



Centre for Health
Equity Studies



FINAL CASE STUDIES REPORT:

Drivers for health equity

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EXECUTIVE SUMMARY

Action to reduce health inequalities needs to start during gestation and should be carried out through the life of the child and throughout adulthood until old age. This may be effected by providing a portfolio of evidence-based delivery systems and interventions across the life course, in particular covering early childhood development, fair employment and working conditions, and welfare, income and social protection.

This report describes case studies based on existing services, policies or practices in these three areas that are key drivers of health inequities. The purpose in conducting these studies was to identify services, policies or practices that are already in place that have the potential to reduce inequalities in health and its social determinants. The reporting of case studies also aimed to inform the process of applying evidence-based research outcomes to 'real life' programmes and policies and provide guidance and policy recommendations to promote greater health equity. They provide an illustration of how policies are put into practice in a range of countries and the implementation issues raised by these.

The case studies built on the research work undertaken earlier in the project in these DRIVERS areas. The observations and key messages derived from the case studies are described below for each driver area.

Case studies were also conducted on advocacy for health equity.

Early childhood

Most early child development programmes were delivered in areas with low levels of service provision. Establishing long-lasting trust-based relationships enabled the delivery of programmes, especially to socially isolated families and children.

Specifically the, key messages are:

1. It is important to provide access to a comprehensive range of universal quality early year services to reduce inequalities during the early development of children, especially for those who come from disadvantaged backgrounds.
2. Services should be proportionally tailored to social and economic need.
3. It is important to recognise the knowledge, capacities, and specific circumstances of parents if interventions aimed at young children and their parents are to be delivered effectively.
4. To ensure that parents have an active involvement in early years programmes, they should receive support and information to understand and contribute to the optimal development of their children.
5. Parents should be empowered to develop their own educational skills, thus strengthening their ability to assist in their children's learning and development.
6. Existing ECD institutions and structures should be strengthened to promote cross-sectoral working between social and medical sectors.

7. The recognition, representation and funding of ECD in all areas of work and policy should be enhanced through high-level leadership. This includes promoting support for children who are deprived or vulnerable.
8. Programmes delivered in families' homes and in accessible centres should be evaluated so as to compare outcomes when using one or other of these settings or a combination of the two.

Employment and working conditions

Common elements can be identified from the disparate studies that may enhance the chances of labour market participation and improve the security components of labour market policy, especially among disadvantaged population groups.

Specifically, the key messages are:

1. Special efforts are needed at different policy levels (national legislation, labour and social programmes; organisations and institutions responsible for medical and vocational rehabilitation services, employer organisations, etc.) to improve return to work among disadvantaged population groups. However, rather than being directed at narrowly defined, formerly deprived subgroups, they should be developed as inclusive policies, addressing the whole spectrum of social inequalities in return to work. Respective policies can be organised in accordance with the principle of proportionate universalism, prioritising subgroups with special needs without neglecting measures that reduce social gradients of return to work within the whole of society.
2. Improving reintegration of disadvantaged population groups should be part of a larger societal movement that aims to strengthen equity and fairness of opportunities. Social norms reinforcing co-operation and a societal climate of solidarity are important elements in this process. Within and across enterprises, corporate social responsibility measures and explicit human resource management strategies addressing the needs of deprived groups should complement this development.
3. In times of macroeconomic crisis resulting in austerity measures of national policies and cuts in public spending, priority should be directed towards maintaining decent levels of social security provision, of health care and of labour market participation. More specifically, infrastructures and personnel delivering rehabilitation services should remain capable of providing their support to all those who need it, rather than favouring population groups who can afford these services.
4. In designing rehabilitation services a client-oriented approach enabling individual counselling should be preferred to 'one-size-fits-all' strategies. Comprehensive skills training that includes a strengthening of social competencies and of work-related motivations and attitudes requires additional training of professionals providing these services as well as appropriate investments into personnel and facilities. Moreover, more effort in documenting and evaluating rehabilitation measures in a systematic and convincing way are required to make a strong case for their further promising development.

Income, welfare and social protection

The importance and role of social protection systems was emphasised throughout the focus groups across all countries. Participants described the need for support to deal with changing life circumstances such as unemployment and ill health. The experience of social protection varied across countries.

Specifically the key messages are:

1. The strong common theme emerging from both the quantitative comparative work as well as case studies, namely that social protection is an important collective resource that contributes to better health and smaller health inequalities, in particular when individual and family-based resources are not sufficient.
2. Most striking is the strong focus on adequacy that emerges from the case studies, where participants give testimony to the importance of sufficient levels of support, which often is not the case for them. This theme echoes the repeated findings concerning the importance of high coverage and high replacement rates. With low coverage or replacement rates there will be considerably less adequacy of the support given, and social protection policies will not be able to offer much in support in terms of collective resources.
3. Another area where case studies duplicate the quantitative findings is regarding the importance of access to employment, and the potential importance of activation policies. This is reflected in the strong equalising effects of active labour market policies seen for younger persons in one of our quantitative studies.
4. Institutions need to take better account of the many different types of programmes and services available, as individuals experience problems caused by several risks simultaneously. Since individuals' problems are integrated so should ideally the services they require. The health services could play an important role in helping to obtain support from other authorities.

Advocacy

Key messages coming out of all the advocacy case studies were the importance of the kinds of evidence useful for advocacy purposes; practices that improve the effectiveness of knowledge transfer and translation; complexity and dynamism in terms of 'who advocates and to whom'; the enablers and barriers of effective advocacy; and, the practices that can help improve effectiveness.

Conclusions

The overarching conclusions from DRIVERS case studies were:

- Providing support by delivering personalised, responsive and readily available flexible services can help achieve improvements in promoting development in early childhood, returning disabled and other socially disadvantaged at-risk groups to work and dealing with changing and or adverse circumstances.
- The information provided by the interviews and focus groups illustrated that employers and staff can contribute to help overcome barriers in accessing support through specific motivations among staff and regulations, by delivering tailored and specialised programmes according to individual need.
- It is important to provide access to a comprehensive range of quality services to reduce inequalities across the DRIVERS areas, especially for those who come from disadvantaged backgrounds. Services should be tailored to social and economic need.
- Multidisciplinary teams and key stakeholders can promote equity in health across the social gradient by delivering evidence-based, comprehensive and effective programmes and services, and well-developed policies across sectors, although these need to vary according to context.

1. INTRODUCTION

Action to reduce health inequalities needs to start during gestation and should be carried out through the life of the child and throughout adulthood until old age. This may be effected by providing a portfolio of evidence-based delivery systems and interventions across the life course (1), in particular covering early childhood, fair employment and working conditions, and welfare, income and social protection. These are considered to be key drivers of health equity (2). During child growth, risks associated with poverty or similar adverse conditions affect development and later life circumstances (3, 4). During adulthood, there are important implications of labour market outcomes regarding health inequalities, given the strong relationship between health and several socio-economic factors such as income, occupation and differential exposure to stressful physical and psychosocial conditions (5, 6). Early childhood development (ECD), beginning prenatally, will influence many aspects of well-being, health, competence in literacy and numeracy, criminality and social and economic participation throughout the life course (7, 8). Welfare resources are provided to ensure well-being and health and to reduce inequalities. But they are also targets for major policy areas and efforts.

The DRIVERS project, a three-year research project funded by the European Union's 7th Framework Programme, focuses on three of the key drivers to reduce health inequities: early child development, fair employment and working conditions and welfare, income and social protection. It assesses the impact of policies and programmes to develop new methods and evidence and provide policy recommendations and advocacy guidance to reduce health inequalities within Europe. The research builds on the recommendations of the Commission on Social Determinants of Health (2), The Strategic Review of Health Inequalities in England post-2010 (7), The Review of Social Determinants and the Health Divide in the World Health Organization European Region (5) and contributes to the EU 2020 initiatives (9).

This report brings together the case studies on programmes and services within the three areas of the DRIVERS project. It also includes case studies conducted on advocacy for health equity. The purpose in conducting the case studies was to identify services, policies or practices that are already in place that have the potential to reduce inequalities in health and its social determinants. The reporting of case studies also aimed to inform the process of applying evidence-based research outcomes to 'real life' programmes and policies and provide guidance and policy recommendations to promote greater health equity. Case studies provide an illustration of how policies are put into practice in a range of countries and the implementation issues raised by these. The case studies were conducted by working in close co-operation with EuroHealthNet, Eurochild, Business in the Community (BiTC) and the European Anti-Poverty Network (EAPN) (9). These organisations are the project's collaborating not-for-profit organisations, agencies and statutory bodies and they co-ordinated the implementation of the case studies via their third parties.

1.2 Evidence collated by DRIVERS on three key areas to reduce health inequities

Case studies described in this report build on the evidence from the research undertaken and/or reviewed in the three key driver areas included in the DRIVERS project. The

information below summarises some key DRIVERS findings and research relevant to the case studies.

1.2.1 Early childhood development

Evidence from intervention studies suggests that performance in the different domains of ECD - described as the development of physical, socio-emotional and language-cognitive capacities in the early years - (10) can be modified in ways which improve health, well-being, and competence in the long term (11, 12). By providing a positive start across the social gradient, children will benefit from improved developmental outcomes during later childhood and throughout their life course (8, 13, 14). During child growth, neuron connections produce cognitive, motor, emotional, behavioural and social developmental skills (15). Childhood risks associated with poverty or similar adverse conditions, such as lack of stimulation or excessive stress, affect brain development (16), and poor health is greater among children of mothers with low education (17). Most social factors, at both the neighbourhood and household levels, influence early childhood health and development extending across a wide range of adverse health and developmental outcomes in early life (18). Early years interventions that are designed to reduce inequalities in health and development and their social determinants must focus on actions with an intensity proportionate to the social needs of the children and their families (3, 4, 7). The quality of parent-child relationships is significantly associated with many outcomes relating to child health and development. Parenting programmes offer valuable opportunities to positively influence child health and well-being, through health-promoting environments, establishing good health behaviours, providing support for families and creating resilience (19). Interventions may be aimed at children, their parents or both, ensuring the best start for children by reducing inequalities in health and development and their social determinants (11, 15, 20, 21).

