

SOCIAL DETERMINANTS OF HEALTH (INEQUITIES) – A EUROPEAN SNAPSHOT AND STIMULI FOR ACTION ¹

DETERMINANTES SOCIALES DE LA SALUD (INEQUIDADES) – SITUACIÓN EUROPEA Y ESTÍMULO PARA LA ACCIÓN

² Marlene Brettenhofer.

³ Luis Gabriel Bernal.

Abstract

Health states are the result of the effect of multiple social determinants of health (SDOH). Health inequities appear as a consequence of the adverse interaction of the SDOH, leading to avoidable and therefore unfair health disparities between and within populations. Although the European population achieves higher levels of health and life expectancy than ever before, health inequities between and within European countries are still widespread and even increasing in some areas. The current economic crisis further shows significant negative impacts on the SDOH and consequently on the health of populations. Furthermore, data suggests that governmental responses of several European countries to the crisis failed to provide sustainable and comprehensive solutions as they do not take health into consideration. However, strong economic, social and health systems seem to act preventatively on negative effects on SDOH and health itself. Moreover, intersectoral governance structures and Health Impact Assessments (HIA) can foster the narrowing of unfair health gaps.

Resumen

Los estados de salud son resultado del efecto de los múltiples factores sociales determinantes de la salud. Las inequidades en salud aparecen como consecuencia de la interacción adversa de dichos factores determinantes, que llevan a disparidades en salud entre diversas poblaciones y entre integrantes de una misma población, las cuales pueden catalogarse como injustas y evitables. Aunque la población europea ha alcanzado altos niveles de salud y esperanza de vida como nunca antes, las inequidades en salud entre y dentro de los países europeos se encuentran aun ampliamente extendidas y en incremento en algunas áreas. La crisis económica actual, además, muestra impactos negativos significativos sobre los factores determinantes sociales de la salud y, por consiguiente, sobre la salud de las poblaciones. Adicionalmente, la información actual sugiere que las respuestas gubernamentales de varios países europeos ante la crisis fallaron en su objetivo de proveer soluciones integrales y sostenibles, en la medida en que estas no toman en cuenta a la salud. Sin embargo, los sistemas de salud, sociales y económicos sólidos parecen actuar preventivamente ante los efectos

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2. MPH, Profesora visitante en la Maestría en Salud Pública, Universidad El Bosque, Bogotá, D.C., Colombia marlene.brettenhofer@gmail.com

3. MD, Especialista en Medicina Familiar, MPH, Profesor en el Pregrado de la Facultad de Medicina y en la Maestría en Salud Pública, Universidad El Bosque. Profesor en la Maestría en Salud Pública, Universidad Javeriana. Director Académico de Javesalud, Bogotá, D.C., Colombia bernal_luisg@yahoo.com

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negativos sobre los factores sociales determinantes de la salud y sobre la salud misma. Por otra parte, el desarrollo de estructuras gubernamentales intersectoriales y de estrategias como la evaluación de impacto en salud, pueden fomentar la reducción de disparidades en salud consideradas como injustas.

Palabras clave: determinantes sociales de la salud, inequidades en salud, desigualdades en salud, disparidades en salud, crisis económica, salud en todas las políticas, evaluación del impacto en salud

INTRODUCTION

Health and health inequities are particularly determined by the health system itself and by many factors outside the health sector, all in all, by the social determinants of health (SDOH). Housing, education, environment, socioeconomic position and many conditions more shape the health status of populations (1). A social gradient is persistent all around the world (1). This picture is reflected in unnecessary and unfair health disparities, which are considered as avoidable, and therefore tackling them is also a need from a human rights perspective (2).

This article provides a brief insight into the inhomogeneity of Europe, where health inequities are persistent and widespread. Considerable health gaps exist between and within European countries (2). Additionally, the economic crisis worsened the situation substantially. The authors claim that Europe's governments did not respond to the crisis in a healthy way. Poor health outcomes increased in the countries which were hit most severely by the crises, namely Spain, Greece, Portugal and Ireland (3).

Therefore, actions on the SDOH are crucial, particularly during times of economic difficulties (3,4). It appears that the main doctrine should be to bring Health in All Policies (HiAP). Thus, European examples are provided about intersectoral governance structures and a Health Impact Assessment (HIA), which were able to trigger HiAP and shape the SDOH.

CLARIFICATION OF TERMS

Europe is inhabited by about 740 million people (5) and covers 50 countries, whereas Armenia, Azerbaijan, Georgia, Kazakhstan, Russia and Turkey are located on both European and Asian territory.

Twenty seven out of the 50 European countries are members of the European Union (EU), which is often

referred to as EU-27. Twenty three different languages are spoken within the EU. In the year 2011, the combined population of the European Union was 502 million people (6). In comparison, by mid of 2012 South America had a combined population of approximately 397 million people (5). Currently, 17 European countries (EU-17) have adopted the Euro as a currency (6).

The World Health Organization (WHO), European Region, covers 53 countries including all European countries except Liechtenstein and Vatican City. Furthermore, Israel, Kyrgyzstan, Tajikistan, Turkmenistan and Uzbekistan are also covered by this WHO region (7).

The following figure provides an overview about the member states of the WHO European Region, the European Union, the Eurozone and the countries, which belong to Europe geographically.



Figure 1. Member States WHO European Region, Europe, European Union, Eurozone

HEALTH INEQUITIES IN EUROPE

Health inequities are considered as differences or inequalities in health, which are avoidable and therefore unjust and unfair (8). There exists no reason at all, from a biological perspective, why people in different countries achieve different life expectancies and a different health status (9). As seen all around the world (1, 9), such disparities are also persistent in Europe (2,10-12).

Although the European population currently achieves on average higher levels of health and life expectancy than seen before, health inequities have not decreased but have partly risen (2,10,11,13). Figure 2 shows the most striking differences in health in the WHO European Region, namely a comparison of life expectancies. In terms of gender, in the year 2010 a gap of 17 years existed for men and of 12 years for women (2). At the EU-27 level, the lowest life expectancy at birth in 2011 was reported for women in Bulgaria (77.8 years) and for men in Lithuania (68.1 years). In

contrast, women born in Spain can be expected to live 85.4 years and men born in Sweden 79.9 years. Hence, existing inequities within the European Union are smaller than at the whole European level, but with a range of 7.6 years for women and 11.8 years for men they are still considerable (14). In the last 20 years, the disparity between the EU average and the national life expectancy has widened for some countries (10). The obvious gender gap in life expectancies is narrowing in most countries, which is assumed to be at least partly a consequence of more equal risk-increasing behaviours between men and women, such as smoking, and improvements in mortality outcomes from cardiovascular diseases among men (15,16).

