8. Dependence on international collaborations and funding
For a number of reasons, much of the good quality research on health inequalities in CEE/FSU comes from international collaborations which are typically funded by western partners. This is not ideal as these projects usually have a limited duration and they are normally not primarily concerned with addressing public health issues of national importance.

In addition, while much of the research on health inequalities in CEE/FSU is conducted in the frame of international collaborations, there is sometimes distrust from national bodies towards western researchers and westerner-lead research. Results from such project are often not reported nationally and are often ignored by national and local policy makers.

9. Bureaucracy and data protection legislations
As mentioned above, data suitable for investigating health inequalities exist in all countries in CEE/FSU. In many countries, however, the use of data, where an individual can be identified, is virtually impossible, due partly to bureaucratic difficulties and partly to data protection legislation. In Poland, for example, according to my information, even established cohort studies sometimes cannot access mortality registers to link participants’ characteristics with the national mortality register. Similarly, according to my information, it has been impossible to obtain permissions to link participants’ characteristics with their morbidity and health care usage data in national health insurance schemes in the Czech Republic and Poland.

10. Lack of national funding
As with other areas of research in CEE/FSU, research into social inequalities in health is chronically and seriously underfunded. This not only limits the conduct of current research, but it also prevents establishment and development of stable research groups, build up of research infrastructure, and recruitment and training of young researchers.

Conclusions
Compared to the situation before 1989, there has been an enormous improvement in the knowledge of social differentials in health in CEE/FSU. There is now at least some information available for each country of the region, and in many countries there are active research programmes into social determinants of health. However, compared to most (but not all) western European countries, there are still large gaps in mapping the extent of the problem and particularly in understanding the mechanisms of how social inequalities in health develop and, therefore, what policy measures could be taken. This is partly due to technical issues related to data availability and data analysis.

However, the last three issues listed above are also symptomatic of the fact that, in many countries of CEE/FSU, health inequalities are not currently seen as a priority or as an important public health issue, both by policy makers and by the biomedical research mainstream. Until the perception of the importance of the subject changes, the quantity and particularly the quality of research will improve only slowly.

Tackling health inequalities in the Netherlands

Mariël Droomers

Summary: This article summarises initiatives and policies to tackle health inequalities in the Netherlands since the late 1980s. Political concerns about health inequalities have again become visible following the change of government in 2007. The new plan envisions integrated actions focusing on prevention and decentralised implementation. This however is very much a work in progress and leaves room for improvement.

Key words: health inequalities, health policy, prevention, the Netherlands

Historical development
Policies on socioeconomic differences in health in the Netherlands developed from a broad concern about socially and economically marginalised groups in the 1980s to specific concern about socioeconomic differences in the 1990s. During the latter decade the Dutch government pursued a research-based approach to tackle socioeconomic inequalities in health. This resulted in the development of several effective interventions. Subsequently, the programme committee overseeing the research programme recommended a combination of the implementation of promising interventions with continued evaluation efforts.

A government advisory committee developed a comprehensive and integrated strategy intended to reduce socioeconomic health inequalities, including a number of quantitative targets. The recommendations spanned the entire range between ‘upstream’ measures targeting socioeconomic disadvantage and ‘downstream’ measures targeting accessibility and quality of health care services. In response the government claimed that it was time for policy and action. The cabinet adopted a policy goal to increase the healthy life expectancy of the lowest socioeconomic group by three years by 2020.

However, at the beginning of this millennium, government policy emphasised
individual responsibility: individuals were encouraged to take responsibility for their own lives. Health inequalities slipped off the agenda of the Dutch government, despite the fact that the Netherlands Court of Audit, as well as the National Health Inspectorate, requested that the government state more clearly what actions it would take to reduce health inequalities.\textsuperscript{7-9} In response the Minister of Health shifted responsibility for implementing interventions to tackle health inequalities to the large cities as part of the Urban Policy Framework. These cities for their part chose to focus on excess weight in youngsters.

**2007: Health inequalities return to the agenda**

The change of government in 2007 revived political concerns about health inequalities in the Netherlands. The present Coalition Agreement states that the cabinet should employ effective prevention policies to bring about smaller discrepancies in life expectancy between different socioeconomic groups. After all, in many respects preventable ill health also represents a societal loss.\textsuperscript{10} Now the Dutch cabinet is seeking to develop a national policy plan to improve the health of the lower socioeconomic groups. The government justifies its involvement in terms of the promotion of rational lifestyle choices, the prevention of social harm caused by unhealthy environments and lifestyles, and the advancement of social justice. The government stresses that individual freedom in lifestyle choice will not be affected.

A new policy plan for dealing with health inequalities related to socioeconomic background, entitled ‘Towards an able-bodied society’, adheres to the principles of integrated policy, prevention, and decentralisation.\textsuperscript{11} In the plan, the cabinet stresses that many aspects of the Coalition Agreement actually form part of the integrated approach essential for tackling inequalities. These initiatives are in different stages of development, so work to tackle the health disparities in the Netherlands is very much a ‘work in progress’.

Although the social or upstream determinants of health inequalities are acknowledged, the policy plan lacks a conceptual framework that clarifies and quantifies the inter-sectoral character of health inequalities. Such a conceptual framework could serve as a common ground for all parties, justify the involvement of other sectors, and stimulate joint action. The framework would perpetuate a truly integrated approach to tackling the social determinants of health inequalities.

