



**JOINT ACTION**

**HEALTH EQUITY EUROPE**

## **Work Package 8 – Improving access to health and related social services for those left behind**

### **Deliverable 8.1 WP8-PFA development**

#### **Report Information**

Contributors:	Andalusian School of Public Health (EASP) Granada, Spain ,in consultation with WP8 participating Member States
Work Package:	WP8- Improving access to health and related social services for those left behind
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#### **Project Information**

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## INTRODUCTION

The deliverable 8.1 in the Grant agreement is worded as follows:

<b>WP8-PFA development</b>	<b>A report on charting exercise and meeting including development of PFA, CA and selection of sustainable implementation actions on improving access to health and social services for those Left Behind will be developed at the end of the first year of the JA (REPORT)</b>
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The deliverable consists of three parts

**Part I.** The report of the WP8 Granada meeting of December 2018 where the basis for the formulation of the WP8 policy Framework for Action, of the WP8 Country Assessments and of the WP8 selection of actions to be implemented were discussed.

**Part II.** The final version of the WP8 Policy Framework for Action, which will be revised by the end of the JAHEE incorporating the lessons learned in the implementation of actions.

**Part III.** The template for conducting the WP8 Country Assessments, which have been completed in September 2019, are available, and have been the basis for the selection of actions to be implemented.

The dissemination level of this Deliverable 8.1 is entirely public

The three documents are included in this deliverable report and are presented in the following pages

The explanatory framework underlying JAHEE (Appendix 1.) clarifies the project wholeness and position each work package into the big picture.

### DISCLAIMER

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## Part I

### Minutes

## WP8 meeting Granada

4th & 5th December 2018

**WP8: Improving access to health care and related social services for those left behind**

**Meeting of Member States participating in WP8 and Observers**



## Participants

COUNTRY	PARTICIPANT
Cyprus	Chryso Gregoriadou
Cyprus	Elena Makrigiorgi
Czech Republic	Eva Ulicna
Czech Republic	Miroslava (Mirka) Skyvova
France	Christine Berling
France	Emilie Sobac
Greece	Apostolis Vantarakis
Italy	Giuseppe Costa
Italy	Mario Braga
Norway	Charlott Nordstrom*
Romania	Geta Popovici
Spain	Ariane Bauernfeind
Spain	Alberto Fernández Ajuria
Spain	Daniel López Acuña
Spain	José Ignacio Oleaga Usategui
Spain	Marixu Pando Letona
Sweden	Asha Jama

\* Even though Norway is not part of WP8, it was invited due to the close link of WP7 (Migrant Health) to WP8

Several other Member States participated by teleconference (skype) in the session on possible interventions to be implemented that took place on the second day of the meeting

## December 4th

14'30 – 15'00

### Opening session

Reyes Álvarez-Osorio, Director of the Andalusian School of Public Health  
 José Ignacio Oleaga Usategui, Director International Health Department EASP  
 Alberto Fernández Ajuria, Professor EASP, Coordinator JAHEE project for Spain  
 Introduction round of participants

### Presentation

-  Reyes Alvarez Osorio and Jose Ignacio Oleaga welcome the participants and highlight the commitment of EASP to be part of JAHEE as competent authority on behalf of Spain.
-  Alberto Fernandez sums up the Spain's JAHEE involvement: He underscored the health organization in Spain and the role of the Autonomic Communities in the health domain, the fact that EASP has been designated as competent authority to represent Spain in this Joint Action. The additional participation of other Spanish affiliated entities : The General Directorate of Health of Barcelona (involved in WP5) The Health Services of

Basque Country (WP6), The Health Institute of Valencia (WP 6 /& 9 ) and EASP involved in WP1,2,3,and 4 as well as WP7 and 9 and the European wide coordination of WP8 .The Ministry of Health keeps overview of all actions involved and takes active part in WP4.

15'00 – 15'30

**Objectives and methodology of the meeting**

Daniel López Acuña, Associate Professor EASP, WP8 Coordinator

**Presentation**

-  Shaping WP8, getting input on changes, inclusions and synthesis. Inviting for open discussions and inputs
-  Harmonization between WP up to a certain extent, as basically they do address different things
-  Country assessment: concentrating on WP8, though we are not expecting to finalize the discussion on the country assessment during this meeting; however, we should be able to discuss about the scope, specificity
-  Start discussion on the ideas of possible implementations per country

15'30 – 16'55

**Roadmap for the work of WP8 during the first year of the project**

Daniel López Acuña, Associate Professor EASP, WP8 Coordinator

Discussion round

**Presentation**

-  Main objective of this Work Package is to contribute to the goal of “*leaving no one behind*” in terms of access to health services and related social services
-  Intended to influence strategies, policies and programs
-  Also including an instrument of capacity building
-  Identify the main challenges, document new innovative practices towards overcoming inequalities
-  WP8 will also produce policy briefs
-  Daniel highlights that interventions will have to be carried out by the system and not just stay as a “pilot project”
-  We need to ensure the ability to evaluate the action
-  Formulating and implementing evidence based recommendations
-  Building a consensus on a PFA on mechanism limiting equity in access health care
-  Developing training materials and implement a pilot project on distance learning

**Discussion**

-  Note: country assessments will have to be completed by 1<sup>st</sup> June 2019 (it has been postponed later and will have to be completed by August 31<sup>st</sup> 2019)
- *Mario Braga* points out that we need a common understand for horizontal and vertical types of interventions
- *Elena Makrigiorgi* would like to know if our choice of action will only be linked to vulnerable groups as for her it would allow to be more focused
- *Giuseppe Costa* points out that the joint action needs to be pragmatic, looking at the country’s public health agenda
- *Giuseppe Costa* mentions that it would be good to clarify in which way each participating country can contribute to each task (e.g. some tasks needs more input from some than the other countries, or rather the WP coordinator than the participating countries)
- *Apostolis Vantarakis*: WP8 is the biggest WP, as includes everyone left behind (except migrants): so, how can we prepare experience with small amount of countries involved in this WP? How can we facilitate a wider range of target groups?
- *Eva Ulikna* asks for clarification on differences/clarification of good practices/case studies/implementation of actions

Action Points

- *Chryso Gregoriadou* asked whether will we have a tool to evaluate?
- *Eva Ulikna* still not sure of type of intervention that can be proposed
- *Asha Jama*: points out that even coming here with an ambition and an action proposal, she is convinced that their assessment might guide them to other findings for interventions
- ↳ Definition will be addressed later in the meeting
- ↳ Daniel Lopez Acuña clarifies that each country can chose from what concerns them the most, and not all have to focus on certain vulnerable groups. Though it would be good to concentrate on how to evaluate the impact
- ↳ reminds each country must be responsible for the choice of action to be implemented and evaluation (funded outside JAHEE)
- ↳ states that the WP8 is a “menu” of vulnerable groups or structural barriers that countries can pick from. This means that we will have general recommendations given the limited recourse we have
- ↳ highlights that the PFA has identified an initial set of good practices -> from there each country can chose and pick an action with the potential of generating an impact
- ↳ points out that there will be a common approach for evaluation, not a single tool as such for all the WPs , hence, each country needs to define a baseline for their assessment to look at the results they want to obtain and the impact on the target population
- ↳ Apostolis Vantarakis offered support to countries for their evaluation. It will have to be a outcome evaluation and not a process evaluation
- ↳ The WP8 group will have to agree on the pertinence of the proposed interventions and their evaluability

17'20 – 18'00

**The WP8 Policy Framework for Action. General considerations**

Daniel López Acuña, Associate Professor EASP, WP8 Coordinator  
Discussion round

Presentation

- 📖 Purpose of PFA 8 is
  - Identification of concrete actions for reducing inequities
  - Development of policies, programs, and practices that can make a difference in reducing disparities
  - Practically oriented
  - What can be done and which are the stumbling blocks to hinder translation of knowledge into action
  - Identification of concrete agendas
  - Implementation of measures that can make a difference in short and medium term - > *this should be a criterion for choosing and intervention*
  - The actions implemented may be downstream actions (entry point influencing the effective delivery of services) or upstream factors

Discussion

- *Giuseppe Costa*: when we use the term “good practice”, we also must acknowledge that some of our implementations can turn into a good practice that can feed back to the PFA again.
- *Alberto Fernandez*: a good experience that exists in a country already, can influence others as well
- *Apostolis Vantarakis*: what do we want with PFA? What will be our target group? Ministries will receive them in the end. After following also WP7 meeting, we do need guidance for the countries criteria’s. Therefore, we need to agree what PFAs should include.

Action Points

- *Mario Braga*: we need to define better the concept of vulnerability. As far as the Implementation is concerned, we have to find a way in which countries will be able to translate good practices into action.
- *Alberto Fernandez*: how many activities are we expecting to implement? What is the minimum number? How diverse should they be? What would be a reasonable number of actions?
  - ↳ PFA to be finalized in the coming months of 2019
  - ↳ Please send comments in writing to Daniel Lopez Acuña
  - ↳ *Giuseppe Costa* as coordinator is working on glossary to be used by all work packages
  - ↳ *Daniel Lopez Acuña*: I do not consider that the PFA will inform the countries with selection criteria for intervention, this may rather be part of the Country Assessment -> this section will be deleted from the PFA
  - ↳ We should propose another document that provide guidance for selection criteria
  - ↳ *Giuseppe Costa*: however, the PFA should provide the limitations of the choice of intervention-> it would be better rewording point 3 in the PFA general aspects
  - ↳ How many actions? ->*Daniel Lopez Acuña* said that we could think of one per country at least; *Giuseppe Costa* agrees that the target is at least one action/country.
  - ↳ *Apostolis Vantarakis*: it might be good to prepare a road map to guide the countries

18'05 – 18'20

**Improving access to health and related social services for those left behind: Towards a common understanding**  
Discussion round

Presentation

- 📖 Health Equity in Europe concluded that it was important to apply the “Equity Lens” not only to Social Determinants but also to other upstream factors.
- 📖 Identify key entry points: that are amenable to change!
- 📖 *Daniel Lopez Acuña* sees a risk in splitting up too much into too many vulnerable groups. That might prevent these groups to be part of the mainstream health system
- 📖 Let us remember, we target curative and preventive care
- 📖 Ensure consistency with SDGs (goal 3 & 10)

Discussion Action Points

- *Mario Braga*: would prefer to use “vertical” and “horizontal”
- ↳ *Daniel Lopez Acuña*: for this PFA, lets ensure we use the dual group

18'20 – 18'45

**Adjourning of the first day of the meeting**

Discussion

Reflections on today's discussions

- Definition of vulnerability: there is a risk of labelling and over labelling. Some groups (eg. disabled) not to be classified as such
- Does the definition of vulnerable groups may jeopardize the analysis of structural issues?
- On the other hand targeted interventions sometimes do have more impact
- Would it not be better to go for the definition of **vulnerability** rather than vulnerable groups?

## December 5<sup>th</sup>

09'00 – 09'30

**Wrap up of yesterdays' points highlighted/discussed**

- Presentation**
- 📖 Country assessments of WP8 will have to be completed by August 2019 (originally June 2019 Milestone, which has been modified)
  - 📖 This also must include the narrowing down of the interventions that will be selected
  - 📖 Selection of country intervention will have to ensure evaluability
  - 📖 The criteria for the selection of intervention will be further elaborated during the meeting
  - 📖 Be reminded that there is no budget from JAHEE for funding the interventions.
  - 📖 PFA: please provide your feedback to *Daniel Lopez Acuña*
  - 📖 Due to early departure of some participants, some country project proposal presentations will be moved forward
  - 📖 Common health entitlements must be considered and not diluted with targeting actions to vulnerable groups
  - 📖 It would be advisable to simplify and define vulnerable groups, as well as underlying factors for generating inequities, e.g. language barriers, service availability in rural areas, co-payment, and waiting lists
  - 📖 Corrections of inequalities should also include the correction in the disparity in entitlements
  - 📖 Possible mechanisms for actions: identification of entry points, enabling effective universality; tailoring the delivery of services to vulnerable groups; translating the equity lens;
- Discussion**
- *Christine Berling*: shares experiences and directions taken by France in their population approach emphasises on simplification of access, new populations, long live approach, specific groups targeted, identification of languages spoken, adjust patient centred approach to needs, etc. In addition, new interventions are screened beforehand for “inequalities”. We are not talking about vulnerable groups. We call them people finding themselves in a vulnerable situation.
  - *Giuseppe Costa*: entitlement is still in many countries at the level of policies, it is not translated into action: e.g. in Italy implementation is still not reflecting it.
  - *Mario Braga*: we have three components: supply side-demand side-interaction of both, even if Italy has a universal system, e.g. dental care is outside; simplification does not always overcome the problem: e.g. if you simplify the co-payment, it does not mean the person is able to pay;
  - *Christine Berling*: if we must take into account underlying factors e.g. housing, environment, they are out of reach of the ministries of health. -> this has to be outlined in the PFA. How can we narrow the scope?
  - *Daniel Lopez Acuña*: why is it difficult to narrow down? In part because of the diversity of health system within Europe and the variations in social protection in all European countries;
  - *Giuseppe Costa*: the success of the joint action would be that a country can influence their countries’ political agenda; this on the other hand makes us more diverse and implies difficulties to agree upon
  - *Daniel Lopez Acuña*: at EU level, there is some openness on health security, tobacco: but when it comes to health services, there is more reluctance
  - *Christine Berling*: could we define in the PFA where could we obtain the highest impact at the European level?
  - *Mario Braga*: universality, simplification, patient centred services...are all principles, it is more difficult to find its translation into direct actions.
  - *Asha Jama*: asks whether each participating country will have to conduct its country assessments: Daniel confirms that each participating country will have to do their country assessment for each WP they are participating in

Action  
Points

- *Apostolis Vantarakis*: would suggest having rather one country assessment that includes all components; in addition, it would be good to include also the new terminologies used on EU level: *One Health, Precision Public Health*
  - *Ariane Bauernfeind*: reflects on the literature review for WP8: even though focused in vulnerable groups, she noticed that many problems identified were cross cutting issues such as: language barriers; availability of services in rural areas (retention and motivation of staff); need of cultural mediators for better understanding of needs; out of pocket payments for drugs and supply issues of drugs (lack of pharmacies in rural areas; mobility (elderly); health promotion often not tailored; lack of understanding of services; waiting lists
- ↳ *Daniel Lopez Acuña* we will try to direct the PFA towards common problems
  - ↳ We have not reviewed yet the major gains on overcoming inequalities within Europe
  - ↳ It will be useful to finding cross cutting problems rather than to classify per vulnerable groups
  - ↳ It will also be useful to define guiding principles for overcoming inequalities but with the intention to move from macro to micro
  - ↳ It will elaborate more on major issues, trends, epidemiology of inequities in access so we can facilitate the country assessment
  - ↳ *ALL*: to elaborate more on the PFA section on best practices, WHO/EU/OECD initiatives->
  - ↳ *Giuseppe Costa*: would be good to know the WP8 literature review filter/search criteria. As well it would be good to present the findings by entry points
  - ↳ *Mario Braga*: concentrate on policy formulations,
  - ↳ keep the extensive information as an annex