However, in this context not just the quantity is important but the years spent in good health (Healthy Life Years, HLY) are crucial. This indicator shows an even more substantial gap across EU member states with a span from 52.3 years to 70.6 years (18.3 years difference) for women and from 52.1 years to 70.5 years

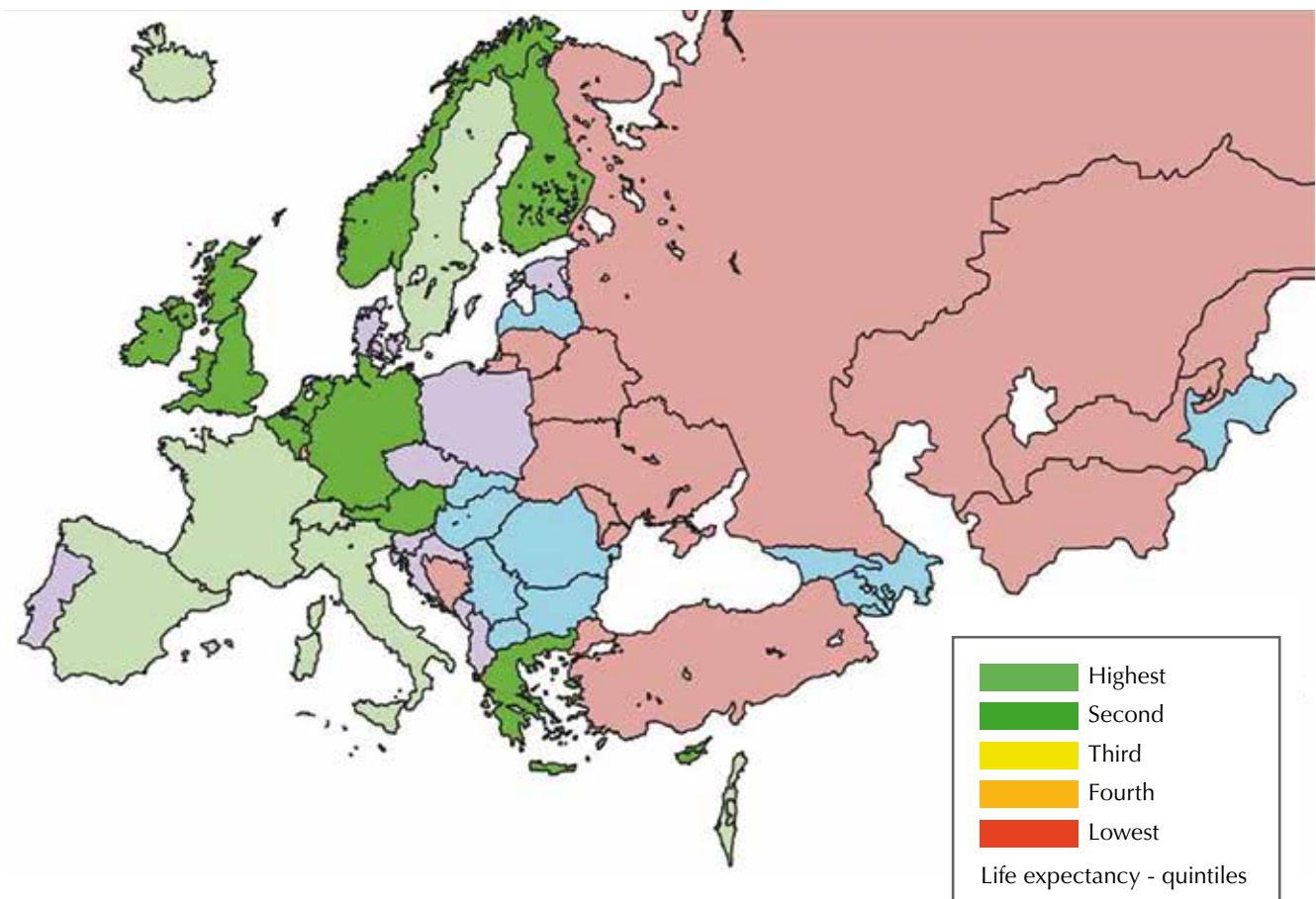


Figure 2. Life expectancy in countries in the WHO European Region, 2010 or latest available (2)

(18.4 years difference) for men (13). Similarly, in the WHO European Region the infant mortality rate varied from 2 deaths per 1,000 live births in Finland, Iceland, Luxembourg, San Marino, Slovenia and Sweden to 53 deaths per 1,000 live births in Tajikistan in 2011 (17). Inequalities in morbidities and mortalities related to cardiovascular diseases, cancer, alcohol-related diseases, injuries and violence are also prevalent and contribute to the above mentioned differences (10,11).

The data reveals a pattern across Europe, demonstrating that, firstly, health inequities are narrower at EU-level compared to the whole of Europe or the WHO European Region and, secondly, the population of Central and Eastern Europe as well as the Baltic States (on the whole, east of the former Iron Curtain including the former Republic of Yugoslavia) has poorer health than the population from Western Europe (11,18).

Disparities across the whole range of different health indicators exist not just between European countries, but also within the states (10). Figure 3 illustrates the differences in life expectancies at birth across the

nomenclature of territorial units for statistics (NUTS) classification two (representing basic regions) for European countries where data is available at that level. The five groups illustrated in different colour codes represent equal intervals of life expectancies. France, the United Kingdom, Germany and Greece even show three different colour codes across their regions. Eastern countries appear more homogeneous, however at very low levels of life expectancy. Only the Swiss and Icelandic populations achieve highest life expectancies at birth throughout all regions (19). Inequitable variations are also omnipresent at the level of cities. For example, the Institute of Health Equity from the University College London (UCL) (2012) demonstrated between the boroughs of London a difference of 9.1 years of life expectancy at birth for males and 8.7 years for females. Furthermore, there is also a disparity of about 10 years of HLY for men and women living in different boroughs (20). In brief, Europe represents a picture of unnecessary health outcome variations at a national, regional and local level.

