22 April 2009

SUMMARY REPORT

Assessment of Territorial Impacts of EU Action to Reduce Health Inequalities

EN

I. INTRODUCTION AND METHODOLOGY

In order to contribute to the assessment of territorial impacts of possible Community action on reducing health inequalities in the European Union (EU), an impact assessment consultation among the partners of the Subsidiarity Monitoring Network was launched by the CoR on 6 February 2009.

The consultation had four main objectives, namely to identify:

- whether local and regional authorities are confronted with health inequalities; how they perceive this problem, its causes and consequences; and whether they use indicators for the measurement and comparison of health inequalities among regions;
- whether local and regional authorities would deem relevant a possible action by the Community to address health inequalities, and in which policy areas; in particular, would EU action add value to local and regional initiatives in line with the principle of subsidiarity;
- the expectations of local and regional authorities with regard to concrete actions to be undertaken by the EU to address health inequalities and the preliminary assessment of their possible impact at territorial level;
- suggestions on best practices and experiences in dealing with health inequalities.

The consultation was carried out by means of a questionnaire, structured into four main sections, each corresponding to one of the above objectives.

Thirteen replies to the questionnaire were received by the deadline of 3 April 2009 or immediately after. Notwithstanding the fact that almost 40 % of the contributions were received from Spanish authorities, the geographical distribution of respondents is to some extent sufficient with respect to a north-south perspective; particular conditions such as island environments and peripheral territories are also represented. However, no contributions were received from the eastern regions of Europe or from partners in Member States having joined the EU between 2004 and 2007.

II. ANALYSIS

1. Health inequalities, context and state of play

1.1 How local and regional authorities perceive health inequalities

With one exception, health inequalities are perceived by all respondents to be a current problem. Perception and awareness at the policy level have, in some

cases, led to the explicit inclusion of the equity principle in territorial planning for health and social affairs, at national and/or regional level. However, some partners noted that notwithstanding sometimes long-standing efforts and policy commitment, health inequalities persist.

The perception of the problem is based on a reasonable knowledge of drivers and trends. This knowledge is derived from a diverse range of tools such as regional health information systems, specific studies, investigations or surveys. The latter, in particular, seem to be the main source of information on health inequalities, while the regional information systems are primarily intended to provide information on the most important health indicators. Health indicators do not necessarily encompass the socio-economic dimension that characterises the occurrence of inequalities over the territory and they are therefore often unable to provide accurate information on health inequalities. One respondent, for example, reported that the reduced incidence of premature death at the regional level was simply the result of averaging values over the whole territory while, in fact, improvements had occurred only in wealthy areas with premature death rates in disadvantaged areas remaining stable.

The most frequently mentioned health inequalities relate to life expectancy, mortality, morbidity, several non-communicable diseases, distribution of resources, exposure to health risks, health behaviour, health self-assessment, accessibility to health services (including general practitioners, hospital stays or admissions, and pharmaceutical consumption) and infrastructure. In particular, it was noted that even if access is universally guaranteed and free of charge, inequalities may still occur in preventive services, specialised assistance, and any other types of care not covered by the public health system.

1.2 Main drivers and determinants for health inequalities

There are two main types of determinants for health inequalities: structural (socio-economic and political frameworks determined by governments) and intermediary. The factors most frequently mentioned as drivers of health inequalities include: (i) socio-economic conditions (unemployment and social exclusion, education and cultural level, income, gender, illegal status of migrants, sharp population increases with associated higher pressure on available resources); (ii) lifestyle (unhealthy diet, lack of exercise, smoking, excessive use of alcohol, road accidents); (iii) geographical features of the territory (remoteness, fragmentation, islands and mountainous environments, all representing concrete barriers to the use of services and infrastructure); and (iv) cultural heritage (people's perception of health systems and issues according to local traditions, organisation and ethnic group). Only one respondent pointed to financial constraints or to the uneven distribution of financial resources among

the various regions as a cause of health inequalities, alongside the inability for national authorities to keep the health system satisfactorily functional.

1.3 Indicators and monitoring systems

Apparently, there is no coherent approach to the use of indicators among the various respondents. Only one partner expressed its concern for comparison and compliance of its health monitoring system with EU and WHO guidelines on health monitoring. Comparability at regional level is reported in several cases and linked to the existence of structured monitoring systems and core indicators common to all regions; sometimes, comparability is tackled at specific administrative levels by means of dedicated projects. Overall however, there is a prevalence of territorial specificity of indicators used, often due to the specificity of the health assistance provided (general or specialised assistance) and of the data sources (national unions, funds, insurance schemes), or to the emphasis given by administrations to the monitoring of specific aspects of health (for example, life style behaviours, or decentralisation level of services) according to the prevailing causes of inequalities. Among those mentioned, there appear to be few indicators shared by a number of respondents (among these 'common' indicators is, for example, the mortality rate). Additionally, they rarely contain the routine socio-economic information necessary to map inequalities. The reference to the geographical level may overcome these constraints and allow for an overlapping of information layers related to health and socio-economic data but the occurrence of this situation is more theoretical than practical. Monitoring systems fully focussed on health inequalities seem to be more the exception than the rule, but they do exist.

1.4 The impact of the current economic and financial crisis regarding health inequalities

In general, effects of the current crisis have not yet been observed, but it is commonly acknowledged that the worsening of socio-economic conditions will result in the increasing of social inequalities, including those related to health. Views on the capacity of the public sector to buffer many of the adverse effects of the economic and financial crisis differ. One partner mentioned that evidence from literature shows an increase of inequalities by social class or gender in several countries during the economic recession of the 1990s, but other remarks pointed out that some countries were able to compensate for the loss of resources (infrastructure, technology and human resources) by means of 'collective' actors such as state, regions and municipalities. The capacity of countries' welfare states and actors to reduce the impact of the crisis in creating or aggravating health inequalities, especially for the most vulnerable groups, may also depend on the magnitude of the crisis experienced at territorial level, with more difficulties foreseen for those local authorities suffering from higher ratio of manufacturing plant shutdowns and unemployment rates.

1.5 The use of Structural Funds for financing health-related projects

The use of Structural Funds for financing health-related projects is common among local and regional authorities; yet, some respondents never asked for financial support through the Operational Programmes of their regions. In general, it is observed that those respondents who benefited from Community funds in the previous programming period (2000 – 2006) have applied for new projects under the new programming period (2007 – 2013). The European Regional Development Fund (ERDF) is the most frequently mentioned financial instrument, and INTERREG, the European Territorial Cooperation and the cross-border cooperation are the most frequently mentioned programmes. There are few references to the European Social Fund.

Several of the projects deal with the introduction of Information Technology (IT) in diagnosis/treatment procedures or in working methods (development of e-wellbeing services, welfare technology, adaptation of the health system to ageing population); others are specifically addressed to combat the social exclusion of the disadvantaged (for example disabled people, people with mental problems, or ex-prisoners) or to support vulnerable groups (families with small children, young and old persons), to promote the exchange of experiences across borders and develop common training programmes, or to build/renew and equip health infrastructures. One project foresees the development of a regional information network. In general, it was noted that although the reduction of health inequalities may not be the primary target of several projects, these projects nevertheless significantly contribute to it.

There seem to be adequate capacities within applying authorities for the preparation and implementation of projects, only one respondent complaining about unclear eligibility for funding, structure and content of projects as well as lack of clarity on mechanisms for cooperation arrangements with other countries.

2. Scope and level of Community action. Relevance for local and regional authorities

2.1 The added value of a possible Community action for reducing health inequalities

Action at Community level is considered necessary. The rationale for calling on Community intervention is that comparability of information and assessment of the state-of-the-art processes at national and regional level can be achieved only through a common guidance established at the European level. The Community

has limited responsibility on health policy, in line with article 152 of the EC Treaty; however, it is recognised that standards and common rules set in those policy areas where Community decisions may be binding influence the occurrence of health inequalities. This is a direct consequence of the fact that reducing inequalities in health is a highly complex issue cross-cutting several policy areas and involving diverse stakeholders at all levels.

The necessary inter-sectoral collaboration at local and regional level aimed at tackling health inequalities could be further encouraged by mainstreaming the inequality issue into Community policies at the European level. The Community is also seen as an authoritative actor able to influence and impact on stakeholders' way of thinking and of acting, as well as on their political commitment. This may occur through the exchange of information and the encouragement of cooperation provided that, in line with the principle of subsidiarity, any action taken remains the prerogative of the competent administrations. Finally, the added value of the Community as a provider of financial resources is broadly acknowledged.

2.2 Which kind of Community action for reducing health inequalities

Though it is recognised that the Community is already undertaking significant initiatives contributing to the elimination of inequalities in health, some suggestions for further action are given. They include: (i) promoting 'Health equity in all policies' following the principle of 'Health in all policies' adopted by the European Commission in the definition of the new Health Strategy (COM (2007) 630 final); (ii) developing an equity-focused health impact assessment as a tool to formulate polices that promote health equity at European and national level; (iii) promoting universal coverage health systems across the EU; (iv) improving mechanisms for monitoring inequalities in health across Europe, for example by establishing a monitoring system able to provide information on determinants and magnitude of inequalities in health. This would require standardisation of procedures for measurement and agreement on common indicators. The target should be the mapping of inequality-related health determinants on the basis of adequate variables at the regional level, enabling comparisons and benchmarking. Further, one respondent suggested the identification of a specific institution to act as an observatory of health inequalities across the EU; (v) promoting research on health inequalities to develop the knowledge base through: the funding of specific programmes; the inclusion of the equality concept in main health-funded projects; and the facilitation of expertise and results' exchange; (vi) supporting learning, initial and continuous training on health inequalities and on the social determinants of health; (vii) promoting exchange of information in general and of best practices in particular. It has been noted by one respondent that making the appropriate

information available to local authorities, while setting regional priorities, could substantially improve health care systems; (viii) encouraging stronger cooperation within administrations at all levels (fostering synergies among sectoral strategies), among the regions, and between the regions and the European institutions; (ix) increasing investment, in particular with regard to the introduction of IT; (x) increasing awareness on the importance of investing in health as a way to invest in social development and on the cost-effectiveness that may derive from the cross-sectoral synergetic planning and implementation.

2.3 Other policy areas where Community action could help to reduce health inequalities

There is a common agreement that health policy alone is insufficient to tackle inequalities in health. Several other Community policies are deemed to be crucial in this regard since they influence both the structural and the intermediary determinants of health inequalities. Community actions relating to environment, education, information technologies, social affairs and labour, cohesion, food and agriculture, consumer protection, economy and trade, internal market, urban planning and housing, and gender equality, are frequently mentioned. Special emphasis is placed on the reduction of exposure to environmental risks, the provision of adequate information to citizens on public and personal hygiene, and education, especially within schools, as an important tool to promote prevention. Where there are cases of remoteness and fragmentation, transport policies are also mentioned.

2.4 The need for a common commitment by Member States to reduce health inequalities

Views on a common commitment by EU Member States to reduce health inequalities vary widely. Proposals range from binding provisions to the simple requirement of inclusion of health inequalities on national political agendas. Minimum obligations should work towards the reduction of inequalities, guarantee the right to healthcare, the physical access to assistance and a minimum quality level of services. On target setting there is also no common agreement. According to some, differences among regions and within the EU are too wide to permit the significant use of quantitative targets: in order to take into account all these differences, targets would need to be either too vague or too simple, thus not representative of a valid incentive for action. Others believe that simple targets would allow for the easy involvement of all, regardless of their starting point, and for a progressive increase of commitment levels and of convergence of performances over time. Suggestions to set different targets according to regional peculiarities were also made.

It was further noted that a common commitment to the reduction of health inequalities would contribute to the creation of a European social model based, according to the definition adopted by the Barcelona European Council in March 2002, on good economic performance, a high level of social protection and education and social dialogue.

2.5 The right tools to ensure that common goals are achieved

Benchmarking is considered by the most respondents to be one of the best tools for monitoring the achievement of common goals. Benchmarking implies the use of indicators and the establishment of reliable information systems providing homogeneous and comparable information. More comprehensively, the establishment of monitoring systems encompassing reporting, benchmarking and dissemination strategies is also suggested.

Other proposed tools include: (i) networking for coordination, discussion, and exchange of knowledge, good practices, working and evaluation methods; (ii) action plans and support programmes; and (iii) binding legal instruments. The Open Method for Coordination is explicitly mentioned only once and in that specific comment it is considered inappropriate for health care (notwithstanding the fact that as from 2006, the method has been applied to an integrated process encompassing inclusion, pensions, health and long-term care).

3. Possible actions

3.1 The need and the form of possible Community funding

Community financing is expected to continue along the lines pursued so far. For some authorities, Structural Funds in general and INTERREG in particular, represent critical financial sources that complement national funds. It has been noted that a common line of funding specifically dedicated to health issues could possibly facilitate regional cooperation and development.

Along the lines outlined under paragraph 2.2, Community funding in the health sector is deemed necessary for:

- Promoting equity-oriented public policies at both national and regional level by emphasising ‘equity’ as a basic value of public strategies and plans and by developing an equity-focused health impact assessment tool for the development of polices that promote health equity.
- Developing the necessary human resources to conduct equity-focused health impact assessments at local and regional level, and equity audits. The latter evaluate how health services are adapted to the needs of different social groups and geographical areas.

- Supporting the identification of entry-points for policy making related to individual social position, exposure to health risks, and level of vulnerability.
- Surveillance and monitoring of health inequalities through the development of common standards for assessment (i.e. indicators) for mapping health inequalities across the EU. Common indicators on local and regional social determinants of health would allow comparability among regions within countries, and across the EU.
- Research, through calls specifically targeting proposals on health inequalities. The involvement of local and regional research units could be encouraged by requesting the networking of different groups working on similar areas so as to promote collaboration among, and strengthening of, local research groups.
- Developing IT for 'telemedicine', particularly relevant for reaching geographically dispersed and remote areas and aimed at delivering home care, more equal access to services and higher quality of assistance, but also at the retention of professional staff in disadvantaged locations. The creation of a virtual library on health sciences would, for example, provide professionals with the most up-to-date information and developments regardless of where they are posted; that would also reduce their perception of being constrained in their professional growth.
- Coordinating cross-border cooperation among regions.
- Supporting learning and training on inequalities and on the social determinants of health for: (i) medical and health professionals through the development of standard and compulsory curricula; and (ii) non-medical professionals.
- Undertaking initiatives on tobacco/alcohol/drug or on specific diseases.

3.2 Foreseeable impact of Community funding for addressing health inequalities

It is important to invest at the local level as equity-oriented public policies can deliver concrete actions to the population, particularly in countries with highly decentralised health care systems. Investing in the health sector to address inequalities should be considered to be a way to increase social development and innovation, while the mainstreaming of health policies into other relevant policy areas can be seen as a tool to increase effectiveness and reduce costs.

Taking action on the decrease of health inequalities can have an impact in terms of increased social cohesion, reduced poverty rates, improved nutrition and increased employment. A general improvement of the population's health would also be expected, which, in turn, would have a positive impact on economic status and the perception of welfare.

Community funding can increase economic activities in non health-related sectors and, consequently, positively impact on regional and national GDP. While for some authorities Community funding does not make a significant difference in terms of available budget, for others it is fundamental for implementation. However, it was observed that the specific assessment of Community funding is not always possible as actions and finances are usually channelled through various national or regional structures, making aggregation of data difficult.

With regard to common obligations, especially in terms of regulations, care shall be put in carefully assessing the impact for governments in terms of costs, which may be unanticipated in a first instance, and of possible market-rigidities, potentially limiting or distorting innovation and growth.

3.3 Actions to be undertaken within the framework of other policy areas

For some respondents there is no policy area that should be exempted from taking health considerations into account. However, mainstreaming concerns of health inequalities should be tackled for at least the following policies:

- Social affairs: health self-assessment especially for those families with lower income that seem more inclined to overload the health system. Specific support for vulnerable groups, improvement of social housing and, in general, any action targeting reduction of poverty and social exclusion.
- Education and training targeting the less educated with the aim of creating conditions for prevention, better interaction with the health systems, improved access to services, and empowerment of both individuals and communities. Awareness campaigns targeting people in general, and students in particular, to facilitate understanding of personal health status and to tackle higher levels of prevention.
- Labour market: improving working conditions for all, by reducing job insecurity, ensuring minimum wages, increasing employment opportunities for those sectors facing difficulties, as well as reducing the occurrence of accidents that tend to be concentrated in manual, often unskilled, sectors.
- Immigration: particularly for those EU border regions subject to heavy migration pressure, provision of health access to legal and illegal migrants should be supported.
- Urban planning and transport: focussing on the well-being of urban dwellers along with the promotion of equity between rural and urban areas, in order to reduce population displacement and abandonment of countryside and mountainous areas. Improving the mobility of both people and services.
- Environment: supporting healthier conditions, particularly by stopping environmental degradation, guaranteeing food safety, water quality and

waste disposal/treatment according to appropriate standards and regulations.

With reference to all policies, it is proposed to include health indicators in the evaluations of relevant non-sanitary Community policies, as has been done in the Lisbon Strategy with 'the number of years lived in good health' indicator.

Finally, it was suggested to implement a more effective interaction between the EU and regional authorities, in light of the fact that in several Member States regions are both legitimated and responsible for health policies and, in several cases, also for social policies.

3.4 Cross-border cooperation and the reduction of health inequalities

It is acknowledged that cross-border cooperation has the potential to reduce inequalities in health but according to one respondent it can also widen the gaps. Periodical independent evaluations (i.e. carried out by agencies not linked to the national health system where inequalities occur) may improve the contribution level of cross-border cooperation schemes to combating health inequalities.

Cross-border cooperation is seen to be appropriate among regions facing similar problems although it needs to be integrated by relevant actions at national and local level, depending on the country's decentralisation structure and geographical position. Locked-in countries and regions have a natural tendency to cross-cooperation while border or peripheral regions' efforts are directed primarily at reducing inequalities within the country's boundaries.

Cooperation with neighbouring countries is also perceived to be essential to combating human trafficking and to providing medical, psychological and legal support to victims.

4. Best practices

The successful policies and approaches proposed by the respondents highlight some important features: (i) whether in a centralised or decentralised governance structure, the implementation role usually falls within the responsibility of local or regional authorities; (ii) the development and the implementation of polices related to health and social affairs are often driven by participatory processes encompassing state and non-state actors; (iii) combating health inequalities may be supported by a well-defined policy framework, allowing for structured implementation; may be fostered through pilot/project-based initiatives to be further disseminated depending on their success; or may be derived from the

complementing, unstructured contribution of interventions undertaken in diverse policy areas (ensuring minimum economic conditions to families with no income, distributing houses to the poorest, providing for regulations in the labour markets pursuing hygiene and security).

