



# ADDRESSING HEALTH INEQUALITIES

*2014 and beyond*

REPORT ON THE FINAL CONFERENCE OF  
THE EU EQUITY ACTION PROGRAMME

JANUARY 23, 2013. BRUSSELS



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This conference was organised by the partners of the EU joint action programme on health inequalities (EQUITY ACTION), covering 15 Member States plus Norway. It brought together over 480 international experts on health inequalities and other stakeholders. Speakers included ministers and senior officials from EU Member States – including the Greek Presidency, representatives of the European Commission and WHO Europe, and scientific and research leaders. The purpose of the conference was to showcase the results of the joint action, assess progress on addressing health inequalities in the EU and to consider opportunities and priorities for future action.

# EXECUTIVE SUMMARY

“Investing in tackling health inequalities contributes to a more just, humane and equitable society with greater social cohesion and greater productivity” said Adonis Georgiadis the Greek Minister for Health for the Greek EU Presidency, speaking at the final conference of the Equity Action programme. His words were echoed by a range of European health ministers, officials and public health experts. The issue is more urgent, given that health inequalities are costing the EU Member States 1.3 trillion euros a year, according to figures released at the conference.

The event was the “culmination of three years of hard work”, according to Jon Rouse, from the Department of Health in England who chaired the event. The programme has explored the various challenges ahead for narrowing health inequalities in Europe and highlighted practical examples for governments to learn from. He said, we are “not just reviewing the achievements of Equity Action but are looking to move the agenda forward to 2020 and beyond, building on the lessons and results of the programme”. The conference was encouraged to hear that the Commission will continue to provide leadership on health inequalities by making it a priority over the next funding period, 2014-2020.

In a video address, Tonio Borg, the European Commissioner for Health, said that differences in social and economic conditions are major drivers of inequalities in health. “This is why achieving the goals of the Europe 2020 strategy – smart, sustainable and, very importantly, inclusive growth – are essential to reduce inequalities”, he added.

Professor Sir Michael Marmot of University College London, emphasised the impact of wider social factors, such as unemployment and poverty, on health inequalities. The conference is a sign that health inequalities are being taken seriously, “now, we’re on the agenda,” he said.

Mark Drakeford, Minister of Health and Social Services, Welsh Government for the UK said the activities of Equity Action showed it could help shape and influence policy development. The programme’s practical bent included assessing the impact of policy interventions on health inequalities, making the best use of EU structural and investment funds, deploying the evidence about ‘what works’ and engaging with partners, stakeholders and regions.

Zsuzsanna Jakab, Regional Director for WHO Europe, said that the WHO European Health 2020 Strategy “asks those wishing to tackle health inequalities to think about improving health and well-being in new ways...[and]...beyond actions on health systems or changing life styles,” she said.

Panel discussions featured country-specific experiences from Belgium, Finland, Greece, Ireland, Lithuania, Spain, and the UK, and the contribution of the European Commission.



PROFESSOR SIR MICHAEL MARMOT OF UNIVERSITY COLLEGE LONDON

“Everyone should be able to reach their health potential wherever they’re from and whatever their background,” said John Ryan, from the Commission’s Directorate General for Health and Consumer Policy.

An overarching message from the conference was that concerted action was needed across government departments – at local, national and EU level – if health inequalities were to be reduced. Though the economic advantages of addressing health inequalities were clearly outlined, it was the shared belief of many at the conference that inequality is an issue that in itself demands attention. Sir Michael underlined his belief that we have “a moral responsibility” to tackle health inequalities.

“You can narrow the social gradient by government action. Health inequalities are not inevitable. This conference shows that we really can make a difference,” he affirmed.

Jon Rouse, in closing, thanked “all the partners and participants in the Equity Action programme who have tried to make a difference and tackle the injustices of inequalities”. While he added that “the arguments are on your side”, he stressed that “we need to make sure we secure a legacy and that the hard work is sustained”.

