Social Determinants and Health:
The role of national action plans in reducing health inequities

Report of a multi-country seminar

Helsinki, Finland, 17 and 18 November 2009
Abstract
This report is a summary of the content and outcomes of a multi-country seminar held in Helsinki, Finland, in November 2009 on social determinants of health and the role of national action plans in reducing health inequities. The seminar was organized by the Ministry of Social Affairs and Health, Finland, in cooperation with the WHO European Office for Investment for Health and Development, Venice, Italy. The aim of the seminar was to highlight the urgency of tackling health inequities and to allow countries to exchange experiences in making the issue a policy priority and developing, implementing and sustaining national programmes for reducing inequities.

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1. Background

On 17 and 18 November 2009, the Finnish Ministry of Social Affairs and Health and the World Health Organization (WHO) Regional Office for Europe (EURO), through the Office for Investment for Health and Development (Venice, Italy), co-hosted a multi-country seminar on Social determinants and health: the role of national action plans to reduce health inequities, in Helsinki, Finland.

During the past century, average health status improved throughout the world; however, this improvement masks an increase in health inequity overall and, more particularly, an increase in health inequity between population groups living in the same country. This is reflected within the WHO European Region, for example in differences in life expectancy between the highest and lowest socioeconomic groups in European Union Member States, which are 10 years for men and 6 years for women (European Commission, 2009). Addressing the social determinants of health and health inequities is therefore high on the agenda for both WHO and European Member States.

The final report of the WHO Commission on Social Determinants of Health (WHO, 2008) drew international attention to global evidence on both the need to act and examples of country action that can be taken to improve health equity. It accelerated awareness and gave a sense of urgency to act. The Commission made three overarching recommendations:

• to improve daily living conditions;
• to tackle the inequitable distribution of power, money and resources; and
• to measure and understand the problem and assess the results of action.

These recommendations can be seen as principles of actions that should be taken in specific national and local contexts (Marmot et al., 2008). The broad directions for translating the Commission’s recommendations were agreed in World Health Assembly resolution WHA62.14, which was endorsed by the Sixty-second World Health Assembly (WHO, 2009).

The demand from countries in the European Region for technical assistance in tackling socially determined health inequities has therefore not only increased but also changed. For example, countries wish to move from setting health equity targets to implementing actions to achieve those targets and monitoring and evaluating progress. There is a growing demand for know-how to tackle the social determinants of health and health inequities in a practical way and to move from application of the broad principles set out in the recommendations of the WHO Commission on Social Determinants of Health to translation and adaptation of those principles into context-specific action plans at national level.

The aim of the seminar in Helsinki was to respond to this changed demand and to build on existing knowledge of actions at country level with technical assistance and collaboration by EURO with Member States in tackling health inequalities. It also provided an opportunity to start a broad consultation on the draft WHO European action guide: Addressing socially determined health inequities. This guide was written as part of the EURO programme of technical assistance to countries for addressing health inequalities and for identifying practical actions that are and can be taken across the WHO European Region to implement the recommendations of the WHO Commission on Social Determinants of Health.
1.1 Purpose of the report

The purpose of this report is to describe the content and the main issues discussed at the seminar, which drew on the final report of the WHO Commission on Social Determinants of Health and its recommendations. The report provides an overview of the different perspectives and issues presented at the seminar. It is expected that this report will provide information to countries that are considering taking action to redress social determinants and to ensure equity and which are drawing up action plans to reduce health inequities. The report should assist national and local stakeholders in planning activities such as seminars and meetings, as it summarizes experiences in getting social determinants of health and health inequities onto the policy agenda and into tangible plans of action.

1.2 Social determinants of health and equity in the European context

The patterns of health opportunities described in the report of the WHO Commission on Social Determinants of Health affect both higher- and lower-income countries. Poverty is a key factor in poorer health in the least well-off countries and among population groups in the same country. Differences in health also follow a strong social gradient (Marmot & Friel, 2008), which reflects the positions of individuals and population groups in society and differences in their access to and the security of resources (e.g. education, employment, housing) and differential participation in civic society and control over life. No country in the European Region remains unaffected, and a range of responses is required, from removing the health disadvantages of certain population groups (e.g. the Roma community), to reducing gaps between groups (defined by e.g. level of education, social position), to tackling the social gradient (Graham & Kelly, 2004).

European Regional Committee resolution EUR/RC58/R4 on Stewardship/governance of health systems in the WHO European Region endorses the Tallinn Charter: Health systems for health and wealth (see www.euro.who.int/document/e91438.pdf). Both the Charter and the resolution address action by health systems on socially determined health inequities and call for intersectoral collaboration to address the broader social determinants of health as well as emphasizing universal access to health promotion, disease prevention and health services as a fundamental means of achieving equity in health (Organisation for Economic Co-operation and Development, 2005). The resolution calls for WHO to support ministries of health in developing skills for leading intersectoral efforts throughout government to address the broader determinants of health.

Two examples of technical assistance and collaboration between EURO and Member States in addressing health inequalities include the European forum on tackling the social determinants of health and reducing health inequities and a technical consultation held as a follow-up to resolution EUR/RC52/R7 on Poverty and health. The European forum, hosted by the United Kingdom in March 2007, brought together Member States, the European Commission and the World Bank to address a number of questions with regard to priorities in increasing policy and programmes to reduce socially determined health inequities across Europe. One outcome of the forum was the European Policy Learning Programme on Social Determinants of Health, based on priorities identified at the forum (see www.euro.who.int/socialdeterminants/invest/20080918_5).

