Health inequalities in European cities: Perceptions and beliefs among local policymakers

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2013-004454
Article Type:	Research
Date Submitted by the Author:	15-Nov-2013
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Primary Subject Heading:	Health policy
Secondary Subject Heading:	Qualitative research, Public health, Epidemiology
Keywords:	Health inequalities, Public policies, Municipal government, Policymaker, Knowledge, QUALITATIVE RESEARCH

Tables

Table 1. Description of the 19 informants*

Identification	City (Country)	Status	Profile	Party
1	Amsterdam (Netherlands)	Officer	Health	NA
2	Barcelona (Spain)	Politician	Health	Eco-socialism
3	Barcelona (Spain)	Politician	Non-Health	Eco-socialism
4	Brussels (Belgium)	Officer	Health	NA
5	Cluj-Napoca (Romania)	Officer	Health	NA
6	Helsinki (Finland)	Officer	Health	NA
7	Lisbon (Portugal)	Politician	Non-Health	Social democracy
8*	London (United Kingdom)	Officer	Health	NA
9*	London (United Kingdom)	Officer	Health	NA
10	Madrid (Spain)	Officer	Health	NA
11	Madrid (Spain)	Officer	Health	NA
12	Paris (France)	Officer	Health	NA
13	Prague (Czech Republic)	Officer	Health	NA
14	Prague (Czech Republic)	Officer	Health	NA
15	Rotterdam (Netherlands)	Officer	Non-Health	NA
16	Stockholm (Sweden)	Politician	Health	Christian democratic
17	Stockholm (Sweden)	Politician	Health	Social democracy
18	Turin (Italy)	Politician	Non-Health	Social democracy
19	Turin (Italy)	Politician	Non-Health	Social democracy

^ NA= Not applicable

* Both informants 8 and 9 from London were interviewed together. The information was generated through 18 in-depth interviews.

Table 2. Further verbatim quoted by the interviewees responding to topics in the interview guide

	Verbatim	ID*
"Can you explain your point of view on health inequalities and their causes?"	*"In Prague there exist some people socially excluded voluntarily and it is very hard to provide health care for those people."*	13
"Is tackling health inequalities a priority of the city government?"	*"For us, it is. It is a priority for a very important part of Madrid Health."*	11
	"You cannot make a separate health policy. Health is a right granted to all persons."	5
"Do you have periodic information on health inequalities?"	*"There is no information. There is no assessment."*	7
	"Yes, we have periodic information on health inequalities and their social determinants…we want to comprehend inequalities, we want them to surface through knowledge because it legitimises developing policies to tackle them."	3
"Are there policies aimed at reducing health inequalities?"	*"The National Support Team model is to work with local partnerships. It's not to work with the health service."*	8
"Which opportunities and barriers do you face when reducing health inequalities?"	*"We come across them all the time and a very important one is the financial issue. Every year we have less money and the crisis only makes it worse."*	13

* Participant identification

Box 1. Interview topic guide

Topics
• *Can you explain your point of view on health inequalities in [name of city]?* • *Which do you consider are the causes of these health inequalities?* • *Is tackling health inequalities a priority in [name of city] or your local area?* • *Do you have periodic information on health inequalities and policies designed to reduce them?* • *Are there policies aimed at reducing health inequalities in [name of city]? Could you name and describe them?* • *Do these policies cover different areas?* • *Were these policies designed with the participation of different social agents?* • *Sometimes some opportunities arise which may enable the implementation of interventions or policies. Please, can you provide any experience or thoughts about this?* • *Which barriers do you face when reducing health inequalities?* • *Do you know of policies funded with European structural funds?*

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ABSTRACT

Introduction

Policymakers are responsible for decision and policy making in the form of laws, guidelines, and regulations. Their knowledge, beliefs and perceptions are relevant in the implementation of these but little is known on the subject and whether it varies across European cities. The objective of this study was to describe the knowledge and beliefs of public policymakers on social inequalities in health and policies to reduce them in cities from different parts of Europe during 2010 and 2011.

Methods

This is a phenomenological qualitative study conducted in thirteen European cities in 2010-2011. The study population consisted of elected politicians and officers with a directive status from these cities. The information was collected by interviewing 19 informants individually. A thematic interpretive content analysis was performed with the support of Atlas.Ti software.

Results

Health inequalities were perceived by most policy makers as differences in life expectancy between population with economic, social and geographical differences. Reducing health inequalities was a priority for the majority of cities which use surveys as sources of information to analyse these inequalities. The majority of policies and interventions were targeted at modifying health behaviours and few were inter-sectoral. Bureaucracy, funding and population beliefs were the main barriers.

Conclusions

It is essential to promote inter-sectoral collaboration and participatory policymaking processes and improving local and national collaboration as well as further monitoring and research. Furthermore it is crucial to train policy-makers and officers and provide them with proven effective measure to tackle health inequalities.

Keywords: Health inequalities, public policies, municipal government, policymaker, knowledge, qualitative research, urban health.

Word count: 5550

Limitations

- Not all the INEQ-cities partners had previous experience with qualitative research methods and their techniques of data collection.
- The topic guide was sent to some of the interviewees beforehand upon request, therefore, it is possible that they may have prepared the answers for the interview.
- In some cities, either officers or politicians were interviewed; it might have been more desirable to have one of each for every city.
- As the interviewees were selected by INEQ-Cities partners from each city, in some cases these were chosen by convenience sampling.

Strengths

- The interviewees included many examples of their everyday experiences and realities providing rich and detailed information.
- Carrying out the interview, an activity seldom performed previously among policymakers, possibly drew them to review the issue, update their knowledge and learn about the INEQ-Cities project and its results on heath inequalities in their cities.
- Since this is an exploratory study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, it will hopefully be a stepping stone for further qualitative research on the topic.
- This study has the important advantage of having collected information from quite a large number of cities throughout Europe.

Introduction

Health inequalities in urban environments are complex (1,2), affect the entire population throughout the health gradient (3) and require a multi-sectoral approach to address multiple social and economic determinants (4). To that effect, although city governments' competences and authorities vary, these have jurisdiction to develop strategic plans and policies, provide services and deliver interventions which may address health inequalities (5-7).

Within governments, policymakers are responsible for decision and policy-making in the form of laws, guidelines, and regulations (8), therefore, their knowledge, beliefs and perceptions are relevant in the implementation of these. Whether the concept of the social determinants of health inequalities is imbedded in their discourse (9,10) in addition to the information on health issues provided to them as reports or surveys by sources such as research centres or universities, may determine the course of the policy-making process (11,12). Furthermore, their perceptions regarding the responsibilities and priorities of city governments and their strategic plans possibly influence the policies in place (5,13). Hence, these issues along with how policymakers make use of their knowledge will influence decision making and affect how health inequalities are addressed by city governments (8,14,15).

The majority of studies exploring the knowledge and beliefs of health inequalities have explored lay perceptions (16-19), furthermore, the few studies describing expert's beliefs focus on researchers and policymakers working in regional and national governments (9,20-22). To our knowledge, there are only a small number of studies concentrating on policymakers working in city governments (23) but no qualitative studies have compared the perceptions of policymakers in different European cities. Therefore, the objective of this study is to describe public policymakers' knowledge and beliefs regarding social inequalities in health and policies which aim to reduce these in thirteen European cities during 2010 and 2011.

Methods

Methodological development

We carried out a descriptive and exploratory qualitative research study from a phenomenological perspective (24) as it sought to capture policymakers' unique accounts of reality in order to capture a breadth of discourses on health inequalities (25). Data was collected from thirteen cities (Amsterdam, Barcelona, Brussels, Cluj-Napoca, Helsinki,

Lisbon, London, Madrid, Paris, Prague, Rotterdam, Stockholm and Turin; see Table 1) from eleven different European countries participating in the Socio-economic inequalities in mortality: evidence and policies in cities of Europe 2009-2012 (INEQ-Cities) project (26) during the years 2010 and 2011.

Participants and sampling technique

The study population consisted of nineteen public policymakers, selected through convenience sampling, see Table 1 (25,27), working in the aforementioned cities' governments during the research period. A sample of elected politicians which included councillors and or aldermen and high ranked, non-elected, officers was selected. Policymakers were chosen from the health sector as well as other non-health sectors to provide a wider range of discourses. Interviews were performed by INEQ-Cities' partners, who interviewed a maximum of two participants, in their respective cities. Furthermore, subjects were chosen only if they held a decision making position.

