

**DETERMINE**  
Working  
Document  
# 1

**Policies and actions addressing the socio  
economic determinants of health inequalities:**

# **EXAMPLES OF ACTIVITY IN EUROPE**

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**DETERMINE – an EU Consortium for Action on  
the Socio economic Determinants of Health**



**The Institute of  
Public Health in Ireland**



## Summary

DETERMINE is an EU Consortium for Action on the Socio-economic Determinants of Health (SDH). The overall objective of DETERMINE (2007 - 2001) is to achieve greater awareness and capacity amongst decision makers in all policy sectors to take health and health equity into consideration and to strengthen collaboration between health and other sectors. This requires, amongst other things, building the evidence-base on policies that address the socioeconomic determinants of health inequalities (SDHI).

This document presents the outcomes of an analysis of questionnaires completed by 15 DETERMINE partners in EU Member States as well as EuroHealthNet at the European level, exploring examples of policies and actions addressing SDHI. The aim of this analysis was to get a better insight into EU governments' experiences with cross-sectoral collaboration to address the social determinants of health inequalities, in order to build on these experiences.

The outcomes point to a wide range of action on the social determinants of health across Europe. Some of the factors which appear likely to contribute to action include:

- Where addressing SDHI is a stated government priority e.g. in the case of Scotland.
- Where there is a cross departmental strategy to address SDHI e.g. the Investing for Health strategy in Northern Ireland.
- Where there is reference to SDHI in policy documents – many examples are available.
- Where there are cross-government mechanisms in place which support the establishment and maintenance of partnerships – e.g. Social Partnership Agreement in the Republic of Ireland.
- Where there are policy tools in place to facilitate action, such as IA and evaluation.
- Where there is evidence available which demonstrates clear links between health and social inequalities – e.g. Netherlands, UK, Scandinavia
- Where there is leadership at both EU and national level – e.g. Finland and UK in EU presidency

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## Introduction

DETERMINE is a three year project (2007-2010) supported by the European Commission and coordinated by EuroHealthNet. It brings together a high level Consortium with representation from 26 European countries with an overall objective of supporting and enabling policy makers and practitioners in all policy sectors to place a higher priority on health and health inequalities when developing policy. Further information on DETERMINE and its predecessor 'Closing the Gap' is available at <http://www.health-inequalities.eu/>.

A core aim of DETERMINE is to strengthen the knowledge base on policies and actions addressing the social determinants of health inequalities (SDHI) from a European perspective. In the first year of the project, partners representing 15 countries and regions worked together to identify and explore examples of such policies and actions both at EU and member state level (referred to as Work Package 5, Task 1). This working document describes the approach used and presents a summary of findings. More comprehensive results are available on the DETERMINE portal. In Year 2, partners will work together to explore the economic arguments for policies and actions addressing SDHI.

## Clarification of terms

Health is determined by many factors outside the reach of the healthcare sector. A *Social Determinants of Health* (SDH) perspective draws attention to the relationship between the social and economic conditions in which people live and their health.

*Health Inequalities* refers to the variation in health at population level by socioeconomic status.

*Social Determinants of Health Inequalities* (SDHI) combines the two concepts in order to emphasise the role of social and economic conditions in people's different rates of health and illness.

Policies and actions addressing the social and economic conditions in which people live are formulated in many sectors outside of health. A *Health in all Policies* (HIAP) approach promotes an explicit recognition by these non-health sectors of the potential impacts of their policies and actions on the health and well-being of citizens.

At the same time a *Social Inclusion/ Poverty Exclusion* approach promotes an explicit recognition by all sectors of the potential impacts of their policies and actions on social inclusion/ poverty exclusion. This in turn can have a profound impact on health.

## Building on the existing knowledge base

DETERMINE complements the work of the World Health Organisation's Commission on Social Determinants of Health (CSDH) (2005-2008), which brings together evidence at a global level on policies that improve health by addressing social conditions. Amongst the goals of the CSDH is to help build a sustainable global movement for action on health equity and social determinants. DETERMINE contributes to this in an EU context.

### Task 1 outline

DETERMINE comprises seven work packages. This working document summarises the first year activities (Task 1) of Work Package 5.

#### Aims and objectives

The aim of this Task was to contribute to the knowledge base by identifying and exploring examples of policies and actions addressing SDHI at EU and member state level.

Given time and resource limitations, this was not intended to be a comprehensive review of all policies in all sectors. It sought instead to identify *examples* of policies and actions that address health inequalities and to explore these examples, how they came about, how they are being implemented, level of success and so on, so that others can learn from them.

Both health and non-health sector policies and actions were included in the research. Each partner was responsible for collecting data within their own country or region. EuroHealthNet, in collaboration with the work package leader, collected data at the EU level.

#### Partners

Partners representing 15 countries and regions across Europe worked together on this task which was co-ordinated by the Institute of Public Health in Ireland. Additionally two international organisations, EuroHealthNet and IUHPE, were represented. A complete list of partners is given in Appendix 1.

#### Design and methodology

A scoping exercise for Task 1 was conducted and presented to members of the DETERMINE management team in September 2007 and again to all members of the Consortium at a meeting in Lisbon the following month. Thereafter, Work Package 5 partners had further opportunity to discuss and contribute to development of the Task at a Working Group Meeting in November 2007. Discussions during these meetings informed the design of a questionnaire which facilitated data collection regarding government policy on SDHI and exploration of actions being undertaken by both the health ministry and other ministries. An abbreviated version of the questionnaire can be found in Appendix 2.

## Overview of responses

Questionnaires were completed by all relevant partners resulting in 16 responses. While the stated occupation of respondents ranged from academic to administrative, all had a health background. In completing the questionnaire, some partners relied solely on their own knowledge and expertise while others collaborated with colleagues and others working in both health and non-health areas.

Partners were encouraged to report findings at the national level where possible. However given different governance arrangements across Europe it was recognised that this was not always feasible or appropriate. Two partners reported at both national and regional levels, three partners at the level of devolved administration and the remaining ten at the national level. All partners reported actions by their respective health ministries and most gave examples of action in at least one other area. Table 1 presents the partner countries with links to relevant ministry websites.

**Table 1: Government level and Ministries considered** (\* denotes limited/ no text in English)

Partner	Government level	Ministries considered
<b>Belgium</b>	National & regional	<a href="#">Ministry of Health, Food chain safety and Environment</a> <a href="#">Flemish Ministry of Welfare, Public Health and Family Tourism Flanders*</a>
<b>Czech Republic</b>	National	<a href="#">Ministry of Health*</a> <a href="#">Ministry of Labour and Social Affairs</a>
<b>England</b>	National	<a href="#">Department of Health</a> <a href="#">Department of Work and Pensions</a>
<b>Estonia</b>	National	<a href="#">Ministry of Social Affairs</a>
<b>Finland</b>	National	<a href="#">Ministry of Social Affairs and Health</a> <a href="#">Ministry of Education</a>
<b>Iceland</b>	National	<a href="#">Ministry of Health</a> <a href="#">Ministry of Social Affairs</a>
<b>Ireland</b>	National	<a href="#">Department of Health and Children</a> <a href="#">Department of Education and Science</a> <a href="#">Department of Environment, Heritage and Local Government</a>
<b>Netherlands</b>	National	<a href="#">Ministry of Public Health, Welfare and Sport</a>
<b>Northern Ireland</b>	Devolved	<a href="#">Department of Health, Social Services and Public Safety</a> <a href="#">Department for Social Development</a> <a href="#">Department for Employment and Learning</a>
<b>Norway</b>	National	<a href="#">Ministry of Health and Care Services</a> <a href="#">Ministry of Labour and Social Inclusion</a>
<b>Poland</b>	National	<a href="#">Ministry of Health*</a> <a href="#">Ministry of Labour and Social Policy</a>
<b>Scotland</b>	Devolved	<a href="#">Directorate of Health and Wellbeing</a> <a href="#">Directorate of Finance and Sustainable Growth</a> <a href="#">Directorate of Rural Affairs and the Environment</a>



<b>Partner</b>	<b>Government level</b>	<b>Ministries considered</b>
<b>Slovenia</b>	National	<a href="#">Ministry of Health</a> <a href="#">Ministry of Labour, Family and Social Affairs</a> <a href="#">Ministry of Agriculture, Forestry and Food</a>
<b>Spain</b>	National & regional	<a href="#">Ministry of Health</a> <a href="#">Ministry of Work and Social Affairs*</a>
<b>Wales</b>	Devolved	<a href="#">Department of Health and Social Care</a> <a href="#">Department for Environment, Sustainability and Housing</a>
<b>European Union</b>	EU	<a href="#">DG Sanco</a> <a href="#">DG Employment, Social Affairs and Equal Opportunities</a> <a href="#">DG Environment</a>

## Use of the term SDHI

While the term *Social Determinants of Health Inequalities* has not yet become common currency across governments, others terms are being used to describe work in this area.