The technical consultation on poverty and health included a review of more than 20 case studies of policies and interventions to improve the performance of health systems in addressing the problems of socioeconomically disadvantaged groups (such as Roma, immigrants, children living in poverty and people furthest from the labour market). It provided a platform for joint reflection on actions to be taken at national and subnational levels, lessons
learnt, policy implications for health systems and the role of health systems in influencing action on social determinants, such as poverty, unsafe employment conditions and social exclusion (see www.euro.who.int/socialdeterminants/poverty/20071106_2).

A number of presidencies of the European Union have addressed the social determinants of health and health inequities, including those of Finland, Sweden and the United Kingdom, with *Tackling health inequalities* (United Kingdom, October 2005), *Health in all policies* (Finland, October 2006) and a plan for increasing labour and employment opportunities (Sweden, 2009). The Spanish Presidency of the European Union during the first half of 2010 will include among its health priorities the monitoring of social determinants of health and reduction of health inequities. In October 2009, the European Commission issued *Solidarity in health: reducing health inequalities in the European Union* (Commission of the European Communities, 2009), with the objective of supporting and complementing actions by Member States and other stakeholders to tackle health inequalities. The communication identifies five means of strengthening existing actions:

- equitable distribution of health as part of overall social and economic development;
- improved data and knowledge bases and mechanisms for measuring, monitoring, evaluation and reporting;
- building commitment across society;
- meeting the needs of vulnerable groups; and
- defining the contribution of European Union policies.

### 1.3 National action plans to reduce health inequalities in the European context

Of the participating Member States, one third have a national action plan with a focus on reducing health inequalities, and just over half have social determinants or health equity incorporated into their existing national health plan or public health approach and are looking at ways to strengthen this aspect. The remaining participating Member States were examining how to get health inequalities on the agenda.

### 2. The seminar

The 2-day seminar was organized by the Ministry of Social Affairs and Health, Finland, in cooperation with the WHO European Office for Investment for Health and Development, Venice, Italy. It drew on the final report of the WHO Commission on Social Determinants of Health and work by EURO with 12 Member States in reducing health inequities through national plans of action. The programme of the seminar is given in Annex I.

#### 2.1 Objectives of the seminar

The main objective of the seminar was to provide a forum for Member States to exchange experiences and explore lessons and issues in country actions in developing, implementing and sustaining national programmes for reducing health inequities. The specific objectives were to:

- identify progress in making social determinants of health and health inequities a priority in national policy,
- report any lessons that had been learnt and
• determine national policy issues and areas in which more work is needed.

### 2.2 Seminar participants

The seminar was attended by nearly 50 participants from 11 European Member States: Estonia, Finland, Lithuania, the Netherlands, Norway, Portugal, Serbia, Slovenia, Spain, Sweden and the United Kingdom (England and Scotland). They included policy-makers, civil servants and researchers as well as experts from WHO and the European Commission. A full list of participants is given in Annex II.

### 2.3 Resources for the seminar

A website was established before the seminar to give participants background information, recommended reading and links to relevant country websites containing national plans of actions, as well as publications by WHO, the Finnish Ministry of Social Affairs and Health and the European Union. The presentations are available on request from the Venice Office by email to info@ihd.euro.who.int.

### 3. Content of the seminar

The Member States represented at the seminar are at different stages in the action continuum. Some are just beginning to place socially determined health inequities on the policy agenda and preparing action plans, while others are 2 or more years into implementing national action plans or monitoring and evaluating impact and progress. In order to facilitate exchanges of knowledge, the seminar included presentations and exchanges on:

- the ways that ensuring health equity as a government responsibility is being translated into practice at country and regional levels and whether these methods are consistent with the findings of the WHO Commission on Social Determinants of Health;
- enhancing and ensuring commitment and public support for placing social determinants of health on the policy agenda and preparing a plan of action;
- using ‘health in all policies’ as a theoretical framework in political decision-making and translating this important value and mandate into action;
- devising policy to address health inequities in a range of different structures and contexts; and
- addressing the challenges and opportunities of advancing health equity policies.

The Minister of Health and Social Services, Paula Risikko, welcomed the participants to Finland and explained that while average health had improved significantly over the past decades in Finland, large inequities remain by gender, region and social group. When the current Government took office in 2007, it established an intersectoral policy programme on health promotion, which seeks to reinforce the structures of health promotion, achieve life-style changes, develop healthy working and living conditions, strengthen basic social and health services, develop new working patterns for health promotion and reinforce the activities and role of nongovernmental organizations. The Ministry of Social Affairs and Health (2008) has launched an intersectoral plan of action to reduce health inequalities in 2008–2011. The priorities of the action plan are social policy measures, strengthening the prerequisites for healthy life styles, improving the availability and quality of social and health-care services for everyone, and improving data for evaluation and follow-up.
3.1 Health equity in all policies

This section describes perspectives on strengthening health equity through the ‘health in all policies’ approach. This includes moving from theoretical concepts to identifying the practical implications of health in all policies, what it means in practice, the possible opportunities, perceived challenges in implementation as well as possible solutions. Other considerations are reviewing income-related health inequity, the responsibility of public policies to choose and implement the right interventions and positive discrimination as a response to health inequities.

Professor Leppo said that, despite success in reducing mortality and raising life expectancy and inclusion of an equity target into many national programmes 20 or 30 years earlier, a social gradient has persisted. For example, in Finland, despite increased life expectancy and drastic reductions in deaths from cardiovascular disease over the past few decades, there are striking differences by social class. After explaining the Finnish structures and processes for integrating health in all policies, he said that intersectoral health policy-making often calls for long-term strategies and commitment. Time and the timing of actions are important: action should be taken when the political situation is favourable, perhaps spreading interventions over time. In the late 1960s, Finland had the highest mortality from chronic diseases in Europe; however, a dynamic phase of policy development starting in the 1970s, with emphasis on primary health care and health promotion and the first national Tobacco Act in the world, resulted in remarkable reductions in mortality rates. Finland also has long experience in incorporating nutritional aspects into agricultural policies and the food industry. Nevertheless, social gradients in health remain. The solution to such inequities is stronger positive discrimination in the context of universalism. The health in all policies approach does not necessarily mean financial investment. On the contrary, increasing taxes on products that are harmful for health increases both revenues and health.