Data collection and generation techniques

Eighteen semi-structured interviews were carried out, within these, seventeen were individual and one had two informants. They were performed from November 2010 to June 2011 using an open-ended question topic guide (Box 1). The interviews provided information on the participant's knowledge and beliefs with regards to health inequalities and policies to address these, as well as the role of the municipal government. The interview topic guide was developed following the requirements listed in INEQ-cities' description of work and was further discussed with other project partners. Three pilot interviews were performed in Barcelona to test the topic guides and final versions of the guide were distributed to the project partners in the abovementioned cities who then conducted the interviews. The sessions were carried out in each city's native language and lasted between 45 minutes and an hour. Interviews were then translated to English by each partner and several sent the transcripts to the informants for approval.

Processing and analysis of information

Transcripts and summaries were analysed on the basis of a thematic interpretive content analysis (24). Interviews were read numerous times until researchers reached pre-analytical intuitions on each of the interviewee's discourses and texts were then coded using predefined and emergent categories. Following, the text was divided following these categories before performing an analysis of the written content and finally it was articulated into results. Two research members carried out the analysis process independently (28) with

the support of Atlas.Ti software (29) and compared the main findings with the original data. The working manuscript was sent to informants through each project partner for approval.

Ethical considerations

Informed consent was obtained through verbal means and the information was anonymised and confidential. No participants received a salary or reward as participation was completely voluntary and the study received formal ethical approval by a research ethics committee (Hospital del Mar de Barcelona Research Ethics Committee).

Results

Three emerging discourses were identified among the interviewees which varied depending on the city where they worked. While London's informants focused on structural determinants as the main causes of health inequalities and described universal policies aimed at these, Prague and Cluj-Napoca's interviewees were not as familiar with the concept of the social health inequalities. Finally, informants from the remaining cities had a mixed approach: although they referred to the wider determinants as the causes of health inequalities, they also suggested downstream interventions to address these. It was not possible, however, to distinguish differences in discourses between officers and politicians or health and non-health informants. Presented below, the results have been arranged in seven sections following the major topics explored in the interviews. The informant's identification (Id) can be seen in Table 1 and one verbatim from each city was selected to illustrate the results described below in Table 2.

Health inequalities and their causes and information regarding health inequalities

Two broad discourses were found within the informant's perceptions and knowledge of health inequalities. The first one corresponds to the majority of informants who were aware of such inequalities and described them as differences in health. These were expressed, for example, as differences in life expectancy.

We have large differences in health: people live five years longer in areas such as Kungsholmen (inner city area of Stockholm municipality) compared to areas such as Järva fältet" Stockholm health politician, ID 16

They also explained that health inequalities existed among the population according to their levels of education or income, gender, age and the neighbourhood in which they lived.

"There are factors which relate to education, employment or unemployment, living conditions, income, social relations and ways of life. Also the social exclusion of young people generates inequalities in health." Helsinki health officer, ID 6.

In addition, the interviewee from Lisbon pointed out that inequalities were increasing as did the informant from Brussels who understood them as a gradient.

The second discourse corresponded to informants from Cluj-Napoca and Prague did not have a clear concept on social health inequalities, as described in the quote below.

"In this city we cannot talk about this concept. It is estimated that there are no legal criteria to make any differences between individuals in terms of access and use of medical care." Cluj-Napoca health officer, ID 5.

Concerning the causes of inequalities, the majority of the interviewees, identified a strong relationship between economic position, educational level and health. Furthermore, low income was perceived as the main cause of unhealthy lifestyle behaviours and reduced access to health care which lead to health inequalities. In addition, other social determinants were highlighted, such as gender, age group, type of household and residential segregation. The current economic crisis and reduced public expenditure were considered to exacerbate the problem and reduce the capacity of action of the local system. In contrast, interviewees from Prague and Cluj-Napoca considered that health inequalities were chiefly a result of individual responsibility.

To monitor health inequalities, the majority of the informants mentioned relying on health surveys which were published periodically in their cities and mortality statistics from their statistics authority (see Table 2, and quote below).

"To track differences in health, a health survey is conducted every four years." Amsterdam health officer, ID 1.

London's interviewees described the need to integrate the different sources of information into one to make access to information easier. Informants from Lisbon and Prague declared not having information or assessment of health inequalities. Furthermore, the interviewee from Cluj-Napoca explained that periodic data of health inequalities was not available as this concept was not applicable.

Reducing health inequalities as a priority of the city government and policies and programs to reduce them

Most interviewees reported that reducing health inequalities was an objective of the city government included in either strategic plans or in specific laws. However interviewees from Prague and Cluj-Napoca did not consider it to be a priority of their municipal governments, whereas the informant from Lisbon had the opinion that even though it should be a priority, it was not.

"Tackling inequalities in health should be a priority in the Lisbon Metropolitan Area and is not, directly, a hotly debated topic." Lisbon non-health politician, ID 7

The interviewees of Paris and Brussels explained that their city governments did not have jurisdiction over health matters as these are responsibility of the regional authorities.

"In France, health is not a responsibility of the cities, although historically it was the cities that were in charge of sanitary aspects." Paris health officer, ID 12.

That's not easy to answer, as not all the areas are governed on the level of the communities or on the city level." Belgium, health officer, ID 4.

When asked about their knowledge of policies that address health inequalities, policymakers described actions aimed at deprived populations and at modifying attitudes and unhealthy behaviours, such as smoking and poor diets. They emphasised the importance of preventive measures and health promotion and education. Policies to improve access to health care services were also quoted as an important means to reduce health inequalities by most interviewees. However, the informants from London highlighted the need to address health inequalities throughout the general population rather than focusing on the most deprived sectors and developing long-term policies aimed at the social determinants, not only proximal factors, such as physical activity and a healthy diet. Moreover, the informant from Madrid described tackling health inequalities at the local level and the informant from Turin highlighted local interventions aimed at addressing unemployment.

"We have to work on the processes…I'm talking from the micro level, which is where I have more experience, but I think that's where the solution lies, in the micro level." Madrid health politician, ID 10.

The informants from Prague, however, did not mention any policies implemented by their city government and referred to national health plans as a reference for health-related issues.

Inter-sectoral collaboration and participation of social agents in policymaking

Interviewees from Madrid, London, Rotterdam and Lisbon referred to strategic plans which fostered inter-sectoral collaboration between different administrations, citizens' and non-profit associations and established local partnerships. Barcelona and Turin, in turn, described inter-sectoral collaboration established only between two sectors, for example between health and welfare or health and education. While Lisbon stated examples of housing policies for groups at risk of exclusion, some informants suggested that inter-sectoral collaboration slowed down the policymaking process and perceived that having different sectors collaborate proved to be difficult.

"Yes. Action on inequalities in health is synonymous with disciplinary cross-cutting. In this sense, this theme is incorporated in several areas such as education, social service, environmental and cultural policies, among others, addressed in the municipal master plan." Lisbon, non-health politician, ID 7.

With respect to community organisations participating in the policymaking process, the majority of the informants thought their city governments collaborated with these, however informants from Rotterdam, Turin and Stockholm considered it was very limited.

"The social networks exist but they need public support. There is no doubt that there should be more shared responsibility among private sector and public services or welfare systems." Turin non-health politician, ID 18.

Barriers and opportunities encountered

One of the principal barriers described was the lack of awareness on changing lifestyle habits among the population. Informants from Stockholm and Lisbon considered the obstacles addressing health inequalities to be essentially related to the population's cultural beliefs. Bureaucratic restraints and resistance from other levels of the administration along with miscommunication with the private sector as well as budget restrictions were described as important barriers by the majority of interviewees. London's one explained that

implementing financial policies from within a city government was complicated in the context of globalisation.

"We come across them all the time and a very important one is the financial issue. Every year we have less money and the crisis only makes it worse." Barcelona health politician, ID 2.

However, informants also referred to opportunities which enabled policy implementation. For example, the interviewees from Barcelona and Rotterdam made reference to working at the community level or with different sectors which led to learning opportunities. Community groups were seen as essentially important in liaising with hard to reach groups. The interviewee from Brussels suggested that the migrant population promoted healthy lifestyle behaviours due to some of their healthier traditions.

"There are definitely opportunities. Other services have problems as well and see the benefits of cooperation with groups who work with migrant population." Brussels health officer ID 4.

Discussion

To the best of our knowledge, this is the first study to explore policymakers' perceptions on health inequalities and policies to reduce these throughout various European cities from diverse geographical areas and with different socio-economic and political contexts. We have shown that the policymakers we interviewed perceived health inequalities as differences in life expectancy among the population defined by their economic, social and geographical background. Regarding the causes of health inequalities, these were perceived as being caused by low-income levels, unhealthy lifestyle behaviours and barriers in accessing health care. Most of the informants agreed that reducing these inequalities was a priority for their local governments and referred to periodic surveys as information sources to monitor them. The majority of policies and interventions were targeted at modifying health behaviours and few relied upon inter-sectoral collaboration. Furthermore, bureaucracy, funding and the population´s attitudes and beliefs towards healthy lifestyles were considered important barriers.

