Deloitte.

Rompiendo el ciclo de la dependencia

Abordar las desigualdades en materia de salud de las familias vulnerables

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Deloitte Centre *for* Health Solutions

Centro Deloitte para Soluciones de Salud
El Centro Deloitte para Soluciones de Salud del Reino Unido es el brazo de investigación de las prácticas de salud y ciencias de la vida de Deloitte LLP. Nuestro objetivo es identificar tendencias emergentes, desafíos, oportunidades y ejemplos de buenas prácticas, basados en investigaciones primarias y secundarias y análisis rigurosos.

El equipo de investigadores del Centro busca ser una fuente confiable de información relevante, oportuna y confiable que fomente la colaboración en toda la cadena de valor de la salud, conectando a los sectores público y privado, proveedores y compradores de salud, pacientes y proveedores.
Nuestro objetivo es ofrecerle perspectivas únicas para apoyarle en el papel que desempeña en la conducción de mejores resultados en salud, el mantenimiento de una economía sanitaria fuerte y la mejora de la reputación de nuestra industria. En esta publicación, las referencias a Deloitte son referencias a Deloitte LLP, la firma británica miembro de DTTL

Contenido

Prefacio

Bienvenidos al informe del Centro Deloitte para Soluciones de Salud ***Rompiendo el ciclo de la dependencia: Abordar las desigualdades en materia de salud de las familias vulnerables,*** que examina cómo los determinantes sociales de la salud afectan a las desigualdades de salud en Europa Occidental.

Nuestro enfoque incluye una síntesis del gran volumen de investigaciones académicas y políticas existentes sobre desigualdades en salud y determinantes sociales de la salud, un análisis de los numerosos conjuntos de datos nacionales e internacionales de métricas de salud y la identificación de ejemplos de buenas prácticas basadas en evidencia. Esto nos ha proporcionado un cierto grado de comprensión de este asunto tan complejo. También destacó que, en lo que respecta a los países de ingresos altos, las desigualdades en materia de salud varían más en el país que entre los países.

Dada la enorme cantidad de investigaciones sobre el tema, este informe pretende examinar los desafíos que afronta Europa Occidental para reducir las desigualdades en materia de salud a través de la perspectiva de algunas de las personas más desfavorecidas de la sociedad, donde el hecho de no abordar las causas y los efectos de las desigualdades en materia de salud ha dado lugar a distintos grupos de familias vulnerables y en problemas.

Hemos desarrollado un conjunto de personajes que representan a los diferentes miembros de una familia "típica" vulnerable. Al centrarnos en este grupo relativamente pequeño, pero económicamente importante de personas desfavorecidas, también hemos podido explorar el impacto de los niveles intergeneracionales de privación social. Nuestra hipótesis es que, si se pueden identificar los sistemas, procesos e intervenciones que podrían ayudar a los países a enfrentar los desafíos de sus miembros más vulnerables de la sociedad, estos mismos enfoques podrían ayudar a mejorar las desigualdades en salud de manera más general.

Por consiguiente, nuestras ideas se presentan de una manera que pretende ser deliberadamente diferente, provocadora y que haga pensar para estimular el debate y la discusión sobre la medida en que los desafíos y las soluciones que identificamos pudieran aplicarse a nivel nacional.

Esperamos que el informe fomente acciones que no sólo aborden las necesidades de las familias vulnerables de todo el mundo, sino que también ayuden a reducir las desigualdades generales en el ámbito de la salud.

Como siempre, agradecemos sus comentarios y sugerencias para futuros temas de investigación.

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Resumen ejecutivo

En Europa occidental, el marcado aumento de la esperanza de vida en las últimas décadas no siempre está correlacionado con la vida de buena salud; de hecho, cuanto mayores son las disparidades de ingresos dentro de un país, mayores serán las desigualdades sociales y de salud. Las explicaciones convencionales de las desigualdades en materia de salud, como la falta de acceso a la atención médica y los estilos de vida poco saludables, proporcionan sólo una parte de la explicación. Las causas más intransigentes son los determinantes sociales de la salud, incluido el acceso y las oportunidades a la educación, el empleo, la vivienda, el transporte público y los servicios de bienestar social.

Todos los países, independientemente de la madurez de sus servicios de salud y asistencia social, experimentan niveles variables de desigualdad en materia de salud en el país, con un exceso de mortalidad y reducciones en años de vida saludables correlacionado con la carencia regional.

En todos los países de Europa occidental, las "familias vulnerables" o "en dificultades", definidas como aquellas que están en contacto con varios departamentos de la autoridad local, incluido el sistema de bienestar infantil o juvenil, son una preocupación creciente. Estas familias rara vez logran romper la espiral negativa, que conduce a la persistencia de la pobreza, la privación y la dependencia transgeneracional del apoyo público. Vivir en familias vulnerables acentúa el riesgo de tener deficientes resultados en la vida para quienes más dependen de las estructuras familiares, especialmente los niños y los adolescentes. La incapacidad actual de abordar los determinantes sociales de la salud de estas familias vulnerables está creando costos y presiones sociales en la sociedad que se pueden evitar.

En el informe se ilustra cómo la adopción de un enfoque basado en el ciclo de vida para las familias vulnerables puede mejorar la orientación, el establecimiento de prioridades y el impacto de los servicios en todas las etapas de la vida. Proporciona pruebas de investigación actuales, así como ejemplos de buenas prácticas centrados en:

- Maternidad y primera infancia, proporcionando una base sólida para el resto de la vida
- Infancia y adolescencia, estableciendo comportamientos saludables y fortaleciendo la resiliencia
- Edad adulta y vida laboral, creado las condiciones para una vida productiva
- Ancianidad y el aumento de la fragilidad, logrando la igualdad en la duración y calidad de vida
- Enfoque integrado de todo el sistema, que mejore los resultados en todas las etapas de la vida.

Es probable que al dar a cada niño el mejor comienzo posible en la vida se entreguen los mejores beneficios sociales y generales para la salud. Sin embargo, romper el ciclo de dependencia para las generaciones futuras también requiere mejoras en las condiciones de vida y de trabajo de los miembros adultos y ancianos de la familia.

Deloitte cree que abordar las desigualdades de los miembros más vulnerables de la sociedad sentará las bases para reducir las desigualdades en materia de salud de manera más general y que es posible lograr un cambio sostenible si todos los encargados de formular políticas, proveedores de servicios públicos, organismos y otras partes interesadas están dispuestos a:

- Trabajar más allá de las fronteras institucionales y profesionales y con el sector público en general para tomar decisiones colectivas sobre cómo y dónde invertir en acciones conjuntas para lograr mejores resultados
- Adoptar un enfoque coordinado de gestión de casos con un punto de enlace basado en la comunidad para acceder a los servicios
- Implementar la analítica y la tecnología digital de manera eficaz tanto en la planificación como en la prestación de servicios
- Proporcionar niveles adecuados de financiación social y de salud, basado en la evaluación económica de los costos y beneficios, y considerando la posibilidad de introducir nuevos modelos de financiación integrada e incentivos alineados en todas las partes del sistema.

En todos los países de Europa existe un margen significativo para trabajar juntos de manera más eficaz para abordar los determinantes sociales de la salud y reducir las desigualdades sanitarias. Este es un imperativo moral y económico, si los países han de proporcionar un futuro equitativo, seguro y saludable para todos.

Todos los países, independientemente de la madurez de sus servicios de salud y asistencia social, experimentan niveles variables de desigualdad en materia de salud en el país, con un exceso de mortalidad y reducciones en años de vida saludables correlacionado con la carencia regional.

Los datos duros de la desigualdad en la salud

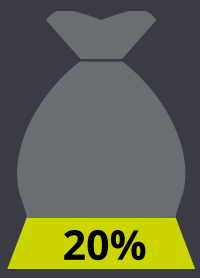
El alto precio de la desigualdad en salud

El cuidado de la salud solo determina

15-25%

de los resultados en materia de salud

Las desigualdades sanitarias representan aproximadamente el 20% de los costes sanitarios europeos (177.000 millones de euros).



Los entornos urbanos tienen una brecha de esperanza de vida de **20** años a lo largo del gradiente social

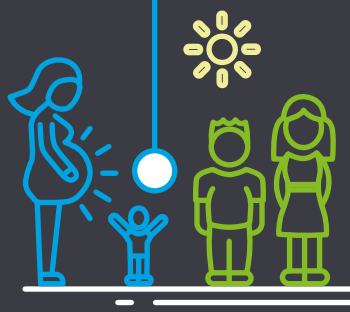
Vulnerabilidad durante todo el ciclo de vida

Maternidad y primera infancia

En el eino Unido la mortalidad infantil es más del **doble** en los grupos socioeconómicos más bajos en comparación con los más altos.

La esperanza de vida de un niño aumenta cuando cumple **1 año**, lo que significa **que su primer año es el más vulnerable.**

Cada año adicional de educación recibido por las madres conduce a una reducción del **7-9% de la mortalidad** entre los niños menores de **5 años.**



La Infancia y adolescencia

Los niños europeos con el mayor nivel educativo pueden esperar vivir **5.6 años** más que aquellos con el nivel más bajo.

Más desfavorecidos

Más afluentes

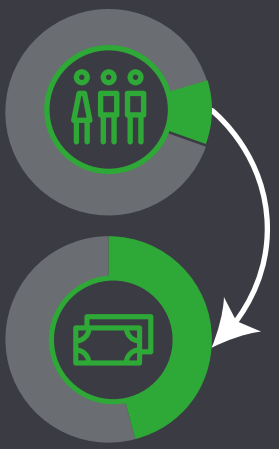
El **40%** de los niños en las zonas más desfavorecidas de Inglaterra tienen sobrepeso, pero sólo el **27%** en las zonas más afluentes.

En la UE, la desigualdad sanitaria contribuye a

700,000 **muertes** y **33m** de casos de mala salud.

Investigaciones danesas muestran que el

10% de los beneficiarios sociales más vulnerables representan...



La desigualdad sanitaria recorta un **1.4%** del PIB europeo (146.000 millones de euros) de la productividad de la fuerza laboral cada año.

...el **46%** del gasto.

Edad adulta y vida laboral

Los trabajadores en empleos mal remunerados están más expuestos a riesgos para la salud.

Cada aumento del **1%** del desempleo europeo entre 1970 y 2007 impulsó un aumento del **0,79%** de los suicidios en edad de trabajar.

En Dinamarca, el tabaquismo y las muertes relacionadas con el alcohol representan el **64%** de la desigualdad social en la mortalidad de los hombres.

El **10%** de las comunidades más desfavorecidas en Inglaterra tienen 5 veces menos espacio verde que el 20% más rico

Vejez

Las personas mayores de los grupos socioeconómicos más bajos tienen un **30 -65%** más de probabilidades de enfrentar enfermedades crónicas.

El aumento de la privación de vivienda está vinculado a un **menor número de años de vida saludables después de los 65 años.**

El **69%** de los europeos que carecen de conocimientos digitales básicos tiene más de 55 años.

Las personas mayores con los ingresos más bajos tienen **5 veces menos** probabilidades de utilizar la web que las personas con los ingresos más altos.

Desigualdades en la salud y el impacto en las familias vulnerables"

"La vida... forma una cadena larga e ininterrumpida de generaciones, en la que la niña se convierte en la madre y el efecto se convierte en la causa".

Rudolf Virchow, 1858[1]

La OMS (Organización Mundial de la Salud) define la salud como "un estado de completo bienestar físico, social y mental, y no simplemente la ausencia de enfermedades o enfermedades"; la salud también incluye la capacidad de las personas para llevar una vida social y económicamente productiva. 2

Tradicionalmente, los resultados en materia de salud se han evaluado midiendo la esperanza de vida al nacer y a los 65 años. Durante el siglo XX, la esperanza de vida aumentó drásticamente entre las poblaciones más ricas del mundo, desde alrededor de 50 a más de 75 años, impulsada por mejoras en la salud pública, la nutrición y la medicina, entre ellas:

- Programas de inmunización y antibióticos que redujeron considerablemente la mortalidad infantil
- Aumento de la salud y la seguridad que redujo los riesgos en los lugares de trabajo manual
- Reducción en el número de personas fumadoras.

El continuo aumento de la esperanza de vida se debe casi en su totalidad a la disminución de la mortalidad tardía como resultado de los progresos sustanciales en la reducción de la mortalidad por enfermedades cardíacas, accidentes cerebrovasculares, tabaquismo y otras causas susceptibles de intervención médica.[3]

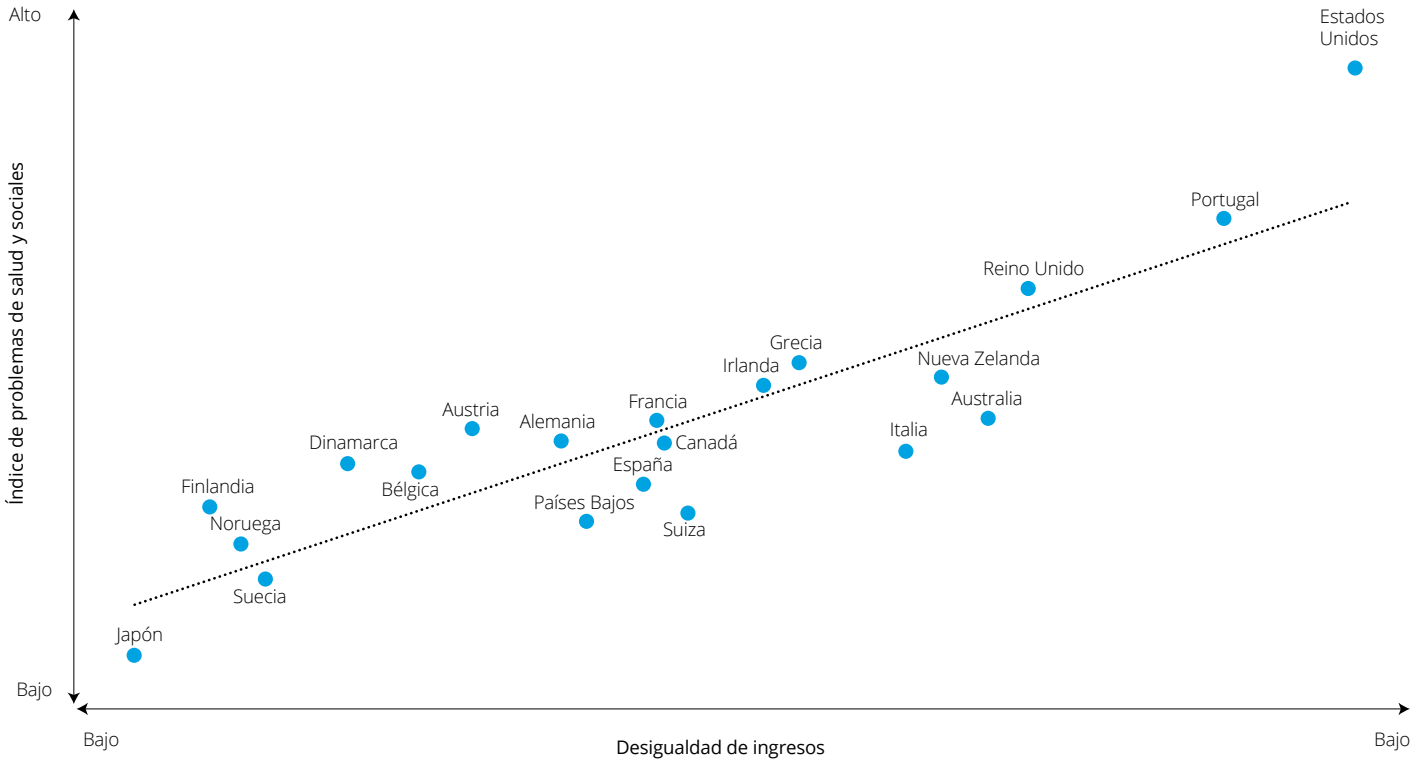
Comprendiendo las desigualdades en la salud

Sin embargo, el aumento de la esperanza de vida no siempre se correlaciona con una vida con buena salud. Las personas viven más tiempo, pero a menudo padecen enfermedades múltiples y complejas de largo plazo. Como resultado, se utilizan indicadores como los años de vida saludables (AVS) como una medida importante de la salud relativa de las poblaciones de la UE. Entre 2010 y 2014, en muchos países de la UE prácticamente no se registraron avances en los AVS para hombres y mujeres, y en algunos países se ha producido un descenso. [4]

Aunque la mayoría de los países de Europa occidental han experimentado una mejora en la esperanza de vida, también han experimentado un marcado aumento de la desigualdad social en las últimas décadas. Una comparación entre países demuestra que cuanto mayor es la desigualdad de ingresos dentro de un país, mayores son los problemas sociales y de salud, que se deben en parte a la reducción de la cohesión social dentro de las sociedades (consulte la Figura 1).

