

EUROPEAN REVIEW OF SOCIAL DETERMINANTS OF HEALTH AND THE HEALTH DIVIDE

Consultation Questions

WHO European Region has put social determinants and health equity at the centre of its revitalized public health agenda and the WHO Regional Director for Europe commissioned a review of social determinants and the health divide in the region. This review will inform the new policy for health for the European Region, Health 2020, as will a companion study on governance for health in the 21st century.

The Review team are currently consulting on the early emerging evidence and ideas coming from this work.

Responses to the consultation, based on the consultation document

<http://www.marmotreview.org/reviews/european-review-of-hi/consultation.aspx>) should be entered on the attached template and returned to europeanreview@ucl.ac.uk no later than 24 November 2011

Information about the consultation

A brief description of the emerging findings from the review and an explanation of the consultation questions can be found in:

Consultation on the social determinants of health and the health divide in the WHO European Region (<http://www.marmotreview.org/reviews/european-review-of-hi/consultation.aspx>)

The consultation *will* be linked to the consultations on the new policy for health in the WHO European Region. Through these processes of consultation and dialogue, a diversity of voices and country perspectives will be reflected in the development of the review, increasing its relevance and robustness as a tool for action to improve health on equal terms in the European Region. At the same time, the process is intended to test the policy options developed through the review and so increase support for action on the social determinants of health and health equity at the national and local levels.

Purpose of the consultation

The consultation is intended:

- To stimulate debate on the social determinants of health and the reduction of health inequities within and between countries in the European Region
- To build further political support, policy alliances and capacity for a social determinant approach across government and partner organizations.
- It asks for input into the strategic conceptual approach developed so far by the Review

- It asks for additional, appropriate evidence and examples of promising practice in tackling health inequities through action in the social determinants of health.

Views are welcomed on the approach being taken by the Review and the emerging concepts and themes.

Further information

Full details of the emerging findings and the work of the review can be found in:

EUR/RC61/Inf.Doc./5 Interim second report on social determinants of health and the health divide in the WHO European Region

<http://www.euro.who.int/en/who-we-are/governance/regional-committee-for-europe/sixty-first-session/documentation/information-documents/inf-doc-5-the-health-divide-european-experiences-in-addressing-social-determinants-for-health>

Consultation Questions

Chapter 1 - Overview

1.1 Please comment on how the social determinants of health approach adopted by the review applies to the situation or context relevant to your response?

This consultation paper response on health inequalities has been prepared in the context of the work focus and expertise of the European Child Safety Alliance – child injury prevention.

Our vision – Making life safer for children

Our mission – To enhance the quality of children’s lives through the power of **reason, solidarity and compassion**.

These key words defined as:

Reason: using evidence and good practice

Solidarity: many countries and professions speaking with one voice

Compassion: putting children first

The European Child Safety Alliance (ECSA) is a network of child safety experts with representatives from more than 30 Member States that have worked collectively over the past 10 years to reduce childhood injuries. Inequalities between and within Member States are a critical factor in addressing child safety issues and are included in activities of the Alliance which are detailed in the ECSA strategic business plan 2010 – 2015.

The European Child Safety Alliance is also a member of the European Public Health Alliance, is involved in their reflection process on health inequalities and has signed the EPHA Charter on Health Equity. We will continue to be involved in their process to move forward the health inequalities agenda and ensure the issues related to child safety are part of this process.

Our Alliance has undertaken projects and activities that include investigating the issue of child inequalities as they relate to injury prevention within the Public Health Programme including our past Child Safety Action Plan initiative as well as our newly funded project, TACTICS, details of which can be found on our website at www.childsafetyeurope.org

Of note, injury and community safety are extremely important aspects of social determinants of health that are not mentioned in the review. This area is recognised as an influence on health as articulated in the Children’s Environmental and Health Action Plan for Europe (CEHAPE) Regional Priority Goal II: *‘prevent and substantially reduce health consequences from accidents and injuries and pursue a decrease in morbidity from lack of physical activity, by promoting safe, secure and supportive human settlements for all children’* (CEHAPE, 2010). ECSA and its country partners have been very active within this policy process.

