World Health Organization
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Reducing health inequities: perspectives for policy-makers and planners

Engagement and participation for health equity

A core principle of Health 2020 is reducing health inequities across the population, along with the importance of participation and responsiveness, with the full engagement of people

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Definition and importance

Central to the European Health 2020 policy framework is the recognition that public policy can no longer only be delivered *(1)*. Participation involves people taking a central role as social agents, members of social networks, as collectives or individual stakeholders, and participating in decisions that affect their health and well-being *(2)*. Engaging and enabling the public to take an active interest in health, making healthy choices and building healthy communities are important for achieving public health goals, contributing to socially sustainable health systems, as well as reducing health inequities *(3)* (see Fig. 1).

Fig. 1. Local people, business and authorities creating solutions for levelling up health in communities and across society

Social mobilization
Inclusive decision-making
Shared accountability

There is a spectrum of approaches to engagement, spanning a range of methods and varying in intensity of participation, depending on the intended policy goals and outcomes. Given the increasing emphasis on developing local solutions to tackle the root causes of social inequities in health, communities and individuals **need to be engaged as the owners/holders of local knowledge** and as important partners in co-creating solutions, along with the local and national authorities, in order to improve health and address the determinants of inequities.

When policies are being designed there is often a lack of understanding of the social, cultural and economic lives of resource-poor members of society. The result is that **interventions are often mismatched to the realities of people's lives** and can fall short of delivering the intended benefits for those most in need. In some cases a consequence is the unintentional benefit to some groups over others, thus widening gaps in health between social groups and geographic areas within a country.

For these reasons, **participation and engagement**, particularly for those with the least voice, **lead to more effective public policies for health equity**.

The public policies that impact the determinants of health equity include education, employment, income security, housing, community and road safety, and water and sanitation.

The multiple benefits of participation and engagement for health equity and well-being

Improving personal and community capabilities

When participation and engagement strategies are used as mainstream approaches in public policy and services, they deliver additional benefits for health and well-being, including strengthening the accountability of public policies and services (such as contributing to monitory democracy[1]) and building individual and community capabilities. These efforts to encourage and improve health and social literacy contribute to improving the effectiveness of public policies and to healthier communities and individuals *(4)*.

Communities – both place-based and in which people share a common identity or affinity – make a **vital contribution** to health and well-being. Low levels of social cohesion in neighbourhoods and institutions (such as schools and workplaces) are associated with poorer health and higher stress, which follows a social gradient *(5–7)*. Participatory approaches play a key role in addressing the link between marginalization and powerlessness, and in tackling the determinants of health inequities *(8)*.

Universal health and social protection systems improve social cohesion when they, for example, intervene quickly to help people to return to work after illness, or manage the health of parents so that children do not become carers, dropping out of school early.

Improving policy outcomes and equity impacts

Engagement and participation policies have repeatedly been to found to deliver improved policy and governance outcomes. A survey of governments in 25 European countries found that open and inclusive policy-making delivered greater trust in governments, high compliance with decisions made, and better outcomes at less cost, as well as driving innovative solutions *(9)*.

Numerous examples exist within the health sector of how local and national authorities are routinely integrating participation and engagement approaches into cross-sectoral policies for health and health equity. The Kyrgyz Community Action for Health Programme, the Lithuanian National Health Plan, the Scottish health strategy "Equally well", the Slovene Programme MURA and the various Swedish municipal social sustainability plans are all examples in which participation of a wide range of community stakeholders has been embedded into the development and implementation of policies *(1, 10–12)*.

Public policies governing the key areas that influence health equity, such as employment and education, also show higher impact in reducing health inequities when they are designed to increase participation and engagement of so-called at-risk groups. This has been well documented in relation to employment policies, whereby a focus on improving both employment and capabilities has been proven to be more effective.

1 Monitory democracy means achieving democracy by monitoring methods, for example, by making public and civic data accessible and transparent *(1)*.