1.2.2 Employment and working conditions

Employment may be beneficial for health in so far as it can lead to a significant improvement of living conditions such as appropriate housing, increased income, better healthcare access and active social participation (22). Thus, the promotion of inclusive labour markets and the development of effective return-to-work services for less privileged socio-economic groups, and specifically at-risk groups, can have an overall positive public health impact and contribute towards a reduction of persistent health inequalities. According to the Council of the European Union, flexicurity refers to the combination of flexible contractual arrangements in the labour market - i.e. deregulation - and employment and sustainable social protection systems (23). One of the particular aspects of the flexicurity concept concerns the need to promote inclusive labour markets by increasing the re-employment opportunities of groups at risk, such as the low skilled, unemployed, in unstable employment, and people with disabilities. Spinal cord injury (SCI) is a serious health condition associated with permanent impairment of several body functions. Employment and vocational rehabilitation of persons with SCI are particularly important in the context of social and health inequalities. Traumatic incidents account for the majority of registered cases of SCI worldwide. This may lead, among others, to increased risks of unemployment, poverty and social exclusion. Homeless and disadvantaged people at risk of homelessness are amongst the groups of people needing intense support in preparing their (re-)integration into work. This is due to the fact that they often suffer from additional problems which act as barriers that reduce their ability to gain work, such as reduced mental and physical health, substance and alcohol misuse, or criminal convictions (24-31). Employment has been considered a crucial step in ending homelessness, given its central protective role in

people's lives (32). Overall, estimates indicate that 77% of homeless people would like to work, yet only 15% currently were doing so (33). A study conducted in 2012 by homelessness agencies indicated that as few as 2 to 14% of people living in homeless hostels and supported housing were actually engaged in paid employment (34).

1.2.3 Income, welfare, and social protection

Throughout the life course, welfare - defined in terms of command over resources (35-38) - includes a range of living conditions. These resources are not only for well-being, health and inequalities, they are at the same time targets for major policy areas and efforts. Economic resources can easily be transformed into a range of further resources that in turn can be important for health. For example, economic resources are linked clearly and directly to health through material, social and psychological factors. Families and individuals draw on economic resources that they themselves generate, mainly through incomes from gainful work. In addition to this source, there are also collective resources provided through the welfare state that can be drawn upon. Such collective resources include social insurances and income transfers - the 'cash' side of the welfare state - and health and welfare services subsidised or free of charge – the 'care' side. It is reasonable to assume that if income and economic resources are of importance for health, then not only market incomes will be important but also the supply and quality of collective resources will be likely to influence people's ability to sustain their health and well-being. In addition, the less people have in terms of individual resources, the more important it is that they can draw on collective resources. Hence, it is important to study general policy areas that affect people's resources, such as social protection policies and to do so in relation to health and health inequalities.

1.2.4 Advocacy for health equity

Advocacy for health equity can be considered "*a deliberate attempt to influence decision makers and other stakeholders to support or implement policies that contribute to improving health equity using evidence*". Advocacy for health equity is therefore an important area to develop further. A systematic review of the academic and grey literature and a series of case studies looking at past and present examples of advocacy for health equity and a workshop were undertaken in the project. On this basis, a conceptual framework with the following six advocacy dimensions was developed within the advocacy strand: data, methods and knowledge translation; who advocates to whom; advocacy messages; tailoring; enablers and barriers; and practices. It provides a tool for breaking down the complexity of advocacy into understandable and discrete elements, and to help learn from contextually specific advocacy efforts and different kinds of evidence.

1.3 Objectives

1.3.1 General objectives of the DRIVERS case studies

The objectives of the case studies were to identify services, policies or practices that are already in place that have the potential to reduce inequalities in health and its social determinants. This was achieved by using the methodologies described below to identify the efficacy, reach, delivery and possible transferability and scalability of interventions – in addition to providing explanations of what works for which groups of people and in what situations.

1.3.2 Specific objectives for each of the DRIVERS strands

i) Early childhood

To identify and describe early years interventions across Europe with the potential to reduce inequalities in health and development among children

ii) Employment and working conditions

To assess the potential health and psychosocial benefits of return-to-work programmes in Switzerland and the UK.

iii) Income, welfare and social protection

To explore, in a comparative country context, the impact of social protection systems, both operations and provision, on health inequality.

iv) Advocacy for health equity

To synthesise existing knowledge and develop an evidence base on advocacy for health equity.

1.4 Summary of questions addressed in each of the DRIVERS strands

1.4.1 Early childhood

- Is there evidence from the case studies that interventions delivered improvements in the domains of childhood development that could contribute to subsequent reductions in inequalities in health?
- Do the services provided by the interventions reach all of their target groups, especially the children and families who would benefit most?

1.4.2 Employment and working conditions

- What roles do the actors involved play in the process of labour market participation?
- What perceptions do beneficiaries and employers have of return-to-work programmes?

1.4.3 Income, welfare, and social protection

- To what extent do social protection policies act as a collective resource for people to draw upon when their own resources are failing?
- Through what mechanisms do social protection policies help prevent health inequalities?

1.4.4 Advocacy for health equity

- What kind of evidence is needed to advocate for and transfer knowledge on health equity to policy making processes?
- Which practices and activities increase the effectiveness of advocacy efforts and who do they target?

2. CASE STUDY METHODOLOGY

2.1 Selection of the DRIVERS case studies

To achieve the aims described above, case studies were selected so as to represent a range of services which had the potential to reduce inequalities in the driver areas mentioned above. To provide a balanced mix of projects, actions with the potential to reduce inequalities in health and development and their determinants were selected while also ensuring a sufficient range of countries to reflect the different contexts in Europe.

2.2 Case studies performed

In-depth investigations were carried out to explore the interventions, programmes or policies illustrated by the following studies:

2.2.1 Early Childhood case studies

- The **Family Network in Austria**: a targeted referral service aimed at families in need, with children aged 0-2.
- **Sure Start** and the **Universal Medical Visitor**: providing caregivers with access to a Children's centre in areas with high deprivation and health visits to children and their families in Hungary.
- **Toybox**: an intervention aiming to reach out to Traveller families in Northern Ireland to enhance the social, educational, emotional, physical, language and cognitive development of children.
- **The Theotokos Centre**: a service aimed at providing unemployed and Roma single mothers and their children with childcare support and programmed activities such as parenting advice in Romania.

2.2.2 Employment and working conditions case studies

- **The Swiss Paraplegic Centre**: a return-to-work programme for people with spinal cord injury, Switzerland.
- **Business in the Community**: a return-to-work programme for homeless people, London, UK.
- **Business in the Community**: examined the role of employers in promoting employability and employment of people from disadvantaged groups, UK.

2.2.3 Income, welfare and social protection case studies

- **EAPN Hungary**: long-term unemployment experiences of the welfare system.
- **EAPN Poland**: focus groups with former drug/alcohol users and/or homeless people.
- **EAPN Portugal**: focus groups with students and people with long-term unemployment/ Not in Education, Employment or Training (NEETs).
- **EAPN/MAKALÖSA**: focus groups with single parent families, NEETS, drug and alcohol users, Sweden.
- **Poverty Alliance**: focus group with people with experience of addiction and in recovery, UK.
- **University of La Laguna in Tenerife**: focus groups with young unemployed graduates, Canary Islands, Spain.

2.2.4 Advocacy for health equity

- **Health 2015:** inter-sectoral co-operation on health inequalities at the national level. *The National Institute for Health and Welfare*, Finland.
- **Advocacy elements in an intervention on child poverty and health:** a child health intervention for disadvantaged families at the regional level. *Dutch Institute for Healthcare Improvement*, the Netherlands.
- **Think Family:** a programme for families with complex needs at the local level. *Blackburn with Darwen Borough Council*, England.
- **Food aid and healthy nutrition programme:** a programme delivering free school meals for children in deprived areas of Greece. *Institute of Preventive Medicine, Environmental and Occupational Health*, Greece.
- **Mental health first aid programme:** a programme to increase detection and treatment of mental health problems in the workplace in Wales. *Public Health Wales*, Wales.

All case studies used qualitative methods. The spinal cord injury and homeless return-to-work programme case studies made use of quantitative methods. A description of the development for each method is provided below.

2.3 QUALITATIVE METHODS

Early years, income and social protection and advocacy strands developed similar protocols or toolkits for third parties to follow to ensure homogeneity. Case studies carried out descriptive and exploratory qualitative research (39) to provide an insight to the knowledge, perceptions and beliefs of beneficiaries, staff and managers following the consolidated COREQ criteria, where appropriate (40).

2.3.1 Participants and sampling

i) Early childhood

Third parties identified 25 parents, programme managers and key professionals across four countries - from within the mentioned selected early years interventions - for in-depth, semi-structured interviews using a purposive sampling approach. They also liaised with programme managers to identify potentially ideal staff and parents - also involved in the interventions - for the focus groups, recruiting 46 participants. A final sample of 71 respondents participated.

ii) Employment and working conditions

Five managers of the return-to-work programme in Swiss clinics and in insurance agencies of the Swiss social security were identified and semi-structured telephone interviews were conducted.

For the return-to-work programme in the UK, purposive sampling was used to identify 12 participants using the following criteria: they had sustained work for at least three months, were unemployed for at least three months prior to completing the ready for work programme and were identified within the UK. A convenience approach to sampling was carried out to identify three Ready for Work Managers in the UK, targeting those in the locations where interviews with clients were taking place.

