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POLICY FRAMEWORK FOR ACTION:

Monitoring Health Inequalities

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Abbreviations

CA	Country assessment
HI	Health inequalities
HIMS	Health inequality monitoring system
HMS	Health monitoring systems
PFA	Policy framework for action

Introduction

The JAHEE project is a Joint Action financed by the Third Health Programme 2014-2020 of the European Union. It represents an important opportunity for countries to work jointly to address health inequalities (HI) and achieve greater equity in health outcomes across all groups in society in all participating countries and in Europe at large. The specific objectives of work package 5 (WP5) are to attract attention to and improve countries' capacity to monitor health disparities.

Much of the focus on such monitoring is based on aggregate descriptions at national levels where averages or proportions are compared between geographical entities. However, inequalities between nations evolve from systematic differences in living conditions, circumstances, and opportunities between population groups within geographical entities. To be able to follow such trends in health, to detect less favourable trends at an early stage, and to reveal the determinants of trends in the population and in subgroups of the population, it is essential to have a national monitoring system in place. In addition, a strong national health inequalities monitoring system (HIMS) is fundamental for countries to assure that no one, in line with the aspirations of The United Nations 2030 Agenda, is left behind. Ultimately, the ambition of WP5 is to in a “do something, do more, do better manner” contribute to the development of participating countries' HIMS.

The work process of WP5

In short, the work process in WP5 on monitoring health inequalities comprises three phases. The first is the assessment phase where participating countries assess their own HIMS against an “ideal” (state-of-the-art) HIMS in order to identify possible areas/actions for improvements. Depending on the current structure of the national health monitoring system (HMS) and the availability of data, these actions will differ. In some cases, the appropriate objective for a specific country might be to do something – e.g. to identify a couple of relevant indicators for monitoring health inequalities (HI). In other cases, the appropriate objective might be to do more – e.g. to extend the existing HMS to include data disaggregated to socioeconomic groups – and in still other cases an appropriate objective might be to do better – e.g. to add indicators based on measures that are more sophisticated. During the second phase, the countries develop and implement at least one of the actions identified during the first phase. The third phase concludes the project by gathering reports on experiences and conclusions from the second phase in order to elaborate final recommendations for progress in HI monitoring in each country at the end of the JAHEE.

Aim of the document

In this Policy Framework for Action, an outline of the core components in an “ideal” HIMS is presented and actions to build such a system are suggested. The framework is based on current empirical knowledge and theories on HI and the mechanisms behind such inequalities. The framework will serve as a “golden standard” to which each country can compare its existing HIMS. The underlying idea is that such a comparison could guide and facilitate an understanding of each country’s development potential.

Structure of the document

This document is divided into three sections. The first is a theoretical section that aims to provide a common understanding of what HI are and how these evolve. To have a common understanding of the concept is necessary not only to develop adequate measures, but also to shape actions and select appropriate interventions.

In the second section, drawing on the structure of the theoretical model and a review of earlier work on HI monitoring, is a suggestion of components that should be included in an ideal HIMS. The peer-reviewed papers and reports are briefly accounted for in appendix 1.

In the third section, a model for choosing actions for implementation and for assessing the current state of participating countries national HIMS is described.

Intended users

This guide is mainly intended for the members of WP5 in the JAHEE project.

Theoretical framework

The socioeconomic circumstances in which people live their lives are closely related to their health. Typically, the lower one's position in the social hierarchy the worse one's health. This association has been found in relation to most major causes of ill health and irrespective of which measure of social position is used. A commonly used definition of HI¹ is that these are the

... systematic, unfair and avoidable differences in health status or in the distribution of health determinants between social groups depending from the unequal distribution of power, money and resources that give rise to inequalities in the conditions in which people are born, grow, live, work and age.

A couple of things are important to highlight. First, we are talking about differences between social groups rather than between individuals. This has theoretical as well as measurement implications. When analysing HI between social groups, the uneven distributions of resources, opportunities, and scope for action that are coupled with position in the social structure are stressed, not variation between individuals. Second, the pathways at work are many and complex. The unequal distributions of resources, opportunities, and scopes for action coupled with positions in the social hierarchy operate in different areas of life, across the life course, and on different aggregate levels along causal chains of mediating factors that tend to cluster. A monitoring system on HI should relate to this inherent complexity by not only reflecting inequalities in health outcomes, but also the processes that give rise to them across the life course and at different levels of aggregation.