Policies which protect people while unemployed and enable re-entry into the labour market have greater impact on health when put into effect alongside financial coverage; such approaches also include outreach counselling, providing support to increase personal mastery and coping skills, along with job-seeking training and mentoring. These active labour market policies are important elements which strengthen the capabilities of those seeking employment. They also have a positive impact in helping to reduce work-related mental health problems and other negative health effects across the entire working-age population. However, they have the greatest health impact on those with less education and skills and are therefore significant policy responses aiming to reduce health inequities *(13)*.

Partners for effective participation

Engagement and participation can be **enabled through investment in building skills, trust and capacity** between the public sector, communities and service users. Mediating agencies, such as nongovernmental organizations (NGOs) and community-based organizations – which have their roots in local communities as well as at pan-European level – are important stakeholders in the new types of partnerships for improving health and well-being across Europe. These non-profit-making stakeholders need to be formally recognized and supported by laws, guidance and regulation.

Current issues and trends

Literacy and engagement and participation

Literacy refers to people having the appropriate skills, knowledge, understanding and confidence to have control over their lives.

Populations with low levels of literacy, including health literacy, are less likely to speak up and participate in engagement activities. **Improving health literacy is critical to creating and/or enabling a population that can effectively participate in engagement activities** *(14)*.

Health literacy follows a social gradient in all countries across the WHO European Region whereby the poor and most vulnerable have the worst literacy levels *(15)*. Many Europeans have difficulties understanding and accessing health care and information about their health. A study of eight European countries found that almost half of the population (47%) have inadequate or problematic health literacy *(16)*. Limited health literacy often correlates with a lack of ability to effectively self-manage health, access health services, understand available and relevant information and make informed health-related decisions *(15, 17, 18)*. Differences in health literacy explain a substantial proportion of inequity in health and in the uptake and use of health services *(19)*.

Improving equity of health literacy within the population

Health literacy interventions targeting the public should aim to improve all individuals' ability to understand health information, which will lead to using these new skills to access and act on the necessary information. The significance of information may not be clear to the public; it may be necessary to **explain to them why particular scientific, clinical and administrative information is important to their health**. The public should not be expected to be experts, but instead to provide their perspectives to help inform policy.

Strategies to improve health literacy involve **building awareness and resilience among individuals and communities**. Effective health literacy involves shifting away from targeting individuals to targeting community health literacy, encouraging all communities to co-create solutions *(14, 20)*.

Table 1 outlines interventions to achieve equitably good health literacy, such as improving social networks and peer support.

Improving awareness of the pathways linking social and economic factors to health for all requires **the causes of the causes** of health inequities to be addressed, as an important part of action to improve health literacy, both among the public and across institutions and government *(21)*.

Table 1. Community-centred actions for health equity and well-being

Actions	Common approaches
Build community capacities to take action on health and reduce health inequities. Members of the public identify local issues, devise solutions and build sustainable social action.	• Community development • Asset-based methods • Social network approaches
Enhance individuals' capabilities to provide advice, information and support or organize activities in their or other communities, using life experiences and social connections to reach out to others.	• Peer support and education • Health trainers • Befriending and volunteer schemes
Involve communities and local services working together at any stage of planning cycle, leading to more appropriate, equitable and effective services.	• Area-based initiatives • Healthy towns and cities* • Co-production**
Connect individuals and families to community resources, practical help, group activities and volunteering opportunities.	• Social economy

* Healthy towns and cities are discussed in full in De Leeuw et al. *(22)*.
** Scottish Co-production Network *(23)*.
Source: based on South *(8)*.

One of the reasons for the lack of substantive policy attention to health inequities could be the lack of public understanding of (and therefore attention paid to) the need for such policies *(24)*. Many countries have taken action to explain the impact of health inequities to the public, either through direct communication – such as Northern Ireland's accessible and interactive webpage explaining the reasons behind its health inequalities policy, entitled Making Life Better *(25)* – or indirectly, through awareness campaigns about health inequalities in the media.

Improving health and equity literacy across government

When elected officials in 13 European cities were asked for solutions to health inequities issues they focused on lifestyles and healthy behaviours, with little mention of the pathways between broader social and economic policies *(26)*.

