https://www.sciencedirect.com/science/article/abs/pii/S0149718912000262?via%3Dihub

Evaluation and Program Planning 36 (2013) 191–197

Contents lists available at SciVerse ScienceDirect

Evaluation and Program Planning

journal homepage: www.elsevier.com/locate/evalprogplan

Defining principles for good practice: Using case studies to inform health systems action on health inequalities

Sarah Simpson [a,*], Michael P. Kelly [b], Antony Morgan [b]

[a] *WHO Regional Office for Europe, European Office for Investment for Health and Development, Venice, Italy*[1]
[b] *Centre of Public Health Excellence, National Institute for Health and Clinical Excellence, United Kingdom*

ARTICLE INFO

Article history:
Available online 14 March 2012

Keywords:
Case studies
Programme evaluation
Evaluators
Data
Health inequities
Social determinants of health
Health systems Action
Health policy

ABSTRACT

This paper presents work using case studies as a source of data to see if we could extrapolate from the specific to the general particularly with regard to understanding what constitutes effective practice in taking action on SDHI and as a way of enabling policy makers to make better use of knowledge within the case studies and as a way of better understanding what works, in what context and why. Case studies are important to evaluators in that they are relatively straightforward to undertake and because those involved in implementing an intervention are usually keen to profile the intervention. A checklist described in this paper will enable policy advisers and evaluators to quickly review a case study and right away see if it contains enough information to assist in the development of policy options for reducing socially determined health inequalities.

1. Introduction

Socially determined health inequalities (SDHI)[2] in the WHO European Region[3] have been increasing (Corsini, 2010; European Commission, 2009; WHO Regional Office for Europe, 2009) and will continue to do so without determined action to counter the social determinants causing the inequalities. The social determinants of health refer to the social conditions, in which people are born, grow, live, work and age, that shape their health and disease exposures, vulnerabilities and outcomes. These social factors may include: employment and working conditions, living environments, availability of and access to health and social protection services, education and social cohesion or connectedness. They also refer to the way in which social class, gender, age and ethnicity norms, values, and discrimination, relate with other determinants of health to increase the vulnerabilities and risks that lead to health inequities (*avoidable and unjust systematic differences in health status between different groups* in a given society) (WHO Regional Office for Europe, 2009). While there has been improvement in overall health status within the region, it is not equally shared across populations either within countries or between countries (Ministry of Health & Social Policy of Spain, 2010).

In 2007 one of the authors (SS) was tasked with identifying examples of "good" practice of health systems actions to tackle socially determined health inequalities from among WHO European countries (WHO Regional Office for Europe, 2011). This task was part of a wider joint action between the World Health Organization (WHO) Regional Office for Europe and the European Union (DG-SANCO) to improve knowledge and tools for policy-makers and practitioners on health systems actions to improve health equity. "Good" practice was understood to mean activities that reduced health inequalities by action on one, some or several social determinants including the health system. However, assessing the quality of any practice – good, promising or best – implies being able to make some kind of an evaluative judgment. A best case scenario for the evaluator is where there are some internationally accredited standards against which to assess the practice. In the field of action on socially determined health inequalities we are not so fortunate, usually developing interventions and or assessing policy responses based on a set of principles largely derived from theory. This makes it a challenge to find specific and actionable knowledge for addressing health

---

* Corresponding author.
E-mail addresses: sjs@ihd.euro.who.int, simpsarahj@gmail.com (S. Simpson).

[1] The views expressed by the author do not necessarily represent the decisions or the stated policy of the World Health Organization.

[2] The term used here – socially determined health inequalities – is taken from the project brief and inequalities is the term used by the EU. We note that it refers to those "differences in health outcomes that are avoidable, unfair and systematically related to social inequality and disadvantage (Whitehead, 1990)."

[3] The WHO European Region encompasses 53 countries or Member States including the 27 countries within the European Union. For more information about which countries this includes please see http://www.euro.who.int/en/where-we-work. Examples were to be drawn from both EU and non-EU Member States within the Region.

0149-7189/$ – see front matter © 2012 Elsevier Ltd. All rights reserved.
doi:10.1016/j.evalprogplan.2012.03.007

inequalities – often we are left noting that ''it depends'' on the context. However this is beginning to change for the better.

There are many examples of initiatives to address the social determinants of health but few that have been systematically evaluated or documented against an agreed set of criteria that demonstrate the difference they make to health inequalities per se. Within the field of health inequalities and in the WHO European Region there is a strong emphasis on collecting examples of inequalities actions through case studies (e.g. DETERMINE project (European Portal for Action on Health Inequalities – Good Practice Database, 2010), HealthQuest (European Commission, 2008) and the case studies collected as part of the global Commission on Social Determinants of Health (WHO, 2011a)). There seems to be an assumption that case studies will *ipso facto* assist policy makers to take action. This paper presents work using case studies as a source of data to see if we could: extrapolate from the specific to the general particularly with regard to understanding what constitutes effective practice in taking action on SDHI; as a way of enabling policy makers to make better use of knowledge within the case studies; and as a way of better understanding what works, in what context and why. Case studies are important to evaluators in that they are relatively straightforward to undertake and because those involved in implementing an intervention are usually keen to profile the intervention. More importantly however case studies enable us to move beyond the numbers, particularly when an indicator or indicator(s) (e.g. differences in rates of physical activity between working age men with differing levels of education within a country) are seen has having an obvious cause and solution (e.g. to better target health education and information for men with lower levels of education).

