

Moving Forward Equity

A PROPOSAL OF POLICIES AND INTERVENTIONS TO REDUCE SOCIAL INEQUALITIES IN HEALTH IN SPAIN

Commission on the Reduction of Social Inequalities in Health in Spain

Commissioned by:

Directorate General for Public Health and Foreign Health

Ministry of Health, Social Policy and Equality



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Prologue to the English edition

Reducing Health Inequalities has been a national priority for Spain since 2008. In November of that year, a Commission on the reduction of Social Inequalities in Health in Spain was set, composed of eighteen national experts and chaired by Carme Borrell- Director of the Public Health Observatory, Public Health Agency of Barcelona -.

This document contains a proposal of 166 specific recommendations to reduce health inequalities in Spain (in short, mid and long term), drawn up by the Commission on the reduction of Social Inequalities in Health in Spain; and it was launched in May 2010. Of all these recommendations, the Commission prioritized 20 policies to be started in the Public Health field.

These 20 policies have been taken into account by the Ministry of Health, Social Policy and Equality to build up The National Strategy on Health Equity that is currently under construction in coordination with the Autonomous Communities; prioritizing nine policies organized in four strategic lines:

A. To develop Health Equity information systems to guide public policies

1. Health Equity National Monitoring Network
2. Health Impact Assessment in Public Policies
3. Report on Health Inequalities in Spain

B. To promote and develop knowledge and tools for intersectoral work: Moving forward to the concept of “Health and Equity in All Policies”

4. Creation of intersectoral bodies
5. Inclusion of specific objectives in health plans
6. Training in Health Equity for professionals of Health sector
7. Actions to raise awareness of the importance of health inequalities

C. To develop a Global Plan for Childhood and Youth Health, which protects equal opportunities for all children’s development, regardless of their parents’ conditions

8. Global Support to Childhood

C. To develop a plan for political visibility of the National Strategy on Health Equity and Social Determinants of Health

9. Political visibility Plan

This prioritisation has been approved by the Working Group on Health Promotion and the National Commission for Public Health (structures of coordination between the Ministry of Health, Social Policy and Equality and the Autonomous Communities). The Working Group on Health Promotion, under the umbrella of the Inter-territorial Council of the National Health System, is the body in charge of the development and monitoring of the Strategy. The

Autonomous Communities are presently developing the process of defining their own mid term priorities.

Regarding this, we would like to point out a main advance in the development of the National Strategy on Health Equity, which has been a training process conducted by the Ministry of Health, Social Policy and Equality in 2011, on the “Integration of a focus on Social Determinants of Health and Equity into health strategies, programmes and activities” intended for public health professionals at national and Autonomous Communities levels.

In addition, on 5th October 2011 the Spanish Parliament approved the first General Act on Public Health, in which equity and Health in All Policies are stated as general principles of public health and will be included in the forthcoming Public Health Strategy, and social determinants and inequalities in health are taken into account in the Public Health Surveillance and Information Systems. The future development of this General Act will be a key element for the implementation of the first two strategic lines of the National Strategy on Health Equity, and will support the inclusion of equity and health in the public policy arena.

We would like to extend warm thanks to all the professionals that have contributed to this document, and also to all the professionals that are facilitating the development and instrumentation of the National Strategy on Health Equity in all local, regional and national administrations and institutions.

Health Promotion Team

Ministry of Health, Social Policy and Equality

Executive summary

Social inequalities in health are unfair and avoidable differences in health between population groups defined socially, economically, demographically or geographically. A growing number of publications have described and analysed social inequalities in health in Spain on the grounds of social class, gender, ethnicity, territory and country of origin. These inequalities have an enormous impact on population health and, therefore, must be a priority for public health policies and a cross-cutting issue within health policies in our country, following the line traced by the main international organisations and several surrounding countries.

After a major process of reviewing evidence and experiences, collecting expert opinion and reaching consensus, the Commission on the Reduction of Social Inequalities in Health in Spain is presenting a total of 27 major and 166 specific recommendations, sorted by priority and divided into 5 sections, each of which deals with several areas.

The sections are as follows (with areas in parentheses):

I. Distribution of power, wealth and resources (health and equity in all policies; fair financing and public expenditure for equity; political power and participation; good global governance).

II. Living and working conditions throughout the life cycle (childhood; employment and labour; ageing).

III. Health-promoting environments (welcoming and accessible physical environments; access to decent housing; environments that promote healthy lifestyles).

IV. Health care (a health system that does not cause inequality).

V. Information, monitoring, research and teaching (information, monitoring and assessment; research; teaching).

To make progress toward equity in health by following the lines proposed in this document, it is critical to:

- Create political and technical bodies to support this priority.
- Have data and monitoring systems to study the evolution of inequality and the impact of policies.
- Promote healthcare and public health interventions that reduce inequalities.
- Establish partnerships to promote policies that reduce health inequalities that occur outside the health sector.

It is therefore necessary that, after these recommendations, commitments and responsibilities are undertaken by all stakeholders.

Foreword

In October 2008 the Directorate General of Public Health of the Ministry of Health established the Commission on the Reduction of Social Inequalities in Health in Spain, a multidisciplinary working group whose mandate was to produce a document, according to the existing knowledge, including short, medium and long-term intervention measures to reduce health inequalities in the field of public health, as well as to identify other intervention areas and institutions involved in the development of these measures. The Commission was made up of 18 experts and technical experts.

This document presents the recommendations of the Commission on strategic policies to reduce health inequalities in Spain to be launched or promoted by the different Government levels and sectors, based on a review of various documents, on discussion among the Commission members and on input from experts outside the Commission.

The complete report of the Commission includes 4 chapters that feature the situation analysis*, which have enabled the development of the recommendations, and have been the basis for the introduction of this document, in which they are briefly reviewed:

- What are health inequalities and what theoretical model do we use to understand their causes;
- Status of the situation and conspicuous examples of health inequalities and their social determinants of health in Spain.
- Main international recommendations and experiences of European countries in the development of policies to reduce health inequalities.
- Introduction of policies to reduce health inequalities in the Health Strategies of the Autonomous Communities, and some outstanding experiences of intervention within and outside the health sector that can reduce health inequalities.

Finally, it includes the recommendations of the Commission to move forward equity in health, based on actions on the political context, living and working conditions throughout the life cycle, life environments, healthcare services, and information, research and teaching.

* Available on

<http://www.mspsi.gob.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/EquidadSalud yDSS.htm>

Introduction and context

INEQUALITIES IN HEALTH: WHAT ARE THEY AND WHY DO THEY EXIST†

Social inequalities in health are unfair and avoidable differences in health between population groups defined socially, economically, demographically or geographically. These inequalities are the result of the unequal health-related opportunities and resources that people have according to their social class, gender, territory or ethnicity, resulting in poorer health among the most socially disadvantaged groups³. A vast number of scientific studies show that health inequalities are enormous, and responsible for a mortality and morbidity excess which is higher than that of the majority of known disease risk factors. Moreover, in the areas subject to study, these inequalities usually increase, for health improves faster among the most advantaged social classes^{4,5}. Scientific evidence also reveals that health inequalities can be reduced if the appropriate public social and health interventions and policies are undertaken⁶.

There are several models that explain the causes or factors that determine inequalities in health. This report will use an adaptation (Figure 1), based on the models proposed by Orielle Solar and Alec Irwin for the WHO Commission on Social Determinants of Health¹ and by Vicenç Navarro⁷. The model consists of two main elements: structural factors and intermediary factors of inequalities in health.

Structural factors are made up by the socioeconomic and political context and the social structure. The socioeconomic and political context refers to factors that significantly affect the social structure and the distribution of power and resources within the latter. It includes: a) Government in its wider sense, that is, political tradition, transparency, corruption, the power of trade unions, etc.; and b) economic and social actors, such as large corporations. Both determine the macroeconomic policies, such as fiscal or market-regulatory policies; policies and power relationships among social agents that affect labour market, and public policies that shape the welfare state: education, healthcare and social protection. In addition, this section also includes the social and cultural values that underpin policies and hierarchies.

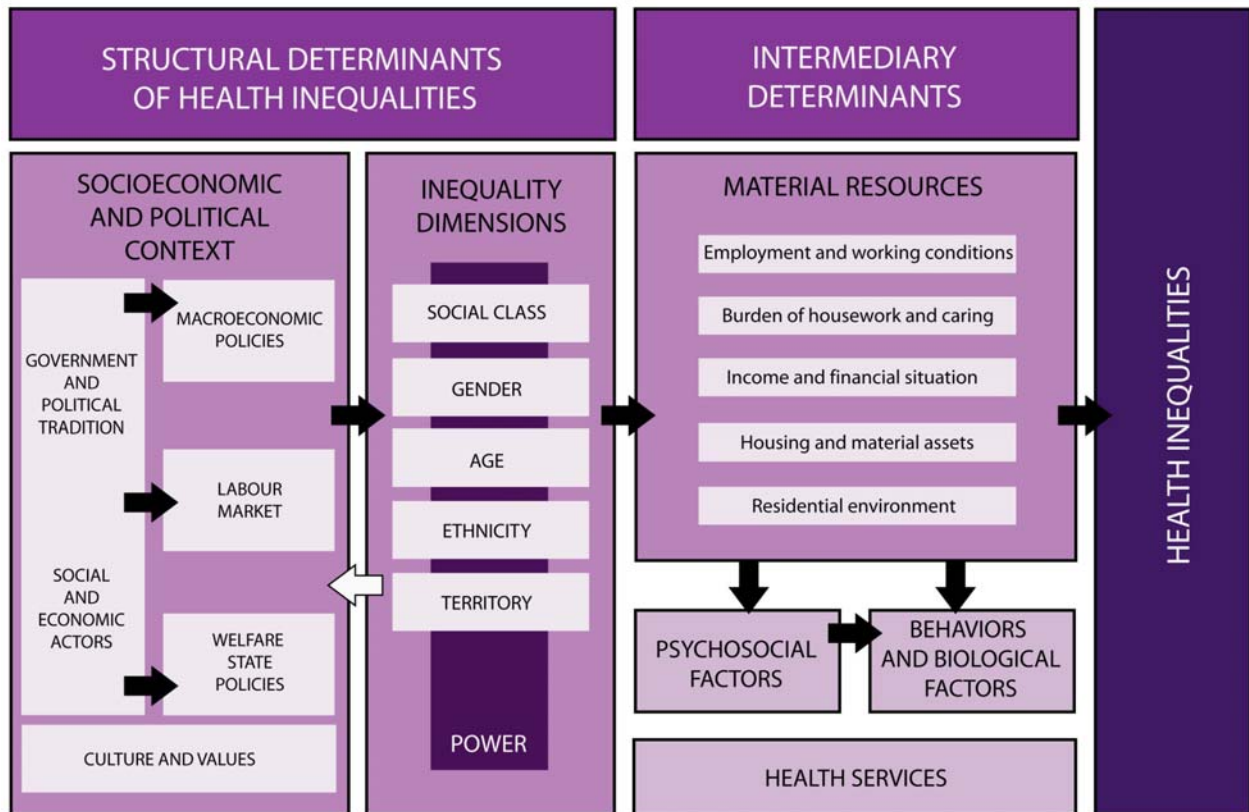
The various dimensions of inequality that determine the power hierarchies in society are social class, gender, age, ethnicity or race and territory. These dimensions define the opportunities for good health and highlight the existence of health inequalities due to power, prestige and access to resources, being the most benefited persons from privileged social classes⁸, men⁹, young and adult persons, caucasians¹⁰ and persons coming from richer geographical areas. These dimensions of inequality are related with the concept of discrimination or “unfair class, gender or race relationships based on institutional and interpersonal practices whereby members of dominant groups accrue privileges by subordinating others and justify these practices via ideologies of superiority or difference”, which are known as classism, sexism or racism¹¹.

The social structure determines inequalities in intermediary factors which, in turn, determine health inequalities. These factors include, first, material resources, namely: a) employment conditions (job situation, job insecurity) and working conditions (physical and ergonomic risks, organisation and psychosocial environment); b) burden of unpaid work (housework and care for persons); c) income level

† Based on Chapter 1 of the Report by the Commission: *Introducción: Las desigualdades en salud, marco conceptual, y principios para las políticas* (“Introduction: health inequalities, conceptual framework and principles for policies”); and on: Borrell C, Artazcoz L. *Las políticas para disminuir las desigualdades en salud* (“Policies to reduce health inequalities”). Gac Sanit. 2008; 22:465-73.

and economic and property status; d) quality of housing and its equipment; and e) neighbourhood or residence area and characteristics. Material resources affect psychosocial processes, such as the lack of control or social support and stressful situations (negative life events), and also affect behaviours that have an influence in health and in related biological processes. Finally, intermediary factors include the health system. Although health services themselves barely contribute to generating health inequalities, less access to health services and a lower quality for less advantaged groups may derive in worse outcomes of the incident health problems.

Figure 1. Conceptual framework of the determinants of social inequalities in health. Commission on the Reduction of Health Inequalities in Spain, 2010. Based on Solar and Irwin¹ and Navarro⁷.



Regarding health inequalities in relation to social class (measured by occupation) or socioeconomic position (measured by education or economic level), it can be noted that the lower the social class, the worse the health status, both expressed in terms of perceived poor health and of a mortality or morbidity excess^{12, 13}. Therefore, these inequalities not only affect a small poorer population segment, but the entire population, as illustrated in Figure 2. In addition, health inequalities continue to reproduce throughout the life cycle: the social class of the family in which we are born, the education level attained, occupation(s) and social class(es) to which we are linked in adulthood, income and property levels, are at once different ways of measuring the power hierarchy based on social origin, and of generating unequal resources and opportunities throughout life that result in health inequalities¹⁴.

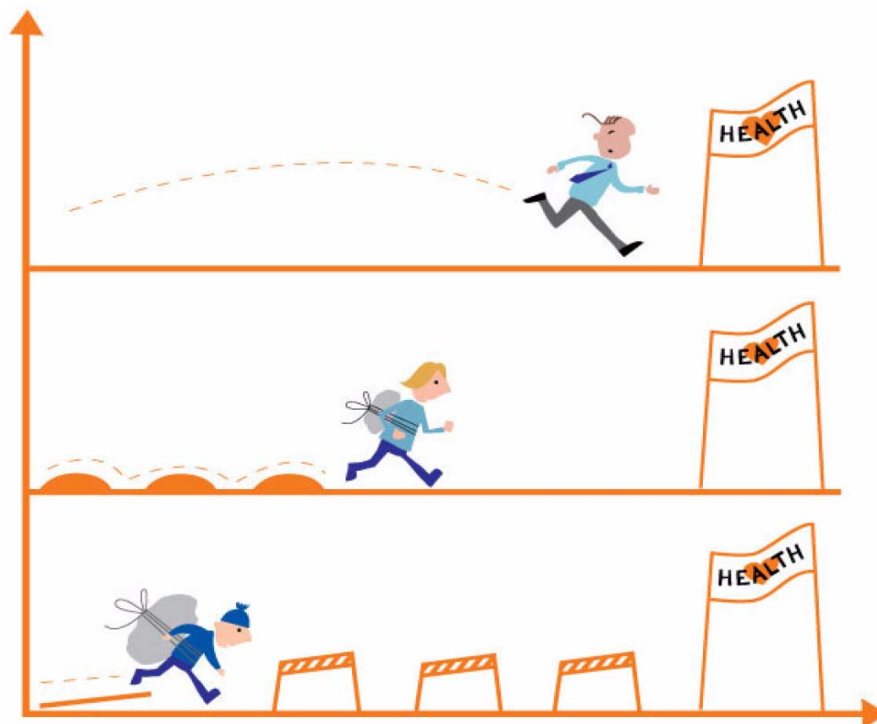
Differences in health between men and women are not only biological, but are also gender inequalities due to the social differences that exist between sexes^{9, 15, 16}. These differences are associated with the diverse socialisation of women and men, which determines various values, attitudes and behaviours, as well as power inequalities, unequal access to resources and also the deep sexual division of labour. This results in worse working conditions for women, with lower salaries and a double burden of work outside and inside the home that affects their health. But gender inequalities in health

also affect men negatively; for example, risk behaviours associated to traditional masculinity (e.g. the consumption of addictive substances or risk driving), are largely responsible for the lower life expectancy of men.

Age (beyond its biological implications), ethnicity and place of origin are other individual characteristics that, depending on the historical context of a country, gain social relevance and can determine health inequalities linked to discrimination and segregation processes. Hence, in the majority of western societies, older persons suffer the consequences of ageism¹⁷. Belonging to ethnic groups such as African Americans in the United States¹⁸, Maoris in New Zealand¹⁹, or Roma in Spain²⁰ involves undergoing processes of interpersonal and institutional discrimination, as well as social and economic exclusion with an impact on health²¹.

Apart from the characteristics of individuals, the social, cultural and economic environment has an impact on the health of the population. That is, regardless of inequalities among individuals, there are also geographical variations in health, associated with the social, economic and healthcare resources of each region. Life expectancy at birth exceeds 80 years in many countries with higher per capita income, and does not reach 50 years in the poorest countries. Moreover, within a country or even a city, child or adult mortality and disability prevalence are progressively higher in areas with lower socioeconomic status^{22,23}.

