Situation analysis and Needs assessment in

Situation analysis and Needs assessment in seven EU-Countries and regions

Reducing Inequalities in Health

Title ACTION-FOR-HEALTH: Reducing Inequalities in Health

Published by Institute of Public Health Murska Sobota

Prepared by Dutch Institute ACTION-FOR-HEALTH: Reducing Inequalities in Health

Co-funded by
the Health Programme
of the European Union

Preface

is publication is the rst of four publications within the project Reducing Inequalities: Action for Health. Action for Health is an EU co-funded project within the framework of the Health Programme. Its aim is to strengthen the capacity of health promotion workers in the region to tackle health inequalities through the promotion of health across Europe by developing action plans within seven regions in seven EU countries: Bulgaria, Croatia, Estonia, Hungary, Lithuania, Slovakia and Spain. e project work is based on experiences gained from a previous Slovenian project for reducing inequalities on the regional level through the promotion of health, performed by the Institute of Public Health Murska Sobota.

Socio-economic inequalities in health pose a major challenge to health policies. ose socio – economic health inequalities can be de ned as di erences in health status or in the distribution of health determinants between di erent population groups (WHO de nition) (1). Health ine qualities can be perceived as systematic and preventable di erences in health status between pop ulations, where the poor su er from poorer health than the rich. Health inequalities exist on the

Ÿ

Health Report 2012, the social determinants of health contribute to 50% of all health inequalities and comprise political, socioeconomic and environmental factors. Another influencing determinant on health inequalities is, according to this report, access to effective health services. At least 25% of health inequalities (differences found within a country's population) are associated with a lack-of access to effective health services. is percentage increases if differential access to basic public health interventions such as access to safe water is included (9).

Health inequalities that can be avoided should be tackled as should interregional health inequalities and differences in the health status of populations in different regions. Not only because inequalities are unjust and unfair, but because they place an economic burden on society. Poor health leads to high health care costs. Additionally, people in poor health are less able to work and learn, affecting the human capital's ability to contribute to the economy. Structural funds aim to reduce regional disparities in terms of income, wealth and opportunities and as a result, disparities in health and health inequalities.

is publication gives an overview of the general health situation and needs to tackle health inequalities in seven European regions together withexamples of promising practices. is knowledge will be used to develop an action plan to tackle health inequalities in these regions through health promotion and structural funding.

ž

-- Š •

1. Bulgaria, Lovech

General data

of the population estimated to be living on the poverty line is even higher for the Lovech area, namely 23.9% (males 24.3%, females 23.6%) (1). According to AROPE's de nition, 66.6% of the population (69.9% of the men and 63.8% of the women) are at risk of poverty or social exclusion in Lovech (1), which is higher than the national average (49.2% of the popu lation, males 47.3% and females 50.9%). e unemployment rate in the Lovech district is close to the national average or 11.2% (2011). e unemployment rate on national level by gender shows a percentage of 12.7% for males and 10.1% for females. e national unem ployment rate of the active population under the age of 25 is 24.6%.

e total population with an upper sec ondary education in 2012 in Lovech is 61.6% compared the national percentage of to 43.4%. Recent data of NIS 2011/2012 shows 18.56% drop-outs from general and special schools at the country level versus7.01% for the region of Lovech (1). Although the educational level is above average, Lovech is still a deprived region.

Health and Health inequalities

Life expectancy at birth in Bulgaria in 2011 was 73.9 years (males 70.7 years, females 77.8 years). Healthy life years (HLY) for women were 65.6 years and for men 62.1 years. Life expectancy at birth is slightly lower in Lovech, namely 73.53 years (males – 70.12, females – 77.20) (1).

e top three health problems at the na tional level according to disease-speci c mortality rates were: cardiovascular diseases (67.0%), cancer (15.7%) and respiratory sys tem diseases (3.7%). Morbidity rates show that cardiovascular diseases (CVD) (14.9%), respiratory diseases (11.3%), and malignant cancers (3.6%) were the leading causes of hos pitalization (1). According to data from 2011 (1), all three health problems are found more often in the north-western and north central regions of Bulgaria.

e leading causes of mortality in Lovech are consistent with those for the country. e CVD-speci c mortality rate is signi cant ly higher than the national average, com pris ing 80.7% of the total regional mortality rate in 2011. e cancer-speci c mortality rate is lower than average. Negative demographic and health trends in Lovech persist and most (socio-economic) indicators are less favourable than the national average.

Needed Action(s) for Health

An aging population, unemployment and deteriorated social status are factors that di rectly a ect health status and increase chron ic non-communicable diseases, both at local and national levels. e leading risk factors for these diseases are lifestyle factors, e.g. smok ing, low physical activity, alcohol consump tion, unhealthy nutrition, obesity and aging.

