Addressing Inequalities Interventions in Regions

Reducing health inequalities in primary care settings in Regions

Edito

Although health inequalities are still increasing, national or regional governments have not yet full taken measures to tackle this major public health and social issue. Despite the continuous increase of health expenditures and major health reforms, inequalities are still present in the European countries. There is an urgent need to provide solutions and guarantee access to health and health care for all citizens. It is a role of policy makers to require that health issues be considered in all policies and to implement, with the support of scientists, efficient solutions.

The health authorities emphasized the importance of primary care on improving the citizens' health and its important role to fight against health inequalities. Health promotion, prevention and new health organizations are a key to develop innovative and efficient actions.

The AIR research project brings tools and information on health systems, policies and interventions that effectively contribute to the reduction of health inequalities in the European regions. These results are part of the construction of a European database on actions and policies aiming at reducing health inequalities through primary care settings. This database should help actors and decision makers to implement new interventions or improve existing actions in their territories.

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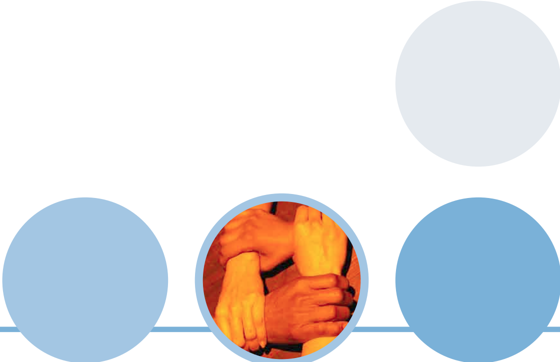


1. Addressing Inequalities Interventions in Regions

The AIR project, Addressing Inequalities Interventions in Regions, is aimed at providing evidence for policy makers on how to reduce health inequalities in the primary care settings.

Today, health inequalities are increasing, affecting more and more disadvantaged populations. Reducing health inequalities is a challenging problem for all European countries and it is also a priority for the European Union's health programmes. The AIR project - Addressing Inequalities Interventions in Regions - began in November 2009 with a precise objective: assisting European, regional and local policymakers in developing their health policy in order to reduce health inequalities in primary care settings. Led by the Regional Council of Aquitaine, the AIR project was carried out in close cooperation with the partners of the ENRICH network and other experts from various health institutions and research centres. 31 partners representing 15 European countries worked together to identify practices and policies developed to reduce the inequalities in primary care settings in European regions. The AIR project provides examples of interventions aimed at reducing health inequalities in primary care, taking into account their efficiency, cost and target population. But it also provides recommendations to decision makers and health professionals. The results of the project will contribute significantly in the reduction of health inequalities in primary care settings in the regions of Europe.

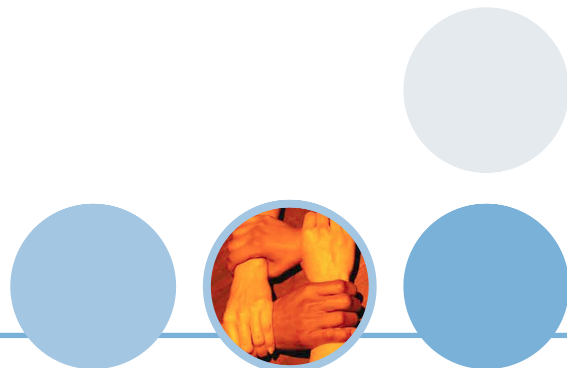
2. Literature review

The first step of the AIR project was a systematic literature review of interventions related to the primary care settings evaluated in order to reduce health inequalities.

123 articles published after 2000, were selected in Medline, the Cochrane Library databases, the Health Policy Monitor and Determine websites, Nber publications and the Eurothine report, if they reported a quantitative evaluation of a primary care intervention on health process or outcome measures among socio-economic groups. Primary care interventions were defined as either related to primary care services (i.e. access to care and prevention for common disease, maternal care…) or organization (i.e. first contact, comprehensive, coordinated care...).

107 evaluated interventions were analyzed to build a typology. Three broad types of interventions were identified: health promotion interventions in the community setting; interventions aiming at improving financial access to care either by providing free care or free or subsidized health insurance; and health care organization interventions. Overall, 74% of interventions were effective in reducing health inequalities, with comparable results for each type of intervention.

Primary care interventions can successfully reduce socio-economic health inequalities. Improving financial access to care increases health care utilization and health outcomes. Universal access to care should be completed with tailored, culturally adapted health promotion interventions led by peer educators. ”Umbrella” interventions can provide a framework to implement several health promotion interventions. Finally, health care organization interventions such as teamwork or disease management can successfully reduce health inequalities.