Figure 2. Health inequalities in relation to social class.



Source: Norwegian Ministry of Health and Care Services (2006). National strategy to reduce social inequalities in health. Report No. 20 (2006–2007) to the Storting.

HEALTH INEQUALITIES IN SPAIN AND THEIR DETERMINANTS[‡]

In Spain, the study of health inequalities has had little political priority. In 1994 a Commission was set to study social inequalities in health, which in 1996 published the report describing inequalities in mortality, perceived health, health-related behaviours and the use of healthcare services in Spain. This report had limited impact²⁴. Later on, several studies have revealed the existence of health inequalities and their evolution over the years^{25, 26}, and even the 2004 report of the Spanish Society of Public Health and Healthcare Management was based on this issue²⁷. Moreover, several Autonomous Communities such as Catalonia^{28, 29}, the Basque Country³⁰ and Andalusia³¹ have produced comprehensive reports on the subject.

These and other studies have displayed how socioeconomic position, gender, territory and, more recently, immigration in Spain are axes of inequality with an enormous impact on population health. For example, between the richest (Navarre and Madrid) and the poorest Autonomous Communities (Andalusia), the difference in life expectancy is 3 years (Figure 3). These differences can be even greater when comparing districts in the same city^{32, 33}.

Social inequalities between men and women and between more and less advantaged classes bring about vast inequalities in mortality and health status; for instance, 55% of women belonging to social class V (unskilled occupations) report good health status compared to 85% of men belonging to social class I (managers and professionals) (Figure 4). In addition, inequalities in some diseases or risk factors are increasing, as is the case of obesity (Figure 5). There are also inequalities by gender and social class in health-related behaviours, such as physical activity, some of them beginning in childhood (Figure 6). Although today persons coming from low-income countries present relatively favourable profiles of mortality and chronic morbidity, results in self-rated health (Figure 7) and mental health already indicate an inequality that could worsen in the future due to their unfavourable living and working conditions. Besides, the Roma population has worse health indicators than the general population, even if belonging to social class V²⁰.

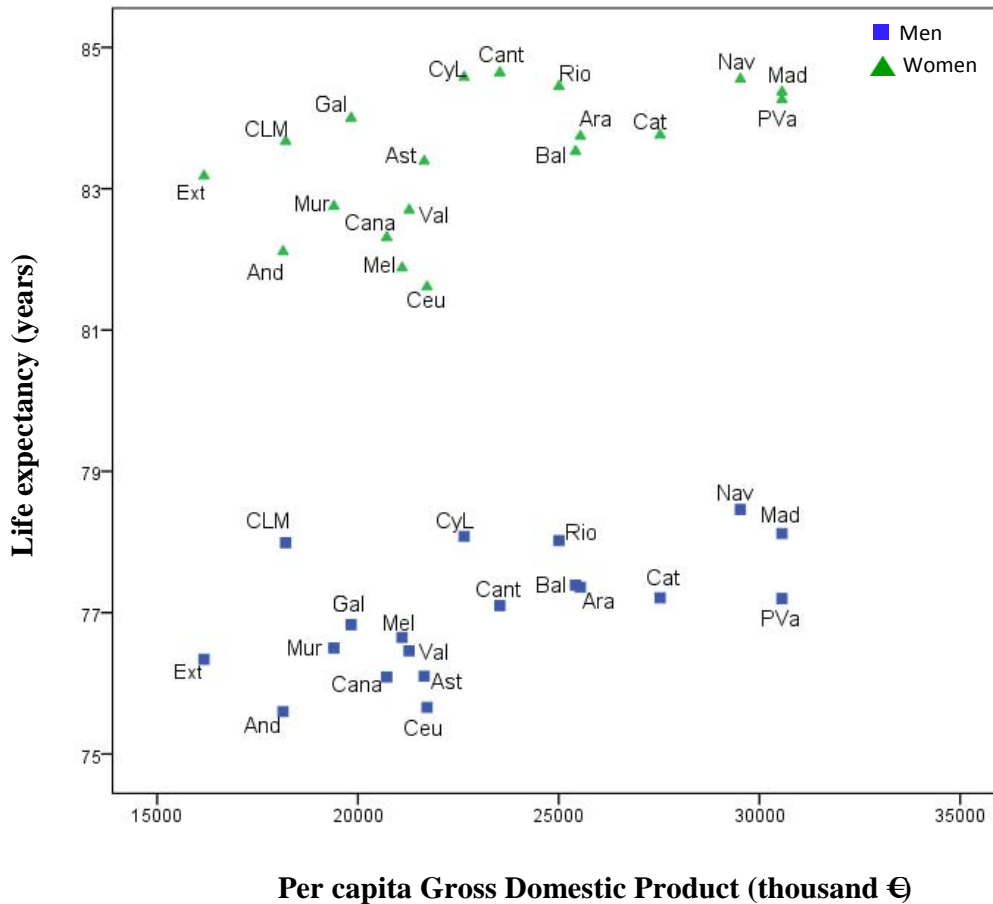
These health inequalities among social groups show and reproduce inequalities in health resources and opportunities. The most disadvantaged social classes or socioeconomic positions, women, and immigrant populations from low-income countries are more exposed to factors such as unemployment or exclusion from paid-work (Figure 8), inadequate income (Figure 9) or employment precariousness (Figure 10). The uneven distribution of roles and power between men and women also leads to different uses of time with an impact on health: the greater burden of domestic work and care prevent women from investing the same time as men in paid work and leisure activities, including physical activity (Figure 11).

In order to understand health inequalities and health-determining living conditions, it is necessary to bear in mind the economic, political and social context of the country. After the Spanish Civil War and forty years of dictatorship, and despite the social and economic progress of recent decades, indicators related to structural policies still show higher poverty and income inequality, higher unemployment and less female participation in the labour market, as well as lower public spending in healthcare and education with respect to the European Union (EU) (Table 1). Curiously, if social transfers are not taken into account, the poverty rate in Spain would be lower than the EU average – greater social transfers in the rest of the EU enable a greater reduction of poverty. Furthermore, the table shows indicators

[‡] Based on Chapter 2 of the Report by the Commission: *Los determinantes sociales de las desigualdades en salud en España* (“Social determinants of health inequalities in Spain”).

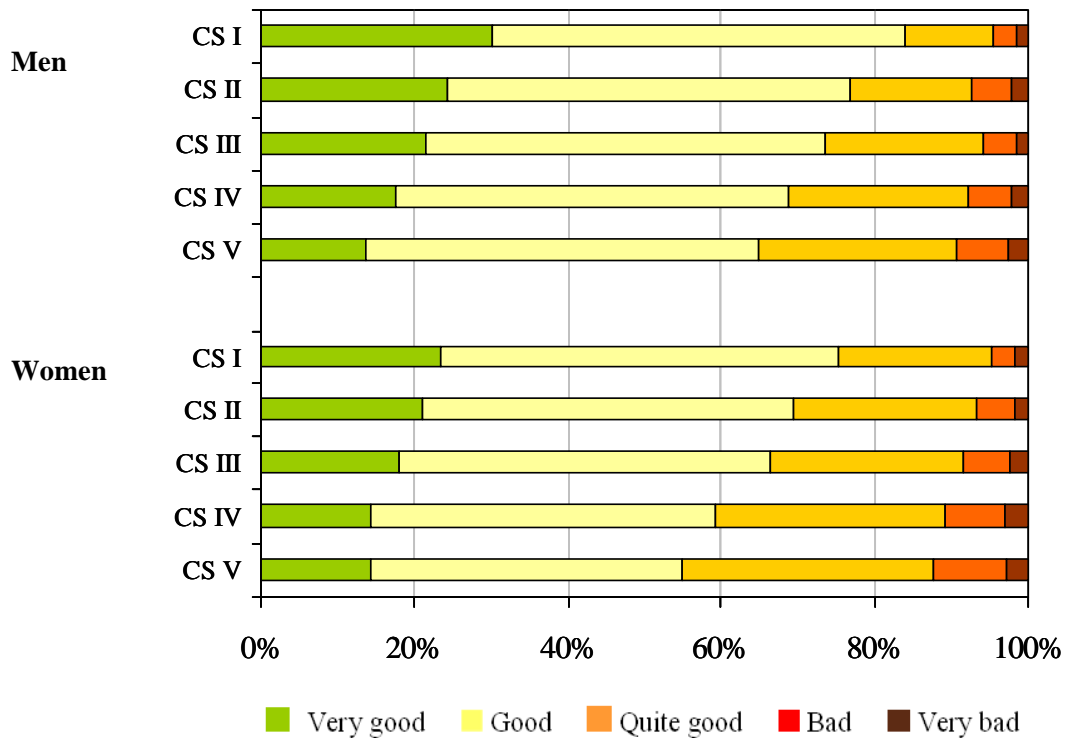
related to the housing market, which on the one hand highlight the highest proportion of house ownership in the EU-15, another structural legacy of Franco's regime³⁴ and, on the other hand, underline the growth experienced in the last decade due to family spending on house payment, which *on average* has exceeded the 30% threshold that, according to experts, cannot be considered sustainable for the household economy.

Figure 3. Life expectancy at birth for men and women according to per capita Gross Domestic Product in the Autonomous Communities. Spain, 2007.



Source: Created with data from the Spanish National Statistics Institute.

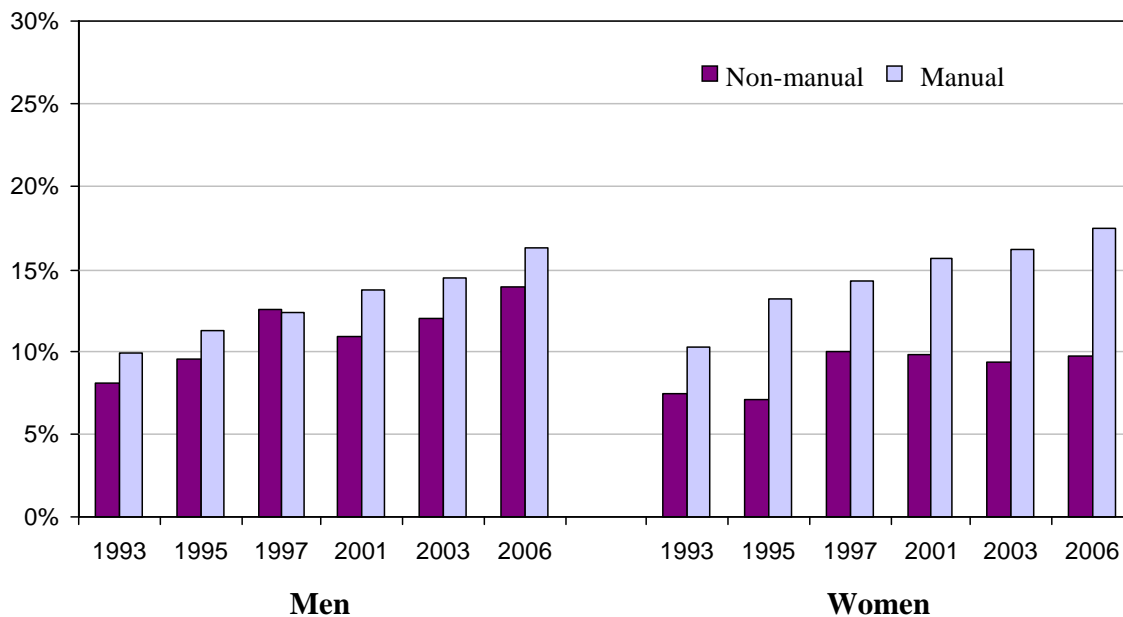
Figure 4. Distribution of perceived health status according to social class among men and women. Spain 2006. Age-standardised percentages.



CS: Social class based on occupation, the most advantaged being I (managers and professionals) and the less advantaged being V (unskilled manual jobs).

Source: Spanish National Health Survey 2006

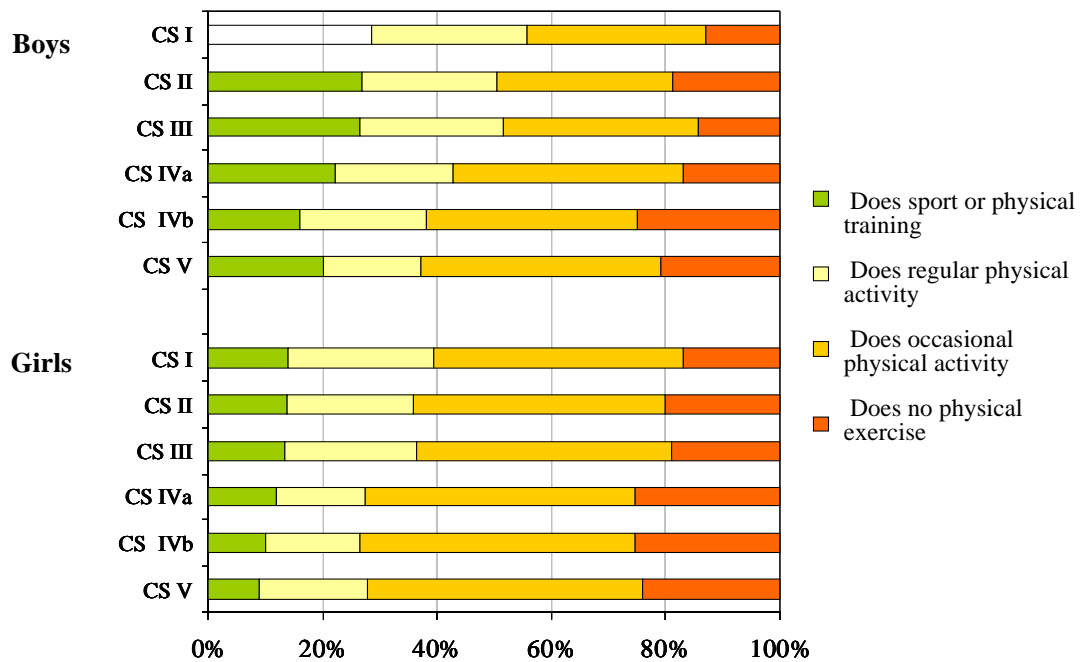
Figure 5. Evolution of the prevalence of obesity (body mass index ≥ 30) according to social class among men and women. Spain 1993-2006. Age-standardised percentages.



Social class based on occupation, grouped into 'non-manual' (classes I-III) and 'manual' (classes IV-V). Body mass index is obtained from weight and size reported by respondents.

Source: Spanish National Health Survey

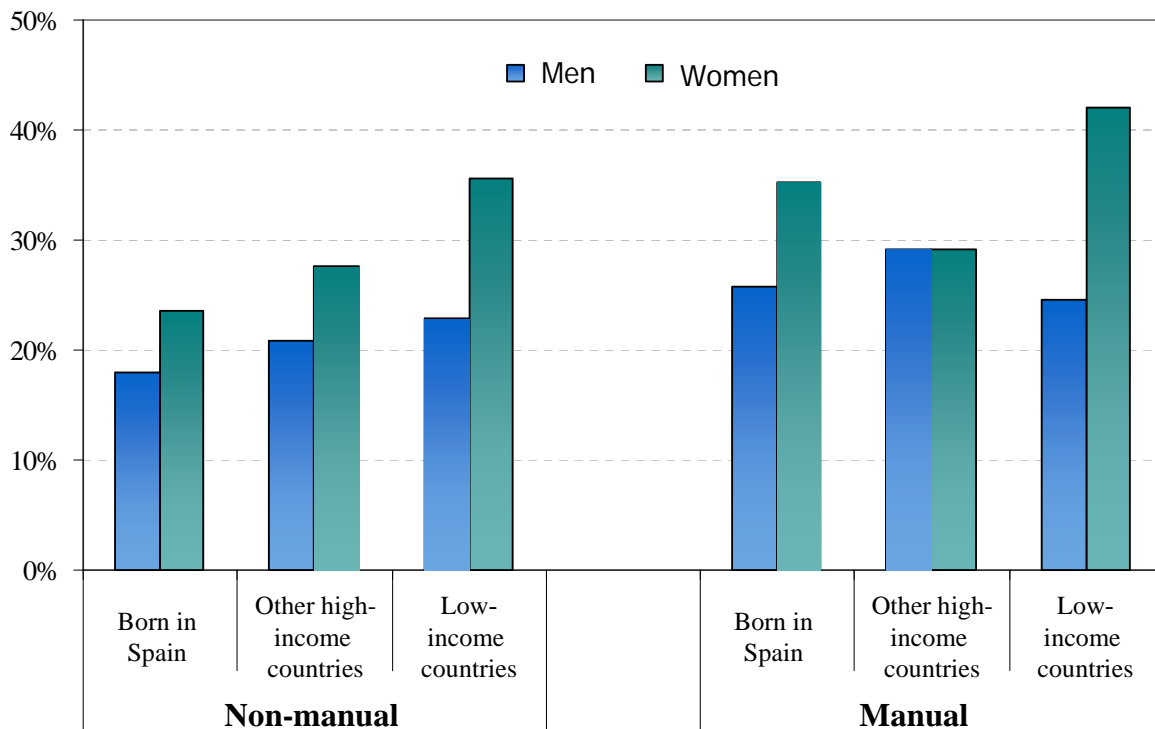
Figure 6. Type of leisure-time physical activity according to social class among children under 16. Spain 2006.