It may be of interest to note that most informants described upstream determinants such as socio-economic and structural factors as the causes of health inequalities but nevertheless focused on describing downstream policies and programmes. This could be due to the fact that the informants work in city governments and even though they are aware of the main causes of health inequalities, their daily routines involve work with downstream policies and programmes. In this regard, city councils as a general norm have little or no authority over

upstream determinants (30) or over health when it is under the authority of higher levels of government; such was the case of Paris and Brussels. In this sense, policymakers seemed to refer to items within their mandate, so even if they understood structural determinants were important in addressing health inequalities, the activities they described were focused within their own jurisdiction. Notwithstanding, targeted interventions which do not aim at reducing inequalities throughout the whole gradient, may end up being diluted into multiple small downstream initiatives and are less effective in reducing health inequalities (31). This also carries the risk of health inequalities becoming the responsibility of each individual, which is already an existing trend (4,32) and downplaying the responsibilities and competences of the city government which will constitute a barrier for local city governments in tackling inequalities (10). Moreover it has been widely argued that if interventions are not delivered carefully, they are likely to increase inequalities as those who are most in need, might not benefit from the intervention (33). However, as described elsewhere (7), the majority of research on health inequalities relates to downstream determinants and focuses on individual lifestyle factors (34), so little is provided to policymakers on the wider determinants and the underlying causes of the causes of health inequalities (35).

Furthermore, with the exception of Brussels' and London's interviewees, the concept of the socioeconomic gradient in health was not present among respondents; their understanding of reducing health inequalities connoted reducing the differences between the most deprived groups and the rest of the city's population. Therefore, their discourses did not seem to acknowledge that inequalities affect the entire population and not only the most disadvantaged populations (36).

Except for Lisbon and the Central-eastern European cities, most of the informants mentioned having access to information on health inequalities through periodical surveys or health reports. Those with access to regular information on health inequalities would be more likely to see the underpinning structural causes and be willing to act upon them. Furthermore, Prague and Cluj-Napoca expressed not being aware of the existence of inequalities in their cities possibly because they were not as familiar with the concept, however there are relevant studies on health inequalities in the Czech Republic (37-39) and in Romania (40). Nevertheless, the overarching INEQ-Cities project (INEQ-Cities, 2012) will provide the cities included in the project with further data on health inequalities at the small area level. However, knowledge on health inequalities is not necessarily related to being provided with information on health as Lisbon's informant was familiar with the concept but stated not having access to periodical information policymaker (17,41). Notwithstanding, data on health indicators and inequalities is important for various reasons; to understand

how causal pathways are established, to design effective policies and interventions and furthermore, because the lack of information could mean governments do not recognise the problem and therefore little is done to address it (3, 12). While elsewhere it was concluded that researchers do not provide policymakers with befitting and timely information (15,21,42), constantly requiring more evidence runs the risk of delaying having to face the problem and making decisions (11). Nevertheless, evidence on the social determinants of health, and particularly on effective interventions and policies needs further research.

The majority of the informants understood that reducing health inequalities was a priority for their city government but only the city governments of Amsterdam, Barcelona, Helsinki, London, Madrid, Rotterdam, Lisbon and Stockholm had health plans, and within these only London has a specific plan for reducing health inequalities, as has also been described elsewhere (12). Our findings partly reflect the different stages of awareness and action undertaken in the cities as it describes a spectrum of different approaches towards inequalities adopted by countries throughout Europe. We understand that a strong political will is inherent to tackling health inequalities and therefore policymakers need to be supplied with information on the social determinants and how the gradient operates (4).

The lack of awareness in city governments regarding the multidisciplinary nature of effective policies to reduce health inequalities together with the existence of structural arrangements which are very difficult to overcome might explain why only five cities described inter-sectoral collaboration. It was viewed by the majority of the informants as a slow and difficult process. Furthermore a similar study (23) observed that the structure of political responsibilities in the Canadian context offered important constraints for inter-sectoral collaboration. However, encouraging it is important; it has been described in a previous study (43) that inter-sectoral collaboration is a recognized relationship between the health and other sectors in order achieve health outcomes in a more effective way than form the health sector alone. Furthermore, only five cities described participatory processes and collaborating with social actors. Including other stakeholders in policy-making processes is an important step to city governance and empowerment, both decisive in reducing health inequalities more effectively (10,30). However, there are many different barriers which policymakers encounter when trying to establish collaborative relationships such as an overall lack of awareness of health inequalities among those who work in the city government, difficulties to coordinate with other authorities, a lack of mandate, and limited resources (1, 2).

Together with the barriers mentioned above, lack of awareness on health inequalities and bureaucratic restraints were the main barriers to reduce health inequalities as quoted by the

interviewees and have been categorised elsewhere as ideological and institutional (3). Institutional limitations are related to values attitudes and opinions; one possible explanation why this approach has been underlined is that informants seemed to focus mostly on lifestyles and healthy behaviours instead of structural determinants as the causes of health inequalities. Furthermore, the second group of barriers referring to rigid bureaucracy and funding might also be reinforced by the ideological barriers and exacerbated by the social and financial crisis and subsequent austerity measures.

Limitations

It may be worth noting that some of the partners participating in the INEQ-cities project were new to qualitative methods and its techniques of data collection. Nevertheless, we consider it a positive fact that researchers from a more quantitative paradigm have participated in this activity. Furthermore, methodological guidance and a detailed research protocol were made available to them. It should be also taken into account that in some cases, the politicians explained their political discourses and it was a difficult task to make them follow the topic guide. As the topic guide was sent to some of the interviewees beforehand upon request, it is possible that they may have prepared the answers for the interview. Moreover, in some cities, either officers or politicians were interviewed; it might have been more desirable to have one of each for every city. Moreover, as the interviewees were selected by INEQ-Cities partners from each city, in some cases these were chosen by convenience sampling. Nevertheless, the study included quite a large set of informants and does not aim to exhaustively represent the discourses of all the policymakers in the cities included in the study.

Strengths

As a relevant strength of the study, the interviewees included many examples of their everyday experiences and realities providing rich and detailed information. They expressed their own beliefs and describing them provides very valuable information on the governance of cities given the key role of policymakers. Moreover, carrying out the interview, an activity seldom performed previously, possibly drew politicians to review the issue, update their knowledge and learn about the INEQ-Cities project and its results on heath inequalities in their cities. This exploratory study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, will hopefully be a stepping stone for further qualitative research on the topic and has the important advantage of having information from quite a large number of cities (44).

Conclusions and recommendations

The majority of the interviewed policymakers gave an account of interventions focused on the immediate determinants and aimed at modifying lifestyles and behaviours in the more disadvantaged classes. Very few described inter-sectoral action although for most cities reducing health inequalities was a priority and policymakers had access to periodic information.

It is essential to promote inter-sectoral collaboration and participatory policymaking processes and improving local and national collaboration as well as further monitoring and research. Furthermore it is crucial to train policymakers and officers and provide them with proven effective measures to tackle health inequalities (4). More funding should be put towards academic research on effective universal policies, evaluation of their impact and training of policymakers and officers on health inequalities in city governments. More evidence is needed to translate to policymakers the importance, effectiveness and cost-benefit of policies to reduce health inequalities. Further advocacy must be carried out to place health inequalities and their implications in the municipal government's agenda and in city health plans.

Acknowledgements

We would like to thank the informants who participated in the interviews and the interviewers who carried them out. This article has been partially funded by the project INEQ-CITIES, “Socioeconomic inequalities in mortality: evidence and policies of cities of Europe”; project funded by the Executive Agency for Health and Consumers-DG Sanco (Commission of the European Union), project nº2008 12 13 and CIBERESP Epidemiología y Salud Pública.

Funding

This work was supported by the Executive Agency for Health and Consumers-DG Sanco (Commission of the European Union), project nº2008 12 13 and CIBERESP Epidemiología y Salud Públic.

Contributorship Statement

All authors made substantial contributions to conception and design of the study and interviews. They carried out the interviews in their own cities and translated these and provided a summary or transcription. Once the data was analysed by the coordinating centre, the authors interpreted the results and provided critical feedback as well as sending the results to informants and providing the coordinating centre with comments or suggestions made by them. Authors also participated in drafting the article and reviewed it critically several times, making substantial comments and suggestions regarding form, analysis and concepts. Authors also reviewed and approved the final version of the manuscript and provided their approval for publication.

Conflicts of interests

The authors declare not to have any conflicts of interest.

Data Sharing Statement

The additional unpublished data from this study are the recordings of the interviews and their transcriptions. This supplementary data is stored in the coordinating centre and the recordings of the interviews were kept by the institutions which carried them out. This data has not been made available to anyone.

