Learning From Others

Comprehensive Health Equity Strategies In Europe

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Disparities in health are complex social and policy problems, deeply rooted in structured patterns of income, education, employment, and social inequality and exclusion. Over the past few years, the World Health Organization and other international bodies and governments across the world have developed and implemented strategies to tackle health disparities. With the European Union encouraging and providing support to their member states, many European countries have come up with comprehensive health equity strategies.

Given the deep-seated systemic roots of health inequities and the complex challenge of addressing their underlying determinants of health across many policy spheres, there is real potential for comprehensive national health equity strategies. At both a symbolic and strategic level, high-level national strategies are significant because they make health disparities a high priority. Reviewing leading European strategies, we identified key conditions for success:

- focus on the social determinants of health
- thoughtful selection of targets and design for evaluation
- mechanisms to steer and coordinate policy within and beyond governments
- strong linkages from the national to local level
- coordination among policy actors

Although many different factors and considerations must be taken into account when developing a health equity strategy for Canada, the experience and insights of other countries provides valuable lessons to be learned. Comprehensive European strategies provide many examples of ways to work toward equity through policy and programs, and demonstrate that action is possible. While driving the health equity agenda requires more than national strategies, such as continued public awareness and concern, innovation in delivering programs, and commitment from the community, together, these examples give an outline of promising directions that can be built upon.

Introduction

Disparities in health are complex problems and well documented; the health of populations is patterned on a gradient where health is better for groups with higher income, education, employment and social status. Particular populations such as women, immigrants, and indigenous peoples are also at a disadvantage when it comes to health. At the global level, the World Health Organization (WHO) Commission on Social Determinants of Health's 2008 report calls for closing the health gap both within and between countries in a generation [1]. At a regional level, the European Union (EU) has provided support to their member states in tackling health disparities, with the development of the web-based European Portal for Action. Several countries have also made reducing disparities a priority. For instance, Australia and New Zealand have focused on reducing disparities in health, particularly for native Aboriginal, Mãori, Pacific peoples, and people with low socioeconomic status [2, 3]; in the United States, policies target racial health disparities [4]. While Canada has contributed to the concept of social determinants of health, through resources such as the Public Health Agency of Canada: Canadian Best Practices Portal website [5], national policies have largely failed to address the unequal distribution of health and its social determinants [6]. Many European countries have developed national strategies as well, including the *Finnish National Action Plan to Reduce Health Inequalities 2008-2011* and *Wales' 2009 Fairer Health Outcomes for All*. In England, their Secretary of State for Health requested an independent review of health inequalities in the country, resulting in the widely influential 2010 *Fair Society Healthy Lives: The Marmot Review*. More locally, regional health authorities, public health departments, service providers and community groups have prioritized health equity.

Addressing complex policy and social problems such as health disparities can benefit greatly from the experience and insights of other countries. This paper looks for lessons to be learned from past and contemporary European health equity strategies.

Background

In Europe, the 1980 *Black Report* first generated awareness on health inequity by linking poverty to health, but the spark leading to wider action is often attributed to the release of the *Acheson Report* in 1998, which detailed health disparities in the UK. Subsequently, the UK presidency of the EU commissioned a report on health disparities in Europe [7]. The EU has remained active in promoting health equality through a series of initiatives, including projects to put together a database of information on best practices and tools to share with member states (Closing the Gap and DETERMINE). Another example is the launching of the European Portal for Action on Health Inequalities in 2011, which provides a sharing space for information, policies, and best practices on social determinants of health and Health in All Policies (HiAP) at the European Union, national, and regional levels [8]. For more information on the portal, please refer to Case Study 3.0. In addition, the European Charter for Health Equity – signed by numerous government parties, European networks, and national, regional and local organizations – expresses the concern for systematic differences in health and affirms a commitment to the values of social justice and human rights when addressing health inequities [9].

In tandem with Europe-wide activity, several European countries have developed their own national policy strategies to reduce disparities in health within their populations. These strategies are comprehensive,

involving action in many sectors and across several determinants of health. They focus on reducing disparities among social groups, emphasize the social determinants of health, and involve collaboration across government departments and local and regional institutions and organizations.

This backgrounder focuses on these European national strategies. It provides an overview of the strategies, how they are structured and what types of interventions they encompass, the main challenges encountered in developing and implementing the strategies, and key components of policy effectiveness. While the strategies vary according to national and local contexts, together their key components, successes and challenges can provide important insights for similar efforts in Canada.

Overview Of National Policy Strategies On Health Equity

National policy strategies to reduce health disparities take on different forms. Health equity strategies are primarily driven by the central government or the health ministry or department. While typically all call for action on the social determinants of health across government departments and levels, the strategies differ on the degree of focus on these determinants. Such differences are most noted on whether or not the strategy is explicitly targeted at health disparities, or if the reduction of inequality is one goal among others. For example, Wales' *Fairer Health Outcomes For All* has a sole focus on reducing health inequalities, while *Socially Sustainable Finland 2020* aims to tackle health inequalities as one goal among others. A summary of how several European strategies are positioned is shown in Table 1 below.