3. Identification of interventions

The second step of the AIR project was to carry out a survey. The aim of the survey was to collect information about all interventions which contribute to the reduction of health inequalities through primary care settings in EU regions, or through policies implemented at national, regional or local levels. 47 questionnaires from 21 European countries were received, resulting in 90 different regional interventions reported.

Among the questionnaires received, a third responded that they are part of a national strategy dedicated to reducing health inequalities, while 46% of respondents stated that the national health strategy includes reducing health inequalities. A quarter of the regions declared enrollment in a specific regional strategy to reduce health inequalities, and 67% of respondents stated that the regional health strategy includes reducing health inequalities. Education, interventions linked to the age, and targeted interventions for disadvantaged groups were considered to contribute to reducing inequalities in health (78% of answers).

Regarding actions implemented in the regional strategies, prevention and health promotion were considered the most effective (99%), followed by organization of care (82%), funding (71%), and access to care (67%).

The results of the first questionnaire highlighted an increasing awareness at national and regional levels of the evidence of health inequalities, and an increasing willingness to take action at a regional level. Further positive results of the survey were a strong cooperation between different sectors (education and social services), and a positive role for primary care, especially in health promotion. Collecting 90 interventions to reduce health inequalities at a regional level could also represent a good view of local and regional initiatives and interventions, reflecting government concern for action. The survey did however highlight a weakness in evaluation of the impact of interventions in reducing inequalities, and difficulties in having a clear and integrated vision between the national and regional levels of the different strategies and results. In conclusion, policy makers and practitioners on one side and researchers on the other have to reduce a first gap between evidence, knowledge and awareness of health inequalities in the health care system.

4. Selecting and analysing interventions

The third stage of the project was to carry out a second questionnaire. The aim was to extend the information about the interventions identified by the first survey so they could be analysed in depth. The task at this stage was to evaluate and assess them by evaluators and according to a set of criteria that measures their effectiveness and quality among other features, and to develop a catalogue of "illustrative practices" and recommendations.

The survey contained contextual information about the interventions, characteristics of the intervention's target group, descriptive characteristics of the interventions and additional documentation was required. The questions were designed to evaluate the interventions based on the following criteria: relevance, appropriateness, applicability, innovation, quality assurance, adequacy of resources, effectiveness in process, effectiveness in results, and mainstreaming.

A total of 46 interventions were analysed from 16 European countries and 20 regions. Interventions were addressed mainly to population of both sexes and at no specific age group (41%). Population from urban and rural settings were reached in almost equal proportions, being unfavourable socio-economic conditions and deprived areas the feature most frequently chosen to define the target. Few of the interventions intended to reduce the inequality gap through influencing structural socioeconomic factors. Primary health care services were not only participant but also represent the context in which most interventions currently ongoing are being developed (74%). Among other contexts, there was relevant involvement of the education sector. On most occasions an analysis was carried out before the intervention to identify the population needs (87%). The methodology used to design these actions and activities has been based more often on informal methods of literature review and experts consulting than formal ones.

Interdisciplinarity was very narrowly understood. Only five out of the forty-six interventions included a social scientist on their team (anthropologist, sociologist, political scientist), and just few others included teachers, economists, politicians, journalist, and legal. Respondents reported innovations on two areas: new ways of working and activities developed specifically for the intervention.

Interventions were reported to be monitored in 80% of cases. Only half had elaborated a report including details of this monitoring. Unwanted side effects found during implementation of the intervention have been reported rarely, only in three cases. About unexpected effects, number of cases reported was higher (10 interventions) and most of them were positive.

The three more stressed lessons learned were the importance of cooperation between institutions and organizations, the involvement and motivation of professionals, and the listening of the different people and institutions needs and the adaptation to the context.

5. Five illustrative interventions

Once the interventions were analysed, each intervention was evaluated by two different evaluators who scored the interventions according to previously established criteria. As a result of the analysis and the evaluation of the interventions, 5 illustrative interventions were chosen to be presented at the final conference of the project in Budapest, on 19th April 2012.

Drug Action Networking in Local Community. Korcula Pilot Project. Dubrovnik-Neretva County. Croatia.

Target population

School children aged 12-18 in the Island of Korcula.

Aim

To decrease the prevalence of drug use among young people.