### These can be broadly grouped into:

- Terms such as Social Inclusion, Poverty Exclusion and Combating Poverty whose main focus is to address root causes of poverty and social exclusion.
- Terms such as Health in all Policies, Health in other sectors and Social Determinants of Health whose main focus is to address the root causes of ill-health.
- The term Health Inequalities which may be interpreted as a descriptor, for example describing socioeconomic differences in cancer rates or as a broader concept encompassing the root causes of ill-health and the unequal distribution of these causes.

Thus it can be seen that the term *Health Inequalities* when used as a broad concept, has a similar meaning to SDHI. At the same time, while there are conceptual differences between the other terms and SDHI, a strong case can be made for their inclusion here. It can reasonably be suggested that government strategies on social inclusion and poverty exclusion set the stage for consideration of principles such as fairness, equity and social justice, all relevant and necessary for action on SDHI. Equally, general awareness of how and where health is determined could be seen as a first step towards addressing SDHI. However the extent to which *explicit* recognition by the non-health sector of their influence on health outcomes is necessary or even desirable in order to achieve action on SDHI is subject to some debate, as exemplified in the box text below.

In Belgium, there are integrated policies on combating poverty at both the federal and regions/communities level which work on the improvement of the different structural causes/determinants of inequality including education, employment and housing conditions. Neither the Belgian policymakers nor the stakeholders on combating poverty refer to these as 'policies that work on the determinants of health or on the social determinants of health', however there is recognition that it is necessary to tackle the structural/social determinants of inequalities in order to improve the health of disadvantaged people.

While the Norwegian Strategy 'Social Inequalities in Health' makes explicit reference to health in its title, nonetheless it was felt that an important factor facilitating collaboration during its development was to focus on the common goal amongst ministries of reducing *inequalities* and not necessarily *health inequalities*. In this way, some common ground was reached and interest grew in targeting the "causes of the causes" of inequalities in different areas (health, labour and education). Bracketing health concerns in this way is likely to have encouraged greater cooperation across sectors than an insistence on "health in all sectors".

For the purposes of this report, given the absence of widespread recognition and acceptance of the term SDHI, examples of policies and actions in all of the areas outlined above are included in the report as they are understood to be making a contribution towards tackling SDHI.

## Overview of findings

Sections one and two focus on national/ regional level action while section three gives an overview of policies and actions addressing the social determinants of health at the EU level. Section three presents an overview of policy and structures relevant for health at the EU level.

The report includes examples of responses from each partner within each section to highlight work being done or relevant issues as reported by respondents. It has not been possible to include all information contained in the questionnaire responses in the text but further information on some policy areas is given in Appendix 3. In addition fuller details on partners responses are available on the DETERMINE portal <http://www.health-inequalities.eu/>.

## Section one: Policy

This section firstly gives examples of where overall government policy is orientated towards addressing action on SDHI. It then describes a number of strategies grouped by those driven by the health sector and those driven by sectors outside of health. Finally it considers research and reports which have contributed to the formation of such policy.

### Overall government policy

Partners were asked to describe overall government policy addressing SDHI in their countries and regions. In responding to this, frequent reference was made to overall government programmes and principles. It was evident that desire for a society based on social justice and equal opportunities are fundamentals of many governments' programmes for action. The principles of the welfare state, which a number of countries across Europe subscribe to, aim to abolish poverty through universal welfare arrangements in relation to work life, the education system and the health services as well as targeted measures for the most disadvantaged groups. In recent years, EU policy on Social Inclusion, including a requirement for member states to draw up National Action Plans on Social Inclusion, has been highly influential in bringing this issue to the attention of many governments.

A number of partners described more specific references to health inequalities. In Finland, the reduction of health inequalities has been set as a goal in the new (2007) Programme for Government. A similar approach has been taken in England (and across the United Kingdom) since 1997 when the Government made tackling health inequalities a priority and set two national public service agreement targets to reduce inequalities in health outcomes by 10% by 2010. The devolved administrations of Wales, Scotland and Northern Ireland have set about tackling this issue in a number of different ways. The focus in Scotland is on sustainable growth and opportunities for all with five newly appointed (in 2007) Director Generals charged with leading work on the following objectives for Scotland: Wealthier & Fairer; Smarter; Healthier; Safer & Stronger and Greener. There is recognition within the Northern Ireland Executive that a coordinated approach is needed to address such issues evidenced by the recent Programme for Government (2007) which names 'Working for healthier people' as one of its top five priorities. In Wales, the statutory duty of the Welsh Assembly Government to consider sustainable development in all that it does is seen as one way to include routine consideration of health, inequalities and the social determinants of health inequalities. A [Review of Health and Social Care in Wales](#) in 2004 concluded that Wales was ahead of the rest of the UK in its approach to reducing health inequalities through joint action across policy areas.

### Strategies developed and led by the health ministry

Partners were then asked to explore the situation from the perspective of the health ministry. Five partners reported having national or regional strategies which focus entirely on addressing health inequalities, while a further three are currently being developed. Additionally, most partners cited their national health strategies as having explicit references to addressing health inequalities. These are explored in more detail below.

## Health Inequalities Strategies

The Northern Ireland [Investing for Health Strategy](#) (2002) was developed to establish a cross-departmental framework for action to improve health and reduce health inequalities across government. In England, the [Programme of Action for Tackling Health Inequalities](#) (2003) sets out a national cross-government plan which has been taken forward by 12 government departments. The Norwegian [National Strategy to Reduce Social Inequalities in Health](#) (2007) aims to mainstream social inequality concerns and to promote the view that 'Equity is good public health policy'. It continues the work set out in the White Paper Prescriptions for a Healthier Norway (2003) and the [Challenge of the Gradient](#) action plan (2005).

A particular focus in Slovenia has been on developing a regional strategy, the [Action Plan for Tackling Health Inequalities in Pomurje Region](#) (2005), in response to the poor social, economic and health situation in the north east of the country. There is also an unpublished national plan to tackle health inequalities. Another regional example comes from Flanders (Belgium) where the [Flemish Decree on Preventive Health Care Policy](#) (2003) is fully supported by the Flemish Parliament in seeking to act intersectorally. Work is currently underway in Scotland where a [Ministerial Task Force on Health Inequalities](#) is due to report in Spring 2008. In Finland, a new National Action Plan on the Reduction of Health Inequalities is being prepared in parallel with the government policy programme on health promotion for 2008-2011 and should be finalised in early 2008. Finally, a Nationwide Strategy on Tackling Inequalities in Health is due to be sent to Parliament in the Netherlands in Summer 2008.

## Health Strategies referring to SDHI

A [National Population Health Plan](#) for 2008-2015 is currently being prepared in Estonia, with five priorities which include 'Strengthening social cohesion and decreasing health related inequalities'. In Poland, the [National Health Programme 2007-2015](#) (Polish text) aims to improve health and quality of life and diminish health inequalities by enhancement of healthy lifestyle, development of a healthy environment and involvement of local authorities and communities. The Scottish [Better health, Better care: action plan](#) (2007) recognises that poor mental and physical health is both a cause and a consequence of social, economic and environmental inequalities. Aims include breaking the link between early life adversity and adult disease and reducing health inequalities, particularly in the most deprived communities. Through the [National Health Plan for Norway 2007 – 2010](#) (Norwegian text) the Government plans to strengthen and coordinate the focus on a more equal and fair distribution of good health through action not only by the health services but by all sectors of society that affect public health. [Designed for Life: Creating World Class Health and Social Care for Wales in the 21st Century](#) (2005) is the Welsh Assembly Government's 10-year strategy to promote health and equitable health services. It provides a framework for the development of localised Health, Social Care and Well-being strategies which local authorities and local health boards have a statutory obligation to jointly develop in order to meet local identified needs. In England, [Choosing Health](#) (2004) sets out the key principles for supporting the public to make healthier and more informed choices with regard to their health. The Finnish [Government Resolution on the Health 2015 public health programme](#) (2001) contains explicit lines of action on health inequalities.