Lovech is one of the demonstration areas that has been participating in the CINDI pro gram in a series of studies and activities aimed at reducing the harmful e ects of multiple risk factors for human health for more than 20 years (since 1995). An association was es tablished in 2004 called the `Public Health Initiative`. is public coalition supports pro gramme implementation. A child component was added to the CINDI program in 2008. e positive results and trends observed over the 10-year period are promising and help

focus e orts primarily on those risk factors characterized by greater stability – smoking, alcohol and low physical activity. A good prospect for this program would be to integrate health services into a broader intersectoral commitment to promote healthy living habits and a health-supportive social environment.

e Lovech action plan will focus on the prevention of smoking. Lovech has the highest smoking rate amongst adults (44.3% males, 33% females) and adolescents (33.7%) out of all the municipalities. e Roma population in Lovech numbers 5705 persons or 4.38% versus 4.87% at the country level (1). More information on the life style habits and health literacy of the Roma population is needed. Implementation of activities related to health promotion and disease prevention should be included in the Lovech Regional Strategy for Roma Integration (2012-2020), which was developed in cooperation with various stakeholders, in particular with Roma NGOs (3). Greater consistency and coordination between all institutions involved in the Roma Integration Regional Strategy is still required.

e Regional Health Inspectorate possesses more comprehensive data about the Roma community in the region, such as employment and educational levels, routine examinations and immunizations as a result of regional strategy monitoring activities. ese data could be of assistance in developing and implementing the action plan for reducing health inequalities.

Challenges that should be considered when implementing the Action Plan include the organization and coverage of the Roma population and the assurance of a su cient number of health mediators for the Roma population in municipalities. e network of health mediators should be expanded so as to comprise at least one mediator for each municipality. Barriers comprise uncertain funding, lack of mechanisms for involving physicians in the Action Plan and insu cient coordination between institutions.

Facilitating factors for the action plan are the existence of the current Regional Strategy for Roma Integration (2012-2020), existing expertise, good training practices, commitment, and the presence of NGOs in the Roma community. e active participation of the municipalities and su cient nancial resources are needed to realise the action plan.

2. Republic of Croatia – Međimurje County

General data

According to the latest population census (2011), Croatia has a population of 4,284,889 inhabitants living predominantly in four of the twenty counties and in the City of Zagreb (1). Me imurje is a county located in the nørth ern part of the Republic of Croatia. (Figure 1). e Me imurje County (Me imurje) is the smallest county with 113,804 inhabitants (55.601 men and 58.203 women). It is the sec ond most densely populated county in Croatia (156.11 inhabitants per sq. km). e county is administratively divided into three towns and twenty-two municipalities. e capital of Me imurje is akovec (2).

Socio-economic factors

Although Croatia is, according to the International Monetary Fund, an emerging economy, socio-economic inequalities do exist between and within the counties. In Croatia 21.1% of the population is at risk of living un

der * [(2)43(1)3it e 5(h)7(e s)-1(m)-11(a03(s)-3(us)-3(us)-3(us)-3(us)-3(us- i)3(us- i)3(a)1(i)-12

coronary syndrome (23). e combination of all these factors will be the focus of the Action Plan for Health in the Me imurje County for tackling CVD among young adult and mid dle-aged men as well as middle-aged and older women who are less educated and nancially dependant.

Needed Action(s) for Health

A number of di erent strategies and plans could contribute towards the successful exe cution of the Action Plan in Me imurje. In the Long-term County Health Plan 2008-2012, County Health Care Plan 2010 (25) and Development Strategy of the Me imurje County 2011-2013 the main topics of the up coming Action Plan for Health Inequality are designated priorities (24;26). Following

3. Republic of Estonia – Rapla County

General data

Estonia is a state in the Baltic region of Northern Europe with a population of 1,286,479 in January 2013 (1). It is a democratic parliamentary republic divided into 15 counties. e Rapla County (Rapla) is situated in the north-western part of Estonia and includes 10 rural municipalities (2). e total population was 34.442 in 2013 of which 48.2% was male and 51.8% female (3). e population of Rapla County constitutes about 2.7% of the total population of Estonia (4).

Socio-economic factors

Estonia has the highest gross domestic product per person among the former Soviet republics (5). It is listed as a “high-income economy” by the World Bank and identi ed as an “advanced economy” by the International Monetary Fund. It is a member of the Organisation for Economic Cooperation and Development. Although it is a high-income economy, 17.5% of the people lived below the poverty line in 2011 (6). A gender-gap exists with regards to income distribution (27% in 2008) as well as a 5.3-fold income gap between the lowest and highest income groups (7). Rapla County is a county where aspects of inequalities, lower educational levels and lower income, are more prominent than at the national level (11). e experience gained in the Rapla County with respect to tailored approaches for speci c target groups and psychosocial interventions will aid in tackling health inequality.

Rapla County is a rural area. Building, transport and agriculture are the primary industries there (8). Public administration, schools, health and social service play also an important role. Although the unemployment rate in Rapla County increased in 2012 (8.7%), it is still lower than average (10.2%) (9). e number of people at risk of living under the poverty line of 60% in the Rapla County equalled the national average of 17.5% in 2011. is may be due to the lower average income of 534 euros in 2011 compared to the national average of 672 euros (10). A lower average income often re ects a lower educational level (11). In 2011, 50.5% (aged 15-74) had an upper secondary education in the Rapla County, which is much lower than the national average of 88.9% (aged 25-64) (12;13). is may explain the lower average income in the Rapla County. is inequity in income and educational levels compared to the national average are socio-economic factors which need to be taken into account when tackling health inequality.