11'45 – 13'30

France

**Member States presentations on proposed actions for implementation (I)**

**Healthcare Services Access Points (PASS)**

- 📖 Multidisciplinary team (social workers, nurse, GP, specialist doctors, dentist)
- 📖 Adjust to the areas specificity
- 📖 Holistic approach
- 📖 Access care for those without social security

Discussion

- Entry point? (first contact) through emergency room of hospital->referral to PASS
- Indicator “Number of patients” would not allow to show for which patients this service is more used
- How is the dissemination of the existence of PASS -> not known before touching emergency room
- What are the inequities that PASS wants to address (beside decongestion of emergency rooms?)-> Capacity of understanding the system

Action Points

- ↳ Formulate more clearly what is the inequity that this project will address
- ↳ Consider the entry point to primary care for people without social security for non-emergency cases
- ↳ Define entitlement for people without social security in access to care in France

Cyprus

**Access of drug users to Opioid Substitution Treatment (OST)**

- 📖 To offer personalized treatment options
- 📖 Initially introduced in prisons

Discussion  
Action Point

- What is the base inequity that you would like to address
- ↳ For example you could define % of prisoners have access to this service compared to % of general population
- ↳ Define a baseline of inequity and then define how to measure the reduction
- ↳ Is your inequity a geographical problem? Eg big city vs small city
- ↳ Re-frame the outline of the project-> define your “unreachable”
- ↳ Maybe you can learn from the big cities use of the service to elaborate in the small cities the underuse of services: sensitisation of availability? Supply to the services?
- ↳ Identify on both: supply and demand side

Greece

**Remote Mental Health Units for elderly people**

- 📖 Where no MH units in hospital
- 📖 Mainly depression
- 📖 Mobile mental health units will go to the village level (problem to motivate psychiatrists to participate)

**Roma Community health promotion with the inclusion of mediators for better access to primary health units (TOMY)**

- 📖 TOMY are newly introduced in the Greek health system
- 📖 Roma don't know yet about existence of services
- 📖 All preventive services will be provided through TOMY
- 📖 Mediator at community will sensitize about vaccination, primary health care and health promotion

- Discussion
- What will be the inequity to be corrected with these two interventions?
  - The proposed time line seems to be sure to reach a satisfaction of a patient with mental health disorder
  - How do you intend to reach out to the elderly e.g. if stigma is the reason for not presenting with mental health disorder, is a mobile unit the right approach? Or if people don't recognise mental health as a problem -> based on what would they present themselves to the mobile unit?
- Action Points
- ↳ There might be the need of comparison of e.g. one region with another/similar or different population
  - ↳ Is it an inequity of availability of services in one area compared to others in access to mental health care?
  - ↳ We can see in these three country presentations, that countries look into projects/interventions which are already in pipeline

14'35- 18'00

**Member States presentations on proposed actions for implementation (II)**

Czech Republic

**Effective health promotion for the people a risk of poverty and social exclusion**

Discussion round

- 📖 Establish health promotion centres
- 📖 Create new positions: social workers, mediators
- 📖 Provide training
- 📖 Create a database
- 📖 Create network of public and non-profit partners
- 📖 Target groups: socially excluded people: unemployed, no or basic education, single parents, receiving social benefits, many of them are Roma populations
- 📖 Lower life expectancy, higher infant mortality, lower birth weight, higher smoker rates...
- 📖 Roma population spread out in different regions of the Republic

Discussion

- It is important to define the inequity that you would like to tackle
- What are the components of the intervention that will reduce inequities?

Action Points

- ↳ Reflect on the indicators that will permit evaluability
- ↳ Limit the scope of the intervention to show the action that will limit the inequity, even if it is implemented within a larger project
- ↳ E.g. address smoking behaviour
- ↳ Based on the presentations so far, we would benefit from a methodological guidance for the interventions

Rumania

**Preventing unwanted pregnancies by increasing access to family planning services**

- 📖 Inequity from geographical and poverty point of view
- 📖 Changes expected: decreasing number of unwanted pregnancies, requested abortion, maternal mortality linked to abortion

Discussion

- Might be good to narrow down the target group e.g. adolescents
- Be careful with indicators: e.g. Maternal mortality numbers are usually low, therefore difficult to notice any changes; how to measure unwanted pregnancy except if done through a survey?
- The centre of your action is "reducing barriers in access to family planning" -> unwanted pregnancy is a consequence

Action Points

- What kind of specific intervention will be directed to the group identified?
- ↳ How have you mapped the access issues to family planning? What is the baseline?

<p>Bosnia Herzegovina (via Skype)</p>	<p><b>Protection of children at risk</b></p> <ul style="list-style-type: none"> <li> Children with PTs</li> <li> Teaching staff at schools</li> <li> Children up to 15 years (elementary school)</li> <li> Outcome: improve ability to learn and to adapt to new situations</li> <li> We are teaching the professors to look at all children and to detect special behaviours and problems, one identified they kids will referred to school psychologists</li> <li> Are there geographical differences</li> <li> You will have to define how the intervention will reduce inequity in access to services for those children</li> </ul>
<p>Action Points</p>	
<p>Serbia (via Skype)</p>	<p><b>Introduction of screening to elder abuse into primary health care</b></p> <ul style="list-style-type: none"> <li> Centred on the elderly</li> <li> Exposed to abuse and violence in the family/community or in residential institution</li> <li> Fear to get out of their surrounding and not asking for help</li> <li> Growing number of elderly -&gt; burden on the society</li> <li> Health care professionals are not prepared to recognise elderly abuse</li> <li> Serbia stays open to adjust their intervention after the country assessment</li> </ul>
<p>Discussion</p>	<ul style="list-style-type: none"> <li>• The project seems to be more focused on screening than on access</li> </ul>
<p>Action Points</p>	<ul style="list-style-type: none"> <li> Frame the intervention in terms of “what is the inequity that this intervention will address” e.g. what is the situation of the target population compared to others: institutional elderly compared to the ones living in family?</li> <li> Define the inequity in terms of access</li> </ul>
<p>Portugal (via Skype)</p>	<p><b>Homeless population-reducing health inequities in the access to health services</b></p> <ul style="list-style-type: none"> <li> National strategy in integration of homeless people (ENIPSSA) started in 2017</li> </ul>
<p>Discussion</p>	<ul style="list-style-type: none"> <li>• Portugal managed to identify a vulnerable group and a specific intervention addressing it. We would like to introduce this logic into all interventions of WP8</li> <li>• You should be able to observe a change over the period. Bear in mind evaluability of the intervention</li> </ul>
<p>Sweden</p>	<p><b>Developing a national guideline fro tailored vaccination communication, including formative phase, intervention development at regional, or local level</b></p> <ul style="list-style-type: none"> <li> Target population: parents attending child health care clinics</li> <li> Those one with main responsibility for immunisation</li> <li> Geographically discrepancies identified-&gt; deeper analyses on smaller size will be stimulated</li> </ul>
<p>Discussion</p>	<ul style="list-style-type: none"> <li>• How this guideline can show that uptake of vaccination will improve in the target population compared to the average level of vaccination in the country?</li> <li>• It is an intervention of capacity building</li> <li>• It would be good to characterize more the groups with low coverage</li> </ul>

- Vaccination coverage are going back in some contexts-> would be good to understand why?

## Italy

**Overcoming barriers to equity in NHS**

- 📖 Introducing health insurance for elderly
- 📖 Allocation: introducing deprivation in the capitation formulas (regions)
- 📖 Co-Payment and waiting lists
- 📖 Introducing the equity lens in Guidelines and technology assessments
- 📖 Target: general population
- 📖 Free of charge medicines among vulnerable: homeless, illegal immigrants
- 📖 Health care services for prisoners

## Discussion

- Are those points still on the government agenda (though the government has changed meanwhile)? -> (yes they are)
- Are there already definitions of inequality in access to health services? -> there are some statistics on social and geographical accesses of services which can be analysed on an annual basis to see how changes in policies might impact.

## Spain

**Abolition of co-payment for medicines and other therapeutic prescription for the retired population as part of the new Royal Decree of 2018**

- 📖 Co-payment was introduced in 2012
- 📖 Hitting specially hard retired population: affecting the access to medicine and their health
- 📖 Probably limited to one Autonomous Community (either Andalucía or Asturias) for the time being
- 📖 The co-payment created inequities within this vulnerable group compared with their situation before the introduction of the decree and the rest of the population

## Action Points

- 📖 Maybe also looking into proportion of compliance with prescribed treatments
- ↪ *Mario Braga* suggests considering data from National Statistic Institute (INE).

18'00 – 18'05

**Closing remarks**

- ↪ Daniel Lopez Acuña suggests that one country proposes another meeting within the WP8 funded outside the JAHEE budget; probably choosing a venue in a central location, not too peripheral
- ↪ He thanks for the participation, inputs and exchanges of interventions, which should help us to guide the direction for the future of WP8.



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HEALTH EQUITY EUROPE

Work Package 8

Improving access to health and related social services for those left behind

Part II

Policy Framework for Action

(Revised Final Draft September 28th ,2019)

Prepared by the Andalusian School of Public Health (EASP)

Granada, Spain

JAHEE WP8 Coordinator

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## INTRODUCTION

The purpose of this Policy Framework for Action (PFA) for the Joint Action on Health Equity in Europe (JAHEE) Work Package 8 (WP 8), is to provide a conceptual and evidence-based foundation for:

- a) the identification of concrete actions for reducing inequities in access to health and related social services which will be implemented, documented and evaluated as part of the JAHEE Initiative, and
- b) the pinpointing of key elements for the development of policies, programs and practices that can make a difference in participating European countries in reducing disparities in the availability, access and utilization of health and related social services focusing in those left behind.

In this regard, this PFA is a practically oriented policy framework. It reviews existing evidence not only from a theoretical standpoint but tries to interrogate it couple of steps further in connection with what can be done.

It intends to shed some light on which are the stumbling blocks that hinder the translation of knowledge into practice, for undertaking feasible and concrete actions that may be interested in the identification of concrete agendas for making practical progress and on the discussion on the political economy of the necessary change.

This PFA concentrates on the implementation of measures that can make a difference in the short and medium term. Measures which are centred around actions, with entry points closer to the factors influencing access to care and effective delivery of services for all.

The problem of health inequities, including those related to access to services, ultimately need to address the roots of the social exclusion processes which produce marginalization. Many measures related to upstream factors, even though important, escape the reach of the health system and pertain to other streams of work in the reduction of health inequities which are being addressed in other WPs of this Joint Action.

Intersectoral action for the reduction of health inequities is an important public health element for contributing to the reduction of health and health care disparities. However, this Work Package 8 concentrates on what can be done within the health sector and what can translate into improving inequitable access to services.

This PFA intends to:

- 1) Take stock of the existing knowledge on:
  - a) the main dimensions of inequitable access to health and related social services in Europe;
  - b) the structural barriers of the health system which trigger inequity in access to services;

- c) the interventions that have proven to be effective for mitigating the impact of processes of social exclusion generating inequities in access to health services;
  - d) the stumbling blocks for advancing policies and programs that favour the implementation of those interventions; and
  - e) the change process necessary to reduce those stumbling blocks.
- 2) Provide the basis for orienting a Country Assessment, contemplated as part of the JAHEE WP8, which will be conducted in the thirteen participating Countries, through the framing of the critical issues in each participating Country resulting of the above-mentioned review. Issues which should be mapped in each country, at either national, regional or local level, with the goal of orienting the selection of the actions to be implemented throughout this project.
- 3) Give elements and provide criteria for the selection of actions to be implemented and evaluated as part of the JAHEE initiative, within this WP 8, which will inform the JAHEE identification of best practices and the development of policy briefs for reducing inequities in access to health and related social services

Therefore, this PFA seeks to be pragmatic, action oriented and as operational as possible.

## II. IMPROVING ACCESS TO HEALTH AND RELATED SOCIAL SERVICES FOR THOSE LEFT BEHIND: TOWARDS A COMMON UNDERSTANDING

### 1. Scope of the JAHEE WP8

The main objective of this Work Package 8 (WP8) of the Joint Action on Health Equity in Europe (JAHEE) is to contribute to the goal of "leaving no one behind" in terms of access to health services and related social services in the EU and related countries.

This will be done through the formulation and implementation of regional, national and local strategies, policies and programs for reducing inequalities in access to health and related social services and through building Countries 'capacity to effectively advance action in this area.

The specific objectives of the JAHEE WP8 are:

- to identify, in the Countries participating in the WP8, the main challenges in securing access to health and related social services to populations in vulnerable situations and to those marginalized from the effective access to certain types of services;

- to generate case-studies of good practices which can be shared and translated into policies, programs and projects;
- to generate policy briefs on the main challenges identified;
- to implement actions for the reduction of inequities in access to health and related social services;
- to support the development of national and regional policies, strategies and programs for reducing inequities in access to health and related social services;
- to foster inclusive policy development processes with the engagement of all relevant stakeholders.

The work that will be carried out in the WP8 will revolve around the following aspects:

1. Building a consensus on a PFA for actions on mitigation of mechanism limiting equity in the provision of health and related social services (building on the international recommendations, literature and relevant Country experience). This PFA will be translated into a tool for conducting a Country Assessment.

At the end of the period of the Joint Action (JA) a final PFA will be consolidated, elaborated according to the lessons learned in the development of the WP8 implementation of activities and integrated in the overall PFA of the JAHEE. The framework will be shared with the governments, professionals, other stakeholders and the public;

2. Identifying in each participating Country the priorities in terms of reduction of inequities in the access to health and related social services. This will provide a repertoire of issues that warrant focused attention and further development at national, regional or local level. These priorities should be expressed in terms of populations in situation of vulnerability which face difficulties in access to quality health services as well as in terms of access barriers than can be tackled and mitigated. Once this mapping of priority bottlenecks in access to health and related social services is completed, identify which undertakings could benefit from a Joint Action platform, so common work can act as a catalytic force for change and effective progress. This may include not only national, regional or local actions but also contemplate the possibility of advancing cross-border actions for improving access to health services in Europe;

3. Consolidate available evidence on key barriers amenable to interventions which hinder access to health services of the populations in vulnerable situations. These should be specific to different population groups as well as to distinct structural access barriers of the health system in each Country and it should generate a repertoire of actionable recommendations. Good practices for improving access to health services for those lagging will be suggested and implemented. This will be translated into policy briefs on successful policies and programs.