CS: Social class based on parental occupation (I: more advantaged, V: less advantaged).

Source: Spanish National Health Survey

Figure 7. Prevalence of perceived poor health according to social class and country of birth among men and women aged 16 to 64 years, Spain 2006. Age-standardised percentages.



Age-standardised percentages. High-income countries included are the EU15 countries + Norway, Switzerland, Iceland, Canada, United States, Japan, South Korea, Australia and New Zealand.

Source: Spanish National Health Survey 2006

Figure 8. Employment status according to social class among men and women (16-64 years). Spain 2006.

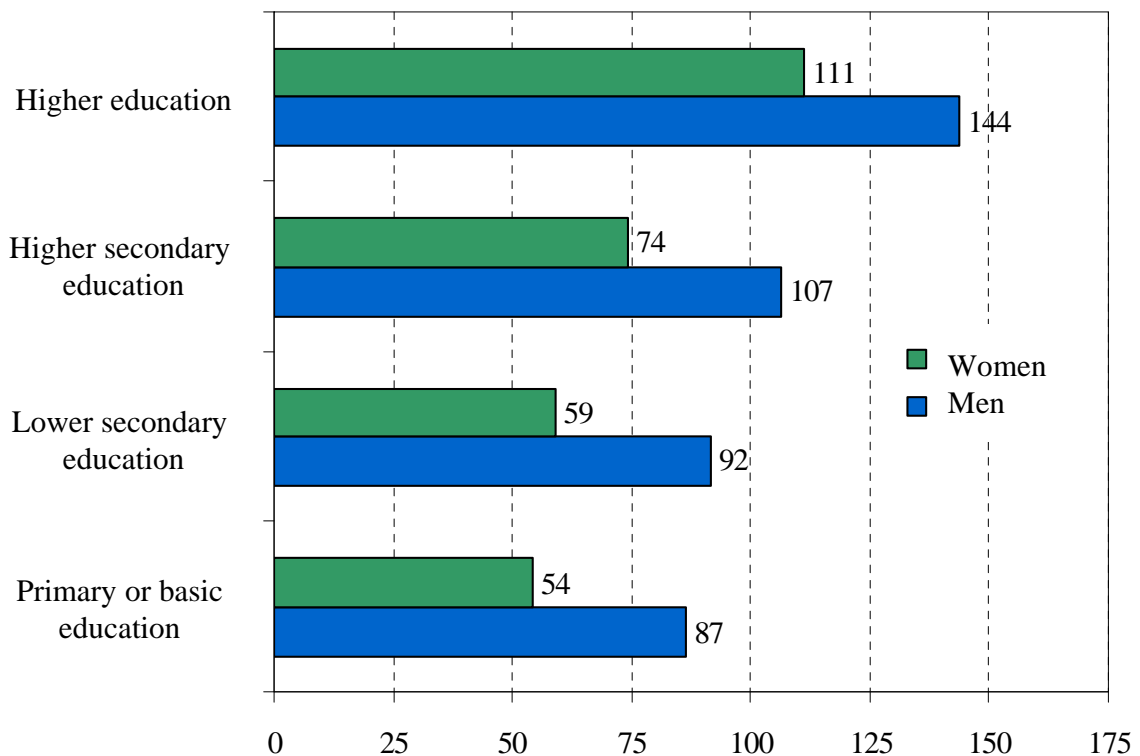


Students, retired persons and pensioners are excluded from the estimate.

CS: Social class based on occupation, the most advantaged being I and the less advantaged being V.

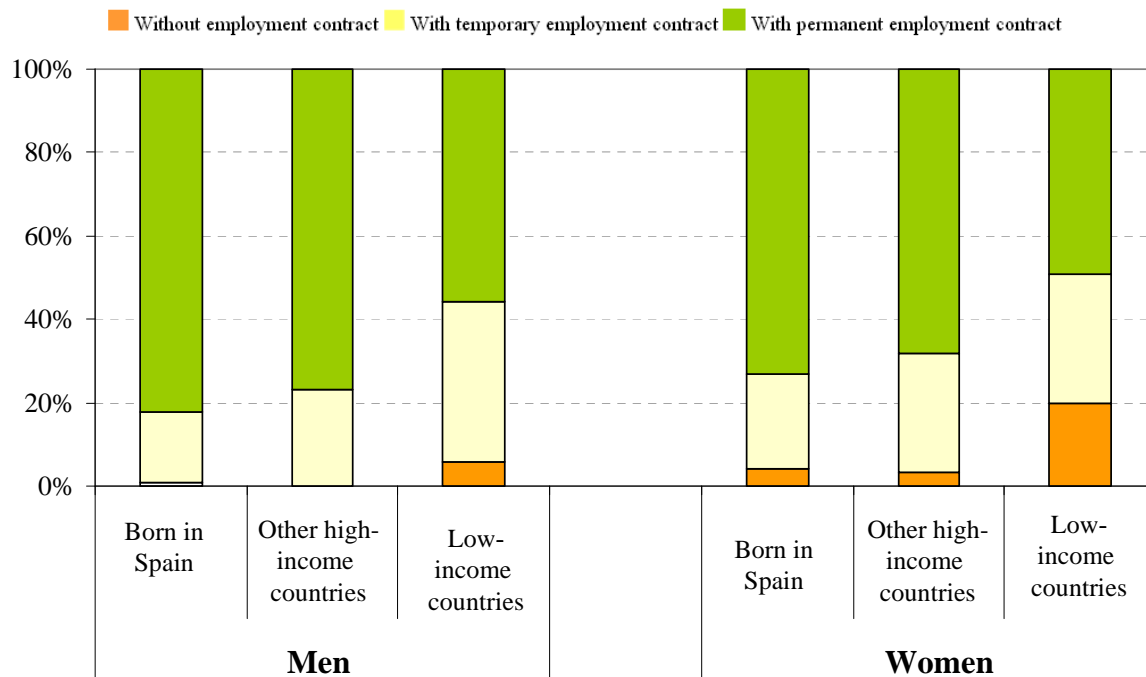
Source: Spanish National Health Survey 2006

Figure 9. Monthly salary index (average=100) according to education level among men and women. Spain 2008.



Source: Spanish Living Conditions Survey 2008

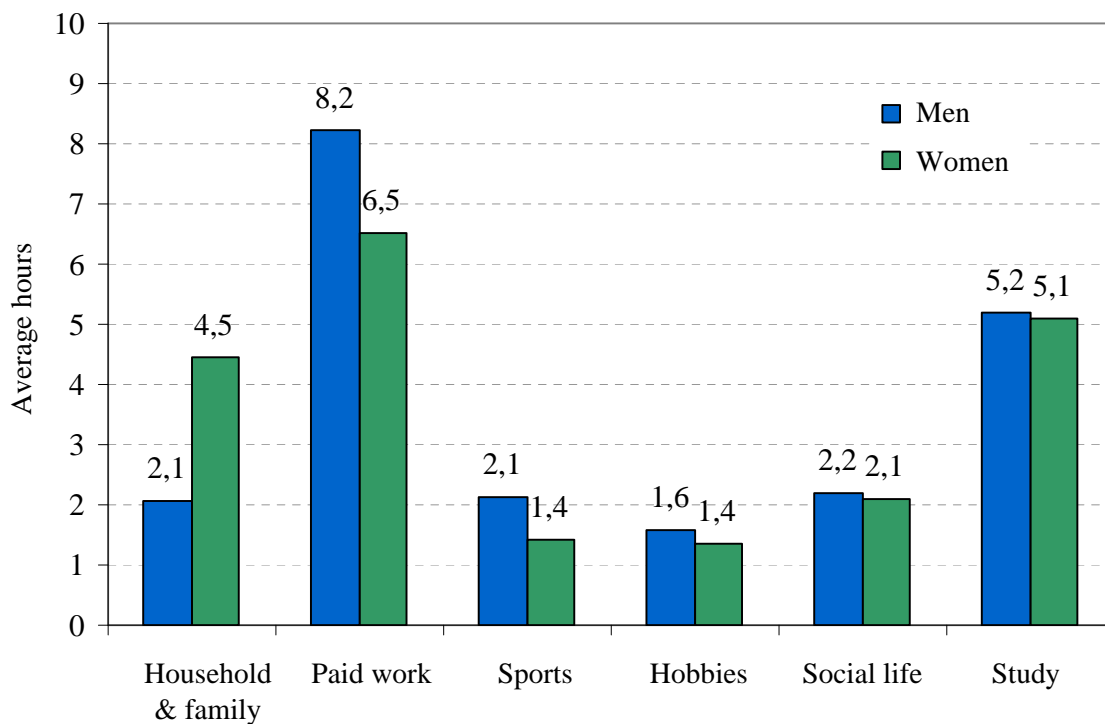
Figure 10. Types of contract among employed persons according to country of birth among men and women. Spain 2006.



Age-standardised percentages. High-income countries included are EU15 countries + Norway, Switzerland, Iceland, Canada, United States, Japan, South Korea, Australia and New Zealand.

Source: Spanish National Health Survey 2006

Figure 11. Average daily time spent on different activities (between persons carrying out the activity) among men and women. Spain 2002-2003.



Source: Spanish Time Use Survey 2002-2003

Table 1. Indicators of policies on macroeconomics, labour market and welfare state. Spain and the European Union, 15 countries and 25 countries.

Policies	Indicator	Spain	EU15	EU25
Macroeconomics	Wealth 2009 (GDP €/inhabit.)	24,200	29,700	26,800
	Income inequalities 2008			
	Gini index	31	30	30
	Richest 20% : poorest 20% income ratio	5.4	4.9	4.8
	Population at risk of poverty 2008 (%)			
	Before social transfers	24	25	25
After social transfers	20	16	16	
Labour market	Unemployment 2009 (% population 15-64 years)	18.1	9.1	9.1
	Female employment 2008 (% population 15-64 years)	54.9	60.4	59.4
Welfare state	Social expenditure on health (% GDP)	5.3	6.2	
	Social expenditure on education 2006 (% GDP)	3.8	4.1	
Housing market	% household spending on housing and energy	1994	23.5	24.7
		2005	30.3	28.4
	Population living in owned home 2006		90.0	70.7
				74.0

GDP: Gross Domestic Product
Risk of poverty: Income below 60% of national median income.

Source: Eurostat

POLICIES TO REDUCE HEALTH INEQUALITIES IN THE INTERNATIONAL CONTEXT

Reducing inequalities: an international priority

Policies to reduce health inequalities are a priority to many countries and respond to goal number 2 of the World Health Organization (WHO) Health Strategy for the 21st Century³⁵: “By the year 2020, the health gap between socioeconomic groups within countries should be reduced by at least one fourth in all Member States, by substantially improving the level of health of disadvantaged groups.”

In 2005, WHO established the Commission on Social Determinants of Health with the purpose of collecting scientific data on possible measures and interventions in favour of health equity and promoting an international movement to achieve this goal. The resulting report⁸ is structured around three basic principles of action:

- **Improving daily living conditions**, that is, the circumstances in which persons are born, grow, live, work and age.
- **Tackling the inequitable distribution of power**, money and resources, namely the structural factors on which living conditions depend at a global, national and local level.
- **Measuring the extent of the problem**, assessing the interventions, expanding the knowledge base, recruiting qualified personnel in the field of social determinants of health and raising public awareness about this issue.

Some principles for equity policies

Some of the principles to be taken into account when seeking to implement policies to reduce health inequalities are (adapted from Whitehead and Dalghren⁶):

- The reduction of inequalities should be achieved by improving the health of the population as a whole (*levelling up*). Moreover, population interventions to improve health should also focus on reducing inequalities.
- There are three approaches to reducing inequalities: focusing on improving the health of the most vulnerable groups; reducing inequalities between these and the most advantaged groups; reducing inequalities across the population, bearing in mind the social gradient at large³⁶. There is consensus on the need to use every strategy, but always giving priority to actions focused on the whole social gradient^{37, 38}.
- Interventions aimed at reducing health inequalities should necessarily be multisectoral and act on the social determinants of health inequalities. At the same time, health services should be based on equity principles.
- It is necessary to have tools to assess the extent of health inequalities and the positive and negatives effects of the interventions implemented.
- The participation of the most vulnerable population in the process of policy design and implementation should be promoted and facilitated.

- Both the analysis of health inequalities and the interventions should consider the different axes of inequality: social class, gender, age, ethnicity and territory or geographical area.

Experience in other countries[§]

Experience shows that in the European context it is possible to develop policies to reduce health inequalities, integrated into sectoral policies and programmes. In this sense, policies to reduce health inequalities have been reviewed in some European countries with interesting experiences (Finland, Sweden, Norway, England, Ireland, Denmark and Holland). The **historical background** and the **political context** help us to understand the development of policies to reduce health inequalities. A very significant milestone was the WHO Charter for action to achieve “Health for All by the Year 2000” (HFA 2000) (1977), whose adaptation for the European region included goals to reduce health inequalities among countries and among social groups within each country³⁵. This statement had a major impact on the policies of the European countries, particularly the Scandinavian countries. The international impact of the Black Report, published in 1980, should also be highlighted, which drew attention to the great weight of health inequalities in the United Kingdom. Thus, in recent decades, several European countries began to formulate goals to reduce inequalities in their health policies and specific strategies. Some countries, like Finland, have come to develop specific strategies after finding that universal policies on health improvement alone failed to reduce health inequalities.

Both the political context and consensus have determined the origin, history and evolution of these policies. Finland, Sweden and Norway have moved towards universal policies, focused on reducing the social gradient in health, which include actions on structural determinants of health, living conditions and health-related behaviours. By contrast, England and Ireland gave preference to a selective focus on least advantaged groups, with actions limited to living conditions and behaviours. These and other **general characteristics of policies** in the countries studied are summarised in Table 2. As an example of the type of policies proposed, Chart 1 gathers some outstanding actions within the strategies of each country.

The **degree of political legitimacy** of these strategies shows many variations. At one extreme, there is the case of Sweden, where health policies were adopted at the Parliament; in an intermediate manner, in other cases, such as Finland, strategies were Government resolutions; and the minimum commitment can be found in examples such as the Netherlands, whose policies are included in a Government memorandum, which essentially contains some general lines of action.

The **multisectoral perspective** is based on involving the different sectoral fields of the various public administration levels, which has also been called “Health in All Policies”. In all the countries studied there is a reference to the responsibility of other Government Departments, and in some documents, such as the English one, the commitments undertaken by each Ministry are laid out. More recently, in Scotland, seven Ministers participated directly in the preparation phase of the strategy to reduce health inequalities. Besides, all countries refer to the involvement and coordination of the different administrative levels, from the state or national to the local level. The predominance of the socioeconomic dimension in the definition of social inequalities has resulted in both gender and inequalities linked to ethnicity, age or country of origin being considered as secondary.

[§] Based on Chapter 3 of the Report by the Commission, *Las políticas para reducir las desigualdades en salud en Europa* (“Policies to Reduce Health Inequalities in Europe”). This chapter reviews the policies to reduce health inequalities of some European countries, with the purpose of showing examples of good practice that can be useful in our milieu.

As for policies related to **healthcare services**, it should be reminded that the countries studied have universal health coverage systems, in which most services are publicly funded. However, some countries have included measures to improve financial accessibility to health services, or territorial allocation of resources depending on the needs.

All countries studied include in their policies a monitoring system on the extent and trends of health inequalities and their social determinants, whether integrated into the existing systems or specific. **Monitoring, research and dissemination of the results** act as key instruments for the development and assessment of policies.

Finally, it should be noted how, after the momentum by the WHO Commission, national initiatives to reduce health inequalities rapidly sprung up worldwide. For instance, two emerging Latin American countries, such as Chile³⁹ and Brazil⁴⁰, are taking important steps forward.

Table 1. Examples of actions within strategies to reduce health inequalities of five European countries.

<p>Finland Reducing poverty through the review, clarification and simplification of the current social security system with regard to taxes, basic benefits and unemployment protection.</p> <p>Norway Changing the tax system in order to ensure a stable income level for the entire population, equal allocation of resources, environmental improvement, job creation and economic efficiency.</p> <p>Sweden Strengthening democracy, influence capacity and human rights, and combating discrimination through adequate policies on the labour market, gender equality, youth, integration and disability, as well as policies supporting popular movements and strengthening vulnerable urban areas.</p> <p>England “Sure Start”: care and development of children under 4 years and parents in disadvantaged areas via free education, home visits or maternity benefits.</p> <p>Ireland Developing a programme of actions to achieve the reduction of health inequalities through the National Anti-Poverty Strategy (improving access to basic and specialised health services).</p>
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Table 2. General characteristics of policies to reduce health inequalities

	Denmark	Finland	Norway	Sweden	Netherlands	England	Ireland
<i>Problem definition</i>	Health of disadvantaged groups	Gradient in health and disadvantaged persons	Gradient in health and disadvantaged persons	Gradient in health and excluded persons	Health of disadvantaged groups	Health in disadvantaged areas and manual workers	Health of disadvantaged groups
<i>Goals</i>							
Focus	Most disadvantaged	Gradient	Gradient	Gradient	Most disadvantaged	Health gap	Health gap
Assessed	No	Yes	No	No	Yes	Yes	Yes
<i>Actions</i>							
Coverage	Selective	Universal and selective	Universal and selective	Universal and selective	Selective	Selective	Selective
Determinants	Behaviours	Structural determinants, living conditions and behaviours	Structural determinants, living conditions and behaviours	Structural determinants, living conditions and behaviours	Behaviours	Behaviours and living conditions	Behaviours and living conditions
<i>Fields and target groups</i>	Disadvantaged groups		Disadvantaged urban areas		Disadvantaged groups	Disadvantaged areas, children and parents from disadvantaged groups	Excluded persons

POLICIES TO REDUCE HEALTH INEQUALITIES IN SPAIN: HEALTH STRATEGIES AND EXPERIENCES OF GOOD PRACTICE

Spain is one of the countries that already have evidence of the existence of socioeconomic inequalities in health, but where policies to reduce them have hardly entered the political agenda⁴¹⁻⁴³. In contrast, policies to reduce gender inequalities in health have been given more priority⁴⁴.