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Health inequalities in European cities: Perceptions and beliefs among local policymakers

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BMJ Open

Health inequalities in European cities: Perceptions and beliefs among local policymakers

Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2013-004454.R1
Article Type:	Research
Date Submitted by the Author:	25-Mar-2014
Complete List of Authors:	Morrison, Joana; University College London, Department of Epidemiology and Public Health; CIBERESP, Pons-Vigués, Mariona; Institut Universitari d'Investigació en Atenció Primària Jordi Gol (IDIAP Jordi Gol), ; Universitat de Girona, Becares, Laia; University of Manchester, Burström, Bo; Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine Gandarillas, Ana; Subdirección General de Promoción de la Salud y Prevención. Consejería de Sanidad. Comunidad de Madrid (Subdirectorate-General for Health Promotion and Prevention. Madrid Regional Health Authority), Domínguez-Berjón, Felicitas; Subdirección General de Promoción de la Salud y Prevención. Consejería de Sanidad. Comunidad de Madrid (Subdirectorate-General for Health Promotion and Prevention. Madrid Regional Health Authority), Díez, Elia; Agència de Salut Pública de Barcelona, ; Ag&#65533;ncia de Salut P&#65533;blica de Barcelona Costa, Giuseppe; University of Turin, Department of Clinical and Biological Science Ruíz, Milagros; University College London, Department of Epidemiology and Public Health Pikhart, Hynek; University College London, Department of Epidemiology and Public Health Marinacci, Chiara; Epidemiology Department, Local Health Unit TO3, ; Ministry of Health, Italy, Hoffmann, Rasmus; Erasmus Medical Centre, Santana, Paula; Centro de Estudos de Geógrafa e Ordenamento do Território (CEGOT), Departamento de Geografia, Universidade de Coimbra, Borrell, Carme; Ag&#65533;ncia de Salut P&#65533;blica de Barcelona; CIBERESP,
Primary Subject Heading:	Health policy
Secondary Subject Heading:	Qualitative research, Public health, Epidemiology
Keywords:	Health inequalities, Public policies, Municipal government, Policymaker, Knowledge, QUALITATIVE RESEARCH

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Keywords Health inequalities, public policies, municipal government, policymaker, knowledge, qualitative research, urban health

Word count: 4212

Abstract

Objective To describe the knowledge and beliefs of public policymakers on social inequalities in health and policies to reduce them in cities from different parts of Europe during 2010 and 2011.

Design Phenomenological qualitative study.

Setting Thirteen European cities.

Participants Nineteen elected politicians and officers with a directive status from thirteen European cities.

Main outcome Policymaker's knowledge and beliefs.

ResultsThree emerging discourses were identified among the interviewees, depending on the city of the interviewee. Health inequalities were perceived by most policy makers as differences in life expectancy between population with economic, social and geographical differences. Reducing health inequalities was a priority for the majority of cities which use surveys as sources of information to analyse these. Bureaucracy, funding and population beliefs were the main barriers.

Conclusions The majority of the interviewed policymakers gave an account of interventions focusing on the immediate determinants and aimed at modifying lifestyles and behaviours in the more disadvantaged classes. More funding should be put towards academic research on effective universal policies, evaluation of their impact and training policymakers and officers on health inequalities in city governments.

Limitations

- Respondents possibly participated due to their willingness, accessibility as well as interest in the area of health inequalities and therefore may be more sensitive to the issue.
- The data was collected 3-4 years ago so parties governing in the cities may have changed.
- In some cities, either officers or politicians were interviewed; it might have been more desirable to have one of each for every city.
- As the interviewees were selected by INEQ-Cities partners from each city, these were chosen by opportunity sampling.

Strengths

- The interviewees included many examples of their everyday experiences and realities providing rich and detailed information.
- Carrying out the interview, an activity seldom performed previously among policymakers, possibly drew them to review the issue, update their knowledge and learn about the INEQ-Cities project and its results on heath inequalities in their cities.
- Since this is an exploratory study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, it will hopefully be a stepping stone for further qualitative research on the topic.
- This study has the important advantage of having collected information from quite a large number of cities throughout Europe.

Introduction

Health inequalities in urban environments are complex[1,2] affect the entire population throughout the health gradient[3] and require a multi-sectoral approach to address multiple social and economic determinants.[4] To that effect, although city governments' competences and authorities vary, they are endowed with jurisdiction to develop strategic plans and policies, provide services and deliver interventions which may address health inequalities.[5-7]

Within governments, policymakers are responsible for decision and policy-making in the form of laws, guidelines, and regulations[8] and their knowledge, beliefs and perceptions are relevant in the implementation of these. It is important to know whether the concept of the social determinants of health inequalities is imbedded in their discourse[9,10] in addition to the information on health issues provided to them as reports or surveys. These topics, explored in this study, may determine the course of the policy-making process.[11,12] Furthermore, their perceptions regarding the responsibilities and priorities of city governments and the city government's strategic plans possibly influence the policies in place.[13,14] These issues along with how policymakers make use of their knowledge will influence decision making and affect how health inequalities are addressed by city governments.[8,15,16]

The majority of studies exploring the knowledge and beliefs of health inequalities have explored lay perceptions[17-20] and the few studies describing expert beliefs focused on researchers and policymakers working in regional and national governments.[9,21,22] To our knowledge, there are only a small number of studies focusing on policymakers in the city government[5,6,14,23] and this is among the first qualitative studies to compare the perceptions of policymakers in different European cities. The use of rigorous qualitative research methods has been on the rise in health services and health policy research[24] to explore the experiences of participants and the meanings they attribute to them, to contribute new knowledge and to provide new perspectives.[25] It is consistent with developments in the social and policy sciences at large and has been described to reflect the need for more in-depth understanding of naturalistic settings the importance of understanding context and the complexity of implementing social change.[26] Selecting policymakers from different European cities provided a description of the different socio-political realities and contexts according to the participant's daily experiences to provider a richer and wider view on reducing health inequalities at the municipal level throughout the continent. Notwithstanding their

diversity, the participant cities share important commonalities as European democracies and urban settings, allowing to explore the study object from a new view. Previous studies[13] in the project have analysed written policy documents in these cities. The objective of this study is to further increase the understanding of how policies are realised, through the perception and beliefs of public policy makers in thirteen European cities during 2010 and 2011.

Methods

Methodological development

We carried out a descriptive and exploratory qualitative research study from a phenomenological perspective[27] as it sought to capture policymakers' unique accounts of reality in order to capture a breadth of discourses on health inequalities[28]. Data was collected from thirteen cities (Amsterdam, Barcelona, Brussels, Cluj-Napoca, Helsinki, Lisbon, London, Madrid, Paris, Prague, Rotterdam, Stockholm and Turin; see Table 1 for information on the cities' profiles) from eleven different European countries participating in the project; Socio-economic inequalities in mortality: evidence and policies in cities of Europe 2009-2012 (INEQ-Cities)[29] during the years 2010 and 2011.

Participants and sampling technique

The study population consisted of nineteen public policymakers, selected through opportunity sampling[28], see Table 2, working in the aforementioned cities' governments during the research period. A sample of elected politicians which included councillors and or aldermen and high ranked, non-elected, officers was selected. Policymakers were chosen from the health sector as well as other non-health sectors to provide a wider range of discourses. Interviews were performed by INEQ-Cities' partners, who interviewed a maximum of two participants, in their respective cities. Furthermore, subjects were chosen only if they held a decision making position.

Data collection and generation techniques

Seventeen semi-structured individual interviews and one semi-structured interview where two informants participated were carried out from November 2010 to June 2011 using an open-ended question topic guide (Box 1). The interviews provided information on the participant's knowledge and beliefs of health inequalities and policies to address these, as well as the role of the municipal government. The interview topic guide was

developed following the requirements listed in INEQ-cities' description of work and was further discussed with other project partners. Three pilot interviews were performed in Barcelona to test the topic guides and final versions of the guide were distributed to the project partners in the abovementioned cities who then conducted the interviews. The sessions were carried out in each city's native language and lasted between 45 minutes and an hour, where clarification of the topics was needed, some interviewers made city-specific questions. The interviewers belonged to partner groups from the INEQ-Cities project. A data collection manual designed by the authors of this study was sent to each partner and interviewer, providing guidelines on how to perform the interview to ensure that these were carried out in a standardised way. Interviews were translated to English by each partner and several sent the transcripts and summaries to the informants for approval. The summaries and the transcripts were sent to the authors carrying out the analysis in English.