Health and Health Inequality

e life expectancy at birth was 75.73 years in the Rapla County in 2010/2011, which is slightly lower than the national average of 76.28 years (14). e life expectancy of women in the Rapla County is 81.0 years, which is 10.6 years longer than for men (15). e

number of these expected life years lived in good health is not known for Rapla County. Nationally, the gure is 57.3 years for women and 52.9 years for men (15).

e three main causes of death in Estonia in 2011 were cardiovascular diseases (53.7%), cancer (24.2%) and injury or poisoning (7.4%) (16). e percentage of people who died of cardiovascular diseases is lower in the Rapla County than the national average (48.9% versus 53.7%). e percentage of people who die of cancer is 1.1% higher for the Rapla County compared to the national average of 24.2%. Estonia has the highest mortality rates due to injuries in the EU (17; 18). e rates for injury and poisoning are slightly higher (9.4%) in the Rapla County than the national average. Various causes of injury and poisoning exist in the di erent stages of life. Between 2006 and 2009, an average of 161 young people (aged 0-18) per 1000 inhabitants su ered traumas and 123 middle-aged people (aged 19-64) per 1000 inhabitants suffered traumas and 71 older people (aged 65+) per 1000 inhabitants (20). Injury mortality is a problem, especially among men; in 2011, 36 men and 5 women died due to injury and poisoning in the Rapla County (16). Poisoning and suicide rank rst in death by injury in males in the 20-60 year age group. Suicide is strongly linked to emotional health and psychological conditions (20). Poisoning can be caused by poisoned water, alcohol poisoning and drugs. Alcohol also plays a very important role in death by injury among men. e majority of middle-aged suicide attempters (82%) were alcohol abusers. Also, most people who died due to injury were found to be intoxicated (20). Alcohol consumption and drug abuse play an important role in the injury rates of youth and adolescents. In Rapla County a study on alcohol consumption implemented in 2010 showed that out of all eleventh grade students aged 17-19 years old, 45% of the boys and 35% of the girls consumed hard liquor every month and 20% of the boys and 8% of the girls consumed hard liquor every week. In Rapla County the percentage of eighth graders who had tried drugs had decreased by almost 7% from 2008 to 2010 (from 17% to 10%); the percentage of eleventh graders who had tried drugs had grown by 9% from 2008 to 2010 (from 28% to 37%) (20). e foundations for health awareness and healthy behaviour are paved in childhood. Promotion of the physical and mental health and social development of children and young people should therefore begin in their youth. Family and the general environment play an important role in improving children's health. e priority actions should therefore be: 1. Promotion of the physical and mental health and social development of children and young people. 2. Prevention of injuries and violence among children and young people. 3. Prevention of chronic diseases and their risk factors among children and young people (22).

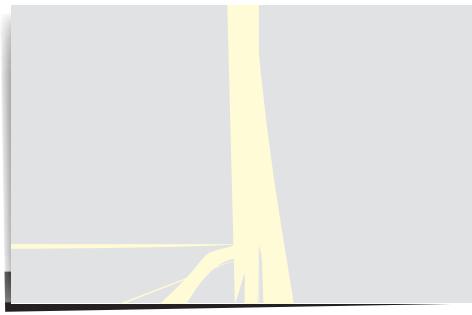
Needed Action(s) for Health

Prevention of injuries and alcohol poisoning is more e ective if access to alcohol is limited. Rapla County introduced one of the rst bans on the retail sale of any kind of alcoholic drinks at night in Estonia in 2003. All municipalities of Rapla County had xed restricted alcohol sales from 10 p.m. to 8 a.m. by 1st January 2008. Since the summer of 2008, the ban on the retail sale of any kind of alcoholic drinks at night has enforced throughout Estonia. Moreover, in Rapla County,

preventive activities related to alcohol are always combined with prevention of other addictions (e.g. smoking, drug abuse) (23; 24).

Rapla County has obtained immense experience regarding health promotion, especially injury prevention, e.g. Rapla County Health Profile (2005, 2011), Rapla County Injuries Profile (2010) and Rapla County Safe Community Program 2004-2009. A very strong network structure and a highly co-operative team for health promotion are in place. All partners have their own budgets for prevention. However, barriers still exist. Rapla County has insufficient knowledge and other resources for implementing situation analyses and evaluating the effectiveness of programmes. Although it possesses some experience in analysing environmental factors which affect injuries, a greater capacity is needed for the impact assessment of mental health as a determinant of injuries (e.g. stress, mental health problems, suicide and related alcohol and drug consumption). The team should be trained in the field of suicide and mental health; risk factors and risk groups should be identified; children in trouble need recognition and professional help. A national injury registry is required to support all this. Hence, the capacity for recognizing and solving mental health problems/disorders and suicide attempts should be established. The ERSI (Estonian-Swedish Mental Health and Suicidology Institute) is willing to play the key role in this field in cooperation with local health promotion specialists and practitioners in Rapla County. Unstable financing support and legislations that don't encourage "grass" level health promotion will be obstacles for building a network organization on this level (24). To be able to do so consistently it is imperative that national political attention will be placed on injuries and damage and their cost (more than 3 million euros per year) needs and the beneficial factors should be taken into account when setting up an action plan for health for the Rapla County.

4. Hungary – Sellye



General data

In January 2012, the population of Hungary was 9,957,731 and spread over seven statistical administrative regions in Hungary (1). All regions in turn, consist of counties; there is a total of 19 counties. The counties are further subdivided into 175 sub-regions ("kistérségek"). One of the counties is Baranya, which is situated in the southern part of Hungary on the border with Croatia (2). The Sellye sub-region lies within the Baranya County. This sub-region had 14,181 inhabitants in 2011 (3).