Quantitative targets have not yet been formulated. The cabinet has postponed the formulation of concrete objectives until further analyses of the latest figures on socioeconomic differences in life expectancy and the publication of the recommendations of a number of advisory reports now in preparation. This fear to set targets might, however, reflect a fear to articulate political ambitions instead. The omission of targets to tackle health inequalities furthermore prevents the merger of this health policy with broader government targets that would increase the effectiveness of such a policy tremendously. For example, the health inequalities target that was adopted by the government in 2001 aimed to increase the life expectancy of lower socioeconomic groups. This health goal can, however, only be achieved by strong inter-sectoral policy and action, backed up by specific targets to achieve the necessary change in other fields.

**An integrated approach**

The Dutch cabinet intends to ensure a coordinated approach, linking the policy components of various Ministries, since most of the conditions for good health lie outside the domain of health care itself. The cabinet actively seeks collaboration between the health sector and other sectors. The policy plan though has only summarised what measures the cabinet has already taken to contribute to the reduction of socioeconomic (health) disparities and disregards potential counter-productive policies and programmes.

Stated policy initiatives can be placed in one of two camps. In the first, the policy is intended to provide a good start to life for everyone, helping to prepare most young people to face their futures. They should be resilient, motivated and have learnt some health skills, thanks to lifestyle education and participation in sport. Despite these efforts, not everyone gets this good, healthy start. A second tranche of policy is therefore directed towards the reduction of the detrimental effects of poor socioeconomic circumstances, such as prevention, spatial planning or environmental policy. This generic policy addresses the total population, if necessary with adaptations to ensure that all population sub-groups are reached.

Prevention lies at the heart of the cabinet’s plans; there will be a greater number of preventive measures to reduce the demand for care in the future. In achieving this, the cabinet prefers methods, which as far as possible appeal to the individual’s own sense of responsibility. The cabinet wants to encourage all individuals to take responsibility for having a healthy lifestyle.

It also wishes to promote cooperation between public health care, curative health care services and home care services, thereby creating a logical and effective chain for both selective and indicated prevention efforts. The Ministry of Health, Welfare and Sports intends to incorporate a number of preventive interventions (such as smoking-cessation or self-management) into standard health insurance coverage.

The plan states that the reduction of health inequalities is by no means the concern of local or national government alone. The efforts of other parties with an interest in health are indispensable. In 2009, the cabinet has been given advice by the Dutch Council for Public Health and Health Care, the Dutch Education Council, the Dutch Advisory Council for the Public Administration, and the Social and Economic Council of the Netherlands, on how to encourage municipalities, schools and companies to promote the health of their members.

**Targeted initiatives**

Inhabitants of deprived districts generally experience poorer health than those living elsewhere in the Netherlands. In mid 2008 the Minister of Housing, Communities and Integration launched a district approach to tackle problems in housing, employment, education, safety and integration in the forty most deprived districts in the Netherlands. The cabinet wants to transform these areas into districts where individuals have more opportunities and feel safe, with a sound infrastructure and sufficient services and amenities, such as shops and sports facilities.

In half of these districts, healthy neighbours experiment will try to improve the health of residents by means of an integrated approach focussing on healthy people, living conditions and the provision of coherent primary health care teamed up with prevention. The cabinet sees these experiments as tests for the parties involved to improve the health of residents, using an integrated approach under municipal direction. The health effects of the district approach, as well as the exper-
this upstream policy research on health and behaviour across disadvantaged neighbourhoods (urbana40) is being carried out by the university of amsterdam, the university of maastricht and the national institute of public health and the environment.

plans and interventions to reduce health inequalities will also apply to migrant groups having a low socioeconomic status. the plan acknowledges that the health problems of migrants may also have different causes which need to be addressed. the problem is that before effective interventions can be implemented more knowledge on the determinants of health and care utilisation by migrants is needed.

conclusion
health inequalities are back on the dutch policy agenda. the recent government-wide policy plan intends to ‘deal with health inequalities related to socioeconomic background’ by means of integrated action, prevention and decentralised implementation. the current plan is however very much a work in progress and leaves room for improvement. clear (ambitious) targets would underline the intention to tackle health inequalities and serve as a guide for action to be developed. although an integrated approach is advocated, the plan is inclined towards the promotion of healthy lifestyles.

dealing with health inequalities, however, requires a coordinated integrated approach, also focussing on the social determinants of health inequalities. the current plan does not suggest any new measures, but relies on actions that were not really intended to deal with health inequalities in the first place. the persistent health inequalities in the netherlands call for a real strategy with proposed actions and interventions, backed up by a specific budget. there is a chance that these issues will be addressed by the cabinet, which as of july 2009 was progressing with work to deal with health inequalities and intending to publish a follow up to the current policy plan.

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new health systems in transition publications from the european observatory on health systems and policies

ireland: health system review

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David McDaid, Miriam Wiley, Anna Maresso and Elias Mossialos

the irish health system can be characterised as having been in a process of constant review and implementation of staged initiatives since the late 1990s.

these reforms have revolved around the abolition of the former health boards and the creation of a single national body, the health service executive. the aim is to make the system more primary and community care driven, backed up by improved access to specialist, acute and long-stay services.

equity is a key concern. access to the primary care system tends to be pro-poor, while in contrast, in the secondary care sector, those who can afford private health insurance can avoid waiting for treatment.

the implementation of promised reforms will be a key challenge, given the substantial economic downturn that the country is now experiencing.