



TENTH FUTURES FORUM

on steering towards equity in health



Oslo, Norway

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1. Why a WHO forum on steering towards equity in health?

There is ample evidence of profound differences between the health status of various population groups in countries in the WHO European Region. Research has also shown that people's health depends on determinants other than health or health systems factors, including socioeconomic and employment status, income, education, gender and ethnic origin. Population groups with a lower socioeconomic position, whether measured by income or education, are more disadvantaged in terms of health status than those with a higher position. Governments in a number of European countries have therefore put some effort into tackling this health divide. Many have adopted strategies, policies and plans to tackle inequities in health in recent years, either as an integral part of national health strategies or through public health programmes focused on those inequities. The main problem is that most strategies for reducing social inequities in health have never been implemented and thus we do not know their impact in terms of reducing social inequities in health. Secondly, it may be too early to evaluate the health effects of strategies actually implemented (e.g. in England), as it can take many years between a change in exposure and a change in health (for instance, the latency time for smoking is around 20 years). Thus the first critical issue is to establish whether action has actually reduced exposure.

The Tenth Futures Forum focused on the experiences of, and put open questions to, participating European countries regarding their endeavours to steer towards more equity in health. The aim was to exchange and learn from experiences, to identify the knowledge gaps on ways of improving equity in health systems, to identify the role of senior health administrators in addressing inequities in health, to govern health systems towards more equity in health, and to promote future planning and cooperation in steering towards more equity in health systems in the European Region of WHO.

Launched in 2001, the Futures Fora are a series of meetings for policy-makers. They aim to generate insights into real-life decision-making issues that are often not available from academic sources. They provide an impartial environment for directors-general of health, chief medical officers and senior advisers to debate difficulties in policy-making. During the Fora, the participants share their experience in concrete decision-making issues, describe the solutions employed and draw the lessons. The Fora apply the Chatham House rule to ensure confidentiality. The Chatham House rule aims to guarantee anonymity to those speaking within it. It allows people to speak as individuals and to express views that may not necessarily reflect those of their organizations, thus encouraging free discussion.

The baseline theme for the Futures Fora in 2005–2007 is health systems governance. Previous fora under this theme have included one on governance of patient safety (Erfendorf, April 2005); and a second on health systems governance and public participation (Amsterdam, October 2005). In line with the subjects of those meetings, the programme of this Forum followed the WHO concept of stewardship and equity in health.

According to *The world health report 2000*, stewardship is the very essence of good health governance, defined as the "careful and responsible management of the well-being of the population". The three basic tasks that contribute to effective stewardship are: formulating health policy by defining vision and direction for the sector, exerting influence through regulation, and using intelligence to identify issues confronting the sector, in order

to monitor and assess its performance.¹ In line with this, the Forum looked at health equity policies, the regulatory role of the government in relation to equity, and monitoring health equity.

Following this introduction, **Chapter 2** presents expectations from the Forum participants. **Chapter 3** addresses the concepts of inequities in health, as well as the challenges and opportunities, and takes a look at national experiences from three European countries. The next three **chapters (4–6)** are structured according to the three stewardship functions and give examples of the practical experiences of a number of countries in developing strategies, policies and actions to tackle inequities in health; and attempt to provide answers to questions such as how health equity policies are developed, implemented and evaluated, and whether they have succeeded in closing the health gap. **Chapter 7** sums up the Forum with its conclusions and recommendations.

¹ *The world health report 2000: health systems: improving performance*. Geneva, World Health Organization, 2000 (<http://www.who.int/whr/2000/en>), accessed 29 May 2007).

2. Expectations of high-level decision-makers of this Futures Forum

The Futures Forum brought together high-level decision-makers from different countries, each of whom brought their own perspective and interests to the topic of steering towards equity in health.

Finland has had equity targets in place for 20 years. However, it has been difficult to prove clear policy benefits from measuring these targets, and policy-makers are now revisiting the issue to see how the targets can be made more visible and useful. It would therefore welcome ideas on ways of approaching equity monitoring for policy-making.

In **Sweden**, there are still significant health inequities. It would therefore be interesting to see whether any country has been able to eradicate the problem and, if not, to discuss why it still exists to such a large extent in many countries. Another interest for policy-makers in Sweden is to measure inequities across the European Union (EU) borders.

Within the **European Commission**, equity policy work, especially on issues such as social inclusion and health, is considered as an area of coordination and cooperation embedded into the European social model. There is hope that it will be given increasing attention during forthcoming EU presidencies. In addition, a new EU health strategy is being developed with an expert group set up by the Commission on Social Inequities.

Ireland has well developed government strategies in place to tackle health inequities but is struggling to fill the gaps between strategies and implementation. Thus, policy-makers are interested in learning about the experiences of other countries. In Ireland, there is widening of interest in this area, for example, the human rights commissions for both the Republic of Ireland and Northern Ireland are developing relationships with bodies such as the Institute of Public Health, one of several organizations on the island with expertise and responsibility for dealing with the problem and taking forward the agenda.

The **Netherlands** has set clear targets in line with WHO's Health for All policy. However, five years on, sufficient progress has not yet been made and this is puzzling. Therefore, it is hoped that the Forum will shed some light on new equity policy options in other countries.

Belgium has numerous monitoring activities and data on health equity in place but there is still a lack of policy implications. A good example is the health survey on socioeconomic status. This revealed that, despite a universal coverage health care system, some people still have trouble covering their medical bills. Thus, there is a maximum cost that patients can afford. The hope is that policy-makers can find parallels in other countries against which to test the Belgian approach towards achieving more effective health equity policy-making.

For **Iceland**, it is of interest to listen and to learn. Even though Iceland is a small country with a small and quite homogeneous population, with perhaps less pronounced health divides than in other countries, there are still concerns about specific population groups such as the elderly and those living in rural areas.

Estonia is faced with the challenge of developing a health policy based on social determinants, work that will necessarily involve crossing borders with other disciplines.

3. Concepts, challenges and opportunities

“Social inequities are health differences resulting from systematic social – and potentially avoidable – processes that are unacceptable from a human rights perspective.”

Concepts: definition and causes

The roots of the concept of equity in health can be traced back to the WHO Constitution, which states that everyone, without distinction of race, religion, political belief, economic or social condition, should be able to attain their full health potential.² Throughout the years, social inequities in health have been a priority issue, considered, as they are, the most unfair of all inequities. This does not imply that other inequities are not important or relevant, as a closer examination of social inequities will reveal.

“Social inequities in health” refers to the differences in health status between different socioeconomic groups that are: a) systematic; b) produced by social processes, rather than biologically determined; and therefore c) potentially avoidable; and d) unacceptable from a human rights perspective.³ Thus, two prevalent features of social inequities are the systematic pattern of differences in health status (visible mortality and morbidity patterns in socioeconomic groups), and the social processes that produce those differences.

The following examples indicate that there is a link between shortfall in population health and social inequities. In the Netherlands, mortality and morbidity in the population would be reduced by 25–50% if men with lower levels of education had the same mortality and morbidity levels as those with university education. In Spain, excess mortality in the more deprived areas compared to more affluent areas amounts to 35 000 deaths per year. In England, if all men aged 20–64 had the same death rates as professionals and managers, there would be 17 000 fewer deaths per year.

Figure 1 may help to give a better understanding of the determinants of health. The model illustrates the different factors that influence health.

It illustrates some of the important determinants of health, including those at the individual level through ways of living such as the use of tobacco or alcohol and a poor diet; those at the social and community level, where support may not exist or may have a negative effect; those at the structural level, such as inadequate housing and working conditions, poverty and income inequality; and those related to inadequate access to effective health services. Overarching factors are those of a societal nature such as the role of women, and economic and labour market conditions. Within this framework, it is important to identify which determinants of health contribute most to explaining observed social inequities in health.