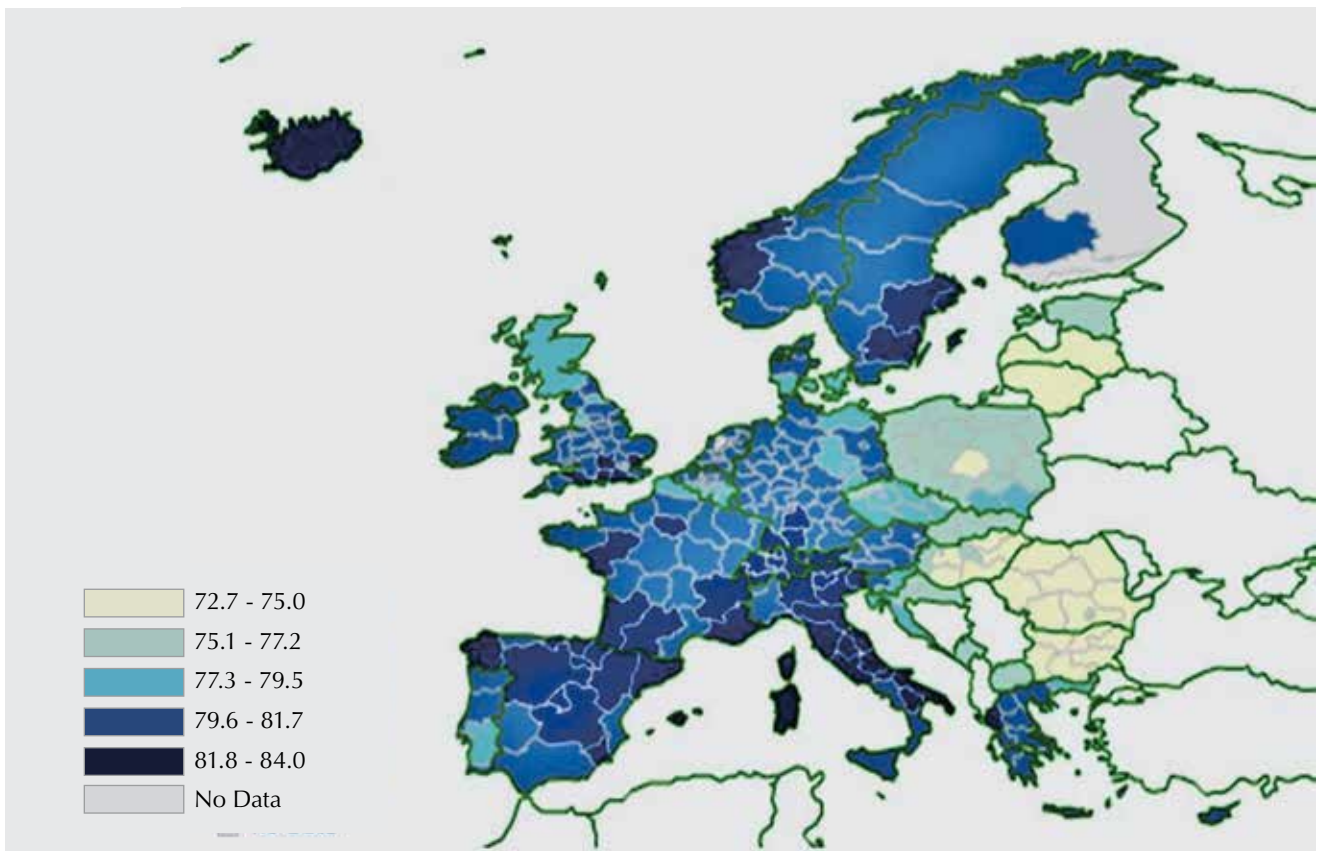


Figure 3. Life expectancy at birth in NUTS 2 regions, 2012 or latest available (19)

SOCIAL DETERMINANTS OF HEALTH (INEQUITIES)

The inequities in health are the consequence of social, environmental and economic inequities. Nowadays it is uncontested that the conditions in which people are born, grow, live, work and age as well as the health system –the so-called social determinants of health– are predictors for poor health or good health (see figure 4). An inequality of these living conditions is a result of an inequitable distribution of power, money and resources. As a consequence, unjust and unfair gaps of health outcomes exist within and between populations. As discussed above, health inequities are widespread in Europe, thus, an inequality across the social determinants of health is prevalent too (1,2,20,21).

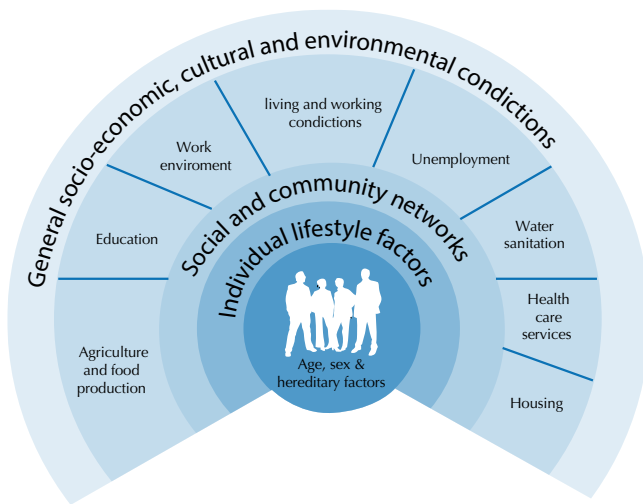


Figure 4. The social determinants of health (22)

THE SPREAD OF WEALTH AND HEALTH

Socio-economic conditions between European countries differ strongly. In 2007, total income of the richest 20% of the population in the EU-27 was five times higher than that of the poorest 20% (23). The Gross Domestic Product (GDP) per inhabitant in the year 2011 showed a west-east divide, as shown in figure 5, where Luxembourg is doing extraordinary well compared to the rest of Europe. Bulgaria, Romania and Latvia report the lowest GDP per inhabitant, which was just less than 60% of the EU-27 average (6). To demonstrate another example, the Gini index (1992-2007), a summary index for income inequality, ranged from 24.7¹ for Denmark to 49.21 in Turkey (23). This

1 0: absolute income equality, 100: absolute income inequality

matters, as in developed countries, for greater equality relative socioeconomic position in society is more crucial than the absolute material conditions of individuals. That is, the more evenly wealth is distributed within a population the narrower are health inequities (24,25). To illustrate the significance of this, a meta-analysis including about 60 million subjects published by Kondo, et al., estimated that mortality rises by 8% when the Gini coefficient increases by 0.05 points (26). Also poverty levels differ extremely between countries. For instance, more than 40% of children aged 0 to 17 years were living in a household at risk of poverty or social exclusion in Romania, Bulgaria and Latvia compared to 14.2% in Finland (27). Thus, which European country a European is born in, determines strongly his or her health as the social determinants of health are shaped differently.