Socio-economic factors

The Hungarian economy is medium-sized and structurally, politically, and institutionally

– Updated Study, the 3 major health problems identi ed at the national level were cardiovascular diseases, cancer and injuries (14). On the local level, in Sellye in 2011, the most-common regional health problems based on the rate of mortality were cardiovascular diseases (41.8%), cancer (30.8%) and respiratory diseases (10.4%) (15). e main health problems among children under 14 years were allergies, asthma, orthopaedic diseases and malnutrition. e Action Plan will focus on children with respiratory diseases (allergy, asthma and other respiratory diseases) and malnutrition. Medical treatment is una ordable for most families. Poor housing also plays an important role in children's health status. For example, 33% of the ats in this area are without su - cient comfort and there is no tap water in 15% of the ats. e sanitation rate is only 17%. Health care services for children and persons in need of care and nursing are insu cient (9). ose conditions a ect health and subsequently, the ability to ful l school requirements (16).

Needed Action(s) for Health

e basis of the Action Plan for the Sellye sub-region is supported by data gathered within the Social Renewal Operational Programme of the New Hungary Development Programme (9). e data represented a professional and methodological foundation for the national extension of the Chances for Children Programme and was commissioned by the Hungarian Charity Service of the Order of Malta in 2012. It helped assess the socio-economic and health status of the sub-region. e knowledge, local expertise and manpower of these programmes can be used to realise a local Action Plan for Health Promotion to tackle upper respiratory diseases and malnutrition among children. Data from the experiences of other EU-funded projects implemented at the local level can also be used.

Within the New Hungary Development Programme, most of the applications in Sellye were submitted within the the South Transdanubia Operative Programme and the Social Renewal Operative Programme. e "Integrated Regional Programs for the Social Inclusion of Children and their Families" within the Social Renewal Operative Programme (S.R.O.P 5.2.3) aims to reduce and prevent poverty, particularly child poverty. e programme "Everything has a solution" – a complex family assistance programme with prevention aims (SROP-5.3.5-09/1) focuses on debt management and preventing further debts for people living in Sellye. A sub-regional outpatient care centre was established in Sellye within the Social Investments Operative Programme

for health promotion (17) such as, for example, a healthy school approach e.g. provision of school meals also in the summer time, a healthy respiratory environment within schools, safe play grounds, promotion of water consumption in schools, results in better school achievements. is school-oriented health approach is a good example of an integrated local health promotion programme which could contribute significantly to children's' health in the Selly sub-region. Based on several local workshops with local experts, decision makers, care and social welfare professionals and representatives of target groups, an appropriate action plan to address the lack of access to clean water, poor housing, and lack of education, malnutrition and upper respiratory problems will be set up.

5. Lithuania, Rokiskis

General data

A total of 2,993,534 people live in Lithuania (average annual population in 2012). Roskiskis is a district in the northeast corner of Lithuania with 33,851 inhabitants (46.5% male, 53.5% female)(1). Around 16,000 people live in the city of Rokiskis (2). Rokiškis is well known for its cheese. "Rokiškio sūris" is one of the largest cheese manufacturing companies in Lithuania. The company is a very important employer in the region and also an important supporter of community initiatives (2).

Socio-economic factors

The net average monthly wage in Lithuania was 461.83 euros in 2011. The gender pay gap was 11.9% in 2011 and income inequality 5.8% (1). The total population aged 25-64 for the whole country possessing at least an upper secondary education was 92.9%, while the percentage of early school leavers was 7.9% in 2011. The unemployment rate in 2012 was 11.7% (14.6% male, 10.6% female) (3). The percentage of the unemployed population aged 15-24 years old was quite a bit higher, namely 27.5% (1). Despite these facts, the percentage of the total population at risk of living under 60% of the income-poverty line in 2011 is quite high, namely 20.0%. Poverty and social exclusion are significant problems in Lithuania.

The monthly net average income for the Rokiskis district was 533.47 euros, which is slightly more than the national average (1). A total of 12.8% of the population in the Rokiskis district are unemployed, which is higher than the national rate. No information regarding the educational levels of the population in the region is available. However, Rokiskis is one of the disadvantaged regions in terms of unemployment and poverty.

Needed Action(s) for Health

Prevalence and incidence of cardiovascular diseases and death could be changed with policies and intervention as well a low-physical activity, malnutrition, smoking and alcohol consumption. Physical activity can be influenced by creating better cycling infrastructure, improving conditions for physical activity in green areas and creating new ones. Malnutrition can be influenced by creating better conditions for buying healthy food and reducing prices of healthy food (making a healthy choice an easy choice). Smoking can be reduced by creating more non-smoking areas and increasing the prices of tobacco products. Alcohol consumption requires special attention because there are a lot of illegal sources for obtaining alcohol products in the country.

Physical activity and nutrition should be tackled first. Low physical activity and malnutrition is a complex problem and causes not only a high prevalence of cardiovascular diseases, but also other diseases.