Purposive sampling was used to target Human Resources and Corporate Social Responsibility Directors (CSR) in companies within Business in the Community's membership for telephone interviews and 13 participants were interviewed. Three BITC member companies participated in the focus groups. Seven CSR Europe member companies completed an online survey.

iii) Income, welfare and social protection

The recruitment framework laid out in the toolkit was modified in practice because some countries had difficulty reaching and recruiting the groups originally specified. Participants were recruited through a multi-method approach; posters, social media, project work, local networks and word of mouth. For the unemployed graduate youths from Tenerife participants were selected using purposive sampling.

iv) Advocacy for health equity

For the Finnish public inter-sectoral co-operation case study key informants were identified in the following ministries: education and culture, environment, finance, employment and economy. For the Think Family case study children's services managers, early years' practitioners, public health officers, Think Family project managers, internal evaluators and members of the Think Family steering group were included. For the Food Aid and Healthy Nutrition programme, key informants from the associations and companies that support the programme and key policy makers were interviewed. The Child Poverty and Health key stakeholders who were involved in implementation of the intervention were interviewed. The Mental Health First Aid case studies carried out interviews with key stakeholders working in the Welsh government.

2.3.2 Data collection

Individual semi-structured interviews were carried out for the early years and return-to-work case studies. These lasted over an hour. Semi-structured telephone interviews were performed within the fair employment and working conditions strand to programme managers, which lasted from 20-30 minutes. Focus groups were used in case studies across all strands as a method for data collection to capture the information provided by the dynamics of group discussion and interaction (39, 41). These had approximately 6-10 participants, with similar socio-economic backgrounds, age and occupation and lasted approximately 1.45 hours. All sessions were performed following a topic guide developed and discussed among researchers. The guide described the issues or questions to be explored. It was developed based on the research questions and objectives as described in the Description of Work (DOW). The lead institutions collaborated with third parties and provided guidance in this phase. In some instances, such as the return-to-work managers' telephone interviews, the interview guide was sent out to participants in advance to help them prepare for the interview. The participants and number of interviews for each case study varied as described above. Not all sessions were recorded; however, notes were taken in all sessions. Draft interview summaries were sent to interviewees for further amendments and consent.

2.3.3 Analysis of the studies

i) Early childhood

The content was organised according to themes previously defined by appraisal and evaluation criteria established across the different case studies, however emerging themes were also explored. The final framework integrated pre-established and emerging themes.

ii) Employment and working conditions

An analysis tool was developed integrating (i) disability and quality management concepts (28, 42-45), and (ii) the results of the study on employment determinants for persons with SCI (46-50).

Notes taken during the employers' telephone interviews were reviewed and coded by the interviewer and a second review was performed by the work inclusion director from BITC. The survey responses were collated using the tools within SurveyMonkey and then entered into a spreadsheet for the purpose of creating graphs to further aid analysis.

iii) Income, welfare and social protection

Analysis was conducted using a process of grounded theory. Data was analysed and coded thematically until no new themes emerged, which allowed the analysis framework to emerge from the data itself. For the La Laguna case study on unemployed graduate youths, semi-structured interviews and focus groups from Tenerife-Canary Islands were conducted, followed by discourse analysis using hermeneutical phenomenology theory.

iv) Advocacy for health equity

For the Finnish intersectoral strategy, an analysis using a social marketing and five "Is" approach: information, ideologies, interests, institutions and interventions, was performed. Data analysis using thematic coding techniques was performed for Think Family and Food Aid and Healthy Nutrition programme case studies. The Child Poverty and Health case study's analysis was based on the six dimensions of advocacy.

2.3.4 Ethical considerations

Informed written and verbal consent was obtained from all the participants for taking notes or recording the sessions. The information was anonymised and confidential. There is no personal relationship between interviewees, participants of the focus group and the authors. Some participants received a small payment or reward.

2.4 QUANTITATIVE METHODS

2.4.1 Employment and working conditions data

For all SCI analyses, persons with SCI between 18 and 65 years old were included from the Swiss SCI Study, a longitudinal cohort study conducted in Switzerland that aims to survey persons older than 16 years who are diagnosed with traumatic or non-traumatic spinal cord injury. SCI data was collected for the first wave only.

The Ready to Work Programme in the UK, used a complete-case dataset consisting of 2480 individuals, of which 70% were men. The study population consisted of homeless individuals participating in the Ready for Work Programme. The data were collected continuously from 1 January 2009 to 31 December 2012. Employment outcomes were monitored until 7 August 2013.

2.4.2 Analysis of the employment and working conditions studies

For all SCI analyses, in order to increase the statistical power of the regression analysis described below, both datasets were imputed ten times by the method of chained equations (51). The odds ratios of current employment status were modelled by fixed-effects logistic regression. Model 1 was estimated with data from the basic module, and model 2 with data from the work integration module. Pool estimates were obtained. For the analysis of how persons with SCI assess their own situation regarding employment, two instruments were utilised: the Barriers to Work Scale of Krause and Reed (52), and the comments on employment given by the survey participants.

Within the Ready to Work Programme, the association between job coaching and success in gaining employment was analysed by multivariate mixed logistic regression with random intercepts by region (Scotland, Wales, Republic of Ireland, and all nine regions of England). Respective analyses stratified by education, ethnicity and age were adjusted for multiple testing. The association between job coaching and success in sustaining employment was analysed by estimating a parametric survival regression model based on a Gompertz distribution for the hazard function. A random-effect intercept adjusting for regional variance was included after consideration of the Akaike (AIC) and Bayesian (BIC) Information criteria. All respective statistical models were adjusted for a number of confounding factors.

3. SUMMARY OF RESULTS

The results from each DRIVER area are summarised below. For each, the summary follows the structure used in each of the DRIVERS case study reports. Selected quotations are provided where available.

3.1 Early childhood

The results explored respondents' perceptions for each of the selected interventions carried out in Austria, Hungary, Northern Ireland and Romania. In all the interventions that were not universal - the health visitor programme in Hungary - the majority of users were from low income or disadvantaged backgrounds. Unemployment, housing and social isolation were some of the issues raised.

“...inherited class system, dysfunctional families, lack of jobs and a lot of barriers.”
Toybox staff

“I have qualifications, but I could not work in that direction because the girl was too small and I had nobody to stay with her. Now I work as an assistant cook at an organisation.” Mother attending the Theotokos centre

Programmes were delivered in areas with low levels of service provision for children and their families, or where people experienced difficulties accessing standard services. The staff participating in the focus groups made reference to a lack of programmes for mothers with poor mental health, post-partum depressions and mother and child treatments in health clinics. They also referred to a shortage of programmes and group interventions for pregnant women.

“It has been very successful at filling the gap between families and other services. It has removed barriers to Traveller children entering education.” Toybox staff

“The local social and child welfare services are overloaded, under resourced and often not able to provide the necessary support.” Sure Start manager

Families across interventions were contacted via the health and social services, community groups and family. For example Netzwerk Familie parents were approached by a parents-counselling programme after having given birth at the hospital. Alternatively, health care professionals who were aware of the programme also referred families and other families were self-referred.

The programmes aimed to provide a space for all parents and children while also targeting those who would benefit most from these. Services were open to the local community. These provided activities with a special focus on children from low income or deprived families to prevent developmental delay. The objectives were to enhance children's development and health. Some programme staff members, for example those from interventions delivered in Hungary, described focusing on various dimensions of development.

“In the centre, he learned a lot of good things; he knows a lot of words and many different songs.” Mother from the Theotokos Centre

“Home visitation includes all dimensions of child development: physical and emotional as well.” Universal programme health visitor

Parenting was a recurring theme across all ECD case studies. Parents were actively involved in activities by staff and respondents referred to long-lasting trust based relationships between staff and parents as one of the basis for the success of the programmes. Building on parents' capacities and existing resources and services was viewed by staff as an important aim to ensure the continuity of positive parenting and healthy child growth and development.

“Parenting knowledge should be provided to the families, e.g. information on the developmental needs of the child and the appropriate ways to respond to these needs must be learnt just like non-violent communication, disciplining, listening to children and taking their views into consideration.” Sure Start manager

Interventions focused on providing parents with support and improving their parenting capacities to assist in their children's learning and development. Programmes sought to empower them and help develop their own educational skills.

“Ask parents for advice...it is not about doing unto parents ...” Toybox staff

“The methodology is based on peer support and formal and informal learning. Both the parents and children have the opportunity to meet and learn from each other” Sure Start manager

The programmes also accompanied parents and provided them with knowledge and information on the developmental needs of children. Toybox staff described their programme as the link between parents and health care services as staff reminded parents while on visits of forthcoming appointments. In some cases staff would also attend doctors' appointments to ensure the children's needs were met. Parents participating in Netzwerk Familie explained that the programme offered support when mothers left the hospital and continued maintaining contact and offering consultation.

Information on evaluations, as described by respondents, was based on monitoring indicators and measuring output and process assessments. No long-term evaluation or comparison with a control group had been carried out. Beneficiaries interviewed across all the interventions but one - the universal home visitor programme - stated being very satisfied with their children's progress in learning skills and improved reading and vocabulary. They also described observing gains in emotional well-being and self-confidence.

“JC has become a lot more sure of himself”; “It’s helped with their speech and they play better together.” Toybox parents

“My youngest daughter came here where she is very well. The children are clean, they receive attention, somebody take care of them and here are specialised personnel which deal with them.” Theotokos Centre mother

The main barriers faced in delivering the interventions referred to in Austria and Hungary were associated with the stigmatisation of users. Mistrust or reluctance to receive the service was described across all countries as a barrier. Professionals had to gain beneficiaries' confidence to overcome these. Limited resources and therefore limited available space were also highlighted.

“People on the other hand are often irritated, angry and sometimes aggressive many of us are scared, try to avoid any conflict. They blame us for the lack of services, free medication, etc., it is getting very hard.” Universal system health visitor

3.2 Employment and working conditions

Results presented describe the three case studies carried out within the fair employment and working conditions strand. These were the Swiss Spinal Cord Injury return to work programme, the Business in the Community Ready for Work Programme in the United Kingdom and human resources and corporate social responsibility directors' views on business' motivations to employ people facing barriers in returning to work.

3.2.1 Employment and working conditions case study 1: Swiss Spinal Cord Injury return-to-work programme

Descriptive quantitative analyses for the Spinal Cord Injury (SCI) case study in Switzerland showed that persons injured in traffic accidents, falls, other traumatic events and especially non-traumatic SCI had lower chances of being in paid employment and in long-term contracts after injury in comparison to persons injured during leisure or sport activities. The analysis of cross-sectional data demonstrated some important features of return-to-work programmes which may contribute towards a reduction of health-adverse consequences of social disadvantage associated with the burden of SCI.

