

TOOLS

HEALTH IN ALL POLICIES AND EQUITY - REALISING THE CHALLENGE

A DISCUSSION PAPER FOR THE EQUITY ACTION PROJECT

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1. INTRODUCTION

The necessity to focus on equity and Health in All Policies has been reiterated as part of Council conclusions in 2006¹, 2010² and 2011³, which in 2011 emphasised that:

“A ‘Health in all policies’ approach with an equity focus should be used in specific policy areas and coordinated activities that have the greatest health impact contributing to reducing the persisting health gaps. This might include health, education, research, environment, agriculture, economy, employment and social policies.”

As well as called European Commission and Member States to:

“Promote the effective implementation of ‘Health in all policies’ approach with an equity focus, to encourage and coordinate all relevant sectors in playing their part in reducing healthgaps within the EU.”

However, the practice of how this should be done has remained more elusive. There is no guidance, practice or training of how to implement Health in All Policies and even less for potential avenues in to address equity in this context. This paper seeks to provide some guidance on potential options in the light of existing practices in HIAP as well as knowledge on equity in the context of public policies.

We have substantial literature on equity and reducing health inequalities as part of public policies and interventions, however tackling equity as part of HIAP often remains unclear and a further challenge. The purpose of this paper is to focus on current potential and prospects of tackling equity as part of Health in All Policies (HIAP) approach. The paper i) first elaborates what is HIAP and how equity is understood in the context of HIAP, then focuses on ii) the state of current knowledge in relation to HIAP and equity, iii) strategic thinking on HIAP and equity, iv) existing tools and mechanisms for enhancing equity as part of HIAP, v) the role of HIAP as part of political decision-making, vi) needs and scope for capacity building in the area, vii) case studies of relevance to understanding the potential and scope for HIAP, and finally viii) discusses potential and scope for equity focus in HIAP at local, national and European level policy making and ix) concludes and suggests potential agendas for action. at European Union level.

¹http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lsa/91929.pdf

²http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lsa/114994.pdf

³http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/134097.pdf



2. WHAT IS HEALTH IN ALL POLICIES ?

HIAP is a means for an end, rather than a defined specific methodology or tool kit. It can be based on a variety of measures adjusting these to different types of policies, rather than a single rigid process. In order to understand what can be done on the basis of HIAP approach or requirements for HIAP, it is important to understand where and on what basis HIAP arguments or action can be brought up or called for. Health in All Policies can offer prospects in relation to:

- i) level where decisions are made extending from local to European Union level
- ii) implications for health systems, population health and health protection
- iii) broad context of public policies extending from both public administration and political decision-making,
- iv) accountability as it relates to the legal basis for HIAP within EU and in Member States, and
- v) variety of processes and levels of cooperation, providing flexibility for HIAP.
- vi) transparency, cooperation and more informed decision-making across sectors
- vii) scope for public participation and more issue-based focus on action

A working definition of HiAP has been as follows:

“Health in all policies is an approach to public policies across sectors that systematically takes into account the health and health systems implications of decisions, seeks synergies and avoids harmful health impacts, **in order to improve population health and health equity**. A HiAP approach is founded on health-related rights and obligations. It emphasises the consequences of public policies on health determinants, and aims to improve the accountability of policy-makers for health impacts at all levels of policy-making. “

What is essential is that Health in All Policies has its focus **at the level of which decisions are made** and thus extends from European Union policy-making to the level of local and community level projects.

It also extends from administrative measures to **political and parliamentary decision-making and accountability**. It is not a replacement for health promotion or directly health-related measures, which can be undertaken as part of health policies, but **a means to reach to other sectors on issues and matters, where action within health sector alone is unlikely to provide results**. This implies that it is always likely to be **complementary and not replacement** to other public health measures and action within health systems. However, in terms of use and focus, it remains broader than health promotion as it covers also **impacts on health protection measures and health systems organisation and functioning**.

Health in All Policies is thus broader than what is traditionally understood as intersectoral action or whole-of-government approach as it extends from the executive or government-lead policy-making to the parliamentary decision-making as well as to **supranational governance**. Furthermore, it is also about **public policies and accountability**, rather than cooperation and intersectoral action only. While HIAP is usually based on and benefits from collaborative action with other sectors, **it does not always require collaboration or joint work**, if health considerations are otherwise taken into account in other policies. In this respect it differs from such multisectoral action or whole-of-society approaches, which would **require** participation and engagement from other sectors in principle.

Health in All Policies can utilise different tools and processes, including broad multisectoral action and inclusion of private sector, but **it is essentially about public policies**. While Health in All Policies usually benefits from intersectoral

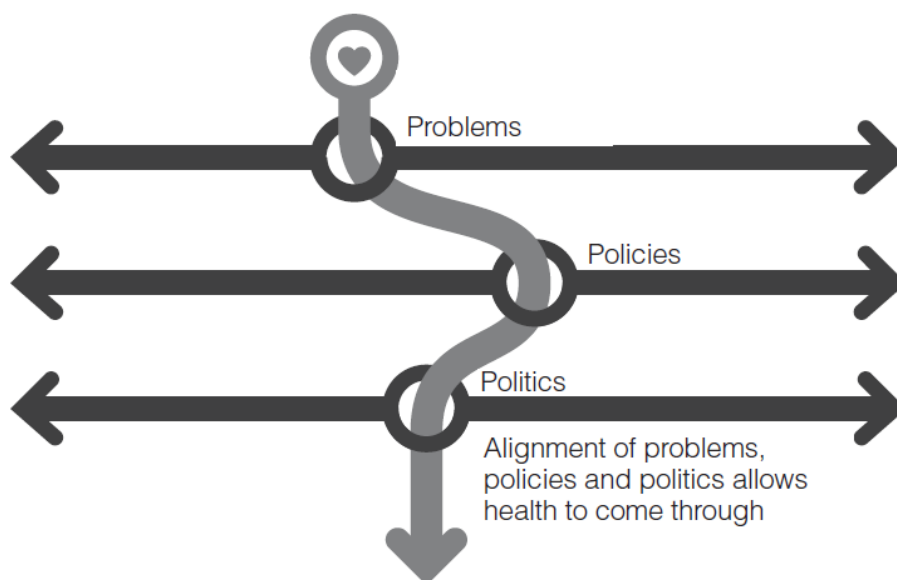


cooperation and alliances as well as requires **public consultation and transparency**, there are **no requirements to include all or any given stakeholders** as part of initial processes, nor to engage with or include such actors with substantial conflicts of interests with the matter in question to the planning and development of policies. However, it does support **broad public participation** with appropriate management of conflicts of interests. Health in All Policies is a long-term approach and **requires a long-term perspective**. It is thus not something that can be achieved through a single legislative measure or process.

Health in All Policies was introduced to European Union in 2006 (Stahl et al. 2006), including analysis on how it relates to European Union policies (Koivusalo 2006). The fact that Health in All Policies is geared to apply at the level of which decisions are made, has a particular appliance to European Union policies and respective competencies between European Union and Member States. This also implies a shared burden of focus between local, regional and national policy-making and decisions made in the context of European Union decision-making.

The accompanying book for the 8th Global Conference on Health Promotion on Health in All Policies implementation emphasised analysis by Kingdon (1995) on different streams and how problem, policy and politics streams need to meet so as to give ground for action⁴. The current paper looks at how equity could be enhanced as part of HIAP, but also makes suggestions for future in the light of stream analysis for cooperation in the area within European Union as part of technical guidance on how to take equity further as part of Health in All Policies. (Figure 1, from Ollila et al 2013)

Figure 1. Kingdon's non-linear framework for policy-making



2.1. EUROPEAN UNION AND HEALTH IN ALL POLICIES

⁴http://www.euro.who.int/_data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf



Health in All Policies is a recognised, area of focus on health, in the context of European Union action and responsibilities. The legal basis for articulation of Health in All policies can be found in the context of **Article 168** (Table 1). A further recognition is made in the context of council conclusions in 2006 during Finnish presidency with focus on Health in All Policies⁵ and in 2010⁶ on equity during Spanish presidency with focus on equity and social determinants of health (Council of the European Union 2006, 2010). Council conclusions on closing health gaps within the EU through concerted action to promote healthy lifestyle behaviours in 2011 have also contributed to the agenda (Council of the European Union 2011).

Table 1. Article 168 of Lisbon Treaty

1. A high level of human health protection shall be ensured in the definition and implementation of all Union policies and activities.

Union action, which shall complement national policies, shall be directed towards improving public health, preventing physical and mental illness and diseases, and obviating sources of danger to physical and mental health. Such action shall cover the fight against the major health scourges, by promoting research into their causes, their transmission and their prevention, as well as health information and education, and monitoring, early warning of and combating serious cross-border threats to health.

The Union shall complement the Member States' action in reducing drugs-related health damage, including information and prevention.

2. The Union shall encourage cooperation between the Member States in the areas referred to in this Article and, if necessary, lend support to their action. It shall in particular encourage cooperation between the Member States to improve the complementarity of their health services in cross-border areas.

Member States shall, in liaison with the Commission, coordinate among themselves their policies and programmes in the areas referred to in paragraph 1. The Commission may, in close contact with the Member States, take any useful initiative to promote such coordination, in particular initiatives aiming at the establishment of guidelines and indicators, the organisation of exchange of best practice, and the preparation of the necessary elements for periodic monitoring and evaluation. The European Parliament shall be kept fully informed.

3. The Union and the Member States shall foster cooperation with third countries and the competent international organisations in the sphere of public health.

4. By way of derogation from Article 2(5) and Article 6(a) and in accordance with Article 4(2)(k) the European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, shall contribute to the achievement of the objectives referred to in this Article through adopting in order to meet common safety concerns.

(a) measures setting high standards of quality and safety of organs and substances of human origin, blood and blood derivatives; these measures shall not prevent any Member State from maintaining or introducing more stringent protective measures;

(b) measures in the veterinary and phytosanitary fields which have as their direct objective the protection of public health;

(c) measures setting high standards of quality and safety for medicinal products and devices for medical use.

5. The European Parliament and the Council, acting in accordance with the ordinary legislative procedure and after consulting the Economic and Social Committee and the Committee of the Regions, may also adopt incentive measures designed to protect and improve human health and in particular to combat the major cross-border health scourges, measures concerning monitoring, early warning of and combating serious cross-

⁵http://www.consilium.europa.eu/ueDocs/cms_Data/docs/pressData/en/lsa/91929.pdf

⁶http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lsa/114994.pdf



border threats to health, and measures which have as their direct objective the protection of public health regarding tobacco and the abuse of alcohol, excluding any harmonisation of the laws and regulations of the Member States.

6. The Council, on a proposal from the Commission, may also adopt recommendations for the purposes set out in this Article.

7. Union action shall respect the responsibilities of the Member States for the definition of their health policy and for the organisation and delivery of health services and medical care. The responsibilities of the Member States shall include the management of health services and medical care and the allocation of the resources assigned to them. The measures referred to in paragraph 4(a) shall not affect national provisions on the donation or medical use of organs and blood.

European Commission has reported on health inequalities in 2003, 2006 and in 2013 (European Commission 2003, 2006, 2013). In addition, an independent external review on social determinants of health and European Union has been completed in 2013 (UCL 2013).

European Commission⁷ emphasises that “since health is determined to a large extent by factors outside the health area, an effective health policy must involve all relevant policy areas, in particular: social and regional policy, taxation, environment, education, research. All EU policies are required by the EU treaty to follow this “Health in all Policies” (HIAP) approach. But to be fully effective, this approach needs to be extended to national, regional and local policies.”

While addressing health inequalities has been addressed by the European Commission as a key action of the EU Health Strategy (2008-2013) (European Commission 2009), the new programme on Health for Growth has another focus. Although the new European Union programme makes reference to the Article 168 obligation of maintaining high-level of health protection in all policies. However, Health in All Policies is not mentioned one time as part of the new European Union programme Health for growth (European Commission 2010). Health inequalities and addressing inequalities are taken up in the context of tackling long-term challenges, access to health care for low income groups, necessity of tackling inequalities for inclusive growth and perhaps most explicitly in emphasis that “the programme should contribute to addressing health inequalities through action under the different objectives and by encouraging and facilitating the exchange of good practices to tackle them”.