An analysis of the approach on inequalities in health strategies or plans that were available in the Autonomous Communities (CCAA)^{41, 44} was carried out several years ago. It was a transversal analysis, since it studied the awareness about inequalities regarding gender and socioeconomic status in health strategies at a given time. Due to the work of the Commission, plans or strategies appeared after the aforementioned publications to find out whether awareness about inequalities had increased or remained the same^e. Two axes of health inequality were analysed: gender and socioeconomic status; and two aspects: symbolic awareness (principles and values governing the strategy, analysis of the health status divided according to these axes); and operational awareness (specific proposals and measurable results in three features: actions on priority health problems, environments in which they develop and supporting objectives, such as the development of information systems, research and training).

As a general result and within the principles and values governing the health strategies or plans of the CCAA, equity and inequalities have been explicitly included, to a greater or lesser extent, as a priority and a value that should govern policies on health and healthcare services. In the CCAA in which a longitudinal analysis has been conducted, this awareness has generally increased (Table 3). The so-called operational awareness, which measures specific proposals, is normally lower than the symbolic awareness, although an increase of the proposals can be observed in the longitudinal analysis (Table 4). Health problems, which is one of the three features used to build the index, presents a greater number of proposals to reduce inequalities, compared to proposals based on environments (more structural) which, for example, do not exist in three CCAA in both periods. In addition, the proposals on gender are more numerous than the proposals referring to the socioeconomic status.

The Basque Country Health Plan showed a greater awareness about inequalities in the previous transversal analysis. The comparison of two health strategies in the new analysis proves that Catalonia and Andalusia, in this order, are the two CCAA with the greatest awareness, which also match the greater number of operational proposals, as to the rest of CCAA and to their previous health strategies.

These results support the idea that it is easier when equity is a general value or objective and we explain it this way rather than produce proposals and launch them as specific issues within health strategies. It is important to take into account that actions included in Health Strategies may not be reflecting all healthcare and public health initiatives promoted by public institutions that are implemented to reduce health inequalities and/ or are preferentially or exclusively addressed to disadvantaged groups or areas.

^e The complete work corresponds to Chapter 4 of the Report by the Commission, *Las desigualdades en los Planes de Salud de España, ¿lo mismo pero más?* ("Inequalities in Health Strategies in Spain: same but more?").

Table 3. Evolution of symbolic awareness about inequalities related to gender and socioeconomic status.

Autonomous Community Period of validity of the Health Strategy	Symbolic awareness	
	By socioeconomic status	By gender
Andalusia		
1999-2002	⊖⊖	⊖⊖
2003-2008	⊖⊖⊖	⊖⊖⊖
Aragon (1999)	⊖⊖	⊖
Balearic Islands (2003)	⊖⊖	⊖⊖
Canary Islands		
1997-2001		⊖⊖⊖
2004-2008	⊖⊖	⊖⊖
Castile-La Mancha (2001-2010)	⊖	⊖
Castile-Leon		
1998		⊖
2008-2012	⊖⊖	⊖⊖
Catalonia		
2002-2005		⊖
2006-2010	⊖⊖⊖	⊖⊖⊖
Extremadura (2001-2004)	⊖⊖⊖	
Galicia		
2002-2005		
2006-2010	⊖	⊖
La Rioja		
1998	⊖⊖	
2009-2010	⊖⊖	⊖⊖
Murcia (2003-2007)		⊖⊖
Navarre		
2001-2005		
2006-2012	⊖⊖	⊖⊖
Basque Country (2002-2010)	⊖⊖⊖	⊖⊖⊖
Valencian Community		
2001-2004	⊖⊖	⊖⊖⊖
2005-2009	⊖⊖⊖	⊖⊖⊖

The symbolic awareness index can take values from 0 to 3. "⊖" = 1 point.

Table 4. Evolution of operational awareness about inequalities related to gender and socioeconomic status.

	Awareness	Health problems		Environments		Supporting objectives	
		Gender	SES	Gender	SES	Gender	SES
Andalusia	High	↑					
	Medium			↑	↑	↑	↑
	Low	●	→	↑	↑	↑	↑
	None			●	●	●	●
Canary Islands	High						
	Medium		↓				
	Low	↓	↓	↑	↑	↑	↑
	No			●	●	●	●
Castile-Leon	High						
	Medium	↑					
	Low	●	↑	↑	↑		
	None			●	●	→	→
Catalonia	High		↑	↑	↑		
	Medium	↑	↑	↑	↑		
	Low		●	↑	↑		
	None			●	●	→	→
Valencian Comm.	High						
	Medium	↑	↑				
	Low		●			↑	↑
	None			→	→	●	●
Galicia	High	↓					
	Medium	↓					
	Low		↓			↑	↑
	None			→	→	●	●
Navarre	High						
	Medium						
	Low	↓	→				
	None			→	→	→	→

Awareness is measured according to the number of proposals included in the Strategy:

Health problems: None = 0. Low = 1-10. Medium = 11-20. High = Over 20.

Health environments and supporting goals: None = 0. Low = 1-2. Medium = 3-4. High = Over 4.

The arrow indicates the change between the first and second Health Strategy analysed. ↑ and ↓ arrows indicate that the Community remains in the same awareness range, but the number of proposals increases or decreases.

Moreover, there are many non-healthcare policies whose implementation may have contributed to reduce inequality in social health-determining factors. In general, there is a lack of accurate data on the effectiveness of these policies, and the impact of non-healthcare policies on inequalities is hardly assessed. However, the following pages provide a very limited array of experiences of different types (laws, strategies and interventions), territorial area (local, regional and national) and competences (healthcare and non-healthcare) which illustrate interesting examples of actions with a possible positive impact on the reduction of health inequalities.

Universal access to health services for the population residing in Spain. Spanish Foreign Persons Act 4/2000 et sqq.

Field of development and sectors involved: State. Ministry of Labour and Immigration and legislative chambers. Ministry of Health (National Health System) and Regional Departments of Health.

Article 12.1 of the Foreign Persons Act (OL 4/2000 and OL 2/2009) ensures that “foreign persons who are in Spain, registered in the municipal register where they habitually reside, are entitled to access healthcare on equal grounds as Spanish nationals”. This law explained how to ensure the right to care for foreign persons that was already set forth in the Spanish General Health Act (Act 14/1986, Article 1) and in the Spanish Constitution (Article 43)^f. This pledge is also an international commitment undertaken by Spain at the time of its ratification of the United Nations International Covenant on Economic, Social and Cultural Rights in 1977^g.

Access to individual universal health card allows the entire Spanish and foreign population residing in Spain, regardless of their administrative status, to access National Health System services. It is therefore a measure that prevents economic barriers to access to health services as well as administrative or discriminatory barriers to services. It is a non-stigmatising and inclusive measure because it provides access on equal grounds for all residents. Its impact can be proven thanks to research on immigrant access to health system, which shows that their level of use of services is broadly comparable to that of the general population^h.

Some of the problems encountered in implementing the provisions of this law are:

- In some municipalities, certain cases of obstacles to census-taking by the foreign population have been documented, which prevents effective access to this right and to obtaining the health cardⁱ. In any case, census-taking is defined as an obligation, regardless of the administrative status, for both the foreign person and the City Council (Art. 15 Act 7/1985 regulating the Rules of Local Government: “Anyone who lives in Spain is obliged to register in the municipal register of his/ her habitual residence” and Art. 6 Act 2/2009).
- Persons who arrive in Spain without papers or meet with difficulties to prove the use of a dwelling in the municipality may encounter complications when registering in the municipal register^j.
- Some foreign persons prefer not to register in the municipal register for fear of expulsion^k.

^f Asociación salud y familia. El derecho de los extranjeros a la protección a la salud en España (“The right of foreign persons to health protection in Spain”). February 2010. www.intermigra.info/extranjeria/archivos/ACCESO_SALUD_INMIGRANTES.pdf

^g Adopted by the UN General Assembly in its resolution 2200 A (XXI), of 16 December 1966.

^h Regidor E, Sanz B, Pascual C, Lostao L, Sánchez E, Díaz JM. La utilización de los servicios sanitarios por la población inmigrante en España (“The use of healthcare services by the foreign population in Spain”). *Gac Sanit.* 2009; 23(Supl 1): 4-11.

ⁱ “El Síndic denuncia que la diversitat de criteris dels ajuntaments en la gestió de l’empadronament d’immigrants provoca desigualtats”. www.sindic.cat/site/unitFiles/2231/524_padro%20immi%20parle.pdf

^j Médicos Sin Fronteras. Mejora en el acceso a los servicios públicos de salud de los inmigrantes indocumentados en el área sanitaria 11 de la Comunidad de Madrid (“Improving access to public health services for illegal immigrants in the health area no. 11 of the Autonomous Community of Madrid”). 2005. www.msf.es/images/InformeMadrid_tcm3-6019.pdf

^k Médicos del Mundo. “Personas inmigrantes”, en: X Informe exclusión social 2005. (“Immigrant persons, in 10th Report on Social Exclusion 2005”) pp. 9-12. www.medicosdelmundo.org/NAVG/pagina/XInformeExclusionSocial.pdf

When considering the impacts of the Act on the social determinants of health, it is important to take into account other aspects that coexist in the latter: on the one hand, the restriction of the right to free movement and establishment of legal residence and, on the other hand, the possibility to access through census-taking to other basic services such as public education and social services.

Health Impact Assessment (HIA) in the Autonomous Community of the Basque Country

Field of development and sectors involved: Autonomous and local. Promoted by the Department of Health, it involves various sectors such as Town Planning, Employment, Housing, Transport and Consumer Protection.

HIA is a useful tool to incorporate health into sectoral policies. It is defined as a combination of methods that enables the assessment of the potential effects of an intervention in the population health, and its distribution among the different groups that compose it^l. Its eminently predictive nature helps decision-making, since it provides evidence-based recommendations to minimise the negative and maximise the positive effects on health and reduce the impact on health inequalities of non-healthcare interventions^m.

In 2005, the Department of Health of the Basque Government started the development of HIA as part of the objective of reducing social inequalities in health, included in the Health Strategy 2002-2010. It aimed at responding to the need for tools to assess the impact of sectoral policies. After the publication of the first methodological guide on HIA in Spanishⁿ, its development in the regional and local governments advanced. The first experience was introducing HIA into a project of urban regeneration of a socioeconomic disadvantaged neighbourhood in Bilbao^o (2006). It was a comprehensive HIA that enabled gaining skills in the implementation of this methodology. Following this HIA, a greenway was incorporated, crossing the neighbourhood through the new park towards Caramelo mount, and a lift was installed in the civic centre, thus improving accessibility for older persons and persons with disabilities. The continuance of the momentum given by this HIA at the municipal level is included in a Comprehensive Model of Health Promotion, which in turn is part of the Strategic Plan of the Department of Health and Consumer Protection (2010-2012).

At the autonomous level, in 2007 the development and validation of a tool to screen regional policies was launched, based on the WHO model of social determinants of health^p, which would help to decide on the convenience of conducting a full HIA. The validation of the tool showed that the type of approach and interaction with non-healthcare sector agents is key to the success of the initiative. In addition, the need to train technical personnel and managers on the perspective of the social determinants of health was also identified^q. In 2010, the HIA will continue with a Consumer Protection intervention and other intervention from the Plan on Drug Addictions

The predominance of the biomedical vision in both the healthcare and non-healthcare fields, the shortage of scientific evidence on the relation between some social determinants and health, the

^l Gothenburg consensus paper, December 1999. <http://euro.who.int/document/PAE/Gothenburgpaper.pdf>

^m Mindell J, Boltong A, Forde I. A review of health impact assessment frameworks. *Public Health*. 2008;122:1177-87.

ⁿ Rueda JR. Guía para la evaluación del impacto en la salud y en el bienestar de proyectos, programas o políticas extrasanitarias. Informe nº. OSTEBA D-05-04 ("Guide for health and welfare impact assessment of non-healthcare projects, programmes and policies. Report no. OSTEBA D-05-04"). Vitoria-Gasteiz: Department of Health, Basque Government, 2005.

^o Esnaola S, Bacigalupe A, Calderón C, Zuazagoitia J, Aldasoro E. Evaluación del impacto en la salud del Plan de Reforma Integral de Uretamendi-Betolaza y Circunvalación ("Health impact assessment of the Comprehensive Reform Plan for Uretamendi-Betolaza and Ring-road"). Vitoria-Gasteiz: Department of Health and Consumer Protection, 2008.

^p Solar O, Irwin A. A conceptual framework for action on the social determinants of health. WHO, 2007.

^q Aldasoro E, Bacigalupe A, Esnaola S, et al. Screening process of regional policies in the Basque Country. 10th International Conference of HIA. 2009; Rotterdam. http://www.osasun.ejgv.euskadi.net/r52-publ01/es/contenidos/informacion/publicaciones_informes_estudio/es_pub/adjuntos/HIA09_basque_country.pdf

political disaffection existing in the youngest European democracies, the insufficient development of intersectoral work and the lack of participation and assessment culture are the main barriers identified in the development and dissemination of the HIA.

Llei de Barris (2/2004) in Catalonia. Improvement of the urban environment in neighbourhoods and towns with higher socioeconomic disadvantage.^r

Field of development and sectors involved: Autonomous and local. Department of Territorial Policy and Public Works, City Councils.

This is the first Act promoted by the left-wing coalition PSC/ERC/ICV-EUiA^s after taking office at the Generalitat de Catalunya for the first time in our democracy. From 2004 to 2009, the annual calls of the investment programme established by law have enabled funding projects in 117 neighbourhoods and municipalities, with a target population of nearly one million residents, and amounting to 1200 million Euros. This investment has been directed mainly to the improvement of public spaces and the provision of green areas (46%) and facilities, such as civic centres for older persons or sports facilities (22%).

The interventions carried out via these projects should reduce health inequalities acting on the intermediary determinants of these inequalities (see conceptual model on page 8), such as living conditions, and particularly the quality of the residential environment. It is also important to assess the mechanism of territorial income distribution when prioritising the use of public resources for works, facilities and services in the most disadvantaged areas.

Another relevant issue that should be noted is that target areas are determined not only on the basis of their precarious socioeconomic status – this fact has, in other experiences such as the French “Sensitive Urban Areas”, entailed some social and media stigmatisation; but on the basis of the quality of projects^t, submitted by the city councils in order to obtain 50% of funding. This also stimulates initiative, decision-making and assumption of responsibility at a local level and close to the needs of the neighbours.

The first assessments of outcomes for the target areas of the first call show some improvement in the social indicators studied, and a good degree of satisfaction among the population as per the quality of life in the neighbourhood according to an *ex post* survey^u.

Finally, the programme has also served as an incentive for other sectors to decide to implement specific programmes in these areas, which partially compensate the social deficit in a programme mainly devoted to urban planning, such as employment, housing and health with the programme “Salut als Barris”^v. The integration of all these programmes and the continuity of both funding and collaboration dynamics represent some of the future challenges.

^r For further information:

Departament de Política Territorial i Obres Públiques. La Llei de barris, una aposta col·lectiva per la cohesió social. www10.gencat.cat/ptop/AppJava/cat/documentacio/publicacions/territori/llei_barris.jsp

^s Partit dels Socialistes de Catalunya/ Esquerra Republicana de Catalunya/ Iniciativa per Catalunya Verds- Esquerra Unida i Alternativa

^t To access the programme funding, certain criteria must be met first, based on demographic and socioeconomic indicators, as well as related to environmental deficiencies. From that moment on, projects are accepted and prioritised from the standpoint of their quality, feasibility, adaptation to the needs, etc.

^u The average score in the index set of indicators (the greater need, the higher score) decreased in target areas from 48.37 in 2004 to 44.79 in 2008. To the question: “Do you think that life in the neighbourhood has improved in the past five years?”, 51.3% of telephone respondents answered “Yes” and 32.8% answered “No”. To the question: “Would you live outside the neighbourhood if you could?”, 14.3% answered “Yes” and 85.7% answered “No”.

^v More information on “Salut als Barris”: www.gencat.cat/salut/depsalut/html/ca/dir3484/index.html

Programa de Empleo de Cáritas Española (Cáritas Española Employment Programme)

Field of development and sectors involved: The programme is state-wide and has the participation of 64 centres of Cáritas Diocesana.