Many strategies have set specific targets with regard to reducing health inequalities. For example, 'Health 21' the national health strategy of the Czech Republic aims 'To decrease differences in health status among different socioeconomic groups by at least one quarter, by 2020, by the improvement of life for the disadvantaged groups'. As well as a general reduction in the gap in premature mortality between highest and lowest socioeconomic groups, the national health strategy in Ireland [Quality and Fairness: A Health System for You](#) (2001) specified actions to be undertaken for particularly

vulnerable groups including travellers, homeless people, drug misusers, asylum seekers, refugees and prisoners. The [Icelandic National Health Plan to the year 2010](#) (2004) has been developed to ensure all inhabitants have right of access to the best possible health service and works to ensure particularly vulnerable groups such as youth, disabled and elderly enjoy the same rights as others. In Spain, the [Quality Plan for the National Health System](#) (2006) has a particular focus on gender inequalities in health which has led to a number of developments in this area including the establishment of a Women's Health Observatory.

### **Strategies developed and led by other (non-health) ministries**

Outside of health, actions addressing health and social inequalities were identified in a range of sectors. Most partners included information on government strategies addressing social inclusion and/or poverty. It is worth noting that, in some countries at least, the different terms are used interchangeably. Furthermore two partners referred to strategies addressing equal opportunities with regard to gender equality.

Education and employment are increasingly being recognised as important social determinants of health and this is reflected in the number of strategies cited in these areas. The relationship between health and environmental issues is also demonstrated in strategies covering a wide range of issues including sustainable development and regeneration.

### **Addressing SDHI in education strategies**

In Ireland [Delivering Equality of Opportunity in Schools](#) (2005) is an action plan for educational inclusion. The Norwegian White Paper on Education Early Efforts for Lifelong Learning (2006) includes a range of measures to target vulnerable groups, among them stimulation of language skills of children below school age, increased quality in day care, close follow up of pupils in primary and secondary schools and measures to reduce drop out in upper secondary schools. Similarly, in England, Sure Start is designed to support the development of pre-school children from poorer families by increasing the availability of childcare for all children, improving health and emotional development for young children and support parents in their aspirations towards employment. In Finland, the [Education and Research Development Plan 2003-2008](#) recognises the correlation between education and health and includes measures to meet the education needs of children, youths and adults.

### **Addressing SDHI in employment strategies**

[Pathways to Work](#) is an Incapacity Benefit Reform Strategy in Northern Ireland which seeks to re-train individuals who have been unable to work due to illness or disability to enable them to gain alternative employment. A range of measures have been put in place in Slovenia to encourage labour market participation among disadvantaged groups including women, older workers, disabled people and migrants. In Norway, the White Paper on [Work, Welfare and Inclusion](#) (Norwegian text) outlines strategies and measures aimed at improved inclusion in working life for people of working age who have problems gaining a foothold in the labour market or who are at risk of dropping out of the labour market. In England, the Department of Work and Pensions (DWP) is responsible for the [Child Poverty Strategy](#). DWP uses a variety of tools and levers to reduce child poverty, principally through the tax and benefits systems. It also consults on its plans across a wide range of stakeholders, including the Department of Health. The Spanish [Strategic Plan for Equal Opportunities 2008-2011](#) (Spanish

text), coordinated by the Ministry of Work and Social Affairs, addresses gender equality in economic participation as well as a range of other issues.

## Addressing SDHI in economic strategies

In Scotland, the [Economic Strategy](#) (2007) describes how a number of priorities for encouraging sustainable economic growth will also affect health and wellbeing. One of the objectives is to improve health and wellbeing in order to enable more people to become economically active.

## Addressing SDHI in environment strategies

The [Environment Strategy for Wales](#) (2006) makes explicit reference to the impact of the environment on economic and social well-being and on health. It also mentions the relationship between a healthy, attractive environment, economic success and attracting and retaining people to work and live in Wales. Direct ill-effects of the environment on health are recognised alongside the positive impact and opportunities that the environment can provide for physical and mental health. Scotland's Sustainable Development Strategy [Choosing Our Future](#) (2005) makes clear links between social and physical environments and health inequalities, for example with respect to environmental justice and area regeneration. Local government has responsibility for ensuring sustainable development and for the wellbeing of their populations. A [progress report](#) is available which highlights activities undertaken in 37 work streams to date.

## Addressing SDHI in urban and regional planning

The Welsh [Planning Policy](#) (2002) sets the framework for the development and use of land taking full account of economic, social and environmental issues. There are explicit references to SDHI across a broad range of planning issues including housing, employment, transport and leisure. A major focal point for intersectoral collaboration between health and planning in the Netherlands is the [Metropolitan Policy](#) (Dutch text), the core of which is combating inequalities at the economic, physical and social level in the neighbourhoods.

## Addressing SDHI in neighbourhood renewal and housing policy

In England, the [National Strategy for Neighbourhood Renewal](#) has been developed to support an integrated approach to regeneration in the most deprived communities, including the New Deal for Communities (NDC) Programme. NDC, launched in 1999, provides 39 of the poorest neighbourhoods with the resources and support to regenerate their communities through local partnerships comprising key local bodies and organisations such as public agencies, local businesses, voluntary bodies and residents. Similarly, the Northern Ireland [Strategy for Neighbourhood Renewal - People and Place](#) has used a multi-sectoral approach to put initiatives in place around core public services in deprived areas. [Powerful Neighbourhoods](#) (Dutch text) is a cooperative initiative between the Ministry of Public Health and the Ministry of Living, Neighborhood and Integration in combating deprivation in 40 selected deprived neighbourhoods across the Netherlands. In Estonia, the links

between data collected under the National Health Development Plan with regard to the health effects of housing have been utilised by the Ministry of Economic Affairs and Communications in drawing up the Development Plan for Estonian Housing 2008 – 2013.

## Social Inclusion strategies

In the Czech Republic the [National Action Plan for Social Inclusion 2006-2008](#) (Czech text) uses the term 'social economy' which has strong implications for SDHI. The main fields of the policy are integration of migrants, elimination of child poverty and moderation of the negative consequences of an ageing population. Financing programmes for NGOs and communities are mainly for projects and activities supporting social services, consulting centres, actions against social exclusion, support of employment for older, disabled people and people at risk of social exclusion, support for activities for life long education, preventive activities against loss of housing, integration of Roma communities, preschool facilities for children from poor families, support for social housing and more.

The [National Action Plan for Social Inclusion 2004-2006](#) has been prepared in connection with Estonia's participation in the European Union social inclusion process. The open method of coordination is applied through the national action plans for social inclusion, which aim to achieve common goals in co-operation between member states. Key areas of social inclusion are in increasing employment, improving accessibility to education, medical care, housing and making use of information technology based opportunities to increase social inclusion. Among the risk groups, particular attention is paid to the long-term unemployed and those excluded from the labour market, school dropouts, children with special needs, disabled people, people with housing problems and victims of violence. This plan is centrally driven and incorporates the work of many different ministries.

In Ireland, the [National Action Plan for Social Inclusion 2007-2016](#) (NAPinclusion) takes a life-cycle approach (Children/ People of Working Age/ Older People) with further sections devoted to 'People with Disabilities' and 'Communities'. Additionally, Social Partnership Agreements have been in place in Ireland since 1987 and until 2005, operated on a three year basis. In 2006, the first 10 year agreement [Towards 2016 - Ten Year Framework Social Partnership Agreement 2006-2015](#) was successfully negotiated. Social inclusion is strongly featured throughout the Agreement.