Professor Casanovas noted that, given the influence of income and wealth as social determinants of health and health equity, public responsibility policies should be monitored to identify the causes and the most cost–effective interventions. At the present stage, the target should not be more social spending for income redistribution but poverty alleviation, job maintenance and sound job creation. Target selection and positive discrimination rather than pure universal access should be the aim, with tailor-made policies for selected groups and monitoring from an integrated perspective.

In general, gaps in health are not mainly due to gaps in access to health care. Family and environment in the early years are predictive of adult outcomes, including health. In the USA, 40% of early deaths were estimated to be due to behavioural patterns, 30% to genetic predisposition, 15% to social circumstances and 10–15% to shortfalls in medical care. Currently, however, about 95% of the money spent on health is for treatment, not prevention. As behaviour is shaped by ability and motivations early in life, intervention programmes to encourage positive traits should form the framework for interrelated policy interventions in health, education and employment.

Income-related health inequality is related to mean income through income elasticity (how mean health responds to proportional income growth and how income elasticity varies with level of income), income inequality (the effect of mean income on the elasticity of factors other than income) and income rank (income-related inequalities in determinants such as age and how they concentrate in social groups). In general, people’s social background and their parents’ health are not the individual’s responsibility and are consequently the first targets of policies to reduce inequality, even though they are difficult to address. In Spain, the labour market has been restructured to keep jobs in companies, by giving subsidies to employers rather than cash benefits to the unemployed, reducing taxes for working families and raising
public revenues not just from taxes. Legislation to control unhealthy nutrition and tobacco and alcohol use represents a new libertarian paternalism, the aim being not to raise tax revenues but to act as a deterrent, to reduce this type of individual expense.

Some participants stressed the importance of the definition of behavioural choices, as behaviour is often largely determined by socioeconomic and cultural conditions and does not represent free choices. It was also considered that positive discrimination should be based on identified gaps in universal health-care systems. Another form of positive discrimination could be to stop negative discrimination against the people who need health care the most. The current financial crisis will not affect public health care, as there are mechanisms for social transfer among different groups. Taxes on harmful products were discussed, and it was agreed that making it difficult to be unhealthy is effective. As the health system encompasses health care, public health and ‘health-for-all’ policies, a strong, adaptable, sensitive universal health-care system must be built on intersectoral actions.

### 3.2 Getting health inequity onto the policy agenda and preparing national action plans

How does the process of getting health inequity onto the policy agenda begin? How can commitment for developing a national action plan be ensured? What are the potential promoting and preventive factors? What steps should be made to take the work forward? These questions and others were discussed in the seminar. Experiences and perspectives from countries with established programmes and action plans for tackling health inequities are presented here, with reflections from countries that are at an early stage of including the reduction of health inequities as a specific aim at different policy levels.

Senator Keon reported that Canada has one of the developed world’s highest infant mortality rates and high mortality due to diabetes and diseases of the musculoskeletal system. The country ranks only ninth among 21 industrialized countries in terms of child well-being. On the Euro-Canada Health Consumer Index, Canada placed last out of 30 for ‘best value for money spent’. A series of reports was prepared to investigate the causes of these poor outcomes, which showed that place of residence, income and early education are important determinants. The fourth report outlined a population health policy and helped to launch a debate on the role of the Federal Government in reducing health disparities. The final report (Standing Senate Committee on Social Affairs, Science and Technology, 2009) proposed a new style of governance, with leadership from the top (the Prime Minister, the premiers of each province and mayors) to ensure a health perspective in all new policies and programmes, including setting up cabinet committees on population health at Federal and provincial level.

In order to take the work forward with the population health approach, health impact assessments will be used to consolidate a sound database and research infrastructure; a population health information system with longitudinal capacity for following the human life course will be established. As most determinants of health are local, local governments will help citizens to build strong, inclusive communities through intersectoral collaboration, including businesses. First Nation, Inuit and Métis peoples are a priority, as their life expectancy is half that of the rest of the Canadian population. All provinces have adopted or are adopting poverty reduction strategies, and the British Columbia ActNow model is recognized internationally as an important example of good practice.

Director Tapani Melkas from the Finnish Ministry of Social Affairs and Health described the preparation of the Finnish action plan to reduce health inequalities. The Plan was prepared for the period 2008–2011 and is being implemented. He highlighted the importance of political support, which is based on the strong value placed on equality, also reflected in the Finnish Constitution, and the evidence of inequality and its implications on public health and
economics. In addition to strong political commitment, which is reflected in the Government programme, he also stressed the importance of an intersectoral process, with wide participation as the key to success. The Finnish plan of action contains five long-term action lines: (1) social policy actions to prevent social exclusion, (2) influencing life style through policy, (3) developing social and health-care services, (4) monitoring health inequalities and (5) strengthening knowledge, information, education and communication. In addition, 15 priorities are to be implemented during the term of the Government.

In the first Scottish policy on equality in health (The Scottish Government, 2008), a ministerial task force on health inequalities, with representatives of seven ministries and the private sector, identified the priorities for intersectoral Government activity, building on evidence to identify practical measures with a measurable impact. At the end of the past century, life expectancy in Scotland was the lowest in western Europe, with eight local authority areas accounting for most of the problem. As well as this geographical difference, studies showed that there was a generational effect: people’s health was affected by the social class and behaviour of their parents. The criteria for deciding on priorities include the degree of inequality in health outcomes, the effectiveness of current and planned action, the feasibility of implementation from the point of view of cost, time and existing organizations and whether the outcome is measurable. The priorities for health outcomes are children’s very early years, mental illness and well-being, cardiovascular disease and cancer, drug and alcohol problems and links to violence. The principles include engaging the individuals, families and communities most at risk for poor health in services and decisions relevant to their health. The present Government has made a strong political commitment and has established intersectoral involvement and concordance between national and local governments. It will reconvene the task force to review and monitor progress.