# CONFERENCE REPORT

Jon Rouse, Director General, Social Care, Local Government and Care Partnerships, Department of Health, England, welcomed participants to the conference by emphasising the achievements of the programme and underlining the need to “secure a legacy” for its work. The EU joint action programme – with 15 Member States plus Norway – has developed a practical approach to health inequalities taking into account the wider social determinants of health and producing valuable lessons through “lots of case studies that we can now draw on across the participating Member States, regions and sub-regions”.

## **THE EUROPEAN COMMISSION’S ROLE**

John Ryan, Acting Director of Public Health in the European Commission’s (EC’s) Directorate for Health and Consumer Policy, introduced the video presentation of Tonio Borg, the European Commissioner for Health. He said there was an urgent need to “close the unacceptable gap that exists between Member States and between regions. Everyone should be able to reach their health potential wherever they’re from and whatever their background”.

Commissioner Borg said that progress had been made in reducing health inequalities in Europe. There had been a “significant decline in inequalities in infant mortality between Member States in the past 10 years” and some “modest reduction” in the gaps in life expectancy between Member States.

But, he added, those with lower incomes and less education continue to have worse levels of health than those on higher incomes and are better educated. “This has changed little over the past five years,” he said. “And while there are some very positive actions aimed at reducing inequalities, the level of policy response across European countries varies greatly.” He pointed out that most Member States do not have national-level strategies in place to tackle health inequalities.

Mr Borg reiterated the Commission’s commitment to reducing such inequalities and stressed that “the efficiency and sustainability of health systems needs to be strengthened – otherwise health systems will not be able to provide healthcare for all citizens. This is why I strongly encourage Member States to invest in sustainable health systems; to invest in people’s health; and to invest to reduce inequalities in health.”

## THE SCALE OF THE PROBLEM

Professor Sir Michael Marmot, Director of the Institute of Health Equity at University College London (UCL), chaired the review teams that produced the report on Health Inequalities in the EU and the WHO report, *Review of the Social Determinants of Health and the Health Divide in the WHO European Region*.

He said Member States should have two clear aims: to improve average health and to reduce health inequalities by bringing the health of less-advantaged people up to that of the most advantaged. Much more can be done at all levels, he affirmed, and we have a moral responsibility to do it. “We should be advocates for doing things differently...We are making good progress on improving health levels overall, but we are making very poor progress on reducing avoidable health inequalities.”

The data showed a general pattern of lower life expectancy in the new Member States in central and Eastern Europe in comparison with those in the West. There were also greater differences between social groups, wider for men but less marked for women, who generally enjoy a longer life expectancy.

Employment is crucial. “I’ve said in every report that work is preferable to benefits and welfare – but the quality of work really matters. When we look across Europe... the lower the social class, the less likely you are going to be in control [of the work you do] and the more likely you are to have work that is characterised by an imbalance between effort and reward.”

“Unemployment is bad for health, and it’s particularly bad for mental health.” He said, “a 3% rise in unemployment is equal to a 3% rise in suicide if there was no [additional] spending on social protection, such as active labour market programmes, family support, healthcare and unemployment benefits.”

While some countries in Europe have stepped up their policy responses in recent years, the trend is by no means universal and some countries have even reduced their efforts. “Financial difficulties are not a reason for inaction. They make action even more urgent,” asserted Professor Marmot. “You can narrow the social gradient by government action. Health inequalities are not inevitable.”

There is scope, he said, for countries where very little is in place, to do something; for countries where some policies are in place, to do better; and for the richest countries, to do more.

# WHAT IS EQUITY ACTION AND WHY DOES IT MATTER?

Mark Drakeford, Minister of Health and Social Services, Welsh Government, UK, underlined the UK's support for this agenda. He said that Equity Action has raised the profile of health inequalities in the UK and across Europe. "Greater awareness of the issues is important and necessary. It helps us to understand the stubborn and persistent nature of health inequalities," he said.

Policies must have a long-term impact on the ground. "Asking the question of what sort of action, means using the evidence to identify the policies that are needed and supporting them with practical guidance." This has been the role of Equity Action, he said.

The programme had four strands. The first strand – led by the Department of Health in England – was about providing governments with the required 'tools' for shaping policy and assessing impact, including through case studies and EU-wide equity audits to identify areas for action. Additionally, health case studies have helped provide tools that generate lessons.