The purpose of this paper is to explore options and potential to reinvigorate focus on public health and in particular, strengthening commitments on Health in All Policies and capacities to act on social determinants of health both as part of national policies and as part of European Union action.

a. INEQUALITIES AS A PROBLEM – EQUITY AS AN AIM OF HIAP IN PRACTICE

The concepts and basis of understanding of equity and health inequalities is often left vague in policy documents. This applies also to how these relate to consideration of health disparities, socioeconomic inequalities or equity and equality in the context of human rights and rights-related legislation or as it relates to fairness and justice. It is of further relevance to the practice of addressing equity to understand what is meant with equity, inequalities and equal treatment in other policies, where there are conflicts of interests and where synergies and alliances can be built in the area. We may require different capacities and focus, for example, in relation to addressing:

- i) health inequalities on the basis of educational or income status

⁷http://ec.europa.eu/health/health_policies/policy/index_en.htm



- ii) equity in relation to socioeconomic gradient
- iii) position and health of lowest income groups
- iv) geographical equity
- v) equity in the context of health systems and universal coverage
- vi) gender and specific minority groups as part of equity considerations
- vii) equal treatment and access to services and social protection irrespective of race, gender or age

There is both avoidable and unavoidable variation in health within and across population groups, but understanding of health inequalities is usually based on **recognition of health inequalities**, which are based on **avoidable mortality** and are considered as **unjust or unjustifiable**. The reference to equity often implies an emphasis on relative inequalities which form a **socioeconomic gradient in health**, which needs to be addressed. Equity also has a particular relevance for health systems in relation to commitments with respect to universal coverage and **equal access to health services** on the basis of need, rather than ability to pay.

In addition to universal approach, additional focus on lower income and more vulnerable groups – as part of **proportional universalism** (Table 2) – is often required. A focus on those poorest only will not address the socioeconomic gradient. Health inequalities are not only a matter of inequalities within different population groups, but as well between populations and geographical areas. This applies **both to health status as well as with respect to access to health care and services provided**.

Table 2. Proportionate universalism (Marmot 2010, p 15)

Focusing solely on the most disadvantaged will not reduce health inequalities sufficiently. To reduce the steepness of the social gradient in health, actions must be universal, but with a scale and intensity that is proportionate to the level of disadvantage. We call this proportionate universalism.

The role and relevance of health systems for health and health inequalities has become more recognised. This relates both to equity in access to services as well as with respect to how health systems relate to broader population health. Health systems can balance social inequalities or impede these. Particular issues relate to **health of minority groups**, such as Roma, and **the rights of specific vulnerable groups**, such as homeless, illegal immigrants, prisoners and those in institutionalised care or how **discriminatory practices** within societies affect health-related rights.

In this paper equity is understood mostly in the context of **socioeconomic gradient and equity in access to health systems, recognising need for proportional universalism for further reduction of health inequalities as well as obligations that arise from the Fundamental Charter of Rights in the European Union**, as adopted part of the Lisbon Treaty in 2009⁸.

2. STATE OF KNOWLEDGE ON HIAP AND EQUITY

⁸http://eur-lex.europa.eu/LexUriServ/site/en/oj/2007/c_303/c_30320071214en00010016.pdf



While literature on Health in All Policies remains still relatively scarce, there is substantial scientific and policy-practice literature on equity, social determinants of health as well as how public policies impact on equity and health inequalities. A substantial number of reviews on social determinants of health have been compiled from global to national and regional levels providing both analytical and descriptive evidence on existence and nature of inequalities and addressing these (see e.g. CSDH 2008, Marmot 2009, WHO 2013a, UCL 2013). A number of websites^{9,10,11} and networks¹² provide equity-related information in Europe.

The problem of health inequalities and the challenge for equity are known, well and freshly articulated at European Union level. Utilising Kingdon's analysis on policy stream, the challenge is not knowing the problem, but ensuring that policies take place and that political momentum to move action further is not lost (Kingdon 1995). The second part of this paper is thus focussed on how equity could be taken further as part of HIAP providing examples of potential mechanisms, tools and avenues to address equity in HIAP.

Global and regional reviews in the field of Health in All Policies and social determinants of health have sought to digest information to a more palatable form and analysis relevant to European policy context. This paper draws in particular from three recent policy openings and papers. First, the contributions of the Health in All Policies –book, compiled for the 8th WHO Health Promotion conference in June 2013 (Leppo et al. 2013), which analyses and discusses scope and potential for implementing Health in All Policies –approach; second, the regional reports on Social Determinants of Health and the Health Divide in the WHO European Region and in the European Union (WHO 2013a;UCL 2013), and third, WHO materials on universal coverage, financial crisis and health financing and on social determinants of health (WHO 2013; CSDH 2008; Blas and Krug 2010).WHO discussion paper by Solar and Irwin (2010 p.5) has also used the Diderichsen model of “the mechanisms of health inequality”, which identify how the following mechanisms stratify health outcomes:

“Social contexts, which include the structure of society or the social relations in society, create social stratification and assign individuals to different social positions. Social stratification in turn engenders differential exposure to health-damaging conditions and differential vulnerability, in terms of health conditions and material resource availability. Social stratification likewise determines differential consequences of ill health for more and less advantaged groups (including economic and social consequences, as well differential health outcomes per se)”

HIAP approach also draws from broader action and focus on prevention of noncommunicable diseases (UN 2011; Leppo et al. 2013), which has driven large share of health promotion efforts in the European region and globally, including measures with respect to tobacco, alcohol and diet. HIAP is also recognised as part of Health 2020 programme (WHO 2013bc), which seeks to enhance HIAP through focus on whole-of-government and broader collaborative action as well as provides guidance on how to engage and utilise workshops and cooperation with other sectors.

Health in All Policies draws focus on governance and intersectoral action (McQueen et al. 2012) with broader interest on governance in relation to WHO Health2020 programme (Kickbush and Geicher 2012, Kickbush and Behrent

⁹http://www.health-inequalities.eu/HEALTHEQUITY/EN/projects/equity_action/

¹⁰<http://www.instituteoftheequity.org/projects/eu-review>

¹¹<http://www.equitychannel.net/>

¹²<http://eurohealthnet.eu/organisation/join-network> , <http://www.eupha.org/> , <http://www.eph.org/>



2013). Further literature on implementation has been drawing in particular, from literature on whole-of-government and whole-of-society approaches, the use of health impact assessments and intersectoral and collaborative approaches within government. These do not, however, generally address specific measures or focus on inequalities in health or health inequalities.

European Commission has compiled information and guidance on using health impact assessment for policies and programmes developed in other sectors, including impacts on health and health systems¹³. However, European Union does not have tools, guidance or analysis for applying Health in All Policies approach either for European level or for national policies in practices. Furthermore, it is now known that health impact assessments are neither routinely used or prioritised as part of European Union integrated impact assessment processes has, however, gained criticism due to its orientation and prioritisation of impacts and methods conducive to business interests (Smith et al. 2010ab). It has also become evident that inclusion and implementation of health impact assessment as part of broader impact assessment processes or in relation to more challenging policies, such as investment, trade and commercial policies, have not gained ground. Analysis of HIA as part of integrated impact assessment found that it was rarely utilised (Salay 2008, Stahl 2009). In practice the gap is not only on implementation of equity as part of health impact assessment, but also lack of consideration of health as part of impact assessments. This supports the prevailing view of public health experts that HIA practice should be based on legal obligation if it is not to become marginalised as part of impact assessment procedures, leading to specific focus on the matter as part of Council Conclusions in 2011¹⁴ (Tarkowski and Ricciardi 2012).

3. STRATEGIC THINKING FOR HEALTH AND EQUITY

a. PURPOSE, LEGITIMACY AND FOCUS FOR ACTION

Strategic thinking is part of technical tools for Health in All Policies and can be used in particular for addressing equity. HIAP can be tackled, for example, on the basis of i) **necessity to respond to and assess policy proposals and initiatives from other sectors so as to ensure accountability for their implications to health and equity**, or in a more health policy driven context as the ii) **necessity to reach over to other sector policies so as to address social determinants of health**. The key in relation to these two aspects of HIAP is that in the case of the former, initiative to act comes from other sectors and legislation prepared for policy purposes in other sectors, whereas in the latter, the impetus is to change policies in other sectors to better respond to needs to tackle health and social determinants of health.

These may require different strategies and focus, in particular, as the former is more likely require addressing not only synergies, but more often also conflicts of interests. This double nature purpose of the HIAP can also lead to difficulties and challenges in relation to what is expected from HIAP in practice.

b. LEGAL FRAMEWORK AND CONTEXT

A key strategic factor for HIAP and equity can be found from constitutional commitments and legal statutory obligations for action. Legitimacy of HIAP as part of European Union policy-making context rests strongly on Lisbon Treaty commitments and Article 168 in ensuring high level of health protection as part of all policies. In most

¹³ See e.g. http://ec.europa.eu/health/ph_projects/2001/monitoring/fp_monitoring_2001_a6_frep_11_en.pdf, and http://ec.europa.eu/health/health_policies/impact/assessment_tool/index_en.htm#fragment0

¹⁴ http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/134097.pdf



European Union Member States, the inclusion of Charter of Fundamental Rights of the European Union as part of Treaty of Lisbon has contributed to this process, in particular, on the basis of Article 35, which states that:

“Everyone has the right of access to preventive health care and the right to benefit from medical treatment under the conditions established by national laws and practices. A high level of human health protection shall be ensured in the definition and implementation of all the Union’s policies and activities.”

European Union Member States often have additional commitments with respect to universal service provision or right to health as part of international treaties or in the context of national constitutional law, which can be important in the context of legitimizing action on equity and Health in All Policies.

However, so far there has been limited analysis on how legal framework and context within the European Union could be used better so as to the benefit of enhancing action on social determinants of health, equity and HIAP as well as how legal and legislative frameworks within Member States could be used in support of HIAP in practice.

c. FOCUS OF ACTION

The strategic focus on action for further focus on HIAP can bear crucial relevance to equity. In practice intersectoral efforts initiated by governments to enhance HIAP are often issue-based in practice, in other words, they are geared towards addressing a particular problem (e.g. obesity) or area of action (e.g. nutrition). While Health in All Policies requires that health is considered in the decision-making of all policies, more cooperative activities and processes are often set to tackle a particular problem. This is also helpful for the motivation and representation of other Ministries to such processes as it enables choice of persons who are more likely to work in a relevant substantive area for action.

In terms of equity a specific focus on reduction of health inequalities or social determinants of health can be envisaged. Alternatively a focus can be put to a particular area of social determinants of health, such as child health and poverty. A number of sectors, including social, education, environment, employment, housing, transport and planning are often taken up as sectors with high impact potential for health inequalities. On the other hand, it is likely that, for equity and social determinants of health, HIAP would be of interest especially in sectors, where it has been least applied to, such as financial, economic, external and commercial policies, including programmes and policies of austerity.

While Health in All Policies remain often a less formal process than health impact assessments, understanding both health and equity implications of proposed policies requires knowledge on the particular policy area and sector. This applies also to the third aspect of HIAP and equity, which relates to the nature and depth of the impact of policies and the number of people that it is likely to affect short and long-term. Regulatory policies and policy decisions in other sectors can have substantial impact on health systems. This implies that it may be not meaningful to use exactly the same frame for all policies, but to adjust analysis on the basis of actual policies and most important expected impacts.

As a means for accountability, health in all policies can thus be considered both as a **reservation of political space for health and equity in the context of political decision-making**, as well as a **technical tool** as part of preparatory and implementation processes. Specific tools are also available and can be used for HIAP so as to tackle equity and focus on inequalities.

4. TOOLS AND MEANS FOR ADDRESSING EQUITY IN HIAP



A large part of “tools” and “means” for Health in All Policies take place in the form of intersectoral committees, joint actions, working groups, consultations and related functions across sectors. The simplest tools and means are inclusion of health equity and distributional impacts of policies as part of the agenda on health or health related issue in question. However, this can be further enhanced with more specific **equity-related checklists, focus areas or questions to be answered** as part of this broader process. This is also the essence of many tools that seek to address equity in HIAP.

Health in All Policies usually includes a form of **participatory processes and consultation**. Participation can enable better focus on inequality and equity as result of broader debate and transparency, but it can also neglect or hide important equity issues both in terms of representation and voice as well all divert focus from equity and gradient of inequalities to most vulnerable and lowest income groups only. Participation can thus never replace focus on equity and distribution as part of health in all policies and is insufficient as a means to address equity. However, transparency and openness of participatory processes remain important, in particular through addressing and recognising conflicts of interests and different resource capacities of nongovernmental organisations in comparison corporate representatives and lobbyists.

There are known more equity and health equity specific means and tools, which can be used to address equity as part of these processes. Those most referred to include **i) Health equity impact assessments/Equity health impact assessments, ii) health equity audits, iii) health equity lens, iv) equity reviews or v) policy analysis for health and equity**. While some tools are developed to address equity by local governments, HIAP applies to the level where decision is made. The higher the policy level of governance, the more important it is to recognise focus on more complex regulatory aspects of policies and how these affect policy space at lower levels of governance.