Analysis of the qualitative data showed that the SCI programme managers ascribed great importance to the following personal characteristics of the injured persons to be successful in returning to work: education, motivation, self-efficacy perceptions, employment history before injury, work performance, language skills, and self-assessment of work skills. There is no standardised return-to-work programme for persons with SCI in Switzerland and each clinic had its own rehabilitation programme. Persons with SCI in Switzerland generally obtained extensive support from society. The Swiss labour market was considered favourable by the managers for persons with injuries and the majority of persons with SCI in Switzerland were formally organised in an association and, thus, given a voice for their special needs at different policy levels. The individual intervention plans defined by the Swiss Law comprised 1) therapeutic measures, 2) vocational adaptation, 3) re-training, 4) part-time employment in the previous job, and 5) complete re-integration in the labour market either as job retention or job acquisition. Persons with SCI had increased chances of being employed if they returned to their previous job not if they had to apply for a new one. The most relevant perceived barriers to work were related to poor health, resources availability and the belief of being discriminated by employers. Also, vocational rehabilitation was described as being bound to tight deadlines and time constraints. There was almost no systematic evaluation of effectiveness and/or cost-benefit analyses of the return-to-work instruments and programmes. In addition, there was neither a systematic data collection on employment outcomes nor feedback channels for participants of the vocational rehabilitation programmes.

3.2.2 Employment and working conditions case study 2: labour market integration of disadvantaged people: analysis of the Business in the Community Ready for Work Programme in the United Kingdom

Quantitative results

The statistical analyses of data from the Ready for Work programme for homeless people in the UK suggested that the chance of (re-)integration in the labour market is 3.70 times higher among those who were supported by a job coach compared to those who were not and that the programme was also associated with sustaining employment.

Qualitative results

Job coaching and ready for work managers

Qualitative analysis showed that managers agreed that job coaching had positive outcomes when the clients or beneficiaries felt they had elements in common with their job coaches.

“It was a really good pairing, we had a lot in common. I said “look, this is what I want to be doing, but I’ve never done it before. Being in a working environment, I wouldn’t know procedures and stuff, you know, I’d be quite lost” and he took me through everything, it was really good.” Ready for Work beneficiary

The clients interviewed had a largely positive experience regarding the support provided by their Ready for Work Manager. This issue arose many times contrasting with their experiences with Jobcentre Plus advisors. Participant’s views were that they were unlikely to find the same level of support elsewhere.

“...they go the extra mile for everyone...they put everyone before themselves...they’re heroes in my mind...” Ready for Work beneficiary

Job club and employee volunteers

Ready for work managers felt that job clubs offered tailored support to clients and clients reported valuing the support received. Two clients gave an example of staff from the job club helping them update their curriculum vitae. The pre-placement training and placements themselves helped clients to re-gain their sense of self-worth and motivate them towards their goal of finding a job as did the opportunity to interact with and learn from business volunteers.

“I done a two week placement with Carillion...it was good, it was tough, bad weather and stuff but good experience and I ended up getting a job from it so it was well worth it.” Ready for Work beneficiary

Experiences with support received elsewhere

The interviews suggested that clients highly valued their contact with charities, however the type of benefit that they gained varied. In several cases clients volunteered for the charities. Clients felt it improved their self-worth and increased their chances of being employed. Clients’ accounts of Job Centre Plus were predominantly negative. They perceived that Job

Centre Plus had a rigid system, dedicated them little time and did not offer sufficient support. Regarding help from probation officers -according to clients- the meetings were regular but it was not always the case that clients saw the same officer each week. Experiences of the interactions with probation officers were mixed: the level of priority given to finding a job depended on the individual probation officer.

“...as long as you’re not reoffending they’re not really bothered if you’re working or not I don’t really think.” Ready for Work beneficiary

The clients with positive experiences were referred to other organisations such as the commercial welfare to work provider. Reported experiences of commercial welfare to work organisations, was positive. Housing keyworkers were not identified as helpful by clients. For approximately half of the clients, family and friends were not a prominent feature in their lives, experience of the support provided by friends and family was mixed.

Employers and the impact of job seeking on self esteem

The interviews suggested that looking for a job on the open market was often a demoralising process that affected a client’s motivation and self-esteem. One of the principal issues referred to was not obtaining a response to job applications from employers. Some clients also said that they felt employers discriminated against them due to factors such as their offending background, lack of experience, age or disability.

Individual factors

Clients described being determined to find a job even if their job search did not have positive outcomes. The motivations behind this determination were different for each client; for some, it was because they had made a firm decision to move away from damaging patterns of behaviour; for others, having a job offered the opportunity for greater independence and more income or a new identity far removed from their previous life styles.

“I told them I wanted to be back in work, that’s why I ended up doing what I was doing (crime) because I was skint; I was desperate.” Ready for Work beneficiary

The importance of individual initiatives of clients was highlighted by managers. A recurrent theme mentioned throughout the interviews for clients was reaching a turning point which encouraged them to return to work.

Sustaining work

Whilst working, three of the clients still saw their job coach and three were still in contact with their ready for work manager and one was continuing to attend the job club. A further two clients said that they knew they could contact them at any time for help, particularly if they needed to find another job.

“Well, my Ready for Work Manager definitely was one of the main reasons that I managed to find work. He’s helped me so much. I still talk to him now.” Ready for Work beneficiary

Only one client reported a positive relationship with their line manager; the company in question was a keen supporter of the Ready for Work programme. It was less clear from the interviews the extent to which clients were still engaging with charities.

Progress and transformation

Several clients spoke about wanting to progress work-wise for various reasons; to move up the career ladder, to earn more or to find a job they considered more suited to their skills and interests. All clients reported challenges in trying to achieve this. For several clients, working had enabled them to make positive changes in their lives. They reported feeling happier, having more income and independence.

“I’ve been battling this problem for so long I really believe it’s my last chance and I can’t go back down that road...I want to do something for my kids, you know. Basically, my kids are my energy, now.” Ready for Work beneficiary

In two cases, the reality of work had a negative impact on their health and well-being due to the effects of shift work or not being able to take sick leave.

3.2.3 Employment and working conditions case study 3: the role of employers in promoting the employability and employment of people from disadvantaged groups

How do companies support or employ people facing barriers to work?

The majority of the companies interviewed on the telephone were working with at least one agency with specialist knowledge and focus on particular barriers to work. A strong theme emerging from the interviews was that employers perceived mainstream agencies - Jobcentre Plus and Remploy were mentioned specifically - as inadequate in meeting specific needs.

“We recognise the traditional approach to recruitment and the traditional routes wouldn’t necessarily reach care leavers and NEETs.” Employer from a BITC partner company

Companies also said that a standard application/interview process often excluded people furthest from the labour market. Alternative recruitment activity cited by respondents included open days held in central points of deprived communities. These included paid working interviews for unemployed people.

What provision do companies put in place to promote the health and well-being of employees from disadvantaged groups?

There was recognition across all the businesses interviewed that employees from disadvantaged groups facing barriers to work often required additional support in the workplace. This was easier to provide if individuals had been recruited through a specialist programme. The methods used by companies to recruit and support people from disadvantaged groups varied according to the culture and structure of the organisation. In order to reach people facing barriers to work, the majority of companies interviewed referred to partnering with specialist agencies, usually non-profit, as they provided unique expertise. Companies interviewed suggested that workplace mentoring and support, a thorough induction upon starting work, flexible working, confidential counselling, advice and financial support, made a crucial difference.

Companies were cautious about engaging with government initiatives or providers due to their complexity and bad publicity, as reported by employers, but there was some engagement with these. Extra support was provided in conjunction with specialist charity partners. It was not clear from the interviews the extent to which corporate parenting was due to the culture of the organisation or the commitment of a small number of individuals within a company.

“We try not to do corporate parenting but we need to do some of it. We’re replacing the family to some extent.” Company manager

What influences company behaviour in relation to the employability/employment of people from disadvantaged groups and the provision of health and well-being support for those employees?

Online survey respondents from the companies participating in the study, referred to numerous external factors which were influential in helping people back into work: brand reputation and legislation/directives depends on the personality and style of each individual leader. These were described as being more relevant than internal factors.

There was general agreement that health and safety legislation in the UK was a major driver of the policies and processes in place, and most reporting, if any, was done in relation to obligations under this law. Participants felt that competition from other companies and customers helped them to strive towards best practice.

“We strive more from a brand perspective to help our customers understand how great a place we are to work. It’s a big message we put out and I think there’s more and more focus on that right now.” Company manager

Companies that tender for public infrastructure contracts are usually required to demonstrate in their bids how they will create employment/training opportunities in the local community. Companies in the UK were wary of the effect that bad publicity could have on their reputation, particularly in relation to the provision of unpaid work experience or helping particular groups, for example ex-offenders. The results of the survey showed that for those companies taking part, the key influencers in relation to health and well-being provision were more likely to be internal. Telephone and focus group participants reported more monitoring and evaluation activity in relation to areas which are controlled by legislation, for example health and safety and discrimination on grounds of race, religion, sexuality, gender and/or disability.

3.3 Income, welfare, and social protection

The results for this driver area are presented separately for questions addressed in the welfare, income and social protection case studies, as follows:

3.3.1 Income, welfare and social protection question one: to what extent do social protection policies act as a collective resource for people to draw upon when their own resources are failing?

An analysis of the findings identified the following key themes:

Levels of financial support

According to respondents, levels or thresholds of financial support were set at minimal levels across the UK, Hungary, Poland and Portugal. In relation to social protection this often left people experiencing poverty and unable to meet many needs such as heating, food and transport. The concept of adequacy was discussed across several countries in terms of the support the country provided and how adequate this was for an effective quality of life. Points regarding the minimum levels of quality of life people should have access to were also raised. In the focus groups in Portugal, Hungary, UK and Poland, issues emerged on the coping strategies people applied to alleviate or manage with the minimal levels of support they were receiving. In Poland, participants spoke of support being predominately provided by that of non-governmental organisations and issues regarding the thresholds of support. In this sense, benefits were withdrawn if a person obtained additional income.