We support the Marmot Review’s approach on the social determinants of health. The conclusions of the final report of the Commission on Social Determinants of Health, “Closing the gap in a generation”, clearly stated that being healthy or not is not an individual choice, but occurs primarily a result of conditions in which people are born and then grow up in. We agree with the Review’s sense of urgency to act now on the unacceptably large, persistent and growing health divide,

As our organisation has a focus on children, our responses in this consultation will predominately be in the context of children and youth and their families.

1.2 In the countries or contexts relevant to your response, do you have evidence on whether health

inequities exist, their size and their relation to social factors?

Background and data information that follows is available on the ECSC website referenced from: Sethi D, Towner E, Vincenten J, Segui-Gomez M, Racioppi F. European Report on Child Injury Prevention. Copenhagen: WHO Regional Office for Europe; 2008

Injuries are the leading public health threat to children in the EU and European Region. Deaths and disabilities due to injury are the largest health burden to children in every Member State in the EU. For every child that dies, hundreds more are hospitalised and several thousand more present to an emergency and accident department. This creates an enormous burden in social and economic terms both on families and society.

According to the WHO European Report on Child Injury Prevention, unintentional injuries are also the leading cause of inequality in childhood deaths. For injuries overall in Europe there is a sevenfold difference between countries with the highest and lowest injury death rates, and up to nine fold differences in the variations within countries. In general, countries from Western and Northern Europe have lower child injury death rates compared to those of Southern and Eastern Europe. Overall boys suffer 3 out of 4 injury deaths compared to girls.

As with many health conditions, childhood deaths from injury show a social gradient irrespective of cause and strongly associated with poverty, single parenthood, low maternal education, low maternal age at birth, poor housing, large family size, and parental alcohol use or drug abuse.

Unintentional injuries are the leading cause of inequality in childhood death, for both males and females. Data shows that the greatest inequalities are in children, rather than any other age groups, re-emphasising their vulnerability to socioeconomic factors. There is a nine fold difference in deaths from unintentional injury in children whose parents are unemployed when compared to those with parents in the highest paid occupations.

Overall childhood injuries show some of the steepest social gradients in mortality. Studies from Greece, Ireland, Spain, Sweden, the Netherlands and the United Kingdom demonstrate that children from less affluent areas suffer and die from injuries much more frequently than their more affluent peers.

Studies of the mechanisms contributing to this social pattern show that one of the major risk factors is the unsafe home, play and road environments of children in deprived areas. This contributes greatly to the risk differentials in deaths in injuries.

Differences in child injury rates between countries within Europe are also found when specific child injury issues are examined.

Road Traffic Injuries (RTI):

- There is a threefold difference in child road traffic injury-related deaths between countries with the highest and lowest rates.
- Children living in low and middle income countries have 60% higher risk of dying from RTI's than those in high income countries.

Drowning

- There is a twentyfold difference in child drowning deaths between the countries with the highest and lowest rates.
- There is a social gradient within countries with the poorest people up to 11 times more vulnerable to drowning than the richest people.
- If child death rates in all European countries matched those of the countries with the lowest rates, 9 out of 10 drowning deaths could be averted.

Poisoning

- There is a thirtyfold difference in child poisoning deaths between countries with the highest and lowest rates, and 9 out of 10 poisoning deaths in children in Europe occur in low and middle income countries.
- If all countries had the same child death rate as the country with the lowest rate, 7 out of 10 poisoning deaths could be averted.

Thermal injuries

- There is an eight-fivefold difference in child thermal injury-related deaths between the worst affected country and the country with the lowest rate.
- There is a social gradient within countries with the poorest people up to 38 times more vulnerable to a thermal injury resulting in death than the richest people.
- If all countries matched the child death rate of the country with the lowest rate, 9 out of 10 thermal injury-related deaths could be averted.

Falls

- There is a twenty-two fold difference in child fall-related deaths between countries with the lowest rates and those with the highest rates.
- If all countries in Europe matched child death rate of the country with the lowest rate, 9 out of 10 fall-related deaths could be averted.