Processing and analysis of information

All transcripts and summaries were analysed centrally on the basis of a thematic interpretive content analysis[27] by 2 researchers (JM and MP). Interviews were read numerous times until researchers reached pre-analytical intuitions on each of the interviewee's discourses and texts were then coded using predefined and emergent categories. The text was divided following these categories before performing an analysis of the written content and finally the content was articulated into results. Two research members carried out the analysis process independently with the support of Atlas.Ti software,[30] and compared the main findings with the original data. The working manuscript was sent to informants through each project partner for approval.[31]

Ethical considerations

Informed consent was obtained through verbal means and the information was anonymised and confidential. No participants received a salary or reward as participation was completely voluntary and the study received formal ethical approval by a research ethics committee (Hospital del Mar de Barcelona Research Ethics Committee).

Results

Three emerging discourses were identified among the interviewees, as follows, depending on the city of the interviewee: London's informants focused on structural

determinants as the main causes of health inequalities and described universal policies aimed at these, Prague and Cluj-Napoca's interviewees were not as familiar with the concept of the social health inequalities. Informants from other cities had a mixed approach, although they referred to the wider determinants as the causes of health inequalities, they also suggested downstream interventions to address these. It was not possible, however, to distinguish differences in discourses between officers and politicians or health and non-health informants. Table 3 shows a summary of the responses giving by each city´s participants. Presented below, the results have been arranged in six sections following the major topics explored in the interviews. The informant's identification (ID) can be seen in Table 2.

Knowledge on health inequalities and their causes

Two broad discourses were found within the informant's perceptions and knowledge of health inequalities. The first discourse corresponds to the majority of informants who were aware of such inequalities and described them as differences in health. These were expressed, for example, as differences in life expectancy.

We have large differences in health: people live five years longer in areas such as Kungsholmen (inner city area of Stockholm municipality) compared to areas such as Järva fältet" Stockholm health politician, ID 16

They also explained that health inequalities existed among the population according to their levels of education or income, gender, age and the neighbourhood in which they lived.

"There are factors which relate to education, employment or unemployment, living conditions, income, social relations and ways of life. Also the social exclusion of young people generates inequalities in health." Helsinki health officer, ID 6.

In addition, the interviewee from Lisbon pointed out that inequalities were increasing as did the informant from Brussels who understood them as a gradient.

The second discourse corresponded to informants from Cluj-Napoca and Prague did not have a clear concept on social health inequalities, as described in the quote below.

"In this city we cannot talk about this concept. It is estimated that there are no legal criteria to make any differences between individuals in terms of access and use of medical care." Cluj-Napoca health officer, ID 5.

Concerning the causes of inequalities, the majority of the interviewees, identified a strong relationship between economic position, educational level and health. Furthermore, low income was perceived as the main cause of unhealthy lifestyle behaviours and reduced access to health care which lead to health inequalities. Other social determinants were also highlighted, such as gender, age group, type of household and residential segregation. The current economic crisis and reduced public expenditure were considered to exacerbate the problem and reduce the capacity of action of the local system.

In contrast, interviewees from Prague and Cluj-Napoca considered that health inequalities were chiefly a result of individual responsibility.

Reducing health inequalities as a priority for the city government

Most interviewees reported that reducing health inequalities was an objective of the city government included in either strategic plans or in specific laws. However interviewees from Prague and Cluj-Napoca did not consider it to be a priority of their municipal governments, whereas Lisbon informant's considered it was not a priority even though they thought it should be.

"Tackling inequalities in health should be a priority in the Lisbon Metropolitan Area and is not, directly, a hotly debated topic." Lisbon non-health politician, ID 7

The interviewees of Paris and Brussels explained that their city governments did not have jurisdiction over health matters as these are the responsibility of the regional authorities.

"In France, health is not a responsibility of the cities, although historically it was the cities that were in charge of sanitary aspects." Paris health officer, ID 12.

That's not easy to answer, as not all the areas are governed on the level of the communities or on the city level." Belgium, health officer, ID 4.

Information on health inequalities

To monitor health inequalities, the majority of the informants mentioned relying on health surveys which were published periodically in their cities and mortality statistics from their statistics authority.

"To track differences in health, a health survey is conducted every four years." Amsterdam health officer, ID 1.

London's interviewees described the need to integrate the different sources of information into one to make access to information easier. Informants from Lisbon and Prague declared not having information or assessment of health inequalities. Furthermore, the interviewee from Cluj-Napoca explained that periodic data of health inequalities was not available as this concept was not applicable.

Knowledge on policies and programs implemented

When asked about their knowledge of policies that address health inequalities, policymakers described actions aimed at deprived populations and at modifying attitudes and unhealthy behaviours, such as smoking and poor diets. They emphasised the importance of preventive measures and health promotion and education. Policies to improve access to health care services were also quoted as an important means to reduce health inequalities by most interviewees. However, the informants from London highlighted the need to address health inequalities throughout the general population rather than focusing on the most deprived sectors and developing long-term policies aimed at the social determinants, not only proximal factors, such as physical activity and fruit intake. Moreover, the informant from Turin highlighted local interventions aimed at addressing unemployment and the interviewee from Madrid described tackling health inequalities at the local level.

"We have to work on the processes…I'm talking from the micro level, which is where I have more experience, but I think that's where the solution lies, in the micro level." Madrid health politician, ID 10.

The informants from Prague, however, did not mention any policies implemented by their city government and referred to national health plans as a reference for health-related issues.

Inter-sectoral collaboration and participation of social agents in policymaking

Interviewees from Madrid, London, Rotterdam and Lisbon referred to strategic plans which fostered inter-sectoral collaboration between different administrations, citizens' and non-profit associations and established local partnerships. Barcelona and Turin, in

turn, described inter-sectoral collaboration established only between two sectors, for example between health and welfare or health and education. While Lisbon cited examples of housing policies for groups at risk of exclusion, some informants suggested that inter-sectoral collaboration slowed down the policymaking process and perceived that having different sectors collaborate proved to be difficult.

"Yes. Action on inequalities in health is synonymous with disciplinary cross-cutting. In this sense, this theme is incorporated in several areas such as education, social service, environmental and cultural policies, among others, addressed in the municipal master plan." Lisbon, non-health politician, ID 7.

With respect to community organisations participating in the policymaking process, the majority of the informants thought their city governments collaborated with these, however informants from Rotterdam, Turin and Stockholm considered it was very limited.

"The social networks exist but they need public support. There is no doubt that there should be more shared responsibility among private sector and public services or welfare systems." *Turin non-health politician, ID 18.*

Barriers and opportunities encountered

One of the principal barriers described was the lack of awareness on changing unhealthy lifestyles among the population. Informants from Stockholm and Lisbon considered the obstacles addressing health inequalities to be essentially related to imbedded cultural beliefs which made adopting healthier lifestyles difficult. Bureaucratic restraints and resistance from other levels of the administration along with miscommunication with the private sector as well as budget restrictions were described as important barriers by the majority of interviewees. London's interviewee explained that implementing financial policies from within a city government was complicated in the context of globalisation.

"We come across them all the time and a very important one is the financial issue. Every year we have less money and the crisis only makes it worse." *Barcelona health politician, ID 2.*

Informants also referred to opportunities which enabled policy implementation. For example, the interviewees from Barcelona and Rotterdam made reference to working at the community level or with different sectors which led to learning opportunities. Community groups were seen as especially important in liaising with hard to reach groups. The interviewee from Brussels suggested that the migrant population promoted healthy lifestyle behaviours, as some of their customs had healthy components.

"There are definitely opportunities. Other services have problems as well and see the benefits of cooperation with groups who work with migrant population." *Brussels health officer ID 4.*

Discussion

To the best of our knowledge, this is the first study to explore policymakers' perceptions on health inequalities and policies to reduce these throughout various European cities from diverse geographical areas and with different socio-economic and political contexts. Three discourses were identified depending on the city of the interviewee: 1) London's approach focused on upstream determinants and policies; 2) Cluj-Napoca and Prague's where informants were less acquainted with social health inequalities and 3) the rest of the cities' informants who perceived health inequalities as differences in life expectancy among the population defined by their economic, social and geographical background. Regarding the causes of health inequalities, these were seen as being caused by low-income levels, unhealthy lifestyle behaviours and barriers in accessing health care. Most of the informants agreed that reducing these inequalities was a priority of their local governments and referred to periodic surveys as information sources to monitor them. Nearly all policies and interventions were targeted at modifying health behaviours and some relied upon inter-sectoral collaboration. Furthermore, bureaucracy, funding and the population´s attitudes and beliefs towards healthy lifestyles were considered important barriers.