The choice of how health and equity are considered is likely to remain at the core of politics of HIAP. For example, whether addressing of equity takes place in the form of drawing attention to the lower income groups only or to the gradient. It has been recognised that equity is not sufficiently considered as part of Health Impact Assessments (HIA) with a particular difficulty to address roots of inequality or causes of causes (Povall et al. 2013). Equity provides a particular challenge for Health in All Policies, which addresses policies rather than project and often at macro-level with more complex aspects and issues related to equity, power and injustice, than decisions at the level of local government. It is thus necessary to recognise that if equity is to be tackled as part of HIA this is likely to need further scope for broader policy analysis as well as focus on policy reviews and legal and policy analysis, including with respect to human and social rights obligations, as part of the toolkit to address health and equity.

However, this paper is based on a practical approach recognising that, while the aims of action on equity should be held high and broad in their focus, scope for action should be given for governments, local governments and the European Commission to address equity and health inequalities, where this can be done.

a. HEALTH EQUITY IMPACT ASSESSMENT/ EQUITY FOCUSED HEALTH IMPACT ASSESSMENT

Equity can be considered as an elementary part of an ordinary Health impact assessment, in the context of health (equity) impact assessment or equity focussed health impact assessments (Table 4)



Table 4. Impact assessment terminology, adapted and amended on the basis of Harris-Roxas et al (2011)

Health impact assessment (HIA)

HIA is "a combination of procedures, methods and tools by which a policy, program or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population" (ECHP 1999).

Health equity impact assessment (HEIA)

HEIA has been suggested as a means to ensure that the potential impacts of a proposal on health equity is considered prior to implementation as part of WHO Commission on social determinants of health (CSDH 2008). Application of a separate specific health equity focussed impact assessment has been endorsed in the context of action on social determinants, but it is generally assumed that there is no need for new and separate methodology to address equity, but there is scope for enhancing how equity is addressed as part of ordinary HIA (Povall et al. 2013)

Equity focused health impact assessment (EFHIA)

EFHIA is related to HEIA and was developed in response to concerns that (i) consideration of health equity is often limited within HIAs, often being restricted to the realm of professed values and aspirations (Harris-Roxas and Simpson 2004), and (ii) that it was desirable to improve the methods for considering equity within HIA, rather than developing a separate form of HEIA. EFHIA focuses on improving the consideration of equity and differential impacts at each step of the HIA process (Mahoney et al. 2004; Simpson et al. 2005). EFHIA can also be adjusted to a limited time frame and resources in a form of rapid EFHIA (Harris-Roxas et al 2011).

The Equity focussed health impact assessment (EFHIA) "uses health impact assessment methodology to produce a complementary and structured way of determining the potential differential and distributional impacts of a policy or practice on the health of the population as well as on specific groups within that population and it assesses whether the differential impacts are inequitable" (Mahoney et al. 2004; Simpson et al 2005). It has been used in the context of Australian and Canadian policies with the intention of emphasising equity in the framework of a health impact assessment. EFHIA (Mahoney et al. 2004, p.12) is geared to answering four questions:

- 1. Is it necessary to consider health within this policy or practice?**
- 2. Does this policy or practice have any (potential) health impacts?**
- 3. Are these health impacts likely to be differentially distributed by socioeconomic status, ethnicity, gender, geography, or some other factor?**
- 4. Are these differential impacts fair?**
- 5. Are these differential impacts avoidable?**
- 6. Do the benefits of changing the policy or practice to moderate or remove these differential impacts outweigh the costs or disadvantages of doing so?**



The use of equity focussed health impact assessment has similar strengths and weaknesses as the use of health impact assessment for the purpose and practice of Health in All Policies. It is also dependent on capacities and knowledge-base that can be used to analyse these impacts, when health impact assessments are contracted out or undertaken as part of broader impact assessment processes. As part of Health in All Policies approach it is most useful for analysis and as a source of information for the policymakers, where issues of concerns for health and equity are at the point of decision-making, whereas audits can be more important in implementation of policies “with a view on health and equity”.

Where there is a formal legal responsibility for HIA, EFHIA can be included as part of this assessment. While there are often limitations for effective use of equity focussed impact assessment at policy level or assessment of implications from legal or regulatory policy changes, EFHIA can always be combined with legal review of analysis on policy space. This could also focus on reporting to decision-makers and commissioning of EFHIA by policymakers or an independent arms-length organisation.

Another avenue for health equity impact assessment is to require a separate equity impact assessment or review as part of health impact assessment on the basis of knowledge on socioeconomic inequalities and impacts on specific groups of concern. While this may not be directly applicable to health inequalities, it provides ground for understanding broader context of inequalities in more detail and in particular situation with more vulnerable groups. This is relevant also to the definition and nature of social impact assessment. If a social impact assessment addresses impacts on equity and socioeconomic inequalities, this can support tackling equity and inequalities as part of HIA.

i. Where it is most useful and applicable

HIA and equity focussed HIA is in its current form likely to be most effective at project and local government level, where also most experience and expertise remains. The legal framework for HIA differs in EU Member States with limited application of HIA or equity focussed HIA in the context of integrated impact assessment or related measures applied at European level (Stahl 2010). A specific challenge is to ensure that where impact assessments are made under broader umbrella as part of integrated, environmental or sustainability impact assessment, health considerations are duly taken into account. Where a legal framework exists, it is important to ensure that health impact assessments, including assessment of equity, gain sufficient focus and investment as part of the impact assessment process (see e.g. Harris-Roxas et al 2012).

At policy level HIA can be very easily applicable to measures, which apply directly to health or focus on specific health determinants, such as tobacco or alcohol, where health outcomes can be effectively assessed. However, this does not necessarily imply that policies would not be taken further as has been shown in the case of Finnish alcohol policies (Melkas 2013).

When impact assessment processes focus also on social impacts and equity, this can help tackling equity also as part of HIA. From the perspective of HIAP, having access both to a comprehensive social impact assessment (SIA) as well as HIA could strengthen the case for equity in HIAP more than emphasis on need to focus on equity as part of HIA only.

ii. European Union policies and support to Member States



European Commission has supported and developed specific guidance on health impact assessment, which also has equity related element in requiring to focus on distribution of health impacts¹⁵, following definition of Gothenburg consensus paper: “Health impact assessment has been defined as a combination of procedures, methods and tools by which a policy, programme or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population” (EHP 1999).

The challenge for the use of HIA for Health in All Policies and equity is not legitimacy of the process or availability or knowledge of methods to implement HIA, but rather *whither* and *how* it is used as part of integrated impact assessment process both at European level and within countries (Stahl 2010, Smith et al. 2010ab, Harris-Roxas et al 2012). While HIA practice remains stronger at local and project level it can be adjusted to respond to strategic and national and European level tasks.

A further challenge and task is to enhance the scope and capacities for expertise in the area of equity focussed health impact assessment as well as capacities and training in the area, including at policy level and the assessment of impacts on health systems. This requires also consideration of linkages with and between social impact assessments and health impact assessment as well as potential common interests and benefits from strengthening focus on both areas, in particular for improved consideration of equity as part of impact assessment processes at European Union policies. While the joint action project training and focus on HIA has provided important opportunity to Member States as part of the joint action, it represents rather a start than a finishing line in the area.

b. HEALTH AND EQUITY LENS

The use of equity lens can be used as a general perspective (see e.g. Victora et al 2003), highlighting equity and state of inequalities in relation to health problems. It has also been used in the context of representing a variety of tools to tackle equity in public health¹⁶. The use of “lens” is frequently based on assumption that it implies a particular focus for assessment of other policies from health or equity “glasses”, thus analysing and screening implications of other policies from health or equity perspective, rather than adopting priorities or perspectives of these policies. This also allows use of scenarios and combination of quantitative and qualitative methods in relation to the problem or policy area, which is being studied.

The general use of health “lens” or “gaze” contrasts to the use of South Australian “health lens” approach promoted in the context of HIAP, which actively accommodates health priorities to those of other sectors so as to achieve win-win options as well as follows up the process to decision-making (Williams et al 2010).

In practice these have different applications. In the broadest form equity lens can be understood as analysis of policies as if equity mattered and it can be used both as a collaborative and an independent tool for analysis of equity implications of policy proposals. It is, however, amenable and vulnerable to politics of definition of equity. It thus allows scope for broad focus for those interested in addressing equity as well as limitation of the approach on the basis of given understanding of equity. While “lens” analysis can in practice represent policy review or policy and legal analysis, these have also been taken up separately due to the current trend of promotion of more restrictive and formal practice in the context of South Australian health lens approach.

¹⁵ See: http://ec.europa.eu/health/ph_projects/2001/monitoring/fp_monitoring_2001_a6_frep_11_en.pdf

¹⁶ See, for example, <http://www.uvic.ca/research/projects/elph/assets/docs/Health%20Equity%20Tools%20Inventory.pdf>



The South Australian health lens approach follows up some practices in HIA in terms of five steps with focus on i) engagement with other sector, ii) gathering of evidence, iii) generation of a final report, iv) navigation of proposals for recommendation and v) evaluation. However, as it adopts a more collaborative stand with an explicit starting point towards win-win options, the scope and focus on equity is likely to be more restricted as well as more likely to be adjusted to fit priorities in other sectors. It is thus a weak means for governance and accountability, where there are strong conflicts of interests with a danger of leading into such “win-win” options, which undermine long-term or structural focus on determinants of health. On the other hand, this is expected to be associated with a stronger commitment to realisation of commitments made through the joint oversight and approval processes implying compromises on both sides.

In terms of Health in All Policies an equity lens avenue provides means for addressing equity as equal, but separate part for assessing health not only in terms of how health implications are distributed, but as well in terms of how policies impact on equity as a separate determinant of health.

i. Where it is most useful and applicable

In its broader form a health or equity lens can be used to assess policies, where equity implications are challenging or are in conflict with other policy goals. Equity lens can be used to highlight issues as part of implementation of policies as well as for policy discussions in decision-making. It can be used also to highlight equity implications of decisions made within health policies or proposals to address health-related policy aims.

The South Australian “health lens” approach is based on a strongly collaborative approach with recognition of necessity to achieve other policy aims and emphasis on “win-win” solutions. It is most applicable for policy collaboration in “like-minded” areas or where equity implications are limited or require minor policy adjustments to allow co-benefits for health and equity, while also achieving other policy goals.

ii. European Union and support to Member States

The Join Action Projects have provided means and scope for exchange and collaboration across governments on social determinants and reduction of health inequalities represent practices of applying health or equity lens in other policies (Determine, Equity Action). Health focussed lens analysis has been used in practice to assess Common Agricultural Policies (CAP). Studies have provided estimates on cardiovascular mortality attributable to CAP (Lloyd-Williams 2008) or more general assessments on public health (Birt 2007). The use of equity “lens” or “gaze” can also be used to include different scenarios or assessment of alternatives “if health and equity would be a priority”. The South Australian approach has not been utilised in practice within Europe, although some aspects, such as cooperation and emphasis on win-win solutions remain high on the agenda.

c. POLICY REVIEWS FOR HEALTH AND EQUITY

Policy reviews for health and equity can be understood as similar to health equity audits, impact reviews and assessments or parts of evidence gathering in equity lens focus. The term “review” can be used as similar to “lens” analysis implying a “gaze” or “overview” on where and what takes place in a policy field. However, in here it is used more as reference to understanding of existing practice and literature in a given policy area covering both scientific research and literature as well as policy documents and “grey” administrative literature.



If impact assessments are set to anticipate impacts of policies, which are to be implemented, the focus on policy reviews for health and equity is based on existing information and studies. While reviews can represent a focus on past knowledge, it can be a useful means to address equity as many proposed policies are not particularly new or can be compared with such policy approaches, which have already been tried and tested within countries or in other countries or regions. The focus is not thus as much in predicting outcomes in a given population, but on what we know about equity impacts and implications of a given policy proposal. In contrast to health impact assessments, which focus on impacts of proposed policies in a given population, policy reviews can give insights on more complex relationships and enable articulation of health concerns in ways simple quantitative or distributional assessments can't tackle through allowing to take into account historical and contextual factors and a variety of studies on the matter.