2. Why is this knowledge important and needed?

When the joint action was conceptualised inequalities in the WHO European region were increasing and health systems within the region were undergoing significant change with potential gaps developing in universal access to health and basic health care services (WHO Regional Office for Europe, 2010a). At the same time, there had been growing awareness and recognition of the need to move beyond measuring and describing the problem of inequalities to looking at actions to better counter them (Millward, Kelly & Nutbeam, 2003). The establishment of the global Commission on Social Determinants of Health (CSDH) in 2005 with the aim to marshal the evidence on what can be done to promote health equity and to foster a global movement to achieve it (CSDH, 2008) is a seminal example of this increased awareness and commitment to substantive action for change. The CSDH came on the crest of efforts by policy-makers, academics, practitioners and governments in the preceding 10–15 years to improve accuracy of knowledge about the nature and extent of inequalities as well as identifying and putting in place policies and programmes to remedy the social determinants of health inequalities (Acheson et al., 1998; Mackenbach & Stronks, 2002). This included different initiatives using evaluations of interventions to generate and or identify the most effective and evidence-informed options for acting. For example the second 6 year programme by the Dutch during the 1990s as well as the national evaluation of Health Action Zones in England (Bauld et al., 2005).

The 6 year programme by the Dutch was designed to gain systematic experience with policies and interventions to reduce health inequalities (Mackenbach & Stronks, 2002). As part of this 12 evaluation studies were commissioned of a range of interventions to tackle inequalities such as an anti-poverty intervention identifying (5 and 11 year old) children during the preventive health screen whose health could possibly be jeopardised due to the lack of money in the home situation, and providing them with a supplementary grant, to be spent on a specific activity or product. The evaluative approaches ranged from observational to quasi-experimental to experimental. Of the 12 evaluation studies seven gave positive results, i.e. there was an improvement in a health outcome and or intermediate outcome such as a lower percentage of pupils in the experimental group who received the anti-smoking intervention commencing smoking as compared with pupils in the control schools. Another example of other outcomes evaluated included decreased physical workload and absenteeism among bricklayers who received training in a new working method for bricklaying but no change in the prevalence of health problems (Stronks & Mackenbach, 2005). The overall 6 year programme was part of an evidence-informed approach with a view to developing a national response. The Committee that oversaw the work wanted to recommend policies and interventions that were known to reduce the exposure of low socioeconomic groups to the factors that are known to contribute to health inequalities. Despite this important investment in evaluation (including use of a range of evaluative approaches) to generate sound evidence for policy action, there were gaps in both the coverage of various policy options and the strengths of the interventions. As a result, the Committee recommended implementation of a combination of both ''promising'' interventions and continued evaluation efforts (Mackenbach & Stronks, 2002; Stronks & Mackenbach, 2005).

The global fiscal crisis has exacerbated existing inequalities in the region with more people moving into poverty and requiring assistance from aid agencies (International Federation of the Red Cross Red Crescent Societies, 2009) including the finding that the Europe and Central Asia (ECA) Region was hit harder than any other region in the world by the global financial and economic crisis and will be the slowest to recover (World Bank, 2011). Such developments have accelerated the need for this knowledge. It has potentially also changed the type of knowledge demanded – policy makers want increased specificity of knowledge about the outcome from potential interventions. As indicated previously this created an incentive to see if we could move beyond generating general knowledge to more specific and actionable knowledge about ''what works and in what circumstances.''

3. The challenges in defining "best" or "good" practice in order to identify it

Terminology such as ''best'' and ''good'' practice bring to mind concepts of benchmarking and standards around which there is consensus and which can be used to assess or evaluate the practice. There are many studies which provide theoretical and even practice based indicators of what ''good'' practice might look like (WHO, 2011b) and how it might be measured (Mackenbach, Judge, Navarro & Kunst, 2007), but there is no real consensus about this, nor an easy system for capturing it. This relates not to the issue of inequalities nor health per se but to complexity and that interventions to improve health equity are usually complex. In addition, because the effectiveness of an intervention is dependent on the context in which it is introduced, we know that what works in one context may not work in another – so it is also important to assess the context. More often we end up with the conclusion that ''it depends''. Furthermore in order to understand the factors that contribute to making an intervention work and to develop a real world perspective, operational information is needed about implementation. This information is not always available nor considered. However this is changing as evidenced by the recent Spanish Presidency of the EU which included as one of its key issues, monitoring of the social determinants of health and the reduction of health inequalities (Ministry of Health & Social Policy of Spain, 2010). There is a strong foundation on which to build and on which we can improve, particularly with regard to incorporating more systematic approaches to the monitoring and evaluation of interventions from the very beginning. We need to draw more from the developments within the field of evaluation in the past 10 years, particularly realistic evaluation approaches (Pawson, 2009) where evaluation is understood to contribute to the development and design of programmes (Wimbush & Watson, 2000).