Attitudes to claimants

Themes emerged regarding experiences of accessing support. Claimants often felt that attitudes among staff employed in areas such as labour offices or job centres were degrading, devaluating and discriminated against them. This was considered to be detrimental to accessing rights and entitlements by participants from the UK, Hungary, and Portugal.

In Hungary the young participants in the focus groups spoke clearly of distrust towards the social protection system and accessing support. This did not apply with the other population groups participating in the study.

Accessing entitlements

Within the evidence collected on young people from Portugal, points were raised about the precarious nature of income when trying to obtain employment and access support, the inflexibility of the system was a key factor. This was similar to the experiences of participants in Hungary. According to respondents, young people within the UK obtained financial support when seeking employment but faced challenges accessing the labour market. In Portugal provision appeared to be more integrated and support was provided more effectively. For example participants discussed support being provided with housing as well as financial assistance. Emergency accommodation such as hostels was also provided.

Participants emphasised on the structural barriers that the social protection system constructed and their feelings of powerlessness in relation to the system. This was largely related to the degree of 'control' people had within their collective experience of the social protection system. In their experiences control lay in the hands of those administering the benefits system.

Conditionality and other barriers to access

An overarching theme emerged regarding meeting the conditions required by the system. Participants' needs and requirements were not always met by the system in terms of service and support provided. Respondents described hardship during transition points such as obtaining employment. For those with disabilities or within more complex situations,

particular challenges were highlighted in terms of obtaining clear and comprehensive advice. Processing errors were reported by respondents in several countries including Portugal and the UK among the at-risk groups and young people. An additional key barrier was the issue regarding documentation required for access to support. Conditionality around provision of benefits seemed a particular cause for concern within Poland, this appeared to have an impact in discouraging people applying. For the more marginalised groups this was often problematic. Other barriers reported were the literacy of participants and the need to complete official forms.

Several points were raised regarding need for training to improve expertise of individual advisors within services. Ensuring staff had non-judgemental and inclusive attitudes that did not stigmatise clients and providing support were seen as important.

Activation Policies

It was highlighted that participants were moved into training programmes which they considered were inadequate in terms of tailoring the assistance provided. Individualised support was cited as a key area. Several examples of participants employing other techniques to obtain employment through contacts from support networks such as family members were cited, for example in Hungary. Volunteering was seen as a key opportunity to improve skills and experience.

Registration of residence emerged as a barrier to employment among participants from Poland who had experienced homelessness. This resulted in many taking on employment without any social protection which respondents referred to as 'grey zone' employment.

Some examples of good practice arose: for example participants in the UK discussed some positive experiences in the transition to accessing support upon release from prison. In Portugal, examples were given regarding participants who had positive experiences in social services because allocated workers followed their case closely and provided support.

Unemployment among graduate youths in Tenerife, Canary Islands

The recent economic crisis affected some countries and regions more than others. Some of the most severely affected were the Canary Islands in Spain. While university educated people fare better, the general economic situation in combination with the austerity measures in social protection systems are causing serious problems also for people in this group, in particular among the young and recently graduated. Hence, unemployed healthcare graduates in the Canary Islands expressed that they were experiencing the progressive weakening of the social protection system in all its forms. They described finding themselves in poor employment conditions which hindered their personal development. Respondents felt that in the past holding a degree was sufficient to guarantee a job but that this no longer applies. Work was described as scarce and precarious when available. It made respondents cope with an unstable future. According to the interviewees, the day-to-day life-style provokes a "burn-out" syndrome that finally generates mental illnesses like a high level of anxiety and depression.

The social protection system, as described by respondents, did not provide a dignified quality of life. They felt that instability during unemployment was very high and that university graduates who have never worked face job insecurity, something which informants described as common in the nursing employment system, can rarely rely on social protection. A feeling of helplessness, as described by informants, made unemployed

graduate youths consider moving to another country as they saw it as the only possibility for self-development. While this does not provide insights *per se* on how to reduce health inequalities, it does provide a clear example of the importance of the gradient. The extent of the crisis is such that graduates are also unemployed and unable to enter the labour market, and this affects their health and well-being. The lack of adequate social protection that could provide collective resources, was experienced by this group, despite the fact that they are likely to have fared better than less educated people.

3.3.2 Income, welfare, and social protection question two: *How does this system of support help prevent health inequalities?*

The degree to which the system of social protection support can help prevent health inequalities was difficult to determine with the information collected. Despite the limitations in support, the social protection system was generally considered to provide some degree of protection against health inequalities by safeguarding living standards and providing a secure base. The degree of impact the social protection system provided varied across countries. The paragraphs below provide examples and the information was provided by respondents which had received treatment for a range of conditions including support with mental health, addiction, physical ailments and disabilities.

Participants from Hungary raised points about the impact of austerity, perceiving that it had contributed to higher rates of mental illness. Counselling was difficult to access, placing additional pressures on people in their day to day lives. This was also raised within the UK, whereby those in the at-risk group discussed a lack of specialist support as did respondents from Poland.

Within Poland, some participants due to their experience of having good health, had not utilised health services in such an acute manner as other participants within the study. Concerns were raised about being denied access to provision despite having social insurance due to administrative processes and gaps in primary health care. Swedish and Portuguese participants reported that people were only entitled to emergency dental care and not ongoing dental treatment and viewed as a key barrier to employment.

The participants from the UK discussed medical assessments and the increased eligibility criteria within the assessment process. Points were also highlighted on the effectiveness of the assessment process in dealing with issues such as mental health or recovery from addiction. This was also a theme within Hungary.

Access to primary care was described as positive. There were variations across countries. Respondents from Poland discussed that specific treatments were difficult to access as staff administering healthcare were unsure if it would be covered by the fund. Evidence was highlighted across respondents, where individuals had borne the high cost of treatment as they were unaware they could access assistance. Within Hungary those who were most in need of support reported finding it difficult to obtain medication. This was not perceived as a barrier to employment.

UK participants discussed the challenges of accessing employment when experiencing ill health. Ill health as result of addiction was key barrier to employment. Long-term substance misuse had left many with additional health conditions and problems. Underlying causes of addiction such as trauma and recovery were also highlighted.

3.4 Advocacy for health equity

Finnish inter-sectoral strategy: to respondents, successful advocacy for health equity requires demonstrating costs and benefits to others as well finding common goals and suggesting opportunities for co-operation. In the respondents' view, the use of health terminology outside the health sector can be counter-productive. Introducing the concept of the social determinants of health (SDH) is a prerequisite to intersectoral co-operation on health inequalities. Interviewees explained that there are multiple advocates, though they may not see themselves as such. Interviewees concluded that advocacy within different ministries requires permanent structures with funding and resources, an appointed responsible body and an internal working group within each ministry. Moreover, being an advocate within a ministry should be a rewarding experience.

Think Family: As described by respondents, local evidence, for example the testimonies of people affected by the intervention were particularly valuable in advocacy efforts; cost-benefit evaluations are also extremely important; there is a need to bolster scientific evidence with other kinds of evidence. Interviewees explained that different advocates can be involved at different points in the advocacy effort; advocates can be dispersed across different departments, but there may be important individuals ("champions") who help move things forward. Having champions is important; they might include expert policy makers who can make the case to elected members. In the view of respondents, health arguments are not enough to persuade policy makers; economic messages are important, but also health as a means of promoting social inclusion and access to work. It was the respondents' understanding that it is important to tailor evidence and frame issues in accordance with the targets of advocacy and stakeholders involved. National policy developments can open windows of opportunity to take action at the local level; financial incentives can act as enablers.

Food aid and healthy nutrition programme: The respondents suggested that advocates should highlight evaluated results and cost-effectiveness. While the public sector values more factual and scientific policy briefs, qualitative evidence including testimonies can also be persuasive. Advocacy materials aimed at the general public and media can make greater use of qualitative evidence than those aimed at government policy makers. The interviewees explained that overall, a 'jigsaw of evidence' appears to work well. They felt that NGOs should demonstrate expertise, have high-level contacts with other organisations (private and public sector) and the capacity to deliver. In the opinion of interviewees, the private sector is likely to support an initiative if they understand the scale of an issue and it fits with their corporate social responsibility (CSR) priorities. If they know the NGO and have links to it at high levels, the intervention is tested and has a credible methodology, is delivered universally (not means/needs tested) and has cost-benefit evidence associated with it, then the private sector is likely to collaborate. In the opinion of the interviewees, the implementing organisation should provide regular updates to funders, ideally with possibilities of meeting beneficiaries. EU level advocacy can exert pressure to act at the national level.

Child Poverty and Health: Interviewees considered it important to make policy makers aware of the scale of a problem and the basic mechanisms involved. Information linking the social and the health issue, and local epidemiological data showing the effects in the local area are convincing in advocacy. Such data should therefore be collected or disseminated

more widely at the municipal level in the Netherlands. In the opinion of the interviewees, advocates should disseminate materials in more than one format if possible. The health argument is effective, but each policy maker may have a different standpoint, and more than one argument should be used in advocacy efforts. Respondents considered it important to identify key people to convince – in this case the Alderman on Social Affairs and Health was an extremely important target of advocacy, who could go on to be a possible ‘ambassador’ of the intervention. Policy makers may be reluctant to take on board new responsibilities, so arguments should be developed with this in mind. The interviewees explained that national networks on poverty and health could help ensure better information flow and increase knowledge and therefore willingness to take action.

Mental Health First Aid: Respondents described making an economic case to policy makers as important. Respondents also explained that lower standards of evidence may be acceptable for policy makers if an intervention is ready to be implemented. According to interviewees, advocates should highlight the international credentials and pedigree of interventions and adapt their messages to the prevailing policy frame. Employers saw CSR awards and staff well-being as important; they explained that dedicated budgets ensure efforts are made to increase staff well-being.