In Sweden, systematic support for regional and local capacity began in the 1980s, when public health came back onto the agenda with the revival of the ‘health for all’ approach. Professional training in public health started in 1986. Between 1997 and 2000, a national public health commission consulted widely at all levels of society to set policy, with high-level political involvement. The commission defined the health objectives and determinants to ensure good health for the entire population as an overarching aim. A minister of public health was appointed in 2002, with a high-level steering committee, and public health has been integrated into the ‘daily business’ of more than 30 national agencies. The indicators for monitoring and evaluating the policy are agreed by involved national agencies and in principal accepted by local municipalities and regional councils to form the basis of a public health policy report, to be delivered by the Government to Parliament once every fourth year from 2005. The indicators must be strongly correlated to health, be valid and meaningful, be adaptable to policy decisions, be relatively inexpensive to administer, and be stratified by sex, age, type of family, geographical level, socioeconomic group and ethnicity, when possible.

In Estonia, the national health plan published in 2009 is the first to address health inequities. Its central objective is to ensure that the people of Estonia live longer, happier and healthier lives, and the focus is on improving not only life expectancy but also the quality of life and the distribution of health outcomes. The process of getting the issue onto the policy agenda stresses the importance of raising awareness, identifying determinants and setting priorities. All future reports on life expectancy, for example, will include information on access to health in different groups. Currently, the Government is monitoring the success of the plan, and Parliament will discuss health determinants within the next 6 months.

Some European countries, such as Portugal and Serbia, are in early stages of getting health inequities onto the agenda. Serbia is a society in transition, and a study by the World Bank showed that most people living below the poverty line are in the Roma community or refugees. In 2003, the Government established a multisectoral commission for poverty reduction,
involving civil society, the media and nongovernmental organizations and is now trying to extend the scope of this committee by involving other ministries.

There is no specific action plan for addressing health inequalities in Portugal, but the Ministry of Health participates in programmes on the issue. Interministerial committees have been set up for specific areas, such as mental health and cancer. Regulations on data confidentiality make it difficult to monitor the distribution of health outcomes from the national health plan, and Portugal is seeking ways to improve data availability for monitoring health inequalities. The Ministry also aims to enhance and support public discussion on its website as well as in community councils of teachers, church representatives, municipalities and patient groups. A national forum is to be held in March 2010.

Some participants in the seminar considered that the pressure of a deadline for launching a programme or action plan is helpful, whereas others considered that time must be given for the resolution of controversial issues, the existence of controversy being useful to ensure that the issue stays on the political agenda. Opportunities must be seized as they arise. Therefore, it is essential that the necessary evidence be ready and up-to-date, so that it can be used in an action plan, or recommendations for action can be prepared quickly. Some countries are not at this stage; for instance, they have no system for collecting information for minimum equity surveillance, let alone for linking and interpreting such data. Others have the data but are unable to use it as needed. In addition, finding funding for generating evidence on social issues such as health inequality can be difficult. Some countries rely on funds from nongovernmental or other organizations. In Portugal, for instance, some work on health strategy development is financed with the proceeds of the European Lottery Guild.

### 3.3 National action plans: implementation and sustaining the effort

This section summarizes presentations by participating Member States with long-term experience in incorporating health equity targets into national policies and plans of action. The main issues covered were the challenges to applying the principles of reducing health inequities into action, setting targets and involving other sectors.

In England and Wales, life expectancy at birth by social class improved between 1977 and 2005. Nonetheless, inequalities remain. For example, access to health services is both a social determinant and affected by other social determinants, such as income, employment, lifestyle, housing, education, the severity and duration of a health condition, age, gender, ethnicity, deprivation, the national and local policy context and the availability of resources. Measurement of health inequalities in England has a long history, and major public health reports, including the Black Report in 1980 and an independent inquiry into inequalities (the Acheson report) in 1998. The Acheson report gave a range of recommendations for future action. *Tackling health inequalities: a programme for action*, released in 2003, set out a programme of action to achieve the 2010 health inequalities targets announced by the Government in 2001 for closing the health gaps in life expectancy and infant mortality between different social, economic and ethnic groups and geographical areas.

In 2004, the Spearhead Group was established to focus on the 70 local authority areas with the worst indicators of health and deprivation. There have been successes and some challenges. Monitoring and follow-up of the targets highlighted the challenge of setting a target that encapsulates the complexity of health inequalities in a simple, meaningful way. A post-2010 strategic review is being undertaken by Professor Sir Michael Marmot with the aim of identifying the evidence most relevant to future policy and action to respond to health inequalities in England, to show how the evidence can be translated into practice and to recommend possible objectives and measures, building on the experience of the current public
service agreement target for infant mortality and life expectancy. At the same time, global factors, such as the current economic crisis, climate change and changing demographics, will continue to affect England’s capacity to tackle health inequalities. For example, England and Wales, like many other western European countries, are faced with the challenge of a large number of unemployed young people as a result of the economic crisis. Therefore, policy responses must take into account wider global factors in a coherent way, for instance taking care that policy responses to stimulate employment and productivity do not have an adverse impact on the environment.