The model of Diderichsen, Evans, Whitehead, et al.² is often used to illustrate the complex processes by which social conditions are linked to HI (Figure 1). In brief, the model illustrates how HI are created through effects of social stratification. The sorting of individuals into groups with different relative social positions is based on characteristics such as education, income, labour market position, ethnicity/immigration, or gender. The uneven distributions of resources, opportunities, and scope for action associated with these social positions are in turn associated with systematic differences in living conditions (specific exposures) and to differential vulnerability to such conditions. In addition, the effect of such exposures might be stronger (differential vulnerability) among people in lower social positions because they have fewer resources in terms of knowledge, networks, time, and/or money to counteract the exposures. People in lower social positions also tend to be exposed simultaneously to many risk factors more often than people in more advantaged social positions. In other words, the specific exposures tend to cluster and interact, and the strength

of the effect is dependent on the co-existence of other risk factors. In addition, it is not only the strength of this effect on health that is dependent on the social position, but also the social and economic consequences of ill health. The impact of ill health on people’s lives and socioeconomic circumstances is likely to be more severe among more disadvantaged social groups and thus to further contribute to processes of social stratification.

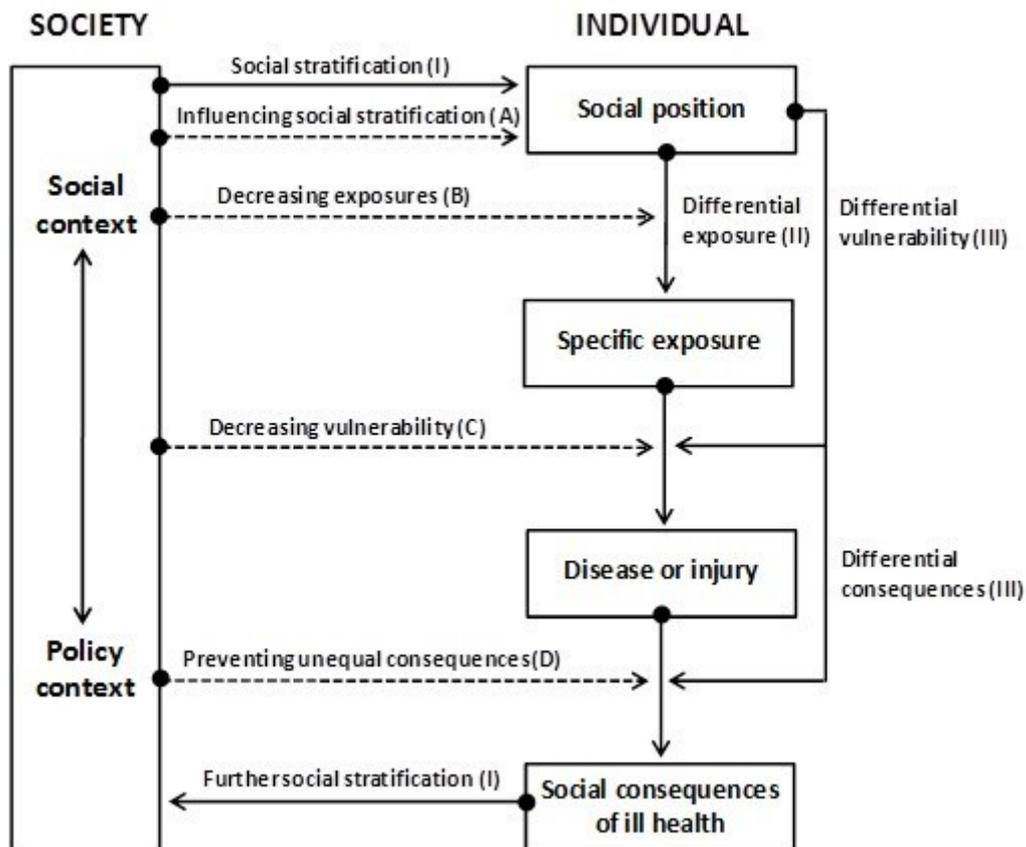


Figure 1. Diderichsen et al. model² illustrating the pathways from social context to health outcomes. A-D illustrating entry points for action. I-III illustrating active mechanisms.

Following from the model, a HIMS with the ambition to reflect the processes linking social circumstances to social inequalities in health requires information on a) social positions and their distribution, b) specific exposures (living conditions and health behaviours) and their social distributions, and c) health outcomes and their social distributions.

Health inequality monitoring: the ideal system

In this section, an outline of the core components of an “ideal” HIMS is suggested drawing on the structure of the Diderichsen et al. model² and earlier attempts in the literature to develop monitoring frameworks for HI. The reviewed literature is briefly accounted for in Appendix 1.

Health inequality monitoring

HI monitoring identifies where inequalities exist and where subgroups of the population stand in terms of health. When health inequalities are determined to be unjust, unfair and avoidable, they are referred to as health inequities. In more recent literature, HI monitoring is understood as a broad surveillance system in which the importance of the technical infrastructure of the systems, quality issues of the data and methods, and consistency and comparability over time and geographical areas is acknowledged. It is also often suggested that HIMS also should reflect policy objectives and mirror the implementation and outcomes of actions.