The second strands was 'regions', led by EuroHealthNet, the Brussels-based network of public agencies working on health. The engagement of regions was achieved by establishing a learning network of 30 regions and carrying out a good practice assessment across a wide range of policy areas. It also sought to "capture regional approaches to tackling health inequalities and to encourage better use of EU structural funds".

Knowledge sharing was the third strand, led by the Dutch National Institute for Public Health and the Environment. Mr Drakeford said "it has sought to develop an informed approach to policy. They have established an EU-wide scientific reference group to collect insights from across the social determinants...and align these findings with Member State actions."

Ways of mobilising stakeholder support was the final theme of the programme led by the German Federal Centre for Health Education and the Hungarian National Institute for Health Development. "This work sought to build commitment to the health inequalities agenda across society – by facilitating international and national stakeholder debates to share experiences and learn about working with government using health equity as a starting point," he explained.

A key lesson from the programme was, he said, that "we need to be in the room where decisions affecting health inequalities are being made, and [that] those decisions are not made narrowly within the confines of health's own responsibilities, but much more widely across the whole responsibilities of government".

He said that the end of the Equity Action programme "should be the beginning of a renewed effort of tackling health inequalities across the EU in what we hope will be an improved economic climate".

# WORKING TOGETHER ACROSS EUROPE: the role of Health 2020 strategy

Erio Ziglio, Head of the WHO European Office for Investment for Health and Development in Venice, Italy introduced Zsuzsanna Jakab, the Regional Director for the European Office of the World Health Organization. He emphasised the need for a cross-cutting, inter-sectoral approach. We need “the whole of government and the whole of society to be engaged in efforts to reduce health inequalities”, he said. “We need urgent sustained political commitment, strong partnerships nationally and internationally. The work carried out through the Equity Action process needs to be scaled up even more across Europe.”

Zsuzsanna Jakab, outlined the goals of Health 2020, a framework to advance health, equity and well-being in countries of the WHO European region. She said one of its main objectives is “to improve health for all and reduce health inequalities”. Europe can do better to both improve health and reduce health inequalities, she said.

“Health 2020 asks those wishing to tackle health inequalities to think about improving health and well-being in new ways [because] population health is linked to societies, and the way they function. This includes the risks and strengths that shape the lives of individuals, families and communities throughout the entire life course.”



Early childhood experience, work and unemployment and access to health systems are examples of the wider factors that shape health, especially during times of austerity. “Reduction of inequalities is not only a priority for the health sector. It is at the heart of policy objectives to reduce poverty, build safe and sustainable communities, increase human capital and reduce social exclusion,” she said.

“New mechanisms of governance” for health are also needed. “We must recognise that alongside national governments, we have regional and local administrations, the private sector, non-governmental organisations, institutions, communities and individuals, all needing to be involved... In the European context, we have unique opportunities to work more cooperatively at all levels.”

## PANEL 1 – Voices and Power

Clive Needle, Director of EuroHealthNet, introduced the panel, which reviewed the stakeholder work strand and explored the opportunities for building support for action on health inequalities across wider society.

Frances Fitzgerald, Minister for Children and Youth Affairs, Irish Government, said that Ireland has one of the youngest populations in Europe with nearly a quarter under the age of 18. “Ensuring [young people’s] good health is vital for our future and our economy.” However, she added, that much research – “not just in Ireland but in the rest of Europe as well – does point to an appalling vista for a proportion of our children”.

“We have invested considerable [resources]... in the last few years to become ‘data rich’ about our own Irish children.” The results show that “for many children we have a very serious issue – for example, in relation to obesity.” We also have strong evidence about the continuities in health. We know that if our children have health issues at three, there is a very real risk that these will continue into adult life.”



Working together is crucial. EPHA “mentors” different groups across Europe on how to engage with policy makers. The Alliance believes in a “broad approach” to health. “Most of the factors that influence health lie outside the health sector – social housing, education, the environment...” she explained. “With the mentoring programmes, we like to show that you must engage with other policy areas as well.”