² Whitehead M, Dahlgren G. *Levelling up (Part 1): a discussion paper on concepts and principles for tackling social inequities in health*. Copenhagen, WHO Regional Office for Europe, 2006 (Studies on social and economic determinants of population health, No. 2) (<http://www.euro.who.int/document/e89383.pdf>, accessed 30 May 2007).

³ Whitehead M, Dahlgren G. *The role of the health sector in reducing social inequalities in health*. Tenth Futures Forum on steering towards equity in health, Oslo, 29–30 August 2006.



Figure 1. The factors influencing health

Source: Dahlgren and Whitehead, 1991⁴

Challenges

“The challenge is to “level up” the health status of the most disadvantaged groups rather than “levelling down” that of the advantaged groups.”

It is apparent that inequities in health status still exist even in countries with high standards of living. However, tackling inequities is not always an easy policy issue to deal with. There are numerous reasons why policy work on equity is so challenging.

For example, looking at the above-mentioned complex social causes of inequity in health, it becomes clear that it will be even more complex to define policies to effectively tackle them. In fact, in many cases in which health inequities occur, they may not necessarily be attributed to one single cause but rather to several. Thus, despite the existence of policy options and strategies to tackle the determinants of social inequities in health, there is still a need to develop them further.

Related to the challenge of the multicausality of health inequities is the fact that it is not only the health sector that might effectively tackle the causes. Other sectors have an important and relevant role to play as well. Therefore, conceptually, the policy work on health equity would need to be of a multisectoral nature. This can be illustrated by the health gradient model. A health gradient reveals a range of sectoral factors (factors related to different sectors of society, e.g. housing, unemployment, lack of education) that can affect health. The gradient shows that individuals with higher socioeconomic status have better health than those with low socioeconomic status. The challenge lies in the fact that, in many countries, the health sector does not have sufficient leverage on other sectors such as education, finance, or employment. This makes equity policy development more difficult.

Another challenge relates to the difficulties encountered in measuring inequities in health for the purposes of policy work. It is a problem faced by many countries and relates back to the point on multicausality, the

⁴ Dahlgren G, Whitehead M. *Policies and strategies to promote social equity in health*. Stockholm, Institute of Futures Studies, 1991.

challenge lying in identifying tools that are comprehensive enough to be utilized by other sectors to change policies in order to address the problems of inequity. So far, most tools only measure impacts on health whereas, ideally, there is also a need to measure the impact on the social determinants of health. Since there is a lack of comprehensive tools, it is difficult to evaluate properly the impact of policies on different social groups. Thus, despite the existence of early preventive interventions in many countries, lack of proper evaluation also hinders progress on the impact of policy. In some instances where action is taken outside the regulatory framework, inequities are promoted rather than prevented.

A further challenge discussed at the Forum relates to the nature of many generic public health programmes implemented at the national level. In some cases, they have actually increased health inequities. For instance, it is known that, in certain countries, tobacco control policies have been very successful in reducing smoking among high- and middle-income groups, but much less or not at all effective within the lower-income groups. A similar negative impact has been observed with some alcohol and injury prevention programmes. Thus, some public health work has actually contributed to increasing the social divide in access to health interventions, and health indicators.

The Forum also acknowledged the problem of reaching all members of the population. This challenge can be seen from two perspectives. In many countries, especially those with large and ethnically diverse communities, the problem relates to language and cultural barriers. In other countries, it relates to differences in social classes, people with higher income and education levels being better informed. Both these cases have broader political implications since, in many countries, the less well-informed and less educated people are those who may not participate in voting, while those who are better informed and tend to vote will have a stronger voice.

Another important challenge faced by many countries is the decentralization of responsibilities for health services from the national to the subnational level and the implications of this on equity policy. Although the aim of decentralization in many countries is to increase technical and allocative efficiency, and to promote equity in terms of access to and utilization of health services, this is not always a clear result.⁵ The level to which that aim is achieved is highly dependent upon the complexity of the decentralization. There is a need to examine the degree of autonomy (formal and actual); the scope of responsibilities; and the degree of public influence on the process. Since the implementation of equity-related policies is one of the biggest challenges faced in decentralization, it is important to clarify the roles and responsibilities of the decentralized actors. In many countries, although responsibilities are clearly allocated, incentives, particularly of a financial nature, are also given. There is no clear indication whether such incentives hinder or promote work on equity policies.⁵

Opportunities

“Most European countries are already seeking to adopt equitable social policies. This is an excellent opportunity for the health sector to play a leading role in reducing inequities in health.”

In order to tackle health inequities, there is a need to accept that they exist; this is the first step towards dealing with them. Fortunately, this is already the case in most European countries, where the issue of inequity has

⁵ Saltman RB, Bankauskaite V, Vrangbaek K, eds. *Decentralization in health care: strategies and outcomes*. Maidenhead, Open University Press, 2006.

been on the agenda for the past 20 years. Many European health care systems are based on the concept of equal access for equal need that implies fair arrangements allowing equal geographic, economic and cultural access to available services for all in equal need of care.⁶ This value-based foundation is considered very useful by policy-makers when addressing the issue of inequities in health.

As stated earlier, the battle against inequities clearly calls for intersectoral collaboration; identifying existing areas of intersectoral collaboration would facilitate this work. An example might be where the ministry of education and the ministry of health collaborate in promoting healthier eating habits in schools; or the ministry of health and the ministry of environment jointly conducting assessments of air quality and its impact on the health of the population.

From a health systems perspective, access to health services provides a good entry point for the health sector to play a significant role in tackling the problems of inequity in health. Although access to health services may not be the most important determinant for inequity in health, it certainly allows the health sector to play a leading role, in particular, if specific functions in the health sector are made accountable for strengthening health equity. The health sector can contribute extensively to reducing inequities in health, for example, by:

- improving general access to health services and strengthening accountability for better access to care;
- boosting prevention and health promotion programmes in general and incorporating equity considerations into any preventive or health promotion programme;
- reviewing existing health policies and programmes to determine whether equity is enhanced;
- reviewing the working environment in the health sector, a major employer, to assess the extent to which it, through its own employment policies, contributes to increased equities in health;
- tailoring information systems to measure socioeconomic differences;
- setting targets in terms of health and acting as consultant for other sectors to help them recognize, and increase their efforts to promote, equity-oriented health development as an integral part of their own sector-specific policies;
- monitoring the actions taken and the changes that may have resulted from them for various socioeconomic groups; and
- making social inequities in health more visible, especially to politicians and professional groups.

⁶ Whitehead M, Dahlgren G. *The role of the health sector in reducing social inequalities in health*. Tenth Futures Forum on steering towards equity in health, Oslo, 29–30 August 2006.

4. National experiences – health equity policies

“We know what causes social inequities in health, and so not only are we capable of action, we are also committed to action.”

Norway

Background

In 2003, the Norwegian government published a white paper on public health called *Prescriptions for a healthier Norway*. This included a short chapter on social inequalities in health, in which the government stated that it should be “an obligation for a democratic country to try to influence the conditions that create social inequalities in health”. This was followed by an announcement that a strategy to combat social inequalities in health would be developed under the auspices of the Directorate for Health and Social Affairs. As the first follow-up phase, the Directorate was assigned to develop a plan of action to reduce social inequalities in health. The plan was called *The challenge of the gradient*. Since the factors that generate and perpetuate social inequalities in health lie far beyond the control of the health sector alone, the Directorate wanted to bring attention to causes and strategic directions for a policy approach to tackle social inequalities in health. This will form a foundation for the next phase – a national cross-ministerial strategy to reduce social inequalities in health.

Figure 2 shows social inequities in mortality in Norway for men (left) and women (right) according to their level of education. There are two clear tendencies: firstly, overall mortality is decreasing quite steeply. Secondly, in spite of the decrease in the overall level of mortality, inequalities between people with different levels of education are large and increasing. The same tendencies are evident in both sexes, although they are less marked among women because mortality is lower for women in this age group.