In Norway, the Plan of Action to Combat Poverty is the responsibility of the whole government with the Ministry of Labour and Social Inclusion taking responsibility for coordinating the policy. The measures run across many sectors and six ministries are responsible for implementation of the policy. The Action Plan was developed during the same period as the Ministry of Health and Care Service's strategy against social inequalities in health and there was frequent contact and collaboration on both issues between these two Ministries on both issues. Indicator reporting in both policy areas will be closely coordinated.

The Slovenian [National Action Plan of Social Inclusion 2004-2006](#) was created by the Ministry of Labour, Family and Social Affairs in cooperation with the ministries and expert services which can, by conducting policies and measures in their respective fields, contribute to reducing poverty and social exclusion, and in dialogue with local communities, social partners and non-governmental organisations. Seminars were organised in all cases (also in cooperation with the EU), where the purpose and contents of strategies were clarified and key problems identified by the participants. The documents adopted were published and made accessible at the Ministry's web page.



In Belgium, the National Action Plan on Social Inclusion demonstrates the open method of coordination in the field of social inclusion. For the development and follow up of the Action Plan, a complex institutional framework was set up to engage the different policy levels, stakeholders and target groups. The Flemish Community produces and updates yearly its own [Flemish Action Plan on Combating Poverty](#) (Dutch text). Given the smaller scale and more limited scope of policy fields involved, as well as the absence of space constraints in its presentation, the Plan gives a detailed account of achievements to date and new measures envisaged for the future. The most recent Plan contains all planned actions from the Flemish government in the period 2005 to 2009 to combat poverty. A new feature is that the 'associations in which the poor have a say' were involved in the development of this Plan. The updating and monitoring of the Flemish Action Plan on Combating Poverty is carried out by a 'Permanent Poverty Consultation', where a distinction is made between vertical and horizontal consultation. Two updates have been made in 2007 and 2008.

The general message of the Polish National Report on [Strategies for Social Protection and Social Inclusion 2006-2008](#) (Polish text) is: *'The strategic objective of Poland is to develop an integrated state policy system, which would result in increased social integration, including the mutual support of the social and economic policy, as well as growth of employment, together with good governance, transparency and the involvement of all stakeholders in the design, implementation and monitoring of social policy'*. The policy has a monitoring system based on process and outcome/impact evaluation and national and EU indicators.

In Northern Ireland, [Lifetime Opportunities 2006](#) is the Government's anti-poverty and social inclusion strategy.

In Spain, all ministries have responsibility for implementation of the [Strategic Plan for Equal Opportunities 2008-2011](#) (Spanish text) which is coordinated by the Ministry of Work and Social Affairs. The Plan mentions the importance of developing bilateral/multilateral meetings and committees. This is part of a wider comprehensive strategy to address not only health but also political and economic participation, education, innovation, knowledge, co-responsibility, health, self perception, violence, diversity and social inclusion, international affairs and stewardship of the right to be equal. The Plan is articulated on 12 main principles, each of these has objectives and each of these objectives has actions to develop. A [report](#) (Spanish text) is available which analyses and compares the Strategic Plan for Equal Opportunities in the Autonomous Regions. One of the main results from this report is that there have been an increase in the numbers of expert meetings in gender inequalities which have identified the necessity of having specific trained and expert people as references for inequalities not only in the health sectors. They have also promoted the creation of joint committees to follow each of these plans in the Autonomous Regions.

In England, health inequalities and the wider determinants of health are understood as part of the [Child Poverty Strategy](#). This is reflected in the inclusion of child poverty as one of 12 national headline indicators which are used to report developments against the national health inequalities strategy. Child poverty is part of the agenda for addressing the infant mortality as a way of extending the focus away from health services to the wider determinants, for example, through joint NHS and local authority action. Housing and overcrowding issues are also part of this wider agenda.

In Finland, the long-term strategy [Strategies for Social Protection 2015](#) explicitly addresses health inequalities as does the National Plan of Action to Combat Poverty and Social Exclusion 2003-2005.

The Scottish Directorate of Health and Wellbeing now also encompasses social inclusion and regeneration. Thus the earlier policy on [Closing the Opportunity Gap](#) and its evaluation now sit within health and wellbeing, as does Scotland's regeneration policy which addresses neighbourhood deprivation.

## Impact of research and reports on policy

In Belgium, the first General Poverty Report was published in 1994, describing the state of affairs on poverty in Belgium. An important, and in those days unique, quality of the document lies in the participation of the poor themselves. The target-group was highly involved in writing the texts, thanks to a solid collaboration with the 'associations in which the poor have a say'. The book gave a never-seen view of poverty and what it means to the people concerned. It was an important eye-opener for many policy makers and informed a multitude of projects and initiatives. The report is published every two years.

A national survey conducted in 2002 in Estonia revealed that increasing gaps in health inequalities had emerged across different education levels, incomes, places of residence and nationalities. In response to these findings, since 2004, all new national health strategies highlight the principle of equity. The reduction of inequalities is generally addressed through a focus on specific populations such as vulnerable groups or communities rather than the population as a whole. Similarly, a Spanish report on [Social Inequalities in health, life styles and health services utilization in the Autonomous Regions 1993-2003](#) (Spanish text) has had important implications for policy making.

A long term project in Finland called [TEROKA](#) has been developed in response to concerns over growing health inequalities. To date, the project has carried out ten years of systematic work on health inequalities.

In Ireland, a number of organisations which work with Government have produced guidance in this area including: [National Economic and Social Forum](#) - Mental Health and Social Inclusion (2007); [Combat Poverty Agency](#) - Tackling Health Inequalities (2005); [Public Health Alliance](#) - Health inequalities on the island of Ireland (2007); [Institute of Public Health in Ireland](#) - Report of the Working Group on the National Anti-Poverty Strategy and Health (2001), Inequalities in Mortality (2001), Closing the gap - Strategic Initiatives for tackling health inequalities on the island of Ireland (2007); [Economic and Social Research Institute](#) - Health services, health inequalities and social gain (2007). As the Public Health Alliance and the Institute of Public Health are all-island organisations, these reports are relevant for Northern Ireland as well as the Republic of Ireland.

## Section two: Structures

Partners were asked to explore the various arrangements and structures in place to support action on SDHI. This section presents information grouped under three broad categories: Financial resources, Offices and committees and Processes.

### Financial resources

Explicit funding for health inequalities was most frequently reported where there was a strategic focus in this area. Other funding mechanisms include those which focus on vulnerable communities.

In Northern Ireland, funding is made available through four [Investing for Health](#) partnerships. There are financial resources to support the health inequalities resource unit in the Norwegian Directorate for Health and Social Affairs as well as a national expert group on social inequalities in health. Similarly, in England there is financial support for a Health Inequalities Unit located within the Policy and Strategy Directorate of the Department of Health. The [Inequalities in Health Fund](#) in Wales provides targeted funding for those in deprived areas while the [Fairer Scotland Fund](#) was recently announced in Scotland.

Other funding mechanisms were described in situations where there may not be explicit allocation of financial resources. For example, in Ireland, Dormant Accounts funding is used to make additional resources available to tackle disadvantaged areas in both rural and urban communities. Similarly Finland's Slot Machine Association has defined a new funding strategy whereby all revenues are used to fund health and social welfare organisations and particularly, initiatives contributing to reducing health inequalities.

### Offices and Committees

With regard to availability of dedicated staff for health inequalities, a similar pattern to that referred to in the financial resources section was noted. Offices with a social inclusion remit were seen to have an important function in addressing health inequalities, particularly where no dedicated health inequalities unit was in place. The strength of committees and groups focusing specifically on health inequalities or more generally on social inclusion, was seen to be in promoting intersectoral working and maximising the potential for health improvement across different policy areas.

## Ministerial and Cabinet Groups

The existence of Ministerial or Cabinet Groups to address SDHI was not widely reported but some examples are referred to here. One Wales highlights the Welsh Assembly Government's ambition to transform Wales into a self-confident, prosperous, healthy nation and society, which is fair to all. Health and inequalities in health are key to this and are fundamental considerations across policy areas. The Chief Medical Officer is a member of the senior management board and plays an important role in maximising the health improvement potential of and highlighting any potential threats to health in policies across the Assembly. In Northern Ireland, the Ministerial Group for Public Health (MGPH) is responsible for coordinating, implementing and monitoring the public health strategy 'Investing for Health'. MGPH members work to influence policy within their respective Departments with regard to action on socially determined health inequalities. Additionally, a UK wide Domestic Affairs Health and WellBeing Committee has been established to consider policy on health and wellbeing, including the prevention of ill-health, the promotion of healthy and active lifestyles and the reduction of health inequalities. Furthermore, the UK Group on WHO CSDH is considering opportunities for the UK

to support the work of the Commission, incorporate learning from the CSDH report at the national level and taking forward the work of the CSDH in the UK.