The Employment Programme at Caritas began more than 30 years ago, materialising in 1981 in the Unemployment Programme and in 1987 in the Programme on Employment and Social Economy. Its main objective is social and labour inclusion of disadvantaged groups or at risk of social exclusion. More than 70,000 persons were assisted in 2008, and more than 95,000 persons in 2009, an increase being attributable to the economic crisis and the unemployment rise. The persons assisted were mainly women (60-65%), foreign persons (60-75%), young persons between 25 and 35 years, and persons living in low socioeconomic status (75% of them having only completed primary education or less)^w. The annual economic investment amounted to over 25 million Euros, financed with public funds (local, regional, national and European, namely the European Social Fund Operational Programme to Combat Poverty) and private contributions.

The activities are part of an integrated insertion pathway, which consists of a series of measures, planned over time and individually adapted to each person that enable diagnosing their situation and establishing a process aimed at improving their degree of employability. In the first phase of **shelter and guidance**, diagnosis is carried out and a Plan of Action is developed, recognising the dignity of every person, often blurred along their pathways of exclusion and discrimination. **Training actions**, more than 890 in 2009, provide training in a job or occupation; they include pre-employment workshops that influence personal training (workshops on social and personal skills, such as assertiveness, conflict avoidance, basic rules of behaviour, self esteem, etc.), and are a key element to access and maintain a job.

The major impacts in health that can be highlighted are:

- a) During the courses and workshops, personal and social skill are gained, employability is improved, and specific training on health issues is received, as in hygiene and nutrition workshops, and in the modules on labour risk prevention applied to specific vocational training; around 16,000 persons participate in these courses annually;
- b) During the development of the training pathway, Cáritas provides a minimum income for the users in need thereof;
- c) Between 12 and 15,000 persons get a job, albeit in most cases it is a precarious job;
- d) Personalised pathways are developed for the insertion of specific groups who suffer poor health, such as drug addicts, persons living with HIV/AIDS, homeless persons and persons with mental health disorders or after-effects;
- e) The publication of the annual report represents an occasion for social awareness, and includes recommendations for the employment policies disseminated through the media, such as the repeated claim to repeal the Spanish Royal Decree that maintains domestic servants in the Special Scheme instead of the Spanish Social Security General Scheme; increasing the minimum guaranteed inter-professional wages and enhancing minimum insertion incomes.

^w Data from the 2008 and 2009 Employment Programme Annual Reports, available on: www.caritas.es.

Projecte RIU: un riu de cultures, un riu de salut Training-action of women acting as health agents in an extremely vulnerable neighbourhood.

Field of development and sectors involved: Local. Public health, healthcare services, local administration (healthcare, social services and local police), education and third sector.

The Public Health Centre of Alzira (municipality of the Valencian Community) is developing a community intervention on health promotion, accessibility and use of healthcare services in vulnerable environments called “Projecte RIU” since 2006. This intervention has been implemented too in the district of El Raval de Algemesí (Valencia) since 2008.

A group of professionals from these sectors have selected and trained 7 women from the neighbourhood through a training-action process (75 hours) including visits to health facilities. Women made a participatory analysis of the health needs of the district and developed mediation actions in four months: individual actions (70 registered actions on guidance and accompaniment to facilities); in-group actions (9 workshops on health and healthcare services with 106 participants); translation and interpreting actions; and awareness actions (3).

The intervention model is based on action on the environment, community participation and empowerment of its members, peer-to-peer education, intersectorality, methodology of participatory research-action and reduction of inequalities.

The assessment of the results is performed through qualitative methodology: 1) individual and group interviews to health agents 0, 6 and 9 months after the intervention; 2) identification of their social network and health issues in which they are mediating within 4 and 9 months; and 3) group interview to professionals within 9 months. The results are:

- Individual and in-group: there has been an empowerment of the agents (improved self-esteem, decision-making and model-for-health behaviour) and a good group atmosphere; prejudices have been deconstructed, and information and self-care have improved, as well as the adequacy of the use of primary healthcare and emergency care on the part of participants in actions.
- Social environment: the institutional network of agents has been expanded, with access to the public health centre, sexual, reproductive and pregnancy healthcare services, hospital, school, adult school, police and associations. The social network has been enhanced (from 49 to 74 persons within 4 and 9 months of the intervention), as well as spaces for dialogue and coexistence, both spontaneous (socialisation) and organised (workshops), and the quality of the relationships with professionals (acceptance and mediation).
- Healthcare services: they have come closer to the citizen, there has been progress in the recognition and awareness of diversity, and participation in community action has also increased.
- Social system: an intersectoral network of 33 professionals has been created. They expressed their doubts about the potential of the model, participating in the process, identifying positive effects and committing to support the next edition of the project.

Results have been returned to the population and sectors involved. The project remains active. For further information, please visit: www.reducirdesigualdadesensalud.org .

Plan Integral de Mejora en Salud Pública de Vallecas (Vallecas Comprehensive Public Health Improvement Plan)

Field of development and sectors involved: Local. Public health, primary healthcare, mental health, environmental health, social services, residents, associations, NGOs, local authorities, etc.

In 2000 the neighbourhood demands led to the obtainment from the Regional Administration, with the purpose of reducing the existing social inequality among the districts of Vallecas (municipality of Madrid) and the rest of the Community of Madrid, of a Special Investment and Action Plan, known as 18,000 Plan or Vallecas Plan^x, which envisaged actions by various Regional Departments. The territorial Public Health Service (Area 1) promoted the Comprehensive Vallecas Public Health Improvement Plan, developed between 2001 and 2007, which obtained a budget contribution of 1,800,000 Euros, hence contracting six technical and two administrative officers for this period.

The project was conceived in a comprehensive and coordinated manner as regards interventions, with the participation of the citizens as the main feature of the plan^y. A Coordinating Commission was created, made up of professionals from the territorial services of public health, primary healthcare, mental health, social services and the Coordinating Committee of Vallecas Residents Associations. Decisions; annual goals and actions were agreed with the resident representatives; demands were analysed and channelled; and everyone participated in local opinion fora.

Some of the interventions carried out that should be highlighted are^z:

- Research/ action study on perceived health needs. More than 450 residents and 250 professionals participated in the process. Maps to locate social and health problems were produced, and conclusions, lines of work and the respective plans of action were agreed: young persons between 12 and 16 years; older persons, environment and primary healthcare.
- Health status assessment through specific morbidity and mortality.
- Study on housing and health conditions in response to the demand of the residents in Barrio Viejo, Puente de Vallecas.
- Identification of environmental risks through a pilot study on biomarkers and a study on the presence of metals in drinking water.
- Upon local demand, the assessment of the programme on older persons of the healthcare area 1 was carried out.
- Via local Health Councils, several projects were implemented, such as the project on “volunteering to accompany older persons to medical appointments”, or the publication of the document “The prescriptions of the residents in El Pozo and Entrevías”.

In a nutshell, it has been a fascinating experience in terms of citizen participation, which allowed healthcare professionals to initiate, mobilise, lead and participate in a work conceived in a comprehensive manner. The visibility provided by professional and resident participation is adding social

^x The agreement was stated in Act 17/2000 establishing the 2001 General Budget for the Community of Madrid.

^y According to the EFQM European Excellence Model, the Comprehensive Plan was the third finalist for its Aiming at the Citizen Integral in the 5th Public Service Excellence and Quality Award of the Community of Madrid (2005).

^z A complete documentation set of the various interventions and a balance document can be found on www.madrid.org/cs/Satellite?c=CM_Actuaciones_FA&cid=1142285691985&idTema=1109266526431&language=es&pagename=ComunidadMadrid%2FEstructura&pid=1109181527641&sm=1. A technical summary of the plan can be found on: www.publicaciones-isp.org/productos/d110.pdf

credibility to the role of Public Health. However, it would be desirable that the Government commits to the continuity of the actions carried out.

Recommendations of the Commission

Recommendations are grouped into 5 major sections, adapted from the conceptual framework of the determinants of social inequalities in health presented in the introduction (Figure 1):

- Part 1. Distribution of power, wealth and resources.
- Part 2. Everyday living and working conditions throughout the life cycle.
- Part 3. Health-promoting environments.
- Part 4. Healthcare services.
- Part 5. Surveillance, research and teaching.

In each section, one or more areas of action were identified. For each area, the coordination of the Commission drafted a first proposal on interventions by adapting international proposals (see section of General documents consulted). Eight working groups of experts were created afterwards, coordinated by Commission members (one group for each of the Parts 1, 4 and 5; three groups for the three areas of Part 2: children, employment and ageing, and two for Part 3: physical environments as well as environments that promote healthy habits), who reviewed, modified and extended the first proposal.

During the second phase, the working groups prioritised recommendations. To this end, each person rated, with a maximum of 10 points, each policy according to its relevance and timeliness, and also pointed out the priority policies within their groups. Based on these ratings, recommendations were divided into maximum priority, high priority or medium priority recommendations. In addition, the main and more general recommendations in each area were established, making a total of 27.

Deadlines must be understood not as the order in which policies have to be initiated (in some cases, there may be policies already implemented in all or parts of the country, and that may need reinforcement, impetus or reorientation), but as the order of priority according to which national, regional and local governments should promote these policies.

Moreover, the Commission gave priority to the strategic policies whose development primarily involves healthcare and public health services. To this end, after having identified them within the set of recommendations of the document, each member of the Commission selected 10 of them. Policies with more than one vote were afterwards grouped into two lists sorted by priority: one list contained 20 policies aimed at public health, and other list contained 15 policies aimed at healthcare services (some policies are in both lists). These lists appear in the appendix, and are also identified in the document with a mark: "PH" in the case of public health priority policies and "HS" in the case of healthcare services.

PART I. DISTRIBUTION OF POWER, WEALTH AND RESOURCES

AREA 1. HEALTH AND EQUITY IN ALL POLICIES

MAIN RECOMMENDATION

Consolidate political commitment to intersectoral action on the determinants of social inequalities in health.

Every decision coming from the various government levels has effects on health, thus, a political agenda that seeks to have some bearing on in health inequalities requires the intervention of different sectors. Some examples are policies on financing, education, housing, employment, transport, social services and health.

It is therefore important to ensure consistency among the different government sectors and spheres. For instance, a food production policy should be consistent with the promotion of healthy eating; or a housing policy should take into account the negative effect on health associated with the promotion of free-market housing, which does not facilitate access to decent housing for the entire population. To achieve this goal, it is essential that health equity becomes a priority at the highest government and political level of a country.

The continuous awareness of society and their representatives is still necessary, through the development and dissemination of studies that display the serious unfair and avoidable health inequalities that are present in the Spanish society. However, the time to move from information to action and political commitment in order to reduce the impact on health of these social inequalities has come.

Interventions to reduce social inequalities in health through public policies require agreed and sustained action over time, which goes beyond the limits of terms of office and the corresponding programmatic statements of political parties. Therefore, a commitment is needed among the political forces to agree on long-term policies, set common minimum objectives, agree on indicators and instruments to monitor them and legitimise assessment bodies with recognised scientific-technical authority and political independence. The political and administrative structure of our society requires, as far as possible, to establish strategies, objectives and actions that cover the three administration levels.

Recommendations of the Commission.

Maximum priority

- The Spanish Ministry of Health, Social Policy and Equality should produce, on a regular basis not exceeding four years, a Report on Social Inequalities in Health in Spain, including recommendations and proposals for intervention. PH
- Create inter-ministerial bodies or commissions with adequate delegated authority and capacity to:
a) identify the current government areas and actions (public policies) with higher potential impact on social inequalities in health, b) identify and periodically propose improvement actions to reduce PH

these inequalities, and c) estimate the necessary resources to undertake them. Similar interdepartmental bodies should be created at the regional and local level.

- Create a Commission on Inequalities as part of the Spanish Inter-Territorial Council of the National Health System.

HS
PH

High priority

- The Spanish Ministry of Health, Social Policy and Equality and the corresponding health departments of the regional and local governments should promote and lead the direction of policies towards the determinants of social inequalities in health. This requires not only political will but also the availability of the necessary resources and qualified personnel to perform it.
- The Congress, Autonomous Parliaments, City Councils and other political bodies (i.e., County Councils) should assume the objective of improving health equity through action on social determinants of health and turn it into a measure of performance for state, autonomous and local governments.
- Establish mechanisms to bind Governments to be accountable to the Congress, Autonomous Parliaments and City Councils on the evolution of health equity. This requires identifying priorities, establishing short, medium and long-term objectives, and agreeing on assessment indicators.
- Create bodies to monitor and assess these indicators, with recognised authority and independence, entitled to obtain the relevant information and with enough legitimacy to tackle political pressures.

PH

AREA 2. FAIR FINANCING AND PUBLIC EXPENDITURE FOR EQUITY

MAIN RECOMMENDATION

Adopt fiscal and social expenditure policies that reduce income inequalities and poverty and encourage investment to address the social determinants of health.

Economic growth alone does not ensure an improvement on population health or a particular reduction of health inequalities. Contrarily, data show that the model of economic growth developed in recent decades has meant a significant increase of social inequalities, also in high-income countries. When economic growth largely benefits the most privileged groups, its health benefits decrease or even disappear and inequalities rise⁴⁵. Previous international crisis experiences prove that, during economic crisis, maintaining the welfare state prevents the increase in poverty and inequalities⁴⁶.

There are plenty of studies that make clear the relationship between income inequality and health: within the most developed countries, those with lower income inequality show better results across the entire population (life expectancy, mental health, obesity...), as well as lower incidence of social problems⁴⁷. Various mechanisms have been described to explain this relationship: in societies with higher income inequality a) the percentage of population experiencing poverty is higher; b) higher competitiveness and stress levels and lower social cohesion and social capital are generated; c) due to decreased power of disadvantaged sectors, investment in public services (such as healthcare or education), from which the whole population benefit, is reduced.

It is necessary to increase financing directed to actions on the social determinants of health. In Spain, public social spending, measured as a percentage of GDP or on a per-capita basis, is considerably below the EU average⁴⁸. Pension and minimum wage allocations are particularly inadequate given the need of establishing and ensuring an adequate minimum wage or income to access the basic requirements for a healthy life^{49, 50}.

Recommendations of the Commission.

Maximum priority

- Reduce income inequalities through progressive taxation, increased social spending and the strengthening of the mechanisms to prevent tax evasion and underground economy.
- Encourage investment to address social determinants of health, for instance, by increasing public social spending (on health, social and educational services, pensions and other social protection benefits, etc.) and by establishing mechanisms to allocate resources to actions on social determinants of health.
- Increase the lowest pensions, unemployment benefits and minimum guaranteed inter-professional wages to levels that overcome the threshold of poverty and enable access to basic health goods.

High priority

- Ensure access to basic health goods, such as employment, housing, food, etc.
- Enhance access to schooling by children from 0 to 3 years and streamline working hours to facilitate access to work by parents and reduce inequalities in child development.
- Enable persons with lower income to access decent housing, by both increasing the supply at affordable prices and introducing additional economic benefits for rental costs.

Medium priority

- Develop and consolidate, through minimum or basic income systems, a system ensuring minimum means for the entire population.
- Improve financing instruments at the local level to allow a more effective response to the social needs of the population.

AREA 3. POLITICAL POWER AND PARTICIPATION

MAIN RECOMMENDATION

State, Autonomous and Local Governments should ensure participation and representation of all social groups in health-related decision-making.

Health equality also depends on the power of individuals and groups to represent and defend their needs and interests with the purpose of changing the unfair distribution of resources across the society. The unequal distribution of power is related to this unfair distribution. Power is expressed in various

dimensions: a) political, which includes the rights contained in the legislation and in the policies and practices where these rights are exercised; b) economic, such as the access to the resources needed for a decent life (income, employment, housing, country, etc.); c) social, which consists of social support and solidarity; and d) cultural, such as respect for diversity of values, rules and ways of life. An emerging dimension of power is associated with access to information.

Recommendations of the Commission.

Maximum priority

- Encourage civil society participation in the development of initiatives in favour of health equity through mechanisms that facilitate decision-making and promote financial support, for example, through participatory local budgets. The implementation of participatory democracy and community action processes should be prioritised in the most socioeconomically deprived areas.

High priority

- Ensure citizen participation and representation in the design of their own environments, in decision-making on basic services, facilities, mobility, as well as in the definition and implementation of intervention programmes, service provision and assessment.
- Promote initiatives on health literacy and empowerment, as well as the effective participation of citizens and users in the healthcare system. Both policies should ensure the preferential inclusion of the most disadvantaged sectors. PH HS
- Strengthen political and legal systems to promote equal participation of all persons, such as the participation of women or population groups at risk of social exclusion.
- Progress on the establishment of mechanisms on transparency and direct monitoring of government action by the citizens, paying attention to the use of various channels that promote access for all social groups.

Medium priority

- Promote equal access to information, new communication technologies and Government information and administrative services.

AREA 4. GOOD GLOBAL GOVERNANCE

MAIN RECOMMENDATION

Adopt a proactive role to achieve international agreements with a positive impact on health equity.