In general all respondents, with a few exceptions, seem to address the problem of health inequalities, at either the policy or the implementation level, along more or less systematic lines. Very few comments were made on the impact at financial and administrative level of the practices described.

Examples of successful approaches include:
At policy level:

- Inclusion in national policies of references clearly legitimating the tackling of health inequalities. This is considered to be a necessary pre-condition to promoting commitment among stakeholders. The more the process leading to the development of policies is participatory, the higher the level of commitment to implementation that may be expected.
- Development of policies at the regional level specifically targeting the reduction of inequalities in health. This approach allows the addressing of the problem in a very structured way.
- Dedicated legislation providing for inter-sectoral interventions aimed at the improvement of the health determinants of populations living in socially disadvantages areas.

At implementation level:

- The establishment of disease-specific (e.g. cancer, stroke) networks at the regional level, allowing for the sharing of infrastructure and resources over the territory as well as of common clinical practices and structured administrative information. Networking implies higher efficiency in planning and use of assets and people, as well as the systematic collection of data for benchmarking.
- The running of early detection and prevention programmes has proven to increase the quality of health assistance through systematic check-ups and screening. Programmes may target specific risk groups (for example, breast cancer prevention for women aged 40-69) or disadvantaged groups such as migrants (with free vaccination).
- The application of IT has demonstrated improved access to services in terms of time-saving, reduction of distance constraints' and qualitative increase.
- Community-based projects and other projects implying the participation of different stakeholders (associations, experts, private sector, other relevant international organisations) show good rates of success.

Specific examples of best practices in the context of health inequalities reduction are:

- free medical prescription and dedicated services for the elderly and other vulnerable groups of the population;
- universal, free access to the health system or to specific treatments (such as emergency) or services (such as vaccination);
- provision of individual support to families or family members through specialised professions such as the 'family nurse';
- health centres, programmes or associations providing multilingual assistance, advice, psychological and social support as well as various health-related information and training activities (including family planning and reproductive health protection) for migrants and socially disadvantaged categories (e.g. long-term unemployed, homeless, single-parent families).

III. CONCLUSIONS

Context and state of play

- Local and regional authorities are confronted with problems of health inequalities. Notwithstanding sometimes long-standing efforts and policy commitment, health inequalities persist. Type of inequalities and prevailing drivers differ across the regions.
- Though the perception of the problem by local authorities is based on an adequate knowledge of drivers, this knowledge is rarely systematic and based on well-established information systems. Major indicators used are health indicators that lack the routine socio-economic information necessary to map inequalities. Comparison between regions within the same country and across countries is unlikely in most cases. As a consequence, there is a strong call for improving monitoring mechanisms across Europe through the development of common indicators on local and regional determinants of health inequalities.

Scope and level of Community action. Relevance for local and regional authorities

- Action at EU level is believed to add value to the competences of national and sub-national authorities.
- Reducing inequalities in health is a highly complex issue cutting across several policy areas and involving diverse stakeholders at all levels. Particularly in cases where health is recognised as a universal right, inequalities usually depend more on factors external to the health system (employment, housing, education, social cohesion) than internal (level and quality of services provided, accessibility). Standards and common rules set in policy areas, other than health, where Community decisions may be binding will influence the occurrence of health inequalities.

- There is no agreement on the setting of common obligations or targets but benchmarking is considered by the most to be one of the best tools for monitoring the achievement of common goals.

Possible actions

- The EU should: (i) promote equity-oriented public policies at national and regional level and develop an equity-focused health impact assessment tool facilitating the development of polices that promote health equity; (ii) support the development and implementation of equity audits to evaluate how health services respond to the needs of different social groups and geographical areas; (iii) include health indicators in the evaluation of relevant non-sanitary Community policies; (iv) support research focussed on health inequalities through dedicated calls; (v) support the development of IT for 'telemedicine'; new technologies will reduce the incidence of some of the factors driving inequalities (such as remoteness) and will enable the retention of professionals posted in disadvantaged locations; (vi) support compulsory learning and training on inequalities and on the social determinants of health by medical and health professionals; (vii) promote awareness and education of the less educated, of the general population and of students in particular, to tackle higher levels of prevention and of self-health promotion, higher access to services and the empowerment of the most disadvantaged or vulnerable; (viii) improve working conditions in general and, in particular, support the reduction of occupational injuries, which are concentrated in manual, often unskilled, sectors; (ix) support those EU border regions subject to heavy migration pressure in the provision of health access to all, regardless of their legal status; (x) focus on the well-being of urban dwellers along with the promotion of equity between urban and rural areas; (xi) improve the mobility of both people and services; (xii) support healthier environmental conditions, in particular by stopping environmental degradation, guaranteeing food safety, water and waste disposal/treatment according to appropriate standards and regulations.
- Common obligations, particularly regulations, should take into account the impact for governments in terms of costs, which may be unanticipated in a first instance, and of possible market-rigidities.
- Cross-border cooperation is seen to be appropriate among regions facing similar problems although it needs to be integrated by relevant actions at national and local level, depending on the country's decentralisation structure and geographical position. Cooperation with neighbouring countries is also perceived as an essential element to combat human trafficking.
- A more effective interaction between the EU and the regional authorities would be necessary, in light of the fact that in several Member States

regions are both legitimated and responsible for health policies and, in several cases, also for social policies.

Best practices

- Successful approaches to reducing health inequalities at the policy/regulatory and implementation level, show that the reduction of health inequalities may be promoted by well defined policy and/or regulatory frameworks; may be fostered through pilot/project-based initiatives to be further disseminated depending on their success; or may be derived from the complementing, unstructured but still effective contribution of interventions undertaken in diverse policy areas.
- Legitimating the tackling of health inequalities in national legislation, developing policies and laws dedicated to health inequalities allow for structured follow-ups.
- Among successful implementation activities are disease-specific networking, early detection and prevention programmes, specific cases of IT application, and community-based projects. In general, participatory approaches, both in planning and in implementation, have proven to be more effective.

IV. APPENDIXES

APPENDIX 1: QUESTIONNAIRE

COMMITTEE OF THE REGIONS – DIRECTORATE FOR CONSULTATIVE WORK
"Networks & Subsidiarity" Unit

EU ACTION TO REDUCE HEALTH INEQUALITIES
Questionnaire on the Assessment of Territorial Impacts
Submitted for consultation of the Subsidiarity Monitoring Network

en

Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

Network Partner:	
Permanent Contact Person:	
Contact details (phone, email)	
We hereby designate the following ad-hoc contact point for the territorial impact assessment on Health Inequalities	
Name of ad-hoc contact point:	
Position held (institution, unit, function etc)	
Postal address (if different from that of network partner)	
Contact details (phone, email)	

1. Health Inequalities - context and state of play
Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.
Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?
Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level? Do these indicators allow you to effectively compare the health situation in your territory with other regions?
Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?
Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.

2. Scope and level of Community action / Subsidiarity *Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).*
Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.
If you think that the EU should act, which kind of action at EU level could better help local

and regional authorities in tackling health inequalities in a more efficient way?

Is Community action within the ambit of health policy alone capable of addressing health inequalities? In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?
Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?
What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?

3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory? What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.

What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.

Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?

APPENDIX 2: RESPONDENTS

Replies to the COR questionnaire on the Territorial Impact Assessment of EU Action on Reducing Health Inequalities

N°	Network Partner	Country	Language
1	Government of the State of Saxony	Germany	DE
2	Hellenic Parliament	Greece	EN
3	Diputació de Barcelona	Spain	EN & CT
4	Basque Government	Spain	EN
5	Government of the Canary Islands	Spain	ES
6	Catalan Parliament (questionnaire completed by the Department of Health of the *Generalitat de Catalunya*)	Spain	ES
7	Assembly of Extremadura	Spain	ES
8	Lombardy Region	Italy	IT
9	Austrian State Governors' Conference (Landeshauptleutekonferenz)	Austria	DE
10	Regional Government of the Azores	Portugal	EN
11	Association of Finnish Local and Regional Authorities	Finland	EN
12	Region Västra Götaland	Sweden	EN
13	ARCO LATINO (questionnaire completed by the *Conseil Général de la Corse du Sud*)		FR

APPENDIX 3: QUESTIONNAIRES SUBMITTED

COMMITTEE OF THE REGIONS – DIRECTORATE FOR CONSULTATIVE WORK
"Networks & Subsidiarity" Unit

EU ACTION TO REDUCE HEALTH INEQUALITIES
Questionnaire on the Assessment of Territorial Impacts
Submitted for consultation of the Subsidiarity Monitoring Network

Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

Network Partner:	State Chancellery of the German Federal *Land* of Saxony
Permanent Contact Person:	Dr Perdita de Buhr
Contact details (phone, email)	0032 2 235 87 30 / Perdita.deBuhr@bxl.sk.sachsen.de
We hereby designate the following ad-hoc contact point for the territorial impact assessment on Health Inequalities	
Name of ad-hoc contact point:	Mr Volker Köhn
Position held (institution, unit, function etc)	Desk officer, State Ministry for Social Affairs of the Federal *Land* of Saxony
Postal address (if different from that of network partner)	Albertstr. 10 01097 Dresden Germany
Contact details (phone, email)	+49 351 564 5793 / Volker.Koehn@sms.sachsen.de

1. Health Inequalities - context and state of play *Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.*
Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?

The background memo indicates that health inequalities are to be understood as inequalities both between and within EU Member States. The memo notes that, while the health of the population as a whole may be improving, the health of the least and less well-off either is improving more slowly than the rest of the population or in some cases is even getting worse in absolute terms. No such local or regional health inequalities can be observed in Saxony.

As a general point, the questionnaire assumes that local and regional health inequalities are an issue, and that action is needed to tackle it. Health policy in Saxony seeks to guarantee a high standard of healthcare at reasonable prices across the entire region. Our policy does not, on the other hand, seek to remove inequalities by providing uniform care at a lower standard. Moreover, the questionnaire gives the impression that removing health inequalities is, or should be, a – if not ***the*** – key political priority. That is not the case in Saxony. Nor is there any public perception otherwise.

Safeguarding a high standard of healthcare across the entire region requires considerable and ongoing effort. Healthcare needs to respond to new developments, such as the impact of demographic change in rural areas.

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

N/A.

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

Saxony can draw on a range of official health statistics, providing information on

- health monitoring;
- hospitals and preventive care or rehabilitation centres;
- in-patient diagnostics;
- causes of death.

Health monitoring is conducted in a uniform way across all the German *Länder* in compliance with the relevant rules (*Indikatorensatz für die Gesundheitsberichterstattung der Länder* – third edition, 2003). In Saxony, a dedicated and publicly accessible website has been set up giving basic statistical health monitoring data. On this site, Saxony's Statistical Office (*Statistisches Landesamt des Freistaates Sachsen*) publishes collected data on public

health as they relate to demographic developments, social, economic and environmental conditions, and healthcare resources, uptake levels, expenditure and costs.

All indicators are classed as federal indicators, core indicators or *Länder* indicators. Federal indicators are calculated and maintained by the Federal Statistical Office (*Statistisches Bundesamt*), the Robert Koch Institute and other federal-level data holders. Federal indicators are, as a rule, used when no *Länder* data are available. Core indicators are designed to apply to all *Länder* and are considered more important than *Länder* indicators. They should generally be comparable across the different *Länder*. Additionally, *Länder* indicators may also be used in the *Länder* if they relate to relevant health priorities. Indicators to be used for comparisons between different regions are always *Länder* indicators.

Extensive information on public health and healthcare across Germany is available on the federal health monitoring website, where it is possible to access, free of charge, over **a billion figures** set out in clear tables. The federal health monitoring online databank brings together health data and health information from more than 100 different sources, including, to a large extent, from federal- and *Länder*-level statistical offices. Data from a wide range of other health-sector bodies are also available. The website indicates data sources, survey details, procurement methods and contact persons. The health data and health information given here are expanded and updated regularly. In addition to data from Germany, the website system also gives international tables from the OECD and the WHO.

The available health statistics facilitate regional comparisons.

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?

No, as statutory health insurance remains in place even in the case of unemployment.

Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000-2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.

No provision was made for ERDF funding for health infrastructure under the Operational Programme during the 2000-2006 programming period. Miscellaneous model programmes that might be considered to come under this heading were simply conducted on an individual basis:

- a telematics project in Görlitz (34) – INTERREG,
- the *AGnES* project (31) – ESF,

– a gender mainstreaming project for hospitals (LS/GL), in Leipzig and Bautzen – ESF.

For the 2007-2013 programming period, health and healthcare have been included at programme level for Objective 3 support. One healthcare project has now been approved. Health is covered by ESF support, with due regard for additionality. In that regard, the Saxony State Ministry for Social Affairs has incorporated a number of elements for mainstream support into its ESF guidelines. So far, 107 measures have received support in this way. Plans are also afoot to support valuable projects relating to the healthcare industry. The details here have still to be finalised.

2. Scope and level of Community action / Subsidiarity

Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).

Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.

This question is impossible to answer as it is too abstract and sweeping in its wording. In particular, clarification is needed as to what inequalities and what specific measures are meant here. To be sure, there can be no objection to allowing the use of Structural Fund resources to build up healthcare in areas where adequate provision is lacking. If, however, the plan is to align health systems (if anything at a lower level), then that is to be rejected both for legal reasons and on the grounds of health policy itself. Under Community law, EU action in this area is confined to complementing national policies and assisting in an organisational capacity to encourage cooperation. The overriding objective of all Community policies and measures is still to secure a high level of health protection – not to align the level of health protection in a bid to remove inequalities.

If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?

We feel it does make sense for the EU to act, with due regard for the subsidiarity and proportionality principles, particularly to support and coordinate national and regional health policy. For instance, making the appropriate information available when setting regional priorities can do much to improve healthcare. Incidentally, it should again be noted that removing health inequalities cannot be an end in itself.

Is Community action within the ambit of health policy alone capable of addressing health inequalities?

In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?
Moves to boost the mainstreaming of health issues across all policy areas are worthy of support. This is a way of raising levels of health protection in those areas that do not yet meet the requisite standards. Preventive health could, in particular, be factored into education.
Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?
Broadly speaking, coordinated EU-level action on the health front is to be welcomed. The aim here must reflect the objective set out under Community law, namely to attain a high level of health protection across the European Union. However, for reasons of subsidiarity, we reject any joint commitment to common milestones and reduction targets. Indeed there are fundamental objections to common milestones and reduction targets in the health sphere, given the very different health systems in place in the Member States and the subjective perception of healthcare by the general public.
What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?
The tools used to achieve common goals will routinely depend on the specific factors of the individual case. Experience to date has shown that action plans and support programmes are the main tools for achieving health objectives. To draft and back up programmes of this kind, benchmarking and, in exceptional cases, also reporting etc. may be useful.

3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the Structural Funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory? What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
It is particularly appropriate that cross-border health projects should be financed via the Structural Funds. This will facilitate an overall improvement in healthcare in border areas.

What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
Greater use of Structural Fund resources might be an option where health inequalities are taken to mean differing levels of care between the Member States and where consideration is being given to how to boost poor care levels. Broadly speaking, preventive action designed to cut the number of illnesses typical among certain professions or certain sections of society are worthy of support. In some cases, considerable success can be achieved through prevention at relatively low financial outlay.
Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?
Cross-border health cooperation designed to raise the level of healthcare deserves support.

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
A model project, dubbed *AGnES,* has been successfully tested and introduced in a bid to safeguard a high level of general-practice healthcare in rural areas. *AGnES* is a German acronym (standing for *Arztentlastende, Gemeindenahe, E-Healthgestützte, Systemische Intervention*) and designates a local, eHealth-supported systemic care delivery scheme designed to take pressure off doctors. The scheme seeks in particular to benefit older, less mobile people in rural areas, who no longer have to travel long distances for routine tests such having their pulse taken or giving a blood sample. Instead, *AGnES* comes to them. The main goals of the *AGnES*-Saxony programme were: 1. to develop the substantive elements of an additional qualification scheme to train people as *AGnES* assistants to work in rural medical practices, with the ultimate aim of permanent employment on the regular labour market; 2. to determine the medium-term outlook on the labour market and 3. to conduct and evaluate an initial test training project.

The scheme consisted of two parts. The first involved concept development, a labour market analysis and the framing of substantive elements for inclusion in the training programme. The second involved the actual training itself. An innovative, additional training programme, based on real-life scenarios, for those employed in general practices (trained healthcare workers and medical/doctor's assistants) was developed and fleshed out. A total of six medical practices and medical staff took part in the project, alongside 280 participating patients. The practices were selected under the auspices of the Saxony Association of Statutory Health Insurance Physicians (*Kassenärztliche Vereinigung Sachsen*). The selected practices were all in regions where provision is currently poor or which are under threat of underprovision in the future. Two were joint practices, with two GPs each. The other four were single-GP practices. Training was given to one member of staff per practice.

This project makes it possible to provide a high level of medical care in rural areas, despite the shortage of doctors. Under the scheme, patients' quality of life is much improved. With *AGnES* in place, medical care is provided by trained assistants who are not themselves doctors. This relieves pressure on GPs who are thus able to treat more patients in their practices. That in turn makes general practice more cost-effective, boosting its attractiveness in rural areas.

EU ACTION TO REDUCE HEALTH INEQUALITIES
Questionnaire on the Assessment of Territorial Impacts
Submitted for consultation of the Subsidiarity Monitoring Network

en

Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play

Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.

Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?

In recent years relevant research has shown that health inequalities pose a problem in Greece. In particular, cases of health inequalities arise in what regards health quality, exposure to health risks and access to quality health services. For example, according to a study conducted by the Institute of Social and Preventive Medicine in 2006, chronic illnesses occur more often in the lower socio-economic classes of society. Illnesses such as diabetes are twice as likely to occur (6,2% vs. 3% amongst the higher socio-economic classes).

This difference is also well reflected in the fact that, according to the study, the life quality of Greek

teenagers is directly affected by the economic status of their families, i.e. students from a higher socio-economic class enjoy a better life quality, but are less autonomous.

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

The causes of the big social health inequalities in Greece are:

a. Fragmented insurance funds
b. Inequalities in benefits
c. An ongoing degradation of the National Health System
d. Lack of sufficient funding

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

Social health inequalities are more prominent in some geographical areas of Greece, since access to health services varies depending on the administrative district of Greece in which one resides.

The root causes of these inequalities are:

a. Different socio-economic (income, unemployment) and environmental conditions
b. Local disparities
c. Uneven distribution of health funds

These, however, are not directly linked with the economic measures and the mortality rate, since the economic level is affected by other social factors such as education, place of residence, social coherence and insurance.

