The Collaborative Partners

During the investigation phase and the dissemination of results, the group of collaborative partners, which involves 16 members, facilitated the processing of information requests within European Regions.

- County Council Gävleborg, Sweden
- EUPHA: European Public Health Association, Netherlands
- L'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 Magdeburg-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: Administraçao Regional de Saude do Algarve IP, Portugal

The Associated Partners

- CRA: Conseil Régional d'Aquitaine, France
- IRDES: Institut de recherche et de documentation en économie de la santé, France
- MeS: Laboratorio Management e Sanità, Scuola Superiore Sant'Anna di Pisa, Italy
- EASP: Escuela Andaluza de Salud Pública, Spain
- HS: Hainaut Santé, Belgium
- DEKUT: De k u t De b r e c e n i Kutatasfejlesztesi Debrecen, Hungary
- UVSB2 (ISPED): Université Victor Segalen Bordeaux 2, France
- DPHEM: Department of Health Nottingham / NHS East Middlands, United Kingdom
- UCY: University of Cyprus, Cyprus
- Research Link: 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

Further information :

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

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EUROPEAN PROJECT

Addressing Inequalities Interventions in Regions

Health Inequalities in Regions

Project contract number 2008 215

Project reference number A/101 281

Addressing Inequalities Interventions in Regions

Health Inequalities in Regions

AIR project - Addressing Health Inequalities Interventions in Regions – was aimed at providing evidence on how to reduce health inequalities in the primary care setting.

Reducing health inequalities is a challenging problem for all European countries and it is also a priority for the European Union's health programmes. 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 results of the project should contribute in the reduction of health inequalities in primary care settings in the regions of Europe

The AIR project provides examples of interventions aimed at reducing health inequalities in primary care, taking into account their efficiency, cost and target population (see website below). Based on the analysis of 46 experiences, it also provides the following recommendations to decision makers and health professionals.

The directory of illustrative interventions is available on the AIR website:

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

Recommendations for policy makers and health professionals

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.

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.