The national strategy to tackle inequalities in Norway consists of a combination of measures directed towards the entire population and social structures for disadvantaged groups. In 2007, the Government issued a strategy to address social inequalities in health, with measures for income distribution, childhood (including education), the labour market, working environments, health behaviour and health services. The attitude of the Government towards health equity has changed, from little emphasis on the issue to making it a top priority since 2007. The intersectoral policy involves both technical and political meetings of representatives from seven ministries. The Government has committed itself to implementing the findings of annual policy reviews, in cooperation with the relevant authorities, and to reporting annually on indicators of progress for each of the 20 or more objectives in the strategy for 2009–2017, with feedback for future policy. In the policy reporting system, six intersectoral working groups have been set up to report on implementation and indicators. With greater recognition by the Government, regions and municipalities have become more active, and a new Public Health Act makes regions and municipalities responsible for actions to reduce health inequalities. The determinants approach has thus been used as a window of opportunity for intersectoral action.

In The Netherlands, the aims of a national programme on health inequalities at the beginning of the 1990s were to generate better knowledge about the size and nature of socioeconomic differences in health and their determinants and to develop and evaluate interventions and policies to reduce socioeconomic inequalities in health. The results were used to set a quantitative target: to raise the healthy life expectancy of the lowest socioeconomic groups by 2020 by at least 25% of the current difference in healthy life expectancy (about 3 years).

In 2003 and 2006, The Netherlands Court of Audit ordered the Minister of Health to establish policy instruments to allow achievement of the Government-agreed goal. It was found that interventions to improve lifestyle were not specifically targeting lower socioeconomic groups and that the relevant policy instruments (e.g. a plan to tackle socioeconomic inequalities) did not exist. The responsibility for interventions to tackle health inequalities was then transferred to the large cities, which chose to focus on reducing overweight among the young. In December 2008, an integrated policy was presented, including prevention and decentralized action, but the plan had no quantitative targets and no links with other Government health targets and was still focused on lifestyle.

As a result, four local councils were asked to review the plan to identify realistic targets. They recommended that the policy emphasize decentralization, thus involving local councils and municipalities in, for example, reducing school drop-out rates, supporting low-income households, integrating migrants and creating a healthy living environment. They also recommended that an intersectoral directorate of health policy be established, with a budget and concrete objectives to improve the health of disadvantaged groups. A policy for dealing with health inequalities was thus drawn up, with a broad, inclusive definition of such inequalities and a focus on integrated action, prevention and decentralized implementation. There is still room for improvement, as the strategy should be linked to other Government targets, and links should be made between lifestyle and social determinants.
An intersectoral approach to a national development strategy can reduce inequalities in health care while at the same time preserving the environment, for instance. Other speakers echoed the importance of action at municipal level. The role of ministries of health is to provide advocacy, leadership, guidance and assistance and to show initiative in incorporating health equity into other policies and interventions. Solid public health capacity is crucial. When interventions are planned and implemented, targets should be defined, with clear planning and sources of stable financing, and their achievement should be facilitated. In some countries within the European Region, training in public health is needed, and data collection remains a challenge for all sectors. As politicians want visible results, such as the effects of a particular policy approach on mortality, it is important to be able to link data collection and analysis closely to policy goals and to be able to attribute the change readily to the action. Participants also noted that all data can be useful: if you can show one municipality that another one is doing better, the first will be stimulated to act.

It was emphasized that the language used by other sectors could be used for public health advocacy and for communicating key messages about acting on inequalities. A number of speakers raised the challenge of communication with policy-makers, for instance with respect to terminology and the types of arguments that appeal to them. Equity is not understood or interpreted in the same way in all Member States; it is therefore important not to use different terms for the same issue or intent and to reconsider the language and arguments that could be used to make the case for action on equity or solidarity. One argument might be that poor health threatens the labour force of the future. Economic arguments however need to be balanced with arguments for improving quality of life and improving well-being in general. Positive examples are the best tool.

3.4 Tools and approaches

EURO is preparing an action guide on addressing socially determined health inequities. It will identify practical policy actions that are being and can be taken across the WHO European Region to implement the recommendations of the Commission on Social Determinants of Health. The purpose of the guide is to identify, describe and briefly analyse practical policy and programme interventions to address socially determined health inequities and raise the health status of less privileged groups to the levels of health and well-being that have been achieved by their more privileged counterparts. It will include reviews of different conceptual tools and models, explore possible entry points and consider strategic issues related to, for example, health system functions, governance, intersectoral work and public engagement.

National action on the social determinants of health and health inequities must involve the whole government, civil society and local communities, business, academia and international agencies. Furthermore, policies and programmes must embrace all the key sectors of society. On the basis of these assumptions, the guide should serve a wide range of European governments, policy-makers, planners and advocates. The key roles of decision-makers and advocates working in ministries of health, the health system and health sector are highlighted. In addition, the guide should be useful for nongovernmental organizations, civil society organizations, donor agencies and national and European institutions working to improve health.

In order to initiate a broad consultation, the action guide was presented at the seminar. Key points of the feedback and input given by the participants are summarized and presented below.

Concepts and theories. In many European countries, achieving a common language for reducing health inequities has been considered. In order to promote cross-sectoral use of the action guide, more attention should be paid to concepts and presenting practical cases.
Politicians in different parties have different views of health equity: some consider that bringing the status of less healthy people closer to that of people who already enjoy better health leads to the socialization of society. This also means that arguments should not be tailored for one political group but that several arguments should be prepared in advance.

The participants discussed the notion of well-being, which fits into a broader government agenda, going beyond the health sector to include education and development. Quality-of-life years is a wider concept than life expectancy, and calculations of how much ill health can be prevented lead to practical results, such as what services can be released if they are concentrated on certain sectors. These are arguments for intersectoral work and demonstrate the resources that can be saved by immediate action.