La OMS define la salud como "un estado de completo bienestar físico, social y mental, y no simplemente la ausencia de enfermedades o enfermedades"; la salud también incluye la capacidad de las personas para llevar vidas sociales y económicamente productivas.

Figura 1. Los problemas sanitarios y sociales empeoran en los países más desiguales



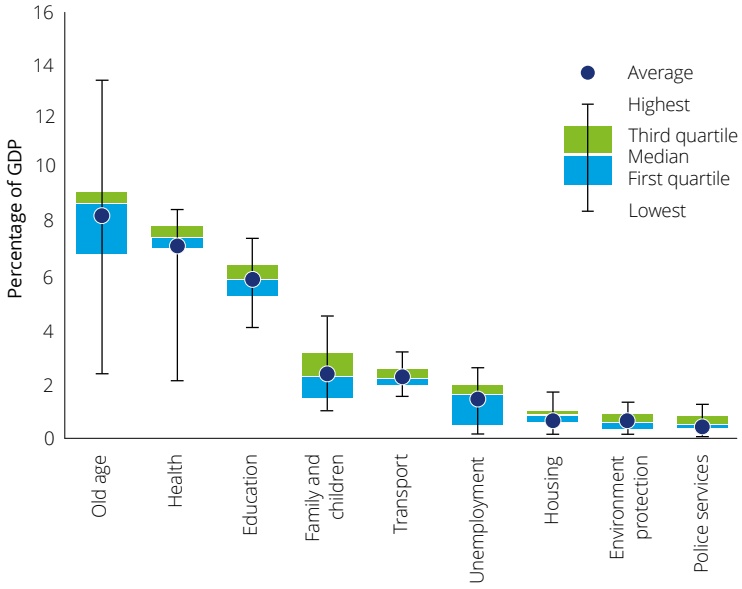
Fuente: The Spirit Level, 2009

Las desigualdades en materia de salud son el resultado de una variedad de factores interrelacionados y superpuestos. Existe una importante distinción entre las desigualdades en salud que son intrínsecas (por ejemplo, la genética) y las que son producto de sistemas y estructuras sociales, privilegios y poder, y que son potencialmente evitables (conocidas como inequidades en salud).

Figura 2. Los determinantes fuera de la asistencia salud y más allá del control individual determinan los resultados de la salud

Figura 2a. Determinantes de la asistencia de salud y su contribución a los resultados sanitarios

Figura 2b. Gasto público general medio en ciertos factores determinantes de la salud (como porcentaje del PIB) en los países de Europa Occidental



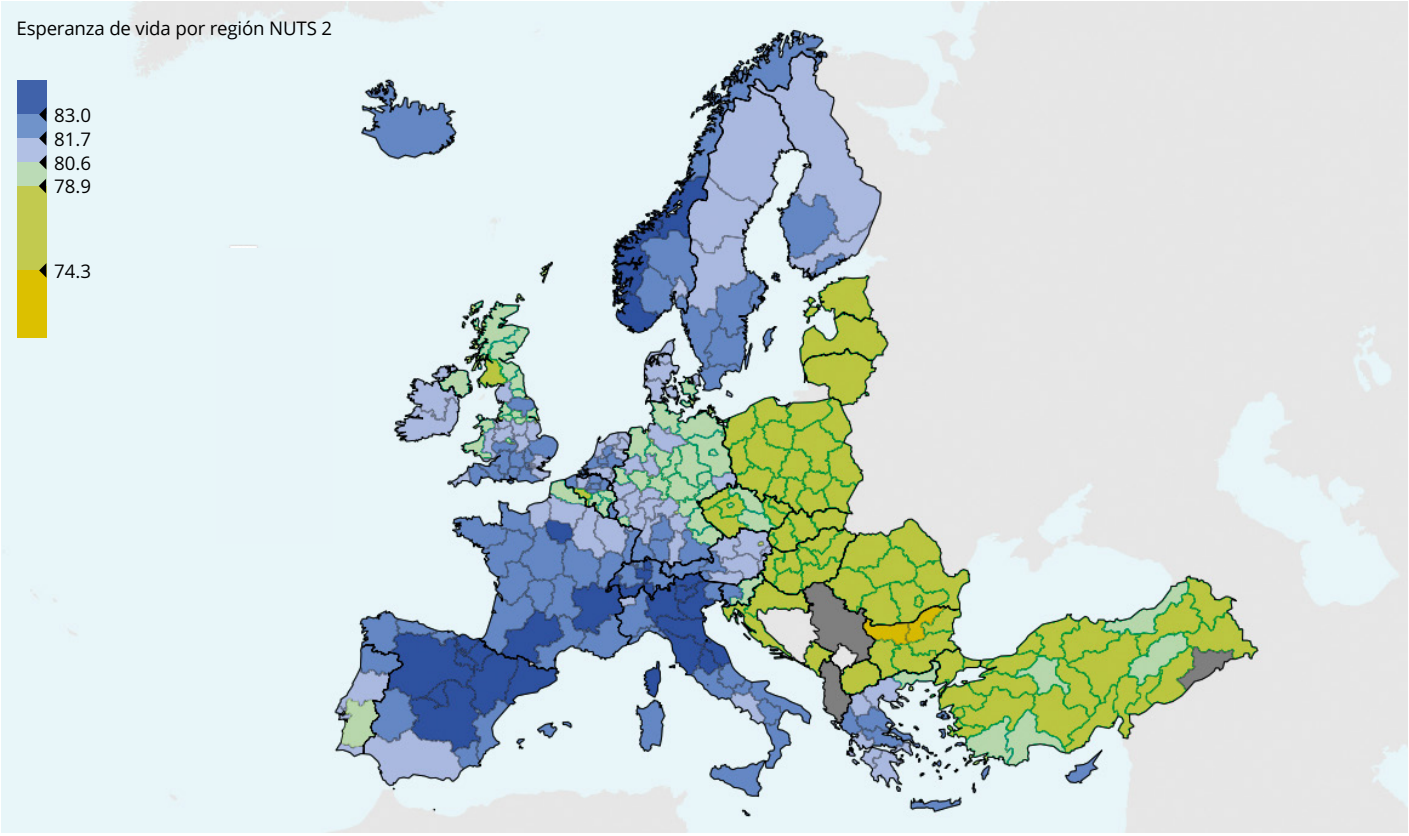
Gasto público por categoría (según se define en la Clasificación de las Naciones Unidas de Funciones del Gobierno)

Source: Deloitte Centre for Health Solutions, 2017; Eurostat, 2015

Las desigualdades en materia de salud son influenciadas por los estilos de vida individuales, la disponibilidad de redes de apoyo social, las condiciones de trabajo y de vida, incluido el acceso y la comprensión de los beneficios de la educación, el empleo, la atención sanitaria, la nutrición, los servicios de bienestar, la vivienda, vivienda, el transporte público y los servicios de acogida. Estos son comúnmente conocidos como los determinantes sociales de la salud (DSS): las condiciones en las que las personas nacen, crecen, viven, trabajan y envejecen. Los DSS están conformados por un conjunto de fuerzas económicas, políticas y ambientales inextricablemente vinculadas, ejercidas a nivel mundial, nacional y local. [11]

La pobreza y las carencias ocupan un lugar central a la hora de considerar lo que crea desigualdades sanitarias y sociales. Además, una mayor comprensión de la epigenética significa que ahora sabemos que las causas sociales y genéticas de la enfermedad no son mutuamente excluyentes. Por ejemplo, un gen específico causante de enfermedades sólo puede expresarse en presencia de desencadenantes de los DSS.[12, 13, 14]

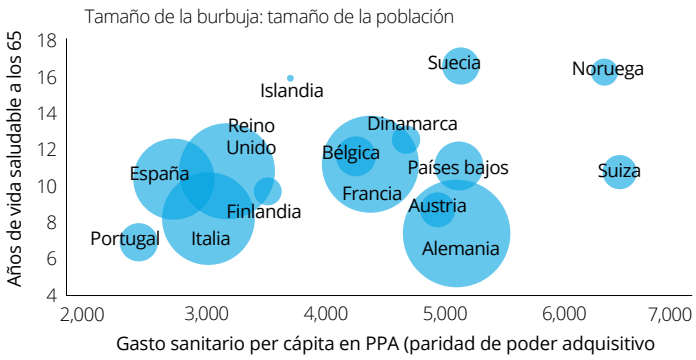
Figura 3. La variación de la esperanza de vida en el país se alinea con las zonas de carencia socioeconómica



Fuente: Eurostat, 2015.

Las inequidades pueden parecer obvias cuando se comparan países de altos y bajos ingresos; sin embargo, existen desigualdades en materia de salud en todos los países, independientemente de la madurez individual de sus sistemas de atención sanitaria y social. Si bien las economías de altos ingresos, con sistemas de salud y asistencia social más maduros, por lo general gastan recursos considerables para mejorar la situación sanitaria y social de sus poblaciones y cabe esperar que hayan reducido la brecha de desigualdades en materia de salud, a menudo ocurre lo contrario. El gráfico 3 ilustra la desigualdad en la esperanza de vida en Europa, y la mayoría de las regiones con exceso de mortalidad se alinean con una mayor carencia regional. 15 La relación entre cuánto gastan los países en atención de la salud y los resultados sanitarios medidos por los AVS es compleja, y el gasto es sólo un pequeño determinante de los resultados (consulte la Figura 4).[16, 17]

Figura 4. Relación entre el gasto sanitario per cápita y los años de vida saludable a los 65 años



Fuente: OCDE, 2014; Banco Mundial, 2015

Un estudio reciente de los datos de mortalidad de 11 países europeos examinó las tasas de mortalidad de 1990-2010 por nivel de educación y clase ocupacional para determinar si los esfuerzos de los gobiernos para reducir las desigualdades en materia de salud en Europa han hecho una diferencia con las desigualdades de mortalidad por grupo socioeconómico. El estudio midió las desigualdades en términos absolutos y relativos, y encontró que en la mayoría de los países europeos había una disminución sustancial de la mortalidad en los grupos socioeconómicos más bajos. Las desigualdades relativas en la mortalidad se ampliaron casi universalmente debido a que las disminuciones porcentuales eran generalmente menores en los grupos socioeconómicos más bajos (las disminuciones absolutas fueron a menudo menores en los grupos socioeconómicos más altos). Además, aunque varios países habían elaborado y aplicado programas nacionales para hacer frente a las desigualdades en materia de salud, los países con o sin estrategias nacionales no difirieron sistemáticamente en sus tendencias de desigualdad en la mortalidad.[18]

El hecho de que no se aborden de manera eficaz y coherente los determinantes sociales de la salud está creando presiones de costos y recursos evitables en los sistemas sanitarios de Europa.

El costo de las desigualdades evitables

En términos económicos, la salud puede considerarse tanto un bien de capital como un bien de consumo:

- La salud como bien de capital considera que las personas con buena salud tienen un valor económico superior al de las personas con mala salud debido a su capacidad de ser económicamente productivas

- La salud como bien de consumo se refiere a la contribución que la buena salud hace a la felicidad, el bienestar o la satisfacción de una persona.[19]

Calcular el costo de la desigualdad es intrínsecamente difícil debido a la limitada investigación sobre los costos. En 2010, una evaluación económica de los datos de mortalidad y morbilidad de la población de Eurostat, junto con los datos del Grupo de Hogares de la Comunidad Europea, estimó que las pérdidas sanitarias relacionadas con la desigualdad en los 25 países de la UE ascendían a más de 700.000 muertes anuales y 33 millones de casos de mala salud. Se estimó que estas desigualdades eran responsables del equivalente al 20% del total de los gastos sanitarios, es decir, 177.000 millones de euros, y el 15% del gasto total en prestaciones de seguridad social. Se estimó que las desigualdades relacionadas con la salud redujeron la productividad laboral en un 1,4% del PIB europeo anual, es decir, 146.000 millones de euros, y el valor monetario de las pérdidas relacionadas con la desigualdad sanitaria en materia de bienestar social es de alrededor del 9,4% del PIB, es decir, 90.000 millones de euros al año. Los investigadores concluyeron que los costos económicos de las desigualdades socioeconómicas en salud en Europa son sustanciales y, aunque los cálculos están sujetos a una incertidumbre considerable, las implicaciones económicas de las desigualdades en salud justifican inversiones en políticas e intervenciones significativas para reducirlas.[20]

Un análisis de investigación publicado en el Reino Unido en 2014 encontró que el impacto en el Reino Unido de algunas de las consecuencias sociales de la desigualdad, incluyendo peores resultados en salud, y mayores niveles de delincuencia podría costar el equivalente de más de 39 mil millones de libras esterlinas al año. La proporción relacionada con la salud es de 12.500 millones de libras esterlinas debido a la reducción de la esperanza de vida sana y de 25.000 millones de libras esterlinas debido a la peor salud mental.[21]

La causa y el efecto de las familias vulnerables

"La vulnerabilidad no es lo mismo que la pobreza. No significa la falta de voluntad o deseo, sino indefensión, inseguridad y exposición a riesgos, conmociones y estrés".