Every Country participating in this WP8 will receive support from WP leader for implementing actions that may constitute best practices. The implementation will be

evaluated in close collaboration with WP3 in a comparative way, so European wide best practices can be suggested.

Several specific case studies according to countries preferences and good practices will be developed. These case studies should be comparable and follow a standard methodology.

4. Identifying key elements for capacity building that ought to be contemplated for building Countries' institutional strength for advancing policies and programs for the reduction of inequities in access to health and related social services.

To this end, developing training materials on Improving Access to Health and Related Social Services for those Left Behind and organizing a generic training package that may be adapted to national circumstances will be contemplated during the third year of the JAHEE project.

2. Setting the boundaries on JAHEE WP8

The Previous EU funded Joint Action on Health Equity in Europe concluded that it was important to apply the «Equity Lens» not only to Social Determinants and other upstream Factors that generate health inequities but to Health Systems aspects as well.

This opens the dichotomy, which is not mutually exclusive, of addressing on one hand systemic issues, with the purpose of reducing the way in which they contribute to the existent gradient of health inequalities in access to health and related social services, and of addressing, on the other hand, the needs of specific groups generally resulting from social exclusion processes situating them at high risk and high vulnerability and leaving them behind.

The approach we have taken is to consider both dimensions and explore its complementarity. To contemplate measures that increase and improve the universalism of health systems at the same time that we identify targeted interventions that may constitute concrete measures of «affirmative action» for mitigating the vulnerability of certain population groups with respect to access to health and related social services.

It is important to consider that in the reduction of inequities in access to health and related social services there is a tension and sometimes even a contradiction between advancing targeted approaches to vulnerable population groups, as an attempt to undertake «affirmative action» in the delivery of services and the universalist approach encompassing general population measures aimed at producing structural interventions addressed to the whole community. We will attempt to reconcile both approaches as part of the work of WP8 and will explore their complementarity.

The application of the «equity lens» has to be linked to very practical objectives of policy and practice. The fundamental purpose of doing so is to identify key entry points to existing situations that are amenable to change, like exposure to system-wide barriers to preventive and curative care or mitigation of the vulnerability to such barriers in certain population groups.

This means looking at the health system as the locus of expression of inequities in the delivery of services, which are amenable to be overcome, and as the scenario where social disparities can be mitigated and reduced through the «social salary» of improving equity in access to health and related social services.

WP8 consists of formulating and implementing evidence based recommendations on improving the access to health services (preventive and curative) and other related social services for people left behind either because they are population groups in situation of vulnerability derived from biological, social, economic or cultural factors or because access to some types of services is hindered for them for one reason or another.

This stream of work is consistent with the SDGs (mainly goal 3 and goal 10). It has been important to advance this formulation building convergence with the larger objectives of the full JAHEE initiative, so this WP8 is complementary and synergistic with the other WPs. Special linkages exist with WP5 led by Sweden on health inequities monitoring and with WP7 led by Norway on the reduction of health inequities for migrants.

As mentioned above, it is critical to identify upstream and downstream mechanisms. In this regard, it is important to drill down into the roots of vulnerability, which imply addressing the roots of marginalization and of social exclusion processes. Simultaneously, it is important to identify downstream mechanisms that encompass remedial actions for mitigating existing inequities generated by those social exclusion and marginalization processes.

The WP8 activities will investigate access barriers that are linked to the way in which services are provided and barriers that are linked to factors on the side of those in demand of services. It will implement both simple and more complex actions for the reduction of inequities in the access to health and related social services and will emphasize innovative approaches with high impact.

### 3. The underlying key factors generating inequities in the access to health and related social services

It is important to identify and assess the evidence on:

- a) the underlying key factors outside and inside the health system determining inequities in access to health and related social services; and
- b) the main mechanisms of generation of health inequalities that result from the architecture and functioning of the health system.

It is critical to understand the relative importance of the different key factors and mechanisms. How do they contribute to inequalities in health outcomes, in the main pathways of care and in foregone care.

The first element to be considered is whether the health system of a Country or Region has a universal approach to health coverage. The underlying element in this case is a series of

common health entitlements for all citizens/residents regardless of their ability to pay, of their socioeconomic position and of any other characteristic of its population group. This implies a centrality of the notion of social protection in health and of Universalism as a contributor to social cohesion. It constitutes an interface of health and social policies.

This is a way of ensuring fairness through an action of the Welfare State and a way to avoid disparities attributable to market approaches introducing inequities in terms of limitation of health benefits for certain segments of the population depending on the ability to pay.

In almost all European countries, health care expenses are mainly financed by public funds, either general taxation based, or insurance based. On average, in the late 2000s, out-of-pocket payments by households accounted for around one-fifth of total health expenditure in the European region. However, this proportion was highly variable among countries.

In more than one-third of the countries, the health care system is based on mixed financing, combining resources from taxation and social insurance contributions. Some of the characteristics of the health system are likely to have an impact on care use or non-use behaviours. (3)

However, this is not the case for all health systems in the European Member States. In some cases, health systems are segmented, with each segment having a differential access to health and related social services. In these situations, there is an underlying factor of differential entitlements depending on the ability to pay and/or the socio-economic position, or the eligibility or not for public insurance. Despite of the fact that health care systems in Europe provide considerable population coverage, still a non-negligible proportion of the population has to forgo or delay necessary or preventive care, often for financial reasons. Some social groups are more exposed than others, which may contribute to increase inequalities in health.

The second element has to do with the dimension of proportional Universalism, namely that an intervention/benefit/opportunity should be offered to everyone with frequency and intensity proportional to the need. This implies that the policies, programs and actions need to take care of those left behind in terms of access over and above the existing Universalism and this is not always the case

When entitlements are universal but only formal, the substantial right to access is not universally distributed. This implies the need of an extra effort of outreach for delivering services to those lagging, although they have the entitlements. The actions needed are related to correcting de facto the provision of services even if inequities do not exist in de jure terms.

The third element refers to the fact that inequities in access where there are common entitlements for all, where there are no financial barriers for accessing the system, are related to other types of structural or functional barriers which hinder effective access. In this case inequities may result from factors other than differential entitlements related to socioeconomic position since the financing modalities are equitable, and the system is fair

from a financial standpoint. These factors require intervention through actions that can eliminate access barriers when underlying differences in entitlements and financing do not exist.

They may be related to rural/urban differences in availability of services, to language and cultural factors, to disparities due to health illiteracy, to the impact of co-payments and other out of pocket expenditures and to waiting lists for certain types of services.

As regards the organisation of outpatient care services, it should be noted that the choice of a primary care doctor is entirely free in two-thirds of the countries. Access to specialists, by contrast, is generally restricted by a gatekeeping system. The density of physicians is much higher in some countries than in others.

Inequities in access to health and related social services in these cases are built into the architecture of the health system and the actions to mitigate them or revert them imply breaking the walls of the architecture of the system to introduce different organizational arrangements to correct inequities.

#### 4. Vulnerability vs Vulnerable groups

The probability of experiencing unmet medical needs varies across countries, and within countries among different segments of society. This creates situations of vulnerability and population groups that are left behind. Similarly, it is well established that health-related behaviours (smoking, alcohol consumption, eating habits, etc.) are socially differentiated. Although such factors are of crucial importance, the role of access to health care should also be considered of paramount importance and the increasing numbers of vulnerable people will generate additional demands on the health care system.

Therefore, where does the targeting of certain population groups come into the picture to address these vulnerabilities?

Is there a role for selective targeting, as «affirmative action» directed to people in situation of vulnerability, for reducing inequalities in access to health and related social services ?

The concept of vulnerability is an important one in public health. Vulnerability is affected by personal factors (usually referred to biological or clinical susceptibility) as well as social circumstances and factors within the environment.

Epidemiologically it is referred to increased likelihood for somebody of developing disease, dying or experiencing disability following a common exposure to given risk factor. Although we are all potentially exposed to risk factors for health at different times in our life, some groups of people carry a higher probability of having a negative health outcome due to susceptibility or increased exposure to this risk factor compared to other groups. (1)

Vulnerability from a health systems standpoint, though, refers to the provision of certain types of services that do not fully reach all the population and create processes of marginalization from the mainstream of service delivery patterns. This is due to conditions

of certain populations that make them vulnerable to benefit more or less than others from potentially available health and social services.

The JAHEE WP8 concentrates on addressing the health care needs of highly vulnerable groups experiencing disparities in the access to health and related social services with respect to the rest of the population.

The expression “leaving no one behind” refers to mitigating the inequitable access of these population groups resulting from social exclusionary processes making them the victims of direct or indirect marginalization.

Some of these groups are:

- Families who are in fragile situation (e.g. lone parents with young children), or or children and families from disadvantaged backgrounds;
- People who have a physical, mental or learning disability, or poor mental health;
- In-work poor;
- Older people who are in vulnerable situations;
- People in unstable housing situations (e.g. the homeless);
- Prisoners (or ex-prisoners in vulnerable situations);
- People living in rural/isolated areas in vulnerable situations;
- Long-term unemployed/inactive (not in education, training or employment);
- Survivors of domestic and intimate partner violence;
- Gipsy, Roma and Traveller (include all those with a cultural tradition of, and commitment to nomadism, including those who live permanently or temporarily in settled housing) (2). This broad definition includes individuals from different socio-cultural backgrounds including Romany (English) Gypsies, Irish Travellers, Scottish Gypsy/Travellers and Eastern European Roma communities.

Supply side and demand side barriers are many and could be identified and classified in different ways. The main mechanisms through which vulnerability in health systems terms is expressed are the following: (2)(4)(5)(6)(7)(8)(9):

- Bureaucratic difficulties;
- Lack of appropriate documentation;
- Not knowing how to navigate the system;
- Not sure what covered/get where;
- Unable to get an appointment/interaction with receptionist;

- Cognitive barriers: Fear of negative healthcare professional attitudes and mentality due to previous bad experience;
- Psychological barriers: mistrust, hopelessness, feeling worthless/unwelcome, depression, fear and anxiety;
- Social isolation and loneliness;
- Unwritten rules of social contract;
- Health information difficult to understand;
- Cultural misunderstanding;
- Language and communication barriers (use of medical jargon and language that the patient is unable to understand);
- Low level of health literacy;
- Long waiting lists;
- Financial barriers: Cost/out of pocket payment/co-payment;
- Inability to take time off work;
- No pharmacy/source of medication;
- Lacking transport.

Annex I provides a detailed literature review of some key factors and promising practices related to the reduction of inequities in access to health and related social services.

### III. INEQUITIES IN ACCESS TO HEALTH AND RELATED SOCIAL SERVICES IN EUROPE ACCORDING TO PREVIOUS STUDIES AND REPORTS

There are various WHO, EU and OECD Reports and Policy Recommendations on Health Equity in Europe that offer pertinent information for the work of this WP8.

The European Parliament adopted a resolution on reducing health inequalities in the EU on the 8th March 2011 (EU, 2011). In response to the proposed actions required, Health Action Partnership International (HAPI) coordinated a Joint Action (JA) to assist Member States involved, and with the Department of Health (England) led the work strand for improving integrated work to tackle socioeconomic and geographic health inequalities. (17)

In 2007, the European Union adopted the first comprehensive EU Health Strategy: consisting of three main objectives: improving citizens' health security; promoting health and reducing health inequalities; and, generating and disseminating health information and

knowledge. It supports wider EU action which has sought to actively engage in a range of policy areas to reduce health inequalities, including recognising the need to address the key drivers of vulnerability, such as poverty and social exclusion, as part of its Europe 2020 strategy (European Commission, 2010b).

In 2013, the European Commission proposed a new policy framework entitled 'Social Investment Package for Growth and Cohesion': which includes a staff working document entitled 'Investing in Health', extending the previous EU Health Strategy, explaining how EU action in the field of health helps to reach the Europe 2020 objectives.

The European Commission has also taken specific action aiming to reduce health inequalities through the Communication 'Solidarity in Health: reducing health inequalities in the EU' which also involved the exchange of best practices and sharing of understanding about the effects of social exclusions. The European Commission has also sought to improve access to healthcare: a communication on the 'effective, accessible and resilient health systems' focuses actions to strengthen the effectiveness of health care systems by developing indicators and increasing the accessibility and resilience of healthcare systems.(18)

Health at a Glance: Europe 2016 STATE OF HEALTH IN THE EU CYCLE, a publication of the OECD, underscored the need of a more effective prevention and quality care to achieve further gains in population health and reduce health inequalities in EU countries. It highlighted that ensuring universal access to care is critical to reducing health inequalities and underscored the importance of strengthening the resilience, efficiency and sustainability of health systems and of monitoring and improving the State of Health in the EU. (20)

The VulnerABLE project was a two-year pilot initiative of the European Commission (DG Santé) run between 2015 and 2017 by ICF, in partnership with EuroHealth Net, the UCL Institute of Health Equity, the European Public Health Alliance, Social Platform and GfK. The project aimed at increasing understanding on how best to improve the health of people living in vulnerable and isolated situations, identify and recommend evidence-based policy strategies, and raise awareness of the findings and support capacity-building within Member States. The project involved a range of research activities, including a cross-national survey with 1938 respondents belonging to potentially vulnerable groups across 12 Member States; a literature policy and data review of existing evidence on health needs and challenges of these groups, and inventory of good practices in addressing health challenges, expert focus groups and interviews with key stakeholders. (18)

Chaupin-Guillot et al have shown that using survey data from the 2009 wave of the European Union Statistics on Income and Living Conditions, it is possible to examine the determinants of unmet needs for medical and dental care in European countries. Special

emphasis is put on the impact of health system characteristics. Four factors are taken into account: the density of doctors or dentists, the rules governing access to practitioners, the method of paying primary care physicians, and the amount of out-of-pocket payments. The analysis was carried out using multilevel logistic regression models. Separate regressions are estimated for medical and dental services. The dependent variable was whether respondents reported that, at least once in the last 12 months, they needed care but did not receive it. The estimation results show that the probability of experiencing unmet medical or dental needs varies noticeably across countries. This inter-country variability seems to be partly explained by the differences in the financing of health care. Indeed, a positive link is found between the share of households' out-of-pocket payments in total health expenditure and the probability of unmet needs. The other contextual factors do not seem to play a significant role. (3)

The new Health Equity Status Report from WHO-Euro provides valuable information about health inequities in the Region, including some relevant for inequalities in health systems.