HI monitoring can be described as a cyclical process divided into a number of reoccurring steps³.

- Defining the objectives of the system.
- Identifying health topics and dimensions of inequality that are relevant in the population under consideration. A conceptual framework of social determinants and inequalities in health is useful to guide the identification and selection of relevant health topics, inequality dimensions and determinants. This step might also be political because it can entail consultations with diverse stakeholders that are involved with matters related to health and health determinants.
- Obtaining data about relevant health indicators and inequality dimensions from one or more data sources.
- Analysing the data. The process of analysing health data includes calculating health estimates by population subgroups and/or summary measures of inequality and analysing trends across time.
- Reporting and disseminating results so that they can be used to inform policy, the public, and stakeholders.
- Evaluating the results. Based on the results, changes might be implemented that will impact and improve health. In order to monitor the effects of these changes, more data must be

collected that describe the on-going state of health; thus, the cycle of monitoring is continual.

- Evaluating the whole system periodically to ensure that problems of public health importance are monitored efficiently and effectively and that that the system meets its purposes and objectives.

Navigating the complexities of the monitoring cycle requires a range of different skills and resources. Technical knowledge and resources to perform analyses, capacity to interpret results and communicate them effectively as well as capacity to advocate for and implement change. To meet these requirements, the HIMS ideally needs to be supported politically, legally, financially and by adequate human resources. In addition, the monitoring should be situated in robust systems and infrastructures that are run by strong national institutions. Developing this infrastructure and these resources may be a long-term ambition for some countries, while for others, existing resources may be strengthened and fine-tuned⁴. Yet, regardless of the current state of HI monitoring or the capacity and the resources available, each component of the monitoring cycle can be strengthened and improved³. Any effort dedicated to build and maintain the knowledge, skills and capacity to conduct HIM will be beneficial for the country and for combating inequalities in health.

Data sources and data collection

A central aspect of a well-functioning HIMS is the availability of data. No data often means no recognition of the problem¹. Simply put, monitoring HI requires two types of data: data about health and data about dimensions of inequality³. Such data can be derived from different sources, all of which have advantages and disadvantages (see Table 1 for an overview). It is important to understand the strengths and limitations of the available sources to ensure that the best available data are used. Ideally, the used data sources should be reasonably accessible, they should be regularly updated, and they should measure the same thing over time to enable time series. This is facilitated if indicators are derived from existing data registers or from data that are collected regularly⁵. The monitoring system should also provide a basis for decisions and efforts at local, regional, and national levels, hence in an ideal system data on different levels of aggregation should be available. This PFA focuses on HIM at the national level, the approach and the suggestions may however also be applied to monitor inequalities within any defined population.

The access to data differs significantly between countries, often due to differences in the existence or absence of personal identifiers and to differences in their legislative frameworks⁶. In some

countries data from different registers can be linked through the use of personal identification numbers. The Nordic countries are for instance well known for their long-term health and welfare registers and their ability to interlink all these different registers. In other countries, legal restrictions prohibit the linkage of health data. Data protection legislation is a delicate balance between protecting the right of the individuals to privacy and the interests and needs of society. In some countries this balance tips more towards protecting the right of privacy than in other countries (in Germany for instance)⁶. In these types of countries, survey data might be the solution. In yet other countries there are no legal barriers that restrict the linkage of data, but time and resources to do so have not been sufficient.

Table 1. Data sources

Type of data	Examples	Advantages	Disadvantages	Improvements
Census	National population and household censuses	Data cover the entire population (or nearly so), providing accurate denominator counts for population subgroups	Contains only limited information on health. Timing of data collection is not consistent	Include individual or small-area identifiers
Vital registration system (civil registration and vital statistics system)	National birth, death, or marriage registries	Can be used to generate reliable estimates for mortality rate, life expectancy, and sometimes cause-of-death statistics. Often linked to information on sex, geographical region, occupation, and education	Incomplete in most low- and middle-income countries. Do not regularly include information on equity stratifiers other than sex	Expand coverage. Include at least one socioeconomic indicator. Include cause of death, birth weight, and gestational age (when not included)
Medical registries	Registries of cancers, dental health, asthma, diabetes, congenital defects, cardiovascular diseases, etc.	Contains information about people who have a specific disease or condition	Only covers people that have been in hospital care	Include individual or small-area identifier
Household survey	Demographic and Health Survey, World Health Survey, Study on Global Ageing and Adult Health, Living Standards Measurement Study	Data are representative for a specific population (often national). Have rich data on a specific health topic as well as living standards and other complementary variables. Often repeated over time, allowing for measurement of time trends. Conducted in multiple countries, allowing for benchmarking	Sampling and non-sampling errors can be important. Survey might not be representative of small subpopulations of interest (so cannot be used to assess cross-district inequalities)	Repeat surveys on a regular basis. Enhance comparability over time and between countries by harmonising survey questions. Increase sample sizes
Institution-based records (administrative data)	Resource records (e.g. number of hospitals, health workers). Service records (e.g. number of immunisations given). Individual records (e.g. medical charts labour and retirement registries)	Data are readily and quickly available. Can be used at lower administrative levels (e.g. district level)	Data may be fragmented or of poor quality. Often data cannot be linked to other sources. Data might not be representative of the whole population	Include individual or small-area identifiers. Create standardisation of electronic records across institutions
Surveillance system	Outbreak disease surveillance, Sentinel surveillance, Risk factor surveillance, Demographic surveillance	Can provide detailed data on a single condition or from selected sites. Sentinel surveillance site data are useful for correction of over reporting or under reporting	Not always representative of a population. Some systems might collect little information relevant to equity stratifiers	Include individual or small-area identifiers. Integrate surveillance functionality into larger health information systems with full coverage