The majority of informants described upstream determinants such as socio-economic and structural factors as the causes of health inequalities but nevertheless focused on describing downstream policies and programmes. This could be due to the fact that the informants work in city governments and even though they are aware of the main causes of health inequalities, their daily routines involve work with downstream policies and programmes. In this regard, some city councils may have limited authority over upstream determinants[4,32] or over health when it is under the authority of higher levels of government; such was the case of Paris and Brussels. In this sense,

policymakers seemed to refer to what was within their mandate, so even if they understood structural determinants were important in addressing health inequalities, the activities they described were focused within their own jurisdiction. Downstream, interventions targeted at disadvantaged populations such as some of the ones described by the interviewees, which do not aim at reducing inequalities throughout the whole gradient, may end up being diluted into multiple small downstream initiatives and are less effective in reducing health inequalities.[33,34] This also carries the risk of health inequalities becoming the responsibility of each individual, which is already an existing trend,[35] and downplaying the responsibilities and competences of the city government which will constitute a barrier for the local city governments in tackling inequalities. Moreover it has been widely argued that if interventions are not delivered carefully, they are likely to increase inequalities as those who are most in need, might not benefit from the intervention.[36] However, as described elsewhere,[5] the majority of research on health inequalities relates to downstream determinants and focuses on individual lifestyle factors,[37] so little information is provided to policymakers on the wider determinants and the underlying causes of the causes of health inequalities.[38]

Furthermore, with the exception of Brussels' and London's interviewees, the concept of the socioeconomic gradient in health was not present among respondents; their understanding of reducing health inequalities connoted reducing the differences between the most deprived groups and the rest of the city's population. Therefore, their discourses did not seem to acknowledge that inequalities affect the entire population and not only the most disadvantaged populations.[39]

Except for Lisbon and the Central-eastern European cities, most of the informants mentioned having access to information on health inequalities through periodical surveys or health reports. Those with access to regular information on health inequalities would be more likely to see the underpinning structural causes and be willing to act upon them. Furthermore, Prague and Cluj-Napoca expressed not being aware of the existence of inequalities in their cities possibly because they were not as familiar with the concept. There are relevant studies on health inequalities in the Czech Republic[40,41] and in Romania.[42] Nevertheless, the overarching INEQ-Cities project[29] will provide the cities included in the project with further data on health inequalities at the small area level. Data on health indicators and inequalities is important for various reasons: to understand how causal pathways are established and to design effective policies and interventions.[4,11] While elsewhere it was concluded that researchers do not provide policymakers with befitting and timely information

[15,22,43] constantly requiring more evidence runs the risk of delaying having to face the problem and making decisions.[44] Nevertheless, additional evidence on the social determinants of health, and particularly on effective interventions and policies is important.

The majority of the informants understood that reducing health inequalities was a priority for their city government. However, only the city governments of Amsterdam, Barcelona, Helsinki, London, Madrid, Rotterdam, Lisbon and Stockholm had health plans, and within these only London has a specific plan for reducing health inequalities, as has also been described elsewhere.[13] Our findings partly reflect the different stages of awareness and action undertaken in the cities as it describes a spectrum of different approaches towards inequalities adopted by countries throughout Europe. We understand that a strong political will is inherent to tackling health inequalities along with supplying policymakers with information on the social determinants and how the gradient operates.[33]

Many of the participants described participation between sectors at some level, even though not all cities showed the same involvement. A study carried out also within the INEQ-Cities project analysing policy documents of some of the cities included in this study showed similar results.[13] Another study[23] observed that the structure of political responsibilities in the Canadian context offered important constraints for inter-sectoral collaboration. Encouraging the continuation of collaborative strategies may have a substantial impact on reducing health inequalities, previous research has shown that inter-sectoral collaboration between the health and other sectors is essential to achieving health outcomes in a more effective way than form the health sector alone.[45] Fewer cities described participatory processes and collaborating with social actors. Including other stakeholders in policy-making processes is an important step to city governance and empowerment, both decisive in reducing health inequalities more effectively.[34,46] However, there are many different barriers which policymakers encounter when trying to establish collaborative relationships such as an overall lack of awareness of health inequalities among those who work in the city government, difficulties to coordinate with other authorities, a lack of mandate, and limited resources.[16,8]

Along with the barriers mentioned above, lack of awareness on health inequalities and bureaucratic restraints were the main barriers to reduce health inequalities as quoted by the interviewees and have been categorised elsewhere as ideological and

institutional.[23] Institutional limitations are related to values attitudes and opinions; one possible explanation why this approach has been underlined is that informants seemed to focus mostly on lifestyles and healthy behaviours instead of structural determinants as the causes of health inequalities. Furthermore, the second group of barriers referring to rigid bureaucracy and funding might also be reinforced by the ideological barriers and exacerbated by the social and financial crisis and subsequent austerity measures.

Limitations and strengths

It should be also taken into account that in some cases, the politicians interviewed gave political discourses and it was a difficult task to make them follow the topics. Participants were selected through an opportunity sampling, they might not be the most representative informants in their fields; other respondents might have wider knowledge on the subject or they possibly participated due to their willingness, accessibility as well as interest in the area of health inequalities and therefore may be more sensitive to the issue. The interviews were carried out by different interviewers from each city in their native language so that participants could express themselves more freely. The results of politicians and officers have been presented together as we found no differences in their discourses. Nevertheless, the informants included in this study were selected following the pre-established criteria so both elected and non-elected informants were highly positioned in their municipal government´s structure and had decision making competences. The data was collected 3-4 years ago so parties governing in the cities may have changed and the elected officials may not be working in decision making positions at the present moment. However, describing these beliefs provides very valuable information on the governance of cities given the key role of policymakers.

As a relevant strength of the study, the interviewees included many examples of their everyday experiences and realities providing rich and detailed information. They expressed their own beliefs and describing them provides very valuable information on the governance of cities given the key role of policymakers. Moreover, carrying out the interview, an activity seldom performed previously, probably drew politicians to review the issue, update their knowledge and learn about the INEQ-Cities project (INEQ-Cities 2012). The findings of the present study to some extent mirrors the findings of the analysis of health policy documents in the same cities, and illustrates the different stages at which cities are concerning work on health inequalities.[13] This exploratory

study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, will hopefully be a stepping stone for further studies and also has the important advantage of having information from quite a large number of cities.

Conclusions and recommendations

The majority of the interviewed policymakers gave an account of interventions focusing on the immediate determinants and aimed at modifying lifestyles and behaviours in the more disadvantaged classes. Some described inter-sectoral action explicitly and for most cities reducing health inequalities was a priority and policymakers had access to periodic information.

Future collaboration between the research centres from Cluj-Napoca and Prague and their local governments could possibly foster more awareness about health inequalities and their causes and the importance of addressing them. Providing decision makers from the municipal governments with information on policies aimed at addressing upstream determinants alongside health indicators should be encouraged further to promote knowledge on their role in addressing health inequalities.

More funding should be put towards academic research on effective universal policies, evaluation of their impact and training policymakers and officers on health inequalities in city governments. Further advocacy must be carried out to place health inequalities and their implications in the municipal government's agenda and in city health plans.

Acknowledgements

We would like to thank the informants who participated in the interviews and the interviewers who carried them out and all the partners involved in the INEQ-Cities project. This article has been partially funded by the project: INEQ-Cities, "Socioeconomic inequalities in mortality: evidence and policies of cities of Europe"; project funded by the Executive Agency for Health and Consumers-DG Sanco (Commission of the European Union), project nº2008 12 13 and CIBERESP Epidemiología y Salud Pública.

Funding

This work was supported by the Executive Agency for Health and Consumers-DG Sanco (Commission of the European Union), project nº2008 12 13 and CIBERESP Epidemiología y Salud Pública

Contributorship Statement

All authors made substantial contributions to conception and design of the study and interviews. They carried out the interviews in their own cities and translated these and provided a summary or transcription. Once the data was analysed by the coordinating centre, the authors interpreted the results and provided critical feedback as well as sending the results to informants and providing the coordinating centre with comments or suggestions made by them. Authors also participated in drafting the article and reviewed it critically several times, making substantial comments and suggestions regarding form, analysis and concepts. Authors also reviewed and approved the final version of the manuscript and provided their approval for publication.

Conflicts of interests

The authors declare not to have any conflicts of interest.

Data sharing statement

No additional data are available.