4. DISCUSSION

The following section links the main results from the case studies outlined in the previous section to the research carried out across the three DRIVERS strands: early childhood development, fair employment and working conditions and welfare, income and social protection, and in the strand dealing with advocacy for health equity.

4.1 Early childhood

This report illustrates early years initiatives delivered in Romania, Hungary and Austria in addition to the UK. Most programmes were delivered in areas with low levels of service provision, the exception to this was Netzwerk Familie. The majority of families and children were from deprived backgrounds. Programmes that were not universal reached beneficiaries using a variety of methods. These included contact in hospitals after delivery, through social services, community groups and relatives. Only the universal health visitor programme delivered in Hungary began in the ante-natal period. The objectives of the programmes were to enhance children's health and development. These were delivered by staff members from the health, psychology and social sectors. Some - Toybox, Sure Start and the Theotokos centre - provided activities to stimulate children's learning through structured play and provided support and assistance for parents. In the three programmes the parents were actively involved in activities and respondents referred to long-lasting trust based relationships between staff and parents as one of the basis for the success of these programmes. Staff and users generally gave very similar accounts of the intervention through their experiences, and parents expressed a high level of satisfaction. The exception to this was the health visitor programme where the two groups of informants put forward a slightly different view regarding the main barriers to implementation. While both groups agreed that limited available resources and space were barriers, staff identified the reluctance of parents to attend some of the services and parents highlighted a bureaucratic approach by staff. The available evaluations were based on monitoring indicators and measuring output and process assessments. No long term evaluation or comparison with a control group had been carried out.

The programmes described were aimed at strengthening parenting abilities to assist in their children's learning and development and were delivered by multidisciplinary teams either at the families' homes or in the programmes' centres – Toybox combined both. The evidence from the systematic review of early years interventions (12) showed that programmes with better outcomes included elements such as interagency participation and combined workshops offered to parents and children.

A meta-analysis describing inequalities across cohorts from 12 European countries, which forms part of the DRIVERS project (17), illustrated that poor health is greater amongst children of mothers with low education. The programmes identified in the case studies focused on improving parents' learning and some provided child care which enabled mothers to improve their qualifications and or skills. However, while focusing on parenting is important, it is also necessary to address the conditions of daily life which make positive parenting difficult. This requires policies aimed at children through an explicit, multi-dimensional and integrated strategy (1) and investment in reducing child poverty and improved living conditions (2). Evidence from a study reviewing the literature on inequalities in ECD and health, which forms part of the DRIVERS project, showed that most social

factors, at both the neighbourhood and household levels, influenced early childhood health and development extending across a wide range of adverse health and developmental outcomes in early life (18).

Interventions selected for this study had undergone different forms of assessment or evaluation. Informants described periodic monitoring, assessing children's performance or collecting data on the delivery of interventions. Evaluation of the programmes included in this study would perhaps allow comparing the outcomes of programmes delivered in families' homes or centres. Outcomes of the systematic review on early years interventions found that interventions with better outcomes combined both (12).

Ensuring a sufficient range of countries to reflect the different contexts in Europe was one of the selection criteria for interventions included in this report. However, examples of early years programmes outside Europe have been well documented: the Nurse Partnership has shown long-term beneficial effects in the USA. Children in the intervention group had higher reading and mathematics tests scores, lower criminality and dangerous behaviours (53). "Sure Start" Australia (54) showed very little detectable difference between the intervention areas and Start-to-be communities where the intervention was yet to be implemented. "Head Start" in the USA (55) improved conduct problems and noncompliance (56, 57).

The study had several limitations, ensuring a sufficient range of countries to reflect the different contexts in Europe was one of the selection criteria for interventions included in this report. The programmes selected were identified from within a sample of interventions provided by third party organisations collaborating with the DRIVERS project and do not necessarily represent all the programmes being delivered across Europe. Nevertheless, the results show similarities with the main findings in the systematic review of interventions (12) which aimed to improve parenting capacities. The interviews and case studies were performed by third parties in each country and this may have caused interviews and focus groups to differ across interventions. Third parties provided University College London (UCL) with summaries of notes taken and recordings of sessions. These differed in length and detail and were at different levels of interpretation. The limitations however were mitigated by the fact that UCL provided a common template and guide for third parties to carry out the case studies. The latter included specific guidance on data collection. The fact that third parties performed the interviews and focus groups may be considered as a strength as these were carried out in their native language.

4.2 Employment and working conditions

One working conditions case study aimed to identify potential health, economic, and psychosocial benefits of the return-to-work social policy in Switzerland, with a special focus on social inequalities in return to work among persons with SCI. The information described in the ready for work programmes was designed to increase knowledge in relation to how companies support or employ people facing barriers to work and what influences the decisions they make in this regard. In order to reach disadvantaged groups, the majority of companies interviewed said that what worked best was partnering with specialist agencies, usually non-profit, as they provided unique expertise as well as a better route through which to reach certain groups, for example, ex-offenders. Most also put in place processes in addition to standard recruitment procedures to make sure that opportunities were accessible. Employees from disadvantaged groups often required additional support in the workplace. There were a range of factors influencing decisions made in relation to employing people

from disadvantaged groups, although broadly speaking it appeared that the decisions were more likely to be externally led. Some decisions were driven by competitors.

The Swiss SCI study had several limitations. First, given the lack of appropriate data it was not possible to estimate the effect sizes of specific instruments of the return-to-work programmes on long-term employment among this population. Thus, the results of the analyses of quantitative data only reflected correlations between important personal characteristics - e.g. age, health problems, employment history and pension benefits - and employment status after injury. Second, the results of the small qualitative analysis are clearly not representative for the whole population of persons with SCI in Switzerland. Third, since data linking specific interventions with employment outcomes was not available due to lack of systematic documentation, it was not possible to perform any kind of cost-benefit analysis of the programmes under study. However, a comparison of re-employment rates of persons with SCI across different European countries (58) provides a strong argument in favour of the comprehensive vocational rehabilitation system which may serve as a model of good practice for other European countries.

Despite considerable efforts from employers to support re-employment of their formerly employed persons with SCI more information and motivation of managers and employers is required to enhance return to work among persons with SCI, especially so if return to former employers is not possible. Unlike some other European countries, return-to-work programmes in Switzerland are publicly funded and guarantee rehabilitation services to all beneficiaries according to individual need. Thus, potential adverse consequences of social disadvantage or social exclusion related to SCI may be substantially reduced. Regulation may eventually produce some disincentive to seek re-employment following SCI rehabilitation. Vocational rehabilitation programmes vary between clinics and, therefore, are not harmonised to a sufficient extent. Moreover, in general, the timing of confronting post-traumatic patients with the demands for vocational rehabilitation may be premature, and programme activities may be too tight. The different eligibility criteria for receiving pension benefits point to an obvious inequity in social policy which causes a series of legal complaints.

Labour market participation can be seen as a crucial step in efforts to assist homeless people to participate in society. The analyses showed significant associations between job coaching of homeless clients and success in gaining employment and with the chances of sustaining employment. This applied to homeless clients of all ages but was most marked amongst younger clients (aged 18-24 years old). Finding positive interventions that help homeless young people into work is key as there is now evidence that a period of unemployment while young can lead to permanent disadvantages over the life course (28). However, the validity of the analyses was limited by several aspects, including selection-bias. Concerning the data set of the client's records, some inconsistencies in data collection were detected that may represent additional confounding. Job coaching as an intervention included many of the success factors identified by other studies including use of individual work place training, rather than classroom approaches. It engaged employers in the design and delivery of the programme, providing tailored support when transitioning to work (59-61). Job coaching of homeless clients could be seen as a reliable indicator of employment success but not as the only cause of labour market re-integration

It would seem that the factors listed above would not be enough on their own to guarantee successful entry into the labour market without the determination and drive of the client; likewise, determination and drive are not sufficient factors on their own to successfully secure and sustain employment, as the additional support sought by clients attests. The extent to which individual motivation plays a role, and how that motivation is created, sustained and can be measured, would need to be the subject of another study.

Furthermore, despite the caution voiced around the value of government programmes - for example, welfare-to-work programmes - they do hold some level of influence over how companies support disadvantaged groups. How companies recruit and support people from disadvantaged groups also depends on the culture of the organisation and the structure. Among the companies interviewed, the ones that reported a more paternalistic culture were more likely to try harder to support people from disadvantaged groups. Companies that were more federalised in structure or with a locally led CSR programme, reported difficulty in taking programmes to scale as ownership for HR or CSR was disparate. However, some decisions were driven by competitors. For example, the provision of private healthcare was a way to attract as well as retain staff. This was usually only available to employees at management level and above, and therefore this particular activity may act to reinforce health inequalities across the social gradient. The work carried out with disadvantaged groups was restricted to the CSR departments of the companies interviewed. The insight gained into how to ensure those employees thrived at work may not be shared with the people making the decisions on how to manage and support the health and well-being of all staff. However, it is likely that this insight could be applicable to other people in the workforce, particularly those in low-paid work. Finally, the companies included in this study did not view the employability work with which they were engaged in the context of promoting health equity. They recognised the benefits to be gained in terms of individual prosperity, social mobility and capital, and benefits to the company in terms of reduced costs, winning business, staff engagement and enhanced brand reputation.

4.3 Income, welfare, and social protection

Particular focus is placed on the design and quality of welfare policies across the life cycle, in particular unemployment protection programmes and early retirement schemes. Some of the key results regard the importance of coverage rates that are a primary prerequisite for replacement rates to be of importance. In short – with high coverage rates health becomes better with increasing replacement rates, in particular among the low education group. A crucial part of the toolkit developed to guide the planning, conducting and analysis of the focus group interviews was to create links with themes from the quantitative analyses. However, it is important to take into account that the differences in design and approach also create a number of 'incomparabilities'. Differences in findings can therefore not be interpreted as flaws in one or the other of these approaches, but must be seen as mainly a result of their different design.