Further a study in England and Wales illustrates that overall rates of death from injury and poisoning in children have fallen in England and Wales over the past 20 years, except for children in families in which no adult is in paid employment. Serious inequalities in injury death rates remain, particularly for pedestrians, cyclists, house fires, and deaths of undetermined intent. (Edwards, et al 2006)

As well, an individual's community is a profound determinant of health, as is shown in the evidence of injury prevention and increasing physical activity to combat obesity. Outdoor exercise is hampered by feeling unsafe, or having no safe place to go out – either because of high traffic, no walkable routes or a lack of safe parks and other spaces. This affects health on an immediate level – obesity rates, for example, but also affects the community's ability to build connections between its inhabitants (social capital) and thus a community's ability to improve its ability to increase safety and reduce both unintentional and intentional injury rates (Parker et al, 2011; Leslie et al, 2010; Carson et al 2010; Kerr et al, 2010; Carver et al, 2010; Kalish et al 2010). Inhabitants of poorer areas may have to walk to school, as there is no other option in spite of the fact that this might expose them to risks in the environment such as high volumes of traffic or poorly maintained or designed walking routes (Rossen et al, 2011). There is evidence to suggest that it also affects chronic morbidity in children. One report found that children diagnosed with asthma who saw or experienced violence were less likely to attend primary care despite experiencing higher rates of asthma morbidity (Walker et al 2008)

The effects of alcohol also have tremendous impacts on children and families with respect to both unintentional and intentional injuries. **More than 7 million children in the EU (9%) live in families adversely affected by alcohol.**

- Parental drinking can affect the environment in which a child grows up through financial strain, poor parenting, marital conflicts and negative role models which leads to greater risks of injuries.
- A large number of studies have reported a variety of childhood mental and behavioural disorders to be more prevalent among children of heavy drinkers than others.
- The risk of child abuse is higher in families with heavy drinking parents.
- Alcohol is a cause of child abuse in 16% of cases (i.e. one in every six cases of child abuse is due to alcohol).
- 23% of all deaths from motor vehicles accidents in children aged 0-15 are due to alcohol in the EU.
- 19% of all child homicides are due to alcohol in the EU

(ECSA – Fact Sheet – Alcohol and Child Injury)

Chapter 2 – The review

2.1 On what key factors should the Review focus in identifying recommendations to reduce health inequity within and between countries in the European Region?

We appreciate the tremendous work and investigation that has gone on to date, efforts to communicate what is known and the continued review that is underway.

Inequality has always existed and in some communities or nations, to a greater extent than in others. Today we see generations of families that are living in poverty, with low education attainment, minimal literacy levels, no or instable work and dependence on social service support for food, clothing and shelter. For many families in many countries these situations are on the rise. This cycle needs to be broken and early intervention policies need to be adopted and implemented to bring children and families out of poverty so they can live and grown to be active, engaged and positive contributors to society.

This review needs to also consider the structural and systemic changes needed across government to address inequities in Europe's economic governance, and the burden and distribution of wealth and financial power within its populations. The increasing fiscal immunity of the large financial institutions, banks and big corporations, as well as this impact on the flow of wealth within Europe, the revenue received by governments and the redistribution of this revenue are all-important factors. The flow of capital and the 'market' is currently outside of fiscal control, the contribution of this to inequalities and the impact on populations should be considered as part of the overall rebalancing of the system.

The review should also consider difficult questions such as how our current system undertakes fiscal governance, the lack of regulation of financial markets, the 'profits before people' (e.g. current alcohol policies in favour of industry), the nature of certain parts of decision-making and perhaps take a look at power distribution within governments themselves – where certain departments considered to be contributing financially wield disproportionate influence and those considered as 'costs' such as health and social support are weaker in terms of overall decision-making. It would be also useful to look at the difficult question of the role of democracy and short-cycle electorate governmental responses, where longer-term thinking and long-term investments (including into prevention) because difficult to justify within the current system.

2.2 What factors should the review prioritize in looking at future trends?

The current economic crisis and the trend of increased financial challenges needs to be taken into consideration as it puts an even greater burden on those who are already in need. As governments and industry are finding ways to manage financial restraint, families in need who have little or nothing to spare are hit even harder and will in turn create a greater financial burden on costs for healthcare, housing, unemployment, etc. For example:

- Education at all levels across communities and countries needs to have policies that ensure children and young people have opportunities for optimal learning. Classrooms sizes are becoming larger, fewer teachers are available, school infrastructure is in need of repair and upgrading so safe and healthy conditions are available. High university tuition or restrictions in availability spaces has limited the number of young people going forward for advanced education, which in turn reduces their opportunities in future job markets and self dependence.
- Availability and cost of childcare can create challenges for women wanting to attain further education or join the workforce, as often the cost of childcare is higher than what can be obtained from the salary attained while working. Social policies for child support, child care and healthcare need to be coordinated with work policies that do not disadvantage women and young people from work or further education.
- In analysing future trends in the field of health inequities, attention has to be given to ways in which the recommended "health in all policies" collaboration can really occur. The evidence defining the problem and effectiveness of interventions has been produced and collected for

some time already; what is needed at the moment is looking into building and crossing the boundaries of the sectors, coordination, leadership, finding new partnerships, social innovation and re-thinking the ways our societies are structured and operate. European values of solidarity, rights-based approach to health and social care, diversity and opportunity should be strengthened in the Review.

- The contribution of inequalities to social instability, violence and even social breakdown and internal conflict are areas that should not be underestimated. Riots, social unrest, breakdowns in social cohesion, racism and the resulting violence are themselves highly communicable, and the impact of growing inequities and potential for conflict and unrest are worth of consideration for this review.

Chapter 3 - Policy Context

3.1 What can the Review do to improve the likelihood that its proposals will be adopted locally, nationally and internationally?

It is very important that the Review has recognised the three levels of necessary political action – local, nation and international – and this should be strongly evident in its recommendations. Too often we see examples of national or international actors attempting to control interventions that are best managed locally or even at the community level. A differentiation of the recommendations towards these different levels of action and actors will increase the likelihood of take-up and successful follow up. The model is relatively straightforward:

Internationally:

- international level proposals should be clearly aiming at creating a framework that allows and facilitates the tackling of inequalities. This includes a European growth strategy that is inclusive and demonstrates a clear link between actions and outcomes. The EU2020 strategy for example, still bases some of its assumptions on the model of the Lisbon strategy with its simple growth model.
- international proposals should also include recommendations for global leadership on inequalities – European bi-lateral and multi-lateral treaties for example continue to create heavy burdens on other regions, such as promotion of alcohol sales.
- international proposals should also embed principals of HiAP where trade, agriculture, fiscal policy, development all belong to group agreements and their impact on health is both large and often detrimental. They should also recognise the European values of solidarity etc., and ensure that these are genuinely embedded in European actions.
- international proposals should work to demonstrate the value and necessity of addressing the causes of the causes in order to maintain European standards of living, quality of life and even peace and prosperity. This would allow advocacy organisations such as ECSA to use the review as evidence for change.

Nationally:

- the responsibility of national governments to both address national policies that contribute to the causes behind the causes of inequalities such as unequal distribution of wealth and resources, and contribute to the creation and support of public health systems and policies that allow appropriate local and community actors to address these imbalances.

Locally:

- the local authorities have the best ability to put policies in place that will meet the priority needs of their communities taking into account cultural, social, political norms and values in combination

with best available evidence to apply what works.

3.2 How can the Review findings be most effectively disseminated?

Considerations for dissemination could include:

- WHO dissemination channels such as European Region conferences, seminars and meetings at the European level and in MS, including high-level officials and local authorities; WHO collaborating centres and networks of excellence in MS; WHO in-country focal points; WHO health cities networks
- European Commission's respective Directorates (according to "health in all policies") and the next Presidencies of the Council of the European Union; the work undertaken by the respective working groups in the European Parliament;
- national institutes of public health in MS, and the International Association of National Public Health Institutes, the International Health Promotion Association, OECD ([section working on Better Life Index](#)), the World Bank (to prove for socio-economic benefits);
- if existing, local and national civil society platforms on social determinants of health and safe community platforms;
- Europe 2020 strategy flagship initiatives ([EU Innovation Partnership on Healthy and Active Ageing](#), [EU New Skills for New Jobs](#), EU Youth on the Move, [EU Platform on Poverty and Social Exclusion](#))
- [EU Platform for Roma Inclusion](#) together with national Roma Integration strategies; where one the main areas for inclusion is through improved health, and reduced health inequalities between the Roma and the general population;
- media, health and social journalism, public information campaigns;
- leaders, powerful and distinguished figures from health- but also non-health sectors including social services, enterprise, justice, agriculture- from all three pillars of modern society (gender and age dimension);
- European Centre for Disease Control (ECDC) especially if currently they are to embrace additional focus on non-communicable diseases, fight against existing but especially re-emerging infectious poverty-related diseases or expressing other dimension of inequities;
- ECSA will also offer our network and those of our partners to disseminate the findings to health actors, other non-health stakeholders as well as other relevant political partners and stakeholders;
- dissemination action needs to be taken to move the key findings of the review into actionable policies that are adopted, implemented and monitored for their effectiveness and transferability to various settings.