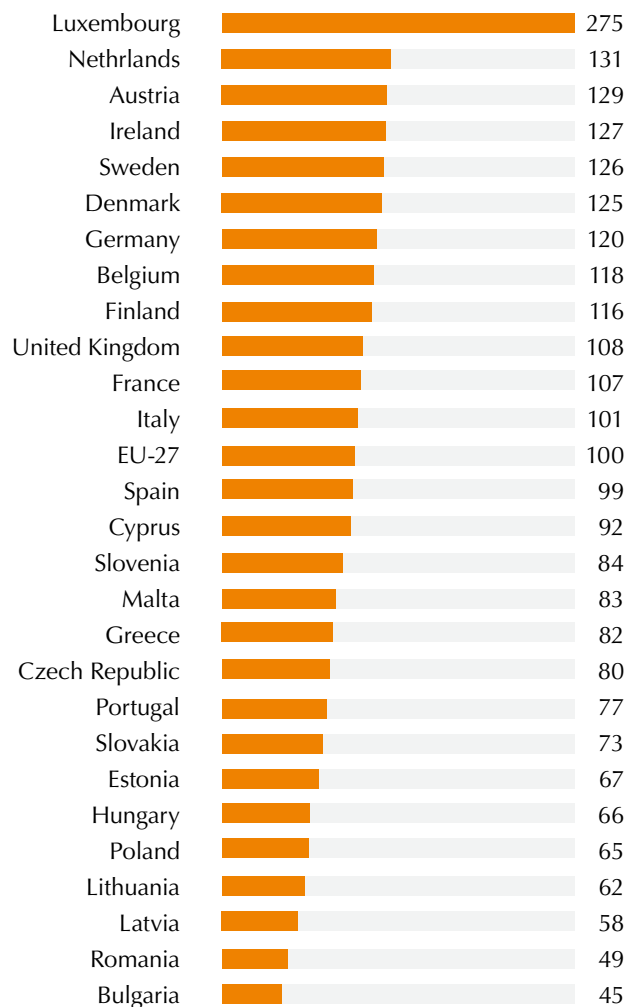


Figure 5. Gross Domestic Product (GDP) per inhabitant, 2011 (6)

Note: Index where the average of the 27 EU-countries is 100.

Various European-specific research studies confirm the association of socio-economic indicators and health. For instance, the higher the average level of household deprivation of a European country, the higher is the likelihood of a child dying before the age of five years in that country. Not surprisingly, Romania, Bulgaria and Latvia show the highest mortality rate of children younger than five years (2) (14, 13 and 10 deaths per 1,000 live births respectively (28). Similarly, Buzeti, et al., confirm that in Slovenia the infant mortality rate is 2.6 times higher for infants born to mothers who attended primary school only compared to infants of mothers with tertiary education (29). Furthermore, statistics confirm that European people with a higher education are less likely to be obese (2). Similar pattern can also be seen in the latest report of the Health Behaviour in School-aged Children (HBSC) study, where 43 countries and regions from Europe and North America participated. According to this study, schoolchildren from families with higher socio-economic status (SES) reported better health, higher life satisfaction and fewer health complaints (30). Even in the more affluent countries of Europe there exist health differences between the most deprived and least deprived people, as illustrated by figure 6 (2), the case of life expectancy by educational level in Sweden.

Factors which determine mostly the population's health vary between European countries. For example, excessive alcohol consumption, poor living and working conditions, smoking, and an unequal access to a good-quality health care system are stronger determinants of

health inequities in eastern countries than they are in the rest of Europe (2,10). Differences in health behaviours between European populations are partly a result of different social and cultural norms (2).

THE EFFECT OF THE RECENT ECONOMIC CRISIS AND GOVERNMENTAL RESPONSES

2007/2008 was the beginning of an economic crisis around the world. Until now, it has had a significant impact on the SDOH (2). An EU-wide survey revealed that the crisis has affected the personal life of 52% of respondents (31). To exemplify the effect on European citizens, figure 7 shows the trend for unemployment rates from 2000 to 2010. Figures started to rise steeply from the second quarter of the year 2008 until now, only recording a slight drop at the beginning of 2011. In November 2012, the seasonally adjusted unemployment rate was highest for Spain (26.6%), Greece (26.0%), Portugal (16.3%) and Ireland (14.6%), the countries which were most affected by the financial downturn (figure 8). The unemployment rate for people aged less than 25 years was even more disconcerting, in Greece 57.6% and in Spain 56.5% (32). Consequently, less income of families may likely affect adequate housing and standard of living. In London, for instance, the downward trend from 2003 to 2009 in the number of households accepted as homeless reversed in 2010 and is now increasing (20). That is to say, the crisis has had a tangible impact on peoples' lives.