One key difference in approaches that may generate 'incomparabilities' is that the case studies primarily focus on specific, targeted groups. These include the homeless, those on social assistance or long-term unemployed. This means that the case studies in general deal with inequalities regarding marginalised groups rather than inequalities as a gradient running through society as a whole. In contrast, the comparative quantitative studies are more focused on general systems of social protection, such as unemployment insurance policies,

and how these differ across countries. This difference is also important for the study findings. Where the quantitative studies in several cases show positive effects of high coverage and replacement rates for the high education groups and the employed, the case studies cannot detect such effects, although they may well be present.

There are of course limitations and shortcomings in all the studies, regardless of their design. Regarding the case studies, it may have been preferable to have more focus groups in each country in order to cover a broader range of groups. However, it must be stressed that the focus group interviews from Hungary, Poland, Portugal, Scotland/UK and Sweden have produced a wealth of voices that give a complex and partly disparate picture, as well as some clear themes that are more or less common across the countries. In turn, some of these themes strengthen and reinforce the main findings from the quantitative analyses undertaken, while other themes and findings are complementary.

The most striking is perhaps the strong focus on adequacy that emerges from the case studies, where participants give testimony of the importance of sufficient levels of support, which often is not the case for them. This theme echoes the repeated findings concerning the importance of high coverage and high replacement rates (62, 63). With low coverage or replacement rates there will be considerably less adequacy of the support given, and social protection policies will not be able to offer much of collective resources.

Another finding that comes out from the case studies is the importance of access to employment, and the potential importance of activation policies. This is reflected in the strong equalizing effects of active labour market policies seen for younger persons in one of our quantitative studies (64). There are also important themes from the case studies that complement the comparative analyses. One of these are the recurring reports of being degraded, devalued and even discriminated during contacts with welfare state workers. Unemployment officers, social workers and others, that many times may be pressured by cuts, big workloads and job stress, are not always treating their clients appropriately. Sometimes this may be personal shortcomings, but often it is rather systematic features, not least when e.g. unemployment 'services' are provided by private contractors. This is linked to Marshall's idea about the social citizenship (65), where duties are matched by rights and these rights are/should be quite different from providing charity.

Another important complementary issue relates to the increased use of conditionality as well as more rigorous eligibility criteria, particularly in programmes directed at those with lower income. The establishment of requirements that need to be met in order to receive benefits is not necessarily harmful, in itself but, like the issue of adequacy, the range of barriers encountered by people in need of support is often experienced as an extra burden and obstacle.

The comparative quantitative analyses carried out in DRIVERS focused on social rights as they are reflected in the type-case family coverage and replacement rates. However, these are in a way the end-products of the systems, the entitlements a typical person could count on to receive. The focus group interviews complement this with other aspects of the institutions that are set up to deliver social security. The organisation of these institutions and how to navigate through them in order to get the benefits are often brought up as problems and obstacles. A common theme emerging from the focus groups is the wish for more integrated and personalised services. While the organisation of services and support

follow a certain logic, with different types of risks handled separately, the individual user is more often than not in need of support from several of these institutions since they often experience problems caused by several of those risks simultaneously. When people's problems are integrated so should the services they require. The health services could play an important role in helping to obtain support from other authorities.

This links to the common finding of the key role played, or that could potentially be played, by the health services. The health services come out as a central provider of support and care in several of the focus group case studies. The importance of various NGOs is also highlighted, and while neither NGOs nor health services has been studied in our comparative studies they are of course very important for many people, and not only to cover purely medical needs.

Taken together, the focus group case studies summarised in this report and the quantitative and comparative work undertaken in the welfare, income and social protection strand of DRIVERS provides important insights regarding the role of income and social protection systems for health and living conditions in different segments of society. Health is better and inequalities smaller in societies where social security in terms of coverage and replacement rates are better. This applies to broad groups in society, but of course the more marginalised groups struggle more when social security systems do not offer adequate protection for periods of unemployment, to take one key example. And while the replacement rates are important, a high degree of coverage must first be achieved for replacement rates to be important. Only that way can adequacy be achieved – by including large shares of the population. But in addition to that the focus group reports stress that the institutions that administer the social protection schemes must be fair and treat their clients as people with social rights and entitlements. This remind us of a central feature of the idea of social citizenship (65) – that modern welfare states offer its citizens a combination of duties and rights, and that the availability of social protection is such a right that can be used when in need rather than a form of charity organised by the state. While cost–control measures can be necessary parts of efforts to handle economic crisis, and various controls of the people claiming their benefits can be important to retain a high degree of legitimacy for the system, there must also be a good deal of respect for the people that seek the assistance of the welfare state. The focus groups have revealed that this is still often not the case.

The welfare case studies were performed in the aftermath of the economic crisis starting in the financial sector in 2008. The consequences of austerity policies, as well as the consequences of a stronger emphasis on a 'leaner' welfare state in several of the case study countries, are clearly felt and articulated by the people in need of support that participated in the case studies. While austerity policies were not a main issue, the quantitative studies provided evidence on the matter.

According to data from Eurostat, Spain was one of the countries in which unemployment increased the most rapidly in comparison to other EU countries in 2008. In only twelve months nearly 1.5 million jobs disappeared, most during the last quarter of 2008. This was the most serious employment crisis faced by Spain to date, despite young people having higher levels of education than previous generations. This led to an unemployment rate of 26% in the second quarter of 2013 (17). Job loss took place in the private and public sectors, the latter following the austerity measures adopted by the Spanish Government. The case

study report on unemployed graduate youths in Tenerife suggested that quality employment needs to be one of the core elements of a social protection system.

This resonates the strong common theme emerging from both the quantitative comparative work as well as the case studies, namely that social protection is one important collective resource that contributes to better health and smaller health inequalities, in particular when individual and family based resources are not sufficient.

4.4 Advocacy for health equity

The section below describes the findings of the case studies and other work - a literature review and an expert workshop - that were carried out in DRIVERS to inform advocacy for health equity.

Dimension 1 – The kinds of evidence needed to advocate for health equity and how to transfer this knowledge to policy-making processes: The case studies brought together respondent's accounts of putting advocacy into practice in which they emphasised the need for cost-benefit data and the need to demonstrate the costs of inaction. They emphasised the importance of having strong evaluation evidence to back up arguments for the introduction of interventions. Similar to the literature review performed for the advocacy strand, the case studies emphasised the utility and persuasive force of using both qualitative and quantitative evidence, balanced according to audience. The persuasive power of quotations or success stories was mentioned in four out of the five case studies. Similar to the literature review, the case studies suggested that use of carefully chosen infographics, bulleted lists, carefully selected references and avoidance of jargon were important means of conveying information.

Dimension 2 – Who advocates for health equity and to whom?: The case studies highlighted the important roles played by policy makers and private foundations in advocating for health equity. As the Greek and Welsh case studies showed, the private sector can take action for a variety of different reasons, and may even act as advocates to government. Unlike in previous work, particularly the literature review, the potential advocacy role of scientists was not stressed.

Dimension 3 – Advocacy messages: The Finnish case study provides useful evidence about how to align messages with the interests of other sectors and the Greek case study showed that health could very well be utilised for advocating to the health sector, but that other themes (such as social cohesion) worked better in other sectors. Unlike the literature review, no mention was made of human rights arguments or those concerning environmental and social sustainability.

Dimension 4 – Tailoring arguments to different political standpoints: Like the other activities conducted, tailoring to different audiences was seen as a central part of advocacy for health equity. In Finland it was seen as essential to tailor to individual ministry: each had its own terminology, goals and working assumptions ("ideologies"). The Greek case study found that evidence, messages and formats had to be carefully tailored to different audiences. Qualitative and emotionally-oriented materials were more persuasive when advocating to the general public and private sector than policy makers. While tailoring of language is essential, it should be consistent with and draw on the evidence base.

Dimension 5 – Barriers (and enablers) of effective successful advocacy: Various enablers were identified. These included the importance of obtaining ‘buy in’ and commitment from people holding senior positions in government administrations and private organisations. In addition, it was seen as important to arrive at a consensus across different stakeholders, to encourage personal contact and co-operation between leaders of different organisations, and for managers to be part of networks on issues of interest. Some barriers had been noted in previous DRIVERS work: difficulties working across sectors and short-term political goals. Other barriers were new: austerity, which puts a strain on budgets and constrains actions that require investment, fear of additional burdens on overstretched staff, or even refusing to recognise a problem for political reasons.

Dimension 6 – Practices and activities that increase the effectiveness of advocacy efforts: The importance of finding champions for an advocacy effort and specific individuals that need to be convinced and taking advantage of windows of opportunity was emphasised. While relating directly to the individual advocacy case studies, they repeat those identified in the literature review.

4.5 Limitations and Strengths

These case studies had both strengths and limitations. These were conducted within set time periods and allocated resources, meaning they were by necessity limited in terms of the efforts that could be expended on them. Despite providing some guidance on how to report the work, there were differences in the formats used. Individual case studies varied to some extent in terms of their ‘fit’ with the wider advocacy for health equity work strand. The methodology employed for the case studies, while not fully harmonised, did show promise for future research on advocacy. The advocacy case studies directly involved the organisations concerned which can help their ongoing advocacy efforts.

5. OBSERVATIONS FROM EACH CASE STUDY AREA

The observations and key messages derived from the case studies are described below for each driver area.

5.1 Early childhood

Most programmes evaluated in the case studies were delivered in areas with low levels of service provision. The exception to this was Netzwerk Familie. The majority of families and children were from deprived backgrounds. Programmes that were not universal reached beneficiaries using a variety of methods. These included contact in hospitals after delivery, through social services, community groups and relatives. Only the universal health visitor programme delivered in Hungary began in the ante-natal period. The objectives of the programmes were to enhance children's health and development. These were delivered by staff members from the health, psychology and social sectors. Some –Toybox, Sure Start and the Theotokos centre - provided activities to stimulate children's learning through structured play and provided support and assistance for parents. In these three programmes the parents were actively involved in activities.