It should be noted that most European supported Initiatives on Equity and Health Systems address the issue of geographical disparities and do not get into other structural aspects of the Health System. The policy formulation and the development of programs for reducing health system inequities has been progressing but it falls short from reaching adequate levels of implementation and translation into tangible benefits for those left behind. Knowledge about inequities in access to health services across Europe needs to be deepened and conceptualized in a more comprehensive way and translation into practice is far from optimal.

There seems to be interest in asking the question on which health inequities can be attributable to the health system, but somehow the question of attribution does not lend itself into clear policy formulations for tackling and reverting those inequities. Of much greater practical importance and usefulness is the identification of entry points for modifying the expression of inequities in the functioning of the health system, its reach and its coverage.

The question of attribution is not in opposition to the one on entry points though They are two different questions both relevant for policy implications. Attribution is about the relevance of different causes and about priority to be given to addressing them. Entry points are about the mechanisms through which health systems may contribute to health inequalities, and their policy implication is that each mechanism is a potential entry point for policy counteraction.

#### IV. RECOMMEDATIONS AND POLICY CONSIDERATIONS

The following recommendations and policy considerations can be derived from the issues identified in the literature review conducted

##### 1. General recommendations to overcome health inequities

- Commitment and dedication of staff at all levels. Keeping alive services in which they passionately believe. Low staff turnover, stability to services. Engaging with – and winning the trust of – groups which have been traditionally regarded as “hard to reach”. Outreach and the use of ‘ambassadors’ or ‘champions’ in the community for successful primary care interventions • Provision of language services – sometimes linked to the bilingual health advocate system. (8)
- Communities and individuals need to be engaged as the owners/holders of local knowledge and as important partners in co-creating solutions, along with the local and national authorities.
- Participation and engagement, particularly for those with the least voice, lead to more effective public policies for health equity.
- Mediating agencies, such as nongovernmental organizations (NGOs) and community-based organizations – which have their roots in local communities as well as at pan-European level
- Improving health literacy is critical to creating and/or enabling a population that can effectively participate in engagement activities
- Build community capacities to take action on health and reduce health inequities. Members of the public identify local issues, devise solutions and build sustainable social action.
- Enhance individuals’ capabilities to provide advice, information and support or organize activities in their or other communities, using life experiences and social connections to reach out to others.
- Involve communities and local services working together at any stage of planning cycle, leading to more appropriate, equitable and effective services.
- Connect individuals and families to community resources, practical help, group activities and volunteering opportunities. (14)
- In order to reduce inequalities, any policy framework should include interventions that address needs specific to local populations and take into consideration the wider social determinants of health.
- Provision of resources at community level would enable a wider dissemination of community-based and culturally relevant targeted interventions. (15)
- Provision of resources at community level would enable a wider dissemination of community-based and culturally relevant targeted interventions.
- Marketing campaigns should be designed to have strong impacts on low socio-economic status groups, for instance relying more on television than on printed materials and including strongly emotional messages. (16)

- Community health workers (CHWs) are proven to be very effective in improving access to healthcare and health equity particularly for population groups most in need. Although there is strong evidence on the role and contribution of CHWs to health outcomes and their integration into health systems in low- and middle-income countries, such evidence is sparse in the context of high-income countries. (17)
- Information resources about illness should be available in forms that people can find and use readily, but it should also be accepted that educational interventions are likely to have only limited impact in altering help-seeking behaviour, and only then for specified conditions.
- Simplistic assumptions about 'deficits' in people's knowledge should be avoided. The potential for interventions aimed at promoting 'appropriate' help-seeking to discourage 'appropriate' help-seeking, by imposing a moral character on using health services, needs to be recognised.
- High levels of non-attendance at services should be treated as a signal of low permeability i.e. a service that is difficult for people to use. Services should assess the extent to which there is social, ethnic, gender, or age patterning of non-attendance and investigate (probably using qualitative methods) reasons for these.
- Services need to establish how much work people have to do, how many resources they need to mobilise in order to use them, and how comfortable people feel about using services. This may be achieved by audits where users are asked about, for example, transport, workplace and childcare arrangements and arrangements for accompaniment or language.
- Services, particularly those that offer preventive or health- maintaining care, need to evaluate how they can make themselves most congruent with the ways in which potentially vulnerable groups tend to use health care.
- Practitioners need to be reflexive (i.e. engage in critical self- reflection) and be explicit about how they respond to presentations and make adjudications about people; and they need to identify the heuristics (rules of thumb) they use in assessing people's eligibility for certain types of services.
- It will also be important to recognise the team-based nature of many decision-making processes, and to understand the contributions that different members of the team make, as well as how the patient's view is incorporated in the negotiations.
- The debate about whether there should be specialised services for particular groups has not yet been resolved. Any evaluation of specialised services needs to pay careful attention to the unwanted effects of specialised services. (7)

## 2. Recommendations in connection with populations groups in situation of vulnerability

### Older people

At the EU level, policy has increasingly focused on healthy and active ageing: the European Innovation Partnership for Active Ageing, established in 2011, is a key policy action aimed at improving the lives of older people. The partnership has brought together more than 3,000 partners across the EU to contribute to the development of policy and support good practice. (17)

### Rural populations

- Improve the level of human resource within rural populations (Policies to recruit, retain and professionally develop staff e.g. financial incentives, flexible and responsive continued professional development, development of practitioners with specialist skills (generic specialist)
- Reforms to service delivery (eHealth / technological solutions)
- Targeted measures to improve access for specific sub-groups (sharing costs across population, etc.
- Outreach services for particular groups (e.g. home visits for the elderly and people who are less mobile) (17)

### Homeless people

- Specialised services for homeless people can be particularly effective where they combine specialist knowledge and understanding with enhanced access. One form of improving access to healthcare is to bypass standard referral routes that require the patient to present at primary healthcare services and bring healthcare services directly to affected individuals.
- There are multiple strategies across Europe being used to combat health inequalities among homeless populations. Strategies may combat more directly either ill health related to homelessness or homelessness more generally but in both cases a holistic view is often taken that recognises the social determinants of poor health and that improving housing situations will ultimately tend to improve health outcomes.
- Better integration of mental health in the programmes implemented to provide healthcare to homeless people.
- Provide integrated services and improve the coordination between social and healthcare services to homeless people.
- One-stop shops: Participants considered that those are needed to connect health services with social and housing services. (17)

### Prisoners

- Use of peer-led approaches: These are approaches where people experiencing incarceration are empowered through training and responsibility to make healthy decisions for themselves and act as health promotion agents for others. (17)

### Survivors of domestic violence

- Health-care providers must offer appropriate clinical interventions to support survivors, including post-rape care (for example, pregnancy/STI prevention, access to abortion, long-term mental health services).
- Tailoring services to survivors' needs: Users should be involved in the development of services and that survivors' perspectives should be better promoted within service design.
- Designing mental health interventions: mental health support should be highly targeted (1)

### Children and families from disadvantaged backgrounds

- Policy responses at the EU level focus on children's rights and reducing poverty: alongside international legislation on the rights of children, the European Commission has demonstrated its commitment to improving the health of children, young people and their families, through policies such as, the Social Investment Package and Recommendations aimed at supporting families to be economically better off, and action plans to prevent and reduce childhood obesity. A variety of approaches exist at the national and local level which aim to improve the health of at risk families: promotion of work-life balance (e.g. supporting lone-parents to get back to work and manage childcare responsibilities) can support families to increase household incomes (RAND, 2014); provision of free school meals can improve child nutrition and health; and, the use of Family Centres which provide a wide range of services to support the health, wellbeing and income of vulnerable families.(17)

### People living in rural/isolated areas

Currently, there is no specific EU- level approach to addressing the health of rural populations. However, the WHO (2010) has set out a number of approaches which Member States should follow to support good health and healthcare provision in rural areas: for example, improve the level of human resources within rural populations (i.e. increase recruitment of healthcare professionals), Improve the regulation and monitoring of rural areas (i.e. focus groups highlighted the need for Member States to take full account of the differences in needs between urban and rural areas when implementing national policies); and improve service delivery in rural areas (i.e. implement a wide range of strategies to guarantee health service provision in rural areas and address geographical inequities in access to healthcare).(17)

### People with unstable housing situations (the homeless)

- There is no overarching approach at the EU level aimed to address the health challenges of people with unstable housing situations: however, a leading aspect of homelessness policy has focused on a Housing First approach.
- At the national level, policy tends to target the specific health needs of this group: the implementation of specialist services and interventions aims to address specific types of homelessness (e.g. roofless), or the specific health needs of homeless (e.g. Tuberculosis), and has been found to be effective in addressing health specific challenges of homeless populations.(17)

#### The long-term unemployed and inactive Health

At the EU level, the Europe 2020 Strategy has set an employment target of 75%: among other things, the strategy aims to support Member States to create sustainable jobs (through the Commission's Employment Package) enhance the employability skills of individuals and reduce poverty, which are likely to have a positive impact on health. A range of activities promoting good health and employment have been implemented by Member States: across the EU, welfare systems have focused on supporting people claiming unemployment benefits back into work, whilst addressing health and wellbeing issues at the same time. This includes interventions to promote and develop positive health behaviours, exercise. (17)

#### The 'in-work poor' Health

Up to now, policies to address issues relating to the in-work poor have made little impact at the EU level and research in this area is scarce: the Commission's Annual Review on Social Developments in the EU stressed a need to address the increase in numbers of in-work poor. At the Member State level, policies can indirectly influence the in-work poor: the majority of policies relate to the in-work poor are often included in wider policies to tackle poverty and social exclusion. These policies can be grouped in to two main forms of response: welfare transfer (i.e. social benefits); and, labour market policies (i.e. minimum wage). Specialist health services have been effective in supporting access to healthcare where universal provision is not available: programmes providing free healthcare treatment for people on low incomes or not covered by health insurance. (17)

#### People in detention

At the EU level, the safeguarding of people in detention's health is primarily addressed by the non-binding European Prison Rules: this sets out standards and principles for the treatment of prisoners, including specific considerations for health problems such as drug addiction, mental health and communicable diseases. A good prison healthcare system is an opportunity to address ill health and reduce health inequalities: the WHO propose a range of policy approaches to improve prisoner healthcare that include, a holistic approach to prison healthcare (i.e. coordination between government departments to deliver quality care), accountability and provision of prison health under health ministries, and health ministry's actively advocating for healthy prison conditions (WHO, 2013). (17)

### Survivors of domestic violence and intimate partner violence Health

There is no EU level legal instrument specifically designed to protect women from domestic violence: however, the passage of the Council of Europe Convention on Preventing and Combating violence against Women and Domestic Violence in 2011 outline key measures to be enacted based on policies to prevent, protect women from violence, provide services for survivors and prosecute perpetrators (Council of Europe). At the Member State level, there is good evidence of policies being used to support this group: these include, providing tools to healthcare professionals to identify and respond to incidents of domestic and intimate partner violence more effectively; improving the provision of appropriate clinical care; and, adopting multi-sectoral responses, including collaboration between health, judicial, child and social care services.(17)

### Persons with physical, mental and learning disabilities or poor mental health

The EU has adopted United Nations Convention on the Rights of Persons with Disabilities: the Commission has built on the Convention with its Disability Strategy 2010-2020, which stresses the right to the highest standards of healthcare for those with a disability. The EU also has a joint action on mental health and wellbeing 2013- 2016: this focuses on seven priority areas including prevention and promoting resilience, improving access to healthcare services and mental health at work and within schools. At the Member State level, policy responses have focused on addressing a range of issues to improve the health of this group: these include, improving the understanding of disability among healthcare professionals to improve healthcare provision and better meet the needs of this group; tackle unhealthy behaviours among this group (e.g. increase levels of physical activity); and, engaging service users in the design of services (e.g. person-centred care).(17)

### Gipsy, Roma and Traveller

Since 2008, the European Commission has organised a European Roma Summit on Roma Inclusion, which provides the opportunity to discuss Roma issues at the highest decision-making levels of the EU, including national and regional authorities, with the involvement of civil society. (6)

In 2011, the European Commission adopted a Framework For National Roma Integration Strategies to define their approach to Roma inclusion, which was adopted by all of members of the European Union (European Commission 2017).

In 2014, The European Public Health Alliance issued a “Position” on Roma Health in Europe, which addresses Roma inequalities in health (EPHA 2014). In 2014, the European Commission published a ‘Roma Health Report’ to present the results of a study on the health status of the Roma populations across EU member states (European Commission 2014). A 2016 report assessing the implementation of the EU Framework for National Roma Integration Strategies describes health inequalities experienced by Roma as an “on-going challenge” (European Commission 2016). (26)

Some of the recommended actions for this population group are:

- Reduce exposure to risk factors such as smoking, obesity, and poor living conditions. (5)
- Include health mediators, who are members of the local Roma community trained to liaise between the community, health practitioners and local health authorities, in order to help improve access to health care for Roma. (10)
- Develop trust between healthcare professionals and service users, and close collaboration with communities
- Ensure that cultural competence training includes the needs and awareness of GRT groups and is routinely provided to all staff pre- and post-qualification
- Retain a file of contacts, details of experienced staff, for example, who speak Roma dialects or who have community contacts (4)

#### V. AN ACTION ORIENTATED AGENDA

##### 1. Possible mechanisms for action

It is important to note that the identification of entry points for solutions is essential, once the key factors that are amenable to intervention are pinpointed.

As discussed before this should consider on one hand filling the gaps that can bring about greater equity by mitigating access problems among the most vulnerable, and on the other hand addressing the gradient related to wider health system's issues and structural problems.

This implies drilling down within the underlying causes of inequities in access to health and related social services mentioned in the above section.

In operational terms, there are four different streams of mechanisms that ought to be considered:

- a) Measures aimed at improving effective universality in the system;
- b) Measures aimed at improving institutional capacity of the health system for translating the «equity lens» into policies, practices and programs
- c) Measures aimed at tailoring the delivery of services to the needs of the people in situation of high vulnerability for reducing existing disparities;and
- d) Measures aimed at developing and strengthening equity accountability mechanisms with the voice of all relevant stakeholders

These four streams are not mutually exclusive and somehow the national, regional and local agendas for reducing inequities in access to health services ought to consider all of them.

