drivers
FOR HEALTH EQUITY

Improving health equity through action across the life course: Summary of evidence and recommendations from the DRIVERS project[1] – Annex A

Recommendations for (a) policy (b) practice and (c) research

	Early child development	Employment and working conditions	Income and social protection
(a) Policy	1. Early years policies and interventions should be of sufficient quality and scale in all member states to tackle the adverse health and developmental outcomes that result from a multiplicity of social factors that operate during early years. 2. Policies and services should empower parents of children to take control over their lives through an explicit, multi-dimensional and integrated strategy, support their children's health and development(beginning during early pregnancy) and promote a greater parenting role for men. This includes family-friendly employment policies (see WP3 for more details) to help parents combine work with their parental responsibilities.	1. It is important to raise awareness among policy makers, political leaders, and responsible stakeholders among employers, trade unions, and occupational health and safety professions, so that the following issues deserve high priority in decision making and planning processes: • There is solid evidence that distinct and defined characteristics of stressful psychosocial work environments in modern economies increase the risk of physical and mental disorders among workers, in addition to, or in combination with more traditional occupational hazards; • Exposure to these work- and employment-related adversities follow	1. Health is better and health inequalities generally smaller when larger efforts are made in terms of social protection policies. Hence, countries that do little can initiate something, countries that have some social protection can do more, and the countries that already do a lot can probably do it better. 2. Another general conclusion is that universalism is not only about high coverage rates or high replacement rates, but also that different types of risks may have to be addressed by different types of programmes. We therefore suggest that a multi-layer universalism that entails different types of programmes for different types of risks probably offers the best collective resource.

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		a social gradient, with less exposure among more privileged parts of the workforce. Particularly pronounced exposure and the related burden of disease is therefore higher among lower skilled people and those in atypical, unstable and dangerous employment; • These adversities can be monitored with reliable tools, their health impacts can be assessed, and interventions to reduce adversity and to strengthen the health of working people can be implemented at different policy levels. Moreover, models of good practice of such interventions are available, including information on their cost-effectiveness, thus addressing the business case; 2. Country-level social protection policies including active labour market policies and occupational health and safety regulations deserve high priority in national budget allocation and tax policies, particularly under conditions of financial constraints and related austerity measures;	3. The health consequences of welfare policies are complex, and in many cases we observe general improvements with little reduction of inequalities. Since the result of increased social policy efforts even in these cases is that the worse-off are better off, such policies should be recommended. 4. Complexity is found in terms of programme design – it is not simply a matter of more of everything. In the case of unemployment insurance it is clearly the case that the first priority is to ensure high or even full coverage, then to increase replacement rates.

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		3. The solid body of currently available knowledge needs to be disseminated through professional declarations by scientific networks, public media campaigns and related channels to motivate responsible stakeholders, political movements, NGOs and the broader public to call for action and to develop targeted initiatives; 4. As a first step of action, work- and employment-related adversities should be monitored in a systematic and regular way, using scientifically approved tools, and their health impact assessed in collaboration with occupational health and safety professionals. Ideally, monitoring would be supported by national regulations and related investments (e.g. Management Standards in the UK, Working Conditions Act in the Netherlands, Work Environment Act in Denmark), but voluntary agreements at regional or local/ enterprise level are useful attempts as well; 5. As a next crucial step, monitoring data need to be translated into policy plans using an established implementation cycle.	

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		To this end, guidance tools on psychosocial risk management approaches are available from the PRIMA-EF Programme. Policy plans can be developed and implemented at different levels, such as organisational level or macro-social level of national policies; 6. Appropriate occupational health and safety services, including the above-mentioned monitoring and programme development tasks, should be developed, financed publicly and independent of employers, prioritising their support to underserved occupational groups; 7. Given the gaps existing between declared national policy regulations/legislation and their implementation in practice, additional efforts are needed to promote healthy work and reduce health inequalities through formalised collaboration between stakeholders, voluntary agreements, and different forms of social dialogue, where the workforce is given voice in appropriate ways; 8. In view of large variations in quality of	

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		work and employment and in health inequalities of employed populations across Europe, and specifically between eastern compared to western, and southern compared to northern countries, policies at the EU level should be developed to reduce these variations by co-ordinating their efforts across established political sectors and resorts and by promoting pro-active strategies. 9. Even though price stability is a fundamental factor in ensuring stability of real income, and even though guaranteeing the competitiveness of enterprises is essential for income maintenance, these economic priorities should not be realised at the expense of fair wages, as is often the case. The goal of attaining high-quality working and living standards across Europe implies respective high production costs of high-quality goods and services. In turn, these costs should result in appropriately high real wages that guarantee a decent quality of life and work for all members of the society.	
(b) Practice	1. Actions should be taken to address the transmission of inequality between	1. The implementation of measures to reduce health-adverse work and	1. Regarding specific policies that have been studied, we can recommend that:

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	generations by: • ensuring that accessible, affordable and high-quality maternity and early years services are available to support and improve parenting capacities among parents and young people – in particular providing health and social care in pregnancy and childbirth and knowledge of effective parenting of young children. • early identification of at-risk families and referral to appropriate services. • ensuring the provision of adequate social protection for parents of young children and addressing the conditions of daily life which make positive parenting difficult (linking WP2 and WP4 – see more details in WP4). 2. Ensure that policies to increase the universality of access to high-quality and affordable early years childcare are promoted. Such policies need to focus on: • adapting interventions that have proven effective in other countries and contexts to to local conditions, through systematic	employment characteristics at the level of organisations, enterprises and businesses needs to be encouraged by enhancing compliance with occupational health and safety regulation; 2. Measures addressing physical, chemical and biological occupational hazards, and those concerning work time regulation, should be integrated into this comprehensive set of measures of promoting good work, by prioritising occupational groups with the greatest needs; 3. Organisational-level interventions addressing working conditions should take a participatory approach, involving employers/managers, professional experts and employees in appropriate ways and addressing change at all levels of the hierarchy, including leadership behaviour; 4. As a lack of control and reward at work are shown to be critical determinants of a variety of stress-related disorders and to be more prevalent among lower occupational status groups, focusing interventions on these dimensions and targeting less	• Increases in the extensiveness of active labour market policies and generosity of unemployment benefits specifically intended for youths are likely to improve health among young adults. • Increased coverage of unemployment insurance is likely to improve health, in particular among those who have a low level of education. • Given high coverage of unemployment insurance, an increased replacement rate is likely to improve health, in particular among low educated. • Increased levels of minimum Income benefits are likely to be linked to lower mortality rates. • Increased generosity of disability benefits is likely to improve health among disabled and sick in the older parts of the working-age population.

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	development and evaluation. • providing services that are of appropriate quality and scale to meet the needs of children most at risk of vulnerability and exclusionary processes. • ensuring levels of care are related to social needs within a framework of universal delivery, so as to reduce social inequalities in health and ECD (see more in Income and social protection report). • providing child care which is flexible to families' needs, thus allowing women to return to paid employment (see more in Employment and working conditions report).	privileged groups within the workforce should be high priorities; 5. The combined effects of making changes to the setting of the work environment and to employee behaviour are encouraged, especially so if the latter aims to improve resources of coping with adverse work as well as promoting a healthy lifestyle; 6. Adequate resources should be allocated to reducing work-related diseases, and to integrating disabled and sick workers into full employment, based on evidence of successful and cost-effective vocational rehabilitation models (e.g. individual placement and support , see also our final report on the case studies[1]).	
(c) Research	1. Greater investment is needed in long-term, harmonised birth cohort studies so as to better understand the variation - across the countries and regions of the European Union - in the lifelong effects of early childhood conditions on health and	1. It is recommended that systematic reviews of studies analysing work and employment as determinants of health inequalities observe best-practice principles in order to strengthen their case (e.g. focus on cohort studies, use of comprehensive,	1. There is a constant need to critically evaluate the concepts and tools we use, in our case how welfare state efforts and output can best be understood and measured. An institutional or expenditure approach is much more fruitful in this

[1] 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/.

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	developmental outcomes. This investment would be analogous to the current investment in labour force surveys and surveys of income and lifestyles. 2. Further evaluation of early years interventions should be carried out within the European context, especially in countries outside the UK. These should include results showing whether interventions had differential impact on disadvantaged groups. 3. Review the role of randomised controlled trials and alternative study designs (e.g. population-based cohort studies, multi-level analyses) to enable a pluralist approach to be taken in evaluating ECD interventions.	theoretically grounded and reliable exposure measures, appropriate statistical analyses); 2. It is recommended that the design, reporting and evaluation of interventions should comply with the best available procedures in social science research designs and statistics (e.g. use of validated measurement instruments, conduction of power analysis, correction of attrition bias, etc.); 3. It is recommended that cross-country studies analysing distal work-related determinants of health inequalities use comparable, well-justified indicators of relevant national labour and social policies, and that these distal determinants are linked with proximal determinants within a conceptual framework, such as the one proposed in our research programme, using appropriate statistical techniques of data analysis.	respect than welfare state regime typologies. It is clear that the findings we produce, and hence the recommendations we may provide, are much more clear and policy relevant when we apply either of the two former approaches. 2. On the basis of institutional or expenditure data, it is important to undertake more refined analyses where it is possible to disentangle different dimension of social policies, and analyse their independent and combined importance for health in different educational groups. 3. This combined approach is likely to require good data on institutional arrangements, social expenditure, as well as the full range of individual living conditions that constitute the individual level social determinants of health. Such data must be properly funded and collected on regularly. Examples include the ESS, EU-SILC, SHARE, etc., but also data on welfare institutions. 4. The social determinants framework has proven essential for a wider understanding of health inequalities, both by offering a better understanding of how health

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			inequalities are generated and by putting policies that address key drivers and their distribution in focus. But people are not only exposed to a range of conditions, and their life chances cannot solely be understood as the resources they control. People act, react and adopt, in different ways and to different extent in different social strata. In order to gain a better understanding of persistent health inequalities, we believe that there must be more room for human agency in the social determinants framework, and in particular 'health related human agency' (Freese and Lutfey 2011). The persistent inequalities in health also in the welfare states that spend the most prompt us to develop both our theoretical approaches and empirical studies further.