As indicated there has been a significant investment in generating (and often recycling) case studies about interventions to tackle SDHI, particularly in the past 8–10 years. However, our initial consultations with the intended users of the examples of "good" practice work indicated they were not convinced that case studies provided useful information in assessing or identifying what type of action was required. They noted that there are a plethora of case studies, of varying quality, but that they did not provide much by way of scientific understanding nor a basis for getting evidence into practice. In particular they were not convinced that policy-makers used case studies to inform policy development, noting the need to make the information in case studies more useful for uptake by changing how information was presented in case studies. Our challenge was to find a way of using case studies differently. We wanted to move from deriving key lessons from single case studies or grouping single examples around a theme to better syntheses of examples of equity actions. This would allow us to generate more specific information about patterns (WHO, 2011b) and the implications of these patterns for guidance (Kelly, Morgan, Bonnefoy, Butt & Bergman, 2007). In short we needed to find a way of moving from treating case studies as single entities to be used deductively. Our solution was to treat the totality of case studies, or more precisely a sub set of relevant case studies as heterogeneous data and using a qualitative approach to synthesise the available information to derive key themes and ideas across the sub set and use the data inductively. Where case studies are treated as single items or examples of good practice and an attempt is made to generalise on the basis of a single case, it presumes some notion of representativeness of the case. This cannot be assumed. Likewise the testimony of the respondents or the reporters of the case have to be assumed to be accurate and unbiased. Neither can this be assumed. Therefore it is much more reliable to pool data from multiple case studies. While of course this cannot eliminate bias nor inaccurate reporting, it is likely to be more representative and therefore more reliable *in toto*. However, unlike pooling numerical values in a meta analysis, we have to pool what are essentially qualitative data in the form of the reports of the various cases.

So we determined to make use of existing data and knowledge to assess whether existing interventions might be relevant to their context. Given the resource constraints that policy makers and practitioners usually face, this was important and particularly so given the significant investment in generating case studies in this field in the preceding years.

4. What we did, why and how?

We considered a variety of possible qualitative approaches and selected meta-ethnography as our starting point as it seemed to offer the most productive way forward and was well suited to the questions in which we were interested. A meta-ethnographic approach means that case studies (our examples) as developed by someone else are used as the source of information, knowledge or data and assessed for main themes and issues. To make this decision, we used the table developed by Dixon-Woods et al. as a basis for selecting the most appropriate qualitative method to use and in light of the circumstances (Dixon-Woods, Agarwal, Young, Jones & Sutton, 2004). The table helped us identify that being realistic, i.e. given available time and resources for the "good" practice work as well as being able to treat a sub-set of relevant case studies, we were best placed to use a meta-ethnographic approach. An alternative was using grounded theory but this would have involved time and resources that were not available to us. Our focus was on choosing an approach that would be "fit for purpose" and enable delivery of a set of largely existing examples in a format that policy makers and practitioners could make better use of for informing development of policy responses to reduce health inequalities.

The first step was to review the available case studies for main themes/concepts, synthesise the findings for each main theme/concept and then analyse the key issues arising from this synthesis (see Table 1). After this step was completed, SS and MK undertook an analysis of these main themes/concepts to identify higher order or translational concepts. For example, moving from the actual texts used in the 10 examples to define equity to identifying a refined and synthesised concept – what the 10 pieces of text said about understandings of equity and the objectives of action when looked at as a whole. Using these higher order concepts, we endeavoured to write the translational concepts up and refine further. This process proved to be quite difficult because we found that there was not enough reported information in some of the case studies used to derive such concepts. We therefore decided to focus on using the findings from the first step to do a policy and thematic analysis and which could be shared with policy-makers at a technical consultation.

Table 1
Template for initial synthesis of examples.

Main concept	Relevance to research question
Attitudes and beliefs (including potential for change)	Context for action – here we sought to record statements that captured how the authors viewed the scope for action
Mechanisms and processes	This was to identify if existing or new mechanisms and processes were used for development of the action. To translate evidence into action other policy makers need to know what others did to make it happen and to sustain it
Intelligence, knowledge and information	Whether new knowledge and information generation was required to create health intelligence or evidence or whether they were able to make the case based on existing knowledge and information
Role of health systems, sector and services	To capture the scope of the health systems response and role of the health system, e.g. was the health system instrumental in working with other sectors or was it very much a health system response
Equity – understanding, explicit, implied	The social determinants of health and equity are often assumed to be the same thing and are not. But also because in some cases equity is implied but not acted on
Timing and stage of development	To get an idea of the sustainability of the action, depth of knowledge and learnings and claims that can be made. This included information about monitoring and evaluation and the types of evaluation undertaken
Enablers	Important process information to assist policy makers in assessing the policy and political environment and regarding contextual factors that support the action
Challenges	As for enablers but the opposite. It may include explicit barriers or challenges or more subtle such as the introduction of other policies or programmes that work in contradiction to the health systems action for improving health equity
Other	To capture outliers and information not necessarily included in the main concepts but potentially relevant particularly in terms of context