Lack of awareness of the causes of the causes of health inequities is one explanation for the lack of political will and systematic action. As such, ministries of health have a key role to play to lead actions to educate and enable their cabinets and local government colleagues to consider the health and equity impact of their policies. An important aspect of this is developing political narratives, which support joint action across government and demonstrate the benefits, as well as the costs to government and societal goals of not taking action. **Local health and well-being profiles, which provide detailed descriptions of the health and well-being needs of the local population, along with social sustainability reports, can be useful tools** for increasing the health and equity literacy of non-health sectors and nongovernmental partners.[2] At an institutional level, involving other sectors as stakeholders through participatory planning from the start of the policy development process and throughout the review stages has also been shown to enhance sectoral understanding of social inequities and the health dimension. Management approaches – including joint sectoral reviews of policies/interventions and use of cross-governmental commissions to assess policy options and evidence – have also been shown to enhance policy coherence for health equity and determinants across government.

Increasing the health literacy in government departments and fostering strong commitment to action on the determinants of health inequities requires a clear and strong political narrative for joint policy action. A 2013 WHO Regional Office for Europe review highlighted the narratives with a strong potential for engaging sectors across government in joint actions that benefit health and demonstrate the value of health equity to broader government goals *(14)*.

Technology

Technologies such as mobile phones (mobile health or mHealth) have the potential to increase opportunities to engage, by providing and receiving information to and from population groups. While technology offers innovative solutions for the entire population to participate actively in the management and monitoring of their own health, at the same time the costs and insufficient knowledge, skills and literacy associated with new technologies have the potential to create health inequalities *(28)*.

Technology can give the public the ability to control agendas and the tools to drive change, such as online petitions, open (government) data analytics, and collective action (through eHealth methods). For example, in the Netherlands the iPhone Spectropolarimeter for Planetary Exploration (iSPEX) project developed an application (app) with which the public collected atmospheric information via their smartphones to measure air quality. The information provided by citizens helped scientists to understand the effects of pollution on health, climate and air traffic and the 3187 citizens are listed

2 See, for example, the Scottish Public Health Observatory's online profiles tool *(27)*.

as co-authors of the article, based on the data they collected *(29)*. Examples such as this improve both public and decision-makers' awareness of issues surrounding air quality and pollution, and in particular their relationship to health *(30)*.

Ensuring equitable access

Inequitable access to digital communications can worsen inequities. In the majority of European countries, more men use the Internet than women. In some countries usage is almost equal, but in others large gaps exist, particularly in terms of gender and number of years of education. Physical access is part of the issue, but knowledge of how to use effectively technologies to support or change health is also a problem. Too often, eHealth/mHealth solutions are aimed at those who already possess a broad set of so-called health skills – including awareness, ambition and self-discipline – capabilities that are usually acquired through formal education *(28)*. As such, equity should be explicitly addressed in eHealth and mHealth and related policy discussions, in order to address inequities in access, skills and knowledge which affect usage and impact *(31)*. NHS England has made efforts to improve the use of eHealth, for example, by funding the Widening Digital Participation programme run by an external non-profit-making social enterprise (the Tinder Foundation). The programme offers training in basic online skills and provides information on using transactional services online, such as booking appointments and ordering repeat prescriptions. In the first two years, 140 892 people received training, the majority of whom were older unemployed people, disabled people and ethnic minorities *(32)*.

Social economy

The social or so-called solidarity economy refers to forms of economic activity that aim to improve quality of life and health outcomes through social objectives and non-profit-making policies *(33)*. Social economies prioritize policies in development strategies that value people and communities instead of only endorsing economic growth *(34)*. The social economy has explicit economic and social (and often environmental) objectives, guided by principles and practices of cooperation, solidarity, ethics and democratic self-management.

Supporting the social economy generates many advantages as a result of its basis in collective action. As such, it is an **important partner** in addressing health equity and should not be regarded as an alternative to the public sector. Workers, producers and consumers work collectively to enhance their capabilities needed to survive, mobilize resources, grow and compete economically, as well as enhancing their capacity to assist others in need through solidarity *(33)*.