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Table 1. City profile indicators[1]

City	Year of the indicator	Population aged 0 – 14 %	Population aged 65 and older %	Population aged 16 - 64 in the labour market %	Unemployment %	Immigrant population %
Amsterdam	2001	16.1	11.3	72.0	13.3	48.3
Barcelona	2005	12.3	20.8	57.2	8.7	21.5
Brussels	2001	18.3	15.4	64.9	18.2	26.3
Helsinki	2004	14.5	13.8	78.9	9.1	7.3
Lisbon	2001	14.9	15.4	73.3	7.6	5.7
London	2001	20.2	12.0	67.6	5.2	24.9
Madrid	2005	12.8	18.7	74.1	8.2	14.1
Paris	2007	14.4	14.1	75.5	11.3	20
Prague	2006	12.3	15.6	74.8	3.5	7.6
Rotterdam	2001	17.2	14.3	69	9	45
Stockholm	2005	18	14.1	76	5.3	24.3
Turin	2005	11.4	23.4	67.8	11.4	5.6

1. The information was provided by each city and proceeds from different information sources

Table 2. Description of the 19 informants*

Identification	City (Country)	Status	Profile	Party
1	Amsterdam (Netherlands)	Officer	Health	NA
2	Barcelona (Spain)	Politician	Health	Eco-socialism
3	Barcelona (Spain)	Politician	Non-Health	Eco-socialism
4	Brussels (Belgium)	Officer	Health	NA
5	Cluj-Napoca (Romania)	Officer	Health	NA
6	Helsinki (Finland)	Officer	Health	NA
7	Lisbon (Portugal)	Politician	Non-Health	Social democracy
8*	London (United Kingdom)	Officer	Health	NA
9*	London (United Kingdom)	Officer	Health	NA
10	Madrid (Spain)	Officer	Health	NA
11	Madrid (Spain)	Officer	Health	NA
12	Paris (France)	Officer	Health	NA
13	Prague (Czech Republic)	Officer	Health	NA
14	Prague (Czech Republic)	Officer	Health	NA
15	Rotterdam (Netherlands)	Officer	Non-Health	NA
16	Stockholm (Sweden)	Politician	Health	Christian democratic
17	Stockholm (Sweden)	Politician	Health	Social democracy
18	Turin (Italy)	Politician	Non-Health	Social democracy
19	Turin (Italy)	Politician	Non-Health	Social democracy

^ NA= Not applicable

* Both informants 8 and 9 from London were interviewed together. The information was generated through 18 in-depth interviews

Table 3. Summary of cities' discourses

City	Knowledge on HI[1] and their causes	Reducing HI as a priority for the city government	Information on health inequalities	Knowledge on policies and programs	Intersectoral collaboration/ participation of social agents	Barriers	Opportunities
Amsterdam	Economic, genetic, environmental, ethnic factors	It is a priority, through changing economic and political factors	Health survey, city memo, collaboration with academics	The city has a Health Plan	There is specific collaboration with other sectors	Funding and the administrative organisation	Health topics are placed in the agenda of organisations
Barcelona	Capitalist economic system, different life expectancy between neighbourhoods structural poverty, traditional and emerging inequalities	HI is a priority but mostly for the health sector and at the local level	Annual city health report and health policy evaluation. Social observatory	Urban regeneration policies. Non-health policies with health outcomes, Health in the neighbourhoods strategy to reduce HI	Not a formal intersectorality, council organisation still compartmentalised. 18 plans with community action, civil society	Financial restraints, factual powers	Proximity to the community and intersectorality
Brussels	Gradient in health, socio-economic position, lack of redistribution mechanisms, segregation, personal traits, access to health care	Reducing HI is an absolute priority	Death certificates, census, national health survey, more data is needed on children	No specific policies aimed at health inequalities	Collaboration is transversal with 3 political structures. Social agents are advisory bodies and also participate in action plans	The liberal course of EU[2]. Geographic proximity of actors	Migrant population contribute to healthy lifestyles
Cluj-Napoca	Health inequalities are not an issue	Reducing HI is not a priority, health is a right for all people	The city has the population health statistics	There are preventive measures for the whole population	There is close cooperation with municipalities	Funding and administrative restraints are a barrier	
Helsinki	Sex, education, unemployment, living conditions, social relations, exclusion of young people and ways of life	Strategy of city council 2009-2012. Resources directed at reducing HI	There is some information because it is a strategy of the city	Healthy Helsinki project to reduce HI. Non-smoking and responsible alcohol consumption programmes	There is not enough intersectorality. Steering committees include various social agents. Intersectorality might be slow	Difficulty to obtain funding. Administrative structures	Funding and good cooperation create opportunities
Lisbon	Socioeconomic, demographic, income and age inequalities. Housing conditions	Reducing HI is not explicitly a priority, but it should be. We have the Municipal master plan	There is no information or assessment	Policies and plan targeted at aging	Intersectorality is inherent in tackling health inequalities	Cultural, economic and legislative obstacles	Initiatives with multiple dimensions

London	Social determinants in a global context. Lack of evidence base of strategies. Policies directed at most deprived instead of all population	The informants did not answer explicitly that reducing HI was a priority	There is not a must on information. Data is pieced together	Primary care interventions, employment programmes, partnership approach, no knowledge on EU funds	There is intersectoral work with local partnerships not only health services	Little capacity to influence the upstream determinants of inequalities	Promoting local integration and pool resources
Madrid	Socio-economic inequalities, housing, lifestyles, education, Income, cultural behaviours. Inequalities at the district level, access to healthcare services	A priority to be dealt with by health care systems	Yes, through research and the annual report	Plan Vallecas to change behaviours. Law for health, programme for the homeless with tuberculosis, for sexual trade workers, for women of Roma ethnicity, children at risk	Plan Vallecas which is multidisciplinary, communitary and participatory. The aim is to work transversally but it is difficult. Neighbours' associations and participation at the micro level	Relations with other institutions, budget delimitation, lack of awareness of the population, little information on the impact of programmes	To integrate the actions on the groups affected by health inequalities
Paris	Access to health care	Health is not responsibility of the city government or a priority	Epidemiological information and on local health issues for specific municipalities	City policy: measures at the city level, preventive measures, public Health programmes in the neighbourhoods	City health workshops	The consideration of health in the context of urban policy	
Prague	Social status, poverty, chosen lifestyle, voluntarily socially excluded	Health inequalities are not a priority	National plan of social politics but no periodic support	Health 21, strategic plan of Prague	Complex a to work with different sectors, social agents make themselves heard	Legislative and coordination issues, financial barriers	NGO´s[3] are very close to the socially excluded
Rotterdam	Socioeconomic differences	Yes, with a broad view on health. Health is a precondition for the life of the city	Health is included in a general biannual survey	Directed at unhealthy behaviour of low SES, air quality and traffic, health plan	Work, participation, education. "Healthy in the city": city health plan. "From complaint to strength", depression and diabetes. Many joint projects but no collaboration with social actors	Long timeframe in cooperating with other networks. Different levels in institutions have trouble communicating	Benefits of cooperation
Stockholm	Structural differences: housing segregation, education level, age group, income, migration criminal acts/safety and living conditions. Health inequalities in Stockholm are very large	Based on health care services. Legislation is there but the educated are the ones who benefit. Accessibility to health care is the highest priority	Public health survey produced every four years, review of health care services, Karolinska Institute Public Health Academy reports	Wide range of choice of health providers, addressed at behavioural and cultural determinants, resources for prevention are too small	Action plan for health, Hard for actors to cooperate voluntary organisations which strengthen the community but nonexistent in participatory process	Lack of competence, knowledge and methods to change behaviours	Resources, Evidenced based health prevention, Engaged people working in health centres

Turin	Housing conditions, overcrowding, economic and employment crisis, deterioration of social conditions	The city has a direct and privileged approach to dealing with inequality but there are conflicts of interest	No use of effectiveness indicators for evaluation and modification of policies	Policies not addressed at specific groups, traffic calming and public transport development, security, social housing, local welfare strategies	Sentinel events arise interest but there is a conflict of interests in the political administration	Structural policies tend to be slow	Social cooperatives for housing by improving existing assets

1. HI: Health Inequalities

2. EU: European Union

3. NGOs Non-Governmental Organisations

Health inequalities in European cities: Perceptions and beliefs among local policymakers

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Keywords Health inequalities, public policies, municipal government, policymaker, knowledge, qualitative research, urban health

Word count: 4212

Abstract

Objective To describe the knowledge and beliefs of public policymakers on social inequalities in health and policies to reduce them in cities from different parts of Europe during 2010 and 2011.

Design Phenomenological qualitative study.

Setting Thirteen European cities.

Participants Nineteen elected politicians and officers with a directive status from thirteen European cities.

Main outcome Policymaker's knowledge and beliefs.

Results Three emerging discourses were identified among the interviewees, depending on the city of the interviewee. Health inequalities were perceived by most policy makers as differences in life expectancy between population with economic, social and geographical differences. Reducing health inequalities was a priority for the majority of cities which use surveys as sources of information to analyse these. Bureaucracy, funding and population beliefs were the main barriers.

Conclusions The majority of the interviewed policymakers gave an account of interventions focusing on the immediate determinants and aimed at modifying lifestyles and behaviours in the more disadvantaged classes. More funding should be put towards academic research on effective universal policies, evaluation of their impact and training policymakers and officers on health inequalities in city governments.