What the Equity Action programme demonstrates is that there is a “need action now... and EPHA in its manifesto for the European elections is calling on all the future MEPs to place people’s health as a priority on the political agenda,” she concluded.

Last year, the Spanish government launched a national plan to promote the well-being of children and adolescents, PENIA. Pilar Farjas Abadía, Spanish State Secretary General for Health, Ministry of Health, Social Services and Equality, told delegates about her government’s use of its ‘Childhood Observatory’ to monitor and evaluate results. The observatory is composed of representatives of all departments with responsibilities towards childhood.

The plan engages all stakeholders and provides a platform for 50 child-focused NGOs. As a result of the strategy, ‘equity’ is now included in other areas of health and education, she said.

In the discussion that followed, Chris Brookes (UK Health Forum) asked whether special ‘go-between’ envoys that work between governmental departments were needed to ensure raised awareness of health inequalities translates into concrete actions. In reply, Frances Fitzgerald emphasised the need for an “overarching mechanism”, but she added that “it’s not as easy as we might assume to work across-departments, as there are very established ways of working”.

Robin Ireland (Health Equalities Group) emphasised that it was important to listen to children. Frances Fitzgerald echoed this need to foster the participation of young people in policy development. “I don’t think enough governments have it as a goal,” she said. “It’s very much a case of building the bridges between the formal structures and the young people...You need to have the mechanisms to make it happen...[and] someone to go out there, [to take charge] and link with where the young people are”.

Peggy Maguire added that EPHA engages with young people, but they are not treated seriously by decision makers or allowed to have a voice. To change, it needs “creative and innovative leadership from the top”, a manifesto and a budget.

An example of EU funding having a positive impact on health inequalities came from London. For the European Social Funding that the city received, ‘health and well-being’ was established as a cross-cutting theme, Justine Cawley (Justine Cawley Associates) told delegates. “This made a tremendous difference because we could see how health could be used with employment and education.”

## PANEL 2 – Fostering Action at the Sub-National Level

The Equity Action programme established a new network of sub-national partners and players, “who really worked extremely hard during the course of the three years to produce a whole range of outputs”, said Clive Needle in opening this panel discussion.

Michael Ralph, Advisor to the Deputy Director General for Implementation, DG Regional Policy and Urban Development, said his department is very busy working on local, regional and national levels on the next round of structural funds...We are talking about programmes [that run] for the next seven to 10 years. And there are some opportunities for health inside of these.”

He explained that Member States are responsible for implementing these programmes but most investments are expected to be made in the less-developed regions. The different EU funds, such as European Social Fund and the European Regional Development Fund (ERDF), need to “work together at the local level so that we can get an overall approach and enhance their effectiveness”.



“We have a cross-sector approach; we take health as an issue together with housing and employment,” he continued. “The social fund has a primary activity of promoting social inclusion...and that can include, as far as health is concerned, improving access to health services, health prevention measures and actions targeted at vulnerable groups.”

ERDF focuses on social infrastructure and offers opportunities to address health inequalities in the context of regional social and economic development. The focus is on poor regions and poor people, focusing on pockets of deprivation and vulnerable groups in less developed regions. “A lot of our interventions in the past haven’t had a proper strategic basis and this means that they’ve not been necessarily that effective.” Member States will need a more strategic approach in future, he said.

“Local and regional authorities have a frontline role in addressing health inequalities... [they] play a key role in providing public health services, in health promotion and in disease prevention,” said Constance Hanniffy, the European People’s Party representative on the Committee of the Regions (CoR) and rapporteur on the EC’s ‘Report on health inequalities in the European Union’.

She underlined the need for reducing health inequalities at all levels, and said that the CoR understands that, given the range of factors that affect health, inequalities cannot be addressed by the health sector alone.

Collaboration at national level was important. “However, it is often at local level that the crucial inter-sectoral approaches can be developed and implemented ...furthermore, it is a precondition that a strong leadership is needed to help drive and implement cross-section commitment to reducing health inequalities.”

The inclusion of health actions across a range of EU-funded programmes will encourage the creation of integrated strategies, she argued. Such an approach will maximise the benefits that can be gained from the resources available. “The CoR strongly encourages the Commission and the authorities within the Member States to prioritise building on [Equity Action’s] excellent work to date.”