The generalisation of the capitalist system has integrated many countries into a single market and has expanded market relations in health-related areas such as water, energy and healthcare. High-income countries and, within them, persons belonging to advantaged social classes, have benefited from globalisation, and this has resulted in a rise of social inequalities⁵¹. Evidence shows that trade

liberalisation has increased wage inequality, economic insecurity and the availability of unhealthy food⁵².

Governments should protect access to basic goods for health (healthy food and environment, housing, education, decent employment conditions and healthcare service), while controlling the factors that damage health. It is necessary to establish international systems where persons coming from both high-income and low-income countries have a voice and an opportunity to set up rules to achieve health equity.

Recommendations of the Commission.

Maximum priority

- Include the public health sector participation in international negotiations with the purpose of ensuring equal access to basic goods for the health of all persons and control the spread of the social determinants that are detrimental to population health.
- Increase aid to less developed countries to 0.7% of GDP and endorse external debt forgiveness.

High priority

- Promote an international legislation that advances towards universal and equal access to basic goods and services, as well as employment standards that ensure greater stability, better remuneration and more hygiene and safety.
- Include the study of public health impact in international agreements.
- Foster participatory democracy and transparency of all decisions at all government levels (national and international).

PART II. DAILY LIVING AND WORKING CONDITIONS THROUGHOUT THE LIFE CYCLE

AREA 5. CHILDHOOD

MAIN RECOMMENDATION

Provide quality education from pre-primary to secondary education, strengthening the public education system, and taking into account physical, social, emotional, cognitive and language development. Devote special efforts to integrate children in a more disadvantaged situation and experiencing difficulties to go to school, and to prevent social and ethnic segregation in the educational system.

Increase enrolment and affordability of preschools for children from 0 to 3 years, advancing towards their universalisation, and including special measures for the most disadvantaged families according to socioeconomic, geographical and social exclusion criteria.

Provide employment conditions (stability, wages) that allow reducing the economic difficulties faced by households, and adequate employment conditions (organisation, working hours, permits) for parents to have time to care for children.

Early childhood development

Living conditions in early childhood, defined as the period from the prenatal stage to the age of 8, are a sound determinant of adult living conditions. Social inequalities in early childhood predict adult health inequalities through inequalities in physical, psychological and cognitive development, as well as in educational attainment. Moreover, it has been pointed out that interventions on early childhood development have a greater effect on the most disadvantaged groups⁵³.

It has been noted that children who attend preschool (0-3 years) achieve better academic results later on⁵⁴. In fact, preschool may be the place where the special needs of some children are detected to allow intervention in early stages. On the other hand, expanding this type of resources is one the main strategies to reconcile family and professional life and to facilitate women's incorporation into the labour market (see Area 6). All these benefits turn the increase of enrolment in preschools into a major social policy to reduce health inequalities that arise in both early childhood and adulthood, and included in the strategies to reduce inequalities of all the countries analysed.

There are two adverse factors that often involve risk situations for children: income deficit⁵⁵, such as that experienced by many households with a sole breadwinner, and attention deficit, that can result from different causes, such as households in which adults work long hours, they are very stressed or have atypical working hours, or are responsible for one-parent families⁵⁶.

Recommendations of the Commission.

Maximum priority

- Increase enrolment and affordability of preschools for children from 0 to 3 years, advancing towards their universalisation, and including special measures for the most disadvantaged families according to socioeconomic, geographical and social exclusion criteria.
- Provide a quality preschool second cycle education (3-5 years) for all children, devoting special effort to include children in a more disadvantaged situation and taking into account physical, social, emotional, cognitive and language development.
- Provide working conditions (stability, wages) that allow reducing the economic difficulties faced by households, and adequate employment conditions (organisation, working hours, permits) for parents to have time to care for children.

High priority

- Promote reconciliation policies for busy parents, establishing the right to access to more flexible arrangements, reduced working hours and parental leaves without being penalised.
- Promote integration policies for mothers who have lost or left their employment.
- Introduce and promote plans and programmes on comprehensive child support that allow monitoring and accompaniment during growth, particularly for the most disadvantaged children or at risk of exclusion, allowing for collaboration among educational, social and healthcare services, implementing detection, care and early stimulation, information and training to parents, grandparents and carers, and at-home programmes, based on international experience.

PH

Medium priority

- Ensure equal access to and quality of healthcare services, beginning with pregnancy and childhood. Promote multidimensional care for pregnant women (nutrition, health education and access to adequate social and economic resources), and uphold the implementation of intervention measures with existing evidence, such as breastfeeding during the first 6 months of life, with particular emphasis on the most vulnerable women.
- Facilitate access to information and educational resources for parents, grandparents and other carers with respect to the comprehensive care needs of their children, such as primary healthcare, which can serve as an information platform on early childhood development services and programmes.
- Encourage the participation of parents and carers, as well as of children, in the design of strategies aimed at the latter, pursuant to the Convention on the Rights of the Child.

HS

Gender socialisation

Gender socialisation from an early age, learning roles according to traditional gender roles and rules that define masculinity and femininity, can have negative health consequences in adulthood, for both women and men. While traditional gender socialisation leaves women in a more disadvantaged situation in society, gender roles link traditional heterosexual masculine personality to health-risk

behaviours. Along with the need of implementing new educational models that do not perpetuate the detrimental aspects of this socialisation, and for the correspondence of these models with real social changes, it is also a priority to address power inequality between women and men in other stages of the life cycle, such as in paid work during adulthood (see Area 6).

Recommendations of the Commission.

Maximum priority

- Promote co-responsibility of parents in the care and education of children and in the division of housework, not only via educational and social but also legal measures, such as non-transferable parental leaves.

High priority

- Introduce co-education in school curricula, supporting it at all educational levels regardless of the educational delivery system (state or private).
- Design programmes paying special attention to gender inequalities and prioritise their implementation in disadvantaged areas (e.g., education and training on housework).

Medium priority

- Take measures to prevent sexist and homophobic messages in the communication media.
- Act on gender inequalities from early childhood through appropriate programmes aimed at parents and carers, thus they can understand their role in the development of self-esteem and self-confidence of children from the beginning of their lives.

The importance of education throughout childhood and adolescence

A quality education system has an enormous potential to promote health (in general) and to reduce social inequalities in health (in particular). Education is also a means for social mobility, enabling persons to improve their socioeconomic status. It can influence the size of social division, increasing social equity through income equality, social conditions and material and training resources for the population⁵⁷.

Children from disadvantaged classes tend to have lower academic performance, contributing, among other factors, to worse employment status and working conditions in adulthood, as well as lower incomes and, more generally, fewer resources and opportunities for health. Usually, children belonging to families with low socioeconomic status need extra support to have the same opportunities as other children when they begin school. It has been observed that this support increases the probability of continuing higher education levels, finding a job, having good wages and lower rates of teenage pregnancy⁵⁸.

Recommendations of the Commission.

Maximum priority

- Provide quality education, strengthening the state education system, from preschool to secondary education, taking into account physical, social, emotional, cognitive and language development.
- Take measures to provide children facing more difficulties to access school, whether for cultural, religious or economic reasons, with equal access to quality education as other children.
- Increase actions to reduce social and ethnic segregation in the educational system, between the most advantaged and the less advantaged residential areas.

High priority

- Carry out preventive and supporting actions aimed at preventing early dropout of school and formal education in disadvantaged populations.
- Improve access to and quality of psychological and educational care, as well as healthcare, for children with physical, cognitive or sensory disabilities. Reinforce the inclusiveness of the education system for children with special educational needs. HS
- Monitor the evolution of the general quality of the education system, particularly the state system, as well as of social and geographic inequalities in academic performance.

Medium priority

- Ensure that schools receive extra resources to adequately respond to the additional support needs of the most disadvantaged children.

AREA 6. EMPLOYMENT AND WORK

MAIN RECOMMENDATION

Encourage permanent contracts with decent salaries preventing inequalities in the types of contracts and retributions.

Increase public services for the care of dependent persons (children and persons with disabilities), and facilitate access mainly for persons responsible for one-parent households and with fewer resources, thus encouraging women's access to the labour market.

Promote strategies to protect labour rights in sectors with a high percentage of informal work, such as domestic service or hospitality services.

International environment promoting the reduction of health inequalities related to employment and work

Interventions to improve employment and working conditions should take into account power relations, labour markets and welfare states. A key element to consider is globalisation, causing the

movement of power over the labour market to big multinational companies and financial institutions above governments. In developed countries like Spain, this situation results in the relocation of companies, increasing insecurity among the working population, a rise in unemployment and job insecurity, and a threat to social and labour rights achieved so far.

In a context of insecurity, workers may be forced to accept hard employment conditions as greater flexibility required by the company or lower salaries. From the standpoint of inequalities, this context urges international cooperation to step up efforts in the defence of social and labour rights of all countries, focusing on policies that promote human development and reduce social inequalities.

Recommendations of the Commission.

Maximum priority

- Include health and health inequalities impact assessment in economic and labour market policies.

High priority

- Agree on universal standards on the labour market, employment protection and labour health for all countries according to the main principles of the International Labour Organisation (ILO). The fulfilment of these rules should be internationally controlled and should include sanctions.

Medium priority

- Foster the agenda for decent work (ILO) and fair employment (Emconet).

Fair and healthy employment conditions

The growing flexibility of labour contracts in favour of further economic growth has negative effects on the health of the working population and the control of their own lives⁵⁹. In Spain, job insecurity is particularly affecting women, unskilled workers, young persons and immigrant persons. Losing a job has also a negative impact on different health indicators, largely related with a loss of income. It is important to consider the fact that receiving unemployment benefits reduces and even obliterates the negative impact of job loss on mental health^{60, 61}. On the other hand, in Spain, many women work full-time as housewives, and many studies encompass the positive effect of paid work on women's health⁶².

Recommendations of the Commission.

Maximum priority

- Promote permanent contracts with decent salaries preventing inequalities in the types of contracts and retributions. Facilitate and encourage the visibility and improvement of contractual relationships.
- Foster strategies to protect labour rights in sectors with a high percentage of informal work, such as hospitality services or domestic service, for which the inclusion in the Spanish Social Security General Scheme is needed.

- Strengthen labour rights during periods of unemployment (severance pay and unemployment benefit), paying special attention to prevent the usually existing gender biases and taking into account the situation of unemployed persons facing more difficulties to access employment.
- Encourage the incorporation of women into the labour market on equal footing, by means of a comprehensive strategy that includes not only labour policy but also fiscal policy (e.g., the abolition of joint taxation in the Spanish personal income tax) and social measures (adequate funding and design of public services).
- Intensify efforts to reduce gender pay inequality, ensuring equal pay for work of equal value, and in contracts, through the design of policies that allow reducing professional segregation on grounds of gender.

High priority

- The creation of healthy and fair employment and the improvement in working organisation and conditions should become a central objective of the government policies, not subordinated to economic policies.
- Increase the resources of the Spanish Labour Inspectorate through a comprehensive strategy to combat tax evasion and underground economy.
- Promote the training of unemployed population, especially those persons facing more difficulties to access employment, such as unskilled persons, women, older persons, persons with disabilities and long-term unemployed persons.
- Increase collaboration between the Ministry of Economy, the Ministry of Labour and Immigration, and the Ministry of Health, Social Policy and Equality of Spain in order to coordinate more effective intersectoral policies and reduce health inequalities.

Fair and healthy working conditions

Exposure to occupational safety, hygiene, ergonomic and psychosocial risk factors is higher among the most disadvantaged working population⁶³. It is essential to reduce dangerous or harmful working conditions by means of effective compliance with legislation on occupational risk prevention, empowerment of workers and introduction of labour regulation in the labour market⁶⁴.

Recommendations of the Commission.

Maximum priority

- Step up compliance with labour regulation on occupational health.

High priority

- Ensure that truly effective risk assessments and prevention actions are carried out, increasing control over the companies in these areas.
- Raise awareness among healthcare professionals on the importance of the employment and working conditions as social determinants of health.

Medium priority

- Thoroughly review the current framework of the Mutual Insurance Companies for Accidents at Work and Occupational Diseases to ensure proper care for all work-related health problems, from both the viewpoint of medical care and occupational risks prevention.
- Mobilise resources, both public and from the forum of mutual insurance companies, to promote research and prevention of accidents and diseases associated with unpaid domestic and care work.

PH

Reconciling work and family life

There is still a marked gender gap in society characterised by the sexual division of labour. The problem of reconciling work and family life arises when trying to combine the two spheres traditionally separated in the classical model: family and paid work, without having completed the transition to a new model based on a balanced distribution of the roles of women and men in the family and in the household, adequate public resources for the care of dependent persons, and a new organisation of working hours and working time. The resulting work overload and role conflict have negative effects on the health of employed women, especially those belonging to the most disadvantaged classes⁶⁵. On the other hand, in periods of economic crisis and excessive household indebtedness, the traditional men's role as the major family breadwinner can expose families to greater economic vulnerability and also have negative effects on their health.

It is not only necessary to facilitate the incorporation of women into the labour market with measures promoting the reconciliation of paid work with care, but also to act on the social and political mechanisms that generate inequalities in the distribution of these works, and gender wage, position and power inequalities within paid work^{66, 67}. Access by many women to part-time jobs helps perpetuating gender inequalities in the role distribution. Besides, it has been widely proved that part-time jobs have worse working conditions, are worse paid, not only in absolute terms but in the rate per hour, limit career advancement, hinder women to occupy decision-making positions, reduce retirement pensions and in Spain are associated with job insecurity^{68, 69}.

Recommendations of the Commission.

Maximum priority

- Increase public services for the care of dependent persons (children and persons with disabilities), and facilitate access especially for persons responsible for single-parent households and with fewer resources, thus promoting women's access to the labour market. To this end, the priority is to eliminate all care benefits incompatible with paid work, increasing the provision of public services for dependent persons.
- Raise awareness on gender inequalities in the household and the family.

High priority

- Foster equitable redistribution of family and household work through measures aimed at promoting the change towards a society where breadwinners/ carers live in equality. To achieve this, an urgent change in maternity and paternity leaves is needed, so that both are equal, non-transferable and entail the same obligations.

- Discourage part-time contracts, promoting the implementation of a 35-hour maximum working week for all workers in the medium term.
- Strengthen gender equality policies, assessing their health impact and ensuring that their implementation has equal positive effects on all social classes.
- Prevent socioeconomic inequalities in leaves to take care of children and relatives and their contextual determinants.

AREA 7. AGEING

MAIN RECOMMENDATION

Guarantee minimum pensions that enable a good quality of life, considering territorial differences in the cost of living.

Speed up the cultural change in social protection services for older persons and their carers towards a universal and preventive scope, not limited to the demand, promoting the improvement and full development of the Spanish Act on the Promotion of Personal Autonomy and Care for Dependent Persons.

Increase the provision of residential facilities and home care, enabling relatives to devote the time to care that is available and desirable in each case, giving priority to the access of persons in greater social and economic need.

Improve healthcare response to dependent care with more and better rehabilitation services, social and health services and home care.

Although age is a cross-cutting axis of inequality similar to social class, gender, ethnicity or country of origin, given the scale of the problem and the existence of specific aspects, ageing is included in this road map as a separate chapter.

Ageism, characterised by prejudices against older persons and the ageing process, entails discriminatory practices and institutional policies and practices that perpetuate stereotypes about older persons⁷⁰. Discrimination or disdain, their low level of political and community influence, their frequent situation of poverty and lower diagnostic and therapeutic efforts are social variables that should be acted upon in order to reduce age-related social inequalities in health.

Social support and participation

The positive effect of participation and social support on health and well-being has been proved⁷¹. Loneliness and grief associated with the loss of the beloved are important risk factors for depression, which is the most common mental health disorder among older population⁷². As in other life stages, individualisation, loneliness and isolation increase among older persons and are an additional factor for social and health vulnerability.

Recommendations of the Commission.

Maximum priority

- Develop physical and social environments enabling active and healthy ageing, ensuring the good conditions of public road and the removal of physical barriers.

High priority

- Increase systematic and active detection of discrimination of any kind against older population on grounds of age, health or social status.
- Raise social awareness on older population and their problems and create social support networks that promote the participation of older persons, such as detection and neighbourhood support networks for older persons living alone.

Medium priority

- Promote active ageing policies in the fields of education, culture, sports and employment, designed to be especially effective for persons of lower socioeconomic status.
- Promote the participation and representation of older persons –of all social groups– in society and in political decisions.

PH

Economic security

Many older persons have low incomes and live in poor housing conditions. Older persons need economic resources to have a decent housing, with adequate temperature control systems, to travel and to participate in social activities. Economic security enables older persons to satisfy grounded needs that add quality to years, and to have independence in decision-making. Many studies state that poverty is one of the main determinants of depression in older persons, especially among women⁷³.

According to data from Eurostat, Spain is, after the United Kingdom, the EU-15 country with the highest risk of poverty among older persons (28%). It is necessary to move towards social protection levels that allow access to adequate living standards for health⁷⁴.

Recommendations of the Commission.

Maximum priority

- Guarantee minimum pensions that enable a good quality of life, considering territorial differences in the cost of living.

High priority

- Introduce corrective actions on gender biases in pension systems (i.e. compensate by number of children, etc.).
- Boost actions to adapt housing conditions to the situation of older persons, especially among the persons with fewer resources, and inform them on the corresponding benefit they can receive.