The present situation regarding social inequalities in health in Norway may be summed up in the following points:

- inequalities in health concern all age groups and both sexes;
- they are significant whether socioeconomic status is measured in terms of education, occupation or income;
- they are significant for most common health indicators; and
- they form a gradient throughout the socioeconomic groups: it is not only that people below a certain threshold of poverty are less healthy than the rest; the richest are healthier than the second richest, who are in turn healthier than the third richest and so on. This is a key point to note with important consequences for policies.

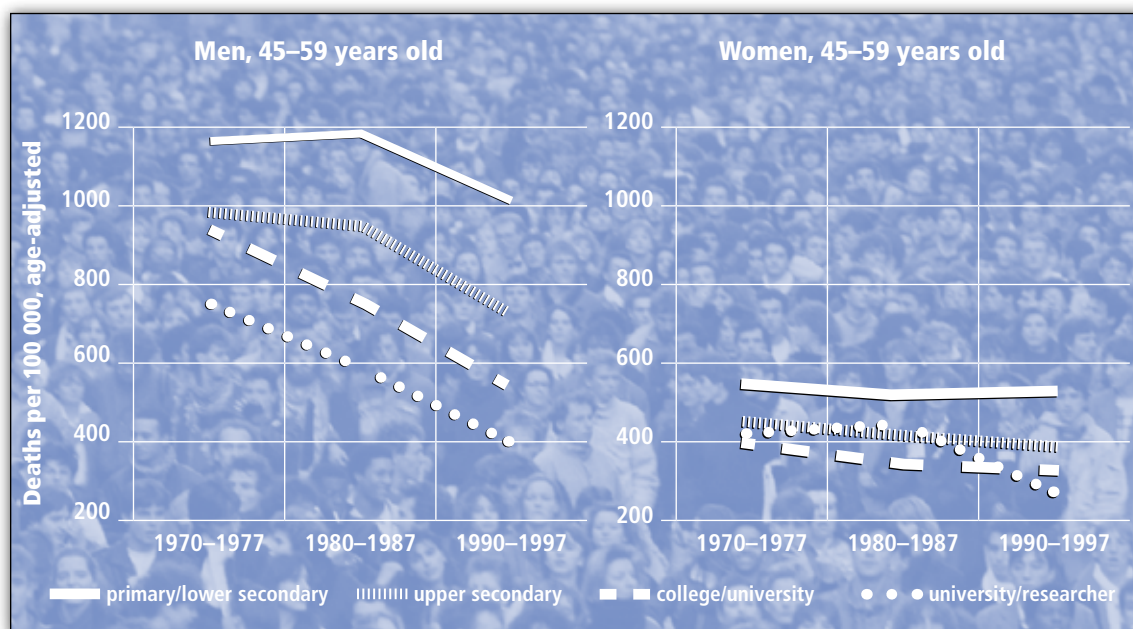
Source: Zahl et al., 2003⁷

Figure 2. Mortality by level of education

Process of equity policy development

In developing the action plan, Norway's Directorate for Health and Social Affairs took into consideration the issues outlined below.

First, a holistic approach was found to be the most useful since social inequities in health concern the whole population and not just a selected group. Since the gradient runs right through all groups, selective measures directed at high-risk groups are not enough. Non-stigmatizing universal strategies are often most beneficial to the poor and prevent people from falling into poverty. This does not mean that we should not selectively target those who are worst off, but we cannot do only that. Second, the social health gradient revealed the importance of structural measures, meaning that, for example, smoking is not simply a matter of individual choice. It is also a consequence of one's social background. Our preventive efforts should therefore focus on the whole causal chain of inequalities, with emphasis on the social determinants. The work carried out in other sectors needs to be in line with work done within the health sector. This will ensure that all layers of social determinants of health are properly addressed.

In order to achieve credibility across sectors, it is also important to tidy our own house. We have to ensure that attention is paid to equity aspects in our own professional advice on health sector reform and public health policies. The Norwegian Directorate of Health and Social Affairs has therefore initiated a process of developing an inequality impact check list as a simple tool to encourage its employees to think through the possible distributional effects of their daily tasks.

⁷ Zahl PH et al. *Bedre Helse–større forskjeller. En analyse av hvordan inntekt, utdanning og husholdningsstørrelse har påvirket dødeligheten i befolkningen i periodene 1970–77, 1980–87 og 1990–97. Rapport 2003:1 [Better health – greater differences. An analysis of how income, education and household size affect mortality in the population, for the periods 1970–1977, 1980–1987 and 1990–1997. Report 2003:1].* Oslo, National Institute of Public Health, 2003.

Lessons learned and recommendations

Based on Norway's own experience, the parts below are key recommendations to other countries developing a policy aimed at health equity.

- Even though data will be lacking, there is still a lot of knowledge, and therefore policy-makers cannot hide behind a “do nothing” option.
- Getting broad political commitment is one of the most essential steps; it is also vital to act on many levels and involve as many sectors as possible. We need to integrate equity objectives into existing policies in all sectors.
- Policy-makers are advised not to get focused too much on individuals or population groups alone; one needs to look at the whole gradient.

Finland

Background

For the past 20 years, all health policy programmes (Health for All 1986, revised Health for All 1993, Health 2015) in Finland have targeted health inequities, but policy-makers feel that there is still more room for improvement. Efforts to combat inequities have therefore been intensified. Some of the arguments for reducing health inequities in Finland were:

- inequities are ethically unacceptable since they are preventable;
- overall, population health progresses most if there is improvement in those population groups with cumulated ill health;
- morbidity variations among educational groups reveal that one of the biggest challenges for the future stems from the impact of labour policies on health inequities;
- a decrease in health inequities helps to secure adequate services for the future;
- ill health increases risk for social exclusion; and
- health inequities have a substantial negative economic impact on the country.

Process of equity policy development

After cross-governmental discussions on equity policy-making, a decision was reached to create an explicit new health equity strategy and action plan and make this the main public health policy target, with the idea that other policies would follow suit.

The process of building a strategy involved the national public health committee, which is intersectoral in nature, and the institutions subordinate to the Ministry of Health. In order to achieve political support, the most useful approach was to take advantage of the parliamentary elections and the programme of the new government. One effective method was to hold national seminars prior to the parliamentary elections and thus ensure that the issue was placed high on the government agenda. There was already good cooperation with the municipalities. To maximize support from other actors and sectors, and at European level, the theme of Finland's Presidency of the EU (second half of 2006) was also related: Health in All Policies (HiAP).

In summary, the main strategic lines of action to combat health inequities in Finland are:

- strengthening and connecting the Health in All Policies theme to ensure that all sectors are aware of and involved in the process;
- strengthening general health monitoring work at the local level, particularly because the statistics currently available concern only health services and are inadequate regarding population health;
- in the context of specific health programmes such as the alcohol and tobacco policies, the goal is to have a clearer indication of the gradient, including a forecast for the future, taking into account the fact that tobacco-related diseases generally manifest themselves after 20 to 30 years;
- increasing equality in access to health services;
- preventing the exclusion of specific population groups, namely children and young people;
- promoting general occupational health; and
- developing activities to monitor health inequalities across the country.

Lessons learned and recommendations

The key recommendations from Finland are:

- health determinants are unequally distributed and can only be improved through active work by many sectors; intersectoral work is therefore vital if inequities are to be reduced;
- high-level commitment in a country is an absolute necessity for, but not a guarantee of, progress;
- a good argument to use to obtain political support is the proof of the economic burden of excess morbidity resulting from inequities; and
- even though health services are provided based on the principle of equity, unequal mechanisms may exist; in-depth analysis and evaluation of such mechanisms is therefore needed.

United Kingdom

Background

In the case of the United Kingdom, economic arguments have been utilized to tackle health inequities, offering an added advantage of cross-governmental support. In addition, there is both strong political will and commitment to battle inequities; these have proved to be crucial and will continue to be in the future.