Elisabeth Rahmberg was introduced by Clive Needle as a “living example” of how to tackle health inequalities. She is Public Health Director, Department of Public Health for the Swedish region of Västra Götaland, which drew up its own health inequalities action plan – a “political framework document”. It was the first regional policy in Sweden to seek to reduce health inequalities – autonomous from central government. It contains concrete actions and measures, and has a “life course perspective, safe and satisfactory growing up conditions, increased participation in working life and aging with a quality of life,” she added.

The regional ministry collaborated with partners to develop the plan, including employment services, county councils and NGOs. “Our participation in Equity Action has given us an added value [in] developing [the] plan of action.” She continued that “though we lack a European forum – in particular, for the implementation and monitoring of results – we would love to see such a forum where we can share our experiences. It is important to develop common goals that we can pursue across Europe.”

Francesca Avolio (Regional Healthcare Agency of Puglia) speaking from the floor said her region has invested 20% of its structural funds in changing its social infrastructure to widen access to health. “This pushed our decision makers to better orientate the new EU structural funds programme, 2014-2020 [towards health inequalities].”

# LOOKING FORWARD TO ACTION ACROSS THE SOCIAL DETERMINANTS: the role of the EU Presidency'



Adonis Georgiadis, the Greek Minister of Health, gave an overview of the current challenges facing the Greek presidency of the EU. He recognised that the burden of health inequalities on lower socio-economic classes, the poor and the socially excluded die younger and suffer from long-term disabilities and chronic diseases.

Moreover, he suggested, the situation is worsening and “the recent economic crisis has further aggravated the health gap among regions, countries and socio-economic groups.” He said that the impact of the socio-economic determinants of health became more apparent with greater adverse effects on the health of the European population.

Mr Georgiadis argued for a “common strategy” to meet these challenges. He said, we need “a global European vision and a unified effort to improve quality of life for our citizens ensuring at the same time greater equity, a more human and accessible health care system”.

“Investing in health contributes to the Europe 2020 objective of smart, sustainable and inclusive growth,” he continued. While he recognised that Greece is facing particular challenges, it is responding to them. “I have developed a number of actions and collaborations with international organisations to tackle health and social inequalities in my country with targeted and well-evaluated health policies,” he said.

The EU and WHO Europe reports led by Michael Marmot set out the wider picture and made it clear that health inequalities “are politically, socially and economically unacceptable. They are also unfair and the promotion of health equity is essential to sustainable development of our health and our European health systems.”

He had some important messages, and said “let us:

- shift our focus of analysis from health care and health services to tackling health inequalities,
- increase our investment in health promotion, health protection and population health,
- adopt better governance for our health systems,
- strengthen European Collaboration towards reducing health inequities, and
- monitor public health progress and increase accountability”

In concluding, he invited his “European colleagues at different Government ministries to take actions on the social determinants of health in order to establish a more equitable, more economically productive and a more inclusive society”.

## **PANEL 3 – Looking Forward: Turning awareness about health inequalities into action**



Lieve Fransen, Director of Social Policies and Europe 2020 in the EC Directorate of Employment, Social Affairs and Inclusion, acknowledged the importance of health in the Commission's work on employment and social affairs, such as the European Semester, the vehicle to capture Member State priorities to help the Commission support and strengthen them.

This Semester is launched with the Annual Growth Survey, which “recognises that better performing social protection is essential to support social change and reduce inequalities and poverty, including health inequalities”. Together with the Member States, the Commission has developed an evidence-based assessment tool. This Joint Assessment Framework now includes health, “to reinforce our work on health in the Semester exercise,” she explained.

It is also recognised that better performing social protection is essential to support social change and reduce inequalities and poverty, and consequently health inequalities which are inextricably linked with poverty.

She also highlighted the Commission's work under the Irish Presidency on “a child-friendly social investment package” integrated with health.

Outlining her government's efforts to turn awareness into action, Pilar Farjas Abadia, the Spanish State Secretary, said that specific protection has been introduced for vulnerable groups. She added that patients in Spain are now able to play a greater role in the development of healthcare policies and actively participate in the process.