The Statutory Health Insurance Fund is the main source of financing for health-programs in Lithuania. The High Cardiovascular Risk Primary Prevention Programme was financed by this fund and significantly affected mortality caused by cardiovascular diseases in Lithuania. EU Structural Funds (European Social Fund, Cohesion Fund and the European Regional Development Fund) are available for financing programs involving local development, quality and accessibility of public services and environmental quality and energy efficiency that are intended to influence the major health problems in Lithuania.

However, the infrastructure of health care institutions in Lithuania does not meet the all necessary quality requirements nor do they meet communal needs sufficiently. Great differences regarding the availability of services exist in smaller municipalities and/or rural areas. Modern technologies and treatments demand greater funds for health care. The problem of the lack of human resources in some areas due to the migration of specialists also exists. The lack of good monitoring systems to observe whether services meet the needs of patients also hinders optimization of these services.

The Action Plan of Lithuania will focus on the prevention of cardiovascular diseases for the entire population and the accessibility of the health care system for all social groups. In order to reach this challenging goal, advanced training skills and an exchange of good practices in and between organisations are required. Greater support for health-politics in the Rokiskis district will also be needed. Enough staff is available. Nevertheless, improved skills of health care workers and the increased competence of health monitoring methods will be needed. Furthermore, financial and political support is also essential for success. Finally, a real challenge will also be the undertaking of efforts to obtain more support and leadership for health improvement and the tackling of inequalities in health through health promotion!

the capital Bratislava is an asset as many of the region's residents commute to work there on a

General data

e Slovak Republic had a population of 5,404,322 in 2011 (1). Slovakia is subdivided into 8 regions. e Trnava is a region in the west of Slovakia. It is the smallest and second most densely populated region in Slovakia, with 554,765 inhabitants in July 2011 (2,709,305 males, 2,838,365 females) (2; 3). e town of Trnava, the 'capital' of the Trnava region has the most inhabitants of the region.

Socio-economic factors

Slovakia is an advanced economy with one of the fastest growth rates in the European Union and the OECD (4). e country joined the European Union in 2004 and the Euro zone in January 2009. Even in a country with such fast growing rates, inequalities do exist between and within the regions and counties. e country had a gender pay gap of 20.5% in 2011 (5). e inequality of income distribu tion was 3.8% in 2011 between the lowest and highest SES groups (6). A total of 13% of the population lived under the 60% income-pov erty line in 2011 (7).

e Trnava region is quite productive in both industry and agriculture. Its proximity to

cardiovascular diseases (CVD) (52.6% vs. 50%), cancer (23% vs. 25.4%), diseases of the digestive system (6.3% Trnava) and injuries (5.4% Slovakia). The three main causes of death in Trnava were: CVD 19.8%, cancer 21.6% and digestive system diseases 20.8% (1). Data regarding underlying health determinants for morbidity and mortality rates due to cardiovascular disease is available at the na

to be addressed and an intervention performed to tackle the burden of CVD on society.

To be able to develop an action plan for health, data from the Trnava region is needed such as information on health determinants which could explain the prevalence and incidence of cardiovascular disease in the Trnava region. Education and health are closely linked and could be key priority in the action plan for health in te Trnava region. A life course perspective is accepted as good practice in public health and health promotion research and practice (20) and should be used; it is an effective way of targeting spe

7. Spain, Canary Islands

In the last ve years, the Canary Islands have ranked below Spain in terms of average income per person and per household. An analysis of income per capita shows that 39% of the pop ulation earned less than 500 euros per month per person, indicating the deprived situation in the Canary Islands. e data for the Canary Islands shows the disadvantaged the soєio-eco nomic position of this region, which together with the ongoing economic crisis, had resulted in serious problems for people’s daily lives and consequently, for their health.

for numerous diseases. Health professionals attempt to discover the reasons for the increasing tendency in overweight of 36.8% of the adult population (42.1% of males and 31.7% of females) and obesity (18.5% of the adult population) The percentage of women who are obese (19.24%) is higher than the percentage men (17.92%), in contrast to the percentages of overweight men and women (13). Special attention is needed for children as the prevalence of overweight and obese children is higher on the Canary Islands than on the mainland.

Being aware of these data and the need for special attention for children with respect to

e history of health mediation in Bulgaria began in 2001 when the Ethnic Minorities Health Problems Foundation developed the concept of health mediator and successfully introduced this new occupation in the Roma neighbourhood of “Iztok” of Kyustendil. e Ministry of Health implemented the PHARE project “Ensuring Minority Access to Health Care” in 2004, which aims to improve Roma people’s access to health services in 15 pilot municipalities, one of which was Lovech. e experience which all the pilot municipalities have gained and the consistent national policy for Roma integration allows municipalities to develop Action Plans for Roma integration and -integration of persons living in a situation similar to that of the Roma, with one of these Action Plans prepared for the Lovech Municipality (2012 – 2014).

Following the adoption of the Health Strategy for Disadvantaged Persons of Minority Descent in 2005, a new occupation – health mediator was institutionalized and included in the National Classi cation of Occupations with a relevant job description adopted. A training program for health mediators was developed and two medical colleges were licensed to carry out training for a fee.

e National Network of Health Mediators was founded in 2007. Further training and quali cations, workshops and conferences for the exchange of experience have been implemented repeatedly since then. e most recent training took place in January 2013. Institutions at the national level – the Parliamentary Health Committee and National Council for Cooperation on Ethnic Integration Issues of the Council of Ministers of the Ministry of Health strongly support health mediation and mediators. e Bulgarian experience of implementing health mediation is considered one of the most successful in the region. e National Strategy for Roma Integration 2012-2020 also gives the health mediators an important role at the implementation stage.