Activities

- Situation analysis and strategic planning.
- Primary Health Care services - education, round table, workshops, meetings.
- Other Health Services special treatment for drug addicts - open new counseling centers: licensed doctor for substitution treatment, media promotion (broadcasts, round tables, public discussion, visitation by ex addicts from COMMUNE etc).
- Schools: lectures, workshops, focus groups, exhibitions, plays for children, exhibitions and public discussions for parents.
- Local community: foundation of DWG (Drug working group), education through lectures and workshops, periodical meeting, joined planning and performing of activities, meetings with majors and local politicians, Control of selling alcohol to children and youth under 18. Drug trafficking control , control children spending night outside without parental control.
- Evaluation.

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Interventions to stop smoking in people with mental health conditions and people in prisons. Andalucia. Spain.

Target population

Persons detained in penitentiaries, people with severe mental disorders in shelters/foster homes, therapeutic communities, long and medium outpatient centres and hospital units.

Aim

To standardize smoking treatment for collectives in positions of inequality and to design and implement a specific model of a smoking cessation intervention for detainees and persons with severe mental disorders.

Activities

1. Collaboration agreements with heads of institutions.
2. Situation analysis: tobacco consumption survey.
3. Raise the awareness of managers, professionals and the institutionalised population about problems caused by tobacco use and the environmental tobacco smoke, help in smoking cessation.
4. Training programme for professionals involved.
5. Organisation of smoking cessation services to all persons involved.
6. Evaluation.

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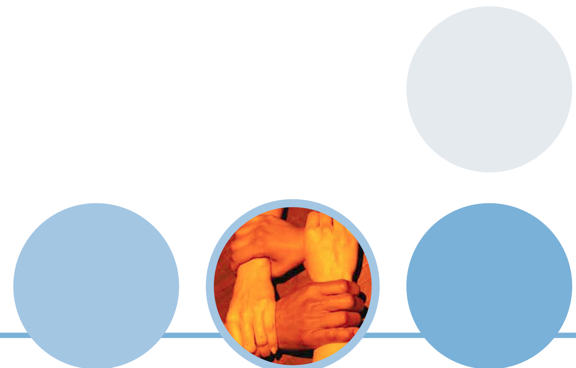

HIV/AIDS Prevention and control. Algarve. Portugal.

Target population

Sexual minorities, prison population, sex workers.

Aim

To develop prevention and counselling activities and early detection of HIV infection among the most vulnerable populations with difficulties in access to formal healthcare services, and among the population in general, using to this purpose the facilities of the partner institutions and/or mobile units. The goals: to promote awareness about the serological status of the HIV infection; ensuring timely referral to specific hospital consultation whenever necessary; to prevent the transmission of HIV infection; to contribute to the social acceptance of infected individuals.

Activities

There is a Centre (CAD) that provides anonymous, free and confidential counselling and detection of the infection. The CAD acts as a support to carry out activities in the community, ensuring ongoing training and technical consultancy to the professionals in the different teams, supplying fast tests and material. Using mobile units or their own facilities, the following are provided: counselling activities, detection (fast test), distribution of information materials and prophylactics, with an organised time schedule, in partnership with institutions and NGOs: in Prisons, among sex workers (street and apartment contexts), among migrants (in the areas where they live or frequently socialise), at universities, shopping Malls, healthcare centres. These activities are reinforced during the summer and on World AIDS Day, integrated into information campaigns. Didactic and informative material is produced.

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Regional Nutrition and Health Program for children and teenagers. Aquitaine. France.

Target population

Children under 18 years of age in Aquitaine, in the educational, family and medical environment.

Aim

General objective: interrupt the increasing prevalence of overweight children, increase consumption of fruits and vegetables, and promote physical exercise.

Specific objectives: optimize early detection of overweight children, improve food supply, implement health education actions in schools.

Activities

Health education actions aimed at children and teenagers (young people).

Training of teachers and canteen staff. Awareness/information actions for medical staff at National Education institutions (nurses and school doctors) about the importance of early detection of overweight or obese people.

Training initiatives on the utilization of validated and common screening tools. Awareness actions/training for local and territory authorities on the importance of improving the food supply at canteens. Awareness actions for the general public.

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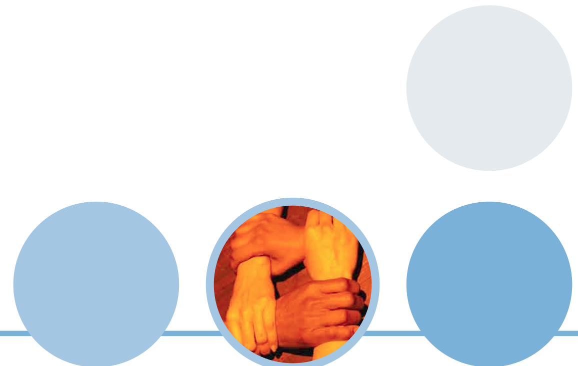

Plan promotion santé 2010-2012 of the Province of Hainaut. Belgium.