Robert Chambers[22]

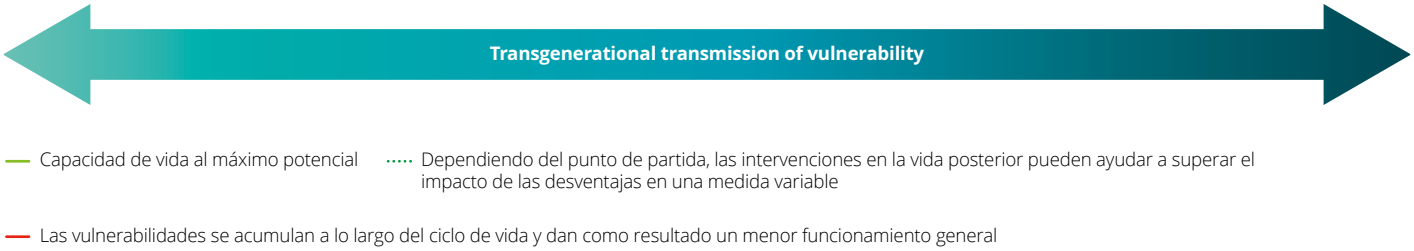
Tradicionalmente, el concepto de vulnerabilidad se utiliza para describir la exposición a los riesgos individuales y la capacidad de las personas para gestionar los riesgos y superar la adversidad. Si bien no existe un enfoque único que defina la vulnerabilidad, los determinantes sociales de la salud y el bienestar contribuyen decisivamente a la vulnerabilidad en todos los países.
A lo largo del ciclo de vida, las vulnerabilidades se superponen: los más vulnerables enfrentan numerosas limitaciones que afectan a las posibilidades del individuo de desarrollar capacidades para hacer frente a problemas y funcionar en la social. Las investigaciones demuestran que las energías mentales de los pobres se centran desproporcionadamente en hacer frente al aquí y ahora, dejando poco espacio para la planificación futura o la realización de actividades que ayuden al desarrollo económico y social de la persona o de los miembros inmediatos de la familia.[23]

De hecho, la experiencia combinada del desempleo y las desventajas económicas y sociales se transmite a menudo de los padres a los hijos. Por ejemplo, el análisis de los datos sobre la población danesa indica que una pequeña minoría de alrededor del 10% de los beneficiarios de prestaciones sociales más vulnerables representa el 46% del gasto. [24] Los niños que crecen en familias en las que los padres están desempleados, están mal educados, están socialmente marginados y tienen probablemente una mala salud física y mental tienen más probabilidades de enfrentar un nivel desproporcionado de abuso físico, sexual y emocional, así como problemas de salud mental y física. También tendrán que luchar por lograr todo su potencial, con consecuencias negativas para sus logros educativos, oportunidades de empleo futuras y años de vida saludables.

En todos los países europeos, la vulnerabilidad familiar es una preocupación creciente.[26] Las "familias vulnerables" o "familias con problemas" se definen como las que están en contacto con varios departamentos de la autoridad local, incluido el sistema de bienestar de la infancia o la juventud. Estas familias rara vez logran romper la espiral negativa, que conduce a la persistencia de la privación y la dependencia transgeneracional del apoyo público. De hecho, los niños y jóvenes conocidos en el sistema de servicios sociales desde la infancia son sobrerrepresentados más adelante en el sistema de prestaciones. Es probable que esta transmisión de desventajas cause el costo más alto a largo plazo, aunque no es cuantificable con precisión.[28]

Los niños y jóvenes conocidos en el sistema de servicios sociales desde la infancia son sobrerepresentados más adelante en el sistema de prestaciones.

Figure 5. Investment in early years enables the development of life capabilities and addresses the transmission of vulnerability



Como muestra la Figura 5, vivir en familias vulnerables dificulta el desarrollo de capacidades para quienes más dependen de las estructuras de apoyo familiar, especialmente los niños y los adolescentes. Las investigaciones demuestran que algunos períodos de la vida son particularmente importantes para el desarrollo de las funciones socioemocionales de la vida, como los primeros años de vida del niño, y las fases de transición entre la educación y la vida laboral.[29]

Las intervenciones que se aplican para tratar de abordar este problema a menudo no crean valor (medible), debido a la fragmentación y a las iniciativas separadas.[30] Hay grandes posibilidades de introducir un enfoque preventivo más específico para hacer frente a los problemas que perpetúan los problemas de las familias vulnerables, especialmente en la primera infancia y en la adolescencia.

Metodología para el presente informe

Hay un enorme volumen de investigaciones académicas, sociales y normativas sobre los DSS y las desigualdades en materia de salud, lo que demuestra que las desigualdades en los resultados en materia de salud son de larga data, profundas y difíciles de cambiar. Este informe se centra en el uso de extensas revisiones bibliográficas, análisis de conjuntos de datos nacionales e internacionales y nuestra experiencia trabajando con responsables políticos de salud y asistencia social, pagadores y proveedores de toda Europa. Analizamos cómo diferentes países están afrontando el reto de mejorar los resultados sanitarios de las familias vulnerables y ayudarlas a mejorar su situación y reducir las desigualdades en materia de salud. Creemos que las lecciones aprendidas en la lucha contra la vulnerabilidad de las familias podrían aplicarse de manera más amplia para ayudar a reducir las desigualdades en materia de salud en la sociedad, mejorando las posibilidades de llevar una vida sana y productiva para todos los ciudadanos.

En el informe se ilustra cómo la adopción de un enfoque para las familias vulnerables basado en el ciclo de vida mejora la orientación, la asignación de prioridades y el impacto de los servicios.

Examina la evidencia actual de la investigación e identifica ejemplos de buenas prácticas para:

- Los períodos de maternidad e infancia
- La infancia y adolescencia
- La edad adulta y la vida laboral
- La ancianidad y creciente fragilidad
- Un enfoque integrado de sistemas completos.

Una acción eficaz para revertir las desigualdades debe involucrar a una serie de organizaciones, desde los gobiernos locales y centrales y organizaciones de educación, vivienda, transporte, medio ambiente, salud y asistencia social, entre otras. Las políticas gubernamentales deben abarcar todos los determinantes sociales de la salud y no centrarse únicamente en el sector de la salud. A menos que las respuestas políticas estén alineadas, pueden ampliar involuntariamente la brecha en materia de salud.[31]

Este informe muestra soluciones que ponen de relieve la necesidad de reunir a las partes interesadas en la acción colectiva para hacer frente a las desigualdades en salud, identificando las estrategias para:

- Fomentar una adopción más amplia de buenas prácticas, incluidas nuevas formas de trabajo
- Desarrollar colaboraciones más eficaces dentro y entre la atención social y de salud
- Mejorar los resultados para las poblaciones
- Optimizar el costo de la prestación de cuidados médicos.

Si bien existe una amplia gama de buenas prácticas de las que se puede aprender, especialmente en la mayoría de los países nórdicos y en el Reino Unido, todos los países tienen margen para reducir la variación dentro del país.

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El ciclo de vida de las familias vulnerables

Los niños vulnerables se convierten en adultos vulnerables

Un enfoque en el ciclo de vida

A lo largo de nuestra investigación hemos identificado desafíos comunes y grupos de desventajas acumuladas que las familias vulnerables comparten en toda Europa. Hemos desarrollado un grupo familiar de 'personas' para ayudar a demostrar la variedad de problemas, motivaciones, comportamientos y expectativas que impulsan la demanda de servicios. Nuestras personas familiares son compuestas y no pretenden abarcar todos los escenarios sociales posibles en los que las familias vulnerables llevan sus vidas. Sin embargo, se basan en el conocimiento de las tendencias demográficas y de población reales, una gran cantidad de literatura académica y conocimientos adquiridos en proyectos, incluidos debates a fondo con proveedores de servicios a familias vulnerables y análisis de encuestas sociales.

Nuestra investigación muestra que las siguientes características contribuyen a niveles significativamente más altos de vulnerabilidad:

- Menor edad media al momento de la concepción
- Menor nivel educativo de ambos padres
- Asistencia social en el momento del nacimiento de los niños
- Desempleo o empleo irregular mal remunerado
- Presencia de al menos un problema de salud, en muchos casos enfermedad o discapacidad de larga data
- Problemas de salud mental, incluida la depresión y la dependencia del alcohol

Mary, 32

Habiendo tenido su primer hijo a los 16 años, María abandonó la escuela temprano sin ninguna certificación y sólo ha tenido una serie de trabajos temporales mal remunerados. Ella depende de los beneficios sociales para sobrevivir y está embarazada de 25 semanas en su cuarto embarazo. María lucha por mantenerse al día con sus consultas médicas prenatales. Ella está tratando de reducir el consumo de tabaco, pero todavía bebe mucho. Su matrona está preocupada por el parto prematuro.

Liam, 20 months

Liam nació a término. Tras la exposición al tabaquismo y consumo de alcohol materno, tuvo bajo peso al nacer. Muestra signos de síndrome del alcohol fetal, es un niño inquieto y ha sido más lento en alcanzar hitos de desarrollo. Recientemente fue ingresado en el hospital para realizar una extracción de dientes de leche.

Kevin, 11

Kevin no tiene contacto con su padre. Ha dejado de ir a un club de actividades juveniles en la comunidad después de experimentar el mismo acoso que sufrió en la escuela por tener sobrepeso. En el último año se ha perdido 35 días de escuela y ha tenido calificaciones bajo la marca de dominio en lectura. La mayor parte de su día lo pasa en línea y es menos probable que termine la educación primaria que muchos de sus compañeros de clase.

Jasmine, 16

Al igual que Kevin, Jazmín no tiene contacto con su padre. En los primeros años de su vida, Jazmín fue cuidada por su abuela. La profesora de Jazmín la alienta a elegir asignaturas de ciencias para prepararse para la universidad, pero Jazmín tiene dificultades para estudiar en casa. Entre la edad de 14-16 años, Jazmín mostró signos de bulimia nerviosa.

Karl, 30

Cuando Karl se enteró del embarazo de Mary regresó a la casa de dos dormitorios con la familia. Dejó la escuela a los 15 años, después de haber sido arrestado por desorden juvenil. A lo largo de su vida, Karl ha estado desempleado, aparte de trabajos manuales ocasionales y de corto plazo. Perdió su último trabajo en una construcción por una lesión adquirida en el lugar de trabajo. Una gran parte de sus beneficios se gasta en alcohol y cigarrillos, aumentando su tendencia a comportarse violentamente y sigue en libertad condicional tras una breve sentencia de prisión por herir a un vecino en una pelea de bar.

Susan, 71

Susan trabajó en una serie de trabajos mal pagados toda su vida. Como madre soltera de María y cuatro hijos mayores, una gran parte de su vida se ha dedicado a mantener a su familia, tanto económicamente como como también como cuidadora no remunerada. Ella depende de las prestaciones por discapacidad y no tiene ahorros para su vejez. Después de haber sido diagnosticada con diabetes a los 40 años, sufrió un accidente cerebrovascular el año pasado y debido a la movilidad reducida ya no es capaz de trabajar. A pesar de vivir cerca, también tiene dificultades para seguir ayudando con el cuidado diario de sus nietos. Preocupada por su familia, se está descuidando a sí misma, se ha perdido sus dos últimas citas de control sano y se siente cada vez peor y más sola.

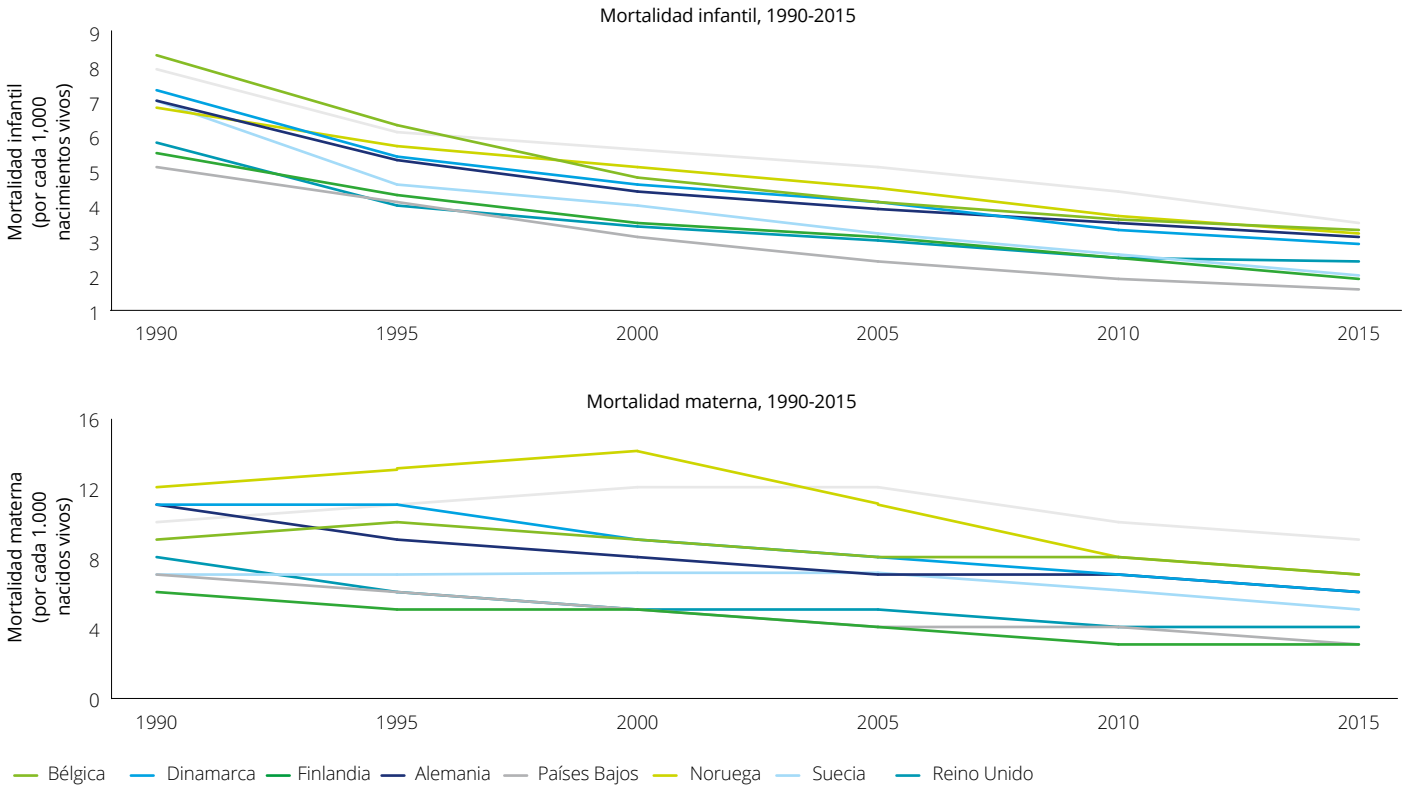
Maternidad y primera infancia

Proporcionar una base sólida para el resto de la vida

Las circunstancias socioeconómicas adversas tienen un efecto acumulativo a lo largo de la vida de una persona. Por ejemplo, el bajo peso al nacer, que tiene una fuerte asociación con la carencia socioeconómica, puede dar lugar a desventajas sanitarias y sociales tanto en la infancia como en la vida adulta. La esperanza de vida cambia durante el ciclo de vida: cuando un niño alcanza su primer cumpleaños, las posibilidades de vivir más tiempo aumentan, lo que indica la vulnerabilidad de la primera infancia. La prestación de servicios eficaces de atención de la maternidad y el apoyo al desarrollo de la primera infancia pueden ayudar a los niños a empezar mejor y a mejorar las posibilidades de tener una vida larga, saludable y productiva.