The following are some practical recommendations for overcoming barriers 3 to health care and related social services derived from the literature review conducted (2)(6)(14)(15)(10)(11)(12)(13)(16):

- Improve the level of human resource within rural populations (policies to recruit, retain and professionally develop staff e.g. financial incentives, flexible and responsive continued professional development, development of practitioners with specialist skills);
- Aim for low staff turnover, stability to services;
- Ensure that cultural competence training includes the needs and awareness of targeted groups and is routinely provided to all staff pre- and post-qualification;
- Engage with and winning the trust of groups which have been traditionally regarded as “hard to reach”;
- Develop trust between healthcare professionals and service users, and close collaboration with communities;
- Outreach and the use of ‘ambassadors’ or ‘champions’ in the community (trust status);
- Include health mediators, who are members of the local community trained to liaise between the community, health practitioners and local health authorities;
- Mediate agencies, such as nongovernmental organizations (NGOs) and community-based organizations;
- Engage communities and individuals as the owners/holders of local knowledge and co-creating solutions;
- Build community capacities to act on health and reduce health inequities;
- Enhance individuals’ capabilities to provide advice, information and support or organize activities in their or other communities, using life experiences and social connections to reach out to others;
- Involve communities and local services working together at any stage of planning cycle, leading to more appropriate, equitable and effective services;
- Connect individuals and families to community resources, practical help, group activities and volunteering opportunities;
- Include Community health workers (CHWs) who are proven to be very effective in improving access to healthcare and health equity particularly for population groups most in need;
- Provide resources at community level to enable a wider dissemination of community-based and culturally relevant targeted interventions;
- Promote Cross-sectoral cooperation based on a community-based approach;

- Provide integrated services/Multidisciplinary care and improve the coordination between social and healthcare services: one-stop shops: connect health services with social and housing services;
- Use targeted measures to improve access for specific sub-groups (sharing costs across population, etc.);
- Join up transport, housing, health and social care;
- Implement outreach services for specific groups (e.g. home visits for the elderly and people who are less mobile) / Mobile home-care services;
- Consider walk in clinics (more relaxed position on appointments);
- Bypass standard referral routes that require the patient to present at primary healthcare services and bring healthcare services directly to affected individuals;
- Advance in reforms to service delivery (eHealth / technological solutions);
- Increase health literacy among potentially 'at risk' people;
- Improve health literacy to create and/or enable population that can effectively participate in engagement activities;
- Provide language services – sometimes linked to the bilingual health advocate system;
- Retain a file of contacts, details of experienced staff, for example, who speak dialects or who have community contacts;
- Provide Information about illness in forms that people can find and use readily;
- Design marketing campaigns to have strong impacts on low socio- economic status groups, for instance relying more on television than on printed materials and including strongly emotional messages;
- Involve persons in their health care plan/patient centred;
- Promote volunteering initiatives (to improve social integration);
- Support access to healthy lifestyle behaviours (exercise, healthy food);
- Better integrate mental health in the programmes implemented to provide healthcare to homeless people;
- Reduce exposure to risk factors such as smoking, obesity, and poor living;
- Tailoring services to survivor needs: women focused, child friendly and non-blaming services.

Interventions addressing these barriers will have a positive impact on everyone. However, specialised services for specific groups in situation of vulnerability should not be discarded

when appropriate and when this does not constitute the creation of parallel services resulting in atomization of efforts and resources.

Annex II Annex contains recommendations and Policy Considerations to overcome health inequities in access to health and related social services as well as recommendations in connection with populations groups in situation of vulnerability

## 2. Addressing the policy practice gap

Knowledge alone is not enough for effecting the necessary changes in reducing inequities in access to health and related social services.

An effective translation of knowledge into practice is warranted so the available information and evidence on what works and what does not work (in terms of practical actions that can produce in the medium- and long-term observable changes can be transformed in effective policies, programs and interventions.

This PFA and the entire JAHEE WP8 seek to explore ways for bridging the gap between knowledge and practice and therefore concentrate on what can really make a difference in the unjust differential access to health and related social services by different population groups.

This is very much related to the Governance issues addressed in WP4 and WP 9, but it has a specificity of its own that require an in-depth analysis of what may work in this domain of reducing inequities linked to the access to health and related social services

## 3. The political economy of acting against inequalities in access to health and related social services

It is also critical not to remain at the level of a technocratic reflection, analysis and recommendations, and to go to the level of analysis of the forces and stakeholders that favour the necessary changes and those that actively or passively resist the transformative agenda necessary to bring about change in the domain of equitable access to health and related social services.

In this regard a targeted process of communication, of dissemination of information and knowledge, of sensitization and advocacy among key stakeholders and of engagement of key political forces involved in the decision making affecting equitable access to services for the Member States populations is of the essence.

## VI. CONCLUSIONS

- ☐ A true Equity approach should be a Universalist one, which should not mean that one size fits all. An approach that does not fall into a logic of «repair policies» and parallel health systems for the different groups in situation of vulnerability.
- ☐ Two tier systems should be avoided and dedicated and targeted approaches within a framework of universal entitlements should be advanced.
- ☐ There must be a basic floor of universalism and social protection for ensuring that equity is incorporated into the health system correcting distortions generated by the social and economic fabric.
- ☐ There is a reality of increased health needs and access barriers of persons living in isolated, marginalized and vulnerable situations. There is consequently a challenge for identifying the most effective ways of targeting these populations groups involving them in the definition of their situation as much as possible
- ☐ It is important to note as well that the risk of oversimplification of the notion of vulnerability should be avoided and similarly the risk of excessive segmentation of vulnerable groups that may lead to a balkanization of the health system response to inequities in access.

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## ANNEX I

## SALIENT FACTORS AND SOME PROMISING PRACTICES FOR REDUCING INEQUITIES IN ACCESS TO HEALTH AND RELATED SOCIAL SERVICES IN EUROPE

## 1. Addressing people in situation of vulnerability

The surveys conducted by the VulnerABLE project have yielded the following information in connection with people in situation of vulnerability that were interviewed with self-reported measures.

## Older people

Older people in vulnerable or isolated situations are reported to have greater difficulty accessing healthcare services. This was primarily due to the cost of healthcare, although difficulty understanding health information provided by doctors, nurses and other healthcare professionals was also a factor. (1)

Older people's experience can be understood within the context of a patient perceived set of unwritten rules or social contract. However, most found it difficult to access primary care due to engaged telephone lines, availability of appointments, interactions with receptionists; breaching their perceived social contract. This left some feeling unwelcome, worthless or marginalized, especially those with high expectations of the social contract or limited resources, skills and/or desire to adapt to service changes. Health professionals described how rising demands and expectations coupled with service constraints had necessitated service development, such as fewer home visits, more telephone consultations, triaging calls and modifying the appointment system. (2)

## Families who are in a vulnerable situation

Individuals from this target group reported that lack of money was a determining factor in access to healthcare. Concerning the feelings of psychological stress, members of vulnerable families were reported to be more likely to feel particularly tense, lonely and depressed.

## People living in rural/isolated areas

They are more likely to report unmet healthcare needs than those living in towns. The most important reason cited by rural residents was cost, while only a low proportion of rural residents stated that long distance was the reason for their unmet needs. High cost was the main reason why they did not visit medical practitioners, receive dental examination/treatment or get medication. After cost, the most important reasons were not knowing if their healthcare insurance covered it; a lack of transport; and there not being a pharmacy/other source of medication in their community. People in rural/isolated areas were very or quite dissatisfied with their healthcare services due to long waiting times that they face before accessing services, or not being able to get an appointment.

## People with unstable housing situations (the homeless)

They are also more likely to have unmet health needs and the most likely to report having unmet needs due to the cost of healthcare. High costs were often mentioned among this group as the main reason for not visiting medical practitioners, getting dental examination/treatment or getting medication. Furthermore, more respondents living in unstable housing situations found health information difficult to understand. Also highlighted: bureaucratic difficulties, inability to pay for treatment and stigma, lack of follow up to treatment, and, accesses to end of life care.

#### The long-term unemployed and the inactive

The findings show that unemployed people were more likely to report bad health than the average respondent. This group reported that lack of money had an impact on their health.

#### The 'in-work poor'

The survey results show that the health situation of this group was good or very good. Respondents within this group reported long standing illnesses, disabilities of infirmity. Regarding the factors affecting the health of the in-work poor, the response was lack of money, followed by stress, work/lack of work and lack of exercise. The main issues encountered when trying to access healthcare were lack of affordability, too long waiting times, inability to take time off work, inability to get an appointment.

#### Prisoners and ex-prisoners

This is the group most likely to say that their health was affected by smoking, and more likely than average to state that alcohol and drugs affected their health. Prisoners/ex-prisoners were the group most likely to state they had not accessed healthcare services within the past year. The group most dissatisfied with the healthcare services they received; with its quality, most frequently due to the length of waiting times.

#### Survivors of domestic violence and intimate partner violence

Health inequalities are not well suited to judging the situation of survivors, as it does not identify this group directly. Survivors were most likely to experience mental health problems and to show signs of psychological stress, such as feeling particularly tense most or all of the time or being depressed. And also, most common for this group is to report very bad health. Following factors affect their health: lack of money and feelings of stress. The main reasons why survivors cannot access medical treatment are being unable to afford it, being unable to get an appointment, having an excessive wait and lacking transport. Cost is also the main barrier to this group accessing medication. Just over a quarter (26%) of survivors are dissatisfied with health services. In order of importance, the main causes are long waiting times, not liking the attitude of the healthcare professional, medical treatment not improving the individual's health.

#### People with physical, mental and learning disabilities or poor mental health

A high proportion of people with physical, mental and learning disabilities report a bad health and are less likely to report a good health. This target group are likely to be

experiencing additional difficulties to their disability. Around a quarter of this target group reported being dissatisfied with health services they received. The issues contributing to the dissatisfaction of this group with medical care were the perceived ineffectiveness of the medical treatment and long waiting times. Physical, mental and learning disabilities were most likely to cite dissatisfaction with the attitude of the healthcare professional, ability to understand health care information, high cost as the main reason for not visiting medical practitioners, not receiving a dental examination/treatment or not getting medication. (1)

#### Gipsy, Roma and Traveller

Key barriers include health systems' bureaucratic processes, discrimination and negative attitudes of some health service staff, cultural misunderstanding and language barriers, low levels of health literacy and affordability. In addition, some barriers relate to service user attributes of Gypsy, Roma and Traveller people, although this may be underpinned by fear and mistrust. Gypsy, Roma and Traveller communities face significant obstacles to exercising their rights to healthcare. (3)

This group experience practical and administrative challenges: lack of appropriate documentation, including adequate citizenship documentation, which affects entitlement to services following recent migration; lack of contribution-related entitlement to welfare; poor or non-existent translation services for migrant Roma; low literacy compounding existing barriers to concordance with treatments; effects of poor or insecure accommodation and frequent movement on wellbeing or access to treatment regimens, particularly for 'homeless' Gypsies and Travellers. (4)

There is evidence for lower self-reported health and significantly higher mortality risk for Roma compared to non-Roma, and greater prevalence of health risk factors for Roma children, including environmental risks, low birth weight, and lower vaccination coverage. Barriers to care include lack of documentation and affordability of care. (5)

Roma populations in Europe suffer greater exposure to wider risks of ill health (e.g. socio-economic and environmental); live less healthy lifestyles; have poorer access to and lower uptake of primary care and preventative health services; suffer poorer health outcomes, in terms of morbidity from both infectious and chronic diseases and have shorter life expectancy. (6)

Some recommendations and implications for practice and policy in connection with the groups mentioned above, according to a review of the literature, are the following:

#### Gypsy, Traveller and Roma communities

Information about illness should be available in forms that people find easy to use, but health information and promotion are likely to have only a limited impact on people's behaviour. If a service has a poor record for attendances, service providers should investigate the reasons and be sensitive to the impact of poverty, gender, ethnicity, or age on attendance. Services should investigate just how much work is involved for people to use them fully and how comfortable people are with the service. Health professionals should

reflect on how they respond to people they see and how they use 'rules of thumb' to make judgements about people's health needs. (7)

The Market Harborough Medical Practice, Leicestershire has identified the following elements: a nurse-led minor illness clinic • hard work to build trust in its service among travelling communities • involved practice nurses and community health visitors • staff trained in the health needs of the Gypsy and Traveller communities • building trust was critical • "More relaxed" position on appointments with Travellers, if they turn up without an appointment. (8)

Outreach programmes for health improvement of Traveller Communities: This study aimed to explain how, for whom and in what circumstances outreach works in Traveller Communities. The trust status of outreach workers is an important context of outreach interventions, in conjunction with their ability to negotiate the intervention focus. The higher the outreach worker's trust status, the lower the imperative that they negotiate the intervention focuses. (9)

Good practice in working with Gypsy, Traveller and Roma communities: This article highlights important literature and good practice relevant to healthcare professionals working with and supporting Gypsy, Traveller and Roma populations. Members of these minority ethnic communities are often seen as 'hard to reach'. Healthcare practitioners frequently identify that mutual gaps in cultural competence and knowledge exist, which can affect ways of working with these populations, leaving service users and professionals baffled and upset, with negative effects on health. By exploring the effects of social determinants of health on these groups and focusing on ways of improving communication and tailored access to services, it is possible to develop effective ways of supporting vulnerable individuals and communities while building trust, enhancing communication and increasing health literacy among potentially 'at risk' people. (4)

Health Mediation models in the EU: Example of good practices: The report compiles health mediation models from participating project partner countries to the Regional Intervention on "Health Mediation and the Roma"(10)

Toolkit on Social Participation: This toolkit was developed to help people to promote social participation in the design, implementation, monitoring and evaluation of strategies, programmes and/or activities to improve the health of the population. It introduces a set of tools that could be applied throughout all the stages of the policy process. (11)

Friends, families and travellers: a guide for professionals working with Gypsies, Roma and Travellers in Children's Service: Gypsy and Traveller children were three times more likely to be taken into care than any other child. Gypsy and Traveller children placed in settled residential homes or other transcultural foster settings typically experience acculturative distress and absolute social alienation in later years. This guide also identifies the benefits of taking a community social work approach, to help develop relationships with Gypsy and Traveller families and identify issues at an early stage to prevent problems from escalating. (41)Homeless People

Housing First: In this model, homeless people are provided with a non-conditional offer of permanent housing. Housing First was at least as good as “staircase” services in improving mental health, substance abuse and physical health with the added feature of being better at keeping people in housing.