We reviewed 10 existing examples from 13 that had already been identified through the consultative process, using the template at Table 1. The interventions reviewed in the 10 examples, covered a period of about 20 years with the earliest having been introduced in the late eighties. The 10 examples ranged from: a health promotion intervention for Roma communities using a peer mediator approach to generate knowledge about health needs within a Roma community and that has lead to major policy changes; through a public health policy which has 11 objectives, most of which have action on the social determinants as their outcome; through to a national whole of government approach to tackling social inequalities across the gradient based on synergies between national health, education and social sector policies (WHO Regional Office for Europe, 2010b).

Policy and thematic analysis showed that there is still need to differentiate between action on social determinants of health and actions to counter health inequalities. They are not the same thing but this is not always made explicit (Graham & Kelly, 2004). For example, we did a sub-textual analysis of the original text included in the original 10 case studies to see where and whether explicit mention was made of equity, or whether it could be implied and or whether it was absent. This enabled us to distinguish whether the action was intended to reduce health inequalities or simply to improve overall population health by tackling those social determinants that contribute to health. Second analysis of the text from the case studies in this section helped us derive greater specificity about the expected change in health inequalities. For example, is it to improve the health of a particular sub-group in the population such as migrants or to reduce the gap between two groups by increasing the healthy life expectancy of the lowest socioeconomic groups in the population at a faster rate than the healthy life expectancy of the highest socioeconomic group (Graham & Kelly, 2004). Only half of the 10 case studies reviewed in the original analysis could be seen as having a specific or specified equity objective. While, an improved focus on measurement and monitoring of the change attributable to action on health inequalities means that this is changing, there is still room for improvement in establishing interventions with more specific objectives and targets.

The examples reviewed highlight gaps in the information in the case studies about how the problem was conceptualised and the solution arrived at. Often this could only be inferred on the basis of limited information. This may be a feature of the use of case studies. Related to the former there are also gaps in information about the policy making process (especially its complexity) and environment. There seemed to be limited evaluation of the actual impact of actions on health inequalities although each example included some form of monitoring and evaluation. Following the initial synthesis, a second analysis was done incorporating some new case studies. This analysis highlighted that while there was limited evaluation of the impact on inequalities and or challenges in saying anything definitive: (a) evaluation and monitoring of inequalities interventions is improving; and (b) the examples represented a spectrum of evaluation activity going from before and after impact of the intervention through to ongoing monitoring on an annual basis. There is an increase not only in more regular use of evaluative approaches but also in the diversity of evaluation design.

For example at the project and local level, the community controlled programme for TB among Roma in Romania collected baseline data so as to be able to measure the impact of the peer mediator and health promotion campaign – before and after effect. Regular collection of data on specific health indicators, e.g. an annual health census together with a complete evaluation of the programme over 20 years, demonstrated that the health promotion among the Navarre Ethnic Minorities programme has meant that health services are increasingly responsive to the health needs as defined by Roma communities. In addition, the evaluation showed positive results in primary health care, women's health, health education and increased school attendance. Finally Norway decided not to use quantitative targets to measure its whole of government and intersectoral approach to tackling health inequalities. Instead, the annual public health policy report presents trends using a set of indicators for the intervention areas and these indicators are aligned with the objectives of the strategy (WHO Regional Office for Europe, 2010a, 2010b) and are based on the intervention map which sets out the theory of change underpinning their approach.

5. Case studies as data: the limitations, advantages and alternatives

Traditionally case studies have been thought to speak for themselves, to consist of empirical data which others will be able to act upon. The act of designing case studies and especially the art of reporting them however requires framing them within a narrative. The narrative provides context and background and some sense of the chronology of events. But as with all narrative it has a form which is typically triumphal, progressive, tragic and so on. The meaning of the story comes from its narrative form and invites the reader to see it typically as successful, or if unsuccessful, to offer a scapegoat or villain who is responsible for its failure (Kelly & Dickinson, 1997). There are a limited range of narrative forms which are used, and this is why the lessons learned from case studies tend to have a repetitive quality. In effect, we get the narrative form rather than the evidence of what has taken place in the intervention. It limits what we can say with any certainty about the results of evaluating actions to reduce health inequalities. This requires us to then be vigilant as evaluators or policy-advisers in questioning when something is presented as best practice and or the alignment of what is being presented as a "good" thing with what we are seeking to evaluate. For example, regarding the latter point, some of the examples focused on effective implementation of the intervention in terms of measurement of impact, i.e. issues such as number of people reached, cost effectiveness of the action and so forth. While important and interesting, it is not the real focus of our interest – we want to know from the evaluation if the intervention made a contribution to reducing inequalities.