En los últimos 17 años, la mortalidad materna en Europa ha mejorado de 35 muertes por cada 100.000 nacidos vivos en 1990 a 16 muertes por cada 100.000 nacidos vivos en 2015, y la mortalidad perinatal ha mejorado de 920 muertes por cada 100.000 nacidos vivos en 1990 a 370 muertes por cada 100.000 nacidos vivos en 2015.[32]. El gráfico 6 muestra que la mortalidad materna e infantil está disminuyendo con el tiempo en la mayoría de los países de Europa occidental.[33] Sin embargo, aunque sigue habiendo una amplia variación en la mortalidad y morbilidad en el país y, en todos los países, las madres y los lactantes de los grupos socioeconómicos más bajos se han beneficiado en menor medida de las reducciones de la mortalidad y la morbilidad.[34] Por ejemplo, en Escocia, más de una cuarta parte de las mujeres de las zonas más desfavorecidas reconocieron haber fumado durante el embarazo, en comparación con el 3,3% en zonas más favorecidas. En todo el Reino Unido la mortalidad infantil es más del doble en los grupos socioeconómicos más bajos en comparación con los grupos socioeconómicos más altos.[35]

Figura 6. La mortalidad materna e infantil en los países de Europa Occidental está disminuyendo



Fuente: Banco Mundial, 2016

La privación y las desigualdades en materia de salud tienen un impacto significativo en la salud materna y en el desarrollo neurocognitivo y físico de los niños, así como en el riesgo futuro de enfermedad del niño.[36] Algunos de los principales DDS que influyen en la salud materno-infantil son:

- Los patrones de comportamiento materno, especialmente en las primeras etapas del embarazo, como la nutrición, el tabaquismo y el consumo de alcohol, están asociados con un bajo peso al nacer y conllevan una variedad de riesgos para el feto, entre ellos un menor desempeño en las puntuaciones de desarrollo y un mayor riesgo de enfermedad en la vida posterior, como epilepsia, enfermedad cardiovascular y diabetes.[37, 38, 39]

- La mortalidad de los niños menores de 5 años se reduce en consonancia con los años de escolaridad que alcanzan las mujeres, independientemente de que la matrícula escolar aumente desde niveles altos (10 a 11 años) o desde niveles bajos (2 a 3 años). A nivel mundial, la educación representa el 51% de la disminución de la mortalidad. Las mujeres con más educación tienden a tener familias más pequeñas, en parte debido a la mejora de las oportunidades de empleo y el mejor conocimiento de los métodos anticonceptivos. Un menor número de niños aumenta las posibilidades de supervivencia infantil y una mejor educación mejora los conocimientos y la adopción de decisiones de las mujeres sobre la atención prenatal, la higiene, la nutrición y la inmunización.[40]

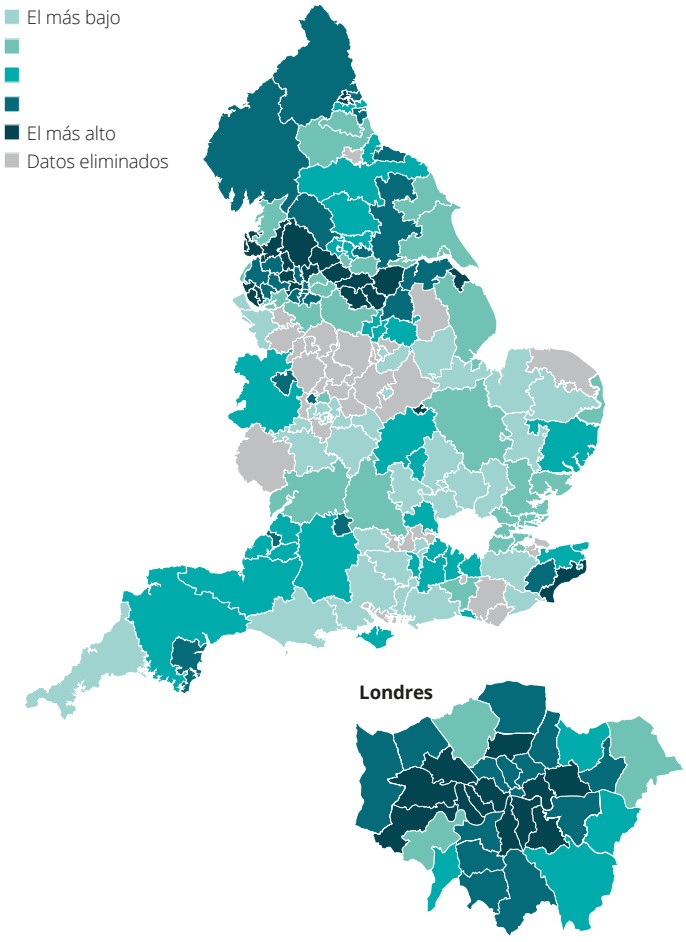
- La reducción de la estimulación cognitiva en los tres primeros años de vida pone en riesgo el desarrollo cerebral del niño y tiene un impacto negativo en la audición, la visión y el control emocional en la vida posterior.[41]

- Los niños de familias más educadas y acomodadas tienen más probabilidades de estar expuestos a un vocabulario más amplio en los primeros tres años de vida, que sirve como un fuerte indicador del rendimiento verbal en los primeros años escolares. En los Estados Unidos, un estudio de la cantidad de lenguaje hablado a los niños en 42 familias midió el número de palabras dirigidas a ellos a los tres años. El número varió de 13 millones de palabras en familias beneficiarias de asistencia social frente a 45 millones de palabras en familias con padres con educación universitaria (una diferencia de 30 millones de palabras.[42, 43]

- La atención emocional dada en los primeros días de vida es probable que determine la epigenética de la respuesta del individuo al estrés, así como las funciones de memoria y atención. El apego seguro al cuidador primario en la vida muy temprana es de fundamental importancia para el individuo para amortiguar la ansiedad y hacer frente a los factores estresantes. La mayor prevalencia de enfermedades mentales maternas en la clase socioeconómica baja constituye un factor de riesgo para los problemas de salud mental más tarde en la vida del niño.[44, 45]

Además, los DSS repercuten en la salud maternoinfantil debido a la interacción entre el comportamiento sanitario y la utilización de la asistencia de salud. Por ejemplo, la variación de 66,6 veces mayor en las tasas de ingreso hospitalario por caries dental en niños en el Reino Unido se explica mejor por una variación en la utilización de los servicios preventivos y los comportamientos sanitarios, correlacionados con la carencia. La mala salud bucal y dental en la infancia repercute en la nutrición y el crecimiento, disminuye la calidad de vida y produce costos de atención de salud evitables (consulte la Figura 7).[46]

Figura 7. Ingreso hospitalario por caries dental en niños de 1 a 4 años por población en Inglaterra



Fuente: El Atlas de Variación en Salud del NHS, NHS Right Care, 2015

Ejemplos de buenas prácticas

Garantizar el mejor comienzo posible en la vida

Ejemplo 1: Mejora de la atención a familias enteras: programa de parteras familiares (Países Bajos)

El sistema holandés de atención a la maternidad es único en Europa y a menudo se menciona como un ejemplo de cómo podrían mejorarse los servicios de maternidad en los países industrializados. La atención domiciliaria dirigida por matronas es la piedra angular de la atención materna neerlandesa, ya que el 85% de todas las mujeres embarazadas reciben atención prenatal en atención primaria y un elevado porcentaje de partos domiciliarios son bajo la atención de matronas y médicos.Históricamente, el estado ha preservado la partería autónoma y el nacimiento en el hogar a través de leyes y reglamentos que dan preferencia a la atención de matronas, el apoyo estatal para su educación y la financiación de investigaciones que demuestran la eficacia de los partos en el hogar atendidos por matronas. La evidencia de la OMS muestra que la atención dirigida por matronas redujo el uso de analgesia con menos episiotomías o partos instrumentales. También aumentó la probabilidad de tener un parto vaginal espontáneo e iniciar con éxito la lactancia materna, así como la experiencia general del paciente. Además, fue más probable que los bebés tuvieran una estadía más corta en el hospital. Los beneficios de la atención dirigida por las matronas se extienden más allá del período perinatal. Mediante la normalización de los procesos de parto y de vida temprana, la maternidad de alta calidad permite a las mujeres y a las familias enteras cuidarse mejor y depender menos del apoyo externo. [47] [48]

Ejemplo 2: Mejora de la salud bucal mediante entrevistas motivacionales únicas (Austria y Australia)

Las causas de las caries dentales son multivariadas y representan una compleja interacción de factores bioquímicos, microbianos, genéticos, sociales y de comportamiento. La educación y las actitudes de los padres, así como el entorno psicosocial y económico de la familia, representan importantes mediadores del comportamiento de los padres en materia de salud bucal en favor de sus hijos. Las investigaciones muestran que las estrategias de entrevistas motivacionales dirigidas a las nuevas madres muestran los mejores resultados en la reducción de caries en niños preescolares. Investigadores austríacos utilizaron una intervención única para cambiar el comportamiento alimentario y de higiene oral de las madres inmediatamente después del nacimiento de un hijo. Un análisis de casos y cohortes a los cinco años demostró que los niños de las madres participantes tenían tasas de caries significativamente más bajas. Un estudio reciente sobre la eficacia en función de los costos llevado a cabo en Queensland (Australia) encontró que una intervención mediante una visita a domicilio durante la primera infancia ahorraría 113 dientes por cada 100 niños y permitiría ahorrar 167.032 dólares por cada 100 niños, en comparación con ninguna intervención. [52] [53]

Las circunstancias socioeconómicas adversas tienen un efecto acumulativo a lo largo de la vida de una persona. Por ejemplo, el bajo peso al nacer, que tiene una fuerte asociación con la carencia socioeconómica, puede dar lugar a desventajas sanitarias y sociales tanto en la infancia como en la vida adulta. La esperanza de vida cambia durante el ciclo de vida: cuando un niño alcanza su primer cumpleaños, las posibilidades de vivir más tiempo aumentan, lo que indica la vulnerabilidad de la primera infancia. La prestación de servicios eficaces de atención de la maternidad y el apoyo al desarrollo de la primera infancia pueden ayudar a los niños a empezar mejor y a mejorar las posibilidades de tener una vida larga, saludable y productiva.

Ejemplo 3: La reducción del número de niños bajo custodia gubernamental, creando oportunidades para que las mujeres vulnerables adquieran nuevas aptitudes para la vida cotidiana que les permitan controlar sus vidas (Reino Unido)

Todas las autoridades locales del Reino Unido tienen mujeres que suelen ser jóvenes, desfavorecidas y que viven con problemas sociales, ambientales y de salud. Estas mujeres a menudo tienen múltiples hijos que posteriormente son trasladados al sistema de atención bajo procedimientos de protección de la infancia. Sus hijos a menudo sufren dificultades físicas y emocionales a corto y largo plazo y corren el riesgo de convertirse en adultos vulnerables que requieren intervenciones significativas de los servicios públicos. Estos niños también corren el riesgo de repetir el ciclo destructivo que causa tanto a las mujeres como a sus hijos un profundo trauma, además de costarle a los contribuyentes cientos de millones de libras.

Lanzado en 2013 en Hackney (Londres), el programa Pause trabaja con mujeres que han experimentado, o corren el riesgo de experimentar embarazos repetidos que produce la pérdida de niños bajo su custodia. Pause fue creado por profesionales con experiencia de primera línea en el ámbito de la protección de la infancia y con adultos vulnerables. Pause ofrece un intenso programa de apoyo terapéutico, práctico y conductual a través de un modelo sistémico integrado, en estrecha colaboración con agencias asociadas (por ejemplo, salud sexual, justicia penal y servicios de drogas y alcohol). Cada mujer tiene un programa a medida diseñado en torno a sus necesidades y objetivos individuales. Durante este programa voluntario, las mujeres deben utilizar una forma fiable de anticoncepción reversible de larga duración que les permita centrarse en sí mismas y dar prioridad a sus necesidades, a menudo por primera vez en sus vidas. Las conclusiones detalladas de las zonas piloto iniciales indican lo siguiente:

• Mejora significativa de la salud y bienestar de las mujeres participantes y sus familias

• Sin la intervención, las 137 mujeres apoyadas por Pause habrían perdido la custodia de 27 hijos más al año a un costo anual de más de 1,5 millones de libras esterlinas para el contribuyente

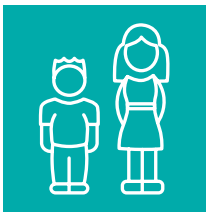
• Costo estimado evitado por niño de alrededor de 39.333 libras esterlinas

• Cada libra esterlina invertida en Pause está produciendo un retorno de un mínimo de £9 en cinco años.

Si todas las mujeres de Inglaterra a quienes se les ha quitado la custodia de dos o más hijos en cuidados pudieran trabajar con Pause, se podría ahorrar más de 2.500 millones de libras en cinco años. En 2016, el proyecto recibió una financiación adicional de 6,8 millones de libras esterlinas del Fondo de Innovación del Departamento de Educación para aumentar su escala y extenderse a nivel nacional. Pause está trabajando para convertirse en un enfoque totalmente preventivo en el futuro, interviniendo en etapas anteriores de este ciclo transgeneracional. Pause se está expandiendo para llegar a más de 43 sitios en los próximos cinco años en todo el Reino Unido.[49, 50, 51]

La Infancia y adolescencia

Establecer comportamientos saludables y aumentar la resiliencia



La pobreza de ingresos afecta a uno de cada siete niños en los países de la OCDE (Organización de Cooperación y Desarrollo Económicos), mientras que el 10% de los niños viven en hogares sin empleo. Desde la crisis financiera de 2008, las tasas de pobreza infantil han aumentado en dos tercios de los países de la OCDE y, en la mayoría de estos países, la tasa de pobreza infantil es superior a la de la población en general.[54]

Los niños que participan activamente en la sociedad son físicamente activos y comen bien tienen muchas mayores posibilidades de convertirse en adultos sanos, activos, productivos y socialmente incluidos. Los niños que viven en familias desfavorecidas desde el punto de vista socioeconómico se enfrentan a mayores problemas físicos directos para su estado de salud y sus comportamientos del cuidado de la salud. También suelen experimentar tensiones emocionales y psicológicas, como conflictos familiares e inestabilidad resultantes de la insuficiencia crónica de recursos. Los efectos de la carencia en la infancia y el estrés acumulado asociado durante la niñez se prolongan durante toda la vida y tienen un impacto negativo en el nivel educativo y en los patrones de comportamiento en la infancia posterior, la adolescencia y la edad adulta joven.[55, 56]

Las investigaciones indican que los niños que crecen en familias vulnerables en los primeros seis años de vida y los que crecen en hogares sin padres ni cuidadores con trabajo muestran resultados particularmente negativos en el comportamiento socioemocional y el desarrollo cognitivo.[57, 58, 59]

Sin embargo, los datos de toda Europa muestran que los niños en situación de pobreza no sólo pertenecen a familias que no trabajan y, de hecho, ahora tienen más probabilidades de estar en familias que trabajan y tienen bajos ingresos que en familias que no trabajan.[60]
Estas familias se consideran "pobres que trabajan", con padres en empleos temporales, mal remunerados y contratos sin un mínimo de horas, o que se constantemente pasan con y sin empleo. Los niños que viven en la "pobreza oculta" corren un riesgo particular cuando las políticas se basan en el nivel de ingresos. [61]