Table 1 National Strategies On Health Inequality		
Cross-government strategies with sole focus on health inequalities	**Central government driven**	- **England**: 2001 Public Service Agreement to reduce gaps in life expectancy and infant mortality by 2010; 2003 *Tackling Health Inequalities: A Programme for Action* - **The Netherlands**: 2008 *Towards an able-bodied society. A policy plan for dealing with health inequalities* - **Norway**: 2007 *National Strategy to Reduce Social Inequalities in Health* - **Sweden**: 2003 National Public Health Policy, updated in 2007 **Wales**: 2009 *Fairer Health Outcomes for All – Reducing Inequities in Health Strategic Action Plan*
	Health department driven	- **Finland**: 2008 *Finnish National Action Plan to Reduce Health Inequalities 2008-2011* - **Ireland** (All Ireland): 2008 *Tackling Health Inequalities – An All-Ireland Approach to Social Determinants* - **Northern Ireland**: 2002 *Investing For Health; A Healthier Future: A Twenty Year Vision for Health and Well-being in Northern Ireland 2005-2025* - **Slovenia**: 2005 *Health Promotion Strategy and Action Plan for Tackling Health Inequities* - **Scotland**: 2008 *Equally Well Report of Ministerial Task Force on Health Inequalities; A Fairer Healthier Scotland: Our Strategy 2012-2017*
Cross-government strategies with health inequalities as one focus among others	**Central government driven**	- **Finland**: 2011 Programme of the Finnish Government - **The Netherlands**: 2007 Coalition agreement to employ prevention policies to reduce socioeconomic gap in life expectancy - **Northern Ireland**: 2007 government priority of working for healthier people - **Scotland**: 2007 government wide goal to make Scotland healthier, especially in disadvantaged communities - **Sweden**: 2003 Public Health Objectives Bill - **Wales**: 2007 *One Wales: A progressive agenda for the government of Wales*; priorities include health and justice; *Our Healthy Future*
	Health department driven	- **Belgium**: 2003 *Flemish Decree on Preventive Health Care Policy* - **Czech Republic**: *Health 21* - **Estonia**: *National Population Health Plan 2008-2015* - **Finland**: 2001 *Health 2015; Socially Sustainable Finland 2020: Strategy for Social and Health Policy* - **Norway**: *National Health Plan for Norway 2007-2010* - **Poland**: *National Health Program 2007-2015* - **Ireland**: 2001 *Quality and Fairness: A Health System for You*

Health in All Policies (HiAP) is an increasingly common approach in many health equity strategies that aims to strengthen the link between health and other policies. HiAP is based on the conclusion that health inequalities are shaped by the broader determinants of health that cannot be addressed through health care alone, that health is a shared value across all sectors, and that the health and well-being of citizens should be taken into account when developing and implementing polices across government policy spheres [10].

More generally, a number of other social determinant-relevant national strategies have been developed in ministries outside of health, either with a goal of reducing social inequalities or improving conditions for disadvantaged groups. These include initiatives on equality of education (Ireland, Norway, England), employment (Northern Ireland, Slovenia, Norway, England, Spain), environment (Scotland), urban and regional planning (Wales, Netherlands, Norway), neighbourhood renewal (England, Northern Ireland, Netherlands, Estonia), and poverty and social inclusion (Czech Republic, Estonia, Ireland, Germany, Norway, Slovenia, Belgium, Poland, Northern Ireland, Spain, England, Finland, Scotland) [11]. Because these address key social determinants of health, their framing and implementation can also be relevant for health disparities.

Goals Of Health Equity Strategies

While all strategies aim to reduce disparities in health, their goals and approaches vary. The issue of disparities may be framed as a problem of disadvantaged groups, a gap between disadvantaged groups and the rest, or a problem across the gradient of the entire population [12]. These different conceptualizations of health disparities may result in different policy approaches and outcomes. For instance, Graham suggests that improving the determinants of only the most disadvantaged groups rather than addressing the gradient could be insufficient in reducing health inequalities if the positive changes to the target groups are outpaced by quicker rates of improvement in better-off groups [13].

In addition, strategies can change over time. For example, over a decade ago, England's focus was on the gap between disadvantaged groups and the rest of the population. Correspondingly, one of its targets was to reduce the difference in life expectancy between disadvantaged areas and the rest of the country, and its interventions have largely been focused on these geographic areas [4]. More recently, England is placing a greater emphasis on the social gradient of health, as recommended by the *Marmot Review,* a post-2010 plan to reduce health disparities for England [14]. Norway emphasizes the gradient as well, stating that disparities affect all social classes, not only the most disadvantaged. Norway promotes an overall reduction in income inequality as the underlying means of reducing health disparity alongside programs targeting certain groups [15, 16].

Most countries state an overarching goal of both improving health overall and reducing disparities in health. Particular strategic focuses can vary significantly. Some countries such as Belgium and Norway put an emphasis on the social determinants of health [17]. Others including Finland, the Netherlands, England, and the Czech Republic aim to reduce disparities between socioeconomic groups in health outcomes such as life expectancy, morbidity, and work ability. Scotland and Iceland do not aim to reduce health gaps, but rather to improve the health of disadvantaged or vulnerable groups such as youth, older people, and people with disabilities. Uniquely, Norway and Sweden emphasize a more equitable population-wide distribution of health and its determinants [12, 15, 18].

Policy Infrastructure

The European strategies vary from those located in the health department to those run by cross-government committees or driven by the central government or prime minister. In many cases, the strategies are

developed nationally, but implemented locally and so require coordination among the different levels of government and sectors involved.