How will a society change; what kind of theories do we have; what kind of theories we need? Conflicts were considered powerful promoters of change; theories of behavioural change should therefore be taken into account. Europe is heterogeneous, and not only different parties but different countries might view ‘equality’ differently. It was proposed that the action guide pay more attention to defining the social environment and include examples of relevant actions. New ways of thinking about social capital could be better reflected in the guide.

Inequities at the local level should be addressed by municipalities, which combine social and health services to address quality of life. In Canada, the ‘state of well-being’ of communities is measured with tools developed by and in collaboration with communities, and the communities themselves determine the actions to be taken. One example of an innovative information system, the Community Accounts, is used in Newfoundland and Labrador, Canada. A public-wide, online data retrieval system provides citizens and policy-makers with a reliable source of key social, economic, and health data and indicators. With the ‘Well-being account’, it allows users to generate data and compile indicators to increase their understanding of the factors that determine the status and progress of their communities and regions.

**From frameworks to action.** The three main areas for action in the draft action guide, as recommended by the WHO Commission on Social Determinants of Health, are improving the conditions of daily life; tackling the inequitable distribution of power, money and resources; and measuring the problem, evaluating action, expanding the knowledge base, training a workforce in the social determinants of health and raising public awareness. The participants considered that better links should be made between those issues.

The guide should specify at which levels of society different strategies and models are relevant, and which measures and actions should be undertaken, by whom, why, in which context and setting and when, with regard, perhaps, to the Millennium Development Goals and reviews of legislation. The conceptual framework of the Commission should be expanded to include welfare regimes and all areas of influence, not just lifestyle and social services. Citizens should be empowered to take care of their own health and well-being on the basis of information provided by the public sector. Intersectoral committees are useful, but the process must be democratic, with transparent discussion, such as parliamentary debates.

Other action areas to be addressed are the accessibility of health service systems; social inclusion, social capital and social unrest; healthy ageing without disabilities; urban renewal; health promotion in schools and at the workplace; and research, with emphasis on evaluation. With regard to health-care financing, performance-related payments could be considered, with user fees and increased prices for some drugs. Monitoring should include community health profiles, covering all determinants.

The participants agreed that information is needed on the process of developing a national action plan to reduce health inequities; this should be covered more fully in the action guide. Also, it should help policy-makers to set objectives and to consider the sustainability of measures more profoundly: some participants commented that the current way of life is
unsustainable. Finally, participants commented that new, innovative ways should be sought for presenting health inequity data, which could be reviewed in the guide.

### 3.5 Health equity in all policies

The aim of this session was to examine health and health equity in all policies. Three main strategies for health and health equity in all policies were introduced: (1) the health strategy, in which health objectives remain at the core of the interaction; (2) the win–win strategy, in which the key is finding mutual benefit; and (3) the cooperation strategy, in which the emphases are on the aims of the other sectors and on establishing interaction.

There are at least three prerequisites for setting intersectoral policies for health equity. The first is the availability of knowledge and understanding about health and its distribution and about the links between policy, determinants and health equity. The information should also be used to monitor and evaluate policy-making and to make policy-makers accountable for their decisions. The second is the availability of knowledge about how the situation can be changed. Thirdly, there must be a political will to make health equity-friendly policies. We should be able to use suitable moments, or we should be able to create such moments. This involves negotiation and networking with people in other sectors, other stakeholders and political entities, taking into account similarities and differences in values and aims.

It is important to ‘get out of the health box’, to establish and maintain health equity as a policy goal and in practice, identify and anticipate policies with major implications, communicate the implications of health equity so that explicit actions are taken and establish proper structures and processes for successful interaction, taking advantage of windows of opportunity.

The session approached these issues, first by inviting experts from other fields to address them and then having a panel discussion on local health-in-all-policies approaches in Finland. To address the first aim, Mr Martin Terberger, Director of the Pharmaceutical Unit of DG Enterprise at the European Commission, and Mr Fintan Farrel, Director of the European Anti-poverty Network, were invited to speak. Unfortunately, Mr Farrel could not attend. In the European Union, pharmaceuticals are dealt with by DG Enterprise, mainly as part of industrial policies and internal markets. The Commission’s role is to propose and implement legislation on the authorization and surveillance of medicines and on pricing procedures, coordinate actions of Member States, promote and conduct research and ensure international collaboration. Equity in pharmaceutical policies has been seen in the context of diminishing differences between Member States with regard to indications, contraindications, warnings, safety and the availability of medicinal products. The Commission has been concerned about delays in authorization and pricing decisions, as well as differences in health technology assessments. So far, the Commission has not otherwise considered ‘equity’ or ‘fairness’ in Member States in pharmaceutical policies.

Mr Terberger stressed that the pharmaceutical industry is a complex, globalized system. Whereas most innovations are made in Europe and the United States, most clinical trials are conducted in China, India and the Russian Federation. About 90% of pharmaceutical ingredients are produced in China and India, but the products are put together in Europe and the United States. The interests of industry have to be protected, as innovation is very costly. A coherent strategy is needed to ensure a true common market in high-quality medicines, to complement national legislation. The Commission has launched a debate on the future strategy for the pharmaceutical sector, to ensure safe, innovative, accessible medicines, and negotiations are ongoing on legislative measures to address certain regulatory challenges.

The Commission’s health mandate is to “strive for a high level of public health protection”. In the new Lisbon Treaty, ensuring high standards of quality and safety of medicinal products is mentioned in Article 168, and this will strengthen the health aspect of pharmaceuticals.
Eeva Kuuskoski was Minister of Social Affairs and Health at the time the ‘health-for-all’ strategy was adopted but is now Director of an umbrella nongovernmental organization, the Association of Voluntary Health, Social and Welfare Organizations. As she has experience from two angles, she stressed the need to formulate a problem and its response very clearly, so that ordinary people can understand it and what should be done. Furthermore, it is important to understand what, concretely, is meant by ‘social determinants of health’. Some nongovernmental organizations have diverse objectives, but some work with the most vulnerable groups, such as homeless people, alcoholics and drug addicts.