Los niños dependen de los adultos para satisfacer sus necesidades individuales, y la evaluación de las carencias infantiles requiere tener en cuenta la distribución de los recursos entre los miembros del hogar.62 Los datos recopilados en toda Europa muestran que los niños de familias vulnerables que viven en entornos estresantes tienen menos acceso o aliento para estar físicamente activos o comer alimentos saludables y, como resultado, son más propensos a ser obesos. En Inglaterra, el 40% de los niños de las zonas más desfavorecidas tienen sobrepeso, pero sólo el 27% en las más ricas. También es más probable que más adelante en su vida adopten comportamientos peligrosos para la salud, y que sea menos probable que los dejen, como el tabaquismo, el abuso del alcohol y las drogas.[63] La comprensión y medición de las carencias infantiles a nivel nacional y transnacional ayuda a orientar los servicios destinados a superar esas desventajas. El Módulo de Bienestar Infantil de la OCDE es un nuevo conjunto de datos para información sobre el bienestar infantil específica por edad. La Figura 8 muestra el comportamiento variable de los países de Europa occidental en la lucha contra los determinantes clave de la salud y las carecias.[64]

Figura 8. Desempeño de las cohortes en la carencia durante de la infancia (clasificación entre 23 países de la OCDE)

	Peso al nacer	Tasa de vacunación	Obsedidad	Ejercicio	Fumar	Carencia educativa	Empleo, educación o formación	Pobreza
Bélgica	15	1	9	12	10	10	14	16
Dinamarca	5	19	1	5	5	2	8	1
Finlandia	2	8	19	3	13	13	11	2
Alemania	12	13	12	15	15	8	4	8
Islandia	1	22	21	8	1	1	3	3
Países Bajos	7	13	3	7	11	6	5	12
Noruega	4	21	8	17	2	3	2	4
Suecia	3	8	15	16	4	17	6	6
Suiza	11	13	4	23	9	7	7	5
Reino Unido	15	18	12	13	7	19	13	9

Tercio con mejores resultados Tercio con medianos resultados Tercio con peores resultados

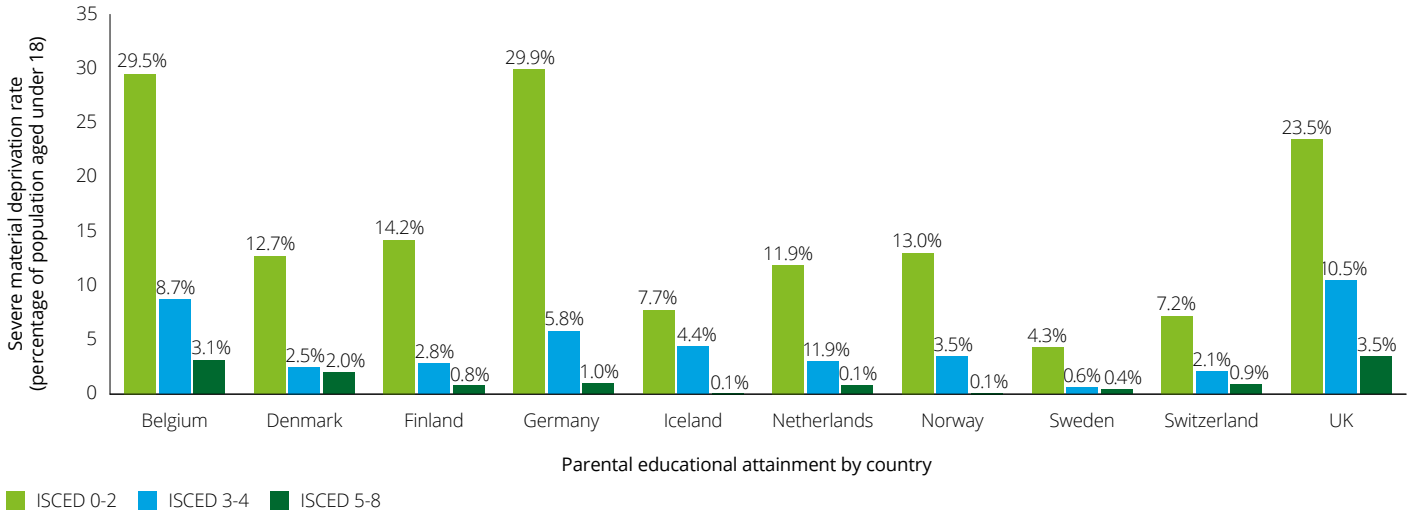
Fuente: Análisis Deloitte del desempeño de los países de la OCDE; OCDE, 2017
Nota: Número de nacidos vivos que pesan menos de 2500 g como porcentaje del total de nacidos vivos; Tasa de vacunación contra la difteria, el tétanos y la tos ferina; Recursos para la escuela a disposición de los niños de 15 años en su hogar, como un escritorio, un lugar tranquilo para trabajar, acceso a Internet y computadoras; Proporción de jóvenes de 15 a 29 años que no tienen empleo, educación o formación

Educational policy plays a decisive role in increasing the chances of overcoming deprivation in childhood. Educational attainment of members of vulnerable families is important for two key reasons: rst, parental educational status is correlated to childhood deprivation (see Figure 9); second, on average across Europe, life expectancy varies by 5.6 years between people of the lowest (76 years) and the highest educational attainment (81.6 years), as de ned by the International Standard Classi cation of Education (ISCED).[65] Early learning in high quality day-care centres can provide a countermeasure to family deprivation and strengthens socio-emotional coping, enhances cognitive development and has a positive impact on school grades, with strongest e ects shown in children from the most vulnerable families.[66]

Family interventions directed at supporting vulnerable families to improve parenting are equally relevant. For example, the population-based behavioural family intervention Triple P-Positive Parenting Programme, developed an rst implemented in Australia, has been successfully replicated in a number of di erent countries, including Iran, Japan and Switzerland. The programme has been successful in reducing behavioural and emotional problems in children and hospitalisation from child abuse, while improving parenting skills and wellbeing.[67, 68]

One of the largest-ever investigations of childhood abuse and neglect and its impact on later-life health and wellbeing is the US Centers for Diseases Control and Prevention (CDC) 'CDC-Kaiser Permanente Adverse Childhood Experiences (ACE) Study'. The study of over 17,000 people enrolled in the Kaiser Permanente health insurance programme was originally conducted in two phases in 1995 and 1997. Participants received physical exams and completed con dential surveys regarding their childhood experiences and current health status. Results indicated that failing to address the social determinants of childhood development meant missing a crucial window of opportunity for individual development, due to the accumulation of disadvantage and latency e ects – with negative consequences for individual wellbeing, social participation and need for support later in life. The CDC's ongoing surveillance of ACEs, assessing the medical status of the study participants via periodic updates of morbidity and mortality data, has continued t nd a strong relationship between the breadth of exposure to abuse or household dysfunction during childhood and leading causes of adult morbidity and mortality. These results have been con rmed in numerous studies in a large variety of countries.[69, 70]

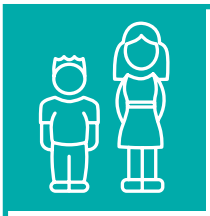
Figure 9. Deprivation rate of children under 16 is related to their parents' educational attainment



Source: Eurostat, 2015
Note: ISCED (International Standard Classification of Education), ISCED 0-2: Less than primary, primary and lower secondary education. ISCED 3-4: Upper secondary and post-secondary non-tertiary education, ISCED 5-8: Tertiary education.
Severely materially deprived persons have living conditions severely constrained by a lack of resources regarding household income, durables, housing and environment; households experience at least 4 out of 9 following deprivations items: cannot afford i) to pay rent or utility bills, ii) keep home adequately warm, iii) face unexpected expenses, iv) eat meat, fish or a protein equivalent every second day, v) a week holiday away from home, vi) a car, vii) a washing machine, viii) a colour TV, or ix) a telephone.

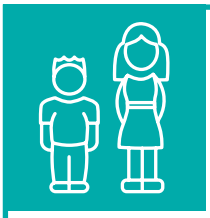
Examples of good practice

Stopping childhood deprivation becoming destiny



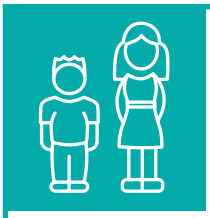
Case example 4: Preventing childhood obesity through cross-sector partnerships (Belgium and France)

Ensemble Prévenons l'Obésité Des Enfants (EPODE, Together Let's Prevent Childhood Obesity) is a community-based intervention programme that enables communities to implement e ective and sustainable strategies to prevent childhood obesity while minimising social and cultural stigma. Originally established in 1992 in France, EPODE has become widespread and has been implemented in over 500 communities in 29 countries. EPODE is a coordinated, capacity-building approach aimed at reducing childhood obesity through a societal process in which local environments, childhood settings and family norms are encouraged to facilitate the adoption of healthy lifestyles in children. The primary EPODE target groups are children aged up to 12 and their families. The programmes are aimed at long-term change to the obesogenic environment that leads to unhealthy behaviours. The evidence-based EPODE methodology takes a positive approach to achieving healthy lifestyle habits and does not stigmatise any cultural food habit or behaviour. It includes ensuring quick access to enjoyable, healthy food and overcoming the present bias and social marketing techniques that enhance risk behaviours. In addition, all messages and actions are tailored to local populations based on needs and demographics to ensure the programme is e ective and inclusive. Evidence from Belgium showed a 22 per cent reduction in the prevalence of overweight and obesity from 2007-10 in the two towns of Marche and Mouscron, compared with non-intervention control towns. The success of the intervention in France and Belgium led to the creation of the EPHE (EPODE for the Promotion of Health Equity) project in 2012 aiming to reduce socioeconomic inequities linked to health-related behaviours of families in seven European countries.[71]



Case example 5: Working together to improve educational attainment and employability (Norway)

In 2015, the Norwegian Directorate for Education and Training, the Directorate for Labour and Welfare, the Norwegian Directorate for Children, Youth and Family A airs, the Directorate of Integration and Diversity and the Norwegian Directorate of Health, were given a joint assignment from their respective ministries: to coordinate, further develop and implement policies ensuring that children and youths aged up to 24 years old complete sixth form education and increase their chances of long-term employment. The government agencies involved in the programme have shown considerable commitment to addressing problems and coordinating processes, routines and working methods. Well-coordinated and consistent management, as well as executives who act as good role models have been vital in sustaining collaboration. The programme-period is 2015-2020 and accompanying evaluation is ongoing.[72, 73]



Case example 6: Improving mental resilience through school-based interventions (Ireland, Netherlands, Norway, UK)

The mental health of children and adolescents is a key challenge, especially in the context of vulnerable families. Educational settings provide a key opportunity for developing strategies for mental resilience and wellbeing. Research shows a favourable cost-bene t ratio when including mental health in educational strategies, as it releases societal resource in terms of mental capital, which includes cognitive, emotional and social skills. For example, the 'Zippy's Friends' programme, which is aimed a ve to seven year olds of all abilities, teaches young children how to develop skills to better manage problems that may occur in adolescence and adulthood. It teaches them how to cope with everyday difficulties, to identify and talk about their feelings and to explore ways of dealing with them. The programme has been implemented in schools in over 30 countries and reached over one million children. A recent randomised control evaluation of the programmes involving 1,177 children in the Netherlands showed signi cant improvement in children's emotional recognition and adaptive coping skills. Parents also reported an improvement in children's social and emotional skills, particularly enhanced motivation and reduced externalising behaviour problems, such as hyperactivity and aggressive behaviours. In addition, an earlier 2012 study with nearly 1,500 children in Norway found improvements in children's academic skills. The programme signi cantly reduced bullying. There was no clear relationship between the e ect of 'Zippy's Friends' and ethnicity, gender or the educational level of parents. A new randomised control trial is currently underway in the UK to evaluate whether taking part in 'Zippy's Friends' improves children's emotional wellbeing and/or helps them to do better academically. The study, conducted by Queen's University Belfast, involves 80 schools and over 3,800 pupils. Final study results will be available in January 2018.[74, 75, 76]

Children who are actively engaged in society, physically active and eat well have signi cantly higher chances of growing into healthy, active, productive and socially included adults. Children living in socioeconomically disadvantaged families face greater direct physical challenges to their health status and health-promoting behaviour.

Adulthood and working age
Creating the conditions for a productive life

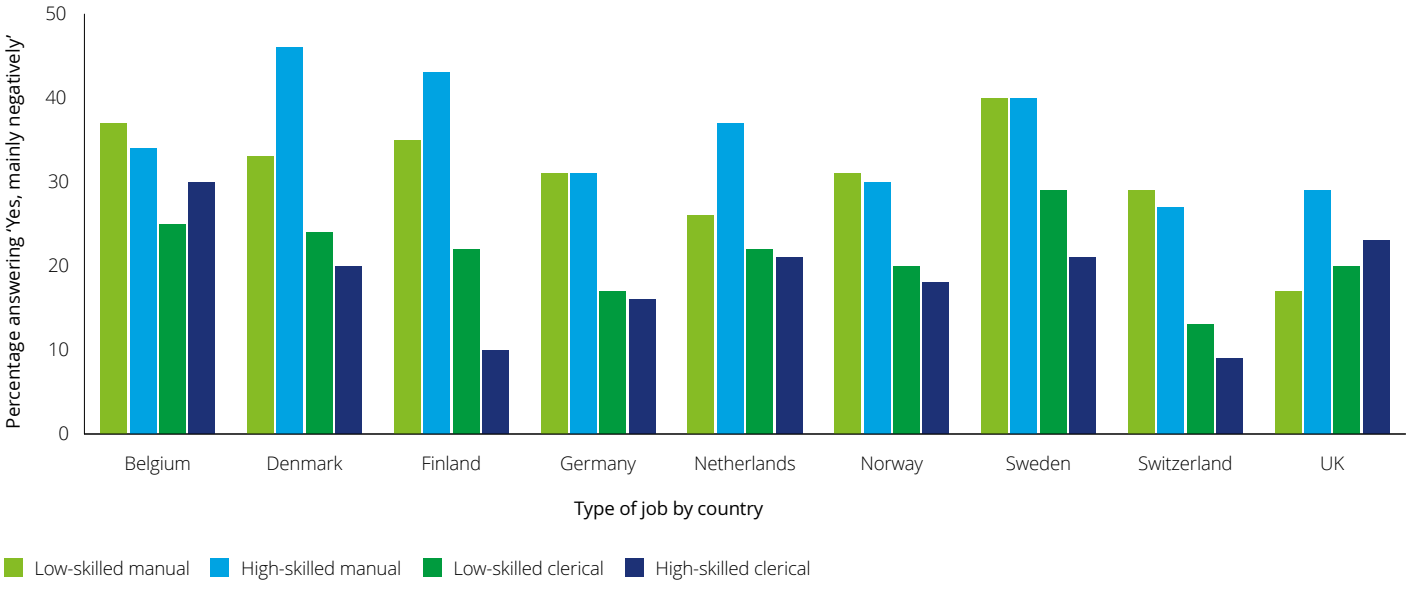
Adulthood and working life accounts for a large part of an average person's economic and productive life and is the stage during which the economic and productivity opportunities manifest themselves including opportunities for social mobility. The childhood and educational factors previously discussed, the type of work people do (if employed), the 'built' environment in which people live and opportunities of social inclusion interact hazardously with behavioural patterns, resulting in increased morbidity and mortality. Moreover, it is during adulthood that the risk of intergenerational transmission of inequalities is being established, depending on the chances of overcoming the social determinants of health in the context of family building and parenting.