A pilot project implementing a baby clinic into a hostel for homeless families to address attachment and developmental issues prevalent among this group. The service was based on collaboration between parent-infant psychotherapy services and health visitors. The study found that indices of mental and motor development of infants improved due to the pilot

Role of a tuberculosis link worker helped address the needs of vulnerable people with tuberculosis. The link workers can mitigate against risk factors that complicate the treatment of tuberculosis such as alcohol and substance misuse by providing enhanced social support.

Other approaches to improving overall health may involve tackling the inequalities in access to healthy lifestyle behaviours such as exercise. Many organisations that provide the opportunity for homeless individuals exist across Europe. One of the more established models of this sort of interaction is street football. (1)

Promising practice: Based in Leeds, York Street offers the full range of medical/health care to be found in a standard general practice, but also provides specialised mental health and alcohol and drug treatment services, therapeutic interventions and substitute prescribing for heroin and crack cocaine. It also provides – free – a welfare rights clinic; physiotherapy; psychological care; legal clinics and housing advice. The service works closely with a social worker to provide integrated care plans for users. Workers provide outreach clinics in several partner agencies, but also work with clients from cafes and on the streets.

Some of the dimensions of this practice are the following: multidisciplinary care across sectors; person-centred care; service user engagement and influence; inclusion of linked primary and hospital services; coordinated care and effective discharge planning in hospital; specialist services/facilities in areas serving high concentrations of homeless people

Case, based in East London, this is a well- established medical centre catering exclusively for homeless people, including homeless migrants, and attempting to address their primary, mental healthcare and substance misuse needs. Health E1 produces leaflets but, mostly, its patients know of it through word-of- mouth. It has close links with local hostels, day centres and charities working with homeless people. The practice runs a combination of open access (walk-in) clinics, along with booked appointments, as this flexible approach best suits the needs of people who often find it difficult to keep to rigid timetabling and appointments. The practice works with prison and the criminal justice system so it can carry on vital treatment for those who have been recently released from prison. (8)

Long -term unemployed and the inactive

The “Action nutritionnelle dans une épicerie solidaire” seeks to improve access to health foods for people on low incomes or at risk of poverty through the provision of healthy food products at an affordable price. It also aims to provide support the long-term unemployed back into employment by providing employment opportunities and work placements to unemployed people in the community. Research studies suggest that providing subsidies and support for people on low incomes can improve the health and wellbeing, including an association between higher disposable income and better health outcomes, and proximity to stores offering fresh food linked to reduce rates of overweight and obesity and better health outcomes.

Promoting positive mental health among unemployed people: a range of interventions, which can support people to improve their health and move them closer to the labour market. The intervention was delivered through a job training centre specialising in re-employment support and was split into lectures for enhancing the individual health competence and a supervised physical training part in a fitness centre. The findings indicate an improvement in both objective and subjective health. This was demonstrated by the reduction in cardiovascular risk factors (e.g. blood pressure), the increase in physical activity and fitness, as well as the reduction in chronic back pain symptoms and depression.

#### People in detention

In Denmark, for example, all prisoners are made responsible for preparing their own meals, and in support of this are given cookery classes and the ability to purchase raw ingredients for meal preparation. One aim of this policy is to improve the nutritional content of prisoners’ food, thereby helping reduce rates of communicable diseases and mental health problems among prisoners. This model has improved knowledge of health eating among prisoners, with a potential knock-on impact on improved prisoner nutritional intake and overall health as a result.

Mobile home-care services have been trialled for former prisoners, in order to support those with Tuberculosis (TB). This involves other former prisoners acting as trained focal persons and administering treatment. The big advantage of this initiative is that ex-prisoners are more likely to trust somebody who has had similar experiences to them. (1)

## 2. Addressing the general population

. The paper Measuring and tackling health inequalities across Europe discusses the measurement, distribution and policy implications of one indicator of access to health care: self-reported unmet need or foregone care. It appears that, overall, people who report unmet need tend to be in worse health and with lower income. However, from a policy perspective, it is important to separate the causes of unmet need into those that are more relevant to policymakers from those that reflect individuals’ preferences and tastes, to view this indicator alongside other access measures such as health care contacts, distance to

facilities, waiting times and supply characteristics, and to examine long-term trends in reporting unmet need and health outcomes.(21)

To make use of health services, people need to mobilize knowledge and information resources, as well as language resources and practical needs such as cars, childcare, telephones and time away from work. These resources may not be equally available to all. Services that require more work to use them tend to disadvantage socially excluded groups.

There is some concern that professional decisions about people's health needs may sometimes disadvantage people because of their racial characteristics or their minority ethnicity, different genders, older people, and poorer people.

A person's suitability for treatment is constantly being negotiated and re-negotiated between themselves and the health service.

People will think of services in terms of how easy or how much hard work it is to access them. It can feel like very hard work for people who must 'navigate' the system by gathering information about what services are available and then finding practical resources to help them before they are able to access those services. Homeless people, travellers and young people especially can be unaware of where to find help.

Communities living in more deprived circumstances are ready to seek help with their health care, but ill health may be regarded as 'normal'. They may be more likely to manage their health as a series of minor and major crises rather than as something that can be maintained positively.

People who are residents of a nursing or residential home can face greater barriers to accessing mainstream and specialist services.

Health professionals' judgments about a person's health needs sometimes disadvantage people of black and minority ethnicity, different genders, older people and people living in more deprived areas

### 3. Addressing health system's structural barriers

Regional disparities in access to health care: a multilevel analysis in selected OECD countries. This paper investigates regional disparities in access to healthcare, measured by self-reported unmet medical needs. The results show that in addition to individual factors, such as age, gender, health status, or education, the characteristics of the region where people live, such as the average skill endowment or employment rate, have a significant impact on the probability of unmet medical needs. The result calls for further investigation on regional-specific factors that could be modified with targeted policies in order to reduce the probability of foregone health care. (22)

HealthEquityGuide.org is a resource with inspiring examples of how health departments have concretely advanced health equity — both internally within their departments and externally with communities and other government agencies. (12)

HEALTH PROMOTION CENTRES IN SLOVENIA: Integrating population and individual services to reduce health inequalities at community level:

PHC services together with public health services reaching out to communities has proven to be a powerful vehicle to reach vulnerable groups. • A contextualized community-based approach enables a prompt and structured response to the needs of vulnerable populations. • An integrated multidisciplinary approach requires transforming service delivery so governance, funding and competencies are aligned. Development of specific training materials and guidelines are needed. • Cross-sectoral cooperation based on a community-based approach is of crucial importance for health equity. • Assuring sustainable financing for health promotion and disease prevention is crucial. (13)

#### 4. Addressing gender inequities in access

Gender and ethnic origin are two factors that may either interact with mechanisms of social health inequalities or act as independent determinants of health inequalities.

Big Data and the Well-Being of Women and Girls: Conventional forms of data household surveys, national economic accounts, institutional records, among others struggle to capture detailed information on the lives of women and girls. The many forms of big data, from geospatial information to digital transaction logs to records of Internet activity, can help close the global gender data gap. This report profiles several big data projects that quantify the economic, social, and health status of women and girls. (27)

Gender bias and sex-based differences in health care efficiency in Polish regions: this study identifies sex-based differences in medical care efficiency and investigates the reasons for these disparities in the gender bias context. Polish medical care suffers from gender bias, which possibly makes men more responsive to medical care. The disparities in the operation of medical care in Poland should be challenged to achieve more equal access to services between sexes and possibly to gain more health from the treatment of female patient. (28)

Gender differences in health: results from SHARE, ELSA and HRS Eileen: The study examines gender differences in health at ages 50 years and older in 11 European countries, England and the USA. There is remarkable consistency in direction of gender differences in health across these 13 countries. The size of the differences is affected in many cases by the similarity in behaviours of men and women. (29)

Understanding the gender gap in antibiotic prescribing: a cross-sectional analysis of English primary care. The gender gap in antibiotic prescribing can largely be explained by consultation behaviour. (30)

Gender gaps — Life expectancy and proportion of life in poor health. The literature suggests that women report worse health but live longer than men — a phenomenon known as the gender paradox in health and mortality. Life expectancy at birth and the proportion of life

in poor health are closely related for both genders. Furthermore, the larger the female excess in longevity, the larger the female excess in the proportion of life in poor health. (31)

Gender differences in the utilization of health-care services among the older adult population of Spain. Compared to men, women report greater morbidity and make greater use of health-care services. This study examines potential determinants of gender differences in the utilization of health-care services among the elderly. (32)

## 5. Addressing social, environmental and economic barriers

Explaining the differences in income-related health inequalities across European countries. Significant inequalities in health (utility) favouring the higher income groups emerge in all countries. They are particularly high in Portugal and - to a lesser extent - in the UK and in Denmark. By contrast, relatively low health inequality is observed in the Netherlands and Germany, and in Italy, Belgium, Spain Austria and Ireland. There is a positive correlation with income inequality per se but the relationship is weaker than in previous research. Health inequality is not merely a reflection of income inequality. (24)

## 6. Access barriers to Social Services

A person with identified social care needs is defined as someone needing personal care and other practical assistance because of their age, illness, disability, pregnancy, childbirth, dependence on alcohol or drugs, or any other similar circumstances.

Challenging context.

Rural and remote areas in many countries experience more pronounced population ageing than urban areas and subsequently, have a higher share of older residents. Lower population density and more geographically dispersed populations make it more difficult and expensive to create and maintain a comprehensive service infrastructure as common in urban areas. Consequently, rural populations have less access to services and activities and their situation may aggravate further when combined with poorer socio-economic conditions. This puts rural populations at a disadvantage compared to urban ones and can be particularly problematic for older people who may face a greater risk of social isolation, reduced mobility, lack of support and health care deficits as a result of the place in which they live. To recognize and meet the needs of older persons in rural and remote areas, policies need to be flexible and sensitive to local variations in cultural and physical realities. They can best be designed and implemented at a local or regional level, and supported by higher levels of government. Strategies should be collaborative to reflect the interlinked nature of many challenges facing older people in rural areas. The following are overall strategies:

- Reducing health inequalities by providing older people with better access to health and social care services including emergency care and mental healthcare
- Joining up transport, housing, health and social care services to improve cost-effective service

provision and access to services for older people • Developing cost-effective transport solutions to afford accessibility to services and better social integration • Improving housing and local environment conditions to allow older people to 'age in place' • Developing volunteering and community-based initiatives to improve social integration of older people • Stimulating bottom-up social enterprises and collaborative ventures to improve the economic diversity and attractiveness of rural areas to encourage in-migration and further economic development.

Isolation and loneliness may not affect all older people equally. Women living alone are at higher risk to be disproportionately affected. They are more likely to be widowed in advanced old age and lack the support of a spouse. Those who are new to a community and have no local family relations may have difficulties becoming socially integrated and finding informal sources for support. This can be an even bigger struggle for older people who are in minority groups that may face high levels of discrimination in more traditional, rural areas. Other older people such as refugees and ethnic minority groups may face similar challenges. The importance of these difficulties should not be underestimated as social integration for older rural people contributes significantly to overall well-being and health. Loneliness has been shown to affect not only mental but also physical well-being with significant links to poor cardiovascular health, cognitive decline, dementia and premature death. Limited transport options and a strong sense of self-reliance that discourage social and civic participation can increase the risks of social isolation and loneliness. (33)

When planning and undertaking assessments for older people with social care needs and multiple long-term conditions, health and social care practitioners should always involve the person and, if appropriate, their carer • Many carers of older people will also need support • The health or social care practitioner leading the assessment should discuss with the person any telecare options that may support them so that they can make informed choices about their usefulness • Ensure that older people have a single, named care coordinator • Review and update care plans regularly and at least annually to recognise the changing needs associated with multiple long-term conditions • Ensure care plans are tailored to each person, giving them choice and control and recognising the inter-related nature of multiple long-term conditions • Ensure there is provision for community-based multidisciplinary support for older people with • Health and social care providers should ensure that care is person-centred and that the person is supported in a way that is respectful and promotes dignity and trust. (33)

Housing and Social Care for the Elderly in Central Europe: The main objectives of the HELPS project are to promote the development of strategies and practices: - that improve the quality of life of vulnerable people with a strategic focus on elderly and - people with disabilities; in the field of housing and social care; - and that increase the autonomy of vulnerable people by allowing them to remain in their recent or, at least, standard forms of housing for as long as possible. (34)

Volunteering as a tool to promote social inclusion in old age: volunteering can in fact be a suitable measure to reduce the risk of or prevent social exclusion. For older people exposed

to the main risk factors such as old age, health restrictions or isolation, volunteering can lead not only to involvement in activities but also to a better integration and inclusion into society. This prevents social isolation and loneliness and stimulates self-determination and a more independent outlook on life. In addition, better recognition, gaining self-esteem and having a higher feeling of belonging to society are further important outcomes. (35)

Fairness and eligibility to long-term care: An analysis of the factors driving inequality and inequity in the use of home care for older Europeans: While poorer individuals are the main users of home care services, most countries seem to under-perform with respect to the goal of reaching horizontal equity in home care service. Namely, we caution that shifting the responsibility and burden of care from the formal sector onto family and informal caregivers will preponderantly affect lower income households and disproportionately favour the rich. (36)

Reducing the harm caused by alcohol cannot be tackled independently but instead encompasses other social, situational and psychological concerns. This has implications for staff working in alcohol treatment services in terms of being sufficiently trained to help individuals manage a complex framework of issues surrounding their alcohol use and to recognise when referral onto other agencies might be required. For this population, treatment access barriers were present far sooner than might be expected, with individuals already being influenced by perceived barriers before treatment seeking intention had developed, which acted as a delay influence upon them. The iterative nature of recognition and delay influences upon the treatment pathway highlights the importance of relapse prevention and aftercare services. Most individuals who present problem drinking behaviour seem likely to have several 'lapses' before successful long-term management can be achieved. Typically, individuals access more than one episode of care and sometimes more than one agency. This suggests that minimising the impact of these is relatively vital within any care planning and emphasises the importance of inter-agency working, particularly for those with dual dependencies. (37)

Differential access to and treatment within the health system contribute to inequities in alcohol-related harm. Actions to address this include: - reducing financial, geographical and cultural barriers to accessing primary care and alcohol treatment services for groups experiencing disproportionate alcohol-related harm; -

Boosting social support and post-discharge care for people engaging in harmful alcohol consumption who are also experiencing other social disadvantages.