Departments And Institutions Involved

For the most part, the European strategies are led, coordinated, and monitored by the department or ministry responsible for health. Placing leadership within the health portfolio can be challenging when the health department is perceived as overstepping its reach to lead or coordinate action on social determinants of health located in other sectors such as labour or education. Some of these challenges and ways to overcome them are elaborated on further in this paper.

While health departments frequently lead, there are often cross-government committees or working groups on reducing health disparities with representatives from several ministries, as is the case in Norway, Scotland, Ireland, Finland and Northern Ireland. For example, Norway's ministry of health coordinated policy development with advisory committees of politicians and bureaucrats from the ministries of finance, education and research, labour and social inclusion, children and equality, justice, local government and regional development [19]. There are also cross-ministerial working groups for each of the strategy's intervention areas [20].

In some cases, the central government coordinates national strategies. In Sweden, the Public Health Objectives Bill was passed in its parliament in 2003, requiring all departments to take responsibility for eleven objectives aimed at creating equitable social conditions for the entire population [21].

Cross-Government Action

Whoever leads, cross-government coordination and action is common and seen to be crucial. European countries promote cross-government action on health disparities in different ways. In England, the Prime Minister's Office developed national targets as part of a cross department spending review. Their *Tackling Health Inequalities* initiative prompted eighteen government units to work collaboratively to inform health equity issues into target areas such as smoking, housing, and nutrition [22]. Although these target areas were reported on in earlier years, they have since been dropped by subsequent governments.

In Sweden, representatives from the Swedish National Institute of Public Health held meetings with directors of other departments to discuss their roles in meeting the national public health objectives as stated in the Swedish National Public Health Policy [23]. Swedish government departments also completed questionnaires on the activities within their sectors that have direct or indirect effects on health, and on proposals for future actions [24]. In strategies from England, Finland, and Ireland, responsibility for specific actions were explicitly assigned to different departments. For example, one of the actions of Finland's *National Action Plan to Reduce Health Inequalities 2008-2011* was to arrange student health services in vocational education settings. The plan specified that the Ministry for Social Affairs and Health, the National Board of Education, and the National Public Health Institute were responsible for coordinating this effort, working with local governments and education providers.

Collaboration and cooperation between different departments is demonstrated in joint programs or shared goals. For example, UK's Sure Start Children's Centres, run by the Department for Education,

combine early childhood education and family health services delivered by the National Health Service, such as the Family Nurse Partnership Program [25-27]. In Sweden, central agencies were interested in synergistic effects between their work and that of public health. For example, reducing alcohol consumption was recognized as both a public health goal and a contributor to transportation policy targets to reduce traffic injuries [24].

National To Local Linkages

In several countries such as England, Scotland, and Sweden, local governments are delegated more responsibility. In England, when the New Labour Party came into power in 1997 and set health disparities onto the political agenda, the NHS coordinated most of the strategies. More recently, there has been a reversal of action, as an increasing number of strategies are organized at the local level [28]. Local governments in Scotland and Sweden also share responsibility in reducing health disparities [11, 24, 29]. Often, health disparity strategies involve national level committees that create policy directions and local groups that implement them, sometimes supported by formal agreements between the local and central governments such as the recently abolished Local Area Agreements in England. Local implementation may be the responsibility of the health board, the municipality, or partnerships among stakeholders. In some countries such as England and Ireland, population or public health staff have been placed into local authorities or health boards.

Some countries mandate specific duties for local authorities, including developing action plans or monitoring disparities. For example, in England and Northern Ireland, local areas are required to form partnership groups who then develop and implement local plans. As of April 2013, England will establish "health and well-being boards" to delegate more power to local authorities with regards to developing and integrating health and social care for adults and children, and taking a lead role in tackling health inequalities. Further, national governments provide varying types of support to local authorities including workshops, statistical information, support teams that visit local areas, frameworks to guide development of local strategies, lists of potential local targets, and dissemination of good practices among localities. Regardless of the level of government that holds more responsibility, it is important to have open communication that allow for ongoing reviews and recommendations to be made.

Case Study 1.0: Scotland's Changing National Policy Strategies And Linkages To Local Areas

Addressing health disparities is a high priority on Scotland's political agenda, especially after the publication of the *Equally Well* Report in 2008. However, the levels of health disparities are high within Scotland's regions and municipalities, and, when compared with the rest of the United Kingdom [30]. Scotland's approach to developing and implementing health equity strategies has evolved over time. Previous strategies consisted of national authorities deciding on particular actions and local authorities reporting back to them. More recent strategies allow for more local autonomy, as national authorities set targets and outcomes, and local authorities frame and implement appropriate strategies in ways that align with community values and needs [30].

The Local Government in Scotland Act 2003 required Scottish Councils to become responsible for coordinating the planning and delivery of public services to their local communities by partnering with stakeholders and creating Community Planning Partnerships (CPPs) [31]. In 2007, Single Outcome Agreements (SOAs) between each local government and the national government were created, as a framework for ensuring that coordinated action was taken across the CPPS to tackle health disparities [32]. These yearly agreements were again drafted and signed in 2009, and will be in June 2013 as well.