East Macedonia and Thrace are the regions of Greece with the highest mortality rate and the lowest GNP per capita.

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?

The situation will get worse as the budget funds earmarked for the health sector will not suffice to cover all needs. Moreover, the financial crisis will create more socio-economic inequalities due to the unemployment rise.

Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.

Greece participates in the following projects:

- **European Early Promotion Project**

The goal of the European Early Promotion Project (EEPP) is to provide a universal service acceptable to all families with small children, and to use a partnership model in professional-parent relationships.

This gave the opportunity to promote parent-infant interaction in all families, and to ensure that resources could be targeted most appropriately to those families in need of more support.

The intention was to: 1) promote parent-infant relationships and subsequently infant mental health; 2) prevent emotional and behavioural problems; and 3) intervene early when necessary. The use of existing primary health care systems was intended to limit the set-up costs and possibly ensure maintenance of the service subsequently.

Primary health care professionals (PHCPs) (e.g. health visitors, community nurses) in five countries from Northern, Central and Southern Europe were trained to conduct promotional interviews with all prospective mothers in their area one month before and one month after childbirth. They were also taught to work with mothers who were identified as parents in need of support by using a specific counseling model to try to prevent the onset of child mental health difficulties.

Overall results show that the intervention group of PHCPs has acquired more knowledge and increased its perceived self-efficacy, while a significant improvement in their accuracy when identifying the needs in families, in comparison with the comparison group, has been noted. These results were more prominent in Greece, Serbia and the UK than in Finland and Cyprus, whereas training satisfaction was high in all sites.

Effects of the intervention on the psychological development of children and family adaptation were evaluated at two years of age in comparison with similar groups not receiving the intervention, using a set of questionnaires, interviews and observation methods. At 24 months differences in the outcome were evident and clearly to the benefit of the intervention group, which also showed significantly higher levels of satisfaction with the intervention it had received.

- **Health Promotion and Educational Support for the Rehabilitation of Offenders (HERO) (IST-2000-26724)**

The main objective of the project in Greece was to develop two sets of support services: a health promotion module, and a learning and skills support module for prisoners preparing for re-entry into society (typically on parole). By the end of the project, the health promotion and educational support services had been tested in one correctional institution in Attica, involving 20 prisoners. The main objectives of the European HERO project have been to:

- develop and successfully determine the conceptual coherence and potential transferability of an innovative approach to offender rehabilitation
- develop and successfully determine viable e-learning and e-health models
- develop and implement a technical platform, applications and tools to deliver the rehabilitation approach
- adapt the technical infrastructure to eight scenarios of use, reflecting different levels of offender environment, varying approaches to rehabilitation and different configurations of user needs
- produce an extensive resource database to support rehabilitation with over 1,600 learning objects
- promote the active use of the resource base in the pilot sites
- enhance the health, learning and personal development outcomes through the use of the services
- develop in response to arising and changing needs of participating users, a number of additional tools and services – including the interactive game “Survival guide”.

General goals of the project according to target group:

For the inmates: To obtain basic IT knowledge; to be informed on job issues and opportunities, when released; to have fun, to break the routine of prison life, to find IT information relevant to their personal interests. To use IT (HERO) as a means for managing life inside and obtain a positive self image and perspective.

For the HERO team: To be able to "open a window" in the prison environment; to provide inmates with basic IT knowledge and health information; to help them during the educational procedure by providing a "space" for discussion.

2. Scope and level of Community action / Subsidiarity

Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).

Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.

The EU and its Member States emphasize the values of social justice and equal opportunities as well as economic progress. To help achieve all three, there is a need for more equitable – fairer – health outcomes for all.

Intersectoral action on the social determinants of health at the EU level is crucial to achieving higher levels of health equity in the EU Member States.

It is also essential for the EU to increase social cohesion, ensure sustainable development and anticipate demographic changes.

If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?

The E.U. can help the Member States to improve their action plans by:

- Developing campaigns to inform the public about nutrition and health risk factors like smoking, alcohol and drugs.
- Developing campaigns in cooperation with the Member States about prevention
- Improving data collection
- Contributing to resolving poor housing issues, poverty, poor educational outcomes, worklessness, homelessness

Is Community action within the ambit of health policy alone capable of addressing health inequalities?

In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?

We believe that the EU can act in co-operation and consultation with the Member States in tackling health inequalities.

The areas where emphasis should be given by the EU are:

- The education of citizens on public and personal hygiene matters in order to protect public health
- Environmental protection. The aim is to understand how the destruction of the environment has a negative impact on human health.
- The Common Agricultural Policy which is an important area for potential progress.

Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?
We realize that both the Member States and the EU must show commitment in order to reduce health inequalities. We propose that this commitment be binding.
What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?
The right tools in order to ensure that common goals are achieved on National and EU level are: - daily data collection - benchmarking

3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory? What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
For our country the issues which should be addressed through future investments supported by Community funding are: - to support families, mothers and children - to engage communities and individuals – strengthening the capacity to tackle local problems and pools of deprivation, alongside national programmes to address the needs of local communities and socially excluded groups (immigrants, asylum seekers and prisoners) - to prevent illness and provide effective treatment and care – by tobacco policies, improving primary care and tackling coronary heart disease (CHD) and cancer. Such funding will prove to be very useful. In particular, we are going to tackle specific problems or support those who may have difficulty in access to services. This includes those living in remote and rural communities as well as teenage parents, vulnerable older people and minority ethnic groups, children who are looked after and care leavers, homeless people, asylum seekers and prisoners. Furthermore, we are going to create national standards and local diversity in service provision.

What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
Actions of other policy areas: - Provide early support for children and families, - Improve social housing and reduce fuel poverty among vulnerable populations, - Improve educational attainment and skills development among disadvantaged populations, - Improve access to public services in disadvantaged communities in urban and rural areas - Reduce unemployment, and improve the income of the poorest - Improve housing quality by tackling cold and dampness, and reduce accidents at home and on the road - Close the gap in infant mortality The impacts of such actions are going to be very useful. In particular, we are going to tackle specific problems or support those who may have difficulty in access to services. This includes those living in remote and rural communities as well as teenage parents, vulnerable older people and ethnic minority groups, looked after children and care leavers, homeless people, asylum seekers and prisoners. Also with these actions will improve the quality and accessibility of antenatal care and early years support in disadvantaged areas.
Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?
It is of the essence for our Country to improve coordination with our neighbours (South-East Europe). The development of cross-border relations is crucial for our Country in order to enhance the cooperation between health authorities. In this way we can prevent outbreaks and also provide treatment for other serious diseases. Cooperation with neighbouring countries is also essential to combat human trafficking and to be able to provide medical, psychological and legal support to victims.

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
In Greece the Ministry of Health and other public agencies such as the Hellenic Centre for Diseases Control and Prevention in co-operation with NGOs have developed various programmes for the following purposes: - The development of psychological support units for cases of family violence or areas that require special assistance (immigrants, single-parent families etc.).

- Training specific population groups in public health issues (e.g. immigrants, single-parent families).
- Psychological support to vulnerable populations.
- The use of the family violence record-keeping application by all hospitals in the country. Efforts are being made to link the research data with geographic information in order to extend the records in all hospitals in the country.
- Free access to hospitals for emergency treatment for foreigners, including illegal immigrants. There is also a free vaccination programme for refugees.
- The cooperation of the Ministry of Health with the Local Education Authority for the promotion of family planning and reproductive health protection and greater accessibility to reproductive health services for new immigrants, Roma immigrants and other vulnerable groups.
- The implementation of the "Help at Home" programme which mainly includes: 1) a complete record and study about the needs of the eldrely and 2) managed care services for the elderly by scientists and volunteers (social workers, nurses, family care), including help at home, medical care, transportation, and psychological support.
- The appropriate measures to protect the health of disadvantaged groups and especially the destitute and uninsured, while free vaccination is provided in the framework of the National vaccination programme
- Social assistance to persons who have been recognized by the competent Greek authorities as refugees or have submitted the relevant application for refugee status, or are temporarily in Greece for humanitarian reasons in order to face emergency situations (food, medical care, child day care, housing and training for vocational rehabilitation).
- The municipalities implement the “Help at home” pilot programme. The programme is funded and overseen by the Ministry of Health. The aim of the programme is to ensure direct communication between elderly persons who are unable to care for themselves and relatives or friends or assistance services, so that they feel less vulnerable.

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Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play
Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.
Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?
To know the inequalities in the level of health of the municipalities that integrate the province of Barcelona, constitutes a priority of the Area of the Public Health and Consumption. That's the reason why we designed, in the last mandate, the project SISAlut (System of information about health). At present this project is in phase of development.

The “SISalut” is a information system, addressed to the municipalities of the province of the Barcelona (Barcelona city excluded). The purpose is to inform on the main indicators of the health situation. It allows identifying the needs and territorial inequalities in health. Also, it’s going to allow identifying inequalities in health among municipalities of the province and defining the supramunicipal policies to obtain a bigger territorial equity.
What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?
Which indicators do you have at your disposal that enables you to effectively map out health inequalities at the local or regional level? Do these indicators allow you to effectively compare the health situation in your territory with other regions?
The project SiSalut, in a phase of development, will allow having systematics indicators of health for municipalities of more than 10.000 inhabitants, and with aggregation at a level pending of specifying for the towns under the 10.000 inhabitants. Indicators of which it is ordered: Structure of population, natality and reproductive health, mortality, mobility according to hospitable registries, injuries for industrial accidents and professional illnesses.
Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?
Yes, we think that the inequalities could be aggravating, especially in municipalities with a bigger ratio of shutdown of plants and of immigration.
Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.
No. But nowadays we need resources to finish the design and to implement the SiSalut (System of information in health) at the provincia of Barcelona.

2. Scope and level of Community action / Subsidiarity *Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).*
Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.

Yes, because its leadership and influence can help to became aware among the responsables of the decisions in the not sanitary sectors, so that they keep in mind the impact on the health when elaborating its politicies. And therefore, to promote intersectorial actions so much at community level as regional as local. Also, the impulse of specific actions, especially if they were of binding character for the member states, it would allow guaranteeing a bigger equity in the territory of the EU.
If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?
To encourage that the governments in their ensemble design and apply policies that take into account the health perspective. For example, establishing as a preceptive the evaluation of the impact in health, like then it got of the impact statements hold environmental, or as in the case of some countries (among them Spain) has been done with the environment impact studies or as in the case of some countries (among them Spain) has been done with the impact of gender. Encouraging the studies of evaluation of the impact in health, by methodological contribution or financing projects that can be extrapolative to other territorial areas. Helping increase the knowledge about the profitability and cost-profit of the transversal work, from the perspective of its impact in the health. Helping evaluate the different experiences with rigor in this area to encourage and to spread the good practices. Encouraging the approval of plans or transversal strategies, at all the levels of the administration. Encouraging the inversion in services and programs of sexual and reproductive health, as mechanism to advance towards the equity of gender. Promoting measures to make aware of the need to improve the training of the professionals of the Public Health to mobilize other agents so that they keep in mind the impact in health of this policies/actions.
Is Community action within the ambit of health policy alone capable of addressing health inequalities? NO, absolutely In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?
It require the generation of synergies and the implication of Social Policy, Education, economic policies, urban planning and housing, agricultural policies, environment, and equality of gender, mainly.
Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?
Undoubtedly.

What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?
- Legislative measures. - Benchmarking between Areas of similar characteristics**.** - Nets of exchange of good practices, of documentation, of work methods, indicators and methods of evaluation... - To Approach the annual plans corresponding to the program Communitarian of Public Health to the local administrations.

3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory? What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
1. Including indicators of health in the evaluations of the biggest part of not sanitary policies of the EU, as it has been made in the Strategy of Lisbon, in which the number of years of life in good health has been included as indicator. 2. Including the health as axle or area of explicit subsidy, in the different lines of economic support, as it has already gotten of the European funds of the regional development, that they can be used to develop and to improve services of health that contribute to the regional development and to improve the quality of life in the regions and municipalities. 3. Supporting economically the projects that encourage directly the empowerment of deprived groups, favoring the interrelation and the mutual support between the people that integrate them.
What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
- Establishing mechanism to encourage an urban planning centered on the health and on the well-being of the people who live there (good prectices, economic support to the actions that they take it into account...) - Promoting the equity between the rural and the urban zones, with inversions to guarantee the rural development in a permanent way and to avoid the displacement of the rural population towards urban zones.

- Encouraging policies for stopping the climatic change and the environmental degradation.
Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?
Yes, between regions with the similar issue (e.g. southeast of Europe), but also through interrelation with the north of Europe areas, or others in which the inequalities in health are of inferior range.

EU ACTION TO REDUCE HEALTH INEQUALITIES
Questionnaire on the Assessment of Territorial Impacts
Submitted for consultation of the Subsidiarity Monitoring Network

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Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play *Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.*
Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?
Inequalities in health are systematic differences in health status between different social groups, which are socially produced (and therefore modifiable) and unfair[1]. It is not only a phenomenon concerning extreme social groups (rich vs poor; higher educated vs lower educated) but a problem affecting the whole population: a gradual decrease in health is observed with decreasing social position, i.e. the so called social gradient of health.

1. Whitehead W, Dahlgren G. Concepts and principles for tackling social inequalities in health: Levelling up Part 1. WHO Regional Office for Europe: Copenhagen; 2007.

Inequalities exist everywhere they have been studied and seem to be increasing in relative terms[2].

In the Basque Country social inequalities in health are perceived as a relevant political issue. The magnitude of social inequalities in health vary depending on the aspect analysed: better results have been reported for inequalities in mortality[3] while a similar situation to other European countries has been shown for other health indicators such as self-assessed health. The existence of social inequalities in the provision and results of health care services have also been reported in the areas of diabetes, and acute myocardial infarction[4,5]. The political awareness about this phenomenon promoted the inclusion of equity in the current Health Policy Plan for the Basque Country 2002-2010. One of the two main goals of the Basque Health Policy includes the improvement of most deprived people's health, and the reduction of social inequalities in health. Comparing with other health plans in Spain, a study showed higher sensitivity to socioeconomic inequalities in the Basque Country[6].

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

The factors causing health inequalities in the Basque Country are the same as those recently described by the Commission on Social Determinants of Health of the Word Health Organization[7], which are basically related to the unequal distribution of the structural and intermediary determinants of health. The structural determinants include aspects related with the socioeconomic and political context, such as macroeconomic policies and welfare state policies, determined by governments, which shape social structures and, consequently, the social position of individuals. This social position, defined by individual's occupation, educational level, gender…. creates inequalities in the distribution of intermediary determinants, which mediate the relation between structural determinants and health inequalities. These intermediary determinants refer to life and working conditions, psychosocial factors, related to social networks, stress and control perception over one's life, and health related behaviours, which have a direct impact on health inequalities. The health

2. Mackenbach JP, Bos V, Andersen O, et al. Widening socioeconomic inequalities in mortality in six Western European countries.International Journal of Epidemiology. 2003; 32: 830-7.
3. Mackenbach JP, Stirbu I, Roskam AJ, Schaap MM, Menvielle G, Leinsalu M, Kunst AE; European Union Working Group on Socioeconomic Inequalities in Health. Socioeconomic inequalities in health in 22 European countries. N Engl J Med. 2008; 358(23): 2468-81.
4. Larrañaga I, Arteagoitia JM, Rodriguez JL, Gonzalez F, Esnaola S, Piniés JA. Socio-economic inequalities in the prevalence of Type 2 diabetes, cardiovascular risk factors and chronic diabetic complications in the Basque Country, Spain. Diabet Med. 2005; 22(8): 1047-53.
5. Aldasoro E, Calvo M, Esnaola S, Hurtado de Saracho I, Alonso E, Audicana C, Arós F, Lekuona I, Arteagoitia JM, Basterretxea M, Marrugat J. Diferencias de género en el tratamiento de revascularización precoz del infarto agudo de miocardio. Med Clin 2007; 128(3):81-5.
6. Borrell C, Peiró R, Ramón N, Pasarín MI, Colomer C, Zafra E, Alvarez-Dardet C. Desigualdades socioeconómicas y planes de salud en las Comunidades Autónomas del Estado español Gac Sanit. 2005; 19(4): 277-85.
7. CSDH. 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; 2008.

system plays also an important role in the generation of health inequalities. In the Basque Country, like in most European countries, access is universally guaranteed and free of charge. However, access and provision are still socially determined, especially in preventive services, specialized assistance, palliative care and services not covered by the public health system.

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

In the last years, we have developed a monitoring system on health inequalities in the Basque Country. The main indicators of this system include: 1) age-adjusted frequency measures for mortality, self-assessed health, long-standing illness, chronic conditions, acute myocardial infarction (incidence, mortality, hospital care), disability, obesity and health-related behaviours (smoking, alcohol consumption, physical activity) according to gender, occupational class, educational level and place of residence; and 2) both absolute (rate difference, slope index of inequality, population attributable fraction) and relative (rate ratio, relative index of inequality) socioeconomic inequality measures for the above cited health dimensions. Moreover, geographic and socioeconomic inequalities in mortality are also analysed using a small-area deprivation index.

The indicators cited above could be used to compare the health situation of the Basque Country with that of other regions. As far as the inequalities in health are concerned, by using the health inequality measures (according to occupational class, and educational level) the situation of our region could also be compared with other settings. Indeed, socioeconomic inequalities in mortality and smoking have been compared with those of other 17 European populations (countries, regions and cities) in the context of the Eurothine project[8].

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?

It seems reasonable to think that that current economic and financial crisis will impact more severely on vulnerable groups, which are less prepared to confront serious economic and social risks. As economic figures are pointing out, unemployment is dramatically raising, especially among unskilled workers. Moreover, media and some political sectors are raising awareness about the fact that current social protection schemes will be unsustainable in the short term, arguing for a reduction of public investments. This will probably increase social inequalities in our societies which, ultimately, will aggravate social inequalities in health.

This hypothesis is supported by evidence showing that after periods of important economic crisis, inequalities in mortality and in other health-related aspects have increased. The case of the Russian economic recession in the 90s showed a substantial decline in life expectancy and the increase of inequalities by social class or gender. Similar examples have been reported for European and Asian countries, such as the Asian financial crisis in 1997, after which a widening of education based on health inequalities was observed in South Korea.

Therefore, in order both to mitigate the effect of the crisis and assure universal protection, it is crucial that in the Basque Country, as in other contexts, welfare state policies are strengthened, especially in the areas of social protection and health care.