Petri Kervola, Healthy Kuopio project, described the main lessons learnt from the ‘healthy city’ project established in 2002. One of the major strategies in establishing the programme was to base it on cooperation, not only between public sectors but also between the city, the university, companies and third-sector organizations.

Seppo Koskinen, Finnish National Institute of Health and Welfare, spoke about the information systems that have been or are being built to facilitate evidence-based policy-making. The Institute has many projects to set up systems for collecting, analysing and presenting data in a format that allows policy-makers to obtain information on their own population and to compare it with that for other Finns, with explanations about what the data mean and what can be done with them. The data cover health outcomes, health determinants, health promotion and health service activities. He stressed the need to present arguments in such a way that they make sense to decision-makers. For example, emphasizing only ethical aspects does not necessarily work, and aspects such as financial implications should also be stressed. He said that focus should be trained simultaneously on both the social gradient and vulnerable groups.

Some participants re-emphasized the need for clear information and for communicating it so that it makes sense to a particular audience. For example, in some countries, the word ‘equity’ has less positive connotations than in others, while socioeconomic development may be considered much more positively.

4. Summary and discussion

How can common ground be created in the complex policy environment? Much discussion at the seminar centred on the challenges and the possible entry points and actions for getting and maintaining health equity on the political agenda. The participants agreed that improving understanding of the importance of taking social determinants of health and health equity into account in developing national structures for policy-making is essential. The participants’ perspectives on the issue are illustrated in Figure 1.

Other themes that emerged during the seminar are summarized below.
A heterogeneity of approaches means that (while we say it all the time) one size does not fit all. This provides a rich source of knowledge on which other countries can draw.

**How long does it take to generate the evidence and make a case?** All the countries with national action plans to address health inequalities specifically (Canada, England and Wales, Scotland, Finland and Norway) had made a detailed analysis of health inequalities. Some participants emphasized that health equity activists should be ready to take advantage of windows of opportunities, i.e. be prepared to take the issue forward when political circumstances allow.

**A variety of processes should be in place to develop and get support for national action plans:** Finland had the Teroka Project and an intersectoral public health committee, which established extensive consultations to develop a plan of action; Scotland had a ministerial task force; the Canadians had a Senate Standing Committee; and in Sweden a national public health committee was established, with diverse membership. All were adapted to the country context and the original mandate but had the key elements of cross-sectoral support, engagement and consultation with all stakeholders and investment in the process.

**The arguments or incentives for action should be strengthened and consolidated.** The draft action guide has largely captured these arguments: equity as an important value and measure of our development as a society, public health effectiveness through improved coverage and reach, and the economic and social costs of not acting. One participant suggested caution in the use of economic arguments. Another incentive identified is ‘shame’, e.g. a high or increasing infant mortality rate can be ‘shameful’ for higher-income countries.

**Get the balance right.** Section 1.3 highlighted the importance of not only tackling poverty or remediying health disadvantage but also addressing gaps and the social gradient, or a combination of these. There was extensive discussion about the use of positive discrimination and achieving the right balance between universal and targeted services for improved health equity.

**Intersectoral action: we are not quite there.** Many of the issues raised in relation to intersectoral action highlighted current or previously identified problems, including creating
incentives for other sectors to work with health, changing the language used or creating a common language, and avoiding ‘health imperialism’. Rather than emphasizing what other sectors can do for health, thought should be given to what health can bring to other sectors to help them achieve their objectives.

**Build on opportunities to collaborate.** Previous European Union presidencies have provided an important foundation for much of the current work on health inequalities within the European Union. The forthcoming Spanish Presidency, with its focus on monitoring health inequalities and building on the work of the WHO Commission on Social Determinants of Health, the European Union Communication and the forthcoming Marmot review, will be important for advancing the issue.

The role of the WHO European Office for Investment for Health and Development, Venice, is to implement strategic objective 7, which is to address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive and human rights-based approaches. This includes working with Member States to translate the Commission’s findings into context-specific know-how for action. The Office provides a portfolio of services to countries to help them improve their capacity to address the social and economic determinants of health. Technical assistance is given to increase institutional (cross-governmental) and human resources, by ensuring that the ministry of health has the ‘right people’ with the ‘right skills’. The countries of the WHO European Region differ widely, all requiring different levels and types of technical assistance.

Capacity for addressing social determinants of health and health inequities depends on a number of elements: sustained policy commitment; a robust, equity-oriented health system; public health capacity, public health information systems, active intersectoral collaboration with proper structures and processes; sustained funding; high priority given to health; social capital and cohesion for health; public engagement and community participation; accountability; health intelligence; monitoring of system performance; communication and advocacy; and other elements, depending on the country. Capacity is assessed on the basis of an evaluation of the evidence for each element with regard to the current position, what should be done and by whom and the next steps to be taken. A European ‘laboratory’ is one option for tackling social determinants of health and health inequities, from problem definition to problem solving. It would have a 4–6-year programme, in which national, regional and local policy-makers work with the Venice office. Reducing health inequalities can be tackled only through alliances and strong partnerships.
References


Further selected publications and web resources

WHO


Finland


Australia


Canada


Norway


Portugal


United Kingdom


European Union


Other websites and resources
Equity Channel: www.equitychannel.net

Estonia


Lithuania
Ministry of Health, Lithuania: www.sam.lt
Hygiene Institute, Health Information Centre: www.lsic.lt
Lithuanian Department of Statistics: www.std.lt
Lithuanian Development Agency: www.lda.lt
Government of the Republic of Lithuania: www.lrv.lt