### Offices and Committees located within or driven by health ministries

The National Public Health Committee in Finland is tasked with developing intersectoral health policy, a central target of which is reducing health inequalities. In Estonia, the [National Institute for Health Development](#) (NIHD) is responsible for coordinating the implementation of all national health related strategies which aim to reduce social inequalities in health. [Health Challenge Wales](#) is the Welsh national focus for supporting health development. It centres on improving health and reducing health inequalities; marketing good health to the public and challenging organisations in all sectors and all individuals to do more to improve health / prevent ill health. As part of Health Challenge Wales, a Public Health Strategic Framework: 'A Healthy Future' is being developed and will provide the focus for public health to 2020. The Framework's two over-arching goals are to 'Improve the quality and length of life' and 'Improve equity in health'. In Ireland, an Interdepartmental Group (IDG) on the prevention of chronic disease has recently been established which focuses on the key determinants of health that are not within the remit of Department of Health. The Flanders region of Belgium has established a Health Promotion Commission which is a structural cooperation between the health and the educational sector and seen to be a successful way of working to implement health policy in all schools (and for all children) in the Flemish community.

### Offices and Committees located within or driven by non-health ministries

In Belgium, the Service for the fight against poverty, insecurity, and social exclusion, established in 1998, is a public body entrusted with the permanent monitoring and dialogue between public authorities (across all levels of government), civil society and associations of people experiencing poverty and exclusion. The NASPI Coordination Unit, located within the Ministry of Labour and Social Affairs in the Czech Republic, operates as part of the National Report on strategies on social protection and social inclusion. In Ireland, the [Office for Social Inclusion](#) is based within the Department of Social and Family Affairs and has overall responsibility for coordinating and driving the government's social inclusion agenda.

#### Processes

A range of different processes were described by partners as having some input into addressing SDHI, including formal and informal consultation processes, impact assessment and other tools and reporting systems. In some cases these are being used systematically and in others, on an adhoc basis.

### Consultation and collaboration in developing policy

There is some evidence of joint cooperation in the development of policy. For example in Norway, the White Paper on Social Inequalities in Health (2007) was developed by the Ministry of Health and Care Services in cooperation with six other Ministries: Finance, Education and research, Labour and social inclusion, Children and equality, Justice and the police and Local government and regional development. In addition, more than 80 different actors from NGOs, labour organisations, research

institutions and regional and local authorities gave input through workshops. More generally, the Norwegian Ministry of Labour and Social Inclusion organises 'poverty hearings' on a yearly basis, to ensure participation in the formulation of policies addressing poverty.

The list of current [consultations](#) in Scotland illustrates how this process can facilitate discussion amongst organisations and individuals of the likely impacts of policy when it is being developed, and provide feed back to government. A similar process is described in Poland, where all formal letters together with comments and observations received are displayed on a [website](#) (Polish text).

The Flemish Action Plan to Combat Poverty contains both horizontal and vertical consultation processes. In the horizontal consultation representatives of people living in poverty (Flemish network), civil servants and a number of experts design, coordinate and monitor the measures in the Plan. At least twice a year, this is supplemented by a vertical consultation in each policy department between the competent minister, the ministry, the 'associations in which the poor have a say' and the field of activity. This is supplemented by annual health conferences.

## Tools and methodologies

Health Impact Assessment (HIA) considers the potential impacts of policy implementation on the health of the population as well as that of specific population groups. The [Welsh Health Impact Assessment Support Unit](#) (funded by the Welsh Assembly Government) has published a range of HIAs that deal with the breadth of central and local government activity in HIA across Wales. Work is on-going to examine the extent of community involvement in HIAs in Wales and to gauge the effect of such engagement on the decisions made and on the communities themselves.

In Ireland, while HIAs have not been carried out systematically to date, the HIA conducted recently on the Integrated Strategy to Address Adult Homelessness is considered a good starting point. In Northern Ireland, there is informal feedback which suggests that HIA raises awareness of health and health inequalities amongst other sectors. However HIA is not a statutory requirement and therefore government departments are not obliged to conduct HIA on a systematic basis. A number of reports including a guidance manual on conducting HIA have been developed by the [Institute of Public Health in Ireland](#) which works with the Departments of Health in both jurisdictions (Northern Ireland and the Republic of Ireland). Unlike HIA, [Equality Impact Assessment](#) is a statutory requirement in Northern Ireland and is therefore used systematically. Indirectly Equality Impact Assessment leads to raised awareness of health inequalities. A similar process in Scotland is [Inequalities Impact Assessment](#) which is used for some policies in some areas of government with plans to extend use for all policies under development. Furthermore [Strategic Environmental Assessment](#) (SEA) requires consideration of impacts of such strategies, plans and programmes on health, although it does not call for a specific consideration of health inequalities. This is a statutory process in Scotland and elsewhere as required by an EU Directive.

The main tool for assessing health policy effectiveness in the Netherlands is the [Inter Ministerial Policy Research](#) (Dutch text), while in Slovenia a financial instrument has been developed to tackle health inequalities.

In England, the Department of Health and the Association of Public Health Observatories have jointly developed a [Health Inequalities Intervention Tool](#) to support planning within Primary Care Trusts (PCTs). By providing detailed information on life expectancy, it allows PCTs to estimate the potential effect on life expectancy if certain interventions are increased. The tool was launched in 2007

and positive user feedback to date is supporting planned expansion of the tool. At the same time, [Community Health Profiles](#) have been developed to provide a snapshot of health for local councils in England using key health indicators which enables comparison locally, regionally and nationally as well as over time. They are designed to help councils and the National Health Service decide where to target resources to tackle health inequalities at the local level.

In Norway, an annual review and reporting system for Social Inequalities in Health is currently being put in place. More than ten national ministries and directorates (including policy areas such as income and taxes, early childhood, education, labour, social inclusion, public health, and the health system) will be required to produce annual reports on achievements (indicators) and policy developments concerning (health) inequalities. The first report is due in May 2009 and it is anticipated that this will run yearly until 2017. It is expected that the review and reporting system will contribute to addressing SDHI through a policy feedback loop. The reviews may identify policies that actually fail to reduce inequalities in social determinants of health. This process is underway in England where a [Status Report](#) on the Tackling Health Inequalities Programme for Action (2007) has recently been published.

## Section three: EU level

### Overview

There is an important interplay between the European Union (EU) and its Member States (MS). EU MS ultimately decide on EU level initiatives, while decisions made at the EU can have an important effect on MS. There has been a greater awareness in recent years of the social determinants of health and health inequalities within the EU. This offers important opportunities for health gain but also presents real challenges to ensure that these issues are reflected in the EU political agenda, thereby stimulating further action within EU countries.

Achieving a high level of health protection for all European citizens has been a clear objective of the European Treaties since Maastricht (1992). The EU Treaties reflect an understanding that this cannot be achieved by the health sector alone and must involve further action on the socio-economic determinants of health. Article 168 in the draft EU Treaty states that 'A high level of human health protection shall be ensured in the definition and implementation of all Community policies and activities'.

#### **Key EU Council Initiatives on Health Equity and determinants across sectors**

- Health Council Resolution of 29 June 2000 on action on health determinants
- Belgian Presidency council recommendation on health inequalities 2001
- Health inequalities was one of the main health themes of the UK Council Presidency, which held an [Expert Conference](#) on this topic in October 2005
- In June 2006 the EU Council adopted a [Statement on common values and principles in EU healthcare systems](#) listing the overarching values of universality, access to good quality care, equity and solidarity
- Health in All Policies (HiAP) was the main health theme of the Finnish Council Presidency. An [Expert Conference](#) on HiAP was held in September 2006
- [Health Council Conclusion on HiAP](#) 30 Nov - 1 Dec 2006
- [EU Council Conclusions June 2008](#) recognise 'the importance of closing the gap in health and life expectancy between and within member states ...'