Although national policies requiring local implementation are increasingly common, some EU countries lack comprehensive national strategies, or, their governments are not pressured to take action. In this case, regions with high levels of autonomy have taken matters into their own hands. Some regions in the EU have higher levels of autonomy than others due to varying political structures, administrative and bureaucratic differences, and traditions and histories which are nation-specific [33]. Regions with higher levels of autonomy, such as in Spain, Germany, and Sweden, usually have greater influences on social and health issues. Another example is in Piedmont, Italy, where local health units in the region are required, under law, to ascertain their population's health disparity levels and corresponding needs [34]. In addition, local health units support mayors to develop and implement policies traditionally outside the health care, aimed at reducing health disparities [34].

Areas Of Intervention

The programs and policies put forward in the various European strategies are diverse, encompassing interventions in the labour market, health-related behaviour, housing, health care, childhood conditions, disability support, neighbourhood regeneration, and inclusion of immigrants. The types of interventions that countries put into place may be typified as: 1) those that address the social determinants of health, 2) those that address healthy behaviours and lifestyles, and 3) those that address the accessibility or quality of health care services. In the Netherlands and Northern Ireland, their focus is more on social determinants and lifestyle, and less on the health care system. Some countries, like Finland, Sweden, Ireland, and Norway have interventions that encompass all these three types. For example, Finland's *National Action Plan to Reduce Health Inequalities 2008-2011* comprises seventeen action proposals under three priority areas: social policy measures, prerequisites for healthy lifestyles, and the availability of social and health care services [35]. Another example is outlined in the case study below.

Case Study 2.0: The North Karelia Project: Intervention To Tackle Cardiovascular Diseases In North Karelia, Finland

Finland has been ranked as one of the world's most livable countries, where citizen equality and high-quality social and health services rank high on government priorities. Although inequality levels are gradually increasing [36], the Finnish population enjoys an increased quantity and quality

of years of life, with lower rates of major chronic, non-communicable diseases, when compared with other European countries outside of Scandinavia . However, the Finnish have not always enjoyed good health. In fact, in the late 1970s, Finland had the highest cardiovascular disease [CVD] rate in the world, particularly in the region of North Karelia [37]. Drawing widespread public concern, the North Karelia Project (1972-1977) was introduced to address CVD through a community-based health intervention program involving multiple sectors and cross-collaboration [37].

The North Karelia Project is an example of a combination of the three types of interventions that countries can put in place to address health disparities. As described above, these are typified as: strategies that address social determinants of health, behavior and lifestyle, and accessibility to and quality of health care. First, the Project addressed one of the social determinants of health: access to healthy food. The Project included the collaboration of different government sectors such as health and agriculture, as well as the food industry, supermarkets, and schools to prioritize the availability of nutritious food [38]. Second, with regards to changing individuals' behaviours and lifestyle, there was an increase in widespread information to alter dietary habits, which led to a decrease in peoples' intake of unhealthy fat and salt overtime [38]. Third, the quality of health care for those with CVD and other chronic illnesses improved, as technology and research led to better treatment.

The North Karelia Project began as a five-year pilot project to assist in the development of nationwide strategies. With declines of population risk factor levels measured by population surveys and disease registers [37], the project was extended to other nearby local areas, and provided a framework and methodology for national action on CVD [38]. Today, the North Karelia Project is renowned among officials in public health and social determinants of health, and is known to be one of the first successful community-based health intervention programs.

Targeted And Universal Programs

The comprehensive strategies put forth by European jurisdictions contain both universal programs available to the entire population and targeted programs directed at specific subgroups. Some examples of universal programs include a national minimum wage and child tax credit in England, as well as a housing allowance for individuals and families below a certain income in Norway [20, 25]. Targeted programs are often aimed at specific population groups facing higher risks of ill health, such as children, the elderly, homeless people, and marginalized immigrants These programs include Norway's language promotion program in schools with at least 25 percent minority language students and the Netherlands' development of local care networks for chronic psychiatric patients [20, 39].

Geographical Approaches To Interventions

Geographical approaches to interventions – in specific neighbourhoods and communities – are common because individuals are more likely to respond to strategies if their community will benefit from them.

Several countries such as Wales, the Netherlands, and Scotland, have taken an area-based approach, aiming to reduce geographic health disparities and/or targeting interventions in the most deprived or disadvantaged areas. Some countries have chosen this route as national governments realize that health gains for the entire population will be unsuccessful unless targeted interventions aimed at tackling health inequities within their population is achieved [40]. For instance, England has noted that national health targets will not be achieved unless significant progress is made in the north-west region of the country, the area with the highest level of disadvantage [40]. In the past, England has identified the one-fifth of Primary Care Trusts (local units of the National Health Service) located in the areas with the worst rates of deprivation and early death. These so-called "Spearhead" areas have received additional funding, created local strategic partnerships with local authorities and organizations, completed comprehensive area assessments, and developed action plans and interventions to improve health outcomes [41]. Geographical approaches are not restricted to communities, but can encompass larger areas, as demonstrated in the Netherlands' national strategy that aim to tackle health inequalities in large cities, such as Amsterdam, Den Haag, and Utrecht [42].