In this project, we sought to work inductively by trying to take the narratives out of the case studies and determining what they really say, in so far as we can from the original case study. To do this we have had to determine what the content of the evidence says, try to understand the constructs which have been used to make the evidence fit a narrative and produce a set of concepts which transcend the narrative and the data. This type of approach involves assessing the degree to which concepts used in one study translate into other studies. The fact is different case studies use apparently different descriptions for similar social processes. On closer analysis of the narrative surrounding these concepts it is clear that sometimes, notwithstanding the semantics, the meaning is the same. The art of translation is determining the degree of overlap or similarity and then drawing this out thematically. This is important because it means that even though case studies appear to be different, this is not a barrier to the synthesis of the data nor of inductive reasoning. But context and narrative are crucial here because if the authors provide insufficient detail, the translation becomes terribly difficult.

5.1. *Limitations*

The outcome of a good case study is to provide insight. A case study is usually the intensive study of a single case for the purposes of generating insight (Gerring, 2007) into a particular issue. As identified, it is designed to tell a specific story and, by its nature, uses narrative or rhetorical tools that can lead to the information in the case study being treated as testimony rather than evidence. The case studies only tell us information they are designed to present and so do require supplementation with additional papers and or interview. Also, the case studies we reviewed were often not focused on describing the complexity of either the problem or the causes. Often assumptions were made about the nature of the problem and its causes rather than making a presentation of evidence to support this problem statement and the subsequent solution. In part this may be due to word limits and the focus and design of the case study template. With the exception of 2–3 of the case studies, they were often about the intervention rather than the processes that surrounded the intervention per se.

Our selection of case studies was chosen to help illustrate typical examples of these types of interventions. Given available time and resources, we sought to identify existing examples that met our criteria, in particular – the case study or write up included enough information to answer key questions, there was a health system focus or the health sector was a key proponent of the action, and there was a focus on social determinants at a minimum and or health inequalities. While half of the examples had been developed for a larger study and using the same template, they still remain explanatory in nature. It is therefore challenging to compare or consolidate them to make a point. For example, we found that in terms of the equity objective, two thirds of the examples reviewed could be categorised as remedying health disadvantage (WHO Regional Office for Europe, 2010b). Finally while not unique to case studies there was often limited information about effectiveness in relation to impact on inequalities and therefore relevance for uptake by policy makers. It relates to both a (previous) lack of investment in systems and capacity for monitoring and application of such data in relation to health inequalities impact as opposed to process or impact evaluation of the intervention. Also it is driven by the previous lack of specificity in the objectives of programmes, e.g. what is the actual equity objective.

5.2. Advantages

Case studies are an existing and readily available source of information which is important for policy makers with limited time and resources. For our field and our region there are plenty of them about the same or similar interventions. This means that some triangulation is possible without additional follow up or interviewing the authors or policy makers themselves. They are increasingly accepted as a form of data which can be used to inform policy development (see for example the work of the CSDH) (CSDH, 2008). The limitations previously identified may also lie with the quality of case studies rather than the method itself and making better and more systematic use of case studies as a source of data rather than exemplar. Finally the global synthesis of health systems actions to improve health equity undertaken as part of the work of the CSDH represented a global synthesis of the evidence on this issue and provided a basis from which to systematically review existing case studies of action. For example, the health systems knowledge network identified four features of health systems with the potential to promote health equity (Gilson, Doherty, Loewenson & Francis, 2007).

Given the processes used by the CSDH knowledge networks to collate and synthesise evidence, these four features – intersectoral action, universal coverage, primary health care and participation and engagement – were seen as having an external validity which could be used to review the case study examples (Gilson et al., 2007). Furthermore the four features identified by this knowledge network were not radically different from what was known and being applied within the field of social determinants and action on health inequalities.

5.3. Alternatives

As indicated previously, grounded theory was the other alternative that we considered. However it was not used because of the limited time and resources available to us for this work. Another alternative is to undertake a systematic review, which is often used in this field. One systematic review undertaken to generate evidence on the impact of wider public health interventions which affect the SDH and health inequalities was identified. It included a focus on access to health and social care but found only four reviews in the ‘‘access to healthcare’’ domain (Bambra et al., 2008). Again, given the parameters of the project (available time and resources) plus the specific mandate to collect examples for a web-based resource, we chose to make better use of the existing available data in case studies.

The 6 year programme undertaken by the Dutch and mentioned previously, used a systematic research based approach and put 12 evaluation studies in place using observation, quasi-experimental or experimental design to compare health outcomes and process measures usually between an experimental and a control group (Stronks & Mackenbach, 2005). This is another possible alternative. Apart from the ethical issues in getting such an evaluation approved, there were limited resources and time available for our approach. Even with this investment and the time available (6 years), problems still remained with the coverage and strength of evidence. The Dutch Committee overseeing the work, noted that no single country can contribute all the knowledge needed for action because of restricted opportunities for implementing and evaluating policies and interventions in any one setting (Mackenbach & Stronks, 2002; Stronks & Mackenbach, 2005).