### EU Health Policy

Health policy in the EU is initiated and implemented by the Directorate General on Health and Consumer Affairs (DG SANCO).

## EU Health Strategy and Public Health Programmes

The EU Health Strategy, 'Together for Health: A Strategic Approach for the EU 2008-2013', provides an overarching strategic framework spanning core issues in health, as well as health in all policies and global health issues. It will be taken forward through a Structured Cooperation Mechanism (still to be developed) and the EU Public Health Programme. The Strategy states that building synergies with other sectors is crucial for a strong Community health policy, and many sectors should cooperate to fulfil the aims and actions of this Strategy.<sup>1</sup>

<sup>1</sup> A wide range of EU policies, developed outside of the health sector, address health. A comprehensive list of all other Treaty Articles that refer to health is available in Annex 6 of the Staff Working Document of the new EU Health Strategy "Together for Health: A Strategic Approach for the EU 2008-2013": [http://ec.europa.eu/health-eu/doc/working\\_doc\\_strategy.pdf](http://ec.europa.eu/health-eu/doc/working_doc_strategy.pdf)

The first EU Public Health Programme (2003-2008) financed over 300 projects of which only four related to health inequalities and three to health impact assessments. The publication [The Health Status of the European Union: Narrowing the Health Gap \(2003\)](#) was published during this Programme and highlighted the need to tackle the uneven distribution of the (intermediate) determinants of health.

The second EU Public Health Programme (2008-2013) places a greater emphasis on health inequalities and the social determinants of health than its predecessor. The Programme states that action in this regard will focus on lifestyle health determinants, such as nutrition, alcohol, tobacco and drug consumption, as well as social and environmental determinants. There will also be an emphasis on improving health indicators and their correlation with socio-economic indicators. DG SANCO and DG Research will work together to ensure that they fund complementary activities.

## Tools and Mechanisms

A key mechanism to ensure that health aspects are taken into account in other policy sectors is the written 'inter-service consultation' which enables DG SANCO to comment on new initiatives developed by other policy sectors. In efforts to stimulate further action on health in all policies, DG SANCO also plans to re-launch its inter-service group on health. Unlike written inter-service consultations, the groups provide a forum for representatives from other policy sectors to meet and to exchange health-related ideas. DG SANCO is currently taking part in numerous inter-service groups set up in other policy areas. Further work will also be undertaken on a more widespread application of Health Impact Assessments (HIA) of EU policies.

## Other EU Policy Areas

While DG SANCO can stimulate action on the social determinants of health inequalities, any real changes initiated via the EU level will come through actions being taken by these other policy areas themselves. There is a great potential for progress in many areas. In some cases important advances are already being made:

The Lisbon Strategy (2000-2010) is the broad overarching strategic policy objective of the EU. It aims to stimulate economic growth and employment while also maintaining high levels of social protection. An important achievement within the Strategy has been to include healthy life years as one of the 50 key structural indicators of success. However, economic competitiveness remains the core objective.

The social (and health) components of the Lisbon Strategy could in future be strengthened by ensuring greater complementarities with the Sustainable Development Strategy (SDS) (2006-2010). SDS emphasises environmental as well as public health and social principles. Guiding principle 6 (of 10) of this Strategy notes that 'the Commission and Member States will promote better health and disease prevention by addressing health determinants across all relevant policies and activities.' This Strategy currently has a much lower political profile than the Lisbon Strategy.



## Budget review

A public consultation and review of the EU budget is taking place to achieve consensus on how it can be shaped to serve EU priorities and meet the challenges of the future. Currently, less than 1% of the budget is being spent on health or directly related issues despite the fact that many surveys reveal that it is a primary concern for EU citizens.

## Structural Funding

About 36% of the EU budget is spent on structural development programmes to ensure greater equity between EU regions. Health was, for the first time, included as an explicit funding area under the new Structural Fund Policy (2007-2013). This means that European Regional Development Funds can now be used to *'develop and improve health provisions which contribute to regional development and quality of life in regions.'* Progress however depends on the extent to which Member States apply their structural funding to health.

## Common Agricultural Policy (CAP)

CAP, which receives over 40% of EU funding, was initially developed to ensure adequate levels of food production in Europe. While CAP strongly influences what is produced and therefore consumed in the EU, health has hardly been considered in the policy reform process. Awareness is slowly rising however, making this an important area of potential progress.

## Employment Policy

As part of the Lisbon Strategy Objectives, EU Member States must work towards the development of a coordinated approach to employment. The EU has significant impact on employment law and employee rights in the Member States, and has developed Directives on, amongst other issues, Discrimination, Equal Pay, Health and Safety and Working Time. Such initiatives can have important effects on health and health equity.

## Social Protection

The EU Open Method of Coordination (OMC) process in the areas of Social Protection (Social Inclusion, Pensions, and Health and Long Term Care) encourages countries to establish objectives and to develop integrated policy goals in these areas. The OMC is a potentially significant mechanism to initiate and strengthen collaboration between the health and social sectors in EU Member States. Health bodies at EU and national level can be more involved in this cross-sectoral process, in efforts to improve health and address health equity. The Commission publishes a yearly Report on Social Protection and Social Inclusion that reviews the main trends across the EU and at national level. The [Joint Report for 2008](#) focuses on child poverty, older workers, private pension provision, health inequalities and long-term care.

## Internal Market

The creation of a European single market can improve overall well-being by stimulating economic growth, lowering prices, generating employment opportunities and thereby changing general standards of living. It can also however, aggravate inequity if people from disadvantaged socio-economic-groups are less able to benefit from its provisions (such as access to goods and services including health or care) or if it leads to the market driven operation of certain services and utilities (gas, electricity, water) generating higher prices or restricting access. Specific Internal Market Regulations that can have both positive and negative effects on health inequalities are, for example, those that relate to tobacco or alcohol, the free movement of patients and health professionals, and the Services Directive and Directive on Services of General Interest.

Other initiatives taking place, for example in DG Enterprise, DG Education, DG Environment can have equally important effects on the determinants of health inequalities.

## Tools and Mechanisms

The Secretariat General is one of the 40 Directorates-General (DGs) and specialised services which make up the European Commission. Its role is to ensure the overall coherence of the Commission's work, by establishing its broad objectives and setting out yearly work plans. It also brings together the college of Commissioners for weekly meetings. The Secretariat General places great emphasis on integrated policy making and on undertaking Impact Assessments of new policy initiatives. These Impact Assessments should consider the economic, environmental and social impacts, the latter of which includes considerations relating to health and equity.

The Secretariat General also coordinates a Sustainable Development Network with one representative from each DG. The Network serves as a mechanism to bring together information from different DGs on what they are doing to support the Sustainable Development Strategy. This information is fed into the bi-annual Sustainable Development Progress Report. While the network does not proactively stimulate synergies that could lead to progress in key priority areas, it does serve to bring together information and to highlight progress or lack of progress on Sustainable Development, which is closely related to action on the Social Determinants of Health.

## Conclusion

This report gives an indication of the breadth of policies and actions addressing the social determinants of health inequalities across Europe. Overall it is evident that there is no comprehensive systematic addressing of SDHI in the partner countries but much work is underway. There appears to be considerable variation in government action to address SDHI amongst the countries represented in work package 5. However some common themes have emerged from the data collection. Factors likely to contribute to action include:

Specific reference by government of the issue of health inequalities in policy documents and/or a cross-government strategy or framework to tackle the issue

Reference to health inequalities being an essential component of other government priorities (such as sustainability and social inclusion)

The availability of research and reports which demonstrate clear links between health and social inequalities.

Evidence of effectiveness of such action is difficult to ascertain due to much of this activity having commenced relatively recently. However a number of partners reported the establishment of review systems which are likely to make valuable contributions to this area in the future.

Furthermore, there is evidence to show that leadership, at both EU and national level, is an important prerequisite to facilitating action on SDHI. However while responsibility may be allocated to one particular sector for driving the process, this needs to be supported by effective cross-government mechanisms which support the establishment and maintenance of partnerships.