Gediminas Cerniauskas, Vice-Minister of Health, Lithuania, which held the EU presidency in the second half of 2013, identified his country's priorities as the tobacco directive and sustainable health. The health sector is important for the EU's economy and its global competitiveness, he stressed. However, we need a better understanding of what health means for Europe. "It is clear that health is not just a grandchild of those big industries [such as coal and steel]. Today, it's a big industry in its own right".

The life expectancy of men in Lithuania is one of the lowest in Europe, with cold weather a particular factor in comparison with other EU countries. But, he said, we have plans to tackle these issues.

Philippe Courard, the Belgian State Secretary for Social Affairs, Families and Persons with Disabilities, said that Europe needs to strengthen its social agenda. Social security is a way of protecting people in times of economic downturns. Belgium has managed to withstand the worse effects of the recent crisis due to its strong social focus. However, he added that all stakeholders need to come together including those from the civil society to best address the key health issues.

Frances Fitzgerald, the Irish Minister said the cost of funding our health services all over Europe is not sustainable and that priorities needed to be identified.

"We need to work harder to ensure that the debate at European level is economic and social. The financial crisis...has really led to far less focus on these health and social issues," she added. We need a "broader definition of health that includes community development".

Health inequalities are also relevant to the "political debate that builds into the reform narrative of Europe" and to initiatives such as the European youth guarantee.

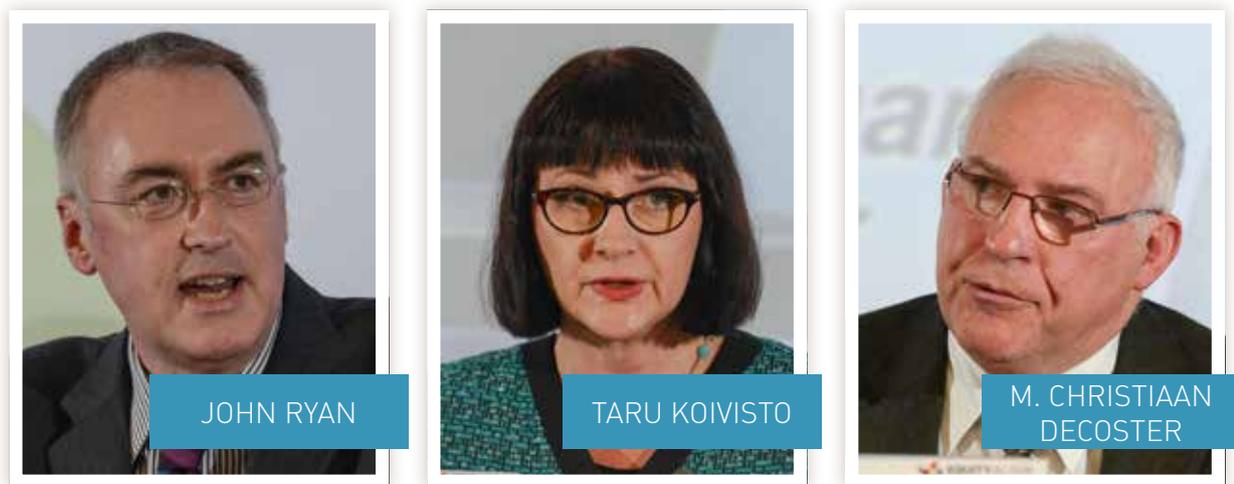
Mark Drakeford, the Welsh Minister, said his government believes in a more equal country because "more equal countries do better economically, they have less crime, they have less fear of crime, they have a greater sense of solidarity and they have fewer health inequalities".

As a result, in Wales, health inequalities are "positioned in that broader equality thrust [and] at the heart of our approach is an enduring belief that good government is good for you."

He said, we are trying to reformulate the relationship between the providers and users of health care on the basis of "co-production – a belief that services work best when the strengths and the contributions of people that provide and use services are recognised as being equally valuable". As much as governments can create the right conditions for tackling health inequalities, individuals have in their own hands the ability to make a difference to their health and the level of healthcare that they receive.