Recent years have seen the introduction of specific national health equity policy targets, such as the National Health Inequalities target: “By 2010, to reduce the inequalities in health outcomes by 10% as measured by infant mortality and life expectancy at birth”.⁸ In line with these targets, substantial planning for action has taken place, as shown below.

2001: a consultation took place on developing a delivery plan for tackling health inequalities.

⁸ Health inequalities guidance and publications: PSA target [web site]. London, Department of Health, 2007 (http://www.dh.gov.uk/en/Policyandguidance/Healthandsocialcaretopics/Healthinequalities/Healthinequalitiesguidancepublications/DH_064183, accessed 30 May 2007).

2002: a cross-cutting Treasury review was performed on the extent and magnitude of existing health inequalities in the United Kingdom.

2003: a consultation exercise followed, leading on to a Programme for Action on tackling health inequalities.

2004: the Derek Wanless report *Securing our future: Taking a long-term view* was delivered; it addressed health inequities implicitly through the major theme of the report, securing good health for the population.

2004: a white paper entitled *Choosing health: Making healthy choices easier* was published.

The next section elaborates further on this policy paper.

Process of equity policy development

The *Choosing health* white paper is a policy document that applies a twin-pillar approach of improving health and tackling health inequities. The considerations for the paper included: helping people to make healthier choices for themselves; protecting people's health from the actions of others; and recognizing the particular needs, and the importance of the emotional and physical development, of the young.⁹

In light of the marked differences in life expectancy throughout the country, there was a need to identify key actions to ensure the successful delivery of the policy nationwide. Thus, to facilitate the better delivery of policy commitments, the following steps have been taken:

- improvements have been made to the procedure for setting targets and measuring whether the targets are met at the local level, in order to determine whether the products delivered actually achieve change;
- the need has been identified to further close the gap between existing political commitments and political statements regarding health inequities and targets for improving health equity by 2010; and
- a package of materials about health choices has been issued in different languages (other than English), in order to reach as many people as possible.

Furthermore, to ensure that momentum is maintained, there will be: a progress report on inequities; a delivery plan on the public health white paper with a focus on both targets and government commitments; and a mapping exercise for delivery and communicating relevant action.

In summary, the following key strategies for tackling health inequities in the United Kingdom have been progressively applied:

- winning of political will;
- definition, description and measurement of existing health inequities;
- identification of key health equity determinants and other factors affecting health inequities;
- evidence-based explanations of inequities/effective policies and interventions;
- establishment of priorities for health equity policy work;

⁹ Department of Health. *Choosing health: Making healthy choices easier*. London, The Stationery Office, 2004 (http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4094550, accessed 30 May 2007).

- setting of targets for health equity work; and
- development of a programme of action based on effective interventions.

Lessons learned and recommendations

As in the case of Finland, an important aspect of the success of the policies in the United Kingdom relates to the fact that equity has been linked to economic arguments. However, there is still a need to make a stronger link with savings in economic terms, and to strengthen the work done across all sectors, not only within the health sector.

According to the British experience, the three most important components of health equity policy work are:

- political determination (this requires political skills and a strong will to maintain momentum and ensure focus);
- building partnerships (not only across the sectors, but also with all other stakeholders such as major businesses, industry and the voluntary sector); and
- targeting people (since inequities happen to everyone, policy-makers need to better understand people's behaviour, thinking more about behavioural change (social marketing approaches can be applied) and looking at strategies used by, for example, marketing approaches, the private for-profit and not-for-profit sectors to reach people successfully).

Discussion and conclusions

The participants agreed that, overall, there is much greater awareness regarding inequities today than there was 30 years ago, as well as much more information on health inequities and their determinants, knowledge with respect to policy options in addressing health inequities and their determinants, and more policy responsiveness in countries to health inequities. However, at the same time, there are also signs that health inequities are actually increasing. This may partly be attributable to a number of modern and often global phenomena, such as the growing size of groups considered as marginalized and disadvantaged within a certain population, or to economic factors such as unemployment, migration or ageing. Diseases also continue to play a dominant role in determining the further widening of the gap between the health determinants of the healthy and the sick. It was agreed that, as knowledge continues to grow, equity dynamics seem to have become bewilderingly complex, necessitating enormous political will and commitment to continue the work on developing and implementing effective health equity policies.

Since strong political will is needed to promote work on equity at national level, any form of collaboration advocating strengthened policies to tackle inequity in health will be welcome and useful to support national health policy-makers in strengthening national equity policies and in sustaining commitment to implementing those policies. Therefore, support from the international level is needed to reinforce the importance of commitment at national level.

Commitment at the international level exists, for example, through the work of WHO. The WHO Regional Office for Europe has, as one of the six strategic directions of its work towards 2020, a direction entitled "All against health inequities, values for health policy". In order to achieve this, health systems will have to become

more equitable. Greater equity in turn requires that there be greater equality in at least some areas, be they life chances, opportunities, capabilities or outcomes. Therefore, the WHO Regional Office for Europe will, in the coming years, focus on assessing the extent to which health inequities are caused by modifiable factors and how they can be influenced and altered by societies, governments and individuals. The WHO Commission on Social Determinants of Health will further advance understanding of health inequities and outline the ways in which they can be tackled.

Inspiration for equity policy developments may also stem from initiatives within countries. For example, in some countries with more highly decentralized decision-making structures, equity policies may have first been developed at a subnational level, by regional or local-level actors. Indeed such actors have often played a visible role, for instance, in the Scandinavian countries, in reducing inequities in health and thereby stimulating national policy developments. The regional and local-level actors will need to continue to play this role. Consequently, not only must work at subnational level be continuously supported and recognized by the national level, but also “best practices” in improving health equity developed at subnational level may be utilized in the development of national health equity policies.

Health equity targets for some time have been acknowledged as possible instruments for equity policy development and implementation. As instruments, they may either be embedded into a general national health policy or its implementation, or used in an explicit national health equity policy or programme. This acknowledgement of the potential of health equity targets has come about in spite of the fact that: a) many countries do not have a tradition of developing national health policies and targets; and b) many of those countries that do have a tradition of developing national policies and health targets encounter difficulties in setting national targets in relation to health equity, in the context of specific governmental action. Thus, in monitoring their targets, countries have a high risk of failure. However, where countries have a record of monitoring the distribution of certain diseases in specific population groups, they have also been able to identify causal relations with governmental actions and thus have proved that the approach of health equity target-setting can actually be set to lead to improvements. An example often referred to in this context is the policy experiment on reducing cardiovascular diseases in the North Karelia region of Finland.

As with any other field of health policy development, effective health equity policy development is dependent on the compliance of all stakeholders. However, there may also be policy frictions in ascertaining the rights of individuals vis-à-vis the rights of society, in particular, for example, in lifestyle choices such as smoking, drug and alcohol abuse, risky sexual behaviour or driving habits. This friction is particularly marked when lifestyle choices do not only affect the individual but also put others at risk. Thus, in some instances, policy-makers may argue that health and changing to healthier forms of behaviour are the responsibility of the individual, while others will argue that governments have the responsibility to ensure and facilitate the right environment for society as a whole, and for people as individuals, to make healthier choices. A recent trend in some welfare-system countries of western Europe has been a shift in focus from society-building to giving rights and choices to individuals. However, participants at the Forum also agreed that, regardless of individual choices made, the health sector will continue to support the attainment of the highest possible level of health, be it for society as a whole or for individual people.

5. National experiences – the regulatory role of governments

Regulation is one of the three core functions attributed to the concept of stewardship. Although there has been substantial concern about health equity over the past three decades, countries have not developed any explicit legislative or institutional framework specifically focused on health equity. The Forum therefore aimed to address the governments' regulatory role from the perspective of the impact on health equity of current, new or planned health reform legislation. The session was designed to initiate a discussion on the ways in which countries regulate their policy commitments to achieving more health equity. Two specific cases were discussed from the perspective of health equity: the current health care reforms in Austria and the 2005 health care reform in the Netherlands.