3.3 What more can be done to ensure geographic reach and to ensure that the recommendations are applicable across the whole of the European region?

- The European Region is very diverse so approaches to meet the diversity of Europe are key, not just one standard approach throughout Europe. Core principles can be recommended, but how they are effectively transferred and taken up in countries, regions and communities needs to be appropriate to the history, norms, cultures and values of that society.
- Established participation and support from all levels of government within countries will be important

to incorporating doable recommendations that countries, regions and communities can and will support.

Regional approaches should be investigated for commonality, and the use of existing geographic networks that countries are comfortable working within should be maximised (e.g., the UNICEF CEE CIS country region).

3.4 Do you have evidence, case studies, examples of action which would help inform the Review's approach?

ECSA as part of the Public Health Programme, led the Child Safety Action Plan project which moved more than 20 Member States to undertake development of national plans to reduce injuries - the leading cause of death, disability, burden and inequity for children in Europe. As part of this project countries also complete assessments resulting in child safety report cards that monitor which evidence-based child safety measures have been adopted, implemented and enforced in countries, as well as the level of leadership, infrastructure and capacity being provided to support efforts to create safe environments for children. www.childsafetyeurope.org

A new ECSA led project, TACTICS, has begun to build on the results of the Child Safety Action Plan project. This includes a number of activities addressing inequity related to childhood injury, the results of which will be analysed and synthesised into a final report on inequalities and their impact on child injuries and prevention efforts.

More details on the TACTICS project can also be viewed on the Alliance website

Safe At Home, the National Home Safety Equipment Scheme managed by RoSPA, is an example of an action closely targeted at reducing the inequality in terms of unintentional home injury. Strict eligibility criteria were applied and the independent national evaluation confirmed that 98.8% of recipients of safety equipment offered by the scheme were in receipt of benefits. Over 77% of families lived in rented housing compared to 31% of the population at the 2001 census. Participation in the scheme among all ethnic groups where there is known to be a higher risk of health inequalities, was also higher than the census figures. This scheme illustrates that, while it would be preferable to eradicate the causes of health inequalities, practical steps can be taken in the meantime to reduce the risks and close the gap. The evaluation, conducted by The University of Nottingham was published on 1 November 2011 and is available at www.rospace.com/homesafety/safeathome/

There is increasing pressure to tackle the wider social determinants of health through the implementation of appropriate interventions. However, turning these demands for better evidence about interventions around the social determinants of health into action requires identifying what we already know and highlighting areas for further development.

A new model in Scotland (modified from the original WHO model) which can be found at the attached link <http://www.scotland.gov.uk/Resource/Doc/254447/0075343.pdf> enables practitioners to place more emphasis on the relationship between 'environment' and health.

As well, it is important to note that community perceptions of safety and actual rates of safety (whether from violence or other crime; or from high traffic volumes and so on) profoundly influence individual decisions about social interaction and physical activity. Thus, focusing on increasing community safety and violence prevention are important determinants of health. For example: McDonald et al (2010) found that children whose parents reported feeling high levels of social control (safety and lack of incivilities in their community) were more likely to walk or bike to school than those children whose parents felt they had little control over their community. Durant et al (2009) and McDonald (2008) echo this by stating that a lack of a safe environment is a profound barrier to health; and Miles (2008) states that the physical environment and perceptions of safety influence an adult's readiness to encourage physical activity in their children – which in turn promotes child development and health.

The connection between the characteristics of a community and inequalities is articulated by Warr et al (2009) who state “qualitative analyses suggested that increased exposure to issues related to aspects of neighbourhood safety were associated with living in a disadvantaged neighbourhood”.

Community design is an important contributor to inequality and poor health. For example, The Committee on Environmental Health (2009) state that school location plays a significant role in rates of walking to school; and relevant changes in policy can increase the numbers of children who actively travel to school. Such changes include actions that reduce parental perceptions of and fear of crime, and safe routes such as pavements and slower traffic. Improved community design and safety can increase walking levels in much of the population (Mason et al 2011).