Medium priority

- Recognise the right to continue working life and to differential retirement age.

Social services and dependent care

Dependency is the major concern, cause of suffering and poor quality of life of older persons⁷⁵.

The documented inequalities by social class and gender on dependency incidence and prevalence⁷⁶, along with socioeconomic inequalities in access to private care resources and gender inequalities in the distribution of care responsibilities in the household⁷⁷, turn the increase in public funds and services for the social care of dependent persons, through advances in the implementation of the Spanish Personal Autonomy and Dependent Care Law, into an essential policy for the reduction of social inequalities in Health in Spain.

Population ageing and the growing dependency compels us to reconsider the design of a health system aimed mainly at acute care, adapting healthcare structures and care models to these situations. The current inadequacy requires population to adapt to the dynamics of the structure, and less advantaged groups have less adaptive capacity, thus taking the risk to obtain less benefit and less effective care.

Recommendations of the Commission.

Maximum priority

- Speed up the cultural change in social protection services for older persons and their carers towards a universal and preventive scope, not limited to the demand, and promote the improvement and full development of the Spanish Act on the Promotion of Personal Autonomy and Care for Dependent Persons.
- Increase the provision of residential facilities and home care, enabling relatives to devote the time to care that is available and desirable in each case, giving priority to the access of persons in greater social and economic need.
- Expand and systematise social and health home care to adapt services to the specific circumstances of the environment in which persons live.
- Improve healthcare response to dependent care with more and better rehabilitation services, social and health services and home care.

HS

High priority

- Promote strategies on emotional and operational support to carers.

Prevention of dependency and restoration of lost function

Albeit it is necessary to strengthen care facilities for dependent persons, nowadays there is enough scientific evidence to affirm that it is possible to significantly decrease the incidence, prevalence and

severity of the disease, disability and therefore dependency. Thus, interventions base on preventive, early and rehabilitation actions should hold a prominent place.

Recommendations of the Commission.

Maximum priority

- Primary care personnel should carry out comprehensive geriatric assessment to older persons with suspected fragility and/ or function loss in order to improve their clinical approach.

High priority

- Improve access to rehabilitation services and technical aid to promote the recovery of the lost function due to falls and other causes.
- Increase control of multi-medication among older persons in the primary care level, particularly among disadvantaged persons.
- Foster the development of healthcare and social psychogeriatric services, as well as those aiming at mental health promotion and prevention (cognitive stimulation workshops, grief assistance, etc).

Medium priority

- Promote hospital geriatric coverage in all areas of health, with universal access to geriatric rehabilitation units.
- Improve coordination among the different healthcare professionals that assist older persons.
- Foster knowledge to manage geriatric problems in all hospital units with more than 25% of patients aged over 70.

PART III. HEALTH-PROMOTING ENVIRONMENTS

AREA 8. WELCOMING AND ACCESSIBLE PHYSICAL ENVIRONMENTS

MAIN RECOMMENDATION

Mainstream health equity into environmental planning, using the frameworks of health impact assessment and healthy urban planning (which involve citizen participation).

Develop urban renewal plans with priorities based on socioeconomic deprivation, that take into account the proposals of the population to improve environmental quality, do not generate speculative processes and include housing inspection and renovation programmes.

Urban plans, policies and initiatives influence the health and well-being of the population. Living in an area with ensured access to basic goods, high social cohesion, designed to promote physical and psychological well-being and that protects the natural environment, is essential to health equity⁷⁸. It has also been highlighted the importance of green and leisure areas, as well as of time spent in the open air, as determinants of good health⁷⁹. The design of the living environment should allow for the needs of the population, particularly the most vulnerable groups such as older persons and persons with disabilities. Urban regeneration plans and processes have shown a positive impact on the health of the population⁸⁰.

Mobility policies can also have an impact on health inequalities, since there is international evidence of increased exposure to air pollution in poorer households and neighbourhoods^{81, 82}; and there is Spanish evidence of higher mortality from road traffic collisions in the provinces with worse socioeconomic level⁸³. Other factors such as those associated with climate change have also more negative impact on the most vulnerable groups. It has been proved that the effects of heat waves and extreme temperatures are worse among poor population groups, older persons, persons with poor health status and children⁸⁴.

Recommendations of the Commission.

Maximum priority

- Mainstream health equity into environmental planning, using the frameworks of health impact assessment and healthy urban planning (which involve citizen participation).
- Develop urban renewal plans with priorities based on socioeconomic deprivation, taking into account the proposals of the population to improve environmental quality and not generating speculative processes that end up displacing the most vulnerable resident population.
- Develop participatory local plans to improve environmental quality in neighbourhoods with higher socioeconomic deprivation.

PH

High priority

- Develop mobility policies that take special account of the different needs for journeys and use of public areas of women, working-class persons and older persons.
- Carry out actions to improve traffic-related environmental quality. National, regional and local strategies are needed, as well as the collaboration of the private sector, to improve technologies, public transport and other measures, such as levying taxes on the use of private transport.
- Promote the creation of green areas and actions to reduce air, acoustic and visual pollution, giving special priority to the most disadvantaged urban environments.
- Ensure adequate accessibility to basic goods for citizens. This includes the support and promotion of commercial establishments in close proximity (which also favour walking and social relations) and local employment, especially in disadvantaged areas. Leisure areas should be considered basic goods and it is important to ensure the efficient use of already existing facilities, such as educational centres during the weekend.

Medium priority

- Design intergovernmental national plans on climate change that mainstream the health equity impact of actions on the various areas that may be affected (agriculture, transport, energy, industry, buildings, waste).
- Increase efforts to ensure a balanced growth between urban and rural environments, with a sustained investment in rural areas, thus they become attractive places to live with stable job opportunities and adequate infrastructure (health, education, roads, public transport and services). It is important to design policies locally, test them in rural areas and encourage cooperation among municipalities, as well as to take advantage of the framework of the Spanish strategy on rural development in effect.

AREA 9. ACCESS TO DECENT HOUSING

MAIN RECOMMENDATION

Ensure access to decent and adequate housing through affordable rental policies, additional benefits, detection of abuse situations and promotion of state-subsidised housing according to criteria that ensure access for persons with fewer resources.

Access to adequate housing is a previous condition for physical and mental health. International experiences show that the interventions improving housing quality and conditioning, and lessening residential segregation can reduce health inequalities^{85, 86}.

However, in the last decade, access to housing has become a major problem due to the spectacular rise in housing prices and the subsequent indebtedness and economic problems of families in Spain, which is the European country with the highest percentage of family homeownership. This situation could have resulted in an increase in health problems related to the need to extend working hours to

meet high-cost mortgages⁸⁷, or to the economic vulnerability that forces the working population to accept harsh working conditions in a context of rising unemployment. Other effects arising from high prices with a potential impact on health have been an increase in socioeconomic and origin segregation by districts, and the delayed transition to adult life among young persons, with consequences in their social health as seen through indicators such as the decision of living in couple or having offspring. Live to pay for housing has become the material reality of many families⁸⁸, jeopardising the possibility of meeting other rights.

Recommendations of the Commission.

Maximum priority

- Promote affordable decent rental housing policies, paying special attention to the most disadvantaged classes; both increasing housing availability and introducing additional economic benefits to renting a property.
- Control housing purchasing and renting prices to prevent abusive pricing, and implement strategies to detect and act against situations of abuse by lessors: blockbusting, eviction or access discrimination.
- Promote state-subsidised housing (VPO, as per its initials in Spanish), for both sale and rent, releasing city-owned land and reviewing access criteria to ensure their use by the population with fewer resources.
- Include programmes on housing inspection and renovation in the rehabilitation plans for disadvantaged urban areas.

High priority

- Ensure access to electricity, water, sanitation, adequate air conditioning in homes that should not depend on the ability to pay, and maintain strict public control over water and energy pricing.
- Prevent socioeconomic segregation and the development of ghettos through an adequate distribution of subsidised housing in all municipalities and districts.

Medium priority

- Promote actions to ensure access-for-all buildings with lifts, ramps, appropriate signposting, handrails on stairs and rest areas with comfortable chairs.

AREA 10. ENVIRONMENTS THAT PROMOTE HEALTHY LIFESTYLES

MAIN RECOMMENDATION

Promote community plans to reduce health inequalities through the participation of citizens, social and healthcare service professionals, as well as other agents with possible health implications. These plans should develop the participatory process in all its phases, from the early stages of their design.

Foster systematic strategies to ensure safe and non-violent schools that promote healthy eating, physical activity and exercise, sexual health and prevention of drug use and traffic injuries. They should focus on structural aspects to make healthy lifestyles at the school community become the easiest option.

Promote areas in all districts where to engage in physical activity for all ages, considering the needs of the various groups and implementing, for instance, programmes directed at families to facilitate reconciliation between work and family life.

Health-related lifestyles are not simply the result of free individual decisions but are largely determined by the physical and social environment⁸⁹. For this reason, health promotion programmes should pay more attention to these structural determinants, consider gender and social class specificities and promote participation.

Physical activity during leisure time is less common among lower socioeconomic groups and women^{aa}. So far, many public health interventions aimed at increasing physical activity and exercise, such as media campaigns or primary healthcare prescriptions have focused on promoting individual behaviour changes. Nevertheless, these interventions change the behaviour of a small fraction of the population (and among the most favoured persons in greater proportion), and furthermore the change usually does not continue in the long term⁹⁰.

Quality of and access to healthy eating are also largely determined by the environment. Families who live in neighbourhoods of low socioeconomic status experience difficulties to buy healthy foods. Some barriers to accessing a healthy diet are prices⁹¹, the shortage of fruit and vegetable stores in some neighbourhoods, cooking skills and time available for cooking. Low-income populations eat fewer fruits and vegetables and childhood obesity is more frequent among families with low education levels⁹².

Social class inequalities in tobacco consumption are increasing among the youngest cohorts in Spain among both men and women^{aa}. Advertising strongly influences youth and tobacco advertisers have adopted the tactic of specifically targeting disadvantaged areas with their tobacco offers. The increase in tobacco prices is the most cost-effective population measure, and also from the equity perspective⁹³.

The prevalence of alcohol abuse is higher among men. However, health impact and the social stigma associated with alcohol consumption are higher among women. Alcohol abuse often relates to structural situations such as hard living and working conditions. Mortality directly attributable to alcohol

^{aa} See Chapter 2 of the full report, “Los determinantes sociales de las desigualdades en salud en España” (“Social determinants of health inequalities in Spain”).

is higher in poorer areas and districts⁹⁴. As in the case of tobacco, the most effective measures to reduce consumption are increasing prices⁹⁵ and limiting access.

Economic, social and cultural inequalities also give rise to inequalities in sexual and reproductive health. Inequalities are mainly clear in economic and territorial access to contraception, emergency contraception and abortion⁹⁶. Teenage pregnancy rates are higher among less educated girls, immigrants and residents in the most disadvantaged neighbourhoods and areas⁹⁷. Being a teenage mother or father reduces their educational and working opportunities and increases the risk of low birth weight and infant mortality, reduces the prevalence of breastfeeding and daughters are more likely to become teenage mothers themselves.

This chapter identifies strategic policies aimed at reducing inequalities in different environments: schools, workplaces and neighbourhoods.

Recommendations of the Commission.

Schools

Maximum priority

- Foster systematic strategies to ensure safe and non-violent schools that promote healthy eating, physical activity and exercise, sexual health and prevention of drug use and traffic injuries. They should focus on improving the physical and social structure to make healthy behaviours at the school community become the easiest option.
- Provide grants for school meals according to the needs of families.

PH

High priority

- Promote activities in school and preschool playgrounds that foster outdoor play and activity, both during school hours by increasing the number of hours of physical education hours, and during extracurricular hours.
- Supervise the quality of school meals, restricting access to unhealthy products in cafeterias and vending machines.
- Promote sexual education programmes in school curricula that allow for inequalities on gender, social class and country of origin with the purpose of ensuring equity and effectiveness.

Medium priority

- Encourage family involvement in all health promotion programmes carried out in the school environment.

Workplace

Maximum priority

- Facilitate access to work by public transport, bicycle or on foot in order to promote social and gender equity not only in physical activity, but also in access to work itself.

- Promote the reconciliation between private, family and work life, rationalise working hours and days as a key tool to generate time and encourage the adoption of healthy behaviours.

High priority

- Ensure the availability of healthy meals at affordable prices in workplaces with canteens.

Medium priority

- Promote the offer by workplace canteens or vendor machines, if any, of healthy food, thus blocking the way to access unhealthy food.
- Encourage the use of stairs and discourage the use of lifts when designing buildings.

Neighbourhoods and municipalities

Maximum priority

- Promote community plans to reduce health inequalities through the participation of citizens, social and healthcare service professionals, as well as other agents with possible health implications. These plans should develop the participatory process in all its phases, from the early stages of their design.
- Promote areas in all neighbourhoods where to engage in physical activity for all ages, considering the needs of the various groups and implementing, for instance, programmes directed at families to facilitate reconciliation between work and family life.

PH

High priority

- Promote maximum speed zones of 30 kilometres per hour and “walk-to-school routes” around schools, especially in the most disadvantaged areas, thus children and adolescents can go to school on foot or by bicycle.
- Increase the availability of fruits, vegetables and low-fat and low-energy-dense food in supermarkets and shops of low socioeconomic neighbourhoods.

Medium priority

- Install escalators and ramps in neighbourhoods with steep uphill paths.
- Address the health needs of persons in prostitution and prosecute sexual exploitation.

PART IV. HEALTHCARE SERVICES

AREA 11. A HEALTHCARE SYSTEM THAT DOES NOT CAUSE INEQUALITY.

MAIN RECOMMENDATION

Ensure the appropriate implementation of the Act on the Promotion of Personal Autonomy and Care for Dependent Persons.

Ensure full universal healthcare for residents in Spain, with 100% coverage.

Include specific objectives to reduce inequalities in health status and in access to, quality and effectiveness of healthcare services in all State, Autonomous and local Health Plans and Master Plans.

Improve access to necessary preventive and curative healthcare services and reduce their costs for the population with fewer resources: e.g. oral health, rehabilitation, visual and hearing aids, medicines, smoking cessation treatment and contraceptive methods.

Although the healthcare system is not the main determinant of population health, it is necessary to include addressing social inequalities in health among its objectives. This is so because, on the one hand, it can mitigate part of the effect of other determinants of health inequalities, but on the other hand healthcare services may also contribute to produce them, introducing social inequalities in healthcare⁹⁸. The persons responsible for the healthcare system can also act as catalysts for change in other governmental policies, as drivers of multisectoral efforts towards equity at the local level, and as an example of good business practice in areas of equity impact.

Inequalities in care needs

There are social inequalities in healthcare needs. Equity in healthcare services should mean that the most disadvantaged social groups, which have more health problems, use more the healthcare services, according to their greater need. In this sense, we should acknowledge the positive role played by the Spanish National Health System in our society, given its characteristics of tax financing and use on demand.

Vigilance should be paid to prevent the “inverse care law” (persons who need less get more/ better service) from occurring and act when it is apparent. For instance, risk equations based solely on clinical factors to determine the prescription of preventive treatments miscalculate the cardiovascular risk of persons of lower socioeconomic status⁹⁹.

Recommendations of the Commission.

Maximum priority

- Include specific objectives to reduce inequalities in health status and in access to, quality and effectiveness of healthcare services in all State, Autonomous and local Health Plans and Master Plans. PH HS
- Promote the participation and the incorporation of the views of citizens and users in the decision-making processes of the Health System, starting at the local level.

High priority

- Include the most important health problems in population groups subject to social inequalities (class, age, gender, ethnicity, disability) as priority objectives of healthcare policies.
- Health decision-making processes (prioritising problems for the development of plans, determining needs, allocating resources, etc.) should allow for social equity criteria, and specific measures (e.g. preventing economic barriers to access) aimed at specific groups should occasionally be implemented. PH HS

Medium priority

- Move towards mechanisms of territorial financing of services in accordance with the needs, involving larger budget allocations for the areas with higher socioeconomic and health disadvantage.

Inequalities in informal care for health problems

Informal care is a substantial source of social inequality (gender, class and ethnicity) since, in an environment of scarce quality public services for the care of persons in need, the most advantaged groups have greater access to private care services (whether professional or not), while disadvantaged groups still depend on their informal care network, which mainly consists of women. Moreover, private care services are usually provided by immigrant women who face very poor employment and working conditions.

Informal care can have a negative impact on the health of persons being cared for^{100, 101}, which should be prevented. The responsibility of caring is public and social (not only individual or of the family) and the cost of caring should therefore be shared by the different society groups and members, both men and women.

Recommendations of the Commission.

Maximum priority

- Ensure the appropriate implementation of the Act on the Promotion of Personal Autonomy and Care for Dependent Persons, and foster the provision of quality public services to meet the needs of dependent persons and carers, especially the most disadvantaged groups who are at a greater risk of poverty and labour and social exclusion.

High priority

- Encourage social and healthcare collaboration and ensure coordination among health services, social services and the “third sector”.