Adapted from O'Donnell O et al. Analysing health equity using household survey data. Washington, DC, World Bank, 2008⁷

Levels of aggregation

Social stratification not only occurs between individuals, but also between geographic entities such as nations, regions, and/or local areas such as neighbourhoods, and thus data on different levels should be considered. Choosing an appropriate level of aggregation for assessing HI is crucial to the validity of the measurement but is limited by the availability of data, which are often restricted to administrative areas that might or might not be relevant for specific HI outcomes. Every effort should be made to access individual-level data as the basis of HIMS because such data give the greatest flexibility for aggregating output on an appropriate level.

There are several issues to consider when deciding which is the appropriate level of aggregation:

- The level of aggregation depends on the objectives of the HIMS – if the purpose is to monitor and compare countries, the country level is enough; if the purpose is to analyse inequalities within countries, then other area levels are necessary (such as states or provinces).
- The level of aggregation should reflect knowledge about the mechanisms driving HI. The problem then is that such mechanisms might well be operating at different levels simultaneously, e.g. ischemic heart disease might be associated with individual-level living conditions, which in turn might be influenced by residential area characteristics that are the results of decisions made at the city, state/district, or even governmental levels.
- The relevant level of aggregation is the one where political decisions are made that can impact on the distribution of the relevant specific exposures associated with the health outcomes of interest. This might well lead to different levels of aggregation depending on which exposure or health outcome is being considered.

Indicators

An indicator is a variable, or a combination of variables, selected to represent a certain wider issue or characteristic of interest. The indicator is used to measure and monitor performance of a system. Indicators of health inequalities can, for instance, be useful for comparing health outcomes and risk factors across population groups or geographic areas and for determining policy priorities. Every indicator is made up of metadata and data. The metadata contain the background information of an indicator and refer to the title, the rationale, and information about how the indicator is actually constructed (Figure 2). Publishing the metadata is essential for proper documentation and transparency in the calculation of the indicator. The metadata are different from the information that is fed into the indicator, the actual figures, which is called the data⁸.

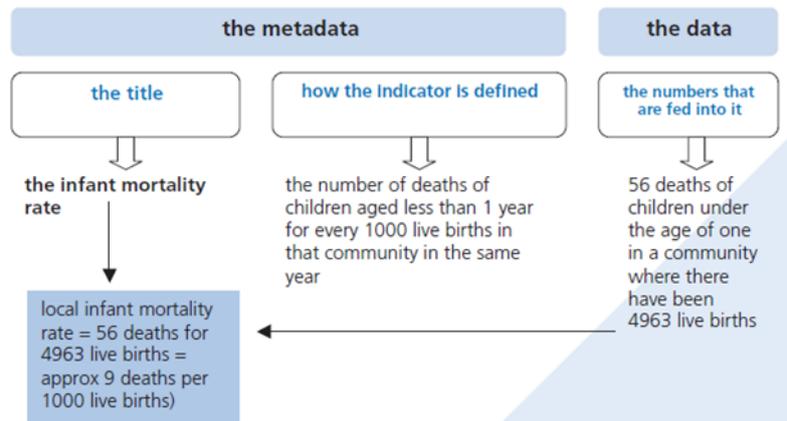


Figure 2. The structure of an indicator. Adapted from *The Good Indicator Guide*⁸.

To be able to select the most appropriate indicators and distinguish between good and bad indicators, it is essential to understand the structures of the indicators and to systematically and critically assess them. A number of quality criteria that might be helpful in this process are listed in Table 2.

Table 2. Proposed selection criteria.