Unemployment and poor employment conditions regarding wages, adverse working conditions exibility to combine work and family life and job security all threaten individual physical and mental health.[77] Analysis of a large data set from 26 EU countries over the period 1970-2007 showed that for every one per cent increase in unemployment, there was an associated 0.79 per cent rise in suicides among people younger than 65 years, with an almost two-fold increase in suicide risk among the long-term unemployed.[78]

Intergenerational inequalities can be stark and the steep increase in long-term unemployment following th nancial crisis in 2008 has disproportionately a ected young working age people. Indeed, the downward trend in suicides seen prior to 2007 began to reverse as the mental health of the unemployed deteriorated, particularly in young men. Data from England shows that male unemployment was associated with about two- fths of the rise in suicide rates, with a correlation between areas of greatest increases in unemployment and steeper increases in suicides in those areas.[79, 80, 81] However, strong social welfare systems can o er protection against unemployment-related mental health risks. For example, compared to Spain higher labour market protection in Sweden helped reduce suicide risks.[82]

Across Europe, low-paid and low quality jobs go hand-in-hand with poor working conditions and higher exposure to health risks.[83] Figure 10 highlights the correlations of workers' skill level and perceived health impacts of working conditions.[84] Employment also has an impact on family vulnerability, with researc nding that the ability to combine family life with paid employment is a determinant of family wellbeing, health and the educational chances of all family members. Single parents and families with many children face higher risks, and the reconciliation of low-paid work and child care is of particular difficulty.[85]

Figure 10. People in manual jobs are more likely to perceive their working conditions as harmful to their health



Source: Sixth European Working Conditions Survey 2015
Note: Survey question: 'Does your work affect your health?' Answer selected: 'Yes, mainly negatively'

The 'built' environment that people live in relates to the density and mix of land use, quality of housing, street layout and connectivity, including public transport, open community space, accessibility to public services, as well as air quality and noise. The most deprived 10 per cent of English communities hav ve times less the amount of green space compared with the most affluent 20 per cent.[86]

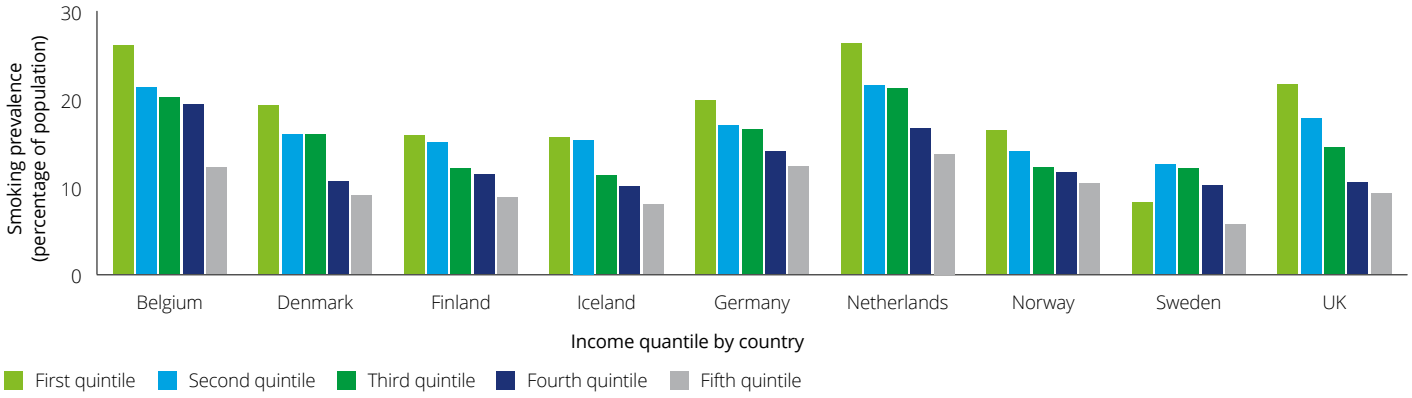
Research shows that this 'built' environment in uences behaviours both relating to physical activity and violence. While perceived friendly and inclusive environments stimulate 'thrival', healthy and collaborative behaviours, harsh urban environments promote a 'survival pattern' of high-risk and aggressive behaviours.[87,88]

Resulting health and social inequalities include:

- higher rates of obesity resulting from low levels of physical activity and reduced access to or understanding of healthy nutrition and diet (Figure 11)[89]
- higher prevalence of smoking is associated with social position, income and educational attainment. Public health interventions targeting a reduction of consumption fail to reach the lowest educated share of population (Figure 12).[90] Evidence from Denmark shows that smoking-related and alcohol-related deaths are the main reason for the social inequality in mortality, and constitute approximately 64 per cent of that inequality among men and 71 per cent among women in 2005–2009[91]
- higher crime rates, including exposure to violence, in more deprived areas. The e ect of this is manifold both for the individual at risk of showing criminal behaviour and for populations living in areas with higher crime rates who are impacted in their mental and physical health as a result from actual or feared crime.[92]

Figure 11. Lower income is related to higher obesity prevalence across Western European countries

Figure 12. Lower income is related to higher smoking prevalence across Western European countries



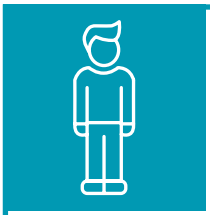
Source: Eurostat, 2014
Note: The first quintile group represents 20 per cent of the population with the lowest income (an income smaller or equal to the first cut-off value), and the fifth quintile group represents the 20 per cent of population with the highest income (an income greater than the fourth cut-off value)

Examples of good practice

Promoting productive participation in society

Case example 7: Promoting health is promoting employment – JobFit (Germany)

The German Federal Employment Agency partners with statutory health insurance funds to embed health promotion into the work of local job centres to improve the health status of bene t recipients and employability. From June 2014 to June 2015, speci c training sessions on healthy behaviours and stress reduction were included in the training curriculum for job seekers in six pilot regions across the country. Jobless people were approached and managed individually to assess individual health literacy, making use of motivational interviewing strategies and building up a targeted health promotion plan. Statutory health insurance programmes provide nancial support to various training courses initiatives, especially prevention courses, stress management and group-focused training sessions. Public health training sessions were also speci cally designed for the 134 members of sta t job centres and those providing the training courses. The programme fostered a network of collaboration between occupation and training institutions for the unemployed, statutory health insurance institutions as well as local charities and businesses. Key results for the 1,366 participants in the pilot programme included a reduction in sickness days, improvement in health behaviours regarding physical activity and nutrition and a reduction in psychosocial stress, while employability was also improved. Self-assessed ill-health reduced from 46 to 32 per cent. The pilot programme has been extended and is being rolled-out in 50 job centres across Germany.[93, 94]



Case example 8: Tackling violence-related ill-health through cross-sector information sharing (UK, Australia, US)

The Cardi Wales) Violence Prevention Programme (CVPP) is a multiagency partnership designed to prevent all forms of violence and reduce violence-related emergency room admissions, particularly late at night and on weekends, when services are overextended and alcohol-related incidents are common. CVPP is a data-sharing strategy, which was developed under the leadership of a professor of surgery and became fully operational in 2003.

Data collected in emergency departments plays a critical role in informing targeted policing e orts and other strategies as emergency departments have the unique ability to share anonymised electronic data about precise location, weapon use, assailants and day and time of the violence that is not always known to the police. Programme evaluation found:

- a 21 per cent decrease in the average rate of total assaults
- a 32 per cent reduction of assaults leading to wounds
- a reduction in monthly hospital admissions in Cardi rom seven t ve per 100,000 population. Hospital admission rates in control group cities increased fro ve to eight per 100,000 population.

The bene t-cost ration of the programme was 14.80 for the health service and 19.1 for the criminal justice system. The project has been adopted in cities throughout the world, most recently in London, Melbourne, Sydney and Canberra.[95, 96]

Case example 9: Stepping up to the challenge – collaboration across public and private sector to promote healthy behaviours (Denmark, Canada, China, Italy, Mexico, South Africa, US)

Private sector organisations increasingly take an active role in addressing healthy behaviours and helping to improve population health in vulnerable communities. These initiatives involve public/private partnerships working together to tackle health inequalities in local communities and promote healthy behaviours in the workplace. For example 'Cities Changing Diabetes' is a partnership programme currently running in Copenhagen, Houston, Johannesburg, Mexico City, Rome, Shanghai, Tianjin and Vancouver. The main programme partners are Novo Nordisk, University College London and Steno Diabetes Center (Denmark), collaborating with a wide range of locally based health partners to share solutions and actions that tackle diabetes in major global cities. In Copenhagen, local partners include the city administration, the University of Copenhagen and the Danish Diabetes Association. Research insights from the global partnership informed the City's updated diabetes strategy and included integrating social norms and choice architecture into urban planning, targeted at vulnerable, hard to reach communities.[97]

Adulthood and working life accounts for a large part of an average person's economic and productive life and is the stage during which the economic and productivity opportunities manifest themselves, including opportunities for social mobility.

Elderhood and increasing frailty

Achieving equality in length and quality of life

Until the mid-2000s, it was assumed that the gulf between rich and poor or educated and less educated was less of a concern in older populations. Age was thought to have a 'levelling o ' e ect on socioeconomic inequalities. However, longitudinal studies have shown that socioeconomic disadvantage is associated with an increased risk of disability, chronic disease and co-morbidity, depression and decline in cognitive function across all age groups. Indeed, older people belonging to lower socioeconomic groups have a 30 to 65 per cent higher risk of almost all chronic diseases than those in more privileged social groups.[98]

Moreover, health inequalities persist and indeed exacerbate in old age. Indeed, the prevalence of disability is 5.8 per cent in people under 18, 44 per cent among 65 to 74 year olds, and 84 per cent of people 85 years and over. Whether adults are disabled before reaching old age or acquire a disability as they age, they are more likely to live in poverty and social isolation.[99]

The English longitudinal study of ageing, conducted from 2002 to 2010, showed that men and women of higher economic status, measured by wealth or education, had the same level of reported good health and functioning as people of lower economic status, who were 15 years younger.[100] Ageing impacts negatively on peoples' ability to be physically active and participate in social activities, resulting in new or worsening of pre-existing long-term conditions such as diabetes, cardiovascular disease and chronic obstructive pulmonary disorder, as well as depression.[101]

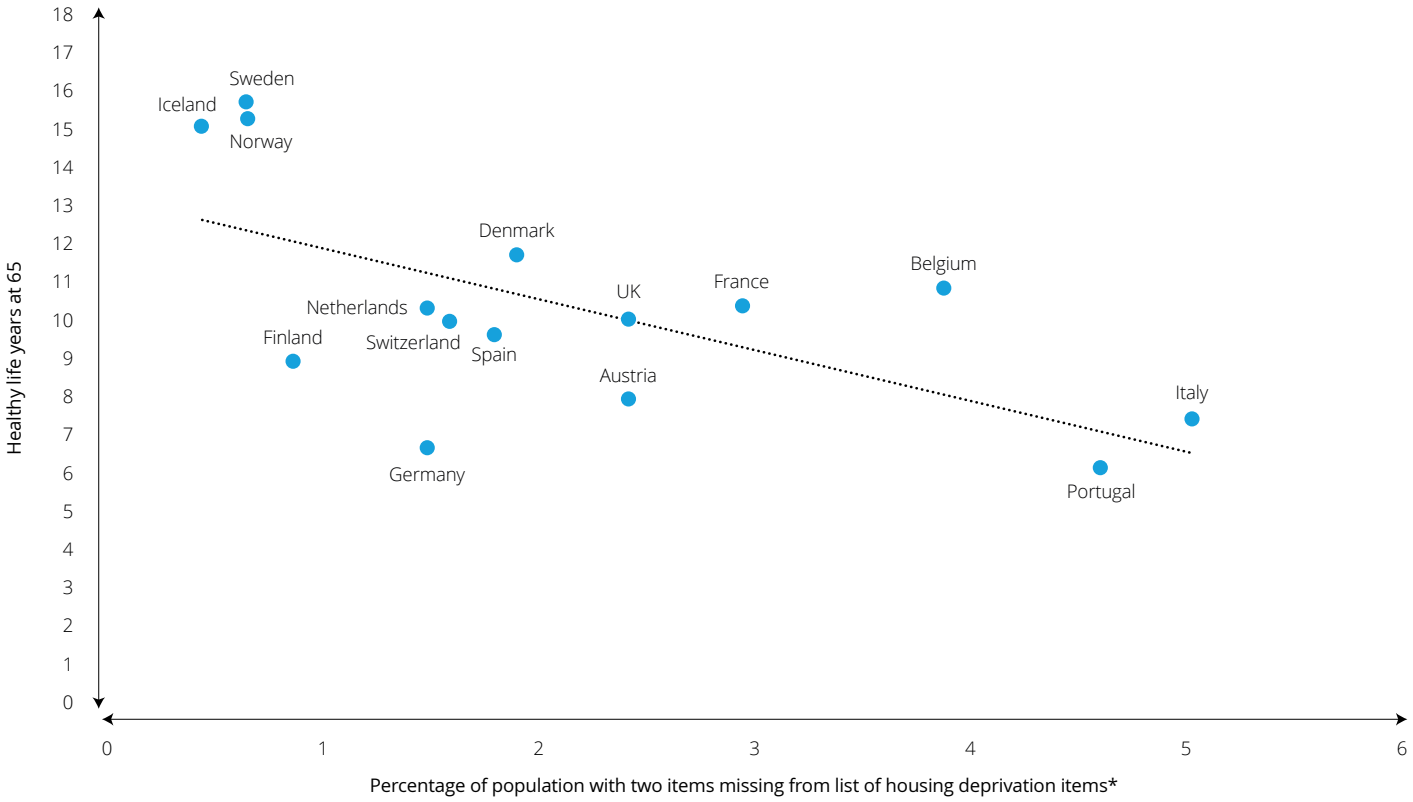
Across Europe depression a ects 10 to 15 per cent of people over 65, with a disproportionate number in lower social economic groups. Indeed, only cardiovascular disease has a greater toll on morbidity and mortality than depression. Yet depression remains under-recognised and highly stigmatised across Europe.[102] Older persons with depression are two to three times more likely to have two or more chronic illnesses and two to six times more likely to have at least one limitation in their activities of daily living. Depression is the major cause of suicide in Europeans. Rates of suicide and self -harm are around 26 per cent higher in Europeans over 65 than amongst the 25-64 age groups. In 90 per cent of EU countries, the suicide rate is highest in those over 75.[103]

Certain 'forgotten' groups of older people are at greater risk of ill-health. These include older women, members of ethnic and cultural minorities, socially isolated and disabled older people. While risk of mortality is higher for most chronic conditions in older men, women present a much greater risk of disability as they age, mostly due to the presence of multiple conditions. Because they live longer, women are also at greater risk of social isolation as they age, with social isolation leading to loss of independence. Many older women are carers and may devote their energies to caring for relatives at the expense of their own health. Women typically do not allow themselves time to convalesce in the same way as men and often take a more stoic and passive patient role, including delaying seeking medical treatment.[104]