Policy reviews are likely to be most useful for the initial take up and “argument” on relevance of HIAP to enable better understanding, where key issues are in a given policy area, and how different policy options relate to equity and health. While policy reviews can be driven by the need to address social determinants of health as has been the case with respect to Marmot reviews, they can be used also with respect to more specific analysis on particular policies, such as nutrition, agricultural or transport policies. While a policy review may not give estimated quantified impact of a particular measure on health outcomes, it can be very helpful in contextualising arguments in current knowledge and understanding of implications of proposed policies to health and equity.

i. Where it is most useful and applicable

Policy reviews in the standard form are most applicable in the context of policies and areas of work, where there is substantial amount of research and knowledge or where research exists, but has had limited policy relevance or not been applied to decision-making in practice. Reviews allow to recap on research and can be important in areas where there are different views across sectors in making a case and argument for health and/or equity (see case studies). However, they are of less relevance for issues and policy changes where impacts are not direct or where there is a limited supply of material that can be reviewed as research tends to follow on existing impacts that have taken place, rather than make synthesis or analyse potential implications of new policy measures.

ii. European Union and support to Member States

In practice some European level assessments, such as Marmot review (WHO 2013a), could already be claimed to represent to some extent this focus. Reviews and assessments of Common Agricultural Policies can also be seen as policy reviews as well as studies made for tobacco legislation. The difference is that reviews would imply more assessment on the basis of existing studies and compiled on the basis of review of these.

LEGAL AND POLICY ANALYSIS FOR EQUITY AND HEALTH

Policy analysis for equity and health utilise methods and means of policy and legal analysis to study implications to equity and health and in comparison to policy reviews. In the context of health systems focus would be on universal access to health care and socioeconomic and geographical inequalities with respect to access to health care and treatment. This type of inequalities are not readily evident in analysis of health inequalities as such, although the role and relevance of health systems for reduction of health inequalities and improving of health outcomes has gained more recognition in the context of addressing of social determinants of health in comparison to traditional public health policies. The use of legal and policy analysis respond to the more immediate needs of policy-making and in particular decisions concerning new regulations at national or European level.



While the focus of legal analysis is on existing legislation, case law and interpretation of law, it can be combined with other aspects of policy analysis so as to anticipate what kind of policy changes this could imply. In addition to the scope of European Union law European Member States this applies to European Social Charter and commitments made in the context of international law, including with respect to human rights.

Policy analysis can be done using a variety of methods, including quantitative and qualitative methods as well as synthesis on the basis of existing knowledge on impacts of different policies on equity within sectoral policies or similar policies implemented in other countries or in other sectors.

In comparison to standard review practice the use of legal and policy analysis is not bound only to existing analysis and reviews and thus provides scope to assess such policy innovations, which are novel or which represent new or changing legislation or policy context and environment as well as allows articulation of interests and priorities of different actors more clearly.

iii. Where it is most useful and applicable

This type of analysis is most useful and applicable to decision-making in the context of national and European Union legislative bodies, such as national parliaments and European Parliament, which are accountable for legislative changes and context as it allows taking up legislative and more complex and indirect implications of changes for responsibilities and regulatory policy space for health and equity. Legal and policy analysis is best applicable to new legislative and regulatory proposals with impacts on how governments can regulate or address particular problem, to learn lessons from other policy areas or compile synthesis on the basis of current understanding. However, while it is useful in providing insight for decision-making and democratic accountability of decision-makers, it is less helpful in guiding or incentivising for action as part of implementation or in providing guidance for local level policy-makers to act on a particular issue. One example of legal policy analysis is the recent ENVI study on legal implications of the proposed US-EU trade agreement (Gerstetter et al. 2013).

iv. European Union and support to Member States

It is in the interest of both European and national level policy-makers to fully understand implications of proposed measures and legislation, especially when this involves legally binding agreements with consequences to national and local governments. European Union has a major role for the legislative framework of most of its Member States with the necessity to ensure that what is implemented is supportive to those obligations, such as health financing, which remain a competence of Member States.

d. HEALTH EQUITY AUDIT

Health Equity audit (http://www.healthinequalities.eu/HEALTHYQUITY/EN/tools/health_equity_audit/). Health equity audit reviews inequities in health for a defined population, takes forward agreed actions to reduce those inequities and monitors the impact of the interventions. It is set to tackle equity in the context of proportionate universalism ensuring that planning and implementation of health policies takes in to account health needs or different populations. It is a resource which can be used to enhance achieving existing political and policy commitments in practice.

The scope for using Health Equity audits for Health in All Policies provides particular scope for learning and exchange for Ministries of Health and Social Affairs and local governments across European Member States as well as for the



work of European Commission in the field of health. In terms of Health in All Policies it can be an important means for understanding, communicating and contextualising health inequalities concerns to other sectors through their identification for the purpose of the latter aim of Health in All Policies. It can thus be seen as part of capacity building for Health in All Policies, in particular at local level of governance and in relation to decentralisation of services provision.

Another avenue for Health in All Policies is to focus on social determinants of health and broader practices of equity audits across different policies and sectors, including health equity audit within the health sector and input into other policy areas for health-relevant services and measures.

i. Where it is most useful and applicable

Health Equity Audit is most applicable as part of implementation and follow up how commitments made are then realised as part of actual policies rather than as aid and support to decision-making or analysis of new policies to be implemented. While the focus on Health Equity Audits has so far been strongly within health sector, it is likely to have scope for application in particular as part of local and regional level work and governance on health.

ii. European Union policies and support to Member States

Health equity audits can be used for ensuring stronger capacities and focus on reduction of health inequalities within health services development. Further exploration in terms of utility and scope in different European Union Member State contexts could be utilised. Consideration should be made whether further focus could be utilised in the context of such European Union exercises as open method of coordination, emphasising learning from best practices from health equity audits. It can be adjusted to be applied also to European Commission work on health in particular as this relates to health measures in the context of structural funds. Equity Action experiences from Health equity audit at European level will be important in assessing further applicability of the tool to European Union policies.

5. APPLYING HIAP IN THE CONTEXT OF POLITICAL DECISION-MAKING PROCESS

The role of political decision-making as part of Health in All Policies has often been implied, rather than applied. Furthermore, it is often assumed that a government acts as “one” with an implicit assumption of a whole-of-government approach. However, in the age of governance by political coalitions and increasing political fragmentation, this may no longer be merely assumed. While strong position of HIAP on the government policy agenda is likely to be supportive to the agenda, the role of parliaments and parliamentary committees should not be ignored. This is due to three reasons:

- 1) Parliamentary issue-based committees can have an important role as part of scrutiny and accountability of decision-making in complex areas and also other work in interdepartmental committees and processes benefits from broader political support
- 2) Health has a strong citizen support and usually benefits from openness and transparency
- 3) Political bi-partisan structures and tools can also enable a longer time-perspective for Health in All Policies as well as in ensure broader support and oversight especially in coalition governments or geographically defined governance and representation.

The potential for utilising HIAP more as part of political decision-making and processes is usually based on five types of functions:



- 1) establishment of **permanent parliamentary review committees** and processes under which new or existing policies are analysed in detail with respect to implications for equity and health, health and social affairs or more specifically on health in other policies
- 2) requiring a more detailed and structured **report on how health and equity concerns have been addressed** as part of legislative process for key sectors, policies or processes of concern,
- 3) establishing **hearings and consultations** with focus on how health and equity are affected,
- 4) appointing **formal inquiry or analysis** to examine a particular issue as a common concern,
- 5) **establishing practice of follow up, reporting and reviews** on tackling of and state of level of health inequalities and equity.

These can be seen as separate options, but they can also be seen as part of broader assessment process, where proposals from other policy areas could become subject to review analysis and potential new legislation become subject to approval and review by health committee. While many parliaments have specific committees for health, these may not routinely address equity-related matters. In some countries equity implications may become scrutinised more as part of social policy focussed committees. A query or initial report on the state of affairs can be required for keeping the issue on the agenda.

Indeed the one and perhaps clearest example of the use of parliamentary committees with relevance to equity and HIAP, has been described in relation to measures to tackle inequalities in health in United Kingdom (Earwicker 2012), which suggests that there could be more scope for considering a more active role for Parliaments in governance and accountability for equity in the context of health in all policies.

a. Relevance to European Union and Member States

There is a variety of options and potential for including Health in All Policies and equity more strongly as part of European Parliament and the work of the Council of European Union (the Council) as well as within parliamentary processes and practice in European Union Member States. Council conclusions in the area provide European-wide legitimacy and context for addressing health inequalities, but their follow up has been limited.

The role of the European Parliament has become more important as part of European Union governance with scope and potential for further role for utilisation of HIAP as part of decision-making for health in particular, when decisions relate to policy decisions with potential long-term implications for health and health systems functioning.

6. ISSUE-BASED ACTION: POTENTIAL FOR HIAP UNDER A CHALLENGING POLICY CONTEXT

If there are value-based or political limits on how equity can be addressed in a particular policy context, focus on actual sectors and policies where HIAP is applied can bear crucial relevance for the aims of the process. In other words, if equity or addressing health inequalities is unlikely to be on the policy agenda, there remains still scope to address those policies, which matter for equity in practice. Furthermore, European Union Member States and governments have made international commitments with respect to particular policy areas and aims, legitimating further action on the basis of these commitments.

Strategic thinking on where public policies can make difference for health and where they make crucial difference to reduction of inequalities and promotion of equity is thus important. European review on social determinants of health had a particular focus on housing, early life years and employment (WHO 2013a). While tackling gradient in



inequalities is important and inherent as part of focus on social determinants of health, there can be such population groups, which demand for further or more immediate attention due to complexity or graveness of their situation, such as Roma in Europe. Furthermore, social determinants have relevance also for health protection and communicable diseases. ECDC technical paper on infectious diseases, financial crisis and social determinants of health has scope and challenges for both vulnerable groups and population at large (ECDC 2012).

It is known that focus on diet, nutrition and tackling noncommunicable diseases can provide substantial avenues to address health inequalities and social determinants of health. Alcohol and tobacco consumption are socially distributed. This implies that consumption taxes are both regressive as well as effective terms of health gains. Water and sanitation as well as housing conditions matter also for the control of communicable diseases.

The necessity to address social determinants of health has been recognised in the context of health systems and financial and economic crises. A particular concern with respect to health systems is the extent to which user cost-sharing can either create barriers to access or lead to poverty. A matter addressed more broadly in the context of WHO report on financing of health care and the United Nations process and resolution on universal access (WHO 2010, UN 2012). Furthermore, in terms of health inequalities, it is not sufficient to focus only on austerity measures, but as well and perhaps even more on how and on what basis economic growth is sought.

This paper will take up three case studies and examples of measures with respect to three emerging aspects in the context of these analyses, with focus on i) children and social policies, ii) non-communicable diseases, and iii) universal access and equity in health systems.

a. Children and social policies

European Union review on social determinants of health highlighted the importance of focus on early life-years and children (WHO 2013a). European Union Member States have made commitments as part of the Convention on the rights of the child. Protection of the rights of the child is also recognised in Lisbon Treaty Article 3¹⁷, which states:

“The Union shall combat social exclusion and discrimination, and shall promote social justice and protection, equality between women and men, solidarity between generations and protection of the rights of the child”

European Commission has also established guidelines for the promotion and protection of the rights of the Child¹⁸. European Commission has in consideration of this, provided for a recommendation on investing in children and breaking the cycle of disadvantage (European Commission 2013). These recommendations include emphasis on proportional universalism as well as for member states to:

“Develop regular and systematic links between policy areas of high relevance to the social inclusion of children and strengthen synergies between key players, particularly in the fields of education, employment, health, equality and children’s rights”

Another aspect of the broader context is the prevention of child maltreatment (Reading et al 2009). Child maltreatment is associated with inequalities and on the basis of recent WHO report remains high within European region and has been underestimated in practice (Sethi et al 2013).

¹⁷ See e.g. <http://www.ecswe.org/downloads/publications/QOC-V3/Chapter-8.pdf>

¹⁸ See: <http://www.consilium.europa.eu/uedocs/cmsUpload/16031.07.pdf>



The focus on children is an example of a potential issue-based focus for HIAP as identified through the European regional review on social determinants (WHO 2013a). A broader agreement on action for children should be gained relatively easily as bi-partisan focus as well as in relation to European Union policies due to broader commitments with respect to Convention on the rights of the child. Furthermore, as follow up of the Convention, many countries are likely to have established own mechanisms for follow up. In the case of children it is necessary also to consider supporting and complementing efforts made, bringing health-related insights, analysis and evidence in support of existing policy initiatives and measures in other fields or common action. It is also a relatively neutral ground for action with a likely long-term impact on health and capacities to stay healthy.