Finally, a Health in all Policies (HiaP) approach across government requires further support. Task 2 of Work Package 5 will focus on one aspect of the rationale for a HiaP approach, that is, the economic argument. It will work with partners, firstly to provide a summary of the literature in this area and then to provide examples of actions in partner countries. The anticipated publication date of this report is mid-2009.

## Appendix I: Work Package 5 Partners

Individual(s)	Organisation	Country
<b>Linda De Boeck</b>	VIG - Flemish Institute for Health Promotion	Belgium
<b>Hana Janatova</b>	National Institute of Public Health	Czech Republic
<b>Bryony Lloyd</b>	Department of Health	England
<b>Eve-Mai Rao</b> <b>Tiia Pertel</b>	National Institute for Health Development	Estonia
<b>Marita Sihto</b>	STAKES	Finland
<b>Jorlaug Heimisdottir</b> <b>Jakobina Arnadottir</b> <b>Stefan Jonsson</b>	Public Health Institute of Iceland	Iceland
<b>Teresa Lavin</b> <b>Owen Metcalfe</b>	Institute of Public Health in Ireland	Ireland
<b>Joop Ten Dam</b> <b>Janine Vervoordeldonk</b>	NIGZ - Netherlands Institute for Health Promotion and Disease Prevention	Netherlands
<b>Claire Higgins</b> <b>Owen Metcalfe</b>	Institute of Public Health in Ireland	Northern Ireland
<b>Elisabeth Fosse</b>	HEMIL/Research Centre for Health Promotion, University of Bergen	Norway
<b>Dorota Cianciarain</b> <b>Mirosław Wysocki</b>	National Institute of Hygiene	Poland
<b>Sheila Beck</b>	NHS Health Scotland	Scotland
<b>Olivera Stanojevic Jerkovic</b> <b>Igor Krampac</b>	Regional Public Health Institute Maribor	Slovenia
<b>Sara Darias-Curvo</b>	University de La Laguna	Spain
<b>Sue Mably</b>	Wales Centre for Health	Wales
<b>Ingrid Stegeman</b>	EuroHealthNet	Europe
<b>Catherine Jones</b>	IUHPE	International

## Appendix 2: Abbreviated questionnaire

1. Are there policies in place in your country that address inequalities? If yes, please give examples.
2. Are there policies in place in your country that address health in other sectors? If yes, please give examples.
3. Are there policies in place in your country that address inequalities in health? If yes, please give examples.
4. Are there structures in place that facilitate intersectoral action/ cross ministry working, which are relevant to health (e.g. Joint committees, Bilateral/multilateral meetings of permanent secretaries)? If yes, please answer the following:
  - a. Please provide examples and details (e.g. How did these structures come about, how are they being implemented? What factors account for their success or lack of success?)
  - b. Do these structures explicitly refer to Social Determinants of Health, Health Inequalities and/or Social Determinants of Health Inequalities?
5. Is there a Ministry or particular personnel allocated to addressing Social Determinants of Health, Health Inequalities and/or Social Determinants of Health Inequalities? Where such resources are allocated please provide details.
6. Is there an explicit allocation of financial resources to addressing Social Determinants of Health, Health Inequalities and/or Social Determinants of Health Inequalities? If yes, please provide details.
7. Has the Health Ministry produced any policies which refer to SDHI?
  - a. If yes, please list examples and state whether the references are implicit or explicit.
  - b. Are such policies publicly available? If yes, please provide web site address links where possible.
  - c. If no documented examples exist are there any other indicators that the concept of SDHI is understood? Please provide details.
8. Please select **one example** which you have identified in question 7a and answer the following:
  - a. Name of policy
  - b. Is there any explanation or rationale given in the policy as to why there are specific references to SDHI? For example is it part of a wider comprehensive strategy to address Social Determinants of Health?
  - c. Has any action on SDHI occurred as a result of this policy/ strategy document? Please provide details of any practices that have been put in place.
  - d. Is there (formal or informal) evidence/feedback to suggest that these actions are effective? If so, what are some of the factors that may account for their success/ lack of success?
9. Does this Ministry use any particular tools/methodologies to facilitate action on SDHI? (For example audits or consultation processes with a specific health focus; appraisal or impact assessment tools).
  - a. Please list the tools being used
  - b. Are they being used systematically or ad-hoc?

- c. Is there (formal or informal) evidence/feedback to suggest that the use of these tools are contributing to a reduction of health inequalities? If so, what are some of the factors that may account for their success/ lack of success?)

**10.** Please select **one example** which you have identified in question 9a and answer the following:

- a. Name of tool/methodology
- b. Are reports or other written documentation on identified tools publicly available? If yes, please provide web site address links where possible.
- c. Please indicate the policy or strategy the tool was applied to. If a report is available please provide a web site address link.
- d. How did the use of this tool contribute to addressing SDHI?
- e. Is there (formal or informal) evidence/feedback to suggest that the use of this tool is contributing to a reduction of health inequalities? If so, what are some of the factors that may account for their success/ lack of success?)

**11.** Has this Ministry initiated any collaboration with other Ministries to address SDHI?

- a. Please provide examples.
- b. Is there (formal or informal) evidence/feedback to suggest that this collaboration is successful? If so, what are some of the factors that may account for this success/ lack of success?)

**12.** Are there any other examples of processes/ mechanisms within this Ministry which address SDHI? If so, what factors account for their success/lack of success?

**13.** Name of (non-health) Ministry

**14.** Has this Ministry produced any policies which refer to SDHI??

- a. If yes, please list examples and state whether the references are implicit or explicit.
- b. Are such policies publicly available? If yes, please provide web site address links where possible.
- c. If no documented examples exist are there any other indicators that the concept of SDHI is understood? Please provide details.

**15.** Please select **one example** which you have identified in question 14a and answer the following:

- a. Name of policy
- b. Is there any explanation or rationale given in this document as to why there are specific references to SDHI? For example is it part of a wider comprehensive strategy to address Health or the Social Determinants of Health?
- c. Has any action on SDHI occurred as a result of this policy/ strategy document? Please provide details of any practices that have been put in place.
- d. Is there any feedback or evidence (formal or informal) to suggest that this action has been successful/unsuccessful in reducing health inequalities? If so,

what factors might account for this success or lack of success.

- 16.** Does the Ministry use any particular tools/methodologies to facilitate action on SDHI? (For example audits or consultation processes with a specific health focus; appraisal or impact assessment tools).
  - a. Please list the tools being used
  - b. Are they being used systematically or ad-hoc?
  - c. Is there (formal or informal) evidence/feedback to suggest that the use of these tools is contributing to a reduction of health inequalities? If so, what are some of the factors that may account for their success/ lack of success?)
  
- 17.** Please select **one example** which you have identified in question 16a and answer the following:
  - a. Name of tool/methodology
  - b. Are reports or other written documentation on identified tools publicly available? If yes, please provide web site address links where possible.
  - c. Please indicate the policy or strategy the tool was applied to. If a report is available please provide a web site address link.
  - d. How did the use of this tool contribute to addressing SDHI?
  - e. Is there (formal or informal) evidence/feedback to suggest that that the tool has been successful in this regard? If so, what are some of the factors that may account for their success/ lack of success?)
  
- 18.** Does this Ministry collaborate with Health or other Ministries in initiatives to address SDHI? Please provide details.
  
- 19.** Please give details of any other processes/ mechanisms within this Ministry which address SDHI and comment on whether there is any (formal or informal) evidence/feedback to suggest that processes and mechanisms are or have been successful? If so, what are some of the factors that may account for their success/ lack of success?