On average in Europe, 31.4 per cent of the elderly live alone.[105] As vulnerable adults get older and frailer, they increasingly need support in their daily lives to continue living in their own homes, including adaptation to the building structures and provision of home-based care.[106] However in the UK, for example, support for people to remain living independently in their own homes has been severely a ected by cuts to care services with spending on home care services reducing by almos fth between 2010-11 and 2013-14. This has undermined the adoption of more preventative approaches that delay or prevent the onset of more intensive care needs.[107]

The suitability of accommodation for older people is critical to their ability to remain as healthy and independent as possible. However, one i ve homes in the UK do not meet the decent housing standards with poor housing costing the NHS £1.4 billion to £2 billion per year in England alone.[108] For example, living in a cold home can make people sick with older people particularly vulnerable, due to increased risk of heart and lung disease as well as worsening conditions like arthritis and rheumatism. Funding for home improvements and refurbishment has declined, which particularly a ects older people on low incomes who own their own homes.[109] Across Europe, higher housing deprivation is correlated with fewer remaining healthy life years at the age of 65 (Figure 13).[110, 111]

Figure 13. Higher housing deprivation rates are correlated with fewer remaining healthy life years at 65



Source: World Health Organization, Eurostat, 2016
*Note: The indicator is defined as the percentage of the population deprived of each available housing deprivation items. The items considered are: leaking roof, damp walls/floors/foundation, or rot in window frames or floor; lack of bath or shower in the dwelling; lack of indoor flushing toilet for sole use of the household; problems with the dwelling: too dark, not enough light

Moreover, inequality in care for older people is in uenced by patterns of utilisation and access to prevention and regular treatment. Utilisation patterns reinforce the inverse care law, which states that those in greatest need of care often have the least access to care and make up hard to reach patient groups. In Europe, urban planning of healthcare services, availability of transport services and variation in health literacy act as barriers to accessing care. The lower utilisation of prevention and regular healthcare contributes to the higher use of emergency care and higher risk of hospitalisation seen among those in receipt of social assistance.[112]

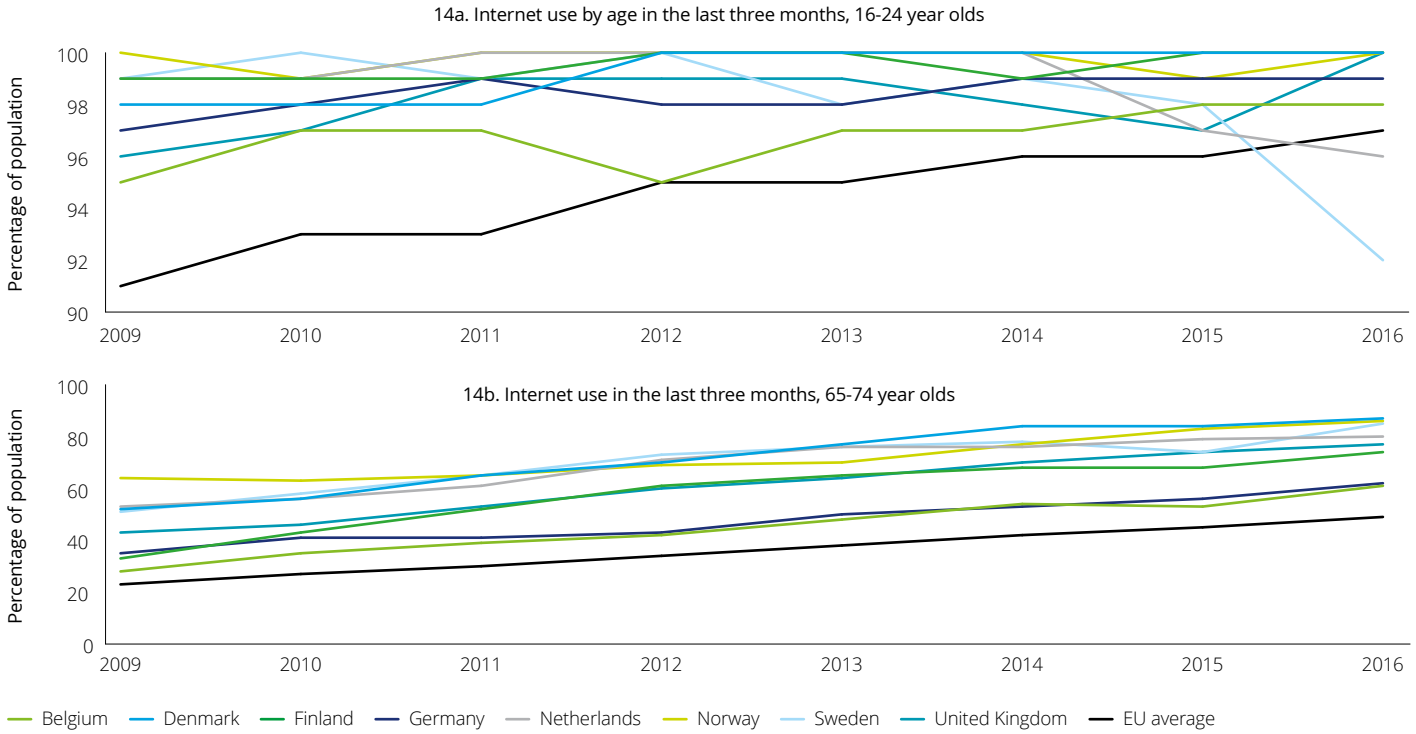
Older people as a group provide an invaluable economic and social contribution to society in areas such as volunteering, childcare and care of other adults. However, older people in vulnerable families who have su ered a life of disadvantage and who are arguably more likely to be needed to provide unpaid support to their family, are less likely to be in a position physically to provide that support, disadvantaging vulnerable families further. Moreover, in vulnerable families the needs of the ageing family members are often inadequately addressed, with elderly family members often left to be cared for outside of the family system, increasing their loneliness and worsening their mental health. The result is accumulating demand and costs to health and social care services across all generations.

To overcome the challenges of increasing demand for services, social isolation and poor health literacy most European countries aim to implement technology-enabled healthcare solutions to improve care and reduce costs. Technology can alleviate the disadvantages, isolation and marginalisation experienced by many older people. When asked about their preferred way of accessing information, older people often mention television and radio. However, increasingly, mobile phones and the internet are helping older people keep in touch with their families and friends. Technology also ensures more safety at home, facilitates healthcare, brings new stimuli into older persons' lives and creates greater access to information.[113]

However, access to broadband internet, mobile devices and computers at household level are becoming a relevant social determinant of health, particularly for older people.

In Western European countries, an average of 11 per cent of individuals do not have access to basic broadband internet at home, with lack of skills and high costs being the main barrier to installation.[114, 115, 116] Internet use varies by age (see Figures 14a and 14b).[117] The share of elderly who use the internet at least once a week, on average in the EU-28 is 41 per cent. Variation ranges from, 83 per cent of weekly users in Iceland to 51 per cent of weekly users in Belgium. Across Europe, over 69 per cent of people who lack basic digital skills are aged over 55 years. According to the OECD, the breadth of internet activities carried out by users of high educational background is on average 58 per cent higher than those with lower education levels. Data from the UK point to a high risk of digital exclusion for older people of low socioeconomic status; older people with the lowest income were ove ve times less likely to be using the internet, than those with the highest monthly incomes. Poorer self-perceived health is also associated with non-use of the internet.[118, 119]

Figure 14. Cross-country and age differences of internet use



Source: Eurostat, 2017
Note: For readability vertical axis values differ between Figures 14a and 14b

Examples of good practice
Ensuring social inclusion, care and support

Case example 10: Providing decent and safe housing for older people to improve outcomes while reducing costs (UK)

Across the UK, housing associations and local authorities collaborate to improve housing standards for older people who are dependent on public housing. For example:

The local housing association in Sta ordshire encouraged investments i tting preventive housing adaptions by arguing that the average cost of a fall at home leading to a hip fracture costs the state £28,665, more than 100 times the cost of providing simple preventive measures such as grab rails and hand rails.

The ExtraCare Charitable Trust supports older people in 14 retirement villages and 17 housing schemes. Its ExtraCare Wellbeing service provides an informal drop-in service for preventive health care and day-to-day support for long term condition management. An independent impact evaluation of 162 new residents versus 39 control participants showed that over the course of 12 months 19 per cent of the intervention group had improved from a 'pre-frail' to a 'resilient' state with more general reductions in levels of depression and cognitive function. Planned GP visits fell by 46 per cent and planned hospital admissions fell by 31 per cent, leading to an overall reduction of 38 per cent of NHS costs for the intervention group, a saving of £1,115 per person per year.

The Hyde Healthy Living Project delivers services to address the needs of patients over 75 who live in an area of multiple disadvantage. The Project is a joint investment between Tameside Council, New Charter Group and Tameside and Glossop Clinical Commissioning Group - working with primary care teams at eight GP practices. Community based triage supports early interventions – both social and medical. The goal of the project is to ensure elderly people receive appropriate community-based support. A cost-bene t analysis illustrated that the project delivered social impact and health outcomes worth £2.81 for every £1 invested, 37 per cent of which in terms of averted healthcare costs.[120, 121, 122]

Case example 11: Remote monitoring and health coaching to improve health of older adults (Finland)

The Finnish project 'Remote monitoring and health coaching in South Karelia' recognised that the most important success factor in the reach of vulnerable older adults with a chronic disease is the combination of e-health and mobile techniques with personal health coaches. Mobile services were provided by mobile teams at home as well as in wellbeing centres in collaboration across nine regional municipalities. The project supported older adults in maintaining socially engaged lives and accessing the internet to enable use of telehealth community-based care. The inclusion in cultural activities addressed isolation, while improving health outcomes at the same time.[123]

Case example 12: Co-creating healthy urban living – the Utrecht health approach (Netherlands)

Utrecht is the fastest growing city in the Netherlands. In 2014, the city analysed the health of its population by collecting data in a public health monitor. Despite generally good health among its residents, health inequalities were detected. The city has developed a comprehensive public health strategy, based on the principles of co-creation and collaboration across sectors, to promote healthier lifestyles and housing. The key elements of the strategy 'healthy city', 'healthy neighbourhood' and 'healthy start' address good health as a goal in itself, as well as a means to deliver other individual goals, such as social participation, professional success and development. The city has worked to create a healthy community at district as well as neighbourhood level, and brings together volunteering residents, community organisations (including schools, local businesses, health and social care providers and insurance companies) and the city authority. It addresses housing standards, nutrition and access to care. The initiative is supported by the national 'Healthy in the City' incentive programme that provides targeted budgets for the reduction of health inequalities particularly in later life, as well as a knowledge sharing platform. For example, Hoograven Together provides a low threshold service for senior citizens that involves elderly residents as providers of social activities and reduces loneliness in that age group. The city is investing in further developing the public health monitor into an up-to-date, transparent knowledge tool to monitor outcomes of the initiatives, including return on investment.[124, 125]

Longitudinal studies have shown that socioeconomic disadvantage is associated with an increased risk of disability, chronic disease and co-morbidity, depression and decline in cognitive function across all age groups. Indeed, older people belonging to lower socioeconomic groups have a 30 to 65 per cent higher risk of almost all chronic diseases than those in more privileged social groups.

Integrated solutions to improve outcomes at all life stages

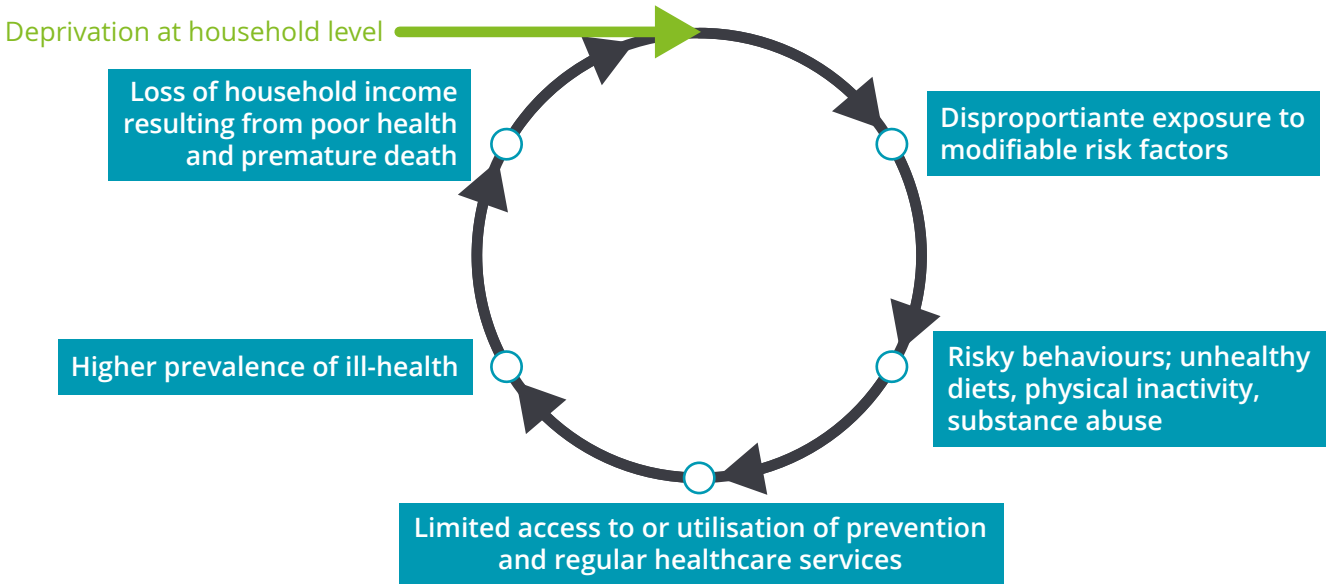
Taking a whole system, life cycle approach recognises that the in uences that operate at each stage of life a ect health and wellbeing throughout a person's life and require targeted integration.

Figure 15 shows how family vulnerability and in particular household poverty and ill-health perpetuate each other. Policy initiatives directed at vulnerable families across Europe increasingly recognise that giving each child the best possible start in life is likely to deliver the best societal and overall health bene ts. However, these initiatives often inadequately link to interventions directed at other life stages and fail to e ectively avoid perpetuation of vulnerability, enable cross-generational support or reduce avoidable costs.

There is a clear consensus among policymakers and health system leaders across Europe that better integration of healthcare and social services systems has the potential to simultaneously address the multiple underlying issues of health inequality and reduce overall costs. However, all the countries examined in this report struggle to implement integrated solutions at a sufficient pace and scale.

This section highlights a set of innovative integrated solutions trialled across Europe, which bring together a wide range of highly engaged stakeholders from local and central government, including education, housing, transport, the environment, police an re and rescue services. It also draws on good practice examples from other parts of the world. The case examples illustrate how lessons learned in tackling vulnerable families through collective action could be applied at scale to help reduce health inequalities, improving the chances of living a healthy and productive life for entire populations.