Target population

The whole population in the province of Hainaut.

Aim

To reduce social inequalities in health among a population with a high rate of chronic conditions, by collaborating with partners from other sectors and establishing the most favourable conditions for health, through accessible actions adapted to the needs of all citizens, and finally to continue to work on raising awareness and mobilising society.

Activities

105 activities have been planned, such as health information and monitoring, social mobilisation, follow-up of local programmes, training, health education, production of materials (leaflets, exhibitions, group animation), networking, mass media, communications, lobbying.

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6. Summary of key findings of the AIR project

The AIR project focused on interventions to reduce inequalities in primary care settings in regions, assuming that many prevention and health promotion actions can be implemented at regional level through primary care providers. Indeed, core values of primary care aim to achieve equal access to care adapted to needs, and thus explicitly include the objective of reducing health inequalities.

Since Second World War, countries in Europe have achieved this objective by a variety of means, including universal access to care and responses to basic needs of populations. In line with an increasing awareness of health inequalities, many national, regional and local health policies include objectives to decrease health inequalities.

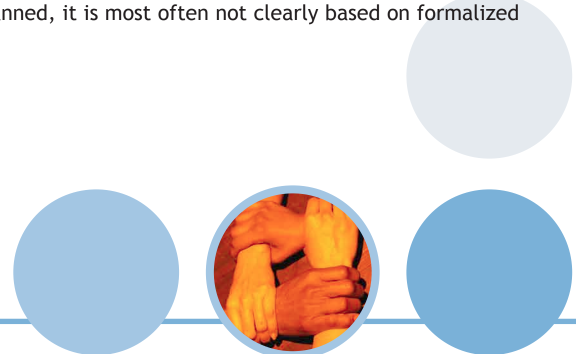
Most regions indicate that health promotion and interventions targeted at disadvantaged groups are priorities. However, there is limited coordination and integration of strategies between national and regional levels. Moreover, priorities remain often at the level of good intentions and are not always clearly translated into specific projects. Policies and interventions are seldom evaluated.

Most interventions are local, which raises the issue on how to scale up interventions as to reach all populations concerned by the targeted problem.

Assessment of interventions and research on reducing health inequalities

Most scientific publications reporting on interventions to deal with health inequalities in primary care are from the US; very few come from Europe. Of published experiences and interventions identified in AIR surveys, very few are dealing with the role of health-care providers in primary care, including their geographical distribution and its impact on health inequalities.

Very few interventions identified in AIR surveys actually include fully developed and scientifically documented monitoring and evaluation processes, including dissemination of results. When an evaluation exists or is planned, it is most often not clearly based on formalized and methodic approaches, and seldom assesses the impact of the intervention.



Knowledge about effective interventions, facilitating factors and barriers

- Although gender is one of the most important axes of inequalities in most societies, gender inequalities have been barely considered in identified interventions.
- Health promotion interventions focusing on health inequalities can be effective, provided members of the targeted community are actually involved in ensuring that the interventions are culturally adapted and mediated by people from the community.
- Disease management and managed care do not seem to have an impact on health inequalities.
- Financial interventions to facilitate access to health care can reduce inequalities in access, but have not demonstrated effects on risk factors. Moreover, the quality of care might not be the same for people targeted by these interventions.
- Very few policies link interventions specifically targeted at reducing health inequalities to general actions aimed at structural socioeconomic factors such as housing, employment or revenue.
- The most illustrative and innovative interventions are those where actors from relevant organizations, sectors and disciplines who are not used to work together are collaborating from the onset. Multidisciplinary and multisectorial collaboration are other key facilitating factors, but involvement of sectors other than health is rare. Primary care physicians are seldom involved in identified interventions.
- Most interventions indicate an involvement of the target populations in the needs assessment to facilitate the design and evaluation of the intervention, but many do not actually involve the final beneficiaries. Many interventions do not use formal methods to conduct this needs assessment.
- Identified major barriers are the lack of human, technical and economical resources, institutional and professional reluctance, and failure to consider cultural and socio-economical characteristics of the target population.
- Identified key facilitating factors are the involvement of cultural and linguistic mediators, and of the education, socio-economic, and research sectors; political and institutional supports are other major facilitating factors.