Medium priority

- Provide “respite” services for carers, prioritising the groups at higher risk of poverty and labour and social exclusion.
- Train healthcare professionals in care for dependent persons and their carers to raise awareness about the needs of carers, achieve greater co-responsibility from persons of their social and familiar environment (especially men) and advice on the existing community resources to support care duties.

Inequalities in healthcare access and quality

It is a priority to guarantee the right of access to the public healthcare system by the entire resident population. Spain has decisively made progress in this sense thanks to the Spanish General Act on the Creation of the National Health System. In the case of foreign population, access to care has been guaranteed, although there are still barriers, as described on page 25.

On the other hand, the concept of “access to care” should include access to diagnostic processes and treatments. In this sense, social inequalities have been perceived in the fields of geographical, economic and cultural accessibility, as well as in terms of functional ability.

Health systems in which Primary Healthcare has a major role achieve a higher level of population health and fewer inequalities¹⁰². Primary healthcare should be the main gateway to the system, should provide continuum of care throughout the life of persons, focusing on the person and not on the disease, and should be coordinated with the system resources that patients require in their care process. The differential use of primary healthcare and specialised healthcare has been documented according to the socioeconomic position due to an overuse of specialised care by persons belonging to more privileged social classes¹⁰³, which could give rise to larger waiting lists and higher resolution time figures for persons belonging to the less privileged social classes. Furthermore, provided that the public healthcare system and private healthcare coexist in Spain, the latter should be prevented from having negative consequences on the public sector; for example, if working conditions are worse in the public system than in the private sector, it may result in a shift of our best professionals towards the private sector.

Recommendations of the Commission.

Maximum priority

- Ensure full universal healthcare for all residents in Spain, with 100% coverage and without discrimination on the ground of their type of Social Security card.

PH
HS

- Expand public coverage for services that are currently insufficient (e.g. oral health, rehabilitation, visual and hearing aids) giving priority, based on equity criteria, to those processes that force population with limited resources to largely have recourse to the private system due to their prevalence and necessariness. HS
- Avoid the lack or the lower quality of services in socioeconomically deprived areas or the most disadvantaged social groups compared to the richest areas. Infrastructure should preferably be publicly owned and managed. HS
- Reduce administrative barriers to census-taking and to obtaining the healthcare card in all healthcare centres, acting on legal requirements and monitoring inequities in local practices.

High priority

- Increase resources and the orientation of the healthcare system towards Primary Healthcare. Progress in community-oriented primary care, acknowledging and encouraging the participation of professionals in interdisciplinary activities and dynamics for community action.
- Ensure the adequate provision of both diagnostic and therapeutic mental health services.
- Eliminate physical and transport barriers to access healthcare centres and services (including diagnostic tests and treatments) for groups with special difficulties (e.g. persons with disabilities, etc.).
- Provide services adapted to the population (e.g. in terms of cultural competence, schedules) with special attention to vulnerable groups. Expand detection services in the streets and in the houses of uncared persons (drug users, mentally ill persons, etc.) as well as harm reduction services.

Medium priority

- Encourage the involvement of healthcare professionals in the quality of public services (service management, training, working conditions, etc.) with special emphasis on the elimination of inequalities.
- Ensure the existence of good criteria to vouch for the quality of healthcare service providers and strengthen the assessment policies by including equity criteria. HS
- Inform potential users about their rights to care, and improve dissemination and knowledge of patients' rights.

Inequalities due to healthcare costs for users

Paying for the care of health problems may be unaffordable or pose a significant burden for the most disadvantaged groups. This is a critical aspect to be considered from the equity perspective. The Spanish public healthcare system is among the systems that produce fewer inequalities as per economic access, since it has a wide coverage of services for the entire population. However, in certain areas, such as oral health and mental healthcare or access to medicines (either because they are not covered or because of the copayment required to the working population), there may be difficulties as regards economic access that end up determining social inequalities in health.

Regarding copayment mechanisms in healthcare, there is evidence that it reduces both necessary and unnecessary demand, and tends to affect health and economy in a biased manner: effects are more negative for persons with less income and disadvantaged social groups¹⁰⁴.

Recommendations of the Commission.

Maximum priority

- Improve access to free medicines for disadvantaged persons. HS
- Discourage the use of copayment as an instrument to lessen healthcare financing problems, given its regressive impacts on economic and health equity. HS

Medium priority

- Include the assessment of secondary costs (travelling, accompaniment, and particularly informal care costs) in the assessment of healthcare policies, services and technologies, especially in those actions aimed at persons with chronic diseases, disability processes, long-term processes or terminal conditions.
- Consider the percentage represented by social and healthcare expenditure with respect to the available household income or the income of individuals in the analysis of healthcare costs.

Inequalities in preventive practices and healthy behaviour promotion

The effectiveness of medical advice in different health-related behaviours has been documented, as well as the existence of gender or class inequalities in the use of healthcare services in relation to addictive behaviours. Interventions to promote healthy behaviours in healthcare should be designed and assessed from the equity perspective, thus preventing lower effectiveness in more disadvantaged groups with a higher prevalence of risk behaviours¹⁰⁵.

Similarly, the significant socioeconomic inequalities in sexual and reproductive health require policies to improve economic and territorial access to family planning services and contraception treatments¹⁰⁶.

Recommendations of the Commission.

Maximum priority

- Systematically include stop smoking advice and treatment in primary healthcare, especially in centres of the most disadvantaged areas, taking into account gender and social class perspective, as well as the cultural differences related to the country of origin.
- Facilitate territorial access to sexual and reproductive health services, as well as to condoms and other contraception methods, emergency contraception and voluntary termination of pregnancy.

High priority

- Reduce barriers to access to treatment of alcohol abuse for socially excluded persons, providing care to walk-in patients or in a state of intoxication.
- Promote interventions to prevent childhood obesity that allow for environmental, socioeconomic, cultural and gender factors in order to achieve greater effectiveness in the most disadvantaged social groups.

Medium priority

- Raise awareness and train primary healthcare professionals on the detection of alcohol abuse, especially among women.
- Promote breastfeeding in healthcare services with interventions especially designed for women of lower socioeconomic status and more disadvantaged areas.

Impact of the healthcare system on the social determinants of inequalities

Healthcare services not only provide healthcare to the population, but also develop a relevant social role as employers, purchasers of products and services, waste generators, etcetera. In all these fields, healthcare services can have positive and negative impacts on population health and on inequalities. Being an example of good practice for health equity in these areas is an opportunity and a challenge for the healthcare system, demonstrating its feasibility and arousing the interest of the healthcare sector itself and of other sectors to work for equity.

Recommendations of the Commission.

High priority

- Ensure decent and fair working conditions to all professional categories, including workers from companies under contract. PH
HS

Medium priority

- Assess the impact of healthcare centre management policies on population health and its determinants. PH
HS

PART V. INFORMATION, MONITORING, RESEARCH AND TEACHING

AREA 12. INFORMATION, MONITORING AND ASSESSMENT

MAIN RECOMMENDATION

Establish a state network for equity monitoring that provides information on indicators of social determinants, health and healthcare inequality, and disseminate it on a regular basis among government and civil society sectors.

The implementation and development of interventions to reduce health inequalities require a continuous monitoring network of the status and evolution of these inequalities. This monitoring network will contribute to: 1) make visible social inequalities in health and their determinants at all levels of decision-making, in the various areas of services and administrations involved, and in society in general; 2) adapt services to the needs of the different population groups; 3) carry out the effectiveness and efficiency assessment of the interventions to reduce health inequalities; 4) conduct a health impact assessment of healthcare and non-healthcare public policies; and 5) identify research needs in this field.

To feed this monitoring network, information systems need to contain the social variables that fit in the conceptual framework of health inequalities and not only variables related to the healthcare sector. In addition, healthcare information systems should be analysed taking into account the different axes of inequality: social class, gender, age, ethnicity or migrant status, residence area, etc. In the Spanish State, most information systems (vital statistics, disease registries, etc.) do not allow to analyse data by social class.

The monitoring network needs to implement a dissemination system that enables information on social inequalities in health and their determinants to reach the different spheres and levels of decision-making in all areas related to health inequalities, as well as all civil society groups and society in general. Moreover, it is important to involve the community in the monitoring of health inequalities in their residence area, as well as the most disadvantaged or excluded groups.

Recommendations of the Commission.

Maximum priority

- Establish a state network for equity monitoring that provides information on indicators of social determinants, health and healthcare inequality, and disseminate it on a regular basis among government and civil society sectors. PH

High priority

- Promote impact assessment of healthcare and non-healthcare public policies on health and health inequalities. PH

Medium priority

- Promote the creation, development and implementation of global equity monitoring systems by WHO and the European Union.

AREA 13. RESEARCH

MAIN RECOMMENDATION

Financing agencies should allocate budget to promote research on the evidence and causes of health and healthcare inequalities, as well as on the effectiveness of interventions to reduce them.

Research is needed on the causes of health inequalities and also on what kind of interventions work best to reduce the problem. Most of financing funds and health research are related to biomedical matters, and there is much less priority placed on research on social determinants of health¹⁰⁷. The promotion of research to assess the effectiveness of healthcare and non-healthcare policies to reduce inequalities can favour the implementation and dissemination of good practice.

Recommendations of the Commission.

Maximum priority

- Financing agencies should allocate budget to promote research on the evidence and causes of health and healthcare inequalities, as well as on the effectiveness of interventions to reduce them.

PH

High priority

- Promote the assessment and dissemination of evidence on interventions to reduce health inequalities.
- Foster and support continuity by financing agencies of strategic lines of research on the determinants of health inequalities with a gender perspective (without biases) and including the most excluded populations.

Medium priority

- Incorporate social inequalities in health as a cross-cutting theme into research on health and healthcare services.

AREA 14. TEACHING

MAIN RECOMMENDATION

Incorporate knowledge on social determinants of health as a compulsory part of undergraduate and postgraduate education in Health Sciences studies and in continuing training of healthcare professionals, including service planners and managers.

The agenda of social inequalities in health is basically political and thus requires political action. In order to undertake it, the various actors involved need to have the appropriate training, such as policymakers, planners, health workers and health students. Additionally, it is necessary to encourage the training of other professionals related to social determinants of health (e.g. urban planners, economists, sociologists, etc.), trade union representatives and the civil society.

The training of health professionals has been largely biomedical, with very little content on social determinants of health. This training is critical to raise awareness among healthcare professionals about the inequalities approach, and to have professionals specialised in research and action on this issue.

Recommendations of the Commission.

Maximum priority

- Incorporate knowledge on social determinants of health as a compulsory part of undergraduate and postgraduate education in Health Sciences studies and in continuing training of healthcare professionals, including service planners and managers.

PH
HS

High priority

- Raise awareness about the importance of social determinants of health among the general population and non-health professionals.

PH

Medium priority

- Train the persons responsible for governmental political planning, organisation and decision-making on the importance of carrying out health inequalities impact assessments of the different policies implemented in a territory.

PRIORITY POLICIES AND INTERVENTIONS IN THE HEALTH SECTOR

After receiving the recommendations of the different working groups and in order to respond to the mandate of identifying the interventions that can be undertaken in the field of health, the Commission gave priority to the policies whose development primarily involves healthcare and public health services. To this end, after having identified them among the recommendations in the document, each member of the Commission selected ten of them. Policies with more than one vote were subsequently grouped into two lists sorted by priority: one list with twenty policies aimed at public health, and another list with fifteen policies aimed at healthcare services (some policies appear in both lists).

Priority policies and interventions in public health

1. Establish a state network for equity monitoring that provides information on indicators of social determinants, health and healthcare inequality, and disseminate it on a regular basis among government and civil society sectors.
2. Promote impact assessment of healthcare and non-healthcare public policies on health and health inequalities (e.g. healthcare management, employment, economy, dependency, equality, environmental planning, mobility, international agreements).
3. The Spanish Ministry of Health, Social Policy and Equality should produce, on a regular basis not exceeding four years, a Report on Social Inequalities in Health in Spain, including recommendations and proposals for intervention.
4. Create inter-ministerial bodies or commissions with adequate delegated authority and capacity to:
a) identify the current government areas and actions (public policies) with higher potential impact on social inequalities in health, *b)* identify and periodically propose improvement actions to reduce these inequalities, and *c)* estimate the necessary resources to undertake them. Similar interdepartmental bodies should be created at the regional and local level.
5. Include specific objectives to reduce inequalities in health status and in access to, quality and effectiveness of healthcare services in all State, Autonomous and local Health Plans and Master Plans.
6. Incorporate knowledge on social determinants of health as a compulsory part of undergraduate and postgraduate education in Health Sciences studies and in continuing training of healthcare professionals, including service planners and managers.
7. Create a Commission on Inequalities as part of the Spanish Inter-Territorial Council of the National Health System.
8. Promote community plans to reduce health inequalities through the participation of citizens, social and healthcare service professionals, as well as other agents with possible health implications. These plans should develop the participatory process in all its phases, from the early stages of their design.

9. Financing agencies should allocate budget to promote research on the evidence and causes of health and healthcare inequalities, as well as on the effectiveness of interventions to reduce them.
10. The Spanish Ministry of Health, Social Policy and Equality and the corresponding health departments of the regional and local governments should promote and lead the direction of policies towards the determinants of social inequalities in health. This requires not only political will but also the availability of the necessary resources and qualified personnel to perform it.
11. Introduce and promote plans and programmes on comprehensive child support that allow monitoring and accompaniment during growth, particularly for the most disadvantaged children or at risk of exclusion, allowing for collaboration among educational, social and healthcare services, implementing detection, care and early stimulation, information and training to parents, grandparents and carers, and at-home programmes, based on international experience.
12. Promote active ageing policies in the fields of education, culture, sports and employment, designed to be especially effective for persons of lower socioeconomic status.
13. Promote initiatives on health literacy and empowerment, as well as institutions that enable the effective participation of citizens and users in the healthcare system. Both policies should ensure the preferential inclusion of the most disadvantaged sectors.
14. Raise awareness about the importance of social determinants of health among the general population and non-health professionals.
15. Mainstream health equity into environmental planning, using the frameworks of health impact assessment and healthy urban planning (which involve citizen participation).
16. Foster systematic strategies to ensure safe and non-violent schools that promote healthy eating, physical activity and exercise, sexual health and prevention of drug use and traffic injuries. They should focus on improving the physical and social structure to make healthy lifestyles at the school community become the easiest option.
17. Ensure full universal healthcare for all residents in Spain, with 100% coverage and without discrimination on the ground of their type of Social Security card.
18. Thoroughly review the current framework of the Mutual Insurance Companies for Accidents at Work and Occupational Diseases to ensure proper care for all work-related health problems, from both the viewpoint of medical care and occupational risks prevention.
19. Health decision-making processes (prioritising problems for the development of plans, determining needs, allocating resources, etc.) should allow for social equity criteria, and specific measures (e.g. preventing economic barriers to access) aimed at specific groups should occasionally be implemented.
20. Ensure decent and fair working conditions to all professional categories within the health sector, including workers from companies under contract.

Priority policies and interventions in healthcare services

1. Include specific objectives to reduce inequalities in health status and in access to, quality and effectiveness of healthcare services in all State, Autonomous and local Health Plans and Master Plans.
2. Incorporate knowledge on social determinants of health as a compulsory part of undergraduate and postgraduate education in Health Sciences studies and in continuing training of healthcare professionals, including service planners and managers.
3. Create a Commission on Inequalities as part of the Spanish Inter-Territorial Council of the National Health System.
4. Avoid the lack or the lower quality of services in socioeconomically deprived areas or the most disadvantaged social groups compared to the richest areas. Infrastructure should preferably be publicly owned and managed.
5. Expand public coverage for services that are currently insufficient (e.g. oral health, rehabilitation, visual and hearing aids) giving priority, based on equity criteria, to those processes that force population with limited resources to largely have recourse to the private system due to their prevalence and necessariness.
6. Improve healthcare response to dependent care with more and better rehabilitation services, social and health services and home care.
7. Ensure equal access to and quality of healthcare services, beginning with pregnancy and childhood. Promote multidimensional care for pregnant women (nutrition, health education and access to adequate social and economic resources), and uphold the implementation of intervention measures with existing evidence, such as breastfeeding during the first 6 months of life, with particular emphasis on the most vulnerable women.
8. Promote initiatives on health literacy and empowerment, as well as institutions that enable the effective participation of citizens and users in the healthcare system. Both policies should ensure the preferential inclusion of the most disadvantaged sectors.
9. Ensure full universal healthcare for all residents in Spain, with 100% coverage and without discrimination on the ground of their type of Social Security card.
10. Discourage the use of copayment as an instrument to lessen healthcare financing problems, given its regressive impact on economic and health equity.
11. Ensure the existence of good criteria to vouch for the quality of healthcare service providers and strengthen the assessment policies by including equity criteria.
12. Improve access to and quality of psychological and educational care, as well as healthcare, for children with physical, cognitive or sensory disabilities.
13. Health decision-making processes (prioritising problems for the development of plans, determining needs, allocating resources, etc.) should allow for social equity criteria, and specific measures (e.g.

preventing economic barriers to access) aimed at specific groups should occasionally be implemented.

14. Ensure decent and fair working conditions to all professional categories within the health sector, including workers from companies under contract.
15. Improve access to free medicines for disadvantaged persons.

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