Austria

Background

In Austria, access to health care and services has been fairly equitable, as regulated by health insurance legislation. In 2006, 99% of the population was covered by the health insurance system. The system provides relatively fair access to services, since utilization and the range of health services provided by the health insurance system are basically not linked to the size of insurance contributions. Most people covered by the system are insured according to their professional group, the remainder by place of residence.

Health equity considerations in recent health care reforms

Two main health equity considerations have been taken into account in the recent health care reforms in Austria. One is the gap between health indicators in urban and rural sites, as reflected, for example in the significant difference in life expectancy; and secondly, health statistics show that there are unacceptable differences between the nine regions of the country, especially between the west and the east of Austria.

A closer look reveals a number of problems relating to the provision and infrastructure of medical services. For example, medical screening programmes such as breast cancer screening were introduced at an unequal pace in the different regions, and generally later than in some other European countries. There is also a significant gap between the numbers of general practitioners and specialists in different parts of the country.

In the past, attempts to tackle these gaps focused on regulating additional incentives to provide more equal access to services across the country. An important programme in this respect was introduced in the 1970s, bringing in a mother and child passport scheme with mandatory examinations until the child reaches the age of five. It includes a financial incentive scheme, whereby the mother receives certain financial benefits after the examination of her child.

More recently, reform endeavours have focused, firstly, on ensuring more systematic general monitoring of health inequities and, secondly, on systematically linking health equity monitoring to health planning.

The Austrian Federal Institute for Health (OBIG) was then established in 2005 to ensure the continuous evaluation of health data. The Institute has also developed the Austrian Health Plan that is implemented at all levels of government, including federal and regional.

Next steps

The next steps specific to health equity under consideration in the reform process include:

- the development of health policy equity targets;
- a review of suitable policy incentives to promote health equity;
- the strengthening of health equity impact assessment in other policies;
- the strengthening of health promotion and occupational health programmes with explicit focus on vulnerable and marginalized population groups; and
- the finalization of the electronic health data record (ELGA) to support health equity monitoring.

Lessons learned and recommendations

- Positive messages and incentives to health care providers, insurers and health consumers aimed at achieving more equity in health seem to work particularly well.
- The Ministry of Health needs to take a more visible lead in advocating health equity work, and be proactive in reaching out to as many stakeholders as possible.
- There should be continuous monitoring of health equity and utilization of the data in policy processes such as service provision planning.

The Netherlands

Background

There were three main reasons for the latest health care reform in the Netherlands. First, there has been a sharp rise in health care costs because of technological progress and there is concern that any further rise will absorb a substantial part of the country's economic productivity. Secondly, most Dutch citizens have grown up with the idea that health care is free, and this lack of awareness of health care costs has, in the past, led to overutilization of health services. The government has stood alone in previous attempts to control health care costs, putting a major focus on regulating prices, for example by reducing maximum price levels for generic drugs, setting budgetary ceilings for health services and the like. This may have hindered innovation in the health care sector. While most efforts in the past have focused on prices, with some remarkable savings, in particular in the area of pharmaceuticals, there were also reductions in the health insurance benefit package with, for example, the exclusion of certain dental and physiotherapy services and a gradual increase in user charges and co-payments to health care services. The termination of the obligation of insurers to contract health care providers is thought to have greatly enhanced the efficiency of providers, particularly in the hospital sector, giving momentum to the further introduction of reforms in the Dutch health insurance market.

Health equity considerations in recent health care reforms

One of the most important changes in the 2006 health insurance reform has been the introduction of a single compulsory uniform health insurance scheme that covers every person in the Netherlands. Those who fail to take out insurance cover are fined. The scheme is operated by about 30 private insurers who are now allowed to make profits. Another new feature is that individuals are free to choose their insurers, and insurers compete on the basis of contribution rates, offering supplementary insurance coverage and a given set of contracted providers. Insurers in turn have an obligation to accept everyone applying for insurance coverage, and the reform legislation explicitly contains provisions preventing insurers indulging in “cream skimming” and risk selection of insurees. Contributions consist of a combination of a capitation fee currently set at €1050 a year, and an income-related share, which is set by the insurers. The basic benefit catalogue is standardized and comprises virtually all essential care. Everyone under the age of 18 is funded through general taxation and there is a special care surcharge to cover premiums for lower-income population groups.

Thus, in summary, the new system is thought to promote equity in the following manner:

- the standard package that insurers must offer is defined by the government and comprises virtually all essential care, from general practitioners to hospital care and medicines;
- insurers are now legally obliged to accept anybody who approaches them for insurance. A risk structure equalization fund has been established to balance the bad with the good health risks of the different insurers;
- in addition to contracting obligation, insurers cannot penalize bad or reward good risks by setting premiums accordingly, as they are not allowed to apply higher premiums. It is hoped that this will equalize insurance coverage and entitlements between young and old, sick and healthy;
- regulation of income solidarity through a special care surcharge from tax revenues has been established, providing monthly allowances to people who cannot afford the fixed contributions, and ensuring that children under the age of 18 are covered from tax revenues.

The visible effects of the reform so far show that almost 30% of all insured individuals had changed insurance companies by autumn 2006, proving that many people are now conscious of their choice of insurers and insurance packages. There is also marked competition to win customers, as reflected in the cost of the nominal premium, which has been kept at only €1038 instead of the predicted €1100.

It is hoped that the reform may encourage further innovative developments in the health care sector, eventually leading to more effectiveness, quality improvement and better customer focus. If the current direction of reform is sustained in the coming years, it may eventually lead to continued development of the “regulated market forces”, including the progressive liberalization of submarkets such as hospitals and institutions. In particular, the greater competition between providers that will follow the introduction of competition between insurers may allow for greater transparency in the delivery of health care and, hopefully, give a better insight into the quality of care.

Remaining health equity issues

A number of health equity implications of the current reform have yet to be tackled. One open question, for example, is how to deal with people who may refuse to pay the fixed contribution. Another problem is that there is evidence that insurers have offered reductions in premiums to people with group insurances, for example certain groups of employees. This has effectively led to unfair differences in the structure of premiums. A third problem has occurred as a result of imperfections in the design of the equalization fund. In contrast to experiences in other countries such as the case of private health insurance policies in Germany, some groups with chronic illnesses are now more attractive to insurers as they lead to higher payments from the equalization fund. There is also a need to review the composition of entitlements in the standard and the supplementary insurance packages vis-à-vis the health indicators of the people insured under them as, already at this early stage of the reform, there is evidence that lower income groups tend not to take out supplementary insurance in some areas, such as dental care. The standard package will also have to be reviewed with respect to preventive care aimed at behaviour modification, an area that is currently relatively weak. And finally, there are population groups that are excluded under the current insurance system, for example people without legal resident permits, the number of whom is increasing in the Netherlands.

Discussion and conclusions

The participants agreed that more work is needed to review and consider more explicit health equity regulation in countries, a field that is currently underdeveloped or blurred by debates about constitutional rights, which currently include certain legal rights to health care, but not necessarily the right to be protected from health inequities arising through health care regulations, or regulations of other sectors. One challenge that may arise in this context is the negative connotation often attached to the concept of regulation, making it problematic for countries to subscribe to it in their legislation. There are also many other open questions with respect to the ideal design of health equity regulations, the level of the health system targeted – supranational, national or subnational – and how and with what capacities they would be implemented and guarded.

The Forum participants agreed that regulatory systems are extremely complex both to comprehend and to design, and that there is thus need for more research on their effective systematization.