Consequences of harmful alcohol use are more severe for those already experiencing social exclusion. Harm reduction measures, such as safe places to sober up and community patrols can reduce inequitable consequences. (38)

The European Mental Health Action Plan 2013-2020:

Mental health services are accessible, competent and affordable, available in the community according to need

People are entitled to respectful, safe and effective treatment

Health systems provide good physical and mental health care for all

Mental health systems work in well-coordinated partnership with other sectors

Mental health governance and delivery are driven by good information and knowledge (39)

Essential Services Package for Women and Girls Subject to Violence: Key to maintaining women and girls' safety is an understanding of the gendered nature of violence against women and girls, its causes and consequences, and providing services within a culture of women's empowerment. This includes ensuring that services are women-focused, child-friendly, are non-blaming, and support women and children to consider the range of choices available to them and support their decisions.

Essential Social Services should include the following:

1. Crisis information 2. Crisis counselling 3. Help lines 4. Safe accommodations 5. Material and financial aid 6. Creation, recovery, replacement of identity documents 7. Legal and rights information, advice and representation, including in plural legal systems 8. Psychosocial support and counselling 9. Women-centred support 10. Children's services for any child affected by violence 11. Children's services for any child affected by violence 12. Community information, education and community outreach 12. Assistance towards economic independence, recovery and autonomy. (40)

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## JOINT ACTION HEALTH EQUITY EUROPE

### Work Package 8

### Improving Access to Health Care and Related Social Services for those Left Behind

#### PART III

#### Country assessment templates on:

- Phase 1: Improving access to health care and related social services for those left behind
  
- Phase 2: Suggested actions to be implemented based on assessment

Final Draft: July 30th, 2019

Prepared by: Andalusian School of Public Health (EASP)

## INTRODUCTION

The main objective of Work Package 8 (WP8) of the Joint Action on Health Equity in Europe (JAHEE) is to contribute to the goal of "leaving no one behind" in terms of access to health services and related social services in the EU and related countries.

This will be done through the formulation and implementation of regional, national and local strategies, policies and programs for reducing inequities in access to health and related social services and through building Countries' capacity to effectively advance action in this area.

To this end a consensual Policy Framework for Action on factors limiting equity in the delivery of health and related social services (building on the international recommendations, literature and Country experiences ) has been developed following a consultation in Granada, Spain, in december 2018 with participating Member States.

The PFA for WP8 gave an overview of areas in which health inequities in access to health and related social services are present. In this field, equity sometimes requires that provisions be unequal, i.e. adapted to take account of needs people may have in contrast to a 'one-size-fits-all' approach.

The PFA has taken stock of the existing knowledge on:

- a) the main dimensions of inequitable access to health and related social services in Europe;
- b) the structural barriers of the health system which trigger inequity in access to services;
- c) the interventions that have proven to be effective for mitigating the impact of social exclusion generating inequities in access to health services;
- d) the stumbling blocks for advancing policies and programs that favour the implementation of those interventions; and
- e) the change process necessary to reduce those stumbling blocks

The PFA is being translated into this tool for conducting a Country Assessment in the thirteen Countries participating in WP8 so it can help to map factors limiting equity in access to health and related social services.

This will be done through the framing of the critical issues in each participating Country resulting from the above mentioned review, at either national, regional or local level, with the ultimate goal of orienting the selection of the actions to be implemented throughout this project.

Hence the CA will provide elements and criteria for the selection of actions to be implemented and evaluated as part of the JAHEE initiative, within WP 8, which will inform the identification of best practices and the development of policy briefs for reducing inequities in access to health and related social services.

Phase 1 in this Country Assessment Template (CAT) document provides a snapshot of the situation on inequities in access to health and related social services in each participating Country. Phase 2 will serve as the basis for “choosing an action”.

Member States will review the national priorities in terms of reduction of inequities in the access to health and related social services for populations in situation of vulnerability. This will provide a repertoire of issues that warrant focused attention and further development.

The ultimate goal is to consolidate available evidence in each participating Member State on key barriers amenable to intervention hindering access to health and related social services, which will help guiding the selection of actions to be implemented as part of the JAHEE initiative.

Following the completion of the Country Assessment, participating Countries will document and evaluate the implementation of selected action(s) for the reduction of inequities in access to health and related social services in view of developing cases of good practices.

WP8 leader will assist each participating Country in selecting the most appropriate action in view of its effectiveness and proven impact: arranging dialogue/consultation via video-conference, emails, etc.; arranging peer support e.g. webinars among relevant participating Member States or finding relevant expertise; offering a template for reporting the results, either at local, regional, or national level.

At the end of the period of the Joint Action (JA) a final PFA will be consolidated, elaborated according to the lessons learned in the development of the WP8 implementation of activities and integrated in the overall PFA of the JAHEE. The framework will be shared with the governments, professionals, other stakeholders and the public in accordance with the communication strategy of the JAHEE.

## PURPOSE

The fundamental purpose of the WP8 Country Assessment (CA) is to select in each participating Country the most relevant priority in terms of reduction of inequities in the access to health and related social services for the purpose of developing a shared good case example.

The priority will be expressed either in terms of populations in situation of vulnerability which face difficulties in access to quality health services as well as in terms of access barriers than can be tackled and mitigated.

It will be important to pinpoint the key barriers amenable to interventions which hinder access to health services of the populations in vulnerable situations.

These should be specific to different population groups as well as to distinct structural access barriers of the health system in each Country and it should generate a repertoire of actionable recommendations.

The Country Assessment is aimed at reflecting on the best opportunities (entry points) for developing country specific actions (doable within the time frame and with available national resources) aimed at tackling health inequities in access to health and related social services.

The aim of the CA is to provide information that will enable partners to make an informed choice of actions the implementation of which will be monitored in the second and third years of the JAHEE initiative.

## PRINCIPLES AND RATIONALE

- The country assessments should be done using quantitative and qualitative information that is publicly available.
- It is beyond the scope of this WP to conduct any new studies or generate new research.
- The country assessment is a mapping exercise that should lead to concrete information that will inform concrete discrete activities.
- The country assessment is NOT a baseline survey at the start of a project.
- The information gathered should be the basis for the selection of actions implemented or to be implemented and monitored for the purpose of the JAHEE.
- CAs from different countries will not be used to establish comparisons among countries.

## METHODOLOGY AND STRUCTURE OF THE COUNTRY ASSESSMENT REPORT

The CA will be carried out in two phases. The steps are described below:

### Phase 1 –Completing the Country Assessment Template

Firstly, all WP8 participants, will identify the person(s) to conduct the tasks for the CA. The overall responsibility for the CA however will ultimately rest with the designated WP8 counterpart from each participant Country.

The country assessment is a mapping exercise and is meant to provide a situation analysis and main steps are as follows:

- Identify Data and Sources
- Desk review of existing data
- Analysis of the desk reviews/collated data

### Phase 2 – Selecting relevant action

In this phase, based on the salient aspects of the analysis of the information gathered in Phase 1, further in-depth assessment should be done for selecting areas for intervention describing the rationale and arguments for their selection.

The JAHEE Grant Agreement states that “the participating MSs will implement actions for reducing health inequities in the access to health and related social services and develop a case study of good practices duly evaluated.

Those countries interested in implementing the suitable best practices will receive policy and technical support from WP8 leader to do it.

Implementation of the actions will be evaluated so European-wide best practices can be suggested.

It also noted that “the WP8 leader will assists each participating Member State in choosing, focusing and setting in motion their implementation actions along the JA period by:

- arranging dialogue/consultation via videoconference, emails, etc.
- arranging peer support e.g. webinars among relevant participating Countries or finding relevant expertise.
- offering a template for reporting the results”

## CA PROCESS PLAN

## Time period    Tasks

1.     August 1st to September 15th ,2019 •     CA Technical Guidance and Template applied in each participating Country
  - CA Template finalized Phase 1 and 2
2.     September 15th to September 30<sup>th</sup>, 2019    •     Feedback from WP8 coordinator
  - Individual Country Assessments Phase 1 and 2 completed
3.     October 3rd    •     WP8 Meeting in Rome
  - Discussion of CA Phase 1 and Phase 2 in each Country
  - Discussion of final proposed actions
4.     October 3rd to October 30th •     Prepare draft CA report with recommended actions
  - Set in motion the implementation of agreed upon actions

## How to fill the template

- We applied a mode for forms and questionnaires in the templates, so don't be surprised if you can only fill in certain fields.
- In order to write on the text boxes, just click on the writing “Click here to enter text” and you will be able to type (before typing you should also delete the same writing).
- For each closed question, please tick on the appropriate slot.
- Please consider that overlaps between other WPs’ country assessment are possible. If your country is already participating in another WP please check if questions are repeated: in that case, you are free to use the same answer.



JOINT ACTION

HEALTH EQUITY EUROPE

## PHASE 1: COUNTRY ASSESSMENT

To be submitted by 15 September

### INFORMATION ABOUT COMPLETION OF THE QUESTIONNAIRE

COUNTRY/REGION: [Click here to enter text](#)

### INFORMATION ON COMPILER

Name(s) [Click here to enter text](#)

Organisation [Click here to enter text](#)

Country [Click here to enter text](#)

Describe the process used to fill in the country assessment (e.g., who has contributed to fill in the template, other agencies/departments/stakeholders have been consulted or not consulted, has there been a participatory process...)

[Click here to enter text](#)

## 1. INEQUITIES IN ACCESS TO HEALTH AND RELATED SOCIAL SERVICES IN THE COUNTRY

This section covers the available knowledge on inequities in access to health and related social services in the country. Please provide a descriptive answer to each question:

- What is the situation of unmet medical needs in your country as of 2017?
- Is there a gradient of unmet medical needs in your country by socioeconomic status, social class, any other socioeconomic grouping, geographical location or any other factor?
- Are there indicators in the routine health information system or in any dedicated monitoring system for identifying inequities in access and related social services?
- Are there indicators available of differential access to health and related social services in the country? What do they reveal in terms of inequities?
- Are there inequities in the access to medicines, diagnostic technologies and preventive or therapeutic interventions?
- Are there inequities in access to different types of health and related social services?
  - a) On primary health care
  - b) On secondary and tertiary care
  - c) On dental services?
  - d) On physiotherapy and rehabilitation services?
  - e) On psychological support and mental health services?
  - f) On ocular health services?
  - i. On preventive and therapeutic interventions for tobacco and substance abuse?
  - ii. On geriatric services?
  - iii. On any other type of health and related social services

## 2. POPULATIONS IN SITUATION OF VULNERABILITY

This section covers populations groups that are particularly vulnerable in your country, except for migrants which fall under the responsibility of WP7.

As the WP8 PFA indicates, “vulnerability from a health systems standpoint is not referred to epidemiological risk factors of the population. It is rather referred to either conditions of certain populations that make them vulnerable to benefit from potentially available health and social services or to the provision of certain types of services that do not fully reach all the population and create processes of marginalization from the mainstream of service delivery patterns.”

Please indicate with a YES or NO whether any of the following populations in potential situation of vulnerability are a group of concern in your country. When appropriate please provide a brief explanation.

- Families who are in fragile situation (e.g. lone parents with young children), or at-risk children and families or children and families from disadvantaged backgrounds
- People who have a physical, mental or learning disability, or poor mental health,
- In-work poor,
- Older people who are in vulnerable situations,
- People in unstable housing situations (e.g. the homeless),
- Prisoners (or ex-prisoners in vulnerable situations),
- People living in rural/isolated areas in vulnerable situations,
- Long-term unemployed/inactive (not in education, training or employment),
- Survivors of domestic and intimate partner violence, among others.
- Gipsy, Roma and Traveller (include all those with a cultural tradition of, and commitment to nomadism, including those who live permanently or temporarily in settled housing). This broad definition includes individuals from different socio-cultural backgrounds including Romany (English) Gypsies, Irish Travellers, Scottish Gypsy/Travellers and Eastern European Roma communities.

- Priority population groups in situation of vulnerability– overview

Describe the priority population groups in situation of vulnerability in your country.

[click here to enter text](#)

- Rationale for considering these vulnerable population groups a priority

Describe what makes these vulnerable population groups a priority for action in your country.

[click here to enter text](#)

- Responsive intersectoral and health policies addressed to population groups in situation of vulnerability

Describe health policies/strategies in your country that address the needs of these groups.

[click here to enter text](#)

- Interventions/ action to address the needs of population groups in situation of vulnerability

Please describe actions/interventions in your country that address the needs of these groups.

[click here to enter text](#)

- Documentation/ evaluation of initiatives/interventions

Have any of the actions/ interventions been evaluated or documented

[Click here to enter text](#)

### 3. POLICIES, GOVERNANCE AND LEADERSHIP

#### CHECKLIST

#### 3.1 Policies, governance and leadership

- Please tick the options that fit with available policies for reducing inequities in access to health and related social services for those left behind in the Country.
- Where available provide links to relevant documents.

#### POLICIES, GOVERNANCE AND LEADERSHIP Comment

1.Are there policies specifically addressing the reduction of inequities in access to health and related social services in the Country. Could you please name them and describe them?  
[Click here to enter text.](#)

2. There are action plans for implementing the policies on reduction of inequities in access to health and related social services in the country [Click here to enter text](#)

3. Could you describe the main measures and/or actions from action plans on reduction of inequities in access to health and related social services in the country which have been implemented?[Click here to enter text](#)

4. Have the implemented recommendations and/or actions on reduction of inequities in access to health and related social services in the country been evaluated? [Click here to enter text](#)

5. Do the key health policies in the country encompass specific actions for addressing inequities in access to health and related social services

[Click here to enter text](#)

6. The national budget has resources specifically allocated for the reduction of inequities in access to health and related social services the country [Click here to enter text](#)

7. There are technical advisory groups/committees that advise government on the reduction of inequities in access to health and related social services the country? [Click here to enter text](#)

8. There are declarations/statements, by Government, NGOs, professional bodies or other, on the reduction of inequities in access to health and related social services the country [Click here to enter text](#)

10. The country has adopted international strategies and declarations on reduction of inequities in access to health and related social services

[Click here to enter text](#)

- Explanations and additional comments to the checklist above. As space is limited in the comments boxes please refer to the number in the table above when providing comments in the box.

[Click here to enter text](#)

3.2 Policies on the reduction of inequities in access to health and related social services in the country

- Does the reduction of inequities in access to health and related social services feature prominently in the country's general health policies in your country?

Please describe how General Health Policies refer to/include/deal with the reduction of inequities in access to health and related social services the country I.e. Please give examples.