The focus on children is also a good example for potential focus and context for alliances and collaborative action. The focus on early childhood and child health has repercussions for gender and ways in which work and family-life can be combined. There is legitimacy for European action as well as evidence as result of reviews on social determinants of health and focus on child poverty more broadly (WHO 2013, Mercier et al 2013). The NEWS comparative analysis on social determinants of health has concluded that increased generosity in family policies that support dual-earner families is linked with lower infant mortality rates, whereas the generosity in family policies that support more traditional families with gainfully employed men and homemaking women is not (Lundberg et al 2008). This also supports the emphasis on capitalizing, where possible, on existing synergies in different policy areas as part of HIAP.

While health systems distribute and redistribute resources, the necessity for cooperation across health and social sectors has become reflected in calls for more integrated care and focus on health and well-being. In this respect close cooperation with social policy sector can be crucially important both for addressing gradient as well as in ensuring that those in the most vulnerable position are will have relevant support. This applies as well to the ways in which support and aid for disability is organised within societies, recognizing close connection between chronic illnesses and disabilities, including mental health problems. On the other hand, it is necessary to note, that full integration of health and social services or policy aims may be problematic if this combines health and social services budgets. This is due to the fact that it may lead to under-resourcing of social services, unless due care is taken to avoid that costs from often more unavoidable health-related costs and measures do not fall under a common budget.

The linkages between broader social policies, redistribution and health are particularly important to any measures for social determinants of health. However, analysis and results that can be drawn at policy level and from macroeconomic changes are likely to remain weaker than with respect to more individual based studies and trials. This could imply a necessity to complement epidemiological evidence with analysis on legal, political and broader policy-based analysis for adequate assessment of particular policies.

b. Tackling non-communicable diseases, tobacco, alcohol and nutrition

The global agenda on non-communicable diseases has traditionally had a strong relationship with social determinants of health and intersectoral action due to the fact that many risk factors and exposures to illness have a social distribution within populations (see e.g. DiCesare et al. 2013). Tobacco and alcohol use have in many countries strong social distribution and the same often applies to obesity. While the relevance of tobacco and alcohol for health inequalities may vary by country, in some countries, such as Finland and Denmark, research implies a major role of these for reduction of health inequalities in practice. WHO work on equity, social determinants and public health programmes emphasises the importance of analysing the socioeconomic context and position within society where these emerge, the differential exposure of socioeconomic groups, differential vulnerability, differential individual



health outcomes and differential consequences for individuals that relate to socioeconomic background (Blas and Kurup 2010).

A number of noncommunicable diseases and conditions vary according to different population groups and socioeconomic status. This implies that the ways in which treatment and prevention is applied, has implications to health inequalities. In general measures, which focus on individual level health education, choice and incentives, are more likely to worsen health inequalities than broader public policy measures. This applies in particular, to so called “life-style” changes, where higher income groups have taken up “healthy” lifestyles and practices faster or where lower income groups may not have been able to exercise “healthy choices”. The importance of the latter has been discussed in particular with respect to nutrition policies and recognised also in the context of Vienna European Declaration on Diet and Nutrition in 2013, which also explicitly takes up HIAP as one of the means to address issues as these relate to diet and nutrition (WHO 2013e).

Non-communicable diseases are an example of focus, where European and Member State action can also benefit from broader global and regional commitments in the area. These have been supportive to preventive action, addressing equity and focus on broad public measures. Broad public policy measures for tobacco and alcohol control, such as policies affecting pricing, have been shown to affect more consumption in lower income groups and in the end resulting in beneficial impacts as this relates to health inequalities (see e.g. Hill et al 2013, Lorenc et al 2013; Babor et al. 2008, Di Cesare et al 2013). They are also focus of European-wide research programmes, such as DEMETRIQ¹⁹. Similar focus and analysis can be made with respect to nutrition and obesity (Di Cesare et al 2013). Further association has been found with fat governments suggesting that the more generous transfer payments are in health and education policy, the lower is the increase of obesity prevalence (Vis and Hylands 2012).

The ways in which non-communicable diseases are tackled has implications for health inequalities. If European Union Member States and the European Commission are to address equity, while seeking to control non-communicable diseases, this is likely to require a further focus on HIAP, fiscal and regulatory public policy measures. Furthermore, the major role of multinational corporate lobbying needs to become tackled at national or international level and it is particularly strong in the field of non-communicable diseases.

Non-communicable diseases do represent a particular case for issue-based action with a substantial scope for progress with existing European networks and links. On the other hand, they also represent a policy area, where health-related priorities for policy changes are often contrasted with major economic interests of the respective industries. The challenge for action is to what extent more effective strategies and scope for regulation are compromised by lobbying strategies of international industries emphasising individual voluntary choice with four identified lobbying strategies with focus on i) influencing research and finding, ii) influencing policy-makers and decision-makers through normalisation of partnership and corporate engagement, iii) general anti-red tape and anti-regulation lobbying, and iv) lobby to influence populations views and opinions as this relates to public health measures and regulation for public health (Moodie et al. 2013) (Table 5)

This context has relevance not only on *how equity is addressed* as part of HIAP, but as well *how HIAP is implemented* as this is likely to affect how and on what basis measures can be taken further. If fiscal and regulatory approaches are

¹⁹ See <http://www.demetriq.eu/>



important for more “equitable” approaches to control through public policies, then the ways in which engagement with industry is understood in HIAP can either hinder or enhance the scope of this in practice. While it would be in the interest of major industries to require and expect early and full participation for the definition and implementation of public health strategies seeking to control and limit the use of products of these industries, it is necessary to note that this is not required by HIAP.

Furthermore, there are reasons to expect that some of the more general impact assessment procedures within European Union Member States in the context of measures concerning better regulation may not be fully compatible with commitments made as part of FCTC convention, whose Article 5.3. guidance for implementation states explicitly that: “parties should interact with the tobacco industry only when and to the extent strictly necessary to enable them to effectively regulate the tobacco industry and tobacco products”. Furthermore, there is evidence on engagement of tobacco industry to the shaping of integrated impact assessment processes within the European Union (Smith et al 2010ab).

Finally, the policy space for regulatory approaches in the field of public policies is affected by other policies, in particular, industrial, trade and investment policies decided and undertaken not only in the context of different policies, but also at different level of governance. The Australia plain packaging case is an example of how national policies can be challenged by multinational industries through trade and investment agreements (Gleeson and Friel 2013, Koivusalo et al 2013). Regulatory chill impact has been associated especially with respect to investment-state-arbitration mechanisms due to potential to claim compensation, but is applicable also to interpretation of precautionary principle, negotiations on regulatory cooperation and on technical barriers to trade. This implies that improved exchange and focus can be important for individual governments challenged multinational industry interests so as to understand and be able to make explicit how broader regulatory approaches proposed by commercial policies contribute to health and equity.

A particular challenge in the context of European policies and HIAP is to ensure that sufficient policy space for health is maintained as part of bilateral and multilateral trade negotiations so as to allow more equity focussed public policies for tackling non-communicable diseases both at national and regional level.

c. Universal access and equity in health systems

The role of health systems for equity in health has not been at the forefront of policy discussions concerning health promotion, which has had its focus more on population health, public health measures and determinants of health. However, the role of health systems has become more important as part of discussions and focus on social determinants of health and health inequalities. The potential role of health systems can be disentangled into three dimensions:

- i) **Health systems impact on poverty and inequalities.** This covers the role of health systems as mechanisms for distribution and redistribution of resources, how health systems are financed and whether those ill are required to pay more than those healthy. Future of European health systems does not only require focus on innovation, but also capacity to evaluate and address clinical benefits and costs of new and innovative treatments and services so as to ensure wise and sustainable use of public resources.



- ii) **Inverse law of care – proportional universalism in ensuring universal access for all.** Health inequalities are affected whether or how health systems address inverse rule of care. Lack of access to health care or treatment, including geographical inequalities in access to care contribute to health inequalities. The role of health systems is thus reflected on how care within national health system varies on the basis of socioeconomic status, gender or other population group or geographical area and to what extent health systems have mechanisms to reach out and operate on the basis of proportionate universalism to address equity.
- iii) **Capacity of health systems to address population health and social determinants of health.** How organisation and structure of national health systems relates to broader determinants of health, organisation of health care and public health policies. WHO data indicates that public health forms only a minor part of overall spending on health (REF). A long-term concern is to ensure adequate support to the institutional basis for follow up, surveillance and analysis in the context of national public health institutes. Finally, the role of primary health care remains crucial for sustainability of financing of health systems.

Internationally, a major focus on health systems has been on health services financing and access to health services. These have been reflected in the WHO Health report on financing of health systems in 2010²⁰ and the United Nations resolution on universal coverage in 2012²¹. Tallinn Charter on Health Systems for Health and Wealth makes explicit reference to the fact that health in all policies belongs to health system requirements²² and emphasised equity and universal access, for example in commitments made as part of Articles 9 and 10²³:

9. *All the Member State of the WHO European Region share the common value of the highest attainable standard of health as a fundamental human right; as such, each country shall strive to enhance the performance of its health systems to achieve the goal of improved health on an equitable basis, addressing particular health needs related to gender, age, ethnicity and income.*

10. *Each country shall also seek to contribute to social well-being and cohesiveness by ensuring that its health system:*

Distributes the burden of funding fairly according to people's ability to pay so that individuals and families do not become impoverished as a consequence of ill-health or use of health services; and is responsive to people's needs and preferences, treating them with dignity and respect when they come in contact with the system.

In the European Union, commitments with respect to access to health care have been made as part of human rights and, in particular, as part of European Social Charter and Convention on the Rights of the Child and further

²⁰ WHO report available from: <http://www.who.int/whr/2010/en/>, WHA resolution available from: http://apps.who.int/gb/ebwha/pdf_files/WHA64/A64_R9-en.pdf, latest World Health report on research for universal coverage, available from: http://www.who.int/dg/speeches/2013/whr_20130815/en/index.html

²¹ United Nations resolution available from:

http://www.un.org/ga/search/view_doc.asp?symbol=A/67/L.36&referer=http://www.un.org/en/ga/info/draft/index.shtml&Lang=E

²² Preambular paragraph two emphasises that: "Within the political and institutional framework of each country, a health system is the ensemble of all public and private organizations, institutions and resources mandated to improve, maintain or restore health. Health systems encompass both personal and population services, as well as activities to influence the policies and actions of other sectors to address the social, environmental and economic determinants of health."

²³ Available from: http://www.euro.who.int/_data/assets/pdf_file/0008/88613/E91438.pdf



strengthened as result of inclusion of recognition of these as part of the Lisbon Treaty²⁴. European Member States have further emphasised values and common principles as part of Council Conclusions and statement on common values and principles in European Union health systems²⁵:

“The overarching values of universality, access to good quality care, equity, and solidarity have been widely accepted in the work of the different EU institutions. Together they constitute a set of values that are shared across Europe. Universality means that no-one is barred access to health care; solidarity is closely linked to the financial arrangement of our national health systems and the need to ensure accessibility to all; equity relates to equal access according to need, regardless of ethnicity, gender, age, social status or ability to pay. EU health systems also aim to reduce the gap in health inequalities, which is a concern of EU Member States; closely linked to this is the work in the Member States' systems on the prevention of illness and disease by inter alia the promotion of healthy lifestyles”.

The concern with health systems is not as much an issue of lack of recognition, but rather the ways in which action is taken both in the context of European Member States and European Union. In the context of national health systems main concerns remain with i) distributional impacts of health system financing, ii) impacts of austerity policies upon health systems, and iii) relationship between health systems and regulatory framework for commercial, trade and investment policies.

Health systems distribute and redistribute financial resources. At best they have a redistributive impact in terms of cross-subsidising across rich and poor populations as well as across those healthy and those with conditions and illnesses requiring treatment and care. At worst health care costs can drive people into poverty or lack of access as has been the case in middle- and low-income countries (WHO 2010).

European Union Member States have commitments with respect to universal access and emphasis on equity has been emphasised also as the “solidarity” principle as part of recognition of common values within European health systems. However, in practice many governments have imposed policies and changes to health systems financing, which may not follow this basis, but can shift a further financing burden to those ill through measures, such as user charges or cost-sharing or through structural factors in financing of social security and health systems either at national, regional or local level.

7. ADDRESSING AUSTERITY MEASURES IN THE CONTEXT OF EQUITY AND HEALTH INEQUALITIES

The challenge for European Union policies is to ensure that the financial crisis that has turned to economic crisis in many of its Member States does not become a social and health crisis as result of austerity measures and policies that have been imposed so as to respond to the crisis. A High-level committee on austerity has taken up on lessons learned from health systems and austerity policies under the auspices of World Health Organization²⁶ (Table 2). Impacts from austerity measures have been reported already from several countries (see e.g. Leguido-Quigley et al 2013, Mladovski et al. 2012, Karanikolou et al. 2010, Stuckler et al. 2009). Reports on population health indicating rise in child mortality

²⁴ Some Member States, such as United Kingdom and Poland, carved out this part from the commitments they made as part of Treaty of Lisbon.