The session discussed a few explicit supply-side mechanisms for regulating health equity commitments: first, financial incentives were discussed and participants agreed that these can be utilized in addressing inequities in health. However, the financial incentives currently offered by governments seem to be weak in making distinctions between social groups, and are thus not equitably available to all. For example, tax exemptions or reductions granted to citizens who prove their healthy behaviour tend to be regressive, as they promote higher-income groups who pay higher taxes and thus will benefit more from tax reductions. Rewarding health equity-compliant companies with tax exemptions or offering incentives only to weaker income groups may be alternatives here. Secondly, the use of market reforms, as in the case of Dutch health care reform, is also a possible approach to regulating for greater equity in health. However, as illustrated by the experience in the Netherlands, the reform will have to be closely monitored as, along with more choice and selection, there are also a number of risks for health equity associated with introducing market elements, for example, risks resulting from unequal access of consumers to information that will help them to make choices, or the fragmentation of quality assurance, leading to a two-tiered system. Making use of existing compulsory systems to solve problems

6. National experiences – monitoring health equity

Health equity monitoring is another governance activity aimed at reducing inequities in health. In most of western Europe, the scope and intensity of monitoring activities vary from country to country and are further complicated by decentralization. There are also major differences in the way countries utilize information about health equity. However, existing monitoring systems can be compared bilaterally, as well as at EU and international levels, in order to track developments and find entry points for policy action. Two national approaches to health equity monitoring were discussed: the cases of Germany and Sweden.

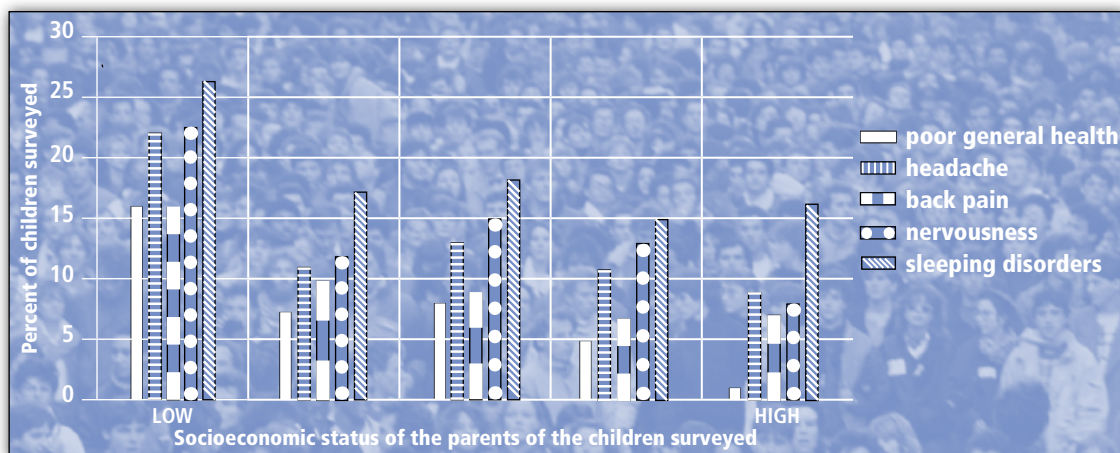
Germany

Background

Germany is a classic continental welfare state that provides most health care under the conditions of social health insurance. The country has a federal system with 16 regions (*Länder*). Health care legislation is developed at national level, and health insurance is also subject to national regulation. However, health promotion and public health actions aiming at tackling inequities in health take place at the regional and community levels. Therefore, monitoring is not necessarily specific to the national level and it is difficult to speak about national experiences.

The organization and utilization of health equity monitoring

It is well known that health inequities exist in Germany. Some work on monitoring health inequities in the past has been linked to poverty and the role of socioeconomic status. For example, there are a number of papers proving a causal link between socioeconomic status and self-reported health status, such as the study by Klocke and Hurrelmann, illustrated in *Figure 3*.



Source: Klocke and Hurrelmann, 1995¹⁰

Figure 3. Socioeconomic status of parents and health of school children in Germany
(3328 children, 11–15 years)

¹⁰ Klocke A, Hurrelmann K. Armut und Gesundheit. Inwieweit sind Kinder und Jugendliche betroffen? *Zeitschrift für Gesundheitswissenschaften*, 1995, 2:138–151.

There are two federal institutions responsible for, among other tasks, monitoring and tackling inequities in health: the Robert Koch Institute and the Federal Agency for Health Promotion. The Robert Koch Institute undertakes monitoring as part of its responsibility for general federal health reporting. The federal health reports include the health status of the population, health behaviour and risks, morbidity, health services and their utilization, and health care expenditure and funding. The focus of recent monitoring activities carried out by the Robert Koch Institute and reported in the federal health reports has included unemployment and health; the health of single parents; poverty and health; and, more specifically, poverty in children and adolescents. The latter included a health survey of 18 000 children and adolescents up to the age of 17 and was conducted nationwide.¹¹ The information collected includes data on physical and mental health; health behaviour; health care services utilization; migration; living conditions; and cross-sectional determinants of health. The Federal Centre for Health Education (BzGA) is mandated to undertake targeted population health promotion interventions such as information campaigns and projects related to training and education leading to recognized qualifications and quality management of health promotion activities in Germany.

There are several ways in which Germany has been utilizing information about health inequities, and discussing measures to tackle them. Many of the measures discussed have been reviewed within the framework of enhancing the health status of socially deprived and poor population groups. For example, in collaboration with WHO, a regular conference on poverty and health has been held each year since 1995. An expert group specifically reviewed poverty and health in Germany between 2000 and 2001, and in 2005, the Advisory Council for Concerted Action in Health Care gave an expert opinion on how to tackle poverty implications on health.

In addition, a nationwide cooperation project entitled “Health promotion for socially disadvantaged people” was initiated by 37 partner organizations, including the BzGA and a major association of company health insurance funds. The project has a number of components, including measures to improve transparency by increasing the exchange of information between players in the field of health promotion; to improve the participatory aspect of health promotion for the socially disadvantaged; to identify and introduce best practices in health promotion; to expand and update the nationwide project database that includes 2700 national health promotion projects;¹² and to establish an internet platform.

There are a number of ways in which the above-mentioned health equity monitoring activities are linked to European activities. For example, Germany collaborates in the European Union project, Closing the Gap, that works with 22 partner countries at EU, national and local levels.¹³

Remaining issues in health equity monitoring

The new government is continuing to put its special focus on poverty and social exclusion. In addition, new legislation to strengthen primary prevention is in preparation; it contains particular provisions for reaching disadvantaged population groups. However, it has yet to be decided whether health equity monitoring would

¹¹ KiGGS – The German Health Survey for Children and Adolescents [web site]. Berlin, Robert Koch Institute, 2005 (<http://www.kiggs.de/service/english/index.html>, accessed 7 June 2007).

¹² Gesundheitsförderung bei sozial Benachteiligten [online database]. Berlin, Gesundheit Berlin e.V., 2007 (www.gesundheitliche-chancengleichheit.de, accessed 7 June 2007).

¹³ European Health Inequalities Portal [web site]. Cologne, European Partners for Equity in Health, 2005 (www.health-inequalities.eu, accessed 7 June 2007).

also lead to actual policy action, such as a new health policy on preventing health inequities and explicitly protecting the health of disadvantaged population groups.

Sweden

Background

Sweden is a highly decentralized country with 21 regions and independent government agencies with different tasks within the health sector. The National Board of Health and Welfare, the National Public Health Institute and Statistics Sweden each have special responsibilities in the field of health and health care monitoring and policy coordination. The 21 regional governments, namely the county councils, are responsible for public health and health care within their regions. The 290 municipal governments are responsible for social and long-term care, as well as the physical environment. Thus, decentralization and the need to coordinate between the different regions pose a challenge to effective health monitoring at national level.

The organization and utilization of health equity monitoring

Health monitoring at the national level is carried out by different institutions including:

- the National Board of Health and Welfare's Centre for Epidemiology, which monitors public health, social problems and health care, and operates large comprehensive health data registries;
- the National Public Health Institute, which monitors and evaluates public health policy in relation to public health goals and social determinants of health;
- Statistics Sweden, which operates population and social registries and measures social conditions, lifestyle and self-assessed health in a national sample survey; and
- the Centre for Health Equity Studies, a national research institute created in 2000 providing an institutional basis for targeted academic research on health inequity.