8. Eurothine. Tackling Health Inequalities in Europe: An Integrated Approach. EUROTHINE Final Report. Rotterdam: Erasmus University Medical Centre; 2007.

Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.
No. Until now, no financial support has been asked to the EU for health related projects.

2. Scope and level of Community action / Subsidiarity *Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).*
Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.
In our opinion, Community policies are crucial to address health inequalities. First, many Community actions relate to both structural (including governance, and macroeconomic, social and public policies) and intermediary (living and working conditions, behaviours, psychosocial factors, social cohesion….) determinants of health inequalities[9], over and above the national or sub-national policies. Community policies that could determine health inequalities include, among others, those on employment and working conditions, those related with the production and distribution of food (e.g., the Common Agricultural Policy), or trade policies. In the case of trade, the relationship between international trade and health has highlighted the need of assuring coherence between international trade and health policies[10]. From a health equity perspective, trade could affect, for example, macroeconomic conditions that, in turn, influence employment level and income inequalities[11]. International trade agreements could also influence health care systems and produce changes in the financing and equity of health services[12]. Second, Community actions can stimulate political commitment at national level, and facilitate the development of national and sub-national policies to tackle health inequalities. Political commitment could be stimulated by reporting and benchmarking health inequalities across nations and regions of the EU. Moreover, other actions could include Community financial support for equity focused social policies, and rewarding best practices to tackle social inequalities in health.
If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?

9. CSDH. 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; 2008.
10. Fidler DP, Drager N, Lee K. Managing the pursuit of health and wealth: the key challenges. Lancet 2009; 373: 325-31.
11. Blouin C, Chopra M, van der Hoeven R. Trade and social determinants of health. Lancet. 2009; 373(9662): 502-7.
12. Pollock AM, Price D. Rewriting the regulations: how the World Trade Organisation could accelerate privatisation in health-care systems. Lancet. 2000; 356(9246): 1995-2000.

In order to tackle health inequalities in the European Union, health equity must be a priority in all policies at Community, national, regional and local level. The Commission on Social Determinants of Health of the World Health Organization has outlined the main actions to promote equity in health[7]. In this section we refer synthetically to the main proposals for action to address health inequalities at EU level. First, we consider actions that exceed the field of health care services, including the use of health equity impact assessment. Afterward, we mention the main issues to consider in health care policy. Finally, instrumental actions related with monitoring, research and dissemination are pointed out.

1) Health equity in all policies. Every aspect of government action and economy have the potential to affect health and health equity – e.g. finance, education, housing, employment, transport, health,... While health may not be the main aim of policies in these sectors, they have strong bearing on health and health equity[7]. This fact was highlighted by the "Health in all policies" strategy of the European Union, which was developed to promote the inclusion of health in the sectoral policies agenda[13]. Furthermore, in order to develop health equity, policy coherence is crucial to assure that policies complement rather than contradict each other in relation to the improvement of health outcomes and, specially, health equity. Intersectoral action for health – coordinated policy and action among health and non-health sectors – must be a key strategy to achieve policy coherence and for addressing, more generally, the social determinants of health and health equity[7].

2) Health equity impact assessment. Health impact assessment has been used as a tool to promote healthy EU policies[14]. Health impact assessment is concerned with reducing health inequalities. Nevertheless, it is worth emphasizing the need to develop an equity focused health impact assessment. The inclusion of such a health equity impact assessment in all EU policies can help to include the best evidence necessary to develop health equity promoting policies.

3) Health care policy. Even if the health-care system is not the main determinant of health, a good quality and equitable health-care system is a minimum requirement for a good population health. Equity must be explicitly recognized as a basic value of health-care systems across the EU. Indeed, universal coverage health-care systems are a distinctive feature of many EU countries.

   Health-care systems play a relevant role in mitigating the effect of other determinants on health inequalities. However, health care services can themselves produce and increase health inequalities. In order to prevent the so called "inverse care law"[15], it is necessary to consider equity as a priority in the financing of the health-care system, in

13. Stah T, Wismar M, Ollila E, Latineen E, Leppo K. Health in all policies. Prospects and potentials. Helsinki: Ministry of Social Affairs and Health; 2006.
14. European Policy Health Impact Assessment. A guide. Health & Consumer Protection Directorate General. European Comission [Accessed the 24th March 2009]. In http://ec.europa.eu/health/ph_projects/2001/monitoring/fp_monitoring_2001_a6_frep_11_en.pdf
15. Hart JT. JT. The inverse care law. Lancet 1971; 1(7696):405-12.

the allocation of resources, in the access to health services, and in the quality of services. At Community level, policies related with health care systems should consider at least the following points: a) EU policies should promote that health-care systems are based on principles of equity, disease prevention, and health promotion. b) EU health care policies should support the preservation of existing universal coverage health-care systems, and extend the coverage in those countries where universal coverage is not yet attained. Furthermore, Community policies must promote the reduction of user charges in the use of health care services. c) As cited above, trade agreements could influence health care systems and produce changes in the financing and equity of health services, compromising the equity achievements of national and regional health-care systems. Community policies concerning provision of services and internal market should take into account their potential impact on equity in the access, provision and quality of health care. d) The attainment of health care equity requests the allocation of health-care resources according to health care needs. In some countries of the EU, low wages and poor working conditions lead to emigration of valuable and experienced health care professionals. Community policies should prevent health human resources brain-drain, focusing on increased health human resources and training, and agreements between EU members.

4) Monitoring and surveillance of health inequalities. Action on the social determinants of health to improve overall health outcomes and reduce health inequalities will be more effective if EU policies are supported on a surveillance system on health inequalities. This system will allow knowing the magnitude of the problem, the population groups specially affected, and the main entry point for action. The surveillance system should include information on: a) social determinants of health, and more precisely indicators pertaining to the main policy areas; b) social inequalities in health, including indicators of health outcomes according to gender, social class, place of residence, and ethnic background-country of origin; c) social inequalities in health care access, use and outcomes, including the social and economic consequences of ill-health. Surveillance of health inequalities across nations and regions of the EU would require the standardization of procedures to measure health and social indicators. The relevance of health inequalities as a public health problem suggests that it would be worth putting in place a specific unit, i.e. a European observatory on health inequalities, for monitoring social determinants of health, and health inequalities across the EU.

5) Research on health inequalities. Both policy formulation and development at Community level need evidences on the social determinants of health, and on the causes and interventions to reduce health inequalities. EU research efforts should include: a) Promoting and funding specific research programmes on the causes of health inequalities, and on interventions to reduce them at regional and local level. b) Enabling the interchange of expertise and experience on health inequalities research among countries and regions, and c) Including health inequalities in main EU health research programmes.

6) Supporting learning and training on health inequalities and on the social determinants of health is a key action to sustain the development of an EU strategy to tackle health inequalities.

7) Promoting dissemination of both evidence and best practices of policies to reduce health inequalities among EU members.

Is Community action within the ambit of health policy alone capable of addressing health inequalities?

In what other policy areas (e.g. social policy, environment, education…) can Community action help to significantly reduce health inequalities?

Community actions must not be limited to health care policy. As stated above, actions to reduce health inequalities involve all policies with a potential impact on health. Regarding structural determinants of health inequalities, Community action should promote policies which increase political power and influence of people, strengthen welfare state and improve labour market conditions and decrease poverty and income inequalities. Regarding intermediary determinants, Community action should promote policies aimed at improving working conditions, housing and surroundings, environment and enhance healthy lifestyles. In order to implement these actions, other causes of inequalities, such as gender, ethnic background or place of residence must be analysed.

Gender inequality combined with limited economic opportunities may be one of the pathways through which the unequal distribution of incomes adversely affects population health[16]. Socioeconomic position is the major contributor to differences in health by ethnic background, but residual differences remain even after accounting for socioeconomic status. So, policies that promote women participation in political power and their economic independence, such as those to make salaries similar and to combine family and work for men and women should be also be included. Also it should be very important to include policies for the integration of ethnics' minorities and to help degraded and rural areas.

Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?

It is crucial that Member States understand the importance of reducing health inequalities since it represents an excellent opportunity to improve health in regions and, consequently, in the whole EU. Moreover, health inequalities have an important impact on citizen's life quality which is, sometimes, greater than that of widely acknowledged risk factors such as tobacco. If this was not enough, there are also economic reasons which support the advance in reducing health inequalities related to the social and economic consequences of diseases and their negative impact on the production capacity of the European population.

A common commitment is also relevant to contribute to the construction of a harmonized "European social model" which will end up being essential to legitimate EU action among European citizens in the long term. Establishing common milestones and health inequalities reduction targets entails advancing in the development of the social sphere of the Community

16. Kawachi I, Kennedy BP, Gupta V, Prothrow-Stith D. Women´s status and health of women and men: a view from de States: Soc Sci & Med. 1999; 48(1): 21-32.

(employment, income, social rights), which has confronted several problems these last years. This is the reason why even if a common position to combat health inequalities is highly recommended (even to avoid the increase of inequalities among countries), past experience shows that it is important that required targets are easily achievable at the beginning for all regions. As these objectives, which could address health-care system related inequalities in the beginning, are progressively achieved, greater commitment could be required. This is a realistic approach given the diverse situations and starting points among different countries, which would tend to converge in this field progressively.

The political commitment at Community level, translated in specific actions to tackle health inequalities, would be one of the more powerful attempt to promote solidarity among countries and regions at EU level, and among citizens within countries. This commitment would reinforce the image of a Community engaged about these problems, and close to the citizen's interests.

What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?

A multilevel monitoring system should be developed, based on reporting, benchmarking and dissemination strategies. This system must include both indicators of health inequalities (health care included) and social determinants of health. Moreover, the creation of a network platform to share knowledge and best practices should be very useful.

3. Possible Actions
The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities

Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory?

What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.

Following the same scheme as in part 2, the main issues future investments supported by Community funding should address, refer to areas out of the health services, health care policy, and instrumental actions in the fields of research, monitoring and dissemination.

1) EU financial support would be of great importance at regional and local level to promote equity-oriented public policies. The evidence shows that an effective strategy to combat social inequalities in health should include actions which address the social gradient (therefore directed to the whole population), combined with a special attention to the most vulnerable groups[17,18] . Both gradient and target oriented strategies should include interventions related to the most important social determinants of health inequalities, which have been recently identified by the

17. Dahlgren G, Whitehead M. Concepts and principles for tackling social inequities in health: Levelling up (part 2). Conpenhagen: WHO; 2006.
18. Norwegian Ministry of Health and Care Services. National strategy to reduce social inequalities in health. Report No. 20 (2006–2007) to the Storting. Norwegian Ministry of Health and Care Services; 2006.

Commission on Social Determinants of Health of the WHO as structural and intermediary. Among the first ones, the EU should help regional government make public policies (e.g. education, housing or social protection) meet needs of the whole population and do not lead to increase social inequalities. Of special importance are labour market policies which should, on the one hand, improve general working conditions for the whole population (reduction of job insecurity by decreasing temporary jobs, assuring decent wages and encouraging people to join trade unions). Investments in labour market targeted actions should include the reduction of occupational injuries, which concentrate in manual, often unskilled sectors, and also the enhancement of employment opportunities for those sectors with more difficulties. This kind of measures would reduce inequalities in the social position of individuals, which consequently would reduce inequalities in the so-called intermediary determinants such as material circumstances (living and working conditions), psychosocial factors (social cohesion and factors such as stress and control) and health related behaviours (tobacco, alcohol, diet, physical activity…). Specific actions should also address the promotion of gender equity as a social value and the reduction of the influence of the socialization process on the gendered roles. Successful experiences already exist[19] in the area of Preschool education to detect how children face systematically gendered practices and to propose recommendations to change this situation.

2) Financial investment should also be directed towards the development of expertise to conduct Health Equity Health Impact Assessment at regional and local level.

3) Regarding health services field, Community funding should:

- Ensure that allocation of resources for health care activities is done according to diverse social group's needs. Relevant interventions would include:

  - Help to develop greater promotion and prevention oriented primary care model, which emphasizes community's participation and empowerment, and specially considers the needs of most deprived areas. Social empowerment strategies can increase awareness of health and health-care systems, strengthening social health literacy and mobilizing health actions. An effective strategy in this field would be the strengthening of community nursing in socioeconomically deprived areas besides a general improvement in primary health care professionals' working conditions.
  - Help to develop health equity audits for health services actions. This is an effective tool[20] to evaluate how health services are adapted to needs of different

19. Scott-Samuel A. Patriarchy, masculinities and health inequalities. Gac Sanit. 2009 [in press]

20. Department of Health. Health equity audit. A guide for the NHS. London: Department of Health; 2003.

social groups and geographical areas and, afterwards, propose recommendations to improve services and reduce social inequalities.

4) Surveillance and monitoring of health inequalities. EU financial support could greatly improve the knowledge on social inequalities in health and policies to reduce them at regional and local level if information about concrete indicators was periodically required to regions. As stated above, indicators about regional and local social determinants of health and evaluation results about interventions should be made available. That would also improve comparability between regions within countries.

5) Research: Specific European funding calls on health inequalities research could be promoted for regional and local research units. Strengthening of different groups working in similar areas should be also facilitated.

6) Supporting learning and training on inequalities and on the social determinants of health at regional and local level is a key action to sustain the development of the EU level strategy to tackle health inequalities. The main actions in this area should be directed:

   -To promote that educational institutions and relevant ministries make the social determinants of health a standard and compulsory part of training of medical and health professionals.
   -To increase understanding of the social determinants of health among non-medical professionals and general public.
   -To promote building capacity for health equity impact assessment among policy-makers and planners at regional level.

Acting on the decrease of social inequalities in health will probably have, mainly, social impacts since a reduction on social inequalities in general will come from increased social cohesion, reduced poverty rates and increased employment. A general improvement of population's health is also expected which will undoubtedly have positive consequences on economic terms and perception of welfare among population.

What actions within the framework of other policy areas could be undertaken to address health inequalities?

What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.

Actions and impacts both within the framework of health policy and other policy areas have been described above.

Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?

The Basque Country is already working within an existing cross-border scheme with the French region of Aquitania in the area of hospital cooperation (basically promoting patients´ and researchers´ mobility) and health surveillance cooperation (for diseases such as legionnaire's disease, tuberculosis, food related infections,...). Based on this existing cooperation scheme it would be possible and desirable to expand common commitments to

reduce social inequalities in health, harmonizing, first of all, health information systems and promoting research in the area. Once a description of the current health inequalities is done and future needs for action are identified, a second stage could include the implementation of common interventions to reduce social inequalities in health.

4. Best practices

What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?

The current health policy in the Basque Country includes the reduction of inequalities in health as one of its two main goals. The main initiatives implemented include:

- Monitoring of social inequalities in health through (a) the promotion of research projects about socioeconomic inequalities in mortality, life expectancy, self assessed health, lifestyles and pathologies such as acute myocardial infarction. The analysis about social inequalities has been progressively integrated as part of the activities developed by the health system and the Health Ministry; (b) the periodic publication of health indicators by sex, socioeconomic position and place of residence; and (c) the development and improvement of health information systems based on the creation of area-based socioeconomic variables, the geo-codifying of addresses, the link of registries with socioeconomic indicators etc.
- Development of Health Impact Assessment (HIA) of non-health policies in order to include health and social inequalities in health in the political agenda, both at local and regional level. In 2006 the first local project on urban regeneration was assessed and the experience showed that HIA is useful to make public policies healthier and promote stakeholders´ participation. From 2007 we are working in the development and validation of a screening tool for regional-public policies to identify those in which a complete HIA should be done.
- Promotion of equity in health care activities through: (a) the introduction of socioeconomic related indicators in the primary health care activities, and (b) the introduction of the gender perspective in the clinical practice guidelines.

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Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play
Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.
Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?
Yes. The Autonomous Community of the Canary Islands is made up of seven islands with different sizes and populations, and different socio-economic structures. This means that respecting the population's right to healthcare, enshrined by the Constitution and current legislation, is complicated and results in significant disparities. On the one hand, the proportion of the population living on islands outside the capital does not warrant the

establishment of certain services *in situ*; on the other hand, this same circumstance means that users of the Canary Islands Healthcare Service in these areas receive care under inferior conditions. This is because they have to travel from their place of residence to receive specialised care on the capital islands, which is very disruptive for them (as they are not in a familiar environment, they are ill and, to various extents, have difficulty travelling, and at times are alone and away from home, as they do not have family members that can accompany them). Another important aspect relates to the financial cost of this process.
The findings of a recent study (I. Abásolo et al., *Análisis del efecto de la condición de "doble insularidad" sobre la equidad en la utilización de servicios sanitarios públicos: el caso de las Islas Canarias*" (Analysis of the effect of 'double insularity' on the fair use of public health services: the case of the Canary Islands)), based on the 2004 Canary Islands Health Survey (*Encuesta de Salud de Canarias 2004*), stated that "*it can be concluded that the condition of "double insularity" affecting non-capital islands, as well as restricting job availability and increasing the costs of supply and provision of products, also represents a real barrier in the use of public health services. On the whole, except in La Palma, residents in the other non-capital islands use GPs and consultants less often than residents of capital islands; moreover, Lanzarote residents use emergency hospital services less often. In line with our model, and bearing in mind the limitations stated in the previous section, these differences cannot be put down to healthcare requirements or demographic or socio-economic factors (at an individual level). These findings would merit a more in-depth analysis, in order to confirm or refute these conclusions"*

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

The archipelago's fragmented status, which for the non-capital islands leads to the abovementioned barriers of double insularity.
Another important factor is population, in all senses: firstly, the population increase that has occurred in the last decade has led directly to higher demand for preferential goods and services in the field of healthcare; secondly, linked to territorial fragmentation, is population distribution. Around 80% of the population of the Canaries lives on the two central islands (Tenerife and Gran Canaria), while the remaining 20% are spread around the other five islands. Combined, the above two factors generate an increase in the geographical range of demand for health services, and the need to provide sufficient, adequate supply of these services, taking into account the region's fragmented island status and the other conditions specific to the outermost areas.

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

The indicators used by the Autonomous Community of the Canary Islands are, firstly, those

included in the 2004 Survey on the health and revenues of the population of the Canary Islands (and previous surveys), which are available on the Government of the Canary Islands' website: http://www.gobiernodecanarias.org/sanidad/scs/1/plansalud/enc_niv_ing.jsp. The following indicators are also used:
- comparative times (isochrones) required to reach healthcare centres;
- waiting lists;
- human resources ratios;
- economic resources;
- access to fibrinolysis
- comparative times (isochrones) for emergency health services to arrive;
- percentage of decentralisation of basic services

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?