²⁵ Available from: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2006:146:0001:0003:EN:PDF>

²⁶ http://www.euro.who.int/_data/assets/pdf_file/0011/186932/Health-and-economic-crisis-in-Europe4.pdf



have been brought up from Greece as well as spending reductions health prevention that would have helped to reduce spending later (Kentikenelis et al. 2011; Ifanti et al 2013). Further attention has been drawn to the necessity to maintain infectious disease control on the agenda as economic crisis has disproportionately impacted vulnerable groups in society (Semenza et al. 2011) While evidence on impacts of austerity on health is emerging, it is important that efforts are not geared only on documenting impacts of austerity, but will tackle the challenge of rising inequalities in the aftermath of crisis.

The experiences from the economic crisis in Nordic countries in the early 1990s was that it was not only direct impacts of the economic crisis and austerity, which mattered, but in particular, how and on what basis economic growth is sought in the aftermath of the economic crisis will influence socioeconomic and geographical inequalities (Kiander 2010). Recent data for Finnish health inequalities confirms the contribution of increasing social inequalities to health inequalities (Aittomäki et al. 2013). Economic growth may also be sought from the health services provision as means to enhance “services economy” and choice with further implications to equity in health systems (Tritter et al 2009). The key is thus not only the immediate impact of crisis and how savings are made in public budgets, but also on what kind of policies are sought for growth. The challenge remains to take into account of the longer impacts of social shade of economic crisis and austerity measures after economic recovery.

The triple burden of austerity for health consists of:

- i) impacts of economic policies on health and social determinants of health, i.e. capacities to stay healthy at population level as result of impacts on socioeconomic inequalities, impacts on unemployment and steepening of income gradient.
- ii) impacts on health systems financing and budgetary allocations for health with consequent needs for cuts in services and spending. As result of difficulties to cut spending on hospital costs, cuts can affect proportionally more local services, primary health care, public health and health promotion or services provided for more vulnerable groups worsening scope to address social determinants of health and health determinants, and
- iii) austerity “scramble” of policies with impacts from reforms sought resulting in increasing costs of care (e.g. commercialisation, out-sourcing and fragmentation of services), increasing inequalities in access (e.g. introduction of choice, geographical inequalities, user cost-sharing and top up fees, excluding groups (e.g. immigrants) from access to care) and lack of balance between public health and health promotion towards securing access to care and treatments (e.g. increasing spending on more individualised high technology care).

The direct impacts of austerity can be tackled through focus on balancing actions through public policies. However, austerity measures can also result in shifting of burden of costs towards local or regional governments and services or mechanisms for cross-subsidisation of health-related spending across richer and poorer regions within societies. It is known that inequalities in access can further vary geographically even when a national health insurance system seeks to minimize financial barriers to care (Gusmano et al. 2013). This is likely to require active focus on ensuring universal access. At European level this applies both to countries and regions and balancing mechanisms can be sought on the basis of geographical areas, as is done through structural funds²⁷, or through support for particular vulnerable

²⁷ Reference to website on structural funds



population groups. Austerity-related policies can be extensive and have been discussed in the context of violation of human rights and housing in United Kingdom²⁸ and social charter and rights to social security in Greece²⁹.

There are some indications that austerity measures in the aftermath of the economic crisis could be more important than economic crisis itself in enhancing inequalities in countries, where welfare states function well, such as in Nordic countries during early 1990s crisis. Furthermore, it is likely that in countries with less extensive welfare state capacities and higher income inequalities during the crisis, the impacts could be more severe also in the aftermath of the crisis depending on the set of austerity measures that are implemented. While some measures are likely to result from political choices, governments can also make mistakes on the basis of false assumptions of introduced measures on the basis of solely economic considerations and assumptions. It is the latter group that will have potential for change as well as scope for further learning across countries. For example, imposition of user charges is often done on the basis of too high assumed potential to generate additional income as well as too little consideration in terms of their impacts on equity in access and distributional impacts of health care financing. Furthermore, crisis-related reductions on spending on prevention-related work, including on drugs, can then become reflected in much higher costs as result of an epidemic, as has been discussed in relation to increase in HIV cases in Greece (Karanikolos et al 2013, Malliori et al 2013). Another aspect of similar measures is the exclusion of illegal immigrants from care, which can further worsen the situation and impact more broadly on health of the population (Gallo et al. 2013).

Increasing drifts and inequalities as result of austerity policies have been reported, last on the 2012 Eurofund survey on quality of life pointing out that (Eurofound 2012, p. 147)³⁰:

“The distribution of opportunities and resources, as well as living conditions, differs systematically between social groups in all Member States. People with lower incomes are not only more likely to have experienced negative financial consequences in the previous 12 months and to report more difficulties in making ends meet, but they report more problems with work–life balance, poorer health and more problems with access to, and quality of, health services. People with lower incomes appear to have been affected relatively badly by the economic downturn and experience reduced satisfaction with family life and lower levels of satisfaction with health and happiness than they did in 2007”

European semester process provides one context for extending HIAP on new economic and fiscal policy coordination within the European Union. Ensuring that European Union Member States, responsible for financing of health systems and social protection, have adequate means, guidance and mechanisms, to ensure that requirements for health systems and social security are adequately met as part of this process would provide longer-term benefits as well as ensuring that proposed policy reforms for public services are in line with commitments made with respect to universal access to health services, equity and reduction of health inequalities. While necessity to tackle unemployment and social impacts of crisis have been raised as one of main messages as part of European Commissions’ annual growth survey for 2014³¹, capacities of Member States and European Commission to address population health, social determinants of health and health systems –related issues in this context remains a challenge for HIAP in practice.

8. EQUITY AND HIAP: NEEDS AND POTENTIAL

²⁸<http://welfarenewsservice.com/united-nations-press-release-uk-housing-bedroom-tax/>

²⁹http://www.coe.int/T/DGHL/Monitoring/SocialCharter/NewsCOEPortal/CC76-80Merits_en.asp

³⁰<http://www.eurofound.europa.eu/pubdocs/2012/64/en/1/EF1264EN.pdf>

³¹



The needs and potential for equity and HIAP in European Union can be put under three main headlines.

1. Establishing practice and capacities for HIAP

The institutionalisation of health impact assessment processes remains weak and in many countries the professional basis on which it relies is limited or to a large extent lacking as it relates to public health or health policy. The same applies to training and **sustainability of long-term capacity building and data gathering for HIAP.** We have substantial epidemiological research on impacts on outcomes in health, but very little that would focus on policies for the practice of HIAP. HIAP can and needs to be seen as a social innovation of the 21st century and this requires investing on capacities within national health institutions and supporting training for practice of HIAP on the basis of multidisciplinary studies. It requires not only skills in epidemiological studies, but combination and synthesis of these with existing capacities in economics, evaluation, policy, politics and communication, which is not currently available within European universities. This has been recognised also in a call for studies adopting individual policy approach in analysis of population health (Pega et al 2013). Equity action project provided an important initial step, but its benefits and networks are likely to fade unless further focus is put on scope on support to **institutionalisation of knowledge resources for HIAP within Europe.**

There is a number of tools, guidance and materials for tackling equity in HIAP. The greatest challenge is not lack of availability of tools or guidance as such, but the extent to which these are applied to proposed policies in practice and the extent to which governments have sufficient human resources to actually utilise these resources in practice. The danger is that after initial focus, enthusiasm and efforts to track developments in the field fade as the focus is shifted to other issues both at national and European level. One of the lessons from the Helsinki WHO conference on Health Promotion in 2013 was that **HIAP requires a critical mass and basis of expertise, exchange and examples to become a practice.**

A further challenge is how governments should address results and analysis of these assessments, in other words, whether tools and mechanisms guide political decision-making and accountability or whether these exists as a formality or “tick-in-a-box” process with little or no political relevance or relationship to decision-making in practice. In this respect the broad role of HIAP and engagement with political process and decision-making is important and requires particular institutionalisation, focus and strengthening, including as part of European Parliament work and functions. This remains still a more limited focus on HIA and HIAP practice, even though it can improve trust of citizens and accountability of policy-makers for decisions they make.

Finally, in the light of the evidence a further focus is needed on how European policies fit with the proposals made by the Council conclusions with a **review on key policies for equity and inequalities as a European-level task for future guidance consisting of the given sectors and policies or including also new policies for analysis at European Union level.**

2. Utilising fully the scope for equity focussed HIAP through effective issue-based action

There is substantial scope in taking HIAP further through effective issue-based action. As discussed before, there are potential areas for focus could be children or action on non-communicable diseases, including with respect to obesity, tobacco and alcohol. Childhood has crucial importance for health in later and is legitimated by strong commitments on the matter both within member states as well as within the European Union. There is also substantial evidence on



social distribution of obesity and tobacco and alcohol consumption as well as how measures to address these affect equity and social inequalities.

Issue-based action offer a means for further focus on both social determinants and HIAP, however, it is not replacement for HIAP otherwise. Furthermore, focus on too narrow basis of particular conditions or individual risk factors can lead towards false sense of action in tackling the “little” wheels, while “larger” ones remain intact. This was recently emphasised in the Scottish review on fundamental causes of health inequalities, which concluded that³²: *“Evidence that all-cause socioeconomic inequalities in mortality persist despite reductions for some specific causes, and that inequalities are greater with increasing preventability, suggests that focussing on reducing individual risk and increasing individual assets will ultimately be fruitless in reducing inequalities and may even increase them.”*

In this respect it is necessary to understand both strengths and weaknesses for issue-based action on HIAP. While issue-based action can be an important avenue for action, in particular, when other avenues are not possible, one off issue-based action can never be a comprehensive solution for addressing all inequalities and its success is conditional to the ways in which inequalities are tackled as part of issue-based action and on whether the issue has relevance of social determinants of health.

3. Effective tackling of austerity challenges

A simple guidance in the context of HIAP in the context of health systems is that i) population-based measures on prevention and health promotion are likely to contribute more to equity than voluntary and individualised approaches, ii) health systems which cross-subsidise across populations and risks have more scope to enhance equity across people and areas than one based on more individualised financing, and iii) austerity measures and growth oriented policies should not compromise or undermine commitments to universal access and equity through introduction or enhancing of inequitable user cost-sharing or cost-escalating commercialisation and reforms. The challenge is thus not only pressure to reduce costs, but as well how and on what basis this is sought.

Ensuring equity is an active, not a passive process and will require oversight and measures both within health sector as well as in the context of other policies. It is also a European issue and a societal issue, which can't be left to the individuals and nongovernmental organisations only. While there has been emphasis on establishment of Office of Health Responsibility with a task of scrutinising all policies in relation to their impacts of health, this should be part of considerations on governance for Health in All Policies³³. A particular challenge is to ensure that while seeking policies which enhance growth, European Union and its Member States do not result in policies which undermine equity and increase health inequalities. This sets a high aim also for the European Semester and how health is addressed as part of this process.

Health systems distribute and redistribute resources. Desperate patients may be pushed to make choices, which they should not be bound to make so as to maintain hope. While European Union Member States have made commitments with respect to common values and health systems, there is a danger that austerity measures combined with emphasis on growth will push health systems towards more inequitable forms of financing and access to health care.

³² http://www.scotpho.org.uk/downloads/scotphoreports/scotpho131018_whatwouldittake_report.pdf

³³ This is suggested by Stuckler and Basu (2013) on the basis of suggestion by Klim McPherson, but could well be understood and utilised.



Concern over financing and investment on health systems was also reflected in the call for action emphasising investment in inclusive health systems for sustainable growth in Vilnius³⁴.

In this respect it is necessary that emerging stronger European Union involvement with health systems has a strong emphasis on equity, universal access and strengthening of public health functions and that positive contribution towards these three aims is required as a cross-cutting aspect from all European actions in the area of health systems. While the WHO and Observatory for Health systems and policy has brought up a new web-resource addressing impacts of financial crisis on health system financing, it is clear that there is a necessity to further³⁵. OECD (2013) report findings suggest that health systems have faced substantial hits in their financing, according to the OECD spending per capita fell in 11 of 33 OECD countries between 2009 and 2011, notably by 11.1% in Greece and 6.6% in Ireland and many countries as well as noted negative impacts from user cost-sharing in some OECD countries (OECD 2013).