Criteria	Description
Validity	The indicator measures what it is supposed to measure and measures the same thing over time.
Relevance	The indicator is relevant and addresses important dimensions of health and HI.
Sensitivity	The indicator is sensitive to changes so that it is possible, to a certain extent, to evaluate the effect of interventions.
Measurable	The indicator can be populated with meaningful data that are collected regularly.
Understandable	The indicator is easy to understand and easy to interpret.
Dimension of inequality	The indicator can be disaggregated into socioeconomic groups (i.e. education, income, gender, age, ethnicity, etc.).

No indicator will perfectly fit all criteria, but it is important that they have been considered and assessed systemically and that any compromises have been judged acceptable and made explicit⁸.

Health indicators

The indicators used to monitor health outcomes should reflect both general health within the population and more specific health outcomes. More general measures of health such as all-cause mortality, life expectancy, and mental wellbeing are often the result of complex causal mechanisms that are usually difficult to disentangle but nevertheless say something important about people's health and wellbeing in the population. Indicators on more specific health outcomes, in contrast, are more specific and linked to known causal mechanisms, e.g. mortality from ischemic heart disease, incidence of pulmonary cancer, low birth weight, and alcohol-related diagnoses. Again, the guiding principle should be that the chosen indicators are relevant and deemed to be important in the monitored context. The leading causes of death in the specific country could, for instance, be relevant specific health outcomes to focus upon. In addition, it might be useful to distinguish some indicators that could be also used for international reporting.

Indicators of social position

Ideally, the health outcomes should be possible to stratify along the most frequently used dimensions of stratification – education, income, occupational status, ethnicity, age, and gender – and at the most appropriate levels (individual, national, regional, and/or local) considering that stratification not only occurs between individuals, but also between geographical contexts. The guiding principle should be that the social indicator that is most readily available and most reliable should be chosen first. Preferably, though, education should serve as a primary stratifier because this minimizes the risk for reverse causality. To allow for international comparability, the ISCED classification of educational levels (or the ISEI index of occupational status) could be used. For children, information about parental education, income, and/or occupation should be used. For individuals out of the workforce, stay at home parents for instance; the dominant social position in the household should be used. To define social position in relation to ethnicity/migrant status or similar concepts might be especially challenging as accurate and comparable data that is collected frequently is limited and in some countries none existing. In addition, the way data is collected and the definitions that are used varies considerably between countries which creates issues regarding comparability and harmonization of data. Yet, more and better disaggregated data on ethnicity/migrant status and similar concepts has been called for as it is essential to better understand how migration affects individuals' wellbeing. At the most basic level information on whether or not a person is a migrant, i.e. foreign-born should be strived for. It is also useful to identify native-born children of migrants (often called the 'second generation', though they are not

migrants themselves). The usual criterion is that one or both of their parents were born in a foreign country. Additional data that may be useful is date of arrival of a migrant, reason for entry (type of permit, e.g. work, study or family reasons; asylum seeker; date granted asylum) and if they are EU/EFTA nationals, or 'third country nationals'.

In the literature there are usually two types of indicators of social position: those that identify certain “vulnerable groups” (e.g. the unemployed, the population at risk of poverty) and those that identify social position, often operationalised as level of education, income and/or occupational status. The former often reflect groups with a low position on the “social ladder” and thereby reflect just one end of the socioeconomic gradient. The latter group consider the spectrum, e.g. from low to high income or from low to high education. The collected indicators should ideally allow for the examination of both vulnerable groups and the gradient.

Interactions between the indicators of social position should be considered by adjusting for or stratifying along multiple dimensions simultaneously. It is well known that different dimensions of social position intersect⁹, yet they often tend to be considered separately. For instance, work on ethnicity and health and work on social determinants of health has in the past often been carried out within different frameworks. To get a thorough picture of the complexity of HI multiple effects need to be considered simultaneously. The success of such adjustments and stratifications depends on data availability, but the ambition should be to consider how age, gender, ethnicity, and/or geographical area might jointly influence the effect on health of the other indicators of social position. This could be particularly important from the policy point of view because the effect of, for instance, education on health might differ between men and women or between individuals with different ethnic backgrounds.

In addition, information on the distribution of the population across social and regional groups should be included in the HIMS because the size of the groups and changes in this distribution are important to consider when determining the impact on HI.

Indicators of specific exposures

The indicators of specific exposures should reflect health-relevant living conditions and behaviours. In countries with a less developed HIMS, the choice of specific exposure indicators might be empirically based either in the sense that they are data driven i.e. that it is data availability that decides which indicators can be focused on, or in the sense that the choice is based on detected needs. For the latter, the underlying idea is that when HI are detected these findings should be

scrutinized with appropriate equity lenses or preferably with health equity audit tools (HEA)¹⁰ in order to identify possible causes for the HI and possible counteractions. A health equity audit is a tool that allows professionals to, in a systematic way, review the detected inequalities in order to identify actions needed to reduce these. Hence, it is not until this point that “causality” issues are elaborated on and a relevant exposure indicator is decided on. Such an alarm system does not require a sophisticated infrastructure of indicators of specific exposures, and the only relevant requirement is that outcome data can be disaggregated along (to start with) one of the recognised dimension of stratification.