The economic crisis will no doubt affect and might contribute to a reduction in the quality of care received by patients, while the crisis itself also causes problems of financial sustainability within the healthcare funding subsystem (reduction of tax revenue). The consequence of this will be a slowdown in the growth of public investment in healthcare (infrastructure, technology and human resources). It is more than likely that this situation will exacerbate existing inequalities in island and outlying regions such as the Canaries.

Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.

A number of healthcare projects have been presented both for the current (2007-2013) and previous 2000-2006 periods. These projects concern infrastructure, set-up and extension of healthcare centres, local clinics, hospital refurbishments, construction of specialist care centres, software updates, and equipment for these centres and the provision of allowances for travel and accommodation.
With regard to the programmes co-financed via these programmes, the Canary Islands Healthcare Service has signed contracts for technical support and for the drafting of projects and management of works.

2. Scope and level of Community action / Subsidiarity
Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).

Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your

answer.

Yes, insofar as these inequalities are caused by structural factors such as double insularity linked to the outlying nature of the Canaries, population distribution and terrain. Community measures could offset the extra cost of services and reduce inequality in this area. Moreover, if the EU established general guidelines for healthcare action in order to minimise inequalities, the actions of Member States and regions would be strengthened.

If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?

Stepping up coordination of health systems within the EU. Providing financial support for Member States and regions with regard to IT (information systems, telemedecine, etc.) and health infrastructure, and providing homogenous information at both national and regional levels, in relation to inequalities in healthcare.

Is Community action within the ambit of health policy alone capable of addressing health inequalities?

In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?

Given the range of competences between the EU, Member States and Regions in the field of health policy and management, it is clear that one party alone cannot fully deal with the problem of healthcare inequalities. What is needed in this specific area is coordination. The EU could establish various "minimum requirements" guaranteeing the quality of care and minimising inequalities in access to healthcare. In this context, an agreement from the EU would serve as a guarantee and proof of the rigour needed from Member States and regions in honouring such rights.

Other policy areas for Community action:

- The impact on individuals' participation in their own healthcare (broadening the range of infrastructure and activities subsidised; publicly owned sports facilities built using European funds and aimed at the entire population, grants for sports clubs with a view to improving health and educating those providing their own care);
- Updating assistance programmes to reduce the impact of remoteness and double insularity on the price of healthy foods (fruit, vegetables, etc.);
- Assistance with improving the emergency transport network in outermost regions, particularly islands, so as to ensure connections between islands and with the mainland;
- The EU should promote common measures for social and health care, given that, in addition to the inequalities mentioned, there is also inequality relating to old people with multiple and chronic illnesses who do not have sufficient social and health centres in which to receive care (long-term care), and must be cared for on hospital wards for critically ill patients (with high opportunity costs). The EU could play a decisive role in promoting and co-financing the infrastructure required.

Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?
Yes, but this would require studies to be carried out at regional level in order to pinpoint the inequalities. There should be a specific European fund for this purpose (reduction of healthcare inequalities, on both a personal and regional level), with distribution criteria that would include the various measurement parameters for these inequalities and their causes
What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?
Firstly, homogenous information (i.e. indicators) that is easily available (on both the EU internet sites and those of the Member States' health ministries). Secondly, the indicators drawn up in this field by each State should also be drawn up at the regional level. The regional variable is considerable, and has an impact on the accessibility of healthcare services. All these tables of indicators should include information on socio-economic status, making it possible to establish correlations with other variables. To this end, as mentioned, robust information systems must be provided for, guaranteeing the quality of information from the different Member States. Another useful tool would be the promotion of Reference Units in the different autonomous communities, which would be coordinated by a central committee managed by the national health service and which would itself participate in EU decision-making bodies. In this context, there should be a European network of Reference Units and Services.

3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory? What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
Investment in communication technology applied to the field of healthcare. In the specific case of outermost regions such as the Canaries, which are also an archipelago, it is essential to promote information technology, as this helps to reduce disparities between islands and brings professionals and users closer together. In our case, there is a need for telemedicine to be heavily promoted. By setting up this technology, we could bring patients closer to the different specialist areas and complementary tests that telemedicine can provide, improve the quality of patient care, and overcome the difficulty of providing specialised personnel in sparsely populated areas which currently offer no professional incentive for working there. This will require good planning, investment in technology and offering incentives for professionals to include telemedicine among their services. More staff will also be needed in

reference centres.
In principle, setting up the telemedicine system would incur initial costs, but once in place it would lead, firstly, to better quality of patient care in areas that offer the worst access to healthcare, a reduction in red tape caused by the differences between the different zones of the autonomous community, lower economic costs caused by transfers, diet, accommodation, tickets, etc., and reduced social impact due to the social and family problems caused by transfers that patients suffer. It would also make it possible to increase the incentives for career development of healthcare professionals in isolated areas. Those who work on the "edge of the outermost regions" and find themselves disadvantaged and subject to professional isolation could gain permanent contact with reference hospitals and their specialist staff.
Moreover, the current difficulty in finding healthcare staff, due to their scarcity, the economic problems caused by the global crisis and the unattractiveness of outermost regions for healthcare professionals whose career development potential is reduced, could be greatly minimised by developing and implementing telemedecine.
Another area for action could be a virtual health science library, which could overcome the inequalities faced by professionals in accessing information.

What actions within the framework of other policy areas could be undertaken to address health inequalities?

What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.

The regions that, for geographical reasons, lie at the EU's external border, such as the Canaries, are subject to strong migratory pressure that has a direct impact on their healthcare system. Our status as an outermost and border region of the EU, together with our geographic proximity to Africa and cultural/historical proximity to Latin America mean that on a daily basis our public health services must bear additional costs in meeting our obligation to provide basic healthcare for the migrant population, regardless of its administrative situation (whether legal or illegal). Therefore, we feel that the EU should support these border regions in providing healthcare to migrant populations (whether or not their situation is legal).

Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?

In principle, it might be a better idea to focus efforts on reducing inequalities within each EU member State. For the Canaries, and for the outermost regions in general, our remote geographical location, cut off from the European mainland, makes it very difficult to address this issue in a feasible, successful manner in the context of cross-border cooperation, particularly when it comes to regional integration with non-EU countries located in close geographical proximity.

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
• The implementation of general programmes for the early detection and prevention of particular diseases prevalent in the EU has shown significant improvements in terms of quality indicators and, in particular, better quality of patient care by the Canary Islands' Healthcare Service. • The new health services based on telemedicine between the islands of El Hierro, La Gomera and Tenerife (where the specialised reference services are located), focusing on telepsychiatry and teledermatology, have helped to reduce certain inequalities affecting access, in terms of both time/distance and quality.

Responses to the public consultation on *EU Action to reduce health inequalities*

Catalan Parliament

On general information

What will the trends be as regards health inequalities?

It depends to a great extent on the sustainability of universal public health systems. At local level (Catalonia), health inequalities have gone down over the past few years, as demonstrated by the responses to Catalonia's Health Survey (ESCA 1994, 2002, 2006). However, recent changes in relation to the economy and work could have a negative impact on this trend.

We should emphasise that among the countries in the EU-15, differences in key indicators have become less apparent, but with the enlargement of the EU and new Member States joining, the results show that health disparities have increased.

Which indicators are needed to enhance the monitoring of the extent of health inequalities within the EU?

Health indicators and social indicators which show the complete distribution of the variable (for example, not only respondents' level of illiteracy but also the distribution of their level of education).

As priority tools: health surveys and reliable, comparable living conditions, stable and comparable health indicators, indicators for social conditions (with the same quality criteria).

On the scope of action at the EU level and subsidiarity

Do you think action at Community level would be decisive in addressing health inequalities? Why?

Yes, because this would ensure that Member States take action which is more similar and comparable. There should be a commitment to common objectives, with indicators on coverage, accessibility, health results, etc. that are linked to variables on social conditions. They should be practical to collect, and should also be easy to evaluate.

There are other factors which will help to reduce health inequalities – some of these should be tackled as an absolute priority and sometimes even ahead of taking action on the health system itself: education and training policies, development and social integration policies, policies promoting employment and healthy working conditions, together with housing, town planning and mobility policies.

How should the EU encourage and support relevant actors to tackle health inequalities?

By visualising the need to invest in health as a way of promoting social development. By passing on the idea that health services are not only an expense but also a source of innovation and development. Investing in health means investing in progress and the potential for moving towards more equal society, which is far better than an unequal society.

Should there be a common commitment at EU level to reduce health inequalities, e.g. establishing milestones and common reduction targets?

Yes, there should be common objectives on the accessibility of services and opportunities for prevention and education.

What should be these milestones and common targets? Which variables? And to what extent?

The differences in basic health indicators should be assessed at regional level within EU countries. Reducing the differences between relatively small areas (e.g. regions) within countries, could allow the progress which has been achieved through equality and accessibility policies to be measured.

What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?

Common indicators should be used that could be measured in any European country. The results could then be compared, allowing successful policies to be evaluated.

To what extent can health inequalities be addressed through health policy? And how?

In principle, increasing access to preventative and curative services together with implementing social policies to avoid exposure to disease risk factors, as well as developing healthcare services for vulnerable sections of the population, should have a real impact on reducing inequalities.

Which other policies, such as social policy, would contribute to reduce health inequalities?

All policy areas have a part to play in the state of the population's health. From the point of view of public health, we believe that all policies from all sectors should be taken into account. Policies on education, housing, employment and social affairs are particularly relevant however.

Possible actions and impact

Taking into account the current economic situation, which immediate actions should the EU or the Member States take to avoid an increase in health inequalities in the short term?

Action should be taken to improve the population's level of education and the main social determinants (income, work, housing, social support). Universal public health systems should also be extended.

Do you believe investment through the Structural Funds can help reducing health inequalities? If so, how and why?

Yes, if the investments target the priority areas mentioned above.

Where should future Structural Funds investment mainly be allocated to be effective in reducing health inequalities? What would be the expected impact of this funding?

To strengthen and extend action on economic development, education and social policy.

What other policies should the EU and Member States focus on to successfully reduce health inequalities?

This depends on the extent to which the health system in question has developed. For some health systems, investment should be made in healthcare itself, while in other countries which have more developed health systems, more cross-sector investments should be made.

To what extent should current coordination and oversight processes within the EU to strengthen common action against health inequalities be improved?

Ensure that independent reports are drawn up to evaluate the system on a regular basis. These reports should be drawn up from studies which should ideally be carried out by agencies which are not associated with the country involved. They could be organised through study groups made up of experts from universities or independent organisations.

What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)?
Health equality cannot be achieved in an environment where social inequalities prevail, and it would be wrong to believe that social inequalities can be solved through healthcare. Achieving health equality and social equality are two avenues of progress which need to develop alongside one another.

What should the EU do to encourage experience-sharing among Member States, regions and local authorities?

A good first step would be to ensure that the bodies for reviewing and auditing health policy (and in cross sector policies which have improving health indicators as a goal) are brought down to regional/municipal level. Given that in many EU Member States the regions have full responsibility for health policy and a significant proportion of social policies, it would be highly desirable for the EU to work more closely with the regions. Providing a structure for the exchange of ideas and good practice between

regions could make policies more effective at reducing health inequalities both among Member States and among the different regions within each country.

How should EU policies be rationalised, in order to ensure they reach their recipients effectively? (Underprivileged people, women, immigrants or children)

See response to the previous question. Specifically, when the target population is made up of disadvantaged groups or groups which have specific healthcare or access requirements, there is a need to boost action at local level (local councils), as they have the most contact with these sections of the population.

To what extent would promoting research be useful to fight against health inequalities? Please give concrete examples.

Promoting two fields of research as a priority: healthcare research and operational research, with the emphasis on analysing the effectiveness and efficiency of measures for reducing inequalities.

Further points

Are you aware of any examples of best practices aiming to reduce health inequalities that might be shared with the Commission and other partners? If so, please give details.

One of our own examples is the experience we have had with the programme which came out of the Ley de Barrios (Law on Neighbourhoods). The Regional Government of Catalonia used the programme to improve living conditions in neighbourhoods which had a high rate of social problems (and health problems as a result). Cross-sector measures were used that would have a positive effect on the health determinants of the population.

Finally, we should point out an important principle: health inequalities in societies with a universal public health system are usually due more to factors outside the health system (work, housing, education, social cohesion, etc.) than to factors inside it. Internal factors are of course also important however: the level of care provided, accessibility, quality of healthcare, etc.

EU ACTION TO REDUCE HEALTH INEQUALITIES
Questionnaire on the Assessment of Territorial Impacts
Submitted for consultation of the Subsidiarity Monitoring Network

en

Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play

Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.

Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?

Yes. There are various different factors in Extremadura which can give rise to health inequalities. One factor is the socio-demographic situation: Extremadura has a population of 1,080,000 and an area of 42,000 km^2 which gives the region a population density of 25 people per km^2. This causes problems for accessing healthcare services. The cultural level of the population also plays a part in health inequalities, as does the technological divide in accessing healthcare.

Extremadura has the same trends for health and gender as the rest of Spain.

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

1-Geographical spread of the population

2-A predominately ageing population

3-Standards of culture and education

4-Income per capita

5-Gender and health

6-Technological divide

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

-Study on the accessibility of primary healthcare

-Level of public health (through surveys)

-Areas covered by healthcare services and health programmes

-Research on the effect education has on health

-Analysis of service demand

-Studies on mortality through the Community of Madrid hospital database

-Review of the situation to develop the Health Plan for Extremadura

-Qualitative research on health and gender

-National health system indicators (National Health System Observatory)

We can compare the health situation in Extremadura with other regions through the National Health System Observatory, the level of public health (health surveys) and the areas covered by healthcare services and programmes.

The rest of the groups of indicators are less comparable among the regions.

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?
There is no doubt that the current economic crisis will have an impact on the use of healthcare which involves the service user paying part of the cost. This is case for medication required by the active working population. However the impact will be minimal due to the fact that in our region and indeed throughout Spain, the universal, free system guarantees equality and fairness in healthcare.
Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.
Between 2000 and 2006 we received funding for infrastructure and buildings which allowed us to modernise and equip the network of healthcare services in Extremadura. We also received interregional funding which allowed us to bring more knowledge into the region's healthcare system. For the period 2007-2014 we will continue to use these funds to develop our centres and ICT for health. We have not used any form of technical assistance (we used our own resources).

2. Scope and level of Community action / Subsidiarity *Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).*
Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.
Going by our experience, the analysis and action should be carried out at Community level in the EU to avoid health inequalities among the population. Disease has no respect for borders, which is why an EU-wide health strategy is required, with a priority heading on Public Health. Subsidiarity should be avoided however, with economic aid playing an exclusive role. An EU strategic healthcare plan should be developed before any economic aid is distributed.

If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?
Action on Public Health and a permanent EU health observatory would certainly be a great help.

Is Community action within the ambit of health policy alone capable of addressing health inequalities? In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?
Inequalities can be reduced if we have a cross-sector action plan. Inequalities arise from other problems, such as communications, standards of culture and education, etc. Policies should therefore take an integral approach and deal with the realities of the specific social context. Policies on employment, development, communications, technology, as well as social, environmental and education policies.
Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?
We have called this a Strategic Plan which will serve as a framework for action and will not only aim to reduce inequalities but also to improve the level of public health.
What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?
A Strategic Plan, using the open method of communication and monitored through the Observatory we suggested above.

3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory?

What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
• Accessibility and communication • Information and communications technology (ICT) • Promoting personal autonomy • Care in situations where disease causes dependency • Employment Such funding would: • Make healthcare resources more accessible • Improve access to healthcare resources through ICT • Improve the purchasing power of the population
What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
See responses to questions above.

Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?
It certainly helps to improve the situation. However, cross-border cooperation has a greater effect on improving the situation for people who live in border areas, which have similar characteristics despite belonging to different countries. Its use is limited however.

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
-Health planning which takes into account the demographic and social context -Studies carried out on the level of public health using surveys, and then ensuring these results are taken into account for health policy -Involving the EU in health management

EU ACTION TO REDUCE HEALTH INEQUALITIES
Questionnaire on the Assessment of Territorial Impacts
Submitted for consultation of the Subsidiarity Monitoring Network

Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play *Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.*
Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?

The Lombardy region encompasses an area of approximately 24 000 km^2 and has over 9.6 million inhabitants. It is subdivided into 15 health areas ("Aziende Sanitarie Locali" [local health centres], ASL) and comprises a significant proportion of mountainous terrain. The regional health system provides universal coverage and is funded by general taxation, with an organisational model that separates the service providers from the purchasers (the ASL). The purchasers are funded by weighted capitation and the service providers are funded mainly (but not exclusively) on delivery of the service.

Against this background, the problem of health inequalities in the Lombardy region has been approached from two angles: foreign nationals in the region on an illegal basis; and geographical differences in both the provision of healthcare services and access to health facilities.

The main problem in respect of illegal foreign nationals is access to health facilities (and the obvious health consequences arising from lack of access both for them and for those coming in contact with them. The re-emergence of sentinel diseases such as leprosy and the increase in cases of tuberculosis are clear examples of this).

The distribution of illnesses (mortality, chronicity, etc.) and of the use of services (admission rates, uptake of outpatient care and pharmaceutical services) varies greatly from area to area, pointing to significant differences (inequalities) to be addressed.

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

There is a very large number of illegal migrants in the Lombardy region, generally spread out across the region (with larger concentrations in certain areas), but also concentrated along ethnic lines. The healthcare experience of the different ethnic groups varies greatly (consider, for example, the Chinese community, who even tend to eschew the system altogether); they come into contact mainly with the emergency services, and often with humanitarian and voluntary organisations working in the region.

Regional inequalities derive, however, from the interaction of the system of services with local customs and culture. As there is such diversity in terms of organisation and culture across Lombardy, there are major differences in the means of access to the various health structures (in certain areas, for example in the East of the region, hospitalisation predominates, whereas in other areas more appropriate forms of access prevail, geared towards regional healthcare).