Adonis Georgiadis, the Greek Minister, summed up the challenge of government by likening it to a Gordian knot: populations are ageing as life expectancies increase; treatments are becoming more advanced but also more expensive and there's less money to spend on them. As a result, governments are introducing reforms to ensure that resources are used as efficiently as possible.

Jon Rouse summed up the session by highlighting the three dimensions for government action: the economic case; the social and moral case, based on fairness, and the democratic case inviting citizens to take "ownership" of the health inequalities issue.



## PANEL 4 – The Role of Governments

This panel reviewed the 'tools' strand of the Equity Action work, with a focus on the impact of policies and the development of a 'health inequalities in all policies' approach.

Christiaan Decoster, Director General of the Department of Healthcare of the Belgian Federal Government, opened by saying that his government has increased the involvement of stakeholders in healthcare. He said their participation is necessary for drawing up a national strategy for tackling inequalities, as he presented the results of the government's policy dialogue with stakeholders.

He recognised that health inequalities are increasing in Belgium and concern the majority of the population. "Each sector and each department can play a role in reducing health inequalities," and while cross-sectoral co-operation is a "complex" process, "it gives results".

Taru Koivisto, Director of the Finnish Ministry of Health and Social Affairs, recalled the conference her government had organised with WHO last June in Helsinki on the implementation of health in all policies, showcasing examples of successful practice from around the world. In building on this work, Finland and WHO have been drafting a framework “giving practical guidance for all of us”. This framework will emphasise political commitment; structure, processes and resources; strong capacity of health ministries; accountability mechanisms and the inclusion of communities and NGOs.

Though Finland has demonstrated a long-term commitment to addressing health inequalities, she emphasised that one lesson learned was the need for sufficient political support because it’s not “self-evident” to other departments to take health considerations into account when devising policy. This is why practical support and guidance, such as factsheets and well-presented documents on trends, are important.

She concluded by saying that “universal measures are more effective for low socio-economic groups” than those targeted specifically at them. Successes have been achieved in the areas of food labelling and healthy school meals and in workplaces.

John Ryan, the Commission’s Acting Director of Public Health said that reducing health inequalities was a “top priority” as Member States face financial crises. This was signified “by several Ministers and Secretaries of State who have made the effort to come and show their political ownership of this topic.” While national government has a central role, “the involvement of patients and citizen groups through empowerment and health literacy is a key element of success” in reducing them.

“I think that there are unbeatable alliances that can be created between governments, business and industry, health professionals and civil society organisations,” he continued, such as Europe Against Cancer. “Data can be used more intelligently to present the unacceptable facts about health inequalities as arguments to make changes in policies across government,” he said.

However, care needed to be exercised when involving industry. In response to a question on the issue, Dr Koivisto said that Finland is one of the most careful countries in its dealings with industry. Thus while in terms of policy the Ministry doesn’t cooperate with industry, NGOs have a strong role to play in cooperating with industry – for example, reducing the salt content in bread.

In concluding the session, John Ryan said that the Commission is working with Member States to find ways of continuing the goals of the Equity Action programme. “Health inequalities are not something that we can put to one side and say ‘that’s done’ – that’s clearly not the case.” One of the first things to look at is how we can extend the involvement to other Member states and regions, he added.

## PANEL 5 – Using the Evidence to Promote Change

This panel focused on the use of evidence to inform policy development and decision-making, the ‘knowledge’ strand of the programme.

Research should inform policy and action, and “EU collaborative research allows us to tap into the richness of Europe’s diversity...taking new actions and new approaches and demonstrating that they work,” said Barbara Kerstiëns, Head of Sector Public Health, DG Research and Innovation.

EC Framework Programme 7 has invested more than €30 million in projects to tackle health inequalities. This “research has demonstrated good examples of policies that work,” she said. The task is to apply the evidence and identify the gaps that inhibit action – the kind of work that has been at the heart of Equity Action.

The Health 2020 programme also has provision for tackling health inequalities, and she said that she welcomes the opportunity to talk with stakeholders to discover the gaps that need addressing.