Settings Approaches To Interventions

In addition to area-based interventions, several countries including the Netherlands, Northern Ireland, and England have also emphasized a settings approach, integrating determinants of health into specific settings such as schools, workplaces, and primary care facilities. The focus of this approach is on treating the social determinants of health comprehensively in one setting, as opposed to a single risk factor [40]. In the UK, Sure Start Children's Centres house early childhood education and advice on health and employment for families [25]. Other initiatives include promoting tooth brushing and fruits and vegetables in schools in the Netherlands, Northern Ireland, and Norway, welfare advisors in primary care facilities in the UK, and health information and referrals available at truck stops in Germany [11, 39, 43-45].

Tools And Research For Program Planning

Equity Focused Planning Tools

The integration of health equity objectives into government programs and policies outside of health is one of the most effective strategies to address health disparities, resulting in a number of countries having planning tools that promote these considerations [40]. Indeed, the use of tools such as Health Equity Impact Assessment/Health Impact Assessment (HEIA/HIAs) was a recommendation of the WHO's report on the social determinants of health [1]. HEIAs are used to determine the potential health effects of government programs on a population group, and offer recommendations on how negative impacts can be reduced and positive impacts maximized [46]. Wales has an Impact Assessment Support Unit, to support and provide advice to those who are in the process of conducting HEIAs. England has developed a Health Inequalities Intervention Tool, estimating the impact of certain interventions on the life expectancy of specific populations. Scotland has developed a model in the Health Inequalities Impact Assessment

project, currently used by NHS Scotland to improve their products and services and ensure that they reach the appropriate people [47]. Health Equity Impact Assessments have also been used in Sweden, while Equality Impact Assessments are a statutory requirement in Northern Ireland, aiming to make equality a concern in all areas of policy [11].

Integrating Research And Policy

Several countries have come up with ways to integrate research into the development of strategies to reduce health disparities or pilot test interventions to come up with best practices. In the Netherlands, the government funded extensive research and studied a number of pilot interventions to determine their effectiveness before expanding them [39]. The Welsh government also funded a number of action research projects, using a bottom-up approach where community-academic partnerships developed unique local interventions [48]. Finland's Project for Reducing Socio-Economic Health Inequalities (TEROKA) is run by a group of health disparities experts who develop research and tools to inform policy action [49]. Similarly, England and Norway both set up expert groups on health disparities to monitor progress or act as advisors [19, 50].

At a broader level, the European Union has been active in promoting equality in health through a series of projects that summarize evidence, record best practices, and run pilot interventions. These include Eurothine, Closing the Gap, DETERMINE, the European Review of the Social Determinants of Health and the Health Divide. These research initiatives and resources provide evidence and policy directions to motivate action on health disparities. In terms of promoting web-based knowledge, the European Portal for Action on Health Inequalities is a great resource an easily accessible if the internet is available.

Case Study 3.0: European Portal For Action On Health Inequalities

In 2011, the Health Equity Action Programme (Equity Action) launched the European Portal for Action on Health Inequalities. Funded by the EU, Equity Action aims to develop capacity building across EU Member States by developing and sharing knowledge between these countries to tackle health disparities by addressing social determinants of health, and supporting the development of effective actions at the EU policy level. The Portal provides a policy and good practices database, and is a great resource for learning and sharing information about research and evidence with regards to health inequalities in general. The website also has specific initiatives, examples of projects, and tools on Health Impact Assessments, Health Equity Audits, data and indicators. Furthermore, all this information can be searched by keywords and/or filtered by:
- The level of implementation (at the EU, national, regional scale or outside the EU)
- Country (if applicable)
- The area of work (e.g. ageing, disease prevention, gender)
- Target group (e.g. ethnic minorities, homeless people, sex workers)
- Setting (e.g. city, school, prison)

The resources and information are continually updated, and anyone can inform the site of missing information of value that can be added.

For more information on the European Portal for Action on Health Inequalities, please go to their website at http://www.health-inequalities.eu/HEALTHEQUITY/EN/home/

Outcomes, Monitoring And Evaluation

Almost all of the national policy frameworks have associated outcome targets. Several countries have quantitative targets, such as reducing differences in mortality between genders, education, and vocational groups by one-fifth by 2015 (Finland) and reducing by 10 percent the gap in life expectancy between more deprived areas and the rest of the country (England). Some countries have targets to reduce inequality in specific areas (e.g. educational attainment, smoking), but without quantifying the level of reduction (Norway, Sweden).

In most cases, countries have identified indicators they use to monitor success. These may be levels of their target outcomes or other factors associated with the outcomes. For example, in addition to its two main targets of life expectancy and infant mortality, England's *Tackling Health Inequalities Strategy* also measured a "basket of indicators" including employment, poverty, crime, and pollution [51]. In Sweden, the eleven national objectives in public health are monitored through 42 determinants, 36 principal indicators, and 47 sub-indicators [24]. Monitoring health determinants as opposed to outcomes reflects a recognition that determinants are the cause of health disparities; determinants may also be more relevant than health outcomes to ministries outside of health [24].

It is widely recognized that monitoring progress is a crucial way to determine if programs are effective and goals are being met, but countries vary in the systems they have set up and their indicators and targets. Finland and Northern Ireland both have accessible online monitoring systems specific to health disparities [52, 53]. Others such as England and Norway have made frequent reporting of progress a priority in their health disparity programs. For example, Norway's *National Strategy to Reduce Social Inequalities in Health* has a reporting system that develops indicators of the development of each of the objectives, with the results published annually from 2009-2017 [54].