Alternatively, in a more developed HIMS the choice of specific exposure indicators could draw from scientific knowledge about mechanisms linking social position to health. The World Health Organization Commission on Social Determinants of Health (CSDOH) framework adapted for the European context might be useful in this process¹¹. The model is similar to the Diderichsen model² but illustrates more clearly specific exposures (in Figure 3 referred to as intermediary determinants) that might link social position to health. As illustrated in Figure 3 four main pathways are distinguished between, exposures related to material resources, psychosocial factors, behavioural and biological factors, and health care services.

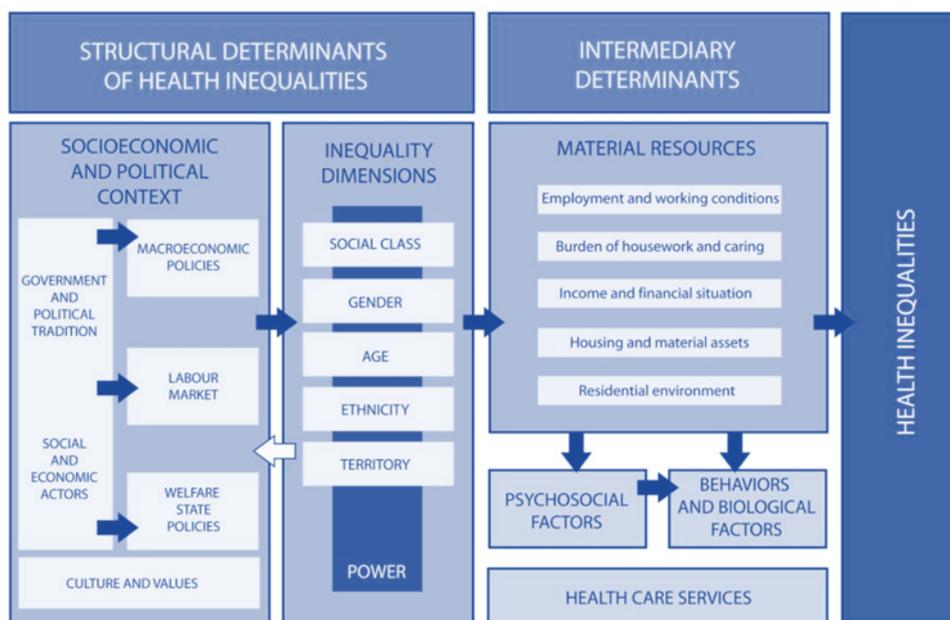


Figure 3. CSDOH framework for Europe adapted from Borrell for the Spanish Commission to Tackle Social Inequalities in Health, 2017¹¹.

The choice of indicators could also depart from policy entry points. The Swedish Commission for Equity in Health¹² lists eight such entry points over the life course, which are very similar to those suggested in British Equality and Human Rights Commission¹³ :

- Exposures associated with early life development
- Exposures associated with the educational system and school
- Exposures associated with work, working conditions, and working environment
- Exposures associated with income/economic resources
- Exposures reflecting the quality of housing and neighbourhood conditions
- Exposures associated with possibilities to practice healthy living habits
- Exposures reflecting the degree of control over life circumstances and the degree of influence and participation in society
- Exposures associated with access to and utilisation of health care, e.g. unmet needs of health care and inequalities in treatment and rehabilitation

These points could of course vary between countries, but the guiding idea is that the choice of indicators should depart from the most central entry points for actions in the specific context.

In appendix 2 are some *examples* of indicators gathered from existing international databases, structured according to the above mentioned policy entry points^{12,13}. The suggested indicators have been developed to monitor health between countries. As such, the indicators does not currently measure inequalities within countries, only in exceptional cases are they available by social position other than gender and age. Yet, given that the indicators rely on data from most European countries they might be, provided that there are data available to break them down by social position, good candidates for being integrated in nation-specific HIMS reporting routines and in existing EU or global HIMS.

Data Analysis

The general recommendation from the literature is that monitoring HI requires a combination of methods because no single method will provide a thorough picture of the degree of HI. Ideally, therefore, several measures should be used in combination. It is advisable to include both a measure of relative and a measure of absolute health inequity because these types of measure are complementary and findings can depend on which type is used. Simple measures of health inequity – such as the rate ratio and rate difference – can be complemented with more complex measures

of health inequity¹. However, rather than different ad hoc solutions, one should try to decide on a number of measures to be used to be able to illustrate short and long-term changes in HI⁵ (Table 3 for an overview). By necessity, the choice of method should be based on the data that are available.