While we have briefly described one approach to interrogating case studies for information on the effectiveness of interventions to improve health equity, we recognise that the approach used to developing the intervention in the first place will not have been simple nor linear. There is additional work going on in the WHO European region which will go some way to addressing this gap through a series of policy learning case studies which look at the factors and action that came together to create the circumstances that enabled the introduction of the particular intervention or action (Strand, Brown, Torgersen & Oyvind, 2010).

6. Some of the implications in taking a realist approach

Policy makers and practitioners may not always need to generate new data to assess or evaluate the relevance and potential effectiveness of an intervention for their practice. Existing case studies provide an important and rich source of data in this field and it is important not to overlook them. Related to this, existing qualitative approaches can be used to review and synthesise such examples. Practitioners may therefore not have to undertake a major exercise requiring significant additional funding and or new methodology to evaluate interventions for their health inequalities impact. It is important however to continue to be vigilant about: differentiating between action on social determinants of health and action on social determinants of health to tackle health inequalities; and identifying if there is really enough information about the actual impact of the intervention on inequalities. It is easy to become enamoured with the description of the intervention and its successful implementation, e.g. 12 training courses held, 250 professionals trained and not look beyond this to see if it (a) had a health impact and (b) if it impacted on inequalities (as defined by the programme). While this information needs to be collected for monitoring of implementation, it can distract from the central question – did the particular policy or intervention make a difference to SDHI? And how? It tells us perhaps about the mechanisms and context but nothing about the outcomes.

Given the time and resource (human and financial) constraints of the policy making environment, it is important to choose approaches for generating evidence in way that is "fit for purpose". This includes making better use of unpublished knowledge and or tacit knowledge (knowledge that is implied or unknown), particularly that which has been created through implementation and learning from practice. Case studies are one mechanism for ensuring that tacit knowledge is systematically collected (Kelly et al., 2007) and for generating evidence from practice about what does or does not work in taking action on SDHI. It is important however to also use a systematic approach in generating and or reviewing the available sources of evidence.

After we undertook the original synthesis of the 10 examples described in Section 4, a detailed template for reviewing existing examples of action and capturing new examples was developed. Fifteen examples (including 9 of those reviewed for the original synthesis) were then developed using this template and were analysed as a set more recently (WHO Regional Office for Europe, 2010b). From this work a checklist (Gawande, 2010) of generic principles was developed for policy advisers or entrepreneurs to use in reviewing existing examples of health systems actions and seeks to advance work in this area by demonstrating how to systematically use and generate evidence-informed options for action from the knowledge contained in a selection of case studies. By policy advisers and entrepreneurs we mean those actors involved in the policy-making process within and outside of government agencies and who are responsible for developing evidence-informed options for action and or for advocacy purposes but who may not be the final decision makers. The checklist is in effect eight key questions that seek to prompt the user to think about the example in a simple and systematic way. Box 1 includes the main eight questions. The checklist can also be used to assist in developing a policy or interventions.

The template for capturing examples includes information on: (a) contexts both in which the action is delivered as well as how they were developed or designed; (b) mechanisms for delivery of the intervention including available resources, structures and capacity building; and (c) outcomes, including the type of monitoring and evaluation that has taken or is taking place. Together with the checklist this should assist policy-advisers in developing evidence informed options suitable to their context. That is, as far as possible, the information in the examples is presented in a descriptive format rather than testimony, so that policy advisers can make their own evaluation about the *fit of the action* to their own context. While the original audience referred to policy-makers, this work has enabled us to make a distinction within this group because policy advisers and entrepreneurs are likely to seek and need to use much more detailed and technical information in constructing the evidence-informed options for action on socially determined health inequalities for consideration by decision makers.

Box 1. The checklist.

1. Is it about action on SDH with the objective of reducing health inequalities? Or does it focus only on tackling the SDH without regard to distribution of impact, i.e. health inequalities?
2. Is the equity objective clearly defined?
3. Do the equity objective and actions match the problem or issue they are designed to address?
4. Has the action been evaluated for its impact on health inequalities?
5. Is the action consistent with the broader policy context? For example, is the social protection system also designed to promote universal coverage? Is there enough information about the broader policy context to be able to assess this?
6. Is there enough information about the health (and/or social) system context to identify essential or fundamental features that need to be in place to support the action?
7. Were additional human, financial and other resources required for implementation of the action, or was it done by redirecting existing resources?
8. What investment was made in building capacity to act and to implement the health-system action? Is there any evidence that this has made a difference to practices within the health system (Gawande, 2010)?