Chapter 4 - Emerging themes

4.1 Which of the emerging themes and issues should be given highest priority in the review?

Where possible, please indicate the arguments and evidence to support the proposed priorities. For example, social and economic costs and benefits or promising practice examples.

This is a challenging question but as inequalities are an issue that transcend all political systems and geographic scopes, a priority would be to determine evidence based approaches and policies that could be taken up at the international, national, regional and local levels across all sectors in a collaborative approach. Priorities should be taken to effectively move recommendations into real policy actions that will effect change.

4.2 Are there other themes or issues that are not included here that you consider to be priorities?

Injury reduction should receive higher priority within this review as it is the largest cause of death, disability, burden and inequalities for children and young people in Europe. This has massive personal, social and economic consequences. Injury and violence prevention in communities is a specific theme both as an outcome measure and as an action point for reducing inequalities and improving population health and wellbeing.

4.3 Do the priorities you have identified change in the short-, medium- and long-term?

Depending on the injury prevention strategy chosen, results can be achieved in the short-medium and or long term. Evidence-based measures that are adopted, implemented and enforced can have immediate effect such has been demonstrated in many road safety measures or upgrading playgrounds to meet safety standards for example.

Implementing social policy changes could also have medium gains with long term benefits for more sustainable, healthier societies.

4.4 Do the priorities differ between low, medium high income countries?

- all countries face a social gradient in health outcomes and health opportunities;
- in all countries of the region the most vulnerable and disadvantaged groups live. There are of course countries where the proportion of such people to a ‘general’ or better-off population is higher, but basically some forms of vulnerabilities – even in relative terms – exist everywhere in Europe;
- all countries face economic crisis and in all countries there are austerity measures introduced – however, different countries decided to prioritise different policies – usually social and healthcare costs savings but not always;
- different countries have differently organised governmental systems and public health systems, public health policies implemented and financed at different governance levels; also a balance

between health promotion-disease treatment approach of public health differs per country;

- systems of organisation and cooperation in the areas of important social determinants of health like education, family, employment, agriculture, transport, justice, research or environment can to a different extent affect health outcomes, especially of the most vulnerable groups;
- low/medium income countries in the region have different pension and other social protection systems, long-term and elderly care is differently organised, focus rather on centralised/institutional care instead of community-based;
- health professionals training, recruitment and retainment schedules might be differently organised; mobility of both health professionals and patients as well as the general population (economic migration) might be bigger in some countries and mainly towards high income countries; professional qualifications and reimbursement factor of cross-border healthcare might be still unregulated;
- changing traditional and cultural norms to increase negative effects on public health like alcohol and drug use, risk taking behaviours, violence, self harm, child abuse and neglect.

4.5 How should action on the social determinants of health be delivered to be most effective? Are there mechanisms or sectors that can deliver action to reduce health inequalities which you consider we have omitted?

To be effective actions should be:

- evidence-based, appropriate to the target group and setting, timely, planned well in advance, take a life course approach; developed, implemented, monitored/ evaluated with the concerned population;
- local authorities are the closest to the affected groups and linked to local needs and preferences (health needs assessment) so should be integral in the development and delivery of interventions across various sectors

4.6 What role should the following:

- Capacity development
- Targets
- Regulation and legislation
- Donor and other trans-national organisations

have in addressing the social determinants of health?

Capacity development:

- for politicians and the professional policy-makers to understand the need for evidence-based and people-centric decision-making process across government, where putting businesses and processes first can lead to damaging and non-health friendly government approaches.
- for local, national and European authorities to actively collaborate with key partners such as civil society and academics and recognise the added-value of such collaboration with and across other sectors to develop, implement and monitor actions to support equity.
- for increased numbers of health professionals to act on social determinants of health, address underlying poverty and social exclusion issues and to act as advocates for their communities and for public health in general, as well as to act as advocates for change towards their policy makers and politicians, whatever level of government they operate at.
- for non-health professionals to be able to understand the links between their areas of work (architecture, urban planning, agriculture, transport etc.) and the impact on the health of populations

and to act as advocates for change in order to tackle health inequities

Targets:

- should be across a social gradient and take a life course approach but important to specifically address the health gaps of the most vulnerable and the most disadvantaged groups, such as children, families and the elderly

For example there are clearly particular health issues at both ends of the age spectrum that need to be addressed. In relation to injury prevention the issues around the larger of number of injuries as a result of home accidents to boys or to young adult males in terms of road accidents highlight the need to address key gender differences.