The basis for reporting and research on health equity in Sweden is national registries of causes of death, cancer, hospital care, birth, extended sickness absences, premature retirement and prescribed drugs, and of socioeconomic indicators such as income and personal wealth, education and family structure. Information from the different registries can be linked through the national personal identity cards that provide key information. This allows comprehensive research on health inequity based on objective records of social standing and medical outcomes. The linkages can be used for research on social and economic consequences of ill health for the individual and the family. The data are safeguarded by strong regulations and high security in order to prevent illegitimate use of personal information.

There are also a number of registries specific to health care provision and utilization, such as the Prescription Drug Registry, which was set up in 2005 and covers all prescribed drugs sold in Sweden with person identification. One example of how the registry can be used is a study investigating social inequity in cardiac medication following surgery. To date, the registry shows that the prescription system in Sweden works fairly equitably in this respect between different Swedish and other Nordic resident groups, taking into account age, gender, and socioeconomic status; but there is evidence that non-Nordic resident groups have poorer access to appropriate cardiac medication.

A number of surveys also contribute to health inequity reporting: the National Survey of Living Conditions, the European Union Statistics on Income and Living Conditions (EU-SILC) and the European Health Interview Survey (HIS-EU).

Reports on health inequities and measures to tackle them have been incorporated in the 2005 *National public health report*, the 2005 *National public health policy report*, the 2006 *National health care report*, the *Environment and health report*, and the 2006 *National social report*.

Strengths and weaknesses of health equity monitoring

There are a number of strengths of health monitoring activities in Sweden. Firstly, there are numerous health data registers and social registers of very high quality readily available that cover the whole population and can be combined with each other, as well as with survey data and clinical data. Secondly, there is also a national social survey of high quality that already includes cross-sectional and cohort (panel) information on health outcomes. Thirdly, in 2003, an explicit goal was set for public health policy efforts. The goal defines a government commitment “to create the societal prerequisites for good health on equal terms for the entire population”. Policy-actionable documents defining measures aimed at achieving this goal are focused on health determinants, and lay out a number of specific areas for monitoring. The monitoring activities have, in general, detected good evidence that the population in Sweden enjoys good health on average, compared to other European countries, and reasonably equitable access to health care.

However, it is important to note that, despite the efforts made, health inequities have not decreased and still persist in Sweden. One possible explanation relates to social cohesion: an increase in ethnic diversity has created new disadvantaged groups. With respect to the weaknesses of health equity monitoring, the censuses on housing and occupation are no longer carried out, making monitoring of these determinants of health inequities a challenge. Finally, the monitoring system in Sweden is not comparable with those of other countries within and outside Europe and, in line with a trend towards integration in European health policy-making, it may become necessary to rethink methods concerning standard solutions.

Discussion and conclusions

Parts of the discussion focused on how best to combine national and international monitoring on health equity. A challenge, as well as an opportunity, for collaboration is that different countries have different health equity monitoring policies. This is an opportunity since there is great potential for reviewing different policy analysis approaches with epidemiological data across countries in an experimental way. Collaboration will certainly contribute to diversifying the information base with which countries may generate catalogues of options for health equity monitoring tools. Ideally, this will also allow the identification of suitable tools to effectively link health equity monitoring activities to policies and evaluating their health equity impact afterwards. However, different approaches to health equity monitoring also pose a challenge since monitoring systems will hardly be transferable across countries. Countries utilize health monitoring at different levels of policy-making and for different purposes, and they differ in the organization, administration and degree of decentralization of their health systems. It is therefore an open question whether international collaboration on health equity monitoring should lead to greater standardization of activities and, if so, whether, for example at a European level, new methods should be developed or collaboration should build on existing systems. But, despite this

open question, there is consensus that countries can join forces in learning from each other and, at the level of the European Union, work has already been initiated to set up common health equity indicators to generate comparable data.

A second main discussion theme focused on identifying specific measures applied in countries whereby monitoring activities are explicitly linked to policy actions. The use of health equity information for policy depends on a number of factors, such as whether explicit mechanisms are linked to the monitors. In some countries, for example, there are provisions that the publication of public health reports has to be followed by meetings of policy-makers to discuss the policy implications of the published data. These meetings may be organized at national and subnational levels and may lead to a discussion on the equity impact of current policies – thus using health equity monitoring for policy evaluation – or a decision to formulate new policies, for instance to combat certain conditions which have been associated with health inequities. Such processes are recommended to ensure that health information is used within policy action. Thus, countries need to be clear on the goals driving the monitoring process, as illustrated in the case example from equity monitoring in Sweden.

A third discussion theme focused on methodological questions concerning the definition of health equity indicators, indicators for determinants of health equity including medical care, and the collection, interpretation, publication and utilization of data. Health equity monitoring and policy evaluation were identified as separate steps. Participants agreed that it is important to distinguish between all these methodological steps.

7. Summary and conclusions

Discussions ranged from the conceptual or strategic to operational issues related to governing towards more equity in health. A glance at the range of experiences presented revealed that some of the countries have set clear targets but have not seen any policy benefits; others are struggling to fill the gaps between strategies and policy; a number of countries have gathered extensive amounts of data but still do not have any significant policies in place; and a few countries have political commitments but no existing means of transforming those commitments into regulations and practical work. Thus, although the Forum revealed numerous good examples for equity policy, regulatory and monitoring work, overall there is still scope for improvement in steering health systems towards more equity in health.

Below are some conclusions and suggested principles for equity policy work in countries derived from this Forum.

1. Working on political and popular understanding and awareness of health equity

Health equity is a value-driven policy issue necessarily raised by any development within – and sometimes beyond – the health sector. In order to tackle health inequities, it must be accepted that they exist, that they have significant socioeconomic consequences and that they can be prevented. It was felt that inequities are ethically unacceptable, particularly since they can be prevented and that there is thus no justification for not placing policy focus on the issue. Thus, high-level commitment in a country is an absolute necessity although, unfortunately, it does not guarantee progress.

The main focus of the Forum was on social inequities in health, described as the differences in health status between different socioeconomic groups that are systematic, produced by social processes – rather than biologically determined – and therefore potentially avoidable, and unacceptable from a human rights perspective. Thus, two prevalent features of social inequities are a systematic pattern of differences in health (visible mortality and morbidity patterns among socioeconomic groups), and social processes that produce health differences.

Political, as well as popular, awareness of these concepts will have to be strengthened, as the Forum found that, in many countries, awareness is not yet sufficient to obtain a critical mass of commitment for policy and action changes at both social and individual levels.

2. Triggering collaboration at all levels to sustain political commitment

The Forum found that the causes of health inequities are bewilderingly complex, and that governmental and institutional accountability for health equity is often not very well defined in countries. Thus, there are three major prerequisites for initiating and sustaining equity policy work: first, it is important not to be overwhelmed by the complexity of the policy task of tackling inequities in health. A step-by-step targeting approach may help in getting started. Second, it is essential for the health sector to take the lead and win broad political commitment. A useful argument to use to obtain political support from other

sectors is the proof of the economic burden of excess morbidity resulting from inequities. Third, not only should the health sector take the lead, it should also act on many levels and involve as many sectors as possible.

One difficulty is in establishing whether declining or rising health divides can be attributed to governmental action. This factor further substantiates the need to join forces at international, bilateral and subnational levels and between sectors in order to obtain or sustain political commitment to work towards more equity in health.

Most health policy decision-makers will subscribe to equity goals, but actions to combat inequities will absorb extra health costs, so there are tradeoffs needed to win and sustain political commitment when trying to incorporate these aspects into reforms and collaboration at all levels.

3. The health sector needs to put its own house in order first

In governing towards more equity in health, the health sector will continue to be responsible for helping people to attain the overall highest possible levels of health – and thus “level up” for better health – be it for society as a whole, or for an individual. The effectiveness of the combination of policy, regulatory and informational measures is dependent on the general context of policy-making in the countries. This responsibility does not weaken policy-makers’ respect for individual health choices.