7. Implications for the practice of evaluation and programme planning

Although general in nature, the checklist is useful as an evaluative lens, it enables policy advisers and entrepreneurs to quickly review an example and right away to see if it contains enough information to assist in the development of policy options for reducing socially determined health inequalities. In particular the first 4 questions force the user to check whether the example is actually about reducing socially determined health inequalities and not just overall population health improvement through action on social determinants. As we have seen just because an example is included in a wider set of related examples under the umbrella of action on the social determinants of health, it does not mean that it has a focus on improving health equity. The checklist is intended to enable policy advisers and entrepreneurs to move beyond the narrative of any case study about action on socially determined health inequalities to identify specifically what was done, to whom and its actual contribution to reducing health inequalities.

The checklist can be used to interrogate, evaluate and better understand examples of action, so that these examples can be adapted and reshaped to achieve a better fit with prevailing circumstances of the particular health system (Kelly et al., 2007; WHO Regional Office for Europe, 2010b). This work is an important example of how existing knowledge can be made more accessible to policy-advisers and entrepreneurs if we use methods that are "fit for purpose" (Kelly et al., 2007) in constructing the evidence base for policy action on SDHI.

Acknowledgements

The original work on which this article is based was undertaken as part of a WHO and European Commission joint project, and received funding from the European Commission under the Public Health Programme 2003–2008.

References

Acheson, D., Barker, D., Chamber, J., Graham, H., Marmot, M., & Whitehead, M. (1998). *Report of the independent inquiry into inequalities in health (the Acheson Report)*. London: The Stationery Office.

Bambra, C., Gibson, M., Petticrew, M., Sowden, A., Whitehead, M., & Wright, K. (2008). *Tackling the wider social determinants of health and health inequalities: Evidence from systematic reviews.* York: Public Health Research Consortium. Retrieved from http://www.york.ac.uk/phrc/D2-06%20Final%20Report.pdf.

Bauld, L., Judge, K., Barnes, M., Benzeval, M., Mackenzie, M., & Sullivan, H. (2005). Promoting social change: The experience of Health Action Zones in England. *International Social Policy, 34*(3), 427–445.

Corsini, V. (2010). *Highly educated men and women likely to live longer. Life expectancy by educational attainment. Population and social conditions. Veronica Corsini. Eurostat.*

Statistics in focus. Retrieved from http://epp.eurostat.ec.europa.eu/cache/ITY_OFFPUB/KS-SF-10-024/EN/KS-SF-10-024-EN.PDF.

Dixon-Woods, M., Agarwal, S., Young, B., Jones, D., & Sutton, A. (2004). *Integrative approaches to qualitative and quantitative evidence*. London: Health Development Agency. Retrieved from http://www.nice.org.uk/niceMedia/pdf/Integrative_approaches_evidence.pdf.

European Commission (2008). *Quality in and equality of access to healthcare services.* European Commission, Directorate-General for Employment, Social Affairs and Equal Opportunities. Retrieved from http://www.epha.org/a/3177.

European Commission (2009). *Solidarity in health: Reducing health inequalities in the EU.* Brussels: Commission Communication. Retrieved from http://ec.europa.eu/health/archive/ph_determinants/socio_economics/documents/com2009_background_en.pdf.

European Portal for Action on Health Inequalities – Good Practice Database (2010). *Project DETERMINE*. Retrieved from http://www.health-inequalities.eu/HEALTHEQUITY/EN/good_practice_database/.

Gawande, A. (2010). *The checklist manifesto*. Great Britain: Profile Books.

Graham, H., & Kelly, M. (2004). *Health inequalities: Concepts, frameworks and policy*. London: Health Development Agency.

Gerring, J. (2007). *Case study research. Principles and practices*. USA: Cambridge University Press.

Gilson, L., Doherty, J., Loewenson, R., & Francis, V. (2007). *Challenging inequity through health systems*. Final report of the Knowledge Network on Health Systems, WHO Commission on Social Determinants of Health. Retrieved from http://www.who.int/social_determinants/resources/csdh_media/hskn_final_2007_en.pdf.

International Federation of the Red Cross Red Crescent Societies (2009). *The economic crisis and its humanitarian impact on Europe. Testimonies from the Red Cross Red Crescent*.

Kelly, M. P., & Dickinson, H. (1997). The narrative self in autobiographical accounts of illness. *Sociological Review, 45*, 254–278.

Kelly, M., Morgan, A., Bonnefoy, J., Butt, J., & Bergman, V. (2007). *The social determinants of health: Developing an evidence base for political action*. Final report to World Health Organization from Measurement and Evidence Knowledge Network. Retrieved from http://www.who.int/social_determinants/resources/mekn_final_report_102007.pdf.

Mackenbach, J., Judge, K., Navarro, V., & Kunst, A. (Eds.). (2007). *Strategies to reduce socio-economic inequities in health in Europe: Lessons from the Eurothine Project in tackling health inequities in Europe: An integrated approach.* Eurothine: Final report, Erasmus MC, University Medical Centre Rotterdam. Retrieved from http://survey.erasmusmc.nl/eurothine/index.php?id=112,0,0,1,0,0

Mackenbach, J., & Stronks, K. (2002). A strategy for tackling health inequalities in the Netherlands. *British Medical Journal, 325*, 1029–1032.