Council of European Union has further welcomed commission recommendations on investing children and drawn focus on social investment and protection, with potential synergies with focus on social determinants of health and Health in All Policies, including on the scope of making social concerns more heard as part of crucial economic policy decisions, for example, in that:³⁶

“As part of current reflections on the role of social protection, including the role of social investment, in the European Union, further consideration is needed on how to make the system of governance more effective within the current frameworks and processes, to strengthen the role of the EPSCO Council, ensure involvement of stakeholders, and improve reporting in the social policy area at national and EU level.

Given the scale and scope of recent changes in economic and fiscal governance as well as the developments in the employment and social situation, there is a need for EU institutions and Member States to ensure that social investment approaches are considered in the current discussion on the social dimension of the Economic and Monetary Union.”

While it is important to gain information on impacts of austerity upon health outcomes, there is a common moral obligation not to wait until unequivocal “evidence” on deaths and increasing mortality and morbidity is available, when health should be considered as part of policies, rather than as an afterthought. In this respect it is important to be able to work together so as to assess and build up more socially equitable policies in the context of European Union policies seeking to gain economic growth shifting from austerity Europe towards a social Europe.

4. Governance and critical mass for addressing HIAP within Europe

While European cooperation and coordination has become strengthened as part of economic policies and in particular, European semester, this has not been accompanied by improved mechanisms to address health and social determinants of health as part of European Union policies or capacities to address how these relate to health and health system needs within Member States. This is the case not only with respect to health inequalities, but as well in

³⁴<http://sveikatosforumas.org/forumas.html>

³⁵<http://www.euro.who.int/en/about-us/partners/observatory/news/news/2013/11/observatory-launches-new-web-platforms-on-health-systems-and-financial-crisis>

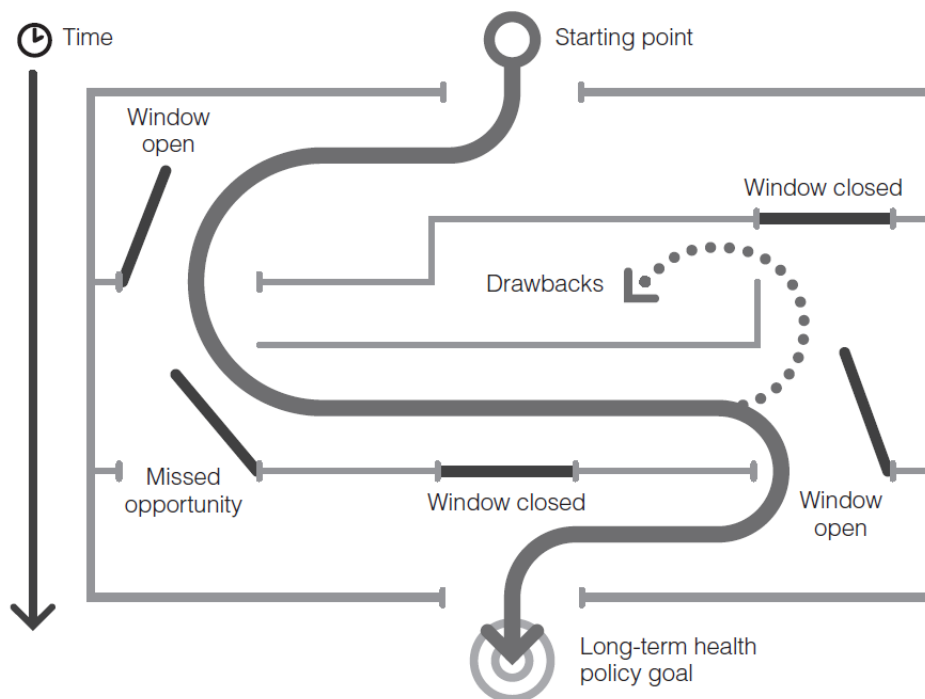
³⁶http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lisa/137545.pdf



relation equity and universal coverage in health systems, maintaining high level of health protection in all policies and enhancing population health. While not only equity in HIAP, but HIAP as such, remains a challenge for European governance, the current changes in European governance can also be seen as a basis for articulation of strengthening and improved capacities in HIAP.

The politics stream of incoming European elections provide also scope to proceed in the area as well as to make clear that European Union is not merely an unaccountable bailout mechanism for banks and shopping forum for corporate friendly regulation or a futile bureaucracy for the consumption of tax payers money in Member States, but seeks to address, improve accountability and tackle issues of relevance and importance of European citizens and commitments in the context of a social Europe. It is in this context that a window of opportunity to strengthen the role of HIAP within European Union and member states is open. (Figure 2, from Ollila et al 2013)

Figure 2. Window for opportunity and shaping of long-term policy-making



9. CONCLUSIONS AND AGENDA FOR ACTION

While European Union and its Member States have boldly taken up both the agenda on tackling social determinants of health as well as addressing equity and Health in All Policies, there is no scope for complacency. The joint action “Equity action” is more a beginning than an end for activities, which require strengthening as well as building further potential for European wide action. However, drawing from the four main needs and lessons learned, there is also scope for considering the emerging complex context of governance in Europe to an opportunity for more articulate action and strengthening critical mass for HIAP within Member State and as part of European Union policy making as whole.



The agenda for action could comprise of six parts:

- i) **Legitimacy and basis for action:** review and analysis of the existing legal basis and case-law of relevance to HIAP in the context of human and social rights commitments, international commitments, European Union treaty obligations and legislation within Member States, so as to guide and inform Member States on the legitimacy and legal basis for HIAP in practice
- ii) **Knowledge and Capacity:** strengthening existing public health and HIAP capacities through European joint action on research, training and institutional support for HIAP, including teaching on HIAP as part of diplomas, practice work and public health-related degrees.
- iii) **Strengthening equity and health inequalities in health programme:** addressing health inequalities in the context of European Health programme as it relates to health systems, infectious diseases and non-communicable diseases. Utilising scope for more equity oriented policies within health and that equity and reduction of health inequalities are discussed in the context of health policy choices and options. Enhancing cooperation across initiatives in the field of health and social policy.
- iv) **Children and youth:** establishing a common joint action with focus on children and youth, poverty and health. This is an area which is not only emphasised by recent European reviews, but also one that has become articulated in the context of multisectoral responses.
- v) **Austerity and growth:** accelerating action on HIAP in the context of growth oriented economic policies and European semester and structural funds. The focus on austerity needs to shift towards means of ensuring that health and equity gain more substantial consideration.
- vi) **Governance:** Enhancing HIAP in the context of European Parliament work, supporting networking, alliances and sharing of knowledge resources, including on how structural funds could be better utilised for health. Analysing potential and possibilities for an independent office with the task of scrutiny for ensuring that health is adequately considered in all policies.

Action on health inequalities and social determinants of health is not a matter of lack of knowledge. We have fresh reviews and analysis on inequalities at European Union level as well as emerging networks and linkages with respect to HIA and HIAP through the joint action. What is necessary now is to realise existing European Commission and Member State commitments as well as to engage and sustain European Union level follow up, action and emphasis beyond the more temporary form of joint action as well as extend this focus to European Parliament functions and activities.

However, it is also important to remember that addressing social determinants of health and health inequalities is not a short haul one communication measure, but a longer term challenge. This is especially so with respect to the often long social shade of economic crises, continuing much beyond economic recovery. A specific programme and communication on universal access, equity and health in all policies should be established to continue with the challenge, based on and drawing from the six parts for action. This would have the added benefit of strengthening the role of public health within European Union policies, which is in danger of becoming increasingly marginalised, as well as in enabling focus on key aspects of health systems development and financing, which matter for universal access and equity.

References:



Aittomäki A, Martikainen P, Rahkonen O, Lahelma E (2013) Household income and health problems during a period of labour-market change and widening income inequalities – a study among the Finnish population between 1987 and 2007. *Social Science & Medicine*, in print, <http://dx.doi.org/10.1016/j.socscimed.2013.10.023>.

Babor T et al. (2010) *Alcohol: no ordinary commodity. Public policy and research*. Oxford University Press, Oxford.

Bartley M (2004) *Health inequality. An introduction to theories, concepts and methods*. Polity press, Cambridge.

Blas E, Kurup AS (2010) *Equity, social determinants of health and public health programmes*. WHO, Geneva. Available from: http://whqlibdoc.who.int/publications/2010/9789241563970_eng.pdf

Bernal JAL, Gasparrini A, Artundo CM, McKee M (2013) The effect of the late 2000s financial crisis on suicides in Spain: an interrupted time-series analysis. *European Journal of Public Health* 2013;23:5:732-736.

Birt C (2007) *A CAP on health ?The impact of Common Agricultural Policy on Public Health*. Faculty of Public Health, London. http://www.fph.org.uk/uploads/r_CAP.pdf

Braveman P, Gruskin S (2003) Defining equity in health. *J Epidemiol Community Health* 2003;57;254-258.

Council of the European Union (2011) *Council conclusions on closing the gap within EU through concerted action to promote healthy lifestyle behaviours*. Brussels 1 and 2 December 2011.

Council of the European Union (2006) *Council conclusions on Health in All Policies (HiAP)*. Brussels 30th November and 1 December 2006.

Council of the European Union (2010) *Council conclusions on Equity and Health in All Policies: Solidarity in Health*. Brussels 8 June 2010.

CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization.

Di Cesare M, Khang Y-H, Asaria P, Blakely T, Cowan MJ, Farzadfar F, Guerrero R, Ikeda N, Kyobutungi C, Msyamboza KP, Oum S, Lynch JW, Marmot MG, Ezzati M, on behalf of NCD Action Group *Inequalities in non-communicable diseases and effective responses* (2013). *The Lancet*, Volume 381;9866:2013:585-597, ISSN 0140-6736, [http://dx.doi.org/10.1016/S0140-6736\(12\)61851-0](http://dx.doi.org/10.1016/S0140-6736(12)61851-0)

Dorfman L, Cheyne A, Friedman LC, Wadud A, Gottlieb M (2012) Soda and Tobacco Industry Corporate Social Responsibility Campaigns: How Do They Compare? *PLoS Med* 9(6): e1001241. doi:10.1371/journal.pmed.1001241

ECDC (2013) *Health inequalities, the financial crisis and infectious diseases in Europe*. ECDC, Stockholm. Available from: http://www.ecdc.europa.eu/en/publications/Publications/Health_inequalities_financial_crisis.pdf

ECHP (1999) *Gothenburg consensus paper on health impact assessment: Main concepts and suggested approach*. Brussels: European Centre for Health Policy, WHO Regional Office for Europe.

Exworthy M (2008) Policy to tackle the social determinants of health: using conceptual models to understand the policy process. *Health Policy and Planning* 2008;23;318-327.



European Commission (2009) Mainstreaming sustainable development into EU policies: 2009 Review of the European Union Strategy for Sustainable Development. European Commission, Brussels. COM (2009) 400final.

European Commission (2013) European Commission recommendation 20.02.2013. Investing on children: breaking the cycle of disadvantage. European Commission, Brussels. Available from: http://ec.europa.eu/justice/fundamental-rights/files/c_2013_778_en.pdf

European Commission (2013) Commission staff working document. Report on health inequalities in the European Union. Brussels, September 2013. SWD (2013) 328 final.

Gallo P, Gene-Badia J (2013) Cuts drive health system reforms in Spain. Health Policy, in print.

Gerstetter C, Mehling M, Eberle A, Sales K (2013) Legal implications of the EU-US trade and investment partnership (TTIP) for the AcquisCommunitaire and the ENVI relevant sectors that could be addressed during negotiations. Policy Department A: Economic and Scientific Policy. European Parliament, Brussels. IP/A/ENVI/ST/2013-09

Gusmano MK, Weisz D, Rodwin VG, Lang J, Qian M, Bocquier A, Moysan V, Verger P (2013) Disparities in access to health care in three French regions. Health Policy, in print.

Gleeson D, Friel S (2013) Emerging threats to public health from regional trade agreements. Lancet 2013; 381: 1507–09.

Hamer L, Jacobson B, Flowers J, Johnstone F (2003) Health equity audit made simple. A briefing for primary care trusts and local strategic partnerships. Working document January 2003.

Harris-Roxas B, Simpson S, Harris E (2004) Equity focused health impact assessment: a literature review. CHETRE, Sydney.

Harris-Roxas B, Viliani F, Bond A, Cave B, Divall M, Furu P, Harris P, Soeberg M, Wernham A, Winkler M. (2012) Health impact assessment: the state of art. Impact assessment and project appraisal 2012:30:1:43-52.