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?
All dealings that people in Lombardy have with the regional health service are recorded in regional data bases. Specifically, records are kept (with universal coverage) of causes of death, hospital admissions, outpatient care and pharmaceutical consumption. These archives are sufficiently detailed to map out the history of each person's healthcare (throughout the region), providing details of the place (at least the municipality) and date of each event. ***By combining the existing data bases in the appropriate way and using a set of predefined algorithms each person can be characterised by their distinctive pathology.*** ***From this data many indicators can be extrapolated and used to monitor the health of the people and their use of healthcare services. It was from this monitoring that the two aforementioned types of inequality emerged.*** ***This kind of detailed information is not available in other regions in Italy, making comparisons difficult.***
Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?
We currently do not have information on this.
Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.
Under the 2000-2006 programming period, a project was presented aimed at promoting health and insurance cards within the INTERREG IIIC operational programme. Alongside the Lombardy region's DG Health, the other partners involved in the INCO-HEALTH project were the region of Veneto (lead partner), the regional health agency of Friuli Venezia Giulia and the health insurance fund administrations of Slovenia and Hungary. ***Under the current programming period (2007-2013), the Lombardy region's DG Health has launched a proposal (as the lead partner) for a project currently in preparation under the Alpine Space operational programme. The purpose of the proposed project (ALIAS) is to establish a network of hospitals capable of providing telemedicine services and of sharing patients' clinical data, with a view to ensuring better health services and more effective continuity of care.*** ***Both projects have made use of technical assistance provided by the respective managing authority.***

2. Scope and level of Community action / Subsidiarity *Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).*
Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.
We do not believe that Community action would bring significant added value in the specific case of the Lombardy region. ***Our system is based on the universal right to healthcare. In this context, the inequalities within the region appear to be well monitored and contained. However, as previously mentioned, Lombardy intends to make use of the Alpine Space programme to improve access to health services for people in the region's mountainous areas.***
If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?
Is Community action within the ambit of health policy alone capable of addressing health inequalities? In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?
Through support for the development of ICT and its applications in telemedicine, with particular focus on chronicity, the EU could help establish access to appropriate services for the more diverse sections of the population.
Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?
Each health system can identify the objectives that it can realistically achieve in its particular circumstances: it is more difficult to envisage common milestones or objectives for all.
What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?
Benchmarking and the identification of best practice could represent important tools for the various health systems.

3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory? What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
Any additional EU resources directed towards developing technologies that would help to bring local health services closer to the patient and enable the development of home care would help enhance, and particularly, harmonise the system of public health services. This would help, inter alia, to curb the depopulation of rural and mountainous areas, by increasing the quality of life there.
What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?
Yes. This is the spirit in which the proposal outlined in point 1 was made, concerning the whole Alpine area.

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
The Lombardy region has taken measures to reduce inequalities in the health sector by establishing pathology networks with an infrastructural aspect – based on the administrative networks (Regional service card – social-health information service), as well as a clinical (guidelines applied to the regional context) and organisational aspect (hub and spoke model). Examples include the Lombardy oncology network, the haematology

network and the network for stroke and the management of acute coronary syndrome. There are obvious organisational implications on integrating resources, which cannot be extended to all elements of the system, and consequently on planning the availability of resources, including in economic terms and in respect of a Health Technology Assessment. Assessing the performance of the various elements of the network – including through benchmarking – also constitutes one of the parameters of qualitative assessment on which to measure the impact of the organisational set-up.

EU ACTION TO REDUCE HEALTH INEQUALITIES
Questionnaire on the Assessment of Territorial Impacts
Submitted for consultation of the Subsidiarity Monitoring Network

Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play

Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.

Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?
In Austria, healthcare reports are drawn up regularly at federal and state level. These reports, or the health indicators on which they are based, which are available to all the states and in some cases also to healthcare regions within the *Länder*, show that health inequalities – i.e. differences in public health among the population - exist in Austria. Thus life expectancy in the western regions of Austria is significantly higher for both men and women than in the eastern regions. Similarly, the western regions in some cases show considerably lower mortality from all the major causes of death than the eastern regions. The (far) western regions of Austria show lower figures for number of hospital stays, or hospital admissions, than other parts of the country. A high concentration of hospital stays is also found in central Austria. Regional differences also exist with respect to lifestyle factors affecting health (e.g. being underweight, obesity, smoking, sport and exercise), and road accidents, broadly but not so markedly between east and west. Regional health information is published in Regis - the regional health information system (http://regis.oebig.at), which is part of Austria's health information system (ÖGIS). Most of the data in Regis is gender-specific. The health status of Austria's population also varies according to age group. Whereas the regional differences in life expectancy and mortality can be demonstrated with the data available, lack of data means that for socio-economic differences this is possible only to a certain extent at the moment. However, specific surveys show that considerable differences exist between social groups with respect to health behaviour, subjective state of health, and life expectancy and mortality.
What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?
The causes of the clear differences in the health of Austria's population between eastern and western Austria with respect to several health indicators are assumed to be the following: - less favourable socio-economic structure and development in some of Austria's eastern regions; - the high proportion of seriously overweight people (BMI>30) in eastern Austria, which seems to be due to poorer eating habits in those regions, and is also corroborated by respondents in Microcensus surveys and by medical check-ups for national service; - relatively lower prevalence of high blood pressure in southern and western Austria

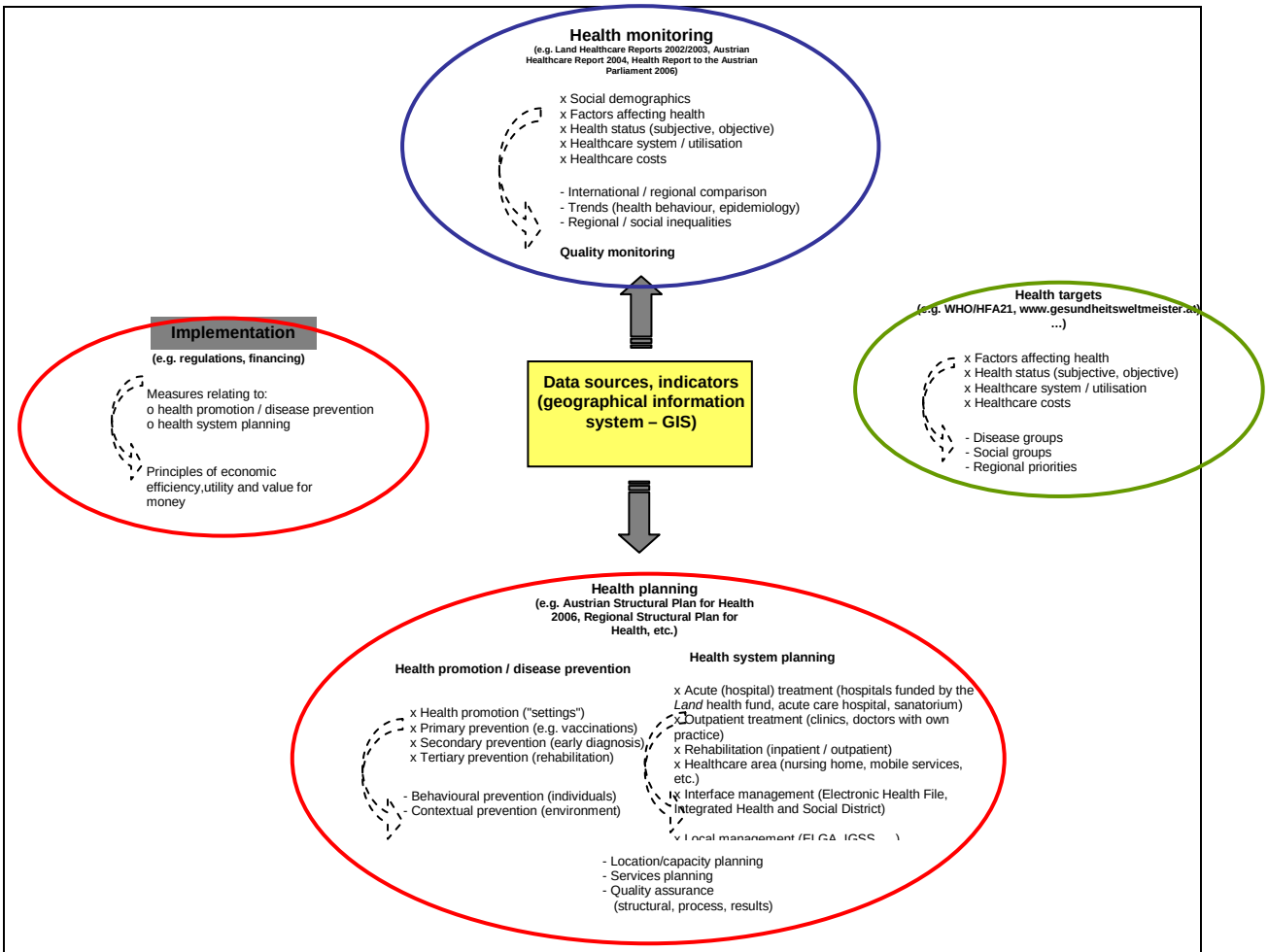
compared with eastern Austria, based on responses to Microcensus surveys;
- smallest numbers of people doing more sport and exercise to improve health in eastern Austria, versus highest numbers in western Austria.

In addition, with respect to socio-economic differences it is observed that in general the better the socio-economic environment, the better people's health behaviour, and thus also their state of health and probably also life expectancy.

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

Austria's regions draw up regular health reports assessing health status in the regions. These reports are based on a concept developed by the Austrian Federal Institute for Health (Bundesinstitut für Gesundheitswesen), which is designed to make state health reports comparable and comply with WHO and EU rules on health monitoring.



The data collected across the country on this basis, which is available in all the regions, concern:

- life expectancy (at birth, age-adjusted life expectancy, disability-free life expectancy, infant mortality, neonatal infant mortality, mortality by main causes of death)
- mortality
- morbidity (hospital morbidity, morbidity by main causes of death, outpatient morbidity, lifetime prevalence of selected chronic diseases, notifiable infectious diseases, sick leave, disability, subjective assessment of mental and physical health, potential alcohol-associated mortality)
- data on factors affecting health (being underweight, obesity, smoking, alcohol consumption, narcotics, sport and exercise, eating habits, attendance at medical check-ups)

On this basis it is quite feasible to compare the health situation between Austria's regions. Comparability at European level is limited owing the different data situation.

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?

Such effects have not been observed to date.
Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.
Health projects have been funded under various Austrian operational programmes. Examples: A number of health projects (e.g. relating to dependency disorders, obesity, asthma, telemedicine) have been funded under the Interreg III A programme Alpenrhein-Bodensee-Hochrhein. One of the programmes of innovatory measures developed in Vorarlberg during the 2000-2008 Structural Fund period, which was co-financed by the ERDF, was designed to develop innovative procedures and technologies for diagnosing specific diseases and set up a centre of excellence for preventive medicine. The state of Carinthia carried out an Interreg III A project jointly with Friuli-Venezia-Giulia region and Veneto during the 2000-2006 programming period on "Cross-border cooperation in patient care". Key elements of this initiative were patient information activities (surveys of foreign guest patients, drafting of multilingual information brochures, development and provision of language courses geared to hospital life), exchange programmes for hospital staff and organising cross-border workshops on the treatment of lymphoedema. This led in concrete terms to the conclusion of an emergency treatment contract between Carinthia and Friuli-Venezia-Giulia and setting up of an "International Training Academy for the Medical Professions – EWIV" (Sanicademia) with the three project partners. During the current programming period, funding was sought – and has already been approved – for another Interreg IV project, entitled "Cross-border and interregional initial and further training in the healthcare sector". A key goal of this programme is to standardise and improve the quality of training for health professionals in the regions of Carinthia, Friuli-Venezia-Giulia and Veneto, to address the challenges of increasing patient and staff mobility, and to pool the resources of the individual healthcare systems so as to ensure sustained consolidation of cross-border activities. The *Land* of Carinthia is the lead partner in this project, and the three regions taking part are already using Sanicademia, which they own, for its implementation.

Tyrol has applied for funding under INTERREG IV for healthcare cooperation in the Pustertal (Alto Adige and East Tyrol). The main objective is cooperation between the hospitals in Lienz, Innichen, Bruneck and Brixen.

Under the bilateral ETC (European Territorial Cooperation) programme between Slovakia and Austria (2007-2013), the cross-border research project "Mobil" (Mobility) was approved. The aim of this project is to develop and combine new procedures, or new tools, for maintaining or improving mobility in old age.

The cross-border project RASGENAS (genetic factors in rheumatoid arthritis in Austria and Slovakia) was also approved under the Austria-Slovakia ETC programme, for the purpose of conducting research on the treatment of rheumatoid arthritis.

2. Scope and level of Community action / Subsidiarity

Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).

Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.

If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?

Is Community action within the ambit of health policy alone capable of addressing health inequalities?
In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?

Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?

What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?

The questions under point 2 are closely related, and are answered together below.

The first point to note is that the EU has a limited remit with regard to health. Under Article 152 of the EC Treaty, the EU is to complement Member States' policies by supporting cooperation between them. The EU cannot have its own health policy which is additional to the policies of the Member States.

Within this remit, the EU is already undertaking initiatives that contribute to eliminating inequalities in healthcare. These include:

- the action programme for public health, which focuses mainly on prevention of serious diseases and is intended to help reduce the impact of such diseases;
- promoting the development of comparable data on health and people's health behaviour, and on diseases and healthcare systems;
- combating and preventing communicable diseases, especially within the network for the epidemiological surveillance and control of communicable diseases, or early warning and response system;
- the Drug Prevention and Information Programme, which also supports cross-border projects;
- fixing of quality and safety standards for organs and substances of human origin, and for blood and blood derivatives.

Given the restricted EU remit in healthcare, no measures based on TEC Article 152 can be envisaged that would go beyond these initiatives already taken and lead to a substantial reduction in healthcare inequalities. The most effective support can be given to national and regional activities by ensuring standardised data collection at European level, in order to guarantee comparability of data between regions.

However, action taken on the basis of standardised data must be taken at regional level. Measures to promote health and awareness in particular, which are especially relevant to combating inequalities in health status, must be "bottom-up" and not "top-down". It is particularly important here that measures be aimed at correcting the substantial differences in regional circumstances.

Quantitative targets, performance comparisons, reports and the open coordination method are not considered to be appropriate approaches for healthcare, especially since there are very wide differences between regions and EU-wide targets therefore seem to make little sense, or they would have to be so vague that they would not provide a relevant basis for action at regional level. On the other hand, exchanging secure data and best practice via networks - e.g. for projects relating to medical quality assurance, prevention and integrated healthcare – is regarded as a helpful way of supporting the regions.

In addition to measures specifically based on its health remit, the EU is active with respect to factors affecting health, also based on other areas of competence defined in the EC Treaty. Examples include advertising and sponsoring in relation to the production, presentation and sale of tobacco products; drugs; food safety; and the environment. This EU action on the major health factors is welcomed and is a substantial support for regional health policy. Generally speaking, the objective of the EU – in accordance with its remit set out in TEC Article 152 – should be to achieve a high level of health protection through transport policy,

environmental policy (e.g. with respect to atmospheric pollutants, noise, drinking water), employee protection, food security, etc. Standards are important here. The EU has already set a large number of relevant binding requirements, and should continue to act in this sphere mainly to improve the health of the EU population as a whole and so also combat health inequalities.

Finally, reducing health inequalities also depends crucially on healthcare provision. Considerable financial resources may be necessary to improve this. The EU can act here on the basis of its regional policy competences, co-financing relevant projects (see point 3).

3. Possible Actions

The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities

Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory?
What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.

In Austria's regions, EU funding - especially from the Structural Funds - is already being used for projects relating to coordination of healthcare provision (in particular cross-border healthcare provision) and to factors that affect health. Projects are financed mainly through the various Interreg programmes.

Measures relating to healthcare provision and health factors are also important starting points for combating inequalities in public health. Cross-border coordination is also particularly important for a country like Austria that is a cultural crossroads. Measures in these areas are therefore continuing. In addition, EU-funded measures – e.g. as part of programmes of innovatory measures such as those during the Structural Fund period 2000-2008 – could be appropriate for solving specific problems. For example, research could be carried out on particular issues relating to socio-economic differences and causative factors in relation to health status.
The specific impact of projects co-financed by the EU are not visible, above all because such projects take place in a national or regional legal and administrative context. Regional budgets are not substantially reduced by such measures, especially since Austria's regions pay a part of Austria's EU contribution.

What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
For other possible actions, see point 2. Actions at EU level should target factors that affect health in particular, in so far as those factors fall within the EU's remit.
Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?
Cross-border cooperation can help to reduce inequalities in public health, but such problems cannot be completely solved through cross-border cooperation. See answers to the first set of questions under point 3.

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
One example of best practice is the increased take-up of preventive screening in Austria achieved by the Confederation of Austrian Social Security Institutions and the *Länder* inviting certain risk groups to check-ups. Examples of projects in Vorarlberg are the "Spass mit Mass" (All Things in Moderation) alcohol and narcotics prevention project (a broad-based, setting-oriented health promotion programme which was developed and implemented in collaboration with relevant stakeholders such as trade and industry, the hotel and restaurant sector, youth organisations and community organisations) and the "Sichere Gemeinde" (Safe Community) project, a region-wide accident prevention programme based on collaboration between the *Land* of Vorarlberg, social security bodies and the "Sicher leben" (Live Safely) institute, which aims to reduce the number of accidents occurring in the home, and during leisure and sports activities. The first *Land*-wide breast cancer prevention programme has been established in Tyrol. Under the Tyrol mammography screening project, all women living in Tyrol between the

ages of 40 and 69 with health insurance are invited to have a free mammogram. Unlike other screening programmes, the project in Tyrol uses existing structures and is notable for its wide involvement of doctors with their own practice. The project was launched in April 2007 in the districts of Innsbruck and Innsbruck-Land, and was extended to all nine districts after a 12-month pilot phase. This is a reference project of the Federal Health Commission.

Specific examples of best practice in the context of the focus on reducing health inequalities are the activities of the Women's Health Programme (WPFG) and Health Promotion in Vienna (WiG). Particular attention is paid to socially disadvantaged groups and migrants: examples include the "Ich schau auf mich" (I take care of myself) mammography screening projects; "Ich bleib gesund – Sagliki kalacagim" (I stay healthy), a Turkish-language service which is part of the preventive screening programme; "Nach Herzenslust" (To your heart's content) – The women of Favoriten live healthily; health information sessions for migrants; health promotion for female cleaning staff in the Vienna Associated Hospitals – "Health at work without borders"; health promotion for long-term unemployed women, "(f)itworks"; health promotion for homeless women; "Stark und fit" (Strong and fit) – heart health for socially disadvantaged men, focusing on migration; "Geh!sund" - a low-threshold mobility programme.

The women's health centre F.E.M. Süd and the men's health centre M.E.N. at the Kaiser Franz Josef Hospital provide multilingual information, advice and various health courses, and these health centres are therefore important contact points for migrants and socially disadvantaged people.

Two of the health centres run by municipality of Vienna, District 15, run a weekly clinic solely for migrants, mainly Turkish-speaking people, at which an interpreter is present.

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Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play

Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.

Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?