Millward, L., Kelly, M.P., & Nutbeam, D. (2003). *Public health interventions research: The evidence.* London: Health Development Agency. Retrieved from http://www.nice.org.uk/aboutnice/whoweare/aboutthehda/hdapublications/hda_publications.jsp?o=497.

Ministry of Health and Social Policy of Spain (2010). *Moving forward equity in health: Monitoring social determinants of health and the reduction of health inequalities.* An independent report commissioned through the Spanish Presidency of the EU. Madrid, Spain. Retrieved from http://www.msps.es/profesionales/saludPublica/prevPromocion/promocion/desigualdadSalud/PresidenciaUE_2010/conferenciaExpertos/docs/haciaLaEquidadEnSalud_en.pdf.

Pawson, R. (2009). *Evidence-based policy: A realist perspective*. London: Sage.

Strand, M., Brown, C., Torgersen, T.P., & Oyvind, G. (2010). *Setting the political agenda to tackle health inequity in Norway. Studies on social and economic determinants of population health, no. 4*. Copenhagen: World Health Organization. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0014/110228/E93431.pdf.

Stronks, K., & Mackenbach, J. P. (2005). Evaluating the effect of policies and interventions to address inequalities in health: Lessons from a Dutch programme. *European Journal of Public Health, 16*(4), 346–353.

Whitehead, M. (1990). *The concepts and principles of equity and health*. Copenhagen: WHO Regional Office for Europe (document number: EUR/ICP/RPD 414; http://whqlibdoc.who.int/euro/-1993/EUR_ICP_RPD_414.pdf, Accessed 16.05.10).

Wimbush, E., & Watson, J. (2000). An evaluation framework for health promotion: Theory, quality and effectiveness. *Evaluation, 6*, 301–321.

CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva: World Health Organization. Retrieved from http://www.who.int/social_determinants/thecommission/finalreport/en/index.html.

WHO Regional Office for Europe (2009). *The European health report: Health and health systems.* Copenhagen: WHO Regional Office for Europe. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0009/82386/E93103.pdf.

World Bank (2011). *Europe and Central Asia*. Retrieved from http://web.worldbank.org/WBSITE/EXTERNAL/COUNTRIES/ECAEXT/0,contentMDK: 21722062~pagePK: 146736~piPK: 146830~theSitePK: 258599,00.html.

WHO Regional Office for Europe (2010a). *Poverty and social exclusion in the WHO European region: Health systems respond*. Copenhagen: WHO Regional Office for Europe. Retrieved from http://www.euro.who.int/__data/assets/pdf_file/0006/115485/E94018.pdf.

WHO Regional Office for Europe (2010b). *Putting our own house in order: Examples of health system action on sociallydetermined health inequalities*. Copenhagen: WHO Regional Office for Europe.

WHO (2011a). *Social determinants of health. Country Work Stream 2005–2008*. Retrieved from http://www.who.int/social_determinants/thecommission/countrywork/en/index.html.

WHO (2011b). *Social determinants themes. Formerly knowledge networks*. Retrieved from http://www.who.int/social_determinants/themes/en/.

WHO Regional Office for Europe (2011). *Where we work*. Retrieved from http://www.euro.who.int/en/where-we-work.

Sarah Simpson is currently a Project Manager with the WHO European Regional Office for Investment for Health and Development in Venice, Italy. In this position she is responsible for a joint EC and WHO/EURO project on health equity which includes developing tools for information sharing on health systems action to address socially determined health inequalities, and working with countries to strengthen their capacity for acting to improve health equity. Before joining the WHO Regional Office for Europe, she was the Coordinator of 8 of the 9 Knowledge Networks of the global Commission on Social Determinants of Health, in WHO, Geneva. Before joining WHO, she was the Programme Manager, Health Impact Assessment at the Centre for Health Equity Training Research and Evaluation (CHETRE), NSW, Australia which included the establishment of a capacity building programme for Health Impact Assessment.

Professor Mike Kelly is Director of the Centre of Public Health Excellence at NICE where he leads on the development of public health guidance. He is Honorary Senior Visiting Fellow in the General Practice and Primary Care Research Unit, Institute of Public Health, University of Cambridge. He is a Fellow of the Faculty of Public Health and an Honorary Fellow of the Royal College of Physicians. In 2010 he was awarded the Alwyn Smith Prize of the Faculty of Public Health for his work on cardiovascular disease and alcohol misuse prevention.

Antony Morgan is an Associate Director in the Centre for Public Health Excellence National Institute for Health and Clinical Excellence (NICE), England, he trained originally as an applied chemist and later in information science and epidemiology. He has worked in Public Health in the English NHS for the last 28 years, at district, regional and national level; he is a Fellow of the UK Faculty of Public Health. At NICE he is currently responsible for producing public health guidance across a range of public health topic areas, including inequalities, community engagement, social and emotional wellbeing of children, sexual health, alcohol misuse, quitting smoking during pregnancy, domestic violence and Hepatitis B and C.