Regulation and legislation:

- Regulation and legislation should not be considered as the action of last resort when they are concerned with public health issues, but should be considered the dominant policy mechanism in certain areas such as injury prevention, alcohol pricing and accessibility, advertising of items with public health aspects such as addictive substances, negative behaviours, sexualisation of women and children, unsafe driving practices and all marketing to children should be regulated.
- It is also worth exploring the value of regulation in architecture and planning rules where there is a public health impact for healthy and safe housing, fire prevention window guards, stair construction, ventilation, temperature and damp, green spaces, etc.
- Regulation is a key factor in promoting health. The example given in the second interim report of a high death rate from road traffic accidents in Lithuania despite a fall in overall death rates highlights the problem sometimes caused by deregulation. As there is a drive in the UK and other states towards deregulation it is important to highlight the impact that regulation has had in reducing injury and death. Seatbelts, Child car seat restraints, packaging of medicines and toxic substances are all key examples from the injury prevention sphere. In an economic climate that seeks to reduce the burden on business it is important that the review addresses the potential harmful impact of over-enthusiastic deregulation.
- Finally the value in supporting regulation of financial markets and other fiscal policies that create huge disproportionate distributions of wealth and power in our societies. It is not difficult to track changes in health inequality outcomes when plotted against relaxing or removing regulation in certain areas such as those above, and therefore the recommendations should include replacing these regulations where this would tackle the main causes of inequities.

Donors and other trans-national organisations:

- Donors and other organisations are able to significantly impact on the expenditure and prioritisation of policies within countries, and therefore should be fully aware and understanding of these recommendations on outcomes within countries. Decimation of health and social support systems and the privatisation of 'public goods' have profound negative impacts on short-term and long-term public outcomes, and greater accountability of these institutions to the tax-payers that fund them is key, as well as the inclusion of representation on their governance structures from professionals in fields such as public health and not just medicine.

4.7 Do you have any further comments, or views on the Review and emerging themes?

Data collection and measurement of aspects of inequality, particularly in injury morbidity rates and rates of exposure to injury are a major gap in knowledge. As highlighted in the Child Health Indicators of Life and Development (CHILD) report (Rigby and Kohler, 2002); indicators of child health and wellbeing should ideally be reported by age group and by socio-economic status. This data would give us more information

about inequalities in Europe and the ability to track the success or failure of interventions / policies that reduce injury and promote the safety of a community.

To conduct effective monitoring a number of improvements in data systems and monitoring processes are needed including:

- An agreed upon minimum set of indicators with standard definitions for measures related to inequalities with commitment that they be used consistently throughout Europe (e.g., measures of socio economic status, children living in poverty, parental education levels, etc.)
- Increased availability of data for children in age categories reflecting the UN definition of children 0 to 18 years of age (including age groups for 0 – 1, 1 – 4, 5 – 9, 10 – 14, 15 – 17).
- Timely and accurate submission of national country data to European databases so comparative and trend analyses can be undertaken at a European level.
- An agreed upon minimum set of indicators for measuring exposures to common child injury risk and protective factors with commitment that they be used consistently throughout Europe on a periodic basis to allow more accurate assessments of risk and effective targeting of high risk groups.
- Investment in structural funds to improve environmental factors related to inequalities should be maximised. Making children's environments inherently safer by using passive safety countermeasures can reverse the social inequalities in injury. These interventions tackle the physical exposures that put children at risk. For example, ameliorating material deprivation at home by providing better housing and modifying the traffic environment to ensure that children are not exposed to dangerous situations have been shown to result in fewer injuries, thereby reducing the safety differentials between different social groups. Social funds should also not be forgotten. An area of focus to consider is investments into good practices to break the continuing cycle of poverty for generations of families. Poor families, having poor children, who later also have even poorer children, continuing for generations being born and raised in unsafe and unhealthy housing conditions, receiving little education, attaining no self supporting employment for themselves later in life (if they survive or are not disable or critically ill) and falling into dependency on alcohol and drugs.

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