Health mediators emerged as a key element in e ectively tackling the greatest health inequalities, particularly those of disadvantaged persons, including minorities. e health mediator is a coordinator, a bridge between people of minority communities and groups on the one hand, and health and social services, on the otso gitw(s)-6(o g)-16(2g)-16(2g)2(a)-281(

2.

always win" approach. is slogan metaphor ically represents the concept "health", and highlights the importance of the "point" in the middle of it.

Objectives

e promotion of health through educational interventions at the community level in the areas of nutrition, physical activity, stress and relaxation, sexual health, tobacco consumption and alcohol are all contained in the Circles of Life. e purposes of each of these areas are:

- t to raise awareness-health promotion in children, adolescents and the adult population,
- t to promote the advantages of a healthy lifestyle,
- t to teach about health risks and improve the perception of them,
- t to teach about the main determinants of health,
- t to prevent health risks.

http://www2.gobiernodecanarias.org/sanidad/scs/contenidoGenerico.jsp?idDocument=4d7d0d3e-a8c5-11e1-a270-87db0c674047&idCarpeta=cc8a68ff-98de-11e1-9f91-93f3670883b5

http://www.youtube.com/watch?v=ay6B0Grqkd4

Promising practice Lithuania

Mental health care access for children with mental, behavioral and emotional disorders in Lithuania

Health inequalities across socioeconomic groups are a health and public policy concern in all countries, being considered a measure of the performance of health care systems. Health inequalities are preventable and inequities in health status are experienced by certain population groups. People in lower socio-economic groups are more likely to experience chronic ill-health and die earlier than those who are more advantaged. Health inequalities are not only apparent between people of different socio-economic groups – they also exist between genders and different ethnic groups [1].

Health care services require appreciable conditions of health care with secured economic, communicative and organizational accessibility of health care for individuals and the community. e quality of health care depends on its accessibility and performance, i.e. whether services for patients are provided or not, and if given whether they are accredited or not. [2].

Analysis of the quality of health care services based only on the assessment of the professional quali cations of medical sta and statistical indicators of population health (mortality, morbidity, complications, disability, frequency of sick leave) is insu cient. Patients' views on health care service quality have become an integral part of evaluating the quality of health care. Patients' evaluations may be used to expose weak links in the health care system, an area which health care managers and politicians should pay more attention [3].

Quality of health care services, satisfac tion of patients, etc. are analysed in di er ent studies. However, there is a lack of assess ment of services for children's mental health in Lithuania.

Purpose:

To evaluate the accessibility of primary mental health care to children (aged 0-17) with mental, behavioural and emotional dis orders in Lithuania in 2008-2010.

Methods:

To describe and evaluate personnel provid ing primary mental health services for children with mental, emotional and behavioural disor ders in di erent regions of Lithuania in 2008–2010. Indicators were calculated (prevalence, number of employees, child psychiatrist-work load) using data from the Health Information Centre of the Institute of Hygiene and State Mental Health Centre database.

Access to the Primary Mental Health Centre (PMHC) was evaluated via the subjec tive opinion of respondents (parents/caretakers of children with mental, behavioural and emo tional disorders). Two PMHCs (one from the city, another from a rural area) were selected randomly in each of the ten regions. A sample was formed by consecutively enrolling approx imately 25 parents/caretakers of children with mental, behavioural and emotional disorders in each PMHC. e sample size totalled 369 respondents.

accessibility in PMHC were assessed as good despite the type of residence (urban or rural) with distance not posing a problem in obtaining services.

Conclusions:

Inequalities were identified between the number of staff (especially child psychiatric staff) and workload in the various regions of the country. In some mental health centres there was no child psychiatrist, but medical services for children were provided. Availability of services in PMHC were considered adequate by the respondents although it was shown that some organizational aspects would have to be adjusted to improve accessibility. Organizational and communicative accessibility in mental health centres were considered to be good, irrespective of the place of residence (city or district) of the patients with distance not considered an obstacle for access to services. Following this study in 2000, the Ministry of Health of the Republic of Lithuania issued Order no. 730 "Description and performance principles of requirements for children's and adolescent psychiatry and psychotherapy services" which specifies in Annex 1 that children's and adolescent health care teams are to be organized in PMHCs which do not have a child psychiatrist, clinical psychologist, mental health nurse or social worker.

To reduce inequalities, the Ministry of Health of the Republic of Lithuania issued Order no. V-943 in 2005: "Primary ambulatory health care services organization and payment arrangements and primary ambulatory health care services and basic price list-mounting" (in., 2005, Nr. 143-5205) which specifies that 20,000 patients instead of 40,000 patients shall be serviced by one full time psychologist in primary health care centres.

References:

CDC Health Disparities and Inequalities Report – United States, Vol. 60; 2011;

Law on health insurance of the Republic of Lithuania. Valstyb s inios. 1996; Nr. 55-1287;

t Kal din R., Petrauskien J., Bankauskait V. Lyginamoji dviej Lietuvos rajon gyventoj sveika tos ir demogra ni socialini charakteristik analiz . Visuomen s sveikata, 1998; Nr.2-3. P. 3-10.