7. Recommendations

- Because most determinants of health and health inequalities lie outside the health sector and are socially and economically grounded, the "Health In All Policies" (HIAP) approach is crucial to deal with inequalities.
- Policies and interventions, including financial instruments, should take into account the economic and social needs of disadvantaged population, and should not focus only on access to health care or health promotion.
- National, regional, and local policies on health inequalities should include specific approaches, such as outreach visits, culturally-adapted mediators, and consciousness-rising of actors, to better target populations through primary care.
- Interventions to reduce health inequalities should always be based on a thorough needs assessment. This assessment should involve representative of the target population, to help adapt the content and means of intervention to specific cultural and social characteristics. All relevant actors, organisations, sectors, and disciplines, including evaluation scientists, should be involved from the outset.
- Planning an intervention should be based on a thorough and realistic estimation of resources needed to meet the objectives. Resources should also cover costs of an appropriate monitoring and evaluation scheme.
- Reducing the scope of an intervention to cope with limited available resources can exacerbate inequalities and waste of resources if the objectives cannot be met.
- As resources are generally limited, it is wise to focus on interventions scientifically shown to be effective, or develop experimentation of new interventions.
- We believe that the lack of specific evidence should not threaten the idea of local action in primary care settings to reduce health inequalities, but should instead lead to more experimentation.
- Translating political will, expressed in national or regional policies, into adequate resources to meet objectives, is the responsibility of political decision makers and the public sector. Additional resources should be sought from other sectors, but the leadership should remain that of the public sector.
- Politicians and policy makers at national, regional and local levels must be aware of the slow and modest effects of interventions and the time needed to deliver a robust evaluation. Interventions usually progress step by step and must be protected from quick expectations and too short political agendas.
- Given the increased burden of chronic disease and behaviour-related risks, there is indeed an urgent need for more research on the role and effectiveness of primary care in dealing with health inequalities in Europe. Dealing with health inequalities in Europe, however, will need to devote specific resources to build capacities so that Member States, regions and local actors can better develop, implement, and evaluate interventions. Actors should also be encouraged to better disseminate information on interventions and results of their evaluation.

8. General conclusion

Core values of primary care, as defined in the Alma Ata declaration (1978) and the WHO report (2008), explicitly include the objective of reducing health inequalities. In the current context of economic crisis and reductions in health budget, universal coverage, and access to care in primary care settings will now be more than ever key to limiting the increase in health inequalities. However, gate keeping, free care, lower copayment, geographical accessibility to services in primary care setting must be driven by political will, at the national as well as the regional level.

Political decision makers have a moral obligation to consider health issues (irrespective of policy area: economical, environmental, educational, social…), and moreover, to take action to prevent exacerbations of health inequalities.

The associated partners

- CRA: Council Regional of Aquitaine, France.
- IRDES: Institut de recherche et de documentation en économie de la santé, France.
- MeS: Scuola Superiore Sant'Anna di Pisa, Italy.
- EASP: Escuela Andaluza de Salud Pública, Andalusian School of Public Health.
- HS: Hainaut Santé, Belgium.
- DEKUT: Dekut Debreceni Kutatasfejlesztesi Debrecen, Hungary.
- UVSB2: Université Bordeaux Segalen / ISPED: Institut de Santé Publique, d'Epidémiologie et de Développement, France.
- DPHEM: Department of Health Nottingham/NHS East Middlands, United Kingdom.
- UCY: University of Cyprus, Cyprus.
- ResearchLink: ResearchLink sprl, Belgium.
- DUNEA: Dubrovnik Neretva County Regional Development Agency, Croatia.
- PEHRG: Poverty, Equity and Health Research Group - University of Perugia - Terni, Italy.
- URIT: Umbria Region Perugia, Italy.
- RT: Tuscany Region Florence, Italy.
- GEORAMA: Georama NGO, Greece.

The collaborative partners

- County Council Gävleborg, Sweden.
- EUPHA: European Public Health Association, Netherlands.
- ARS Aquitaine: Agence Régionale de Santé d'Aquitaine, France.
- Lincolnshire Primary Care Trust, England.
- SAS: Servicio Andaluz de Salud, Spain.
- URPS: Union Régionale des Professionnels de Santé d'Aquitaine, France.
- Leicestershire County and Rutland PCT, England.
- Leicester County Council, England.
- Debrecen University, Hungary.
- MS-LSA: Ministry of Health and Social Affairs Saxony-Anhalt, Germany.
- UOMS: University of Applied Sciences Magdebourg-Stendal, Germany.
- CSJA: Consejeria de Salud - Junta de Andalucia, Spain.
- RUBSI: Research center in behaviour and social issues, Cyprus.
- JPII: John Paul II Hospital in Krakow, Poland.
- MSP: Ministry for Social Policy - Health, Elderly, Community Care, Malta.
- ARS Algarve: Administração Regional de Saúde do Algarve- IP, Portugal.

Further information:

http://www.air.healthinequalities.eu/

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