In a health analysis we must consider several types of inequalities, such as the distribution of resources, equal oportunities for population to acess the system, the population satisfaction for marginal needs and equal results per population by region. We must also takie under account an analysis regarding inequalities in the social, economic and living conditions.
In the Azores islands, there is a tendency to equality in the health resources acessibility,

which means that all population have equal acess to the azorean health system. When we compare european indicators with azorean indicators we verify that they reflect a similar reality. Nevertheless, the regional inequalities are resultant from the people's perception of the health system and related to the number of general practioneers, per capita. General practioneers, per law, can not have more then 1.500 people in their lists, which means that some population aren't included in a general practioneers list, so therefore there is inequality regarding the acessibility to the health system, reflected by the lack of medical doctors in the region. The lack of GP makes the system depend on Emergency Rooms (ER), where GP work 24 hours per day to prevent health diseases and the fact that people don't have acess to a consultancy, because they don't have a GP to assist them.
Another cause of health's inequalitites is related to the acknowledgment people make of their health situations. This situation is depending on the socio-economic status, level of education and place of residence, which make the acessibility to the health system differ from one another. These situations doesn't represent a problem because there have been several projects concerning theses factors to diminish it's inequalities.

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

The first of all is the lack of general practioneers or the concentration of general prationeers in urban regions, which provoque lack of practioneers in some areas of the Azores islands.

This fact reflects the acessibility health inequality by the population, in some islands as the major regional difficulty, because doctors are needed in islands where the accessibility is restricted.

A GP as to be available 24 hours per day in all islands, specially small islands, with one health centre, where the geographic restrictions are larger then in islands where we have several health centres and hospitals.

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

The indicators at our disposable are life expectancy at birth, healthy life years, rate of incidence of diseases and rate of mortality. These indicatores allows us to effectivelly compare the health situation with other regions. But other indicators would be an asset, for example the acessibility per age, acessibility per economic conditions and acessibility per level of education. The regional azorean health system is proceeding to the implementation of a regional network system which allows to work in simultaneaous with all hospitals and

health centers and therefor all information regarding the population will be available for all health professionals and therefore improve a better and more efective servive to the population.

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?

The current economic and financial crisis will have impact on employment, diminishing it's level, which will lead to deterioration of the population's living conditions. This deterioration of living conditions will lead to hte incremetnation of consultants from general practioneers, related to stress, cardio-vascular problems and others. Therefore, we can conclude that the waiting lists, by general practionners, will increase.
On the other hand, the azorean government has a policy for free medical prescription to older people without resources, so with a economic crisis situation we believe that there will be an increase of governamental financement to purchase their medical prescription.

Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.

We have submitted a project to reestruturate all emergency rooms/departments in the health centers and regional hospitals to implement in each emergency room/department a cardio device to prevent heart failures. There was a need to prepare and implement such projects and there were several programmmes from european foundations to fund this project. Nevertheless there have been in some projects difficulties to acknowledge what projects can be developed or how is the structure of these projects, so it is needed a technical assitance to prepare and implement such projects. First of all the european projects have to be more clear about what projects can be considered elegible for funding and how can we implemet projects with other countries.
There is also a project which is being developed and financed by European funding, which is a regional network informational system that combines all health institutions in one general mainframe, with the objective of transforming all organizational culture equal in terms of medical, professionals' procedures. More than establishing a software, it's purpose is to sustain an equal health procedures, in different regional institutions, so that information can be easily compared, studied, worked upon and restrain it's inequalities if existing.

2. Scope and level of Community action / Subsidiarity
Addressing health inequalities requires action of a transversal and cross discipline nature,

which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).
Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.
Action at community level would allow countries and regions to have more resources to reduce health inequalities. Community action would lead people in local regions to exchange information regarding there health status and make the health system nearer the populations needs. This would ensure that all who strive for improvement and equity in global health have the information and resources they need to succeed, because information is more disconcentrated by the population. It would be essential that the member states offer more information regarding methods to reduce inequalities or more financial funding to implement health programmes.
If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?
EU should give information regarding health plans and their sucessfulled implementation, increase financial funds for project implementation, techical assistance in project implementation, increase of general practioneers in locals where they are needed, increase investment in promoting better ways of life with schools interventions, diminish social inequalities, improve mechanisms to monitor inequalities in health across EU members by imposing data collection via systematic and comparable information, best practice exchange information regarding inequlities.
Is Community action within the ambit of health policy alone capable of addressing health inequalities? In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?
Community action is helpfull in several areas, namelly education, environment and social policy. In education it is important to implement information regarding early prevention health issues in schools, so children much learn about health issues and preventing situations with their life conditions or ways of life to combate some diseases and less fortunate aspects of their lives. Education represents the tool people have to acess their health situation because in most cases it is delegated to a general practioneer, which means that people have to transfer information regarding their lives and then become a result of others actions. Education becomes a powerfull tool for health because population becomes more aware of their conducts and therefores more responsbile for their own helath status. In terms of social policy it is important that community action participate in forums, debates,

policy legislation, impact of policy in the population, develop personal skills in terms of social welfare, create supportive environments wich allows people to be closer and safe.

In environment policy areas, it should be able to resduce exposures to toxic pollutants through collaborative action at the local level, help communities to understand all potential sources of exposure to toxic pollutants , work with communities to set priorities for risk-reduction activities , ceate self-sustaining, community-based partnerships that will continue to improve the local environment.

Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?

The reduction of health inequalities should take under mind the regional aspects and singularities of each island. Inequalities exist in several regions, but to compare them it will be needed several aspects of the region. We need to have in mind that regions have their singularities, so it is not possible to implement projects or programs which lead to equal results. Nevertheless, there should be a common commitment by member states to reduce health inequalities, with different targets, by regions.

What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?

Legal certainty by binding legal instrument, internet exchange knowledge (benchmarking) at a specific link created to exchange information, european or international guidelines regarding inequalities indicators and best practice to reduce them, local groups discussing health issues in forums with repercussion in european forums.

3. Possible Actions

The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities

Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory?

What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.

In the Azores islands there are several programmmes to be implemented in the next 4 years, all of them to benefit people so therefore we can say that they intend to reduce the inequalities of the health system, which are: Regional Programme of Fight Against the Pain,

Regional Programme of Prevention and Diabetes Control and Fight against Obesity, Regional Programme of Promotion of the Oral Health, Regional Programme for the Health of the Elderly People and People in Situation of Dependence, Cares Continued and Palliative, Regional Programme of Prevention and Control of the Cardiovascular Illnesses, Regional Programme of Prevention and Control of the Onchology Illnes, Regional Programme of Respiratory Prevention, Regional Programme of Control of Infection Associated to the Cares of Health, Regional Programme of School Health, Regional Programme of the Medical Prescription, Regional Programme of Mental Health, Regional Programme of Public Health, Regional Programme of Prevention of the Bad Use and Abuse of Substances and Drugs, Regional Programme of Maternal-Childlike Health and Family Planning, Regional Programme of Emergency and Medicine of Catastrophe, Regional Programme of HIV-AIDS.

In the implementation of the above programmes, we need to realise that their sucess depend on resources available. Issues related to funding new equipment and formation for human resources of new procedures related to health issues have a lower budget for health issues and are very limited so it is essential to have further funding. If funding is not possible, then it should be supported by community help, so it should be implemented by community programmes/projects.

When considering a new regulatory intervention is justified, or an existing regulatory intervention has been effective, two critical issues must be taken into account. Firstly, the overall capacity of governments to regulate markets is necessarily limited. Thus, regulatory action should only be undertaken and continued where the harms being addressed are substantial and cannot be ameliorated efficiently and effectively in other ways and secondly, substantial unanticipated costs may arise due to regulatory impacts that were not foreseen. In particular, regulation may impose constraints and rigidities on markets, potentially limiting or distorting innovation and growth.

In terms of economic nature, such funding would increase economic activities in other sectors and would increase their sales and therefore increase regional and national GBP, because of the inter-sectorial activities developed within the economy. In terms of social impact, such funding would apply the alliance and forces within other organisations or with voluntary structures to help the evaluation and development of habits and ways of life, patterns of educational attainment and performance (schooling); health status (life expectancy, mortality rates, disease prevalence); population growth, density and age structure; personal and government savings (investment rates); physical capital stock; trade policy; quality of public institutions.

In terms of social nature, we believe in a positive impact of nutrition, primary care interventions, prevention services, health promotion, etc, on childhood growth and development and/or subsequent physical performance and work productivity.

In terms of budgetary nature, the impact of decentralization of health systems upon health outcome (defined as the transfer of functions, resources and authority to local levels of government), will improve skills and ways of know how between institutions, which will increase their productivity and knowledge, because information leads to savings in budgets and therefore we must realise that decentralization represents the conditions for effectiveness.

What actions within the framework of other policy areas could be undertaken to address health inequalities?

What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.

In the social affairs policies it should be understood that the family structure, income and education are fundamental for achieving results in self-promotion health standards. Families with lower income normally have tendency to overload the health system and to repeat consultants.

In the education policies it should be taken under account that education is a fundamental tool to some ages with no acess to the healt system, therefore we must transfer the health professionals to the schools and implement information to the students. When we verify the accessibility of people to the health system we verify that the ages between 12 and 18 are non-existing, so their should be a educational programme where people become more aware of their health situation.

In terms of social and living conditions, like number of people having the minimun wage or social reinsertion remuneration their should continue to have programmes where people can have financial resources to be reinserted in the society. It is necessary to act in the ways of live and living conditions, not only with financial help, but too with educational programmes towards these specific families.

Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?

There are several projects, such as INTERREG III B, which allows cross-border cooperation schemes and allowed regions to evaluate and implement projects. The programs/projects implemented in the azorean islands had it’s funding in this specific programme.

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
In the Azores islands, the government had had several inictiatives to reduce health inequalities, such as: ✓ Politics of free medical prescription, to older people and other needed population; ✓ Maintainance of free acessibility to the system, for all population; ✓ Implementation of the figure of nurse family nurse, which will have a nearer to social, individual and familiar problems; ✓ Equal funding to health centers, regarding their needs; ✓ Implementation, to families with no income, the remuneration of social insertion, which allows all families to have the minimum economic conditions; ✓ Social distribution of homes to people with lower income; ✓ Regulatory obligations in labour markets to ensure hygiene and security.

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Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

Network Partner:	Association of Finnish Local and Regional Authorities
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1. Health Inequalities - context and state of play *Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.*
Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?
In Finland, socioeconomic health inequalities persist despite the efforts undertaken through health and social policy. Narrowing health gaps has been the objective of Finnish health policy since the 1980s. This objective has not been achieved and the inequalities have largely remained unchanged or partly even grown. We have social inequalities in work ability and

functional capacity, self-rated health, morbidity and mortality. Narrowing of the inequalities will have a positive effect on public health and help to secure the services as the population ages, raise the employment rate and restrain the costs.

The life expectancy has increased in Finland what indicates that health status has improved also.

The regional and local dimension of health policy plays a key role due to the closeness to citizens. In Finland, the municipalities are responsible for the health care of the citizens, so they have to follow-up the health situation of the citizens (health profiles of the municipalities).

Finland has a national action plan to reduce health inequalities 2008-2011, lead by the Ministry of Social Affairs and Health.

Different regional councils have also made strategic plans how to reduce health inequalities (f.g. North Karelia, Kainuu, North Ostrobothnia, Central Finland, under planning in Lapland and South Ostrobothnia).

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

Causes creating health inequalities:
- unemployment, poverty
- poor education, drop-outs from school
- access to and use of health and social services

Influencing factors are:
life styles: risk use of alcohol, excessive drinking, smoking, unhealthy diet and lack of exercise

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

Indicators:
- rate of unemployment
- number of social beneficiaries
- access to and use of health and social services

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?
Yes, because the unemployment is growing. Unemployment is usually directed to those with less education and poorer jobs. If we cannot secure the basic services (social, health and education) accessible to all we will have difficulties with growing health inequalities.
Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.
East Finland: THE INNOVATIVE ACTIONS OF EASTERN FINLAND PROGRAMME (2006-2008) Welfare technology as an instrument of social innovations The programme's main objective is to create innovations, products and operation models, which are based on users' and customers' needs and promote welfare in Eastern Finland, and at the same time generate new business activities and strengthen the position of Eastern Finland as user of and pioneer in the welfare technology. The East Finland Region of Innovative Actions consists of four regions, South Savo, North Savo, North Karelia and Kainuu. The programme focuses clearly on three central priorities: I Achievement of user-based social innovations II Development of welfare related products for international markets III Development of business innovations in welfare technology http://www.innovatiivisettoimet.fi/en/isit/index.htm South Finland: SAFE HOME research and development project 2009-2011 (A30723) Laurea University of Applied Sciences (coordinator), Turku University of Applied Sciences The purpose of the project is to investigate, develop, produce and evaluate e-wellbeing services for promoting the health and wellbeing of various client groups. The aim is to broadcast interactive programme and chosen e-services via CaringTV and through other technological platforms. The research tasks are: • What kind of e-wellbeing service concept is? • What are the expectations and the needs of the clients and experts? • What are the methods of the produced services? • What are the costs of produced e-services? • What are the experiences of the clients and experts of the interactive programme broadcasting and e-services during the project? Safe Home –project is based on Action research. User driven methods are applied during the research process e.g. for the testing and evaluating peer support, consultation as the methods for supporting clients´ coping at home. One aim is to apply ProcessQuide Programme for process modelling in the field of health care and social welfare. The chosen client groups are: 1) elderly: people living at home or in service house environment, home care clients; 2) clients from social and family work: families of small children, young persons; 3) persons with mental health problems; 4) disabled person / persons with learning disabilities. Contact persons: Ms Johanna Leskelä, Project Manager / EHYENÄ subproject, johanna.leskela@laurea.fi and Ms Paula Lehto, Principal Lecturer, PhD, paula.lehto@laurea.fi

PARETO – Adapting Service Systems for an Ageing Society
PARETO 2008 – 2011 is a development project funded by European Regional Development Fund ERDF and the participating municipalities. The aim of the three-year project is to find and implement new and innovative solutions and working methods that would adapt the service systems to serve the needs of an ageing population.

The rising need of care, shortage of workforce and diminishing financial resources are the main drivers of the structural change in service systems. We can no longer afford current modes of operation – swift changes have to be made on the level of structure and organisation to guarantee care delivery in the immediate future. Old-fashioned premises present another major challenge as they are poorly suited to support a comprehensive reform.

The main pressure for change is on the heavily institutionalised Finnish elderly care system, but the change affects the service systems on all levels of care delivery: welfare services, housing services, primary care and special health care services. PARETO is comprised of five subprojects, the themes of which cover the entire scope of services and their development.

The partners of the project are the Institute of Healthcare Engineering, Management and Architecture HEMA at Helsinki University of Technology TKK, the City of Espoo, the City of Järvenpää, Kouvolan Yritysmagneetti Ltd and Kymenlaakso Hospital District.

The Espoo subproject Mobile Health Services aims at creating and implementing a new service model for home care based on mobile technologies.

The Järvenpää subproject aims at restructuring services through the planning of a Health Campus that would bring together primary care, elderly care, special housing and welfare services in the centre of the town.

Kouvolan Yritysmagneetti is a regional development company that supports the development of the former hospital area in Valkeala to become a centre for wellness and tourism businesses.

Kymenlaakso Hospital District seeks to modernise and reorganise the operations and premises of special care in Kymenlaakso region into two hospitals and to develop the Kotka Wellness Park in the area of the central hospital.

PARETO is co-ordinated by the Institute of Healthcare Engineering, Management and Architecture HEMA at Helsinki University of Technology TKK. The TKK subproject consists of work packages that support the development work of the four other subprojects.

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North Finland: will be delivered later on.

2. Scope and level of Community action / Subsidiarity

Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).

Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.

Social inclusion is important: combat poverty.
The responsibility for health care lies on Member States that's why EU level policies and legislation should not hinder Member States from organising and financing their health services. EU level legislative measures and rules for marketing could affect the determinants

and risk factors of health inequalities. At EU level the actors should ensure that health equity impacts of EU-level policies are assessed and acted upon so as to reduce health inequalities.
If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?
Exchange of best practices during conferences, network meetings, study trips, funding for projects. A stronger cooperation among regions and between regions and the European institutions is fundamental to foster a better and more equal health for all.
Is Community action within the ambit of health policy alone capable of addressing health inequalities? In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?
Health policy alone can not influence the reduction of health inequalities but it has an important role in health promotion and prevention. Health in All Policies approach is very important because health inequalities are affected by policies that are not in the scope of the health systems' activities. Very many policy areas influence the reduction of health inequalities: Environment – water, waste, air etc. Education – better educated know more and they have usually better paid jobs and then the possibility to make informed choices. Social policy Labour legislation e.g. working time, injury prevention, working conditions Food legislation – ban for food products which are unhealthy (dangerous for health) Alcohol limitations (taxation and pricing of alcohol and import limitations)
Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?
A common commitment like the reduction targets could be possible but one has to remember that the systems and circumstances are very different in different Member States. It is important to broaden the scope of public health research to give emphasis on the determinants of health. There is a need to develop the knowledge base on health inequalities. The research should cover policy measures to reduce health inequalities.

What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?
Reporting. A report of the European Commission on its actions to reduce health inequalities is welcome.
3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory? What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
Funding for projects like training and education of those with less education.
What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
Vulnerable target groups most in risk to suffer from health inequalities are the elderly, migrant communities, the poor and the unemployed. In all these policies the health aspect should be taken into consideration: - To ensure decent housing and living conditions. - To enable healthy nutrition. - To find working places for unemployed.
Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?
One possible topic in the existing cross-border cooperation schemes could be reduction of health inequalities. This could allow to bring EU next to the citizens and the citizens could find this topic very important for them.

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
The North Karelia Project began in 1972 as a project to prevent cardiovascular disease among residents of this province of Eastern Finland. The Finnish Heart Association coordinated the initial discussions, which included community representatives, national experts, and several representatives of the World Health Organization (WHO). Later, the program expanded to include other noncommunicable diseases. The project has shown that high rates of heart disease are not inevitable; community-based projects guided by experts can reduce rates dramatically. http://www.cvhpinstitute.org/links/northk.htm http://www.ktl.fi/attachments/english/organization/ppuska/northkareliaprojectarticle.pdf

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Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play

Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income, education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.

Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?

Yes, inequality in health is a major political concern from a health perspective. The overall

health in the population of Västra Götaland, as in Sweden, is good but the health divide between socioeconomic groups is surprisingly large. One example might be premature death, i.e. death before age 75 in this case. The regional overall trend is towards a reduced incidence. In 1996 the regional mean was about 400 deaths per 100000 males 1-74 years. In 2006 this figure was about 330 per 100000. However, in the most disadvantaged areas the trend is stable between 1996-2006 at about 850 premature deaths per 100000 males whereas in the most affluent areas there are steeper downward trends from about 300 deaths per 100000 males in 1996 to about 220 deaths per 100000 in 2006. So according to data on premature deaths there seems to be a *widening* gap between areas so that premature deaths risks are negatively correlated with affluence in the area.