Promising practice Croatia

''Together we are stronger – the education project of peer assistance in addiction''

Risky behaviour in connection to the use of addictive substances is becoming an even more prominent public health problem in Croatia, as well as in the Me imurje County. After the ''Picture of Health of the Me imurje County'' was implemented, excessive alcohol consumption and smoking were chosen as one of five priority problems in the county. In 2007, the task group dealing with the aforementioned problem initially carried out a qualitative research on alcohol consumption among children and youth entitled ''Youth and alcohol'', followed by a quantitative research called ''Attitudes, habits and use

of addictive substances among youth in the Me imurje County''. e survey carried out on a randomly selected group of pupils in the seventh and eighth grades of primary school and second grade of secondary school showed the beginnings of alcohol consumption to be shifting to a younger age – many of our respondents had been drinking alcohol regularly since the seventh grade. By the second grade of secondary school, 66.3% of the boys and 47.7% of the girls had experienced drunkenness, which is considered risky behaviour. e fact that 12.3% of the boys in the seventh and eighth grades are smokers (daily and periodically) is alarming, while 8.4% of girls of the same age group could also be categorised as smokers.

Alcohol consumption and smoking appear to be the most common examples of the use of addictive substances among children and youth in the county, and the results of the research that con rm this statement have been presented and published. e survey did not show signi cant di erences in these habits between the pupils of urban and rural schools.

e association ''SMILE'' with the goal to help children and youth, which is active in Me imurje County, has designed and carried out the proj27(r)-(08(t)-37(y)f6(o)3(n)-20(s)-10(u)-29(m)(o b)-8(ee)-10(e)-2(n e)-19(1(r)-11(i.0

Promising practice Hungary

“Promoting Sure Start” Project – Social Renewal Operative Programme 5.1.1.-09/9

e project was implemented in Northern Hungary, in Sárospatak, a small region of Borsod-Abaúj-Zemplén County. Due to the disadvantaged situation of the small region (ageing and a declining population, an ınem

e mentors helped the independent work of trained health educators during the train ing period.

e members of the target group conducted activities related to the organization and man agement of “Health Days” in their own settle ments. ey participated in health education tasks with the guidance of health visitors and as sistance of social workers. To raise awareness of the importance of lung screening, they contact ed the population personally, disseminated leaf lets and helped organize screenings in screening buses. us, they assisted the care service sys tem. ey gained experience regarding the care system not only as clients, but also as actors.

Some of the members of the target group had the opportunity to attend social care-training, which provided a certi cate of the National Quali cations Register (NQR).

After the completion of the program, contact was kept with participants. ey received sup port in nding work with their employment continuously monitored and quarterly round-table discussions organized. Consultations

e EAAD (European Alliance against Depression in English or Eesti Depressioonivabaks in Estonian) project is a EC public health project (2004-2008). e main aim of this 4-level community-based intervention program was to prevent suicidal behaviours through the development of a sustainable net

e aim was to disseminate concepts on how youth depression and how to raise awareness to cope with negative emotions, how to prevent about this disease among youth.

Promising practice Slovakia

In 2011, 105,738 people who identi ed themselves as members of the Roma com munity lived in Slovakia (SOSR, 2013a). e Roma community (hereafter referred to as Roma) is the third most common nation ality in the Republic (80.7% Slovaks, 8.5% Hungarians, 2% Roma). Compared to an ear lier census conducted in 2001 (89,920 – 1.7% Roma) the number of Roma had increased by 0.3% (ibid.). Although o cial estimates put

Roma health mediators (about 30 community workers) worked for four days in the commu nity and one day in the o ce of the RPHA.

e RHM's work was focused on health-ed ucation, medical assistance, monitoring of life style and health status, cooperation with local schools and stakeholders and organization of sport activities (MHSR, 2007; Kállayová and Bošák, 2012; National Authority of Public Health, 2008b).

e implementation of educational interven tion activities in the eastern part of Slovakia, respectively in the Olšovce-Kecec

r-1(e)-18(g)-69(i)5(o)10(n)9(,(i)-12(an p)9(r)-11 a)-8(c)-16(t)-19(i)6(c)-23(a)-34(l)1 eampl6 ne,diarcenzainsio2((n)-22(i)32,t)-19Ii

eieo2((H)21(e)-23(R)421(n16(t)-35(l(a)36((n)-6(dDh)35ie)-20vt))4(e)-9rc)-19(s)85(i77tw)440

r52787(t)-65(i)35(e)2h-1(e5

Roma communities for the years 2009-2015. Accessed 16 April 2013. Available at: http://www.uvzsr.sk/docs/info/podpora/romovia/romovia_2_etapa.pdf

t National Authority of Public Health, 2008b. Evaluation Report on 1st phase – Health promotion program focused on marginalized Roma communities for years 2007-2008. Accessed 16 April 2013.

Low income levels do not necessarily re ect countries. Regional percentages of people at poverty. For example, o cial data shows that risk for living under the poverty line are gener Spain has the highest average net income ad ly lower than the national average in the par the seven countries, but also one of the highest pating countries. In the AROPE rates (used percentages of people living at risk of be- also in the EU 2020 report on poverty), data ing poor. In addition, the minimum salary in on the severely materially deprived or those Spain is established at € 645.30 in 2013 (see living in households with very low work in- Table 1). e proportion of the population at sities were also taken into account in addition risk for living under the poverty line in 2011 to data for the proportion of the population at ranged from 13.0% to 21.8% between the risk of poverty.