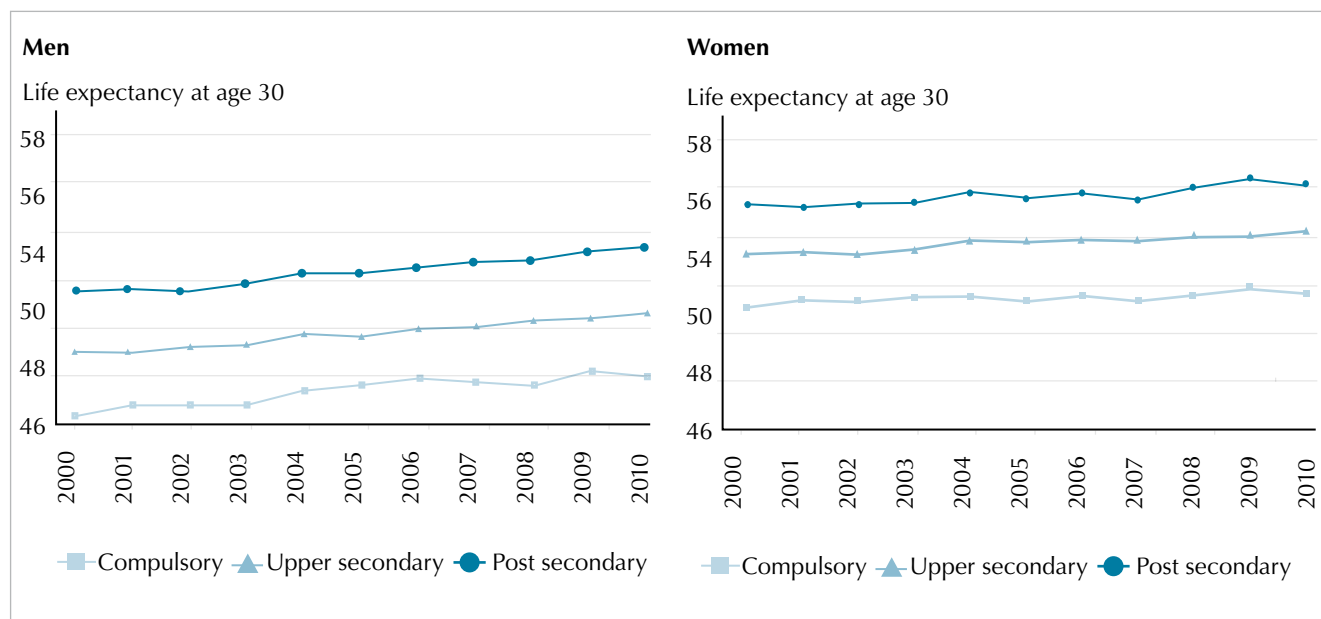


Figure 6. Life expectancy at age 30 by education and sex, 2000-2010, Sweden (2)

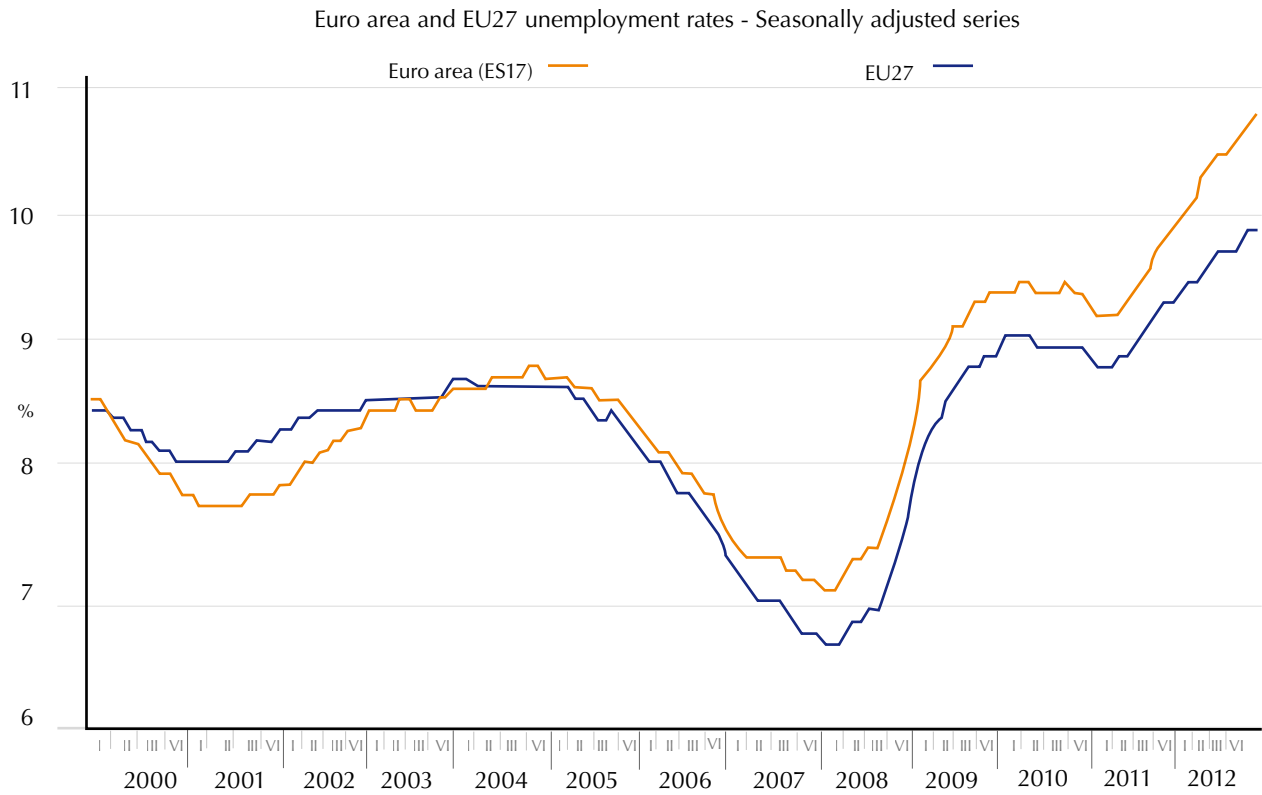


Figure 7. Unemployment rates by Euro area and EU-27, 2000-2012 (seasonally adjusted) (32)

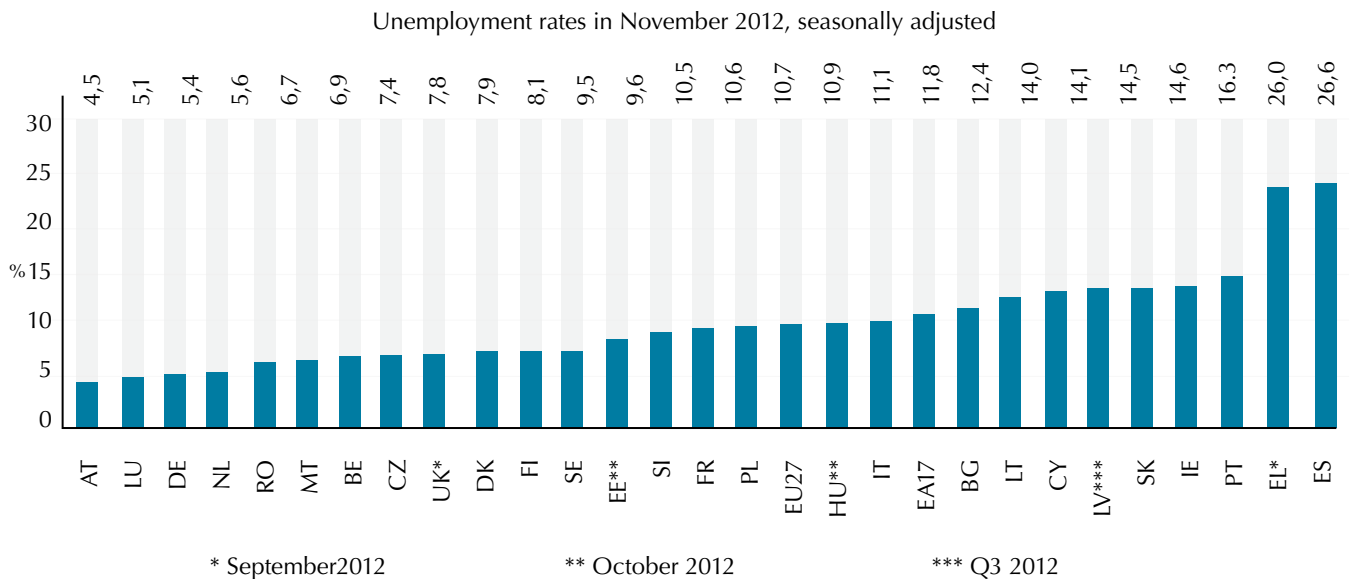


Figure 8. Unemployment rates, European Union, November 2012 (seasonally adjusted) (32)