The social economy is frequently described as the "third sector", the "non-profit-making sector" or simply as the work of NGOs. It is a growing field, representing approximately 10% of all European companies and 6.5% of total employment at European level *(35)*.

The social economy involves community-oriented small-to-medium enterprises, as well as larger, multinational businesses which wish to work with local individuals, business and authorities to create local solutions which affect the social determinants of health (SDH) and health inequities. The American United States Steel Corporation (US Steel) worked with Roma communities in Slovakia, where it has a large

presence in Košice as the largest employer in east Slovakia. The corporation's Equality of Opportunity project aims to integrate Roma citizens from the surrounding settlements into the local labour market. Roma are a marginalized and vulnerable population group that is considered hard to employ. The project has had a positive effect on health inequities by providing employment, which is a major socioeconomic determinant of health. While improving health was not a main objective of the project, it reduced health inequities by improving housing and increasing health prevention activities *(36)*.

Social entrepreneurship is a free enterprise model which aims to create sustainability and fairness. Organizations such as Ashoka – the world's largest association of social entrepreneurs – provide start-up financing and professional support services to new social entrepreneurs *(37)*. Regional organizations also exist in Europe to support social entrepreneurs. The South East European Centre for Entrepreneurial Learning (SEECEL) is an independent, non-profit-making institution supporting eight countries. It develops and supports lifelong entrepreneurial learning in the region to create sustainable economic growth and development, enhancing employment opportunities across a wide range of the population and influencing health and health equities *(38)*.

The social economy can also be built by funding projects at national level – such as through nationally funded lotteries (e.g. in England and Wales) *(39)*, taxation and municipal duty (in Scandinavian countries) *(40, 41)*, or through European Union (EU)-wide initiatives, such as those focusing on corporate social responsibility *(42)*.

The European Health 2020 policy framework states that the social economy should be considered an equal actor in delivering health services *(14)*. By creating healthier and more equitable work opportunities, the social economy improves health equity by increasing social inclusion and improving social cohesion.

Community resilience

Resilience refers to the way people manage their lives and live well, despite adverse situations, such as living in poverty. This includes factors related to individuals, as well as the communities and/or context in which they live, such as social support, social class, culture, and so on *(43, 44)*.

Health 2020 states that, *"building resilience is a key factor in protecting and promoting health and well-being at both the individual and community levels"*. It specifies that the development of supportive environments is instrumental in building resilience. According to Health 2020, collaboration among policy sectors and the full engagement of civil society are key for developing supportive environments and for strengthening resilience *(45)*.

Various definitions of resilience can be found in the scientific literature. Notwithstanding their differences, they all point to the fact that resilience is related to processes and skills that result in good individual and community health outcomes in spite of negative events, serious threats and hazards *(46–49)*. In the literature, community resilience is usually associated with social relationships and the activation of local resources that enable communities to cope with, counteract and anticipate unhealthy stressors *(50–52)*. The latter may include social and economic stressors such us poverty, natural disasters, isolation and other unfavourable circumstances.

Community assets such as level of solidarity and mutual trust among its members, and quality of social networks have proven to be protective and promoting factors to health and well-being *(53)*.

Asset-based approaches to health improvement aim to promote and strengthen the factors that support good health and well-being, protect against poor health, and foster communities and networks that sustain health. These approaches consider how people live and how to enable them to realize their potential; specifically, to increase the health resilience of families and communities, and as an approach to reducing social inequities *(54)*. This has been taken up in mainstream policy in several countries across Europe. A number of Swedish municipalities have mobilized strong political commitment in order to implement a health equity-in-all-policies approach, working towards a broad social sustainability agenda that encourages ownership across sectors *(11)*. A number of initiatives are improving the intersectoral approach to reducing health inequities in Sweden, including: the Commission for a Socially Sustainable Malmö *(55)*, Västra Götaland's report Together towards social sustainability: actions for health equity in Västra Götaland *(12)*, Region Östergötlands *(56, 11, 12)* and newly established commissions in Gothenburg and Stockholm cities.