Table 3. Measures of health inequalities

Range – how big is the gap?	Absolute and relative difference between two contrasting groups
Steepness – how steep is the gradient?	Regression-based indices that consider all groups separately, e.g. relative index of inequality or slope index of inequality
Scale – how big is the problem?	An account for the numbers involved and current trends; possibly also “total impact” indices, e.g. Population attributable fraction (PAR) and index of dissimilarity
Trends – what happens over time and in space?	Whether indicators imply a reduction or increase in HI is often a foundation for policymaking, e.g. visualized in line graphs

Adapted from the Scottish Long-term Monitoring of Health Inequalities 2017¹⁴

In addition, given that socioeconomic groups can vary considerably in their age structure it is essential, whenever possible, to use HI measures that are age-standardised or adjusted for age.

Dissemination and communication

The HIMS should be developed so that regular reporting on HI and its determinants is possible. The results should be published periodically in a communicative format that helps policy-makers and other stakeholders (including the public) understand the results of the inequality analyses³. Ideally, a dissemination plan should be designed to define the dissemination objectives, the activities, the targets, and the tools to be used. In addition to the traditional means of disseminating, such as reports, seminars, and leaflets, other formats such as websites, social media, slideshows, and videos should also be considered to facilitate the communication and understanding of the results (see Marin-Gonzales et al., 2017¹⁵ for more examples). Without investment in communication skills and appropriate reporting channels the results of monitoring may not reach the target audience.

Stakeholders

Stakeholders might include staff from ministries of health and statistical officers, policy-makers, researchers, health-care professionals, civil society groups, nongovernmental organisations, regional officers, local governments, and the public.

Evaluation

Appropriate evaluation of the HIM is central. Policy-makers are increasingly looking to quantitative evidence in order to identify priority areas for action and to inform decision-making processes. These data serve as an important basis for identifying where inequalities exist and – when monitoring is done over time – how they change over time¹⁶. It is therefore essential that the system and its results are evaluated and that changes are implemented, indicators developed and more data collected to enable an ongoing and accurate monitoring of the state of HI¹⁷ and of outcomes of implemented actions.

A model for choosing actions for implementation

This chapter is supposed to provide an overview of the envisaged project process.

The aim of WP5 is to identify, attract attention to, and improve the within-country capacity to monitor HI, and the participating countries will have to put into practice their commitment to this aim through concrete activities. The choice of activities has to be based on reliable information about the current state of the HIMS, and such information will be collected as part of specific country assessments (CAs). Building on the structure of the HI monitoring process (as described on page 8) information about the scope of monitoring, data availability, data analysis, reporting, evaluation and HI indicators will be collected. The results of the CAs will serve as a “baseline” for the countries from which feasible activities to improve the HIMS will be identified, comparing the current system with the “ideal” monitoring system. To ensure comparability and consistency across countries, templates will be developed and used to summarise and structure the results of the CAs (M5.2).

Criteria for the selection of activities

The choice of actions will depend on the results of the mapping of the current HIMS (summarised in the CA) and the particular gaps, promising entry points, and/or priorities that have been identified in each country when comparing their system with the ideal system. The WP coordinator will support the partners in this process, facilitate exchange of experiences, and suggest clusters of countries with similar approaches to allow for common discussions that can help overcome difficulties that could arise. Complex actions requiring a long-term approach are out of the scope. However, some preliminary activities facilitating such complex actions can be eligible as actions implemented within the WP.

Given the diversity of existing HIMSs and access to data among participating countries, a major objective of WP5 is to reduce the gap between the current HMS and an “ideal” system. This should be done in steps. Depending on the status of the current health information system and the availability of data, a stepwise approach can entail

- conducting the mapping of the current HIMS and taking steps to promote the construction of an evidence base for the current status of the HIMS
- establishing at least one meaningful indicator of HI, possibly prioritizing HI indicators that also could be integrated in existing EU or global HIMS.

- strengthening the equity perspective in current health monitoring by introducing equity stratifiers
- developing more sophisticated measures that could be used to guide policy and decision makers
- developing a system of HI information revealing trends in health outcomes and the associated risk factors and social determinants along the causal pathways

The ultimate goal should be a national monitoring of HI that comprises a broad set of data, mirroring the most relevant health outcomes in subgroups of the population and their associated risk factors and underlying social determinants, thus facilitating evaluation of health policies and supporting prioritisation. Participating countries are however encouraged to start on a small scale and to concentrate on getting well-functioning and regular HIM of a few health indicators in place before successively adding on indicators based on experiences learned, identified needs, or priorities in the public agenda of monitoring. In some countries performing the CA and taking steps to promote the construction of an evidence base for the current status of the HIMS might be the most useful contribution JAHEE can make.