Notes: AT: Austria; BE: Belgium; BG: Bulgaria; CY: Cyprus; CZ: The Czech Republic; DE: Germany; DK: Denmark; EE: Estonia; EL: Greece; ES: Spain; FI: Finland; FR: France; HU: Hungary; IE: Ireland; IT: Italy; LT: Lithuania; LV: Latvia; LU: Luxembourg; MT: Malta; NL: The Netherlands; PL: Poland; PT: Portugal; RO: Romania; SE: Sweden; SI: Slovenia; SK: Slovakia; UK: The United Kingdom; EU-27: European Union; EA17: Euro area.

Of course, impacts have not halted from affecting peoples' health as well. A report by the UCL Institute of Health Equity (2012) pointed out that data from past recessions suggest that the likely impacts of economic downturns are more mental health problems, increases in domestic violence and a rise of infectious diseases, as well as higher mortality (20). Particularly, long-term unemployed people show poorer physical and mental health. Data confirm that the EU-27 average of suicides witnessed a decline since 2000, but started to increase in 2008 and 2009, in times of recession (4,33). However, countries with good social protection were able to counteract increases in suicides. Thus, economic downturns without an upward trend in suicides are not inevitable (3). Unfortunately, such welcoming lessons learned are not the rule. A survey in Spain conducted in 2006 and 2010 offered evidence that patients from primary care centres had significant increases in depression, anxiety, somatoform and alcohol-related disorders, which were associated with unemployment and mortgage-payment difficulties (34). Also Greece reported about worsening of mental health problems (4). Unfortunately, the statements of the UCL Institute of Health Equity (2012) (20) were further confirmed, for instance, by Greek infectious diseases data. Particularly HIV infections rose dramatically (3,4). Another Greek study by Zavras, et al., reported about associations between poor self-related health and the economic crisis, too (35). In contrast, fewer road traffic deaths were predicted due to income cuts in households and therefore less car use (3,20). However, as road safety is quite good in many European states, effects were only reported from European countries where road deaths are still common (3,4). To conclude, health impacts of the economic crisis have been considerable, especially in countries such as Greece and Spain. The question is though, whether measures by the governments helped to protect the people or whether they reinforced the widening of health inequities.

Unfortunately, publications suggest the latter (36) as austerity policies have been adopted as a European response to the economic crisis. Austerity measures failed to provide a holistic and long-term solution, because they were just taking into account the economic picture. However, even from a pure economic view, it is possible to say that the policies did not work as European countries with vast imposed saving programmes like Ireland, Greece, Portugal and Spain have not recovered yet (3,37).

It is a vicious cycle. Several countries, such as Italy, Greece, Portugal and Spain, even reported cuts in health budgets. These cuts were partly imposed

because of rising unemployment and therefore less social insurance contributions. On the other hand, health systems would actually require more resources as unemployed people are sicker. Hence, there are also European countries which increased their health budgets (4). Nevertheless, more than a quarter of respondents of an EU survey stated that affordability of general healthcare had deteriorated (38).

A Greek study found out that significantly more people who felt they needed health care did not access it (4). Concurrently, the government of the United Kingdom (UK) introduced severe cuts to the welfare system. As a consequence, estimates suggest that only 36% of London's housing will be affordable to Housing Benefit recipients compared to 75% before these cuts were imposed (20). In addition, austerity measures, which widen the health gap, become even more unreasonable when considering the estimations by Mackenbach and colleagues regarding the economic impact of health inequities. They claimed that yearly losses due to less labour productivity are about 1.4% of the GDP of the European Union (€ 141 billion).

Furthermore, they argued that 20% of these losses accounted for the health care systems (39). Thus, it can be assumed that cuts in health budgets during recessions, where people are more in need of health care, exacerbate health inequities and consequently worsen as well the financial situation (4). However, to illustrate the priorities in our world, Marmot and Bell stated a great example:

“[...] Scaling up, it would cost \$100bn to upgrade the world's slums. A few months ago we wondered who would find such an outlandish figure for anything? But more than \$5 trillion has been found to bail out the financial sector in rich countries. Clearly there is money for investments judged to be important [...]” (36).

It is then assumed that action on the SDOH to tackle health inequities would actually generate economic benefits (2,3). Marmot even argues that health measures instead of economic indicators should be used to show whether a population is thriving or not (9). More equal societies with less health inequities are stronger and more cohesive, also in times of crisis (2). Hence, economic difficulties are rather a reason for action than inaction on SDOH. Unfortunately, due to the stringent austerity programmes within the EU, opportunities to reinforce actions on the SDOH remained mainly unused, especially in countries which were most badly affected by the financial crisis (3,4).

ACTIONS ON THE SOCIAL DETERMINANTS OF HEALTH – EUROPEAN EXPERIENCES “DO SOMETHING [...] DO MORE [...] DO BETTER [...]” (40)

Something should be done to improve the SDOH even when resources are limited, more should be done when first steps have already been taken and better should be done when the commitment of governments to reduce health inequities is already high. This was the key message of a task group preparing the European Health 2020² policy, which is the WHO response to current health challenges (40). This simple slogan should be the central notion to all health ministries and across the whole of governments, as health inequities, as described, are socially unjust and economically unacceptable. Therefore action on the SDOH is essential (2).

Health in All Policies (HiAP) is one approach to address the SDOH. As health determinants lie mainly outside the health sector, such as housing, education, transport, environment and many more, intersectoral governance structures are required (41). McQueen, *et al.*, (41) and Kickbusch & Gleicher (42) were among others commissioned with the preparation of the evidence base for Health 2020 and provided important information about European and worldwide experiences on how to govern for health. This section provides knowledge and examples drawn from these publications. In addition, Health Impact Assessment as a ‘tool’ to trigger HiAP is described and an example is given.