Harris-Roxas BF, Harris P, Harris E, Kemp LA (2011) A rapid equity focused health impact assessment of a policy implementation plan: an Australian case study and impact evaluation. International Journal for Equity in Health 2011,10:6, <http://www.equityhealthj.com/content/10/1/6>.

Hill S, Amos A, Clifford D, Platt S (2013) Impact of tobacco control interventions on socioeconomic inequalities in smoking: review of the evidence. Tobacco Control. Published Online First: 17 September 2013 doi:10.1136/tobaccocontrol-2013-051110

Ifanti A, Argyriou A, Kalofonou FH, Kalofonos HP (2013) Financial crisis and austerity measures in Greece: Their impact on health promotion policies and public health care. Health Policy 2013:113, Issue 1, Pages 8-12, DOI: 10.1016/j.healthpol.2013.05.017

Karanikolos M, Mladovsky P, Culys J et al. (2013) Financial crisis, austerity and health in Europe. Lancet 2013:381;1323-31.



Kentikelenis A, Karanikolos M, Papanicolas I, Basu S, McKee M, Stuckler D. Health effects of financial crisis: omens of a Greek tragedy. *Lancet* 2011; doi:10.1016/S0140-6736(11)61556-0

Kickbush I, Behrent T (2012) Implementing a Health 2020 vision: governance for health in the 21st century. Making it Happen. WHO, Copenhagen. Available from: http://www.euro.who.int/_data/assets/pdf_file/0018/215820/Implementing-a-Health-2020-Vision-Governance-for-Health-in-the-21st-Century-Eng.pdf

Kickbush I, Gleicher D (2012) Governance of health in the 21st century. WHO, Geneva. Available from: http://www.euro.who.int/_data/assets/pdf_file/0019/171334/RC62BD01-Governance-for-Health-Web.pdf

Kingdon J (1995) *Agendas, alternatives and public policy*. Little Brown, Boston.

Koivusalo M, Labonte R, Wibulpolprasert S, Kanchanachitra C (2013) Globalization and national policy space for health and a HIAP approach. In: Leppo K, Ollila E, Pena S, Wismar M, Cook S (eds) (2013) *Health in All Policies. Seizing opportunities, implementing policies*. Ministry of Social Affairs and Health, UNRISD, WHO Observatory on health systems and policies, Helsinki. Available from: http://www.euro.who.int/_data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf

Koivusalo M (2006) Moving health higher up the European agenda. In: Stahl T, Wismar M, Ollila E, Lahtinen E, Leppo K (eds) *Health in All Policies. Prospects and potentials*. Ministry of Social Affairs and Health, Helsinki.

Legido-Quigley H, Otero L, la Parra D, Alvarez-Dardet C, Martin-Moreno J, McKee M (2013) Will austerity cuts dismantle the Spanish healthcare system. *British Medical Journal* 2013;346:f2363. Doi: 10.1136/bmj.f2363.

Leppo K, Ollila E, Pena S, Wismar M, Cook S (eds) (2013) *Health in All Policies. Seizing opportunities, implementing policies*. Ministry of Social Affairs and Health, UNRISD, WHO Observatory on health systems and policies, Helsinki. Available from: http://www.euro.who.int/_data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf

Lloyd-Williams Ff, O'Flaherty M, Mwatsama M, Birt C, Ireland R, Capewell S (2008) Estimating the cardiovascular mortality burden attributable to the European Common Agricultural Policy on dietary saturated fats. *Bulletin of the World Health Organisation* 2008;86:7:535-541

Lorenc T, Petticrew M, Welch V, Tugwell P (2013) What types of interventions generate inequalities? Evidence from systematic reviews. *J Epidemiol Community Health* 2013;67:2:190-193 doi:10.1136/jech-2012-201257

Lundberg O, Aberg M, Stjerne MK, Bjork L, Fritzell J (2008) *The Nordic Experience: welfare studies and public health (NEWS)*. Health equity studies No 12. Stockholm, CHES.

Lundberg O, Aberg M, Stjerne MK, Elstad JJ, Ferrarini T, Kangas O, Norstrom T, Palme J, Fritzell J (for the NEWS Expert group) (2008) The role of welfare state principles and generosity in social policy programmes for public health: an international comparative study. *The Lancet* 2008;372:1633-40.

Mariachiara Di Cesare, Young-Ho Khang, Perviz Asaria, Tony Blakely, Melanie J Cowan, Farshad Farzadfar, Ramiro Guerrero, Nayu Ikeda, Catherine Kyobutungi, Kelias P Msyamboza, Sopha Oum, John W Lynch, Michael G Marmot, Majid Ezzati, on behalf of The Lancet NCD Action Group,



Marmot MG, Allen J (2013) Prioritizing health equity. In: Leppo K, Ollila E, Pena S, Wismar M, Cook S (eds) (2013) Health in All Policies. Seizing opportunities, implementing policies. Ministry of Social Affairs and Health, UNRISD, WHO Observatory on health systems and policies, Helsinki. Available from: http://www.euro.who.int/_data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf

Malliori M, Golna C, Souliotis K, Hatzakis A (2013) Letter in Lancet. Lancet 2013:382;392.

Mahoney M., Simpson S., Harris E., Aldrich R., Stewart Williams J. (2004) Equity Focused Health Impact Assessment Framework, the Australasian Collaboration for Health Equity Impact Assessment (ACHEIA).

Melkas T (2013) Health in All Policies as a priority in Finnish health policy: a case study on national health policy development. Scandinavian Journal of Public Health 2013:41:suppl 11: 3-28.

Mladovsky P, Srivastava D, Cylus J, Karanikolos M, Evetovits T, Thomson S, McKee M (2012) Policy summary 5. Health policy responses to the financial crisis in Europe. WHO, European Observatory on health systems and policy. Available from: http://www.euro.who.int/_data/assets/pdf_file/0009/170865/e96643.pdf

McCartney G, Collins C, Mackenzie M (2013) What (or who) causes inequalities: theories, evidence and implications? Health Policy, in print.

McGrady B (2011) Trade and public health. The WTO, Tobacco, alcohol and diet. Cambridge University Press, Cambridge.

McIntyre D, Thiede M, Dahlgren G, Whitehead M (2006) What are the economic consequences for households of illness and of paying for health care in low- and middle-income country contexts?, Social Science & Medicine, Volume 62, Issue 4, February 2006, Pages 858-865, ISSN 0277-9536, <http://dx.doi.org/10.1016/j.socscimed.2005.07.001>.

McCarthy M (2011) Health and the European Structural Funds in the new member states. European Journal of Public Health 2012:23:3:522-523.

McQueen DV, Wismar M, Lin V, Jones CM, Davies M (2012) Intersectoral governance for Health in All Policies. Structures, actions and experiences. WHO, Copenhagen. Available from: http://www.euro.who.int/_data/assets/pdf_file/0005/171707/Intersectoral-governance-for-health-in-all-policies.pdf

Mercer R, Hertzman C, Molina H, Vaghri Z (2013) Promoting equity from the start through early child development and Health in All Policies (ECD-HIAP). In: Leppo K, Ollila E, Pena S, Wismar M, Cook S (eds) (2013) Health in All Policies. Seizing opportunities, implementing policies. Ministry of Social Affairs and Health, UNRISD, WHO Observatory on health systems and policies, Helsinki. Available from: http://www.euro.who.int/_data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf

Moodie R, Stuckler D, Monteiro C, Sheron N, Neal B, Thamarangsi T, Lincoln P, Casswell S (2013) Profits and pandemics: prevention of harmful effects of tobacco, alcohol, and ultra-processed food and drink industries. The Lancet 2013:381;9867: 670-679. DOI: 10.1016/S0140-6736(12)62089-3

Nowatzki NR (2012) Wealth inequality and health: a political economy perspective. International Journal of Health Services 2012:3; 403-424



OECD (2013) Health at a Glance. OECD, Paris.

Ollila E, Baum F, Pena S (2013) Introduction to Health in All Policies and the analytical framework of the book. In: Leppo K, Ollila E, Pena S, Wismar M, Cook S (eds) (2013) Health in All Policies. Seizing opportunities, implementing policies. Ministry of Social Affairs and Health, UNRISD, WHO Observatory on health systems and policies, Helsinki. Available from: http://www.euro.who.int/_data/assets/pdf_file/0007/188809/Health-in-All-Policies-final.pdf

Quaglio G, Karapiperis T, Woensel L, Arnold E, McDaid D (2013) Austerity and health in Europe. In press, Health Policy

Pega F, Kawachi I, Rasanathan K, Lundberg O (2013) Politics, policies and population health: A commentary on Mackenbach, Hu and Looman. *Social Science and Medicine* 2013;93:176-179.

Reading R, Bissell S, Goldhagen J, Harwin J, Masson J, Moynihan S, Parton N, Santos Pais M, Thoburn J, Webb E (2009) Promotion of childrens' rights and prevention of child maltreatment. *Lancet* 2009;373:332-343

Semenza J C, Tsovala S, Lim T-A (2012) Economic crisis and infectious diseases control: a public health predicament. *European Journal of Public Health* 2012;22:1:5-6.

Simpson S, Mahoney M, Harris E, Aldrich R, Stewart-Williams J (2005) Equity-focused health impact assessment: a tool to assist policy makers in addressing health inequalities. *Environmental Impact Assessment Review* 2005;25:772-782.

Smith KE, Fooks G, Collin J, Wishaar H, Mandal S, Gilmore A (2010) "Working the system" – British American Tobacco's influence on the European Union Treaty and its implications to policy: an analysis of internal tobacco industry documents. *PlosMedicine* 2010;7:1:e1000202.

Salay R, Lincoln P (2008) Health impact assessment in the European Union. *Lancet* 2008;372:860-1.

Stahl T, Wismar M, Ollila E, Lahtinen E, Leppo K (2006) (eds) Health in All Policies. Prospects and potentials. Ministry of Social Affairs and Health, Helsinki.

Stuckler D, Basu S, Suhrcke M, Coutts A, McKee M (2009) The public health effect of economic crises and alternative policy responses in Europe: an empirical analysis. *Lancet* 2009;374:315-23.

Stuckler D, Basu S (2013) *The Body Economic. Why austerity kills.* Allen Lane/Penguin books, London.

Tarkowski S, Ricciardi W (2012) Health impact assessment in Europe – current dilemmas and challenges. *European Journal of Public Health* 2012; 22:5:612.

Thomas S, Fayter D, Misso K, Ogilvie D, Petticrew M, Sowden A, Whitehead M, Worthy G (2008) Population tobacco control interventions and their effects on social inequalities in smoking: systematic review. *Tobacco Control* 2008;17:230–237. doi:10.1136/tc.2007.023911.

UCL (2013) Review on social determinants of health and European Union.

United Nations (2011) Political declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases. United Nations, New York. A/66/L.1.



Vandoros S, Hessel P, Leone T, Avendano M (2013) Have health trends worsened in Greece as result of the financial crisis ?A quasi-experimental approach. *European Journal of Public Health* 2013:23:5:727-731

WHO (2013a) Review of social determinants and the health divide in the WHO European Region: final report. WHO, Copenhagen.

WHO (2013b) Health 2020. A European policy framework and strategy for the 21st century. WHO, Copenhagen. Available from: http://www.euro.who.int/_data/assets/pdf_file/0011/199532/Health2020-Long.pdf

WHO (2013c) Health 2020. A European policy framework supporting action across government and society for health and well-being. WHO, Copenhagen. Available from: http://www.euro.who.int/_data/assets/pdf_file/0006/199536/Health2020-Short.pdf

WHO (2013) Outcome document for the high-level meeting on health systems in times of global economic crisis: an update of the situation in the WHO European region. EUR/RC63/13+EUR/RC63/Conf.Doc./9. 29 July 2013.

Victora CG, Wagstaff A, Armstrong Schellenberg J, Gwatkin D, Claeson M, Habicht J-P (2003) Applying an equity lens to child health and mortality: more of the same is not enough. *Lancet* 2003;362:233–41

Vis B, Hylands T (2013) Fat government, thin populace ? Is the growth of obesity prevalence lower in more generous welfare states. *Int J Social Welfare* 2013:22:360-373

Xu K, Evans DB, Kawabata K, Zeramdini R, Klavus J, Murray CJL (2003) Household catastrophic health expenditure: a multicountry analysis. *Lancet* 2003; 362: 111–17

Ostlin P, Schrecker T, Sadana R, Bonnefoy J, Gilson L, Hertzman C, Kelly MP, Kjellstrom T, Labonte R, Lundberg O, Muntaner C, Popay J, Sen G, Vaghri Z (2011) Priorities for research on equity and health: towards an equity-focussed health research agenda. *Plosmedicine* 2011:8:11:e1001115.