If optimal results are to be achieved, there are certain essential requirements for the implementation of policies that promote equity. These are related to: the existence of political will and popular support/acceptance; ensuring professional competence through training; securing adequate financial resources; developing and communicating clear mandates; and developing sufficient organizational capacity. Once the essentials are in place, the health sector can play a number of roles as outlined below in improving inequities in health.

4. Improving overall access to health services

Improving overall access to health services was identified as one of the lead strategies for the health sector to work towards more equity in health, particularly if specific functions in the health sector are made accountable for strengthening health equity. Improving access to services will need to be addressed on numerous levels. As one step, matching health services more closely to needs would facilitate work on trying to reduce barriers to access to effective care and to prevent the medical poverty trap. This might, for example, be achieved by prioritizing certain population groups most in need. Monitoring is also an essential tool in trying to improve access to health services.

The Forum also found that a reduction in health inequities would help to secure adequate services for the future.

5. Boosting preventive and health promotion programmes, especially among deprived population groups

A reduction in inequities might be partly achieved by using the potential of existing public health programmes such as those related to tobacco, alcohol, injury prevention, diet and physical activity.

However, the Forum also found that some programmatic public health work has actually contributed to increasing the divide between population groups in access to health interventions and health indicators, and thus has in reality increased health inequities. Another aspect of the circle is that ill health increases risk for social exclusion.

It is therefore important to place particular emphasis on those population groups with cumulated ill health that are traditionally ill-informed. For example, there are various equity-oriented tobacco control strategies:

- taxation/pricing policy – providing equitable disincentives for unhealthy behaviour;
- advertising bans – for example, targeted at specific population groups;
- targets for reducing smoking set by socioeconomic group and gender – with particular attention to those at particular risk;
- gender- and social class-specific health education programmes – tailoring education programmes to the audience;
- extra “tailored” programmes in disadvantaged areas – prioritizing interventions to those most in need;
- smoke-free workplaces (in cooperation with labour unions) – protecting all smokers and non-smokers alike, irrespective of their social position;
- stronger legislation on smoke-free public places – protecting all smokers and non-smokers alike, irrespective of their social position;
- cessation services in all primary care facilities – tackling the problem at the point of entry to the health system; and
- intensified efforts with maternal and child health services to promote “smoke-free babies” – protecting those who cannot yet express their own interests.

Finally, policy-makers are advised not to focus only on specific individuals or population groups, but to look at the whole gradient.

6. Designing and applying effective health equity tools at all levels of policy-making

In addition to the health promotion programmes mentioned above, tools for promoting equity-oriented health policies may include:

- national policy documents with an explicit focus on reducing health inequities, or the incorporation of health equity sections into existing national health policies;
- explicit supply- and demand-side health equity regulations designed at supranational, national and subnational levels, addressing, for example, incentives, market mechanisms, benefit packages and others, and ensuring the relevant implementation capacities;
- information systems that capture socioeconomic factors;

- policy monitoring systems which include (governmental) actions taken and changes achieved;
- monitoring measures to assess, and regulatory measures to tackle, morbidity variations between groups of different educational levels that stem from the impact of inequities in labour policies;
- health equity targets expressed in terms of both health and the determinants of health;
- further development of health equity impact assessment methods; and
- awareness-raising tools to make social inequities in health visible for politicians, professional groups and the general public (strengthening is one of the most important aspects of this, but few people know about it so we need to make it known and embed it into the political process).

7. Strengthening monitoring and evaluation of health equity and policies

Health monitoring can be a powerful tool in creating momentum to influence politicians towards certain actions. One important result of monitoring is that it highlights the huge lack of data, and the need for better evidence. In western Europe, monitoring systems differ from country to country, and there is often the further complication of decentralization. However, existing monitoring systems can be compared bilaterally, as well as at the EU and international levels, to track developments and find entry points for action. Monitoring should be more explicitly linked to policy-making processes such as policy development, planning and regulation, to ensure that there are clear goals in the process towards progress.

There may be certain policy-making mechanisms that actually promote health inequities: for instance, some general health promotion programmes may be well intended but still tend to target the well-informed and better-off consumers. Therefore, an in-depth analysis and evaluation of such inequity-promoting policy mechanisms need to be conducted.

8. Facilitating the role of other sectors in relation to the wider determinants

The Forum shared that, because of the multicausality of health inequities and their determinants, the health sector is not the only one that could effectively tackle their causes. Other sectors also have an important and relevant role to play. Therefore, conceptually, the policy work on health equity would need to be of a multisectoral nature. However, the actual challenge lies in the fact that, in many countries, the health sector does not have sufficient leverage on other sectors such as education, finance or employment, and this makes equity policy development more difficult. It means that the health sector needs to play a more proactive role in getting health on the agenda of other sectors in order to increase their competence in relation to health. One example is that of health-promoting schools, where health is put on the agenda of the education sector. When addressing inequities, the focus should be on health determinants, where it will be much easier for other sectors to have an influence and be able to change their policies and actions and monitor them according to their impact on health determinants.

Health equity interventions must be prioritized, to help reduce social inequities and their impact. There is a need for improved tools to measure and monitor the health equity aspects of other policies, with an explicit link to policy development, showing that looking at indicators alone is no longer sufficient.

9. Consulting with society

The Forum also reflected on the importance given to citizens, focusing on the shift from a collective to an individual approach. As in any field of health policy development, the effectiveness of policies will ultimately depend on the compliance of individuals. This requires policy-makers to share information on the decision-making processes, and perhaps even to empower citizens to participate in such decisions by means of consultation, choice or representation. Regarding health equity, the Forum also found that there is still much to be done to increase popular awareness on the issue. One possibility is to engage citizens more proactively in open debates about the health equity implications of developments within the health sector and beyond.

10. Learning from and collaborating with the private sector

The Forum also identified the need for governments and health policy decision-makers, in formulating policies against health inequities, to acquire better knowledge about people's behaviour and to better understand the dynamics of behavioural change. In this context, it was particularly recommended that the way in which the private sector addresses people through marketing approaches should be studied.

Several possibilities were also suggested for building partnerships with the power to establish mutual support systems between the private and public health sectors, for example with the public health policy community supporting market action by making healthy food more profitable.

11. Developing demand-side policy and supply-side regulatory measures

Given the Forum's approach to governance and the responsibility of the state in steering towards more equity in health, most of the measures discussed were supply-side oriented. There is, however, a need for more work to be done to analyse and optimize the policy options available to address the demand side for healthy choices. More information is needed in this area. One example is the determinants of a healthier lifestyle for the disadvantaged. In addition, it is the demand of the better-off that drives the market and this must be taken into account, as well as its implications.

12. Promoting equity policy work at subnational level

Equity policy development and implementation need to be continuously supported and recognized at national level. Best practices in improving health equity at subnational level have to be better utilized for the development of national health equity policies. However, the Forum also highlighted the need to generate more evidence on the effectiveness of equity policy tools applied at subnational levels. For example, there was consensus that implementation of equity-related policies is one of the biggest challenges faced by decentralization. This may, in part, be a result of the fact that the roles and responsibilities of decentralized actors in respect of health equity policies are not sufficiently clarified. However, in some

countries, although responsibilities are clearly allocated, incentives, especially those of a financial nature, are also added. Because of the lack of policy analysis, there is as yet no clear indication whether such incentives hinder or promote work on equity policies; this is an area that requires further attention.

13. Deciding about health equity targets

Health equity targets have been applied in some but not all of the countries represented at the Forum with different experiences. They are seen as tools to support, but not replace, health equity policies, regulation and monitoring, for example in the design and communication of intersectoral health policy goals. However, health equity targets cannot be applied in isolation. They may work best if they are linked to explicit policy commitments, continuous measurement activities and, most importantly, to clear accountability structures for cases in which they are not met.