Assets-based approaches are also central to many health and development strategies and are reflected in European and international policy frameworks that directly address health improvement *(4, 57–59)*. Examples include the European Health 2020 policy framework *(14)* and those non-specific health policies which directly address the social and economic determinants of health equity (such as the Europe 2020 Strategy). Such approaches are also strongly featured in the global Sustainable Development Goals (SDGs), agreed upon by Member States and the international community to increase participation, community resilience and the systematic engagement of communities and diverse stakeholders in policy implementation and monitoring.

In this way, the SDGs reflect a growing trend to regard partnerships and participatory consultation, decision-making and implementation as standard components of fair and equitable governance. The SDGs recommend that people living in poverty are included in the development of policies and strategies to ensure a sustainable future that benefits everyone and excludes nobody. They also support good governance by recommending increased participation, transparency and accountability.

As with the SDGs, resilience has also been integrated into broad policy movements as an output and guiding approach in implementation design. For example, social sustainability is being pursued by some countries as an approach to increasing health, social and economic equity and sustainability.[3]

The value of participation and engagement for achieving health equity objectives is also being taken up through mainstream approaches in health and social programmes, specifically those designed to address the root causes of vulnerability and the unequal opportunities in life and health. The Scottish Assets Alliance initiative has demonstrated an impact on improved parenting and child development indicators *(61)*, and a WHO initiative to reorient health programmes to focus on equity has designed a toolkit for social participation in health, aiming to strengthen public health capacities and outcomes for health equity *(2)*. Box 1 describes various types of engagement and their usefulness for addressing healthy equity. In addition, national and local governments are implementing resilience approaches in public health initiatives to reduce vulnerability, as well as to address the SDH and reduce health inequities *(62)* (See Table 2).

3 See, for example, WHO Regional Office for Europe *(60)*.

Box 1. Types of engagement and usefulness for increasing equity in health

Individuals can be engaged through shared decision-making, giving them more choice and control over how, when and where they receive health care. In this way, public engagement is a **two-way process**, involving communicating health information to the public and receiving feedback, ideas and challenges **from** the public. This type of engagement can foster increased awareness of health issues and factors influencing health, as well as increasing understanding of and commitment to resolving problems by means of solutions arrived at jointly by public service providers and members of the public.

Community engagement involves engaging communities of place (geographic) and/or interest (e.g. age, ethnicity) in actions to identify (and improve) health and the factors shaping health decisions and opportunities. Engagement of communities facilitates change at a local level by strengthening the capacity of communities to identify options to exercise greater control over the factors that influence health, such as how services are designed and how local neighbourhoods are developed and managed by the public sector and other stakeholders (such as businesses and voluntary associations).

Co-production involves seeing people as assets and building on their capabilities to identify problems and find solutions themselves, rather than seeing them as problems to be fixed. Co-production shifts the balance of power from professionals to local people and communities, placing service users on the same level as the service provider, and drawing on the knowledge and resources of both parties to develop solutions and improve services *(63).* The aim is to engage a public that are able to participate in (as a key part of) decisions and actions to tackle the social determinants of health inequalities. Co-production is grounded in an **asset-based approach to health**.

Table 2. Activities that may contribute to enhancing resilience

Dimensions	Activities
Living environment	• More and better quality green space (and making better use of it) • "Healthy Homes"-style initiatives* • Fuel poverty reduction • More new affordable housing • Private landlord licensing • Collective gas and electricity purchasing
Economic systems	• Welfare benefits and debt advice • Action against loan sharks • Credit unions • Fewer gambling outlets in poor areas • Living wage policies • Local job creation through purchasing policies • Support for small businesses in poor areas
Social relationships	• Community clubs and associations • Community arts projects • Befriending schemes • Social isolation reduction
Community governance	• Neighbourhood partnerships or boards • Councillor-led local area solution-focused meetings • Participatory budgeting • Housing associations owned by tenants • Other public mutual bodies

* For example, addressing illness and deaths from: temperature extremes, indoor air pollution, and communicable diseases spread as a result of poor living conditions *(64)*.
Source: Collaboration for Leadership in Applied Health Research and Care North West Coast *(62)*.

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