Figure 15. The vicious circle of social deprivation and ill-health



Source: Deloitte Centre for Health Solutions, 2017

Examples of good practice

Case example 13: An integrated approach to support at-risk families (Denmark)

Danish population data shows that children and young people who are known to the social services system from childhood are overrepresented in the bene t system later in life. Deloitte Denmark supported the Ministry of Social A airs and Interior and the Danish Labour Market Authority in developing and testing a new integrated approach and monitoring tools to address the needs of vulnerable families. A systematic screening of the resident's needs, based on a standardised, nationwide assessment method supports the local case manager with structured knowledge of a resident's challenges, resources and desires. The frequency of reporting enables continuous monitoring for signs of progress in the families in terms of wellbeing, employment, school attendance, leisure activities and other indicators. The overall costs of the interventions and bene ts are also monitored to document the social return on investment. Data is compared to a baseline measurement conducted at the start of the initiatives as well as to a control group. To achieve the greatest impact in the interventions, each of the project municipalities applies a cooperation model ensuring integrated, standardised interventions across all participating organisations. The project was initiated in 2014 and currently ten project municipalities monitor and report data on around 400 families every three months. Outcomes include improved wellbeing and functional level for parents and children. Results to date indicate a:

- 15 per cent increase in the number of adults in regular employment and in educational programmes
- 10 per cent decrease in children's absence from school
- 9 per cent decrease in adults su ering from stress and depression
- 16 per cent increase of children of reporting adequate wellbeing.

Satisfaction among participating families and social services sta s high. An economic evaluation of the intervention indicates annual savings of $88,100 when a family with moderate problems is pulled out of vulnerability and $117,500 when a family with extensive problems improves to having light remaining problems. Considering the costs of the programme this means that if merely 1 family out of a cohort of 25 successfully overcomes disadvantages, the project will reach break-even.[126, 127, 128]

Policy initiatives directed at vulnerable families across Europe increasingly recognise, that giving each child the best possible start in life is likely to deliver the best societal and overall health bene ts.

Case example 14: The wider public health workforce – making every contact count (UK)

Increasingly, Fire and Rescue Services in the UK partner with colleagues across the public sector to address health inequalities in the community, based on the understanding that bot re hazards and health follow a social gradient. Preventative strategies that addres re risks include deprivation, housing conditions, smoking habits and social isolation and simultaneously deliver bene ts to population health. For example, the Fire and Rescue Services in Merseyside are tackling social and health inequalities in the community by educating people about the bene ts o tness, healthy eating and a healthy lifestyle. The Service developed a wide range of preventative initiatives, such as the Fire Fit programme launched in 2008. Fire ghters are used as role models to help encourage people to take part in sporting activities. The programme has been rolled out across the whole community, supporting more than 40 events a year. Each week teams o re ghters go to schools, particularly those identi ed as having high needs, and conduct 60- to 90-minute sessions which include activities such as football and running for Year 5 and Year 6 children. In 2015 Fire Fit received funding to run a physical activity programme for schools in Toxteth, to improve long-term motivation for behavioural change. Fire Fit developed a partnership with researchers from Liverpool John Moores University to examine the e ects of the programme. The study found that in comparison to regular physical education, classes that Fire Fit developed increased levels of motivation for physical activity and engaged more children from vulnerable groups. Girls, in particular, bene ted from the non-competitive environment of the sessions and showed an increase in long-term uptake of physical activity. The research team which is now led b re ghters is exploring how to increase volunteer coach participation to successfully expand the Fire Fit programme. Another element of the Fire Fit brand is a £5.2 million purpose-built youth centre with sporting facilities which opened in 2013. The Fire Fit Hub was built with funding from the Merseyside Fire and Rescue Service, the Department for Education and Liverpool City Council. Most recently the Fire Fit programme developed a strategic alliance with Liverpool Football Club Foundation Kicks Programme, the official charity of Liverpool Football Club, to work i ve of the most deprived areas of the region. The programme uses football and the strong brand of LFC as the 'hook' to engage with teenagers and young adults and o ers a range of educational sessions from the Fire Services and other agencies, tackling wider issues such as alcohol and drug abuse, road safety and knife crime.[129]

There is a clear consensus among policymakers and health system leaders across Europe that better integration of the healthcare and social services systems has the potential to simultaneously address the multiple underlying issues of health inequality and reduce overall costs. However, all the countries examined in this report struggle to implement integrated solutions at a sufficient pace and scale.

Case example 15: Co-designing integrated care with all local populations (Sweden)

Jönköping County Council is a regional government authority serving 340,000 people in southern Sweden. It plans, funds and provides health services for the population working in partnership with local government to ensure that these services are connected with other services and policies. Jönköping has a high degree of autonomy over decision-making as a result of Sweden's system of devolved government. For more than 20 years the Council has pursued a vision for its residents of a good life in an attractive county. People are engaged in health dialogues at di erent stages in their lives to discuss their own health and discover intrinsic motivations that can be used to stimulate healthy behaviours. When people require support from health and social care services, professionals work in partnership with patients and their families to design services around the outcomes that matter to them. Jönköping's Passion for Life programme, which is targeted at older age citizens, uses group meetings to increase older people's social connections and provide support to empower them to lead healthy lives. Meetings (called 'life cafes') are held in di erent places depending on the topic discussed – for example, in gyms if the focus is on exercise – and are supported by coaches and volunteers. The 'life café' model has been adapted to increase social connections for di erent population groups. This includes group meetings focused on the needs of minority populations, intergenerational issues and connecting people with similar medical conditions so that they can support each other to manage their own health. Jönköping performs well on a range of population health measures when compared with other Swedish regions. It ranks as one of the highest in terms of life expectancy and proportion of people reporting good health and among the lowest in terms of avoidable mortality rates (such as deaths related to smoking). It also ranks highly in the number of people reporting having discussions about their lifestyles in primary care. The county's work on improving care for older people has led to signi cant reductions in hospital admissions for this group.[130, 131]

Case example 16: Connecting to Care programme in Saskatchewan (Canada)

Launched in the pilot cities of Regina and Saskatoon in 2015 with initial government funding of C$1.5 million, Connecting to Care builds on the 'hotspotting' approach, which searches administrative data to identify the subset of patients who account for a disproportionate level of healthcare utilisation and costs. According to the Saskatchewan Health Quality Council, 1 per cent of Saskatchewan's patients accounted for approximately 21 per cent of hospital costs. Connecting to Care uses proactive outreach to prevent hospitalisations and emergency department visits by focusing on the timely use of community-based services, including support for medical, mental health and addiction treatments, as well as assistance with social needs. A team of providers, including a nurse, counsellors and wellness advocates coordinates and oversees personalised plans for each patient in the Connecting to Care programme. Patients are selected on the basis of their prior healthcare use and identi ed needs, as well as healthcare provider referrals. Technology plays a critical role in the programme, including the use of electronic health records (EHRs), connections with community support partners and mobile phones to check in with clients. While formal evaluations of the two pilot programmes are not yet publicly available, the Regina pilot has reportedly seen reductions in both emergency visits and hospitalisations. Reductions in hospitalisation is signi cant and an average of C$1,400 was saved per each avoided day of hospital care.[132]

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"Health inequalities and social determinants of health are not a footnote to the determinants of health. They are the main issue."

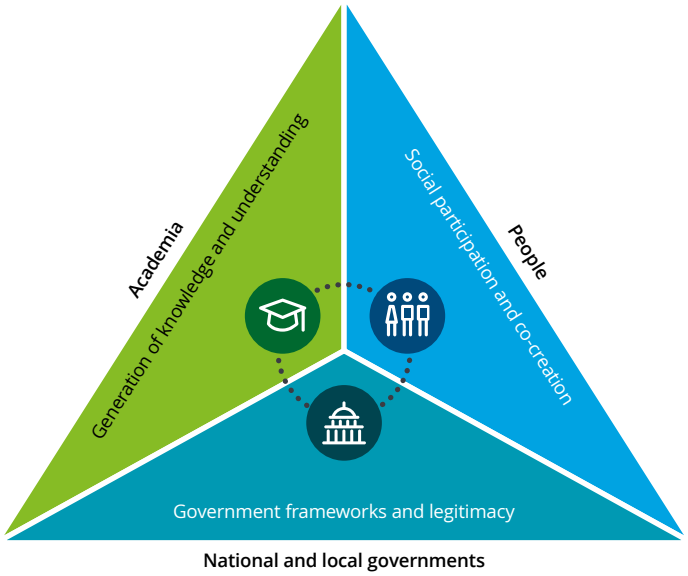
Sir Michael Marmot[133]

The evidence presented in this report illustrates the dilemma that many high-income countrie nd themselves in. On the one hand, medical science and technologies have provided the tools and information to drive dramatic advances in health outcomes; on the other hand, many countries are seeing avoidable health inequalities between the better-o nd worse-o ncreasing.

Indeed, in most major cities in high-income countries there is an extremely wide social gradient in life expectancy running from the most affluent areas to the most deprived both in terms of life expectancy and disability free life years. For example, the social gradients across London, Glasgow and New York all show around a 20-year gap in life expectancy.[134]

Most Western European countries, despite their mature health and social services systems, have struggled to tackle the causes and impact of health inequalities and nowhere is this more evident than in the challenge presented by vulnerable families. These families have multiple and complex problems, including parents who do not even consider a decent job an achievable goal and children who are at serious risk of a lifetime of disadvantage, from cradle to grave. Historically, these families have often received services that have tried to respond to individual problems and often at times of crisis – whether truancy, domestic violence, anti-social behaviour or unemployment. However, the failure to tackle these causes e ectively is often rooted in a siloed and reactive approach, rather than delivering integrated services and cross-sector actions. This report has deliberately focused on the most disadvantaged groups of society, those vulnerable or troubled families, in the belief that tackling their inequalities will lay the foundation for reducing health inequalities more generally.

Figure 16. The triangle that moves the mountain



Source: WHO, 2009

Figure 16 illustrates the need for a trilateral partnership approach to e ect change involving academic researchers, policymakers and the wider public working together to address the enormous social and economic challenge of health inequalities.[135] A data- and evidence-driven understanding of interacting factors needs to be translated into policy interventions that are co-created, empower the citizen and meet local needs. Policymakers need to ensure that governance frameworks provide legitimacy and authority over the deployment of resources based on the evidence presented and public support.

The examples of good practice throughout this report highlight that sustainable change is achievable, if stakeholders are prepared to learn from what has worked elsewhere, and come together to work across institutional and professional boundaries. Allowing traditional boundaries between service providers and users to become 'porous' is pivotal for success. Collaboration can achieve what lies beyond the e ective scope and capabilities of any individual stakeholder. This includes peer-to-peer networks and shifting skills, competencies and accountabilities. Key stakeholders from multiple agencies, national and local governments, civil society and accountable private sector organisations need to work with citizens and take collective decisions on how and where to invest in joint actions to achieve better outcomes.

Successful initiatives share a coordinated, case management approach with a community-based gatekeeping point for accessing services. They include planning for stronger social protection and building healthy and cohesive communities, and show the importance of overcoming short-term thinking as well as the fragmentation of service delivery.

After a certain point, increasing overall spending on healthcare does not equate to better health, although spending on prevention and early interventions can and does make a di erence, especially in the early years of life and as people start to become frail and more reliant on support to remain independent. However, as our previous report, *Vital Signs: How to deliver better healthcare across Europe*, shows investment in prevention across Europe has declined since 2009, following the globa nancial crisis.[136] Indeed, in 2013 funding directed at prevention across European countries averaged only three per cent.

At the same time, per-capita spending on social services, bene ts and publicly funded infrastructure has also reduced as governments seek to keep up with the growing demand for services at a time of increasing resource constraints. These difficulties are exacerbated when it comes to collaboration across funding and operational silos, leading to difficult discussions on how to raise and allocate funding across sectors for interventions that will tackle the social determinants of health, and for which outcomes are likely to be several years down the road.

Our research has identi ed the following key actions for stakeholders to break the dependency cycle and reduce the health inequalities experienced by vulnerable families.

A data- and evidence-driven understanding of interacting factors needs to be translated into policy interventions that are co-created, empower the citizen and meet local needs. Policymakers need to ensure that governance frameworks provide legitimacy and authority over the deployment of resources based on the evidence presented and public support.

Key actions for stakeholders

Policymakers in national and local governments need to develop programmes to help their population become more resilient, and in particular to tackle the complex problems of their least well-o nd most disadvantaged members of society. Actions that strengthen the intrinsic resilience of communities and populations include:

- combining policies across the life span that harness synergies and follow the approach of proportionate universalism, where policies are directed at everyone but provide the strongest support to the most vulnerable
- providing public services at a local level, based on a single citizen identi er, to enable real-time monitoring of the e ects of interventions. Cross-country sharing of evidence on intervention e ectiveness will help all governments model the return from investment in social programmes, for example, early childhood interventions where the outcomes can take years to become apparent
- reducing poverty through strategies that address income inequalities and support equality of opportunity and outcomes
- securing the success of the above policies by providing adequate health and social care funding. This includes new models of integrated, citizen-centric funding in relation to planning, commissioning and provision of services to avoid cost-shifting and ensure incentives are aligned across all parts of the system.

Public service providers and their workforce need to continue to develop new patterns of working collaboratively across professional, institutional and organisational boundaries. These include:

- further integrating health promotion and prevention as a core objective into the daily routines of the wider public sector workforce, including teachers re and rescue services, housing officials and police
- undertaking a standardised assessment of the social conditions of the individual and families a rst point of contact with public services, especially healthcare
- applying insights gained from social determinants of health scores and other predictive models to inform decision-making and proactive prescribing of social and clinical interventions
- signposting to other services and social prescribing where appropriate
- agreeing a key worker approach to act as gatekeeper to reduce the multitude of unconnected services and professionals surrounding the families with disparate and repetitive assessments, thresholds, appointments and measures
- focusing relentlessly on measurably improved outcomes for families.

Academic partnerships play an important role in the ongoing research to unravel the complex interconnections of social determinants of health and health outcomes. Research should focus on:

- developing and applying innovative analytical tools to health economics research
- aggregating and segmenting population data to give a real-time picture of the population being served
- continuous tracking and analysis of outcomes as well as return on investment.

Third sector and private sector organisations need to participate in sustainable relationships to support the use of social prescribing as well as to counteract consequences of poor working and production conditions on the health of employees and neighbourhoods. Actions include:

- engaging in sustainable business practices that reduce the environmental impact on health and safety
- improving workplace safety and job security
- partnering in public-private partnership interventions that address social determinants of health.

Individuals and families should be encouraged and supported to engage in the co-design and co-delivery of interventions, which are based on individual skills and capabilities and supported by initiatives to improve the health literacy of citizens. While this is generally easier for those less a ected by social disadvantages, tailored interventions can help all individuals develop the con dence to engage with their own health and wellbeing, for example by encouraging active participation in programmes o ered by local communities.

All stakeholders should consider the role of analytics and digital technology to help provide more efficient and cost e ective support across the range of interventions, including:

- usin nancial modelling tools to assess fun ows and pay for health and social outcomes
- information sharing, albeit challenging, is key for whole family working and enables problems to be tackled more e ectively
- integrating analytics and interoperable IT across all public services
- increasing transparency through data visualisation tools and dashboards that monitor system performance and indicate high-risk areas in real time
- applying sophisticated machine learning and software models that predict risks at an aggregate population and individual level
- deploying data-driven triggers that automate communication with citizens, making use of behavioural insights and choice architecture to optimise citizen engagement
- developing digital platforms to make resources and knowledge more accessible, encouraging adoption of strategies that have worked elsewhere
- providing education and training to citizens in the use of digital technology.

Across Europe there is signi cant scope for all stakeholders to work together more e ectively to tackle the social determinants of health. Reducing health inequalities is a moral and economic imperative in order to secure a healthy and sustainable future for everyone.

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