The Institute of Public Health of Ireland carried out an assessment of the health impact of sugared drinks, as part of the ‘tools’ strand of the programme. Noëlle Cotter from the Institute highlighted this work and Ireland’s focus on the importance of early intervention as underscored by Michael Marmot’s report. Parents have been identified as critical to a child’s early years and life chances, she said. Research shows that “parenting interventions work”.

Providing a universal service, however, is crucial. It can help guarantee the reach of a programme and help “de-stigmatise” it. Moreover, interventions that include the child as



well – and not just the parent – are shown to be most effective. While such interventions are generally positive and cost effective, she noted that evaluation results only cover the short to medium term, and rely on self-reporting. She said that “refresher interventions might be needed throughout childhood to reinforce those interventions in the early years,” until the evidence is clearer about their long-term effects.

Merel Schuring, from Erasmus University in the Netherlands, reiterated that “labour participation is an important determinant of health inequalities”. One of the reasons, she said, was the higher prevalence of mental health problems among the unemployed.

Such problems are also more common among temporary staff (as opposed to those on permanent contracts). She said her work had shown that those with a low socio-economic status are particularly vulnerable to the adverse effects of temporary employment. Moreover, high levels of income security and low employment protection in Nordic countries is a greater buffer against health inequalities in comparison with the reverse situation in Mediterranean countries. “A focus on lifelong learning also ensures the continuing employability of workers.”

Areas needing more research include factors that make specific groups more vulnerable to the adverse effects on temporary employment, the types of labour market policies that lead to less health inequality and higher employment, and the steps needed to support those with chronic diseases in the labour market.

Angela Donkin, a Senior Advisor at UCL Institute of Health Equity in London, said that while more research is always needed, the messages coming from the conference have been reassuring. “It’s no longer necessary to make the case [for addressing health inequalities], it’s about what works.”

This approach yielded the parenting interventions document, a good example of what can be achieved. Echoing Noelle Cotter, she acknowledged the lack of long-term evaluation of interventions. “Researchers need to get involved in the design of these evaluations and make sure that health inequalities are included,” she argued.

From the conference floor, David Murray (Matrix) said that more research was needed to support the economic case for investing in reducing health inequalities. “Even though this is a justice issue, it is naïve to think that we won’t be required to make economic arguments”, he said.

Astrid Stuckelberger (Institute on Global Health, Geneva) said one of the problems was that inequalities can cross generations. “If we don’t break the vicious circle with a trans-generational perspective then we will...never reach equity in society,” she said.

Barbara Kersteins said that there is an opportunity under Horizon 2020 for Member States to build their own research initiatives such as Joint Programming or ERA-Net funding.

## LOOKING FORWARD: final reflections on the challenges ahead

Michael Marmot said: “we are on the agenda – this is terrific. When Jon Rouse asked the Commission ‘if we are still going to be on the agenda?’, John Ryan said ‘yes’. Ministers talked about implementing strategies for health inequalities and social determinants of health – and that is all terrific. We can synthesise the evidence of impact, so we can give advice on policies – we can look at the health equity impact of all government policies. It is not just economic policies but social policies as well.”

He touched on the global dimension to health inequalities, saying that “we are dealing with common problems”. In India 80% of women are employed in the “informal” sector and face the same insecurities as those temporary workers in Europe. He concluded by saying that to promote health equality is an absolute privilege. “We are on the side of the angels.”



Jon Rouse, in closing, thanked “all the partners and participants in the Equity Action programme who have tried to make a difference and tackle the injustices of inequalities”. He added that “while the arguments on our side, we need to make sure we secure a legacy and that the hard work [of the programme] is sustained”.

## Keeping in touch with the Joint Action

You can find out more about the Joint Action and keep in touch with its work in the following ways.

- **Our website**  
<http://www.equityaction-project.eu>
- **Our newsletter**  
Equity Action News - Subscribe on our website
- **Our Twitter feed** - @equityaction

You can also contact our co-ordinator directly  
[mark.gamsu@hapi.org.uk](mailto:mark.gamsu@hapi.org.uk)



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