INTERSECTORAL GOVERNANCE STRUCTURES

Kickbusch and Gleicher point out that we are faced with new challenges in the governance for health nowadays. Our world is shaped by a global interconnectedness, as seen by the economic crisis or demonstrated by climate change, as well as an interconnectedness of the SDOH (42). The authors state:

“[...] governance is co-produced by a wide range of actors at the level of the state (such as ministries, parliaments, agencies, authorities, commissions), society (as businesses, citizens, community groups, global media (including networked social media) and foundations) and supranationally (such as the European Union and the United Nations) [...]” (42).

Solutions therefore require action at all levels and policy-makers need to leave their thinking in policy silos. This represents also the access point for collaboration as other policy sectors need collaborative solutions to tackle their challenges, too. Furthermore, Kickbusch and Gleicher stress the notion that not just a whole of government approach but also a whole of society approach including the engagement of citizens is crucial. They argue that there are five types of smart governance for health:

1. Governing by collaboration

The study suggests that success is dependent from the process and design of the collaboration including the tools and mechanisms used. Transparency, accountability, good communication, trust, commitment and understanding are vital aspects.

2. Governing by engaging citizens

Partnering with and empowering the public becomes a more important aspect, especially with the improvement of technologies such as smart phones and through the use of health applications or social networks that can facilitate these processes or co-produce governance for health.

3. Governing by mixing regulations and persuasion

A mix of regulations should be applied, ranging from sanctions to giving incentives through rewards as well as persuasion by making the healthier choice the easier choice approach.

4. Governing through new independent agencies and expert bodies

Evidence as support is fundamental.

5. Governing through adaptive policies, resilient structures and foresight

Health problems are complex and so are the solutions. Therefore, policies need to be adaptive and structures need to be resilient even in unanticipated events. Furthermore, new forecasting methods are required as health problems are mainly of a long-term nature (42).

These smart governance strategies are shown in figure 9 in relation to the bigger picture of health governance.

² Further information about Health 2020 is available at: <http://www.euro.who.int/en/what-we-do/health-topics/health-policy/health-2020>

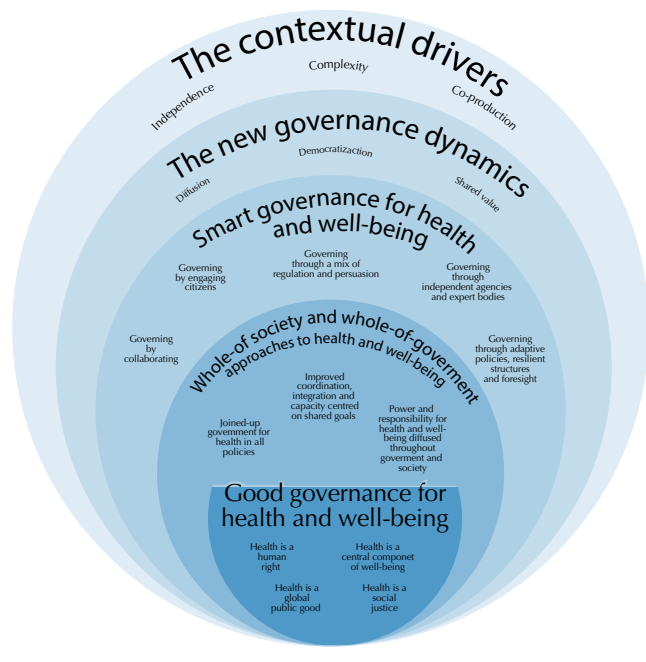


Figure 9. Smart governance for health (42)

To provoke Health in All Policies, intersectoral structures are of great value to enable collaboration. McQueen, *et al.*, (41) described experiences with such structures from various countries, whereas excerpts of three case studies thereof are given subsequently.

Case study 1: Health Select Committee - United Kingdom (UK)

In the UK parliament, an all-party committee is allocated to each department of state. The committees can shape policies through the task of writing reports with recommendations. All reports are published and an official response by a parliamentary debate is compulsory. The Health Select Committee (HSC) is in place to support the health department. Despite efforts to tackle health inequities explicitly since 1997, the gap widened. Thus, the HSC announced an inquiry in health inequities in the year 2007 and invited for the submission of written evidence. Subsequently, 154 written papers were submitted. Afterwards the Committee undertook eleven oral sessions with experts, interested parties, officials and ministers to discuss the raised issues and gather further evidence. The committee report of March 2009 identified several key challenges and produced recommendations about actions on the SDOH. In May 2009 the government’s response was published and the recommendations were taken on. Even after elections, the implementation did not lose importance and tackling health inequalities is still a high priority in the UK (41).

The success factors in this case can be summarized as:

- › The politicians showed will to act on health inequities.
- › All parties are represented within the parliamentary committees.
- › The process was covered by the media (BBC).
- › The process was supported by written and oral evidence.
- › The very influential reports *Closing the gap in a generation* of the WHO Commission on SDOH chaired by Sir Michael Marmot, the Marmot Review *Fair society, healthy lives* and *The spirit level* by Richard Wilkinson and Kate Pickett (all together renowned British academics) were published during the time of the process and presented further evidence, which opened a window of opportunity by giving additional impetus to the debate (41).

Case study 2: Traffic safety committee - Slovakia

Interdepartmental committees enable collaborative work of existing government ministries around a topic of shared interest. A permanent traffic safety committee was established by the Slovakian government in 2004. The committee was chaired by the Ministry of Transport, Post and Telecommunications. Representatives of the Ministries of Internal Affairs, Finance, Defence, Justice, Education and Science, Environment, Health and Construction and Regional Development were part of the committee. The committee was charged with the task of evidence gathering, goal and target setting, advocacy, health education, monitoring and evaluation as well as leadership on the theme. The work of the committee contributed remarkably to a dramatic increase of traffic safety (41). From 2008 to 2009 the number of accidents dropped from 59,008 to 25,989, fatalities from 558 to 347, severely injured people from 1,806 to 1,408 and slightly injured people from 9,234 to 7,126 (43).

Experiences show following lessons learned from inter-departmental committees or units:

- › These units usually have sufficient personal resources.
- › Political will is necessary that they work best.
- › The members of the units are able to continue to work on the priority topic although politicians are already busy with other tasks.

- › However, experiences show that such units can be sometimes too intellectual and too impractical, especially in regard of bureaucratic processes.
- › Political tensions are unlikely to be resolved by interdepartmental units (41).

