Basic Income Experiment. A pilot of this new social security model began in Finland at the start of 2017, to address the question of whether providing a basic income could help to simplify the current social security system and to provide those who are currently unemployed with stronger incentives to find employment. The experiment, which is being administered by KELA, provides a partial basic income to a series of selected unemployed persons. This basic income of 560 Euro is tax free. Participants can still receive insurance based benefits, housing and children’s allowance, or other incomes if they find a job (which would be taxed). With this new form of social security the Finnish government wishes to remove ‘incentive traps’ where work does not pay enough to justify a loss in benefits and ‘bureaucratic traps’ where people fear

navigating the social security system, which they perceive as lacking transparency. Professor Kangas indicated that designing and implementing the experiment has proved very difficult, given the complexity of the Finish social security system. When asked for example why minimum income, and not insurance benefits were chosen, he indicated that this was in part a political issue, since unemployment funds are in the hands of trade unions, who would not have agreed to this for fear that people would no longer join them.

Clive Needle, Senior Policy Advisor at EuroHealthNet

reminded participants of the enormous challenges people are facing and the climate in which health and social systems are operating, as we live in societies being shaped by disruption and innovation. He raised the question of how health, well-being and equity can be achieved and how new social rights can be implemented in this context. The EU Pillar of Social Rights could be a potentially innovative approach for social rights, including access to healthcare, childcare and support for children, education, training and life-long learning, and social protection. While it affirms that everyone has the right to timely access to affordable, and good quality preventive and curative health care, “a right is only truly a right when there is a means to enforce it.” He noted that innovations were shaping the world, but that there could be a lack of vigilance as to who was using and benefiting from these innovations.

He stressed that there could be a scenario, as outlined in the EC’s White Paper on the ‘Future of Europe’, for an EU where health and equity were considered ‘beyond the scope’ of EU activities, despite the fact that many of the measures taken at EU level impact directly on health and equity. He called attention again to EuroHealthNet’s REJUVENATE call for action to ensure public health and health promotion actors respond to these real challenges.

Dr Eileen Scott, from NHS Health Scotland UK,

then provided information on the situation in Scotland in relation to health and well-being. NHS Health Scotland's work focuses on reducing health inequalities, which is regarded as a 'lost-potential.' They recognise, however, that tackling health inequalities means more than just addressing physical health issues. NHS Scotland produces evidence, works with local actors to develop inter-sectoral actions and with policy makers to implement 'health in all policy' (HiAP) approaches. NHS Scotland's current priorities include fairer and healthier policy, a fair and inclusive economy, healthy and sustainable places, and transformational public services. Children, young people and families are also a high priority, since 1 in 5 children in Scotland live in poverty, even when both parents work. Efforts are currently underway to provide assistance to new parents so that they can navigate the benefits system more easily and gain knowledge about other available opportunities which could benefit them, since evidence shows that these kinds of actions help to reduce health inequalities. There is also a plan to provide more hours of free child care, particularly to disadvantaged families. A hurdle they face is that income and wealth are not powers devolved to the Scottish Government, so they must be careful not to provide these services in a way that increases parents' incomes.

Nicoline Tamsma, President of EuroHealthNet,

concluded the conference. She indicated that a health in all policies (HiAP) approach, and making connections between individuals, ideas, projects, and organisations at regional, national, and EU levels, is at the heart of what EuroHealthNet does. She also said that it was no coincidence that the Seminar was taking place in Finland, with its rich tradition of HiAP. The presentations and discussions reflected that politics matter a great deal to health, since achieving more equitable health is beyond the ability of health care systems, and requires coordinated action across government. Ms. Tamsma indicated that a lot could be gained by making sure that appropriate health indicators are connected across political systems. She said that speakers had provided inspiring examples of daring policies and innovations, and that the presentations reflected that there is a need to go beyond win-win situations and to seek synergies, shared agendas with shared responsibility.