## Appendix 3: Other policies

Partner	Other health policies	Other non-health policies
<b>Belgium/ Flanders</b>	Action Plan on the prevention of suicide (2006-2010)	Flemish Action Plan on Combating Poverty Strategic Action Plan 'On your health' Tourism for All Policy Local Social Policy Policy on equal educational opportunities
<b>Czech Republic</b>	Policy for Disabled Citizens 2006-2009 Healthy Ageing HIV National Strategy	Action Plan on Environment and Health Work Health Safety (2004) Strategic Family Policy (2005) Strategy on preparation for ageing 2008-2012
<b>England</b>		Fuel Poverty Strategy
<b>Estonia</b>	Prevention of Cardiovascular Diseases HIV strategy	Regional Development Implementation of Population Politics Estonian Integration Plan Traffic Safety Juvenile Delinquency Strategy for Juvenile Work
<b>Finland</b>	Strategies for Social Protection 2015	<a href="#">Sports Policy</a> <a href="#">Youth Policy</a> <a href="#">Children, Youth and Families Policy</a> Reform of Prison Laws Clean Water Traffic Safety
<b>Iceland</b>		
<b>Ireland</b>	<a href="#">Health Promotion Strategy</a> (2000) <a href="#">Primary Care</a> (2001) <a href="#">Cancer Control</a> (2006) <a href="#">Mental Health Policy</a> (2006)	<a href="#">Sustainable Development</a> (1997) <a href="#">National Spatial Strategy</a> (2002) <a href="#">Delivering Homes Sustaining Communities</a> (2007) <a href="#">National Development Plan 2007-2013</a> <a href="#">Social Partnership Agreement 2006-2015</a>
<b>Netherlands</b>	Choosing a Healthy Living Being Healthy, Staying Healthy	Education Disadvantaged Policy Poverty Policy Green and Health



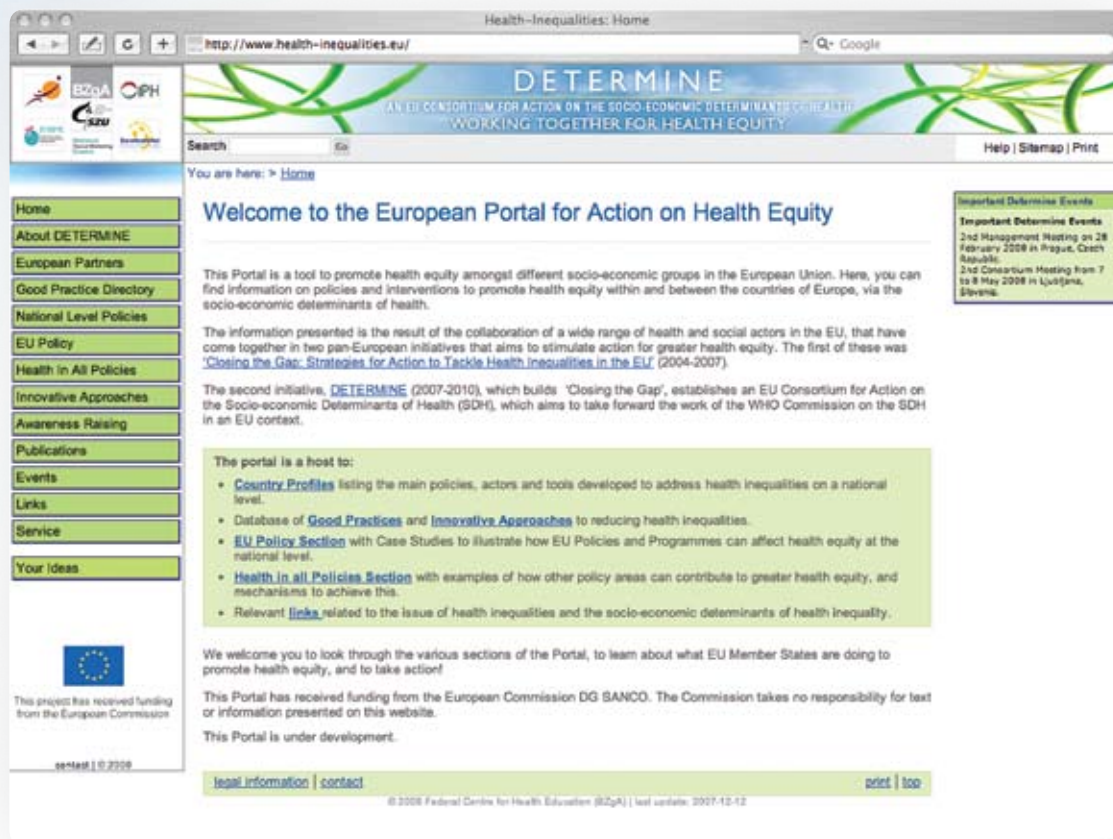
Partner	Other health policies	Other non-health policies
<b>Northern Ireland</b>	<a href="#">A Healthier Future 2005 – 2025</a> <a href="#">Fit Futures</a> (2005)	Lifetime Opportunities (2006) Racial Equality Strategy 2005-2010 <a href="#">Ending Fuel Poverty</a> Regional Development Strategy 2025 <a href="#">Success through Skills</a>
<b>Norway</b>	<a href="#">Recipe for a healthier diet</a> <sup>1</sup> <a href="#">Tobacco Control</a> <a href="#">Working together for physical activity</a> *	Work, Welfare and Inclusion
<b>Poland</b>	Prevention and Treatment of Cardiovascular Diseases	<a href="#">Human Trafficking</a> <a href="#">Family Violence</a> * <a href="#">Social Maladjustment</a> * <a href="#">Social Discrimination</a> <a href="#">Labour Market Participation</a> * <a href="#">Social Integration of Women</a> <a href="#">National Development Strategy</a> <a href="#">National Cohesion Strategy</a> Programme on Environment and Health <a href="#">Infrastructure and Environment</a> <a href="#">Human Capital</a>
<b>Scotland</b>	<a href="#">Improving Health</a> (2003)	<a href="#">Social justice</a> (1999) <a href="#">Closing the opportunity gap</a> <a href="#">Building better cities</a> (2003) <a href="#">Scotland's transport future</a> (2004) <a href="#">A Smart, Successful Scotland</a> (2004) <a href="#">Homes for Scotland's people</a> (2005) <a href="#">People and place</a> (2006) <a href="#">National Transport Strategy</a> (2006)
<b>Slovenia</b>		Labour Market and Wage Policy Social Protection Policy Social Inclusion Policy Pension Policy Regional Development policy Fiscal and Budget Expenditure policy Housing Policy
<b>Spain</b>	<a href="#">Multisectorial Plan for HIV and AIDS 2008-2010</a> * <a href="#">Mental Health Strategy of the National Health System</a> *	<a href="#">National Strategic Plan for children and adolescents 2006-2009</a> *

Partner	Other health policies	Other non-health policies
<b>Wales</b>	<a href="#">Chronic Respiratory Conditions Management of Chronic Conditions in Wales</a> <a href="#">The Community Services Framework A Therapy Strategy for Wales Designed to Tackle Cancer in Wales</a>	

\* Denotes limited or no text in English



## Interested in learning more about DETERMINE and its outcomes?



The screenshot shows the homepage of the DETERMINE portal. At the top, there is a navigation bar with the DETERMINE logo and the tagline "AN EU CONSORTIUM FOR ACTION ON THE SOCIO-ECONOMIC DETERMINANTS OF HEALTH WORKING TOGETHER FOR HEALTH EQUITY". Below the navigation bar is a search box and a "Help | Sitemap | Print" link. The main content area features a "Welcome to the European Portal for Action on Health Equity" heading. The text explains that the portal is a tool to promote health equity among different socio-economic groups in the European Union. It mentions two pan-European initiatives: "Closing the Gap: Strategies for Action to Tackle Health Inequalities in the EU" (2004-2007) and "DETERMINE (2007-2010)", which builds on "Closing the Gap" and establishes an EU Consortium for Action on the Socio-economic Determinants of Health (SDH). A sidebar on the left contains a menu with links to Home, About DETERMINE, European Partners, Good Practice Directory, National Level Policies, EU Policy, Health in All Policies, Innovative Approaches, Awareness Raising, Publications, Events, Links, Service, and Your Ideas. A sidebar on the right lists "Important Determine Events" including the 2nd Management Meeting on 28 February 2008 in Prague, Czech Republic, and the 2nd Consortium Meeting from 7 to 8 May 2008 in Ljubljana, Slovenia. The footer contains a "legal information | contact" link, a "print | top" link, and a copyright notice: "© 2008 Federal Centre for Health Education (BZgA) | last update: 2007-12-12".

See: [www.health-inequalities.eu](http://www.health-inequalities.eu)