Case study 3: Fund for a healthy Austria – Austria

Delegated financing is another example to bring health in other sectors. In Austria, for example, the Fund for a Healthy Austria (Fonds Gesundes Österreich, FGÖ) was established in 1998. The institution has the leadership of prevention and health promotion in Austria. The Fund's board is chaired by the Health minister. The Ministry of Education and the Ministry of Finance have a seat as well as representatives of the federal, state and municipal government levels. Furthermore, a scientific advisory committee supports the Fund. The main tasks of the institution are co-financing of health promotion projects, raising awareness through public media campaigns, organising health conferences, cooperating with international umbrella organisations and to offer training for people. The Fund receives € 7.25 million each year of public funds (44). In 2008, the FGÖ co-financed € 4.24 million for projects, which met the required high quality standards, in workplaces, schools and municipalities, as well as international projects and research. With this amount of money it was possible to create projects of a total value of € 20.16 million. The remainder was paid by other stakeholders, such as state governments, companies, insurers or other external funders (41).

Experiences with delegated financing suggest:

- › Delegated co-financing can promote intersectorality if other sectors are addressed.
- › Co-financing can trigger ownership and sustainability of stakeholders outside the health sector.
- › High-level governmental commitment, for example, by the health minister as the board's chairman, is essential but to close linkages with the political agenda should be avoided.
- › It may not provide the optimal solution to achieve comprehensive intersectoral collaborations in every context (41).

McQueen, *et al.*, showed that European countries are experimenting with different structural implementations to foster HiAP. The study analysed cabinet, parliamentary, and inter-departmental committees, ministerial mergers, delegated financing, joint budgeting, public

engagement, health conferences and industry engagement. The analysis highlighted that there is no magic bullet, but HiAP is possible. Critical aspects throughout all analysed options were the need for political will and commitment, partnerships, acknowledgement of health as a societal goal, the urgency of the problem, leadership (especially by health ministries), context, resources and implementation practicalities (40,41). Furthermore, a "... combination might be up to twice as effective as the single most effective intervention ..." (42), that is, different approaches at different levels (41).

HEALTH IMPACT ASSESSMENT

Finally, Health Impact Assessment (HIA) is also an instrument to foster Health in All Policies (45) and to shape the social determinants of health. Health Impact Assessments aim to predict positive and negative impacts on health and equity before the implementation of policies, projects or programmes. Health Impact Assessments include recommendations to maximize positive health effects and minimize negative health effects (46). An HIA could be undertaken for proposals of all kind of sectors representing the social determinants of health.

In Europe, Health Impact Assessments are in use, but not rigorously. The European Commission implemented an integrated impact assessment (IA) with the focus on economic, environmental and social impacts. However, in 2005/2006, the European Commission undertook 137 impact assessments, but 73 did not consider health impacts at all as health is not a compulsory aspect of the integrated IA tool.

During the Finnish Presidency in 2006 HiAP was set on the EU agenda. In 2011, during the Polish Presidency there were still concerns expressed, that HIA has to be strengthened considerably. Some experts argue that HIAs need to be made mandatory in the European Union to generate best impacts (47). It seems that especially during the critical times of the economic crisis the important measure to assess the effects of austerity programs and welfare savings on potential health impacts before their implementation, remained widely unused at the European level as well as at national levels. Overall, the European countries are at different stages regarding experiences with HIA (48). Austria, for example, carried out the first HIA for a nationwide policy in 2011/2012 (49), which is described in more detail subsequently.

Case study 4: Health Impact Assessment for the implementation of making one year kindergarten compulsory

In 2010 the decision was made to attempt a first try of a HIA on a nationwide policy in Austria, namely about the implementation of making one year kindergarten compulsory. That is, the policy declared that children have to attend one year kindergarten for a half-day before they achieve the entry-age for primary school. It was explicitly declared as a pilot project to test HIA-methods in practice. Therefore, the topic was not a typical HIA theme as the policy was already implemented and the HIA was not made before the policy was introduced, where chances for adaption in accordance to the recommendations are best (50).

The process followed the renowned guidelines and a range of methods were used for evidence gathering to assess positive and negative health impacts for the three scenarios of having no 'compulsory kindergarten-year', one 'compulsory kindergarten-year' or two 'compulsory kindergarten-years'. The project was divided in the stages screening, scoping, assessment, reporting and follow-up. The project team carried out a literature research, a survey at a region-wide meeting of kindergarten directors in Styria and a focus group in Vienna. Additionally, a policy analysis and a population analysis were conducted. A participatory approach was chosen, where decision makers, representatives for parents, children, affected professions, disadvantaged groups (single parents and disabled persons) and experts for education and HIA itself were involved in the process (49,50).

The results showed that one year being obligatory for children to attend kindergarten has mainly positive impacts on health compared to not being obligatory at all. It is expected that educational achievements will improve. Social, cognitive, linguistic, emotional and motor competences can be promoted and children with special educational needs can be better supported. It is assumed, that the positive impacts will especially affect socio-economically disadvantaged children. Moreover, an obligatory second year would further increase the positive impacts. However, as some regions report staff shortages for kindergartens, it is supposed to have negative impacts on staff and the children. As a consequence, the report advocates for high quality in training of staff and the working environment (e.g. sufficient personnel, limited amount of children in one group, time resources for further training and preparation) (50).

The process analysis demonstrated that the involved stakeholders were satisfied with the instrument. Due to the multidisciplinary of the project team and stakeholders involved, awareness for the linkage of health and other sectors was raised among the participating persons as this quote shows: "The interdisciplinary collaboration was a benefit, because it opened new perspectives, extended the knowledge and we became aware of linkages." (51) However, the project evaluation showed as well that resources for participative processes and for a pilot project can be underestimated easily (51). All in all, the HIA 'compulsory kindergarten-year' had benefits and the feedback of the involved people was promising, but there is still a long way to go to achieve well established structures for HIA in Austria (50).

CONCLUSION

Widening and constant health gaps in Europe are unacceptable and, therefore, action on the SDOH is required. A span of about 18 live years spent in good health between European states (13) means that there are considerable differences in how people can live their lives in Europe. Actions in accordance with the Health in All Policies mindset need to be adopted by health ministries and the health sector, who should act as champions and leaders in the governance for health (2). A whole of society and whole of government approach is important to tackle health inequities (2) and the establishment of strong economic, social and health systems, which feature perseverance also in times of constraints, are also mandatory to protect people's health from negative impacts (3). Whether structural measures are taken to foster intersectoral collaborations or instruments such as Health Impact Assessments are used, it is important to note that combined approaches at different levels are necessary (41,42). The main message for governments is: Do something, do more, do better (2).

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CONFLICT OF INTEREST

The authors declare no conflict of interest in this article.

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