Evaluations of the impacts of these strategies exist, but to a limited degree. England has led in monitoring progress on its national targets, while the Netherlands has reported on the outcomes of specific projects [39, 55]. More common are implementation or process evaluations that determine how well governments have taken up the strategies, how localities have responded, and what actions have been taken [56]. These process evaluations have largely found that effectiveness of policies depends upon having commitment from senior management, strong leadership, and engagement with local communities; hindrances included a lack of systems or infrastructure for implementation, a lack of understanding of targets at the local level, or inadequate timeframes within which to implement policies [24, 55-57].

Where outcomes have been evaluated, they have largely shown inconsistent or unclear results – improvements on some indicators, worsening on others [39, 55-60]. In other cases, monitoring has been inadequate, making it difficult to determine whether changes were due to health disparities strategies or to other factors [59].

Evaluating strategies to reduce health disparities is particularly difficult because effects may be long term and impacted upon by other policy measures over the same time period [14]. Further, each strategy contains several interventions, and even within a single intervention, there are multiple activities, making

it impossible to capture the program and its mechanism of impact in a single model for evaluation [61]. Additional barriers to evaluation arise when funding dedicated to evaluation is not provided, no comparison or control group is included, or when interventions are implemented too quickly, without evaluation built into their design [62]. Perhaps most fundamentally, policies can be changed before their potential impact can be realized. For example, the objectives of the English Health Action Zone program were transformed many times over its lifespan; the initiative's budgets were cut in the midst of implementation, the National Health Service was restructured, and the program was superseded by subsequent area-based interventions [63, 64].

Challenges

In the development, coordination, and implementation of European national strategies to reduce health disparities, several challenges have arisen. Cataloguing these challenges may be helpful in learning how to avoid them or overcome them in the future. In analyzing each challenge below, promising directions to address them are also set out.

Making And Sustaining A Commitment

While strategies make strong statements on reducing health disparities and on social determinants of health, there are important barriers to subsequently implementing the strategies effectively. Strategies must be followed up with corresponding funding, coordinating infrastructure, and staff, which has not always been the case [14, 56]. Projects are often implemented over a short period of time or an election cycle, which is not appropriate for the long term work required to reduce disparities [14, 56]. In some cases, government sectors outside of health do not see their mandates as pertaining to health and are less likely to collaborate in implementing policies [24]. Without strong senior leadership and high level support, strategies may not be implemented effectively [65]. Even when strategies have high level political support and are centrally driven, they may be fragile with the change in governments. For example, UK's 2010 change in government resulted in many changes to the NHS, including the discontinuation of health inequality targets on life expectancy and infant mortality, along with their associated support and performance mechanisms [66].

Promising directions to address this challenge:
- Generate commitment from senior management or local leaders to drive the equity agenda; 'local champions' were an integral part of leading some area-based initiatives in England [56].
- Encourage leadership from senior government officials [56]; one possible way to achieve this is by building health disparity goals into departmental and senior civil servants' deliverables.
- Make planning and goal-setting government-wide activities [67]; several countries have central steering committees with members from several departments.
- Embed and institutionalize strategies to prevent the discontinuation of programs even when different governments come into power.

- Provide adequate resources including funding, training, time, and coordination.

Staying Focused

While the written strategies may be comprehensive in addressing the social determinants of health and involving different government sectors and institutions, this broad, cross-sector emphasis proves difficult to adhere to in practice. Some countries have suffered from a "lifestyle drift" where structural determinants are neglected in favour of a focus on individual behaviours. This occurred in Sweden when a more conservative government came into power and shifted the focus of the Public Health Objectives Bill to personal choice and responsibility around parenthood, healthy eating, exercise, and tobacco [68].

A second challenge is health-system drift, where interventions tend to focus on health services rather than on other determinants [69]. This might be more likely to occur when a strategy is led by the health ministry, as opposed to a more cross-sectoral strategy like Sweden's. Similarly, ensuring that funding is used for prevention over acute care may be difficult in systems where health care costs are high. For example, in some of England's Spearhead areas, extra funds were diverted to acute care in hospitals [65].

An equal challenge in sustaining these strategies is the structure of governmental politics. Impacts on health disparities take time to become evident, but in some cases, those responsible for implementing programs felt political pressure to gain "quick wins," undermining longer-term investment in the strategies [56]. Further, programs suffer instability due to changes in government priorities or the election of new leaders. This occurred in the Netherlands when momentum built during pilot interventions was curtailed after an election in 2003; not until another new government was formed in 2007 did health disparities regain a place on the government's agenda [49, 67]. Similarly, the change in the UK's governing party in 2010 from Labour to a coalition of Conservatives and Liberal Democrats led to large changes to public policy, particularly in health. For example, the NHS system change abolished Primary Care Trusts at the end of March 2013, which were responsible for ensuring that local health and social care needs are met [29, 70].

Promising directions to address this challenge:
- Develop strategies as cross-government responsibilities, rather than under the health portfolio. For example, Sweden's strategies are central government efforts [69].
- Create short, medium, and long-term goals, with short-term actions occurring within the scope of the current government's mandate, as proposed in Scotland [71].
- Target funding specific to disparity efforts, as has been proposed in England [65].
- Build consensus with other political parties and the public during strategy and development stages, as was done in Sweden and the Netherlands [24, 67].
- Monitor and evaluate ongoing and completed strategies to build on successes and enable innovation.