[Click here to enter text](#)

- Exclusion in health policies in your country

Are there any population groups excluded systematically? If yes, what are the reasons?

[Click here to enter text](#)

Are there explicit policies for reducing this exclusion?

[Click here to enter text](#)

- Are there health policies specifically addressing the reduction of inequities in access to health and related social services?

Please describe any national or regional policy/strategy dealing with the reduction of inequities in access to health and related social services.

[Click here to enter text](#)

- Implementation of health policies specifically addressing the reduction of inequities in access to health and related social services in your country

Please describe other stakeholders than ministry of health involved in implementation of the strategies/policies/actions on the reduction of inequities in access to health and related social services

[Click here to enter text](#)

### 3.3 General responses to the inequities in access to health and related social services

- Which are the measures or actions that have been put in place in your Country for reducing inequities in access?

Describe the measure orations that are being implemented in the Country in response to the inequities in access to health and related social services?

[Click here to enter text](#)

- Measured impact on populations health and on access to health and related social services

Please describe how these measures/actions have made a difference to the health status of the population and to their access to health and related social services?

[Click here to enter text](#)

- Attention to inequities in access to health and related social services the country

Has societal and governmental attention to inequities in access to health and related social services in the country increased in the last five years? If yes, because of which reasons?

[Click here to enter text](#)

- Drivers of change

Has there been improvement or decline in the awareness in connection with inequities in access?

What has been the main drivers of this improvement/decline?

[Click here to enter text](#)

- The role of civil society and NGOs

Please describe the role of civil society, professional associations; lobbying organizations etc. in building/ sustaining political commitment to the reduction of inequities in access to health and related social services the country

[Click here to enter text](#)

- Governmental commitment to the reduction of inequities in access to health and related social services in the country

Has governmental political commitment to the reduction of inequities in access to health and related social services in the country evolved. Are there formal mechanisms to guarantee the gains obtained (laws, accountability frameworks, resource allocation)?

[Click here to enter text](#)

- Awareness of inequities in access to health and related social services in the public in the country?

Has the public awareness on inequities in access to health and related social services the country improved?

[Click here to enter text](#)

#### 4. ENTITLEMENTS TO HEALTH AND RELATED SOCIAL SERVICES, UNIVERSALIST ACTIONS AND TARGETED INTERVENTIONS

- Does the health system of the Country or Region contemplate a Universal approach to health coverage for all population groups?

[Click here to enter text](#)

- Are there common health entitlements for all citizens/ residents regardless of their ability to pay, of their socioeconomic position and of any other characteristic of its population group?

[Click here to enter text](#)

- Is the health system in your Country a segmented one with a differential access to health and related social services depending on coverage by social security, private insurance or governmental health services?

[Click here to enter text](#)

- Needs of specific groups generally resulting from social exclusion processes situating them at high risk and high vulnerability

Describe the needs of specific population groups resulting from social exclusion situating them at high risk of vulnerability and leading to inequities in access to health and related social services

[Click here to enter text](#)

- Measures that increase and improve the universalism of health systems

Describe the measures taken by the health sector, directed to the reduction of inequities in access to health and related social services through increasing the universalism of the system

[Click here to enter text](#)

- Targeted interventions for mitigating the vulnerability of certain population groups

Please select one example and describe the interventions in your country that may constitute concrete measures of «affirmative action» for mitigating the vulnerability of certain population groups with respect to the reach and access to the health system and the provision of health and related social services.

[Click here to enter text](#)

## 5. ACCESS TO HEALTH AND RELATED SOCIAL SERVICES

Under this heading falls health-seeking behaviour (including ‘demand-side’ barriers to accessing health care, health service utilisation, treatment adherence, and ‘health literacy’). Data on health service utilisation are always difficult to interpret, because they reflect the influence of at least three factors: people’s state of health, health-seeking behaviour, and the accessibility of health services.

A very useful type of outcome that could be studied is the level of unmet needs for medical services. Data on this topic is collected regularly in the survey EU-SILC.

- Access to health and related social services- overview

Describe the general population service portfolio contemplated in the national health system in terms of health and related social services.

[Click here to enter text](#)

- Access to health and related social services – out of pocket payments

Describe policies on co-payments.

Note: As Health Care Coverage varies from country to country this refers to uncovered payments that the patients must cover themselves.

[Click here to enter text](#)

- Are there different types of services with unequal access?

Click here to enter text

- Are there access barriers that are linked to the way in which services are provided?

Click here to enter text

- Are there access barriers that are linked to factors on the side of those in demand of services?

Click here to enter text

- Key barriers amenable to interventions which hinder access to health services of the populations in vulnerable situations

Please indicate if any of the following measures for overcoming barriers in access to health care and related social services are being applied in your country. Respond YES or NO and briefly explain if yes:

- Improve the level of human resource within rural populations (Policies to recruit, retain and professionally develop staff e.g. financial incentives, flexible and responsive continued professional development, development of practitioners with specialist skills).
- Aim for low staff turnover, stability to services.
- Ensure that cultural competence training includes the needs and awareness of targeted groups and is routinely provided to all staff pre- and post-qualification.
- Engage with and winning the trust of groups which have been traditionally regarded as “hard to reach”.
- Develop trust between healthcare professionals and service users, and close collaboration with communities.
- Outreach and the use of ‘ambassadors’ or ‘champions’ in the community (trust status).
- Include health mediators, who are members of the local community trained to liaise between the community, health practitioners and local health authorities.
- Mediation agencies, such as nongovernmental organizations (NGOs) and community-based organizations.

- Engage communities and individuals as the owners/holders of local knowledge and co-creating solutions.
- Build community capacities to take action on health and reduce health inequities.
- Enhance individuals' capabilities to provide advice, information and support or organize activities in their or other communities, using life experiences and social connections to reach out to others.
- Involve communities and local services working together at any stage of planning cycle, leading to more appropriate, equitable and effective services.
- Connect individuals and families to community resources, practical help, group activities and volunteering opportunities.
- Include Community health workers (CHWs) who are proven to be very effective in improving access to healthcare and health equity particularly for population groups most in need.
- Provide resources at community level to enable a wider dissemination of community-based and culturally relevant targeted interventions.
- Promote Cross-sectoral cooperation based on a community based approach.
- Provide integrated services/Multidisciplinary care and improve the coordination between social and healthcare services: one-stop shops: connect health services with social and housing services.
- Use targeted measures to improve access for specific sub-groups (sharing costs across population, etc.).
- Join up transport, housing, health and social care
- Implement outreach services for particular groups (e.g. home visits for the elderly and people who are less mobile) / Mobile home-care services
- Consider walk in clinics (more relaxed position on appointments)
- Bypass standard referral routes that require the patient to present at primary healthcare services and bring healthcare services directly to affected individuals
- Advance in reforms to service delivery (eHealth / technological solutions)
- Increase health literacy among potentially 'at risk' people
- Improve health literacy to create and/or enable population that can effectively participate in engagement activities
- Provide language services – sometimes linked to the bilingual health advocate system.

- Retain a file of contacts, details of experienced staff, for example, who speak dialects or who have community contacts.
- Provide Information about illness in forms that people can find and use readily
- Design marketing campaigns to have strong impacts on low socio- economic status groups, for instance relying more on television than on printed materials and including strongly emotional messages.
- Involve persons in their health care plan/patient centred
- Promote volunteering initiatives (to improve social integration)
- Support access to healthy lifestyle behaviours (exercise, healthy food)
- Better integrate mental health in the programmes implemented to provide healthcare to homeless people.
- Reduce exposure to risk factors such as smoking, obesity, and poor living
- Tailoring services to survivors needs: women focused, child friendly and non-blaming services.

## 6. RESPONSIVENESS OF HEALTH AND RELATED SOCIAL SERVICES

- Health services responsiveness to people's needs

Are health services responsive to the needs of people "left behind", for populations in vulnerability situations?

[Click here to enter text](#)

- Health personnel responsiveness

Please summarize the responsiveness of health personnel.

[Click here to enter text](#)

- Health information

Please summarize availability of information on inequities in access to health and related social services in your country.

[Click here to enter text](#)

Could you please identify if any of the following constitutes a barrier in your country?  
Respond YES or NO and briefly describe if yes:

- Bureaucratic difficulties for navigating the health system
- Lack of clarity on what services are covered and which ones are not
- Difficulties for obtaining appointments/ for interaction with receptionist
- Existence of cognitive barriers: Fear of negative healthcare professional attitudes and mentality due to previous bad experience
- Psychological barriers: mistrust, hopelessness, feeling worthless/unwelcome, depression, fear and anxiety.
- Feeling of social isolation and loneliness
- Difficulties for understanding health information
- Cultural misunderstandings
- Language and communication barriers)
- Low level of health literacy
- Long waiting lists
- Inability to take time off work for medical appointments
- No availability of pharmacy/source of medication
- Lacking transport for reaching health facilities

PHASE 2: MAIN CONCLUSIONS OF PHASE 1, AND SELECTION OF ACTIONS IMPLEMENTED OR TO BE IMPLEMENTED IN THE COUNTRY TO REDUCE INEQUITIES IN ACCESS, WHICH WILL BE DOCUMENTED AND WILL HAVE THE POTENTIAL OF BECOMING BESTPRACTICES

To be completed by September 15th

The commitment of JAHEE in each work package is to implement a feasible ('easy') action and if possible set the foundation for a complex challenge, either at local, regional, or national level, and to identify mechanisms linking these levels, taking into account the possibilities and interests in each Country

Each Country will have to select a feasible and a complex action which will be implemented, documented and evaluated over the period of the JAHEE initiative (fall-2019 to summer-2021)

To do so, Countries will have to:

1. Define the nature of the action that will be implemented.

What specifically will be done, documented and systematized.?

What exactly will entail the distinct intervention which will be implemented and documented?

2. Define the target population of the action that will be implemented.

How will it be defined?

Will it be done at national, regional or local level?

3. What is the Theory of Change of the Action to be Implemented?

How is it envisioned that the intervention proposed will modify existing inequities?

Can changes be observed over the period of the project?

4. How will the evaluation of the implemented action will be done?

Does it meet a criterion of evaluability?

How will the baseline be defined?

Which kind of outcomes or intermediate outcomes will be used to evaluate the effectiveness of the action?

5. Which indicators will be used to assess the effectiveness of the implemented action?

Are they reliable?

Are they being collected routinely, or will there be an ad-hoc data collection as part of the JAHEE initiative?

The central question that it should be borne in mind when addressing this section is: What is the rationale for having selected the action being implemented or to be implemented so it can become a best practice that can be shared at European level?

- Main conclusions derived from the Phase 1 of the Country Assessment

[Click here to enter text](#)

- Explain in detail, following the previous five points, the actions to be implemented and or being implemented that will be selected and documented and the potential to be best practices addressing policy practice gaps in the reduction of inequities in access

[Click here to enter text](#)

- Explain the rationale for suggested feasible and complex actions and why they constitute a good example of the approach currently undertaken by the Country

[Click here to enter text](#)



JOINT ACTION

HEALTH EQUITY EUROPE

Suggested action promoting equity in access to health and related social services for those left behind

Name of feasible action [Click here to enter text](#)

Brief description

[Click here to enter text](#)

Implementation level

National

Regional

Local

Other [Click here to enter text](#)

Approach

Comprehensive cross government strategy

Isolated cross government action

Comprehensive institutional strategy

Isolated institutional action



JOINT ACTION

HEALTH EQUITY EUROPE

Suggested action promoting equity in access to health and related social services for those left behind

Name of complex action      [Click here to enter text](#)

Brief description

[Click here to enter text](#)

Implementation level

0      National

0      Regional

0      Local

0      Other [Click here to enter text](#)

Approach

0      Comprehensive cross government strategy

0      Isolated cross government action

0      Comprehensive institutional strategy

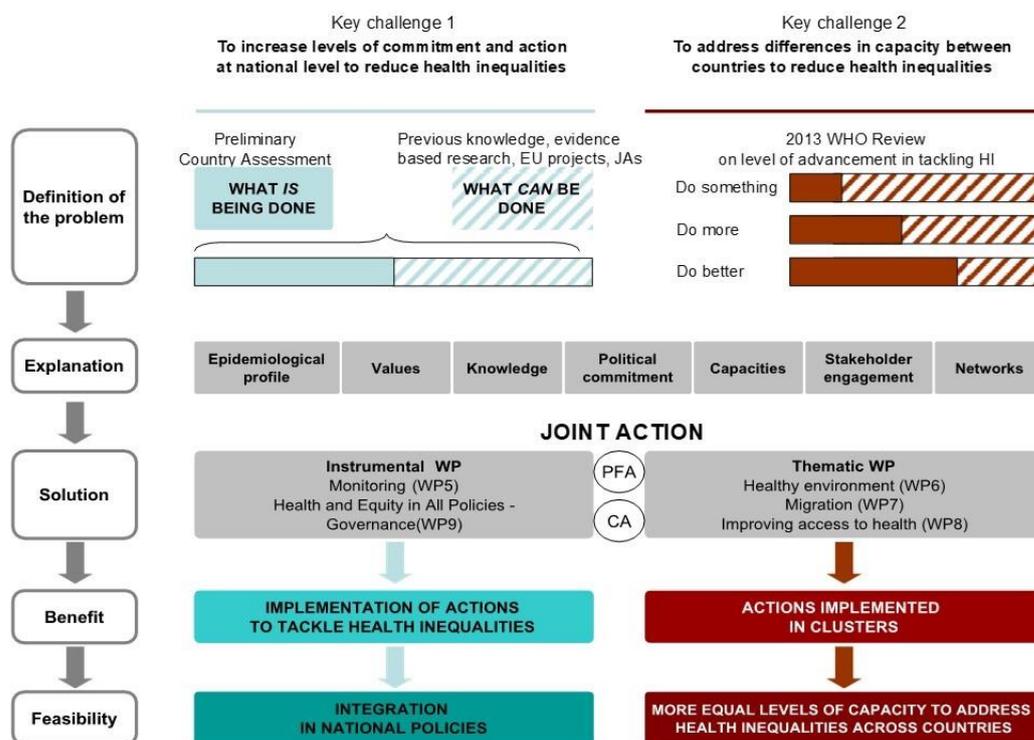
0      Isolated institutional action

## SOURCES AND REFERENCES

List the sources consulted and include the relevant references

APPENDIX 1

Explanatory framework (theory of change) underlying JAHEE



For any further information on JAHEE <https://jahee.iss.it/>