As in most European regions, the health divide along socioeconomic conditions at the individual and contextual levels is found for many non-communicable diseases but also for self reported health.

The political objective in the Region Västra Götaland is to enhance a sustainable development. Health inequalities which are possible to tackle, are not compatible with such policy objectives.

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

This is a very difficult question due to the complexity of health inequalities. Many scholars have tried to explain this phenomenon. Some have listed numerous key factors, others "webs of causation", still others have pointed on the impossibility to identify certain *Causes* since societies are totally open systems with a huge degree of complexity.

The Swedish public health policy acknowledge the complexity and points to the importance of dealing with the social determinants for health. This way of thinking is influenced by the WHO approach to tackling inequalites in health (e.g. "leveling up"; "the causes of the causes").

Inspired by this reasoning, we consider it to be fruitful to identify efficient entry points for policy making and programmes and from that identify such mechanisms that are possible to influence. We therefore suggest to categorise important causes/factors/exposures/mechanisms involved in inequalities in health.

I. The individual social position is a starting point. Stratification processes (e.g. residential segregation, discrimination at working places and in schools) are drivers behind which social position a certain individual will occupy, together with living conditions and circumstances along the life course. One important policy entry point is to neutralize the effects from negative social stratification. Health investments in childhood would be especially important from a strategic point of view.

II. The social position is associated with which factors/risks the individual will be exposed to. Another policy entry point will be to neutralize mechanisms that exert health threats or to promote "healthy" mechanisms, especially among those at lower social positions. One example could be working environment legislation.

III. A third strand relates to the possible differential vulnerability for exposures/factors influencing health. A universal exposure might have different effects in different groups in the population. This might be due to the tendency of risk factor clustering among disadvantaged groups so that the total burden of different exposures will have more severe consquences among groups with lower social position. One example might be alcohol consumption which in Sweden is relatively even between social classes but the health consequences of consumption are more detrimental among lower social classes.
IV. Deteriorated health has consequences for the individuals living conditions, affecting capabilities and functionings. The social position will influence the consequences of deteriorated health, to what degree the economy, the ability to work and participate in social life will be hampered.
V. Certain socioeconomic consequences are crucial for the success of rehabilitation. Exclusion from working life might be devastating for a person with a psychiatric diagnosis without work as compared with the situation where the same person is employed.

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

It is well known that Swedish health statistics are of good quality. We are able to map geographical differences in health, even at a small geaographical level. However, it is less suited to describe socioeconomic inequalities in health since health statistics rarely contain routine socioeconomic information. The main socioeconomic categories used in routine administrative registers are gender and age. Thus, in spite of a strong politically committed ambtion to reduce inequalities in health, we do not have access to appropriate data in order to monitor inequalities at a regular, routine, basis. We are reduced to do ecological inferences, with well known risks for erroneous conclusions.

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?

Such an assumption seems reasonable from a theoretical perspective. However, if the hypothesis that health is partly dependent on available (economic and cultural) resources, be it individual or collective, is valid, the degree to which health inequalities will grow, will be dependent on how succesful “collective” actors (e.g. state, region and municipalities) will be to compensate for loss of resources as a result from the crisis. The experiences from the Swedish economic crisis during the 1990-ies exhibit some support for this way of thinking (documented e.g. in an extensive official governmental report SOU2001:79).

Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.
No and Yes; No, if projects that *explicitly* aim at reducing inequalities in health are requested; Yes, if a wider scope is considered. And if so, there are quite a few good candidates. Some of them aiming at improve health care system capability to tackle health problems of patients from disadvantaged social groups more efficiently (e.g. "Widening horizons"), which would relate to category IV and V in my answer for question 1 above; other projects aim at increase opportunities for people with physical or mental dysfunctionings to enter labour market (e.g. "To work for the Good Life"), which would go directly under cat. V. There are also a number of projects relalting to the Cohesion Policy, which aim at a sustainable regional development. These projects will probably reduce the effects of segregation and discrimination, and, thus, would influence category I from above. However, to my knowledge, none of these projects have hitherto not been evaluated with respect to their capacity to reduce inequalities in health.

2. Scope and level of Community action / Subsidiarity *Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).*
Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.
Yes. The obvious reason is that policy decisions at Community level will have impact on actors way of thinking – such decisions are at least to some degree normative and thus, important. The perhaps less obvious reason is that since reducing inequalities in health is a highly complex issue, it involves several policy areas, actors and different kinds of approaches, there is a need for collaboration. Collaboration at the regional level is appropriate, since many of the regions have public health and health care as responsibilities, enough power to perform skilled mapping and interventions and at the same time are "close to the people". Knowledge and awareness of peoples living conditions and other important contexts is better than at the national level. The Community, in my opinion, should therefore address health inequalities at the policy level but also support and facilitate regional collaboration aiming at reducing inequalities in health.

If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?

1. at the policy level, to identify and address health ineq:s as a major and crucial obstacle to a sustainable Community development, potentially threatening the Cohesion Policy in the long run.
2. take initiatives for mapping health determinants relevant for inequalities in health, with adequate variables at the regional level which makes comparisons and benchmarking possible
3. take initiatives for regional collaboration for interventions and programmes aiming at reducing inequalities in health
4. take initiatives for and support interregional collaborative evaluations of interventions and programmes aiming at reducing health ineq:s
5. support multi-center research to better understand mechanisms behind the production and reproduction of health inequalities

Is Community action within the ambit of health policy alone capable of addressing health inequalities?

In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?

No. It should be obvious from recent and extensive evaluations on social determinants of health inequalities (e.g.the WHO Commission on the subject 2008, the Swedish NEWS report 2008 and Whitehead & Dahlgren WHO-reports on tackle inequalities in health 2006-07), that health care in itself is certainly an important but still just one part of an efficient approach to tackle inequalities in health.
Succesful strategies must comprise more or less most policy areas, whereof which the above mentioned are crucial but others, such as labour market, financial, health care, housing, could well be added.

Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?

That would probably be helpful but the difficulties with setting meaningful reduction targets and milestones should be acknowledged. Perhaps the most important achievement with an effort to arrive at a consensus among Member States would be just to put health inequalities on the political agenda?

What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?
Interregional collaboration on measurement, implementation and evaluation would indeed be valuable but also benchmarking, reporting and coordination issues.

3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory? What would be the foreseeable impacts of such funding? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
The important issues might be categorised along items I-V above (question 1). 1. issues aiming to reduce negative health impact from social position, e.g. health threatening residential segregation, discrimination in schools and workplaces 2. issues aiming to reduce harmful exposures related to social position, e.g. “underinvestment” in welfare insitutions in disadvantaged residential areas 3. issues aiming at reducing “vulnerability” associated with social position, e.g. regulations/legislation to affect availability to tobacco/alcohol/drugs, initiatives to increase availability to healthy food 4. initiatives to reduce negative consequences of ill health, e.g. organise health care so that patients in disadvantaged social postions will be adequately examined, treated and rehbilitated in spite of possible shortage of economic/cultural resources, organise social welfare insitutions so that patients living conditions will not deteriorate due to disease Even if many of these initiatives are falling outside the responsibility of the Community, a common funding will be important to enable regional collaboration on R&D within this area.
What actions within the framework of other policy areas could be undertaken to address health inequalities? What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
See paragraph above.

Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?
Yes. A crucial question within the cross-border framework is to what extent such cooperation schemes actually contribute to widening health inequalities. For example, if affluent patient groups use the opportunities to access health care across borders more than do disadvantaged groups, the schemes will actually widen health gaps, given that the schemes are efficient.

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
I would suggest the strong political committment to the overarching objective in the Swedish Health Policy, ‘‘to create the social conditions to ensure good health on equal terms for the entire population’’. In my opinion, this gives Public Health a strong legitimacy to develop theory and methodology to tackle inequalities in health. This is stressed in the recently committed Regional Public Health Policy where strategies are outlined in six “challenges” towards reduced health inequalities. Due to a thorough participatory process when developing the policy, many, perhaps most, of possible regional actors and stakeholders has been involved and feel committed to the content. The committed participation will be incredibly valuable in the future work.

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Questionnaire on the Assessment of Territorial Impacts
Submitted for consultation of the Subsidiarity Monitoring Network

en

Please complete and submit by email to subsidiarity@cor.europa.eu by **Friday 3 April 2009**

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1. Health Inequalities - context and state of play

Significant differences in health can be observed between EU countries and regions and within any country and region. Most of these differences are not distributed randomly but show consistent patterns. Inequalities in health concern systematic differences in health status related to socioeconomic differences as captured for instance in occupation, income,

education, age, gender, ethnicity, sexual orientation, place of residence or geography related criteria.

Are inequalities in the level of the health situation of the population in your territory a problem you are confronted with? Could you give a short description?

The causes are:

- socio-economic
- geographical

What are the causes creating the aforementioned health inequalities in your territory or the factors influencing their manifestation?

The causes are:

- socio-economic
- geographical

Which indicators do you have at your disposal that enable you to effectively map out health inequalities at the local or regional level?

Do these indicators allow you to effectively compare the health situation in your territory with other regions?

INDICATORS:

- **SOCIAL:**
  - The occupational integration minimum income (R.M.I.) granted by the General Council sources: DRASS – CAF – MSA.
- Specific solidarity allowance (ASS) source: UNEDIC
- Single-parent allowance (API) source: CNAF – MSA
- Allowance for disabled adults (AAH) source: CNAF – MSA – INSEE- CG.
- Additional minimum old age allowance (ASV) 13 indicators
- Basic universal illness coverage (CMU) source: CNAMTS MSA RSS
- Additional universal illness coverage (CMUC)
- Allowance for loss of spouse (SNAV MSA estimation DREES
- Additional disability allowance source: CNAMTS CDC estimation DREES
- Housing for people in unstable situations: number of places in CHRS (centre d'hébergement insertion sociale - social insertion housing centre) source:

DRASS FINES RED CROSS FRATELLANZA

- Units for access to healthcare (Permanences d'accès aux soins de santé - PASS)
- Statistics and indicators on health and social issues (STATISS)
- Eviction (Prefecture of Corsica)
- Rented social housing (INSEE)
- Excessive debt (source: Banque de France)
- Estimation of population (source: INSEE 1999 – 2007) estimation 2015 (DSS)
- Trends in over 75s from 1999 to 2007

- **MORTALITY - MORBIDITY:**

Premature mortality rate, comparing men and women

- **EQUIPMENT:**
  - Doctors
  - Nurses
  - Pharmacists

The summer influx of people and the fact that many patients are taken to the mainland make it difficult to correlate data regarding some illnesses (15% of hospitalisations on the mainland).

-

Do you appreciate that the current economic and financial crisis will have impacts in terms of creating or aggravating health inequalities in your territory?
YES impact cannot be assessed at the current time
Have you submitted any project related to health (infrastructure or other nature) for financing within the Structural Funds under your region's Operational Programme under the current (2007-2013) or previous (2000 – 2006) programming period? Please give a short description and please mention whether you needed any form of technical assistance to prepare and implement such projects.
NO

2. Scope and level of Community action / Subsidiarity

Addressing health inequalities requires action of a transversal and cross discipline nature, which would lie within the sphere of competences shared by the Community and the Member States (either at national or sub-national level).

Do you think action at Community level would make a difference (added value) in addressing health inequalities as compared to the present situation? Please explain the reasons for your answer.

There are three separate aspects:

- **TRAINING**

For health and social sector professionals (training activities)

- **OBSERVATION**

Pooling of social databases (Morbidity), of interest as regards movement of people between SARDINIA and CORSICA

- **ACCESSIBILITY**

Access to technical platforms.
Pooling information.
Implant in CORSICA diagnostic x-ray equipment for CORSICA SARDINIA ITALY SPAIN

If you think that the EU should act, which kind of action at EU level could better help local and regional authorities in tackling health inequalities in a more efficient way?

LOGIC FOR REGIONAL PLANNING:

- Road infrastructure
- New communication techniques (cable, TV transmission)

Example: the school health system is not computerised, the equipment would cost EUR 20 000, the French State does not have it.

Cost of training:

Financial assistance for ongoing training: promote initial training.
Health inequalities in the Mediterranean call for an institution in France, Spain or Italy.

Is Community action within the ambit of health policy alone capable of addressing health inequalities? In what other policy areas (e.g. social policy, environment, education etc) can Community action help to significantly reduce health inequalities?
Action needs to be multi-targeted: -take into account the environmental and educational aspect -the fight against carriers
Should there be a common commitment by Member States at EU level to reduce health inequalities (e.g. commitment to common milestones and reduction targets)?
YES A joint commitment on the guarantee of physical access and the **RIGHT** to healthcare. - Coverage of emergency health and social care - Prevention = Education and Action regarding the environment - Educational programmes: health education for mutual assessment of prevention measures (young children) - Reduction of environmental risks (unhealthy living conditions, pollution-free, balanced diet (pesticides))
What would be the right tools to ensure that common goals are achieved on national and EU level (benchmarking, reporting, open method of coordination)?
• Coordination with centralised guidance • Scoreboard of objectives • Yearly monitoring

3. Possible Actions *The expectations local and regional stakeholders have regarding proposals for future Community policy actions to reduce health inequalities*
Which issues should be addressed by future investments supported by Community funding (e.g. within the framework of the structural funds or financed through the European Investment Bank or other sources) for an effective reduction in health inequalities in your territory? What would be the foreseeable impacts of such funding? If possible, refer to impacts of a

regulatory, administrative, economic, social, environmental or budgetary nature.

- **On living conditions:**

- On unhealthy living conditions (RADON, ASBESTOS) policy with the Provence-Alpes-Cote-d'Azur region.
- On lung cancer: smoking encouraged by preferential rates in CORSICA.
- Linking Radon with tobacco multiplies the risk of lung cancer by 17.
- SOUTH CORSICA is at greater risk than UPPER CORSICA: high level of natural radio-activity.

- **On water:**

¼ of the population is supplied with water of low bacteriological quality.

- **On the air:**

- electricity testing
- road traffic
- forest fires
- natural discharge: unsorted household waste

- **Food safety:**

- virulent epidemic of blue tongue disease
- Slaughtering standards

- **Cardiovascular factors:**

- 1% of the population hospitalised each year.

- **Development of research into the FREE PRACTICE OF MEDICINE**

- **Analysis of obesity:**

- calculation of BMI (body mass index) by age bracket and gender

- **Premature mortality:**

544 premature deaths: men more affected than women (71%).
54 % of these premature deaths are considered to be **AVOIDABLE.**
Causes are: tumours, lung cancer, traffic accidents.
High rate of suicide

What actions within the framework of other policy areas could be undertaken to address health inequalities?

What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.

- **Spatial Planning**

Better mobility of populations and offer
Accessibility to speedy real-time responses and reduction of need for professionals to travel

What actions within the framework of other policy areas could be undertaken to address health inequalities?
Nutrition Planning Fighting causes of tobacco addiction Fighting artificial and natural drugs

What would be the foreseeable impacts of such action(s)? If possible, refer to impacts of a regulatory, administrative, economic, social, environmental or budgetary nature.
See above

Do you think it is possible to address issues of health inequalities within the framework of existing cross-border cooperation schemes (e.g. cooperation between regions around the Baltic Sea, the North Sea, the Alpine area, South-East Europe)?
YES

4. Best practices
What are examples of successful policies in your region that could be used as best practice reference for initiatives to reduce health inequalities (kind of action, financial or administrative implications, etc)?
Regional public health plan (PRSP) Regional plan for environmental health (PRSE)

Glossary of acronyms:

C.A.F.: CAISSE D'ALLOCATIONS FAMILIALES (Family Allowances Fund)

C.AV.I.M.A.C : CAISSE ASSURANCE VIEILLESSE INVALIDITE ET MALADIE DES CULTES (Old age, disability and illness insurance fund for congregations)

C.D.C : CAISSE DES DEPOTS ET CONSIGNATION (Deposit and consignment office)

C.H.R.S : CENTRE HERBERGEMENT INSERTION SOCIALE (social housing association)

C.N.A.V : CAISSE NATIONALE D'ASSURANCE VIEILLESSE (National Old Age Insurance Fund)

C.N.A.M.T.S : CAISSE NATIONALE ASSURANCE MALADIE TOUS REGIMES (National health insurance fund)

C.M.U : COUVERTURE UNIVERSELLE MEDICALE (Universal medical coverage)

C.M.U.V : COUVERTURE UNIVERSELLE MEDICALE COMPLEMENTAIRE (Additional universal medical coverage)

D.R.E.E.S : DIRECTION DE LA RECHERCHE DES ETUDES ET EVALUATION DES STATISTIQUES (Directorate for research and statistical evaluation)

D.R.A.S.S : DIRECTION REGIONALE DES AFFAIRES SANITAIRES ET SOCIALES (Regional directorate for health and social matters)

D.S.S : DIRECTION SOLIDARITE SANTE (Health directorate)

E.N.I.M : ETABLISSEMENT NATIONAL DES INVALIDES DE LA MARINE (National Institution for Disabled Mariners)

F.I.N.E.S.S : FICHIER NATIONAL DES ETABLISSEMENTS SANITAIRES ET SOCIAUX (National database of health and social institutions)

F.N.S : FONDS NATIONAL DE SOLIDARITE (National solidarity fund)

FRATELLANZA : ASSOCIATION CORSE DE SOLIDARITE (Corsican solidarity association)

F.S.V : FONDS SOLIDARITE VIEILLESSE (Old age solidarity fund)

I.N.S.E.E : INSTITUT NATIONAL DES STATISTIQUES ET D'ETUDES ECONOMIQUES (national institute of statistics and economic studies)

M S.A : MUTUALITE SOCIALE AGRICOLE (Agricultural scheme)

P.A.S.S : PERMANENCE D'ACCES AUX SOINS DE SANTE (Units for access to healthcare)

R.S.I : REGIME SOCIAL DES INDEPENDANTS (PROTECTION SOCIALE) (Social scheme for self-employed people – social protection)

S.T.A.T.I.S.S : STATISTIQUES ET INDICATEURS DE LA SANTE ET DU SOCIAL (Statistics and indicators on health and social issues)

U.N.E..D.I.C : UNION NATIONALE INTER-PROFESSIONNELLE POUR L'EMPLOI (National inter-professional union for employment)