Evaluation of the project

Evaluation is the process of continually gathering and assessing information to determine whether progress is being made in a project towards pre-specified goals and objectives and to highlight whether there are any unintended (positive or negative) effects from the project and its interventions. Evaluation is an integral part of the project cycle and good management practice. In the JAHEE project, the whole JA will be monitored and evaluated based on the fulfilment of the deliverables in the middle of and at the end of the project. In addition, each WP and each participating country will be monitored and evaluated based on the fulfilment of the WP deliverables. This evaluation will be conducted in the middle and by the end of the JA by WP3 with support from the WP coordinators.

References

1. WHO (2008). Closing the gap in a generation: health equity through action on social determinants of health. Final report of the commission on social determinants of health. Geneva: World Health Organization
2. Diderichsen, F., & Hallqvist, J. (1998). Social inequalities in health: some methodological considerations for the study of social position and social context. In B. Arve-Parès (Ed.), *Inequality in health—a Swedish perspective*. Stockholm: Swedish Council for Social Research.
3. WHO (2017). *National health inequality monitoring: a step-by-step manual*. Geneva: World Health Organization
4. Hosseinpoor, A. R., Bergen, N., Schlottheuber, A., & Boerma, T. (2018). National health inequality monitoring: current challenges and opportunities. *Global health action*, 11 (sup1). doi:10.1080/16549716.2017.1392216
5. Vågerö, D. (2017). Löpande bevakning och rapportering av folkhälsa och ojämlikhet i hälsa. Underlagsrapport nr 9 till Kommissionen för jämlik hälsa S 2015:02. Stockholm: www.kommissionjamlikhalsa.se
6. OECD (2013) *Strengthening Health Information Infrastructure for Health Care Quality Governance. Good practices, new opportunities and data privacy protection challenges*. Retrieved from <http://dx.doi/10.1787/9789264193505-en>
7. O'Donnell, O., Van Doorslaer, E., Wagstaff, A., & Lindelow, M. (2008). *Analyzing Health Equity Using Household Survey Data: A Guide to Techniques and Their Implementation*. Washington DC: World Bank
8. Pencheon, D. (2007). *The Good Indicators Guide: Understanding how to use and choose indicators*. Retrieved from National Health Service Institute for Innovation and Improvement: <https://www.england.nhs.uk/improvement-hub/publication/the-good-indicators-guide-understanding-how-to-use-and-choose-indicators/>
9. Bauer, G. R. (2014). Incorporating intersectionality theory into population health research methodology: Challenges and the potential to advance health equity. *Social Science & Medicine*, 110, 10-17. doi:<https://doi.org/10.1016/j.socscimed.2014.03.022>

10. Makin the case: health equity audit. Retrieved from the National Institute for Health and Clinical Excellence:
<https://www.webarchive.org.uk/wayback/archive/20140616174221/http://nice.org.uk/nicemedia/docs/Making%20the%20case-13-03.pdf>
11. Borrell, C., Malmusi, D., & Muntaner, C. (2017). Introduction to the “Evaluating the Impact of Structural Policies on Health Inequalities and Their Social Determinants and Fostering Change” (SOPHIE) Project. *International Journal of Health Services*, 47(1), 10-17. doi:
10.1177/0020731416681891
12. Lundberg, O. (2016). The Swedish Commission for Equity in Health: A summary of the interim report. Retrieved from www.kommissionjamlikhalsa.se/en
13. Equality and Human Rights (2018). Is Britain fairer? The state of equality and human rights 2018. Retrieved from <https://www.equalityhumanrights.com/sites/default/files/is-britain-fairer-2018-pre-lay.pdf>
14. Long-term Monitoring of Health Inequalities (2017). Retrieved from Scottish Government <https://www.gov.scot/publications/long-term-monitoring-health-inequalities-december-2017/>
15. Marín-González, E., Malmusi, D., Camprubí, L., & Borrell, C. (2017). The Role of Dissemination as a Fundamental Part of a Research Project: Lessons Learned From SOPHIE. *International Journal of Health Services*, 47(2), 258-276. doi:10.1177/0020731416676227
16. WHO (2013). Handbook on health inequality monitoring with a special focus on low- and middle-income countries. Retrieved from: <https://www.slideshare.net/RockefellerFound/health-inequality-monitoring-with-a-special-focus-on-low-and-middleincome-countries>
17. Centers for Disease Control and Prevention. (2001). Updated guidelines for evaluating public health surveillance systems: recommendations from the guidelines working group. Retrieved from: <https://stacks.cdc.gov/view/cdc/13376>

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