Netherlands

Slovenia
WHO Country Office Slovenia: www.euro.who.int/slovenia.
Spain


# Annex I. Agenda

## Day 1 – Tuesday 17 November 2009

<table>
<thead>
<tr>
<th>Time</th>
<th>Session</th>
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<tr>
<td>09:00–10:45</td>
<td>Opening session: Health equity as government responsibility</td>
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<td></td>
<td>Chair: Dr Pekka Puska, Director-General, National Institute for Health and Welfare, Finland</td>
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<td></td>
<td>1. Dr Paula Risikko, Minister of Health and Social Services, Finland</td>
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<td></td>
<td>Government's role in reducing health inequities</td>
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<td>2. Dr Erio Ziglio, Head, WHO European Office for Investment for Health and Development, Venice, Italy</td>
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<td>Translating the findings of the WHO Commission on Social Determinants of Health into action within the WHO European Region</td>
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### Session 1: Strengthening health equity through health in all policies approach

Chair: Dr Pekka Puska, Director-General, National Institute for Health and Welfare, Finland

1. Professor Kimmo Leppo, former Director-General of Health, University of Helsinki, Finland  
   *Finnish efforts to reduce health inequities through a health in all policies approach*

2. Professor Guillem López Casasnovas, University of Pompeu Fabra, Barcelona, Spain  
   *Health equity as a goal in a the current policy environment: prioritizing and acting on health inequities*

### Session 2: Reducing health inequity through a national plan of action

Chair: Ms Aino-Inkeri Hansson, Director-General, Department for Promotion of Welfare and Health, Ministry of Social Affairs and Health, Finland

Mr Keon, Chair of the Canadian Standing Senate Committee on Social Affairs, Science and Technology  
*Using the WHO Commission on Social Determinants of Health as a way to progress SDHI in Member States*

### Session 2a: Reducing health inequity through a national plan of action – getting health inequities onto the agenda and developing a plan

Chair: Ms Maija Perho, Director, Ministry of Social Affairs and Health, Finland

1. Finland – Dr Tapani Melkas, Director, Ministry of Social Affairs and Health  
2. Sweden – Dr Bosse Pettersson, Senior Ministerial Adviser, National Institute of Public Health  
3. Scotland – Professor Carol Tannahill, Director of the Glasgow Centre for Population Health

Panel: Facilitator Mr Clive Needle

- Serbia – Dr Ivana Misic, Assistant Minister, Ministry of Health
- Estonia – Dr Maris Jesse, Director, National Institute for Health Development
- Portugal – Professor Maria do Céu Machado, High Commissioner for Health
14:15–15:45  Session 2b: Reducing health inequity through a national plan of action – implementation and sustaining the effort

Chair: Ms Taru Koivisto, Ministerial Advisor, Ministry of Social Affairs and Health, Finland

1. England and Wales – Ms Maggie Davies, Principal Adviser, International Health Improvement, Department of Health
2. Norway – Ms Tone Torgersen, Senior Adviser, Directorate of Health
3. Netherlands – Dr Mariël Droomers, Senior Researcher, National Institute for Public Health and the Environment

Panel: Facilitator Professor Juhani Lehto, Tampere University, Finland

- Slovenia – Ms Tatjana Buzeti, Director, Centre for Health and Development Murska Sobota
- Lithuania – Mrs Viktorija Voolfson, Chief Specialist, Public Health Department, Ministry of Health
- Spain – Mr Davide Malmusi, Service for Health Information Systems, Public Health Agency of Barcelona, on behalf of the Ministry of Health and Social Policy

16:00 – 17:30  Session 3: Mechanisms and levers: the European policy response on social determinants of health – an action guide

Chair: Dr Erio Ziglio, Head, WHO European Office for Investment for Health and Development, Venice, Italy

Dr Franklin Apfel, Managing Director, World Health Communication Associates, United Kingdom

Day 2 – Wednesday 18 November 2009

09:00–10:45  Session 4: Policy-making for health equity: creating common ground in the complex policy environment

Chair: Dr Eeva Ollila, Ministerial Adviser, Ministry of Social Affairs and Health, Finland

Mr Martin Terberger, Head of Pharmaceuticals Unit, European Commission

*Health in pharmaceutical policies*

Discussion and questions: Facilitator Mr Clive Needle

Panel with policy-makers, researchers and nongovernmental organizations: Facilitator Mr Clive Needle

*Getting and maintaining health equity on the political agenda: implications for Finland and other countries within the WHO European Region*

- Mr Petri Kervola, Programme Manager, Healthy Kuopio Programme, City of Kuopio
- Dr Eeva Kuuskoski, Secretary-General, Association of Voluntary Health, Social and Welfare Organizations
- Dr Seppo Koskinen, Head of Unit, Institute of Health and Welfare

11:15–12:30  Session 5: Moving forward

Chair: Dr Jussi Merikallio, Director, Association of Finnish Local and Regional
Authorities

1. Dr Daniel Catalán, General Directorate for Public Health and Foreign Health Affairs, Ministry of Health and Social Policy, Spain
   
   Spanish Presidency of the European Union

2. Ms Nicole Valentine, Technical Officer, Department of Ethics, Equity, Trade and Human Rights, World Health Organization, Geneva

   Implications for taking forward the work of the WHO Commission on Social Determinants of Health in other WHO regions. Reflections from WHO Headquarters

Plenary discussion and questions: Facilitator Mr Clive Needle

12:30–12:45  Session 6: Closure

1. Dr Erio Ziglio, Head, WHO European Office for Investment for Health and Development, Venice, Italy

2. Ms Aino-Inkeri Hansson, Director-General, Department for Promotion of Welfare and Health, Ministry of Social Affairs and Health, Finland
Annex II. List of participants

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Dr Jorma Jarvisalo, Medical Director, KELA, Finland
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