Establishing long-lasting trust-based relationships enabled the delivery of programmes and the provision of services, especially to socially isolated or hard to reach families and children. The programmes achieved better outcomes in children's health and development by providing flexible services, activities carried out by multidisciplinary teams and adapting to and understanding the families' circumstances. Empowering parents helped develop their own educational skills. By providing a comprehensive network of professionals across disciplines, programmes aimed to cover some of the gaps in insufficient ECD and health service provision. Specifically the key messages are:

1. It is important to provide access to a comprehensive range of universal quality early year services to reduce inequalities during the early development of children, especially for those who come from disadvantaged backgrounds.
2. Services should be proportionally tailored to social and economic need.
3. It is important to recognise the knowledge, capacities, and specific circumstances of parents if interventions aimed at young children and their parents are to be delivered effectively.
4. To ensure that parents have an active involvement in early years programmes, they should receive support and information to understand and contribute to the optimal development of their children.
5. Parents should be empowered to develop their own educational skills thus strengthening their ability to assist in their children's learning and development.
6. Existing ECD institutions and structures should be strengthened to promote cross-sector working between social and medical sectors.
7. The recognition, representation and funding of ECD in all areas of work and policy should be enhanced through high-level leadership. This includes promoting support for children who are deprived or vulnerable.
8. Programmes delivered in families' homes and in accessible centres should be evaluated so as to compare outcomes when using one or other of these settings or a combination of the two.

5.2 Employment and working conditions

Although the case studies included in this report differ in their target populations, methodologies and regional characteristics, some common elements can be identified that may enhance the chances of labour market participation and improve the security components of labour market policy, specifically among disadvantaged population groups.

First, it is obvious that well-developed national social and labour policies contribute to a significant extent to improved return to work rates, as evidenced in case of persons disabled by spinal cord injury in Switzerland. Second, specialised agencies in charge of vocational rehabilitation, e.g. non-governmental organisations such as Business in the Community in the UK, can achieve relevant improvements in returning socially disabled groups to work. Third, employers can have a pro-active role in this process, and specific motivations and mandatory regulations may enhance their commitment. Specifically the key messages are:

1. Special efforts are needed at different policy levels (national legislation, labour and social programmes; organisations and institutions responsible for medical and vocational rehabilitation services, employer organisations etc.) to improve return to work among disadvantaged population groups. However, rather than being directed to narrowly defined, formerly deprived subgroups, they should be developed as inclusive policies, addressing the whole spectrum of social inequalities in return to work. Respective policies can be organised in accordance with the principle of proportionate universalism, prioritising subgroups with special needs without neglecting measures that reduce social gradients of return to work within the whole of society.
2. Improving reintegration of disadvantaged population groups should be part of a larger societal movement that aims at strengthening equity and fairness of opportunities. Social norms reinforcing co-operation and a societal climate of solidarity are important elements in this process. Within and across enterprises, corporate social responsibility measures and explicit human resource management strategies addressing the needs of deprived groups should complement this development.
3. In times of macroeconomic crisis resulting in austerity measures of national policies and cuts in public spending priority should be directed towards maintaining decent levels of social security provision, of health care and of labour market participation. More specifically, infrastructures and personnel delivering rehabilitation services should remain capable of providing their support to all those who need it, rather than favouring population groups who can afford these services.
4. In designing rehabilitation services a client-oriented approach enabling individual counselling is to be preferred to a 'one-size-fits-all' strategy. Comprehensive skill training that includes a strengthening of social competencies and of work-related motivations and attitudes requires additional training of professionals providing these services as well as appropriate investments into personnel and facilities. Moreover, more effort in documenting and evaluating rehabilitation measures in a systematic and convincing way are required to make a strong case for their further promising development.

5.3 Income, welfare and social protection

The importance and role of social protection systems was emphasised throughout the focus groups across all countries. Focus group participants described the need for support to deal with changing life circumstances such as unemployment and ill health.

The experience of social protection varied across countries. The levels, adequacy and coverage all varied. Issues around administration, knowledge of rights and entitlements as well as thresholds and levels of support all shaped the experiences of claimants and their quality of life. The different demographic groups sampled had different needs from the social protection system. However, the importance of the social protection system and its relationship with health was a common theme.

A number of barriers and issues affected individuals' experiences of accessing support, such as ill health, disability, mental health, literacy, numeracy and language barriers. More targeted support was required to overcome these. In many countries participants spoke of distrust in the administration and service delivery. There were recurring reports of being degraded, devalued and even discriminated against in contacts with different welfare state staff. Unemployment officers, social workers and others, were under pressure from cuts, large workloads and job stress and did not always treat their clients appropriately. This was most common when services were provided by private contractors.

There was an increased use of conditionality and more rigorous eligibility criteria, in particular in programmes directed at those with lower income. The establishment of requirements to be met to receive benefits is not necessarily harmful in itself, but like the issue of adequacy, the range of barriers encountered are often experienced as an extra burden and obstacle.

A common theme was the need for more integrated and personalised services. While the organisation of services and support followed a certain logic, with different types of risks handled separately, the individual user frequently experienced multiple risks and therefore was more often than not, in need of support from several institutions. Specifically the key messages are:

1. The strong common theme emerging from both the quantitative comparative work as well as case studies, namely that social protection is an important collective resource that contributes to better health and smaller health inequalities, in particular when individual and family based resources are not sufficient.
2. Most striking is the strong focus on adequacy that emerges from the case studies, where participants give testimony to the importance of sufficient levels of support, which often is not the case for them. This theme echoes the repeated findings concerning the importance of high coverage and high replacement rates. With low coverage or replacement rates there will be considerably less adequacy of the support given, and social protection policies will not be able to offer much of collective resources.
3. Another area where case studies duplicate the quantitative findings is regarding the importance of access to employment, and the potential importance of activation policies. This is reflected in the strong equalising effects of active labour market policies seen for younger persons in one of our quantitative studies.
4. Institutions need to take better account of the many different types of programmes and services available as individuals experience problems caused by several risks

simultaneously. Since individual's problems are integrated so should ideally the services they require. The health services could play an important role in helping to obtain support from other authorities.

5.4 Advocacy for health equity

The case studies conducted as part of DRIVERS provide useful real-world examples of advocacy. They help corroborate the findings of the expert workshop, advocacy mapping exercise and literature review, and provide further evidence of effective practices across the six dimensions of advocacy for health equity. As noted in the literature review, empirical evidence of advocacy for health equity is scant, and these case studies go some way to providing new evidence to inform advocacy practice. It is useful to note some of the divergences between what was found by the literature review and the case studies: reduced attention to research methodologies, the more minor role assigned to scientists and public health, reduced emphasis on human rights and sustainability as arguments, reduced emphasis on neoliberalism as a pervasive barrier to advocacy, and the need for policy–research networks to help facilitate the production and use of research evidence in policy processes. This is not wholly surprising given the specific contexts and actors involved in these five case studies.

Of more interest are the convergences. In particular, these relate to the kinds of evidence useful for advocacy purposes, practices that improve the effectiveness of knowledge transfer and translation, complexity and dynamism in terms of 'who advocates and to whom', many of the enablers and barriers of effective advocacy, and the practices that can help improve effectiveness. In some cases, these case studies have nuanced and deepened knowledge, indicating just how useful empirical evidence is to this nascent field of research and hopefully encouraging future work on this important topic

6. CONCLUSIONS

The case studies reported here included very diverse interventions, services and policies. However together with the scientific evidence across the three driver areas they point to some key principles that may enhance the delivery of programmes and the provision of services. The case studies suggested that:

- Providing support by delivering personalised, responsive and readily available flexible services can help achieve improvements in promoting development in early childhood, returning socially disabled/at risk groups to work and dealing with changing and/or adverse circumstances.
- It is important to provide access to a comprehensive range of quality services for all to reduce inequalities across the Driver's areas, especially for those who come from disadvantaged backgrounds. Services should be tailored to social and economic need.
- The information provided by the interviews and focus groups illustrated that employers and staff can contribute to help overcome barriers in accessing support through specific motivations and regulations by delivering tailored and specialised programmes according to individual need.
- Multidisciplinary teams and key stakeholders can promote equity in health across the gradient by delivering evidence based, comprehensive and effective programmes and services and well-developed policies across all relevant sectors, although these should vary according to context.

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ANNEXES

The following DRIVERS reports should be considered annexes to this report.

Early child development

Morrison J, Goldblatt P, Pikhart H, Ruiz M. Early child development: Report on case studies. Report produced as part of the 'DRIVERS for Health Equity' project. Research Department of Epidemiology and Public Health, University College London. London: 2015. Available from: <http://health-gradient.eu/>.

Employment and working conditions

Siegrist J, Montano D, Hoven H. Case studies on selected return-to-work services for persons with disability and social disadvantages. Report produced as part of the 'DRIVERS for Health Equity' project. Centre for Health and Society, Faculty of Medicine, Heinrich Heine-Universität. Düsseldorf: 2015. Available from: <http://health-gradient.eu/>.

Income, welfare and social protection

McHardy F, Lundberg O. Report on Income and Social Protection for the EU Drivers Project: Synthesis of case study evidence compiled by European Anti-Poverty Network. Report produced as part of the 'DRIVERS for Health Equity' project. European Anti-Poverty Network. Brussels: 2015. Available from: <http://health-gradient.eu/>.

Focus groups with young unemployed graduates (La Laguna)

Darias-Curvo S & Betancort M. Young, well-educated and unemployed: The deterioration of social support and the labour market in the Canary Islands. Case study report produced as part of the 'DRIVERS for Health Equity' project. University of La Laguna. La Laguna: 2015. Available from: <http://health-gradient.eu/>.

Advocacy for health equity

Farrer L, Marinetti C. Advocacy for health equity: Case studies synthesis report. Report produced as part of the 'DRIVERS for Health Equity' project. EuroHealthNet. Brussels: 2015. Available from: <http://health-gradient.eu/>.



DRIVERS (2012-2015) is a research project funded by the EU's 7th Framework Programme. It aims to deepen understanding of the relationships between some of the key influences on health over the course of a person's life - early childhood, employment, and income and social protection - and to find solutions to improve health and reduce health inequalities.

The research is undertaken by a consortium including leading research centres and organisations representing the public health sector, civil society and businesses.