Clear Objectives And Targets

While national objectives and targets are a means of inspiring policy action, there are dangers to be avoided. A narrow conceptualization of health disparities neglects the entire gradient of health disparities or misses certain population groups. When targets are directed at disadvantaged areas, they may serve to stigmatize those areas and also overlook the heterogeneity of the population both within and outside a target area [14, 59]. This issue of heterogeneity is further reinforced by the fact that affluent groups tend

to be more active within the community, resulting in a situation where interventions impact the most well off people in a given area without reaching more disadvantaged residents within and outside the area. Similarly, targets based on disadvantaged population groups may also be stigmatizing, making health disparities a problem of vulnerable groups instead of recognizing their population wide nature [12, 14, 15]. Most fundamentally, inequality has many dimensions, which may not be possible to incorporate in a single target [14].

Promising directions to address this challenge:
- Use a variety of indicators to monitor progress such as Norway's basket of indicators [14, 55].
- Emphasize the gradient of health disparities. For example, Norway's strategy opens with the statement that "A fair distribution is good public health policy" [15, p. 5].

Evaluation

Even though monitoring and evaluating strategies can be helpful in staying focused, evaluating policies to reduce health disparities is a challenging task for several reasons. Many of the potential effects are long-term, making them difficult to measure. In some cases, there is a lack of measurable indicators or inadequate indicators are chosen for easily accessible and available data. While some health disparity outcomes have been evaluated, there have been few clear positive outcomes or consistent trends. Without evaluation, it is difficult to understand whether or not interventions are working [72]. Further, outcomes may vary depending on how they are measured. For example, in Scotland, absolute improvements have been made in the most disadvantaged areas on all six indicators; however, relative inequality has only improved on three [55].

Promising directions to address this challenge:
- Consider different dimensions of an indicator such as absolute and relative measures and the scale of problems, as recommended in Scotland [71].
- Build evaluation plans into strategy development, including process indicators in addition to outcome indicators [14], as potential lessons to be learnt extend beyond the evaluation of the program's results. Other lessons include discovering the most important processes that impact the results, and when particular steps should be taken.
- Develop non-generic evaluation plans that take community and organizational contexts into account and ways that programs impact population groups differently.

Cross-Sectoral Collaboration

Working across different departments and levels of government is a considerable challenge. In health disparities strategies, there is tension between ensuring that the determinants approach is well understood by all sectors involved, without creating a perception that health trumps all other policy areas. Health departments must work with other sectors on integrating equity into their policy areas, without imposing external targets on them [19]. Non-health departments may not have knowledge of social inequalities in health, feel that their mandates do not encompass health disparities, or be reluctant to share information [24, 56]. Still, the health sector often fails to initiate collaboration [17].

In the case of area-based interventions, local health authorities and governments may not serve the same catchment areas, making collaboration more difficult [56]. In some cases, policies in other sectors

may contradict the aims of health disparity strategies. For example, in Finland, increased user fees for municipal health services are out of line with the goal of equal access to services [73].

Further, with government interest in evidence-based policy-making, connections between researchers and policy-makers are also important.

Promising directions to address this challenge:
- Locate steering committees outside of the health portfolio or in a separate population health role [14].
- Clearly define roles and deliverables for various departments, institutions, and levels of government. For example, Norway and Ireland specify which departments work on each action. At best, this should be accompanied by an expectation that actions will be taken and reported on. In Sweden, 23 central state agencies and 21 county administrative boards were required to report on the measures they had taken to reach national public health objectives [24].
- Work as a more 'joined up' government as in Scotland where a total of five government departments work on shared national objectives.
- Focus on synergistic effects between departments and the linkages between social determinants and health [24, 74]. For example, Sweden's non-health agencies asked for a booklet on determinants so that they may better understand how their work is related to health disparities [24].
- Differentiate between areas over which the health sector has control and should take lead action and those where it has little control and should act as an advisor or negotiator [20].
- Try new, innovative strategies for cross-collaboration, such as the "Large Scale Change" approach in England. Please read Case Study 4.0 for further information.

Case Study 4.0: Drink Wise North West: Rebalancing The Relationship With Alcohol With Large Scale Change Approach

In the North West region of England, alcohol related harm and deaths play a significant role in hospital admissions, and continue to be a factor in the widening health disparities in the region [75]. Working with Drink Wise North West, the NHS Alcohol Challenge Project targeted Chief Executives of Acute Trusts, PCTs, and Local Authorities in the region, and aimed to reduce alcohol related admissions by five percent in two years [75]. The project used the "Large Scale Change" Approach, a model that draws on best practices from the private, public, and voluntary sector, and requires the participation of many stakeholders and partnerships to discuss and deliver practical changes to systems, processes, and ways of thinking. Members for the Alcohol Challenge included individuals from the NHS, Local Authority, Police, Voluntary Sector, Social Care, and Housing [75]. The Large Scale Change Approach altered the dynamic of the project members, as steering committees were not setup, nor were detailed one- or five-year strategies [75]. Instead, telephone conferences ensued twice a month, and members worked on short-term plans ranging from one to three months, allowing for stricter deadlines to be met and increasing the speed of the project [75]. An evaluation of the project in September 2011 outlined that the

trends on implementation are positive; however, it is too early to determine if the project will have an effect on health inequalities in the region.