Country Level	Monthly Income	Unemployment	Secondary Education	At risk of Poverty (income) 2011 (%)	(AROPE)
Bulgaria	€ 454.60 (2011)	12.4% (2012)	43.4% (2012)	22.3% (2011)	49.1%
Croatia	€ 737.00 (2010)	18.3% (2011)	58.3% (2011)	21.1% (2010)	32.7%
Estonia	€ 672.00 (2011)	10.2% (2012)	88.9% (2011)	17.5% (2011)	21.7%
Hungary	€ 483.00 (2012)	10.9% (2012)	82.1% (2012)	13.8% (2011)	31.1%

Country Level	Life Expectancy	HLY	NHP1 (mortality rates)	NHP2 (mortality rates)	NHP3 (mortality rates)
Bulgaria	73.9 years (2011)	65.6 m 62.1 f			

issues for speci c target groups (e.g. Roma people). Other needs consisted of support in building networks, strengthening partnerships and support for an intersectoral approach in

Preface, Health & health inequalities in EU, Methods used

1. WHO, Glossary terms used, 2013, http://www.who.int/hia/about/glos/en/index1.html
2. Michael Marmot, Fair Society, Healthy Lives – Marmot Review, 2010
3. Saan& De Haes: Gezond e ect bevorderen, het organiseren van e ectieve gezondheidsbevordering. NIG Woerden, 2005
4. Saan, de Haes, Hekkink: Eindrapport pilot referentiekader 206-2007, NIGZ, 2007
5. Saan ea.: (artikel): Gezondheid duurzaam bevorderen. Gezondheidsbevordering is een marathon, geen sprint. 8 (2010): 255-66
6. World Health Organisation Europe. e European health report 2012:charting the way to well-being.

Croatia

1. e Croatian Bureau of Statistics, Census 2011, available at http://www.dzs.hr/Hrv_Eng/publication/2012/07-01-02_01_2012.htm(e Croatian Bureau of Statistics, First Release, Zagreb, 15 JUNE, 2011, number; 7.1.2. Migration of population of the Republic of Croatia, available at http://www.dzs.hr/Hrv_Eng/publication/2012/07-01-02_01_2012.htm
2. Wikipedia. Me imurje County. http://en.wikipedia.org/wiki/Me%C4%91imurje_County
3. At-risk-of-poverty rate by sex (source: SILC) %, (EUROSTAT, 2010), available at http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=en&pcode=tessi010&plugin
4. Table-Inequality of income distribution, Income quintile share ratio (EUROSTAT 2011), available at http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=en&pcode=tsdsc260&plugin=0
5. e Croatian Bureau of Statistics. Employment and Wages 2011. Statistical reports, Zagreb, 2012, available at http://www.dzs.hr/Hrv_Eng/publication/2012/SI-1476
6. EUROSTAT; 2011. available on http://epp.eurostat.ec.europa.eu/tgm/table.do?tab=table&init=1&language=en&pcode=tessi010&plugin
7. e Croatian Bureau of Statistics, Employment and Wages 2011, Statistical reports, Zagreb, 2012, http://www.dzs.hr/Hrv_Eng/publication/2012/SI-1476.pdf
8. Croatian Bureau of statistic. Census of population, households and Dwellings, 2001.Population aged 15 and over, by sex and educational attainment, by towns/municipalities, available at http://www.dzs.hr/Hrv/censuses/Census2001/Popis/H01_01_07/H01_01_07.html
9.

17.

7. Eurostat Database,

6.

20. Osler, M. (2006), ‘ e life course perspective: a challenge for public health research and prevention,’ Europea Journal of Public Health 16 (3), p. 230
21. Wikimedia Commons (2013) Kraje Since July 24, 1966 (Regions of Slovakia) https://en.wikipedia.org/wiki/File:Slovakiakrajenumbers.png (Accessed: 23rd May 2013)

Spain

1. INE (National Statistics Institute), 2010-2013, Spain
2. Wikipedia, Canary Islands, Spain, http://en.wikipedia.org/wiki/Canary_Islands
3. ADECO report, 2013. Fundación ADECO, Spain. http://www.fundacionadecco.es/Home/Home.aspx?Modo=Acc (It can´t be easily access because you have to ask for that)
4. Eurostat,

Conclusions

1. Bulgaria (Lovech region), Croatia (Medimurje County), Estonia (Rapla County), Hungary (Sellyesubregion), Lithuania (Rokiskis), Spain (Tenerife), Slovakia (Trnava region).
2. Saan& De Haes: Gezond e ect bevorderen, het organiseren van e ectieve gezondheidsbevordering. NIGZ, Woerden, 2005
3. Saan, de Haes, Hekkink: Eindrapport pilot referentiekader 206-2007, NIGZ, 2007
4. Saan ea.: (artikel): Gezondheid duurzaam bevorderen. Gezondheidsbevordering is een marathon, geen sprint. TSG 8 (2010): 255-66
5. Bulgaria (Lovech region), Croatia (Medimurje County), Estonia (Rapla County), Lithuania (Rokiskis), Slovakia (Trnava region).

Co-funded by
the Health Programme
of the European Union