Local To National Connections

In most countries, strategies have been drawn up at the national level, but are implemented locally. In some cases, there have been challenges in supporting a connection between national policy goals and local implementation. For example, national level targets like infant mortality levels may not be relevant at the local scale where numbers are small and data is less available [14]. Localities may have inadequate policy skills to address health disparities or lack resources to monitor their progress; there may be a lack of reporting from the local to national level; there may be a lack of incentives; or localities may have a poor understanding of targets or strategies [24, 55, 76]. Further, the timelines set out in national policies may be unrealistic for local areas where partnership development, area assessments, and fund transfers take a considerable amount of time to initiate, and effort to sustain [72]. The main challenge is finding a balance between encouraging local action with strong community partnerships and engagement, while also being able to work toward national goals [65].

Promising direction to address this challenge:
- Develop communication and support systems between local and national levels such as Local Implementation Teams in Ireland.

Success Conditions

Developing and implementing strategies to tackle health disparities is not without difficulty; however, the European initiatives reviewed provide guidance on important components of comprehensive strategies and indications of how challenges can be overcome. These conclusions elaborate the key success conditions and lessons learned from European strategies.

Focusing On The Social Determinants Of Health

Successfully tackling health disparities requires the need to look beyond individual behaviours that influence health and focus on the broader social determinants, such as education, access and affordability to nutritious food, and employment opportunities. Addressing these upstream factors in a sustained manner will require changes in public policies, financial resources, and comprehensive programs. However, when incentives to drive policy and action are aligned appropriately, solutions to tackle health disparities will be easier to implement.

Thoughtful Selection Of Targets And Design For Evaluation

In order to meaningfully evaluate a program, evaluation and monitoring should be built into its initial design. A program's theory, the mechanism through which interventions are expected to improve outcomes, should inform decisions about appropriate targets, indicators and evaluation methods [61]. In this way it

is possible to determine why programs work or do not work in particular contexts, and then refine them accordingly.

Setting targets can be a valuable way to motivate policy and track progress, but they must be selected thoughtfully. Targets should be attainable in the chosen timeframe, and since effects on health disparities are often gradual, it may be useful to determine short, medium, and long-term outcomes [71]. Monitoring such targets may require that new information is measured or shared within government, and the development of monitoring systems has been an important aspect of many of the European strategies. In order for cross-sectoral action to be taken, various government departments as well as local authorities should feel that they have both a mandate and ability to reach national targets.

Mechanisms To Steer Policy

Some countries have implemented some sort of policy steering mechanism. These include setting quantifiable targets and mandating health equity as a priority in a national strategy or legislation, or by considering health inequality in all policies through the use of impact assessments. Senior government commitment, along with corresponding resource allocation, also drives the equity agenda. These policy steering mechanisms are essential in motivating action to reduce health disparities, although each mechanism has different strengths and weaknesses [69].

Leadership and research are also ways to motivate policy. Several countries have conducted pilot studies or put together advisory research groups. Champion leaders who not only develop effective teams but also communicate the multisectoral nature of health disparities and promote the development of sustained national strategies are instrumental in driving health disparity policies forward.

Strong Linkages From The National To Local Level

Municipalities and local organizations are central in implementing and adapting national strategies. Thus, supporting localities with resources, time, funding, monitoring, and training is important for meaningful action. While it is sometimes difficult to implement top-level strategy in a local context, a policy development process that is participatory and involves local actors at the outset helps to create interventions and targets that are more relevant and feasible at the local level. The European strategies recognize the importance of the local role, and have demonstrated different approaches to national-local cooperation that vary depending on national and local contexts.

Coordination Among Policy Actors

In order to implement strategies beyond the health sector, coordination among different governmental levels, departments, and organizations is required. Central government leadership helps to spread responsibility across government, instead of just within the health sector. It is helpful for national and local authorities and different government departments to share common objectives and also have well defined responsibilities in meeting those objectives. Health in All Policies is an emerging approach that aims to strengthen the links between sectors and encourage all to take responsibility in tackling issues in the social determinants of health. If strategies are developed in consultation and in partnership with

many departments, those outside of health are more likely to see themselves as having a role in reducing health disparities [24]. There is no formula for who should take the lead in developing and implementing policies, but a well thought out, careful conception of the objectives and responsibilities of different actors is essential and allows for much more comprehensive strategies.

Conclusion

Comprehensive national level strategies are significant because they make health disparities a high level priority. Although there is limited data and statistics on strategies' impacts in reducing disparities, the growing number and scope of these national strategies in Europe have generated greater awareness of health disparities across government and among local partners. Still, driving the health equity agenda requires more than national strategies, but also continued public awareness and concern, innovation in delivering programs, and commitment from the community.

Key directions to reduce national health inequalities include the need for thoughtful planning and cross-collaboration, infrastructure to support policy implementation, and ongoing evaluation and improvement of interventions. There are no fixed rules on how to develop and implement comprehensive strategies, and context is always important. Those designing strategies must be adaptive and sensitive to political and local circumstances while working towards coherent overall objectives. European strategies to reduce health inequalities provide an abundance of examples of ways to work toward equity through policy, and demonstrate that action is possible. Together, they give an outline of promising practices to improve health equity.

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