Limitations

- Respondents possibly participated due to their willingness, accessibility as well as interest in the area of health inequalities and therefore may be more sensitive to the issue.

- The data was collected 3-4 years ago so parties governing in the cities may have changed.

- In some cities, either officers or politicians were interviewed; it might have been more desirable to have one of each for every city.

- As the interviewees were selected by INEQ-Cities partners from each city, these were chosen by opportunity sampling.

Strengths

- The interviewees included many examples of their everyday experiences and realities providing rich and detailed information.

- Carrying out the interview, an activity seldom performed previously among policymakers, possibly drew them to review the issue, update their knowledge and learn about the INEQ-Cities project and its results on heath inequalities in their cities.

- Since this is an exploratory study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, it will hopefully be a stepping stone for further qualitative research on the topic.

- This study has the important advantage of having collected information from quite a large number of cities throughout Europe.

Introduction

Health inequalities in urban environments are complex[1,2] affect the entire population throughout the health gradient[3] and require a multi-sectoral approach to address multiple social and economic determinants.[4] To that effect, although city governments' competences and authorities vary, they are endowed with jurisdiction to develop strategic plans and policies, provide services and deliver interventions which may address health inequalities.[5-7]

Within governments, policymakers are responsible for decision and policy-making in the form of laws, guidelines, and regulations[8] and their knowledge, beliefs and perceptions are relevant in the implementation of these. It is important to know whether the concept of the social determinants of health inequalities is imbedded in their discourse[9,10] in addition to the information on health issues provided to them as reports or surveys. These topics, explored in this study, may determine the course of the policy-making process.[11,12] Furthermore, their perceptions regarding the responsibilities and priorities of city governments and the city government's strategic plans possibly influence the policies in place.[13,14] These issues along with how policymakers make use of their knowledge will influence decision making and affect how health inequalities are addressed by city governments.[8,15,16]

The majority of studies exploring the knowledge and beliefs of health inequalities have explored lay perceptions[17-20] and the few studies describing expert beliefs focused on researchers and policymakers working in regional and national governments.[9,21,22] To our knowledge, there are only a small number of studies focusing on policymakers in the city government[5,6,14,23] and this is among the first qualitative studies to compare the perceptions of policymakers in different European cities. The use of rigorous qualitative research methods has been on the rise in health services and health policy research[24] to explore the experiences of participants and the meanings they attribute to them, to contribute new knowledge and to provide new perspectives.[25] It is consistent with developments in the social and policy sciences at large and has been described to reflect the need for more in-depth understanding of naturalistic settings the importance of understanding context and the complexity of implementing social change.[26] Selecting policymakers from different European cities provided a description of the different socio-political realities and contexts according to the participant's daily experiences to provider a richer and wider view on reducing health inequalities at the municipal level throughout the continent. Notwithstanding their

diversity, the participant cities share important commonalities as European democracies and urban settings, allowing to explore the study object from a new view. Previous studies[13] in the project have analysed written policy documents in these cities. The objective of this study is to further increase the understanding of how policies are realised, through the perception and beliefs of public policy makers in thirteen European cities during 2010 and 2011.

Methods

Methodological development

We carried out a descriptive and exploratory qualitative research study from a phenomenological perspective[27] as it sought to capture policymakers' unique accounts of reality in order to capture a breadth of discourses on health inequalities[28]. Data was collected from thirteen cities (Amsterdam, Barcelona, Brussels, Cluj-Napoca, Helsinki, Lisbon, London, Madrid, Paris, Prague, Rotterdam, Stockholm and Turin; see Table 1 for information on the cities' profiles) from eleven different European countries participating in the project; Socio-economic inequalities in mortality: evidence and policies in cities of Europe 2009-2012 (INEQ-Cities)[29] during the years 2010 and 2011.

Participants and sampling technique

The study population consisted of nineteen public policymakers, selected through opportunity sampling[28], see Table 2, working in the aforementioned cities' governments during the research period. A sample of elected politicians which included councillors and or aldermen and high ranked, non-elected, officers was selected. Policymakers were chosen from the health sector as well as other non-health sectors to provide a wider range of discourses. Interviews were performed by INEQ-Cities' partners, who interviewed a maximum of two participants, in their respective cities. Furthermore, subjects were chosen only if they held a decision making position.

Data collection and generation techniques

Seventeen semi-structured individual interviews and one semi-structured interview where two informants participated were carried out from November 2010 to June 2011 using an open-ended question topic guide (Box 1). The interviews provided information on the participant's knowledge and beliefs of health inequalities and policies to address these, as well as the role of the municipal government. The interview topic guide was

developed following the requirements listed in INEQ-cities' description of work and was further discussed with other project partners. Three pilot interviews were performed in Barcelona to test the topic guides and final versions of the guide were distributed to the project partners in the abovementioned cities who then conducted the interviews. The sessions were carried out in each city's native language and lasted between 45 minutes and an hour, where clarification of the topics was needed, some interviewers made city-specific questions. The interviewers belonged to partner groups from the INEQ-Cities project. A data collection manual designed by the authors of this study was sent to each partner and interviewer, providing guidelines on how to perform the interview to ensure that these were carried out in a standardised way. Interviews were translated to English by each partner and several sent the transcripts and summaries to the informants for approval. The summaries and the transcripts were sent to the authors carrying out the analysis in English.

Processing and analysis of information

All transcripts and summaries were analysed centrally on the basis of a thematic interpretive content analysis[27] by 2 researchers (JM and MP). Interviews were read numerous times until researchers reached pre-analytical intuitions on each of the interviewee's discourses and texts were then coded using predefined and emergent categories. The text was divided following these categories before performing an analysis of the written content and finally the content was articulated into results. Two research members carried out the analysis process independently with the support of Atlas.Ti software,[30] and compared the main findings with the original data. The working manuscript was sent to informants through each project partner for approval.[31]

Ethical considerations

Informed consent was obtained through verbal means and the information was anonymised and confidential. No participants received a salary or reward as participation was completely voluntary and the study received formal ethical approval by a research ethics committee (Hospital del Mar de Barcelona Research Ethics Committee).

Results

Three emerging discourses were identified among the interviewees, as follows, depending on the city of the interviewee: London's informants focused on structural

determinants as the main causes of health inequalities and described universal policies aimed at these, Prague and Cluj-Napoca's interviewees were not as familiar with the concept of the social health inequalities. Informants from other cities had a mixed approach, although they referred to the wider determinants as the causes of health inequalities, they also suggested downstream interventions to address these. It was not possible, however, to distinguish differences in discourses between officers and politicians or health and non-health informants. Table 3 shows a summary of the responses giving by each city´s participants. Presented below, the results have been arranged in six sections following the major topics explored in the interviews. The informant's identification (ID) can be seen in Table 2.

Knowledge on health inequalities and their causes

Two broad discourses were found within the informant's perceptions and knowledge of health inequalities. The first discourse corresponds to the majority of informants who were aware of such inequalities and described them as differences in health. These were expressed, for example, as differences in life expectancy.

We have large differences in health: people live five years longer in areas such as Kungsholmen (inner city area of Stockholm municipality) compared to areas such as Järva fältet" Stockholm health politician, ID 16

They also explained that health inequalities existed among the population according to their levels of education or income, gender, age and the neighbourhood in which they lived.

"There are factors which relate to education, employment or unemployment, living conditions, income, social relations and ways of life. Also the social exclusion of young people generates inequalities in health." Helsinki health officer, ID 6.

In addition, the interviewee from Lisbon pointed out that inequalities were increasing as did the informant from Brussels who understood them as a gradient.

The second discourse corresponded to informants from Cluj-Napoca and Prague did not have a clear concept on social health inequalities, as described in the quote below.

"In this city we cannot talk about this concept. It is estimated that there are no legal criteria to make any differences between individuals in terms of access and use of medical care." Cluj-Napoca health officer, ID 5.

Concerning the causes of inequalities, the majority of the interviewees, identified a strong relationship between economic position, educational level and health. Furthermore, low income was perceived as the main cause of unhealthy lifestyle behaviours and reduced access to health care which lead to health inequalities. Other social determinants were also highlighted, such as gender, age group, type of household and residential segregation. The current economic crisis and reduced public expenditure were considered to exacerbate the problem and reduce the capacity of action of the local system.

In contrast, interviewees from Prague and Cluj-Napoca considered that health inequalities were chiefly a result of individual responsibility.

Reducing health inequalities as a priority for the city government

Most interviewees reported that reducing health inequalities was an objective of the city government included in either strategic plans or in specific laws. However interviewees from Prague and Cluj-Napoca did not consider it to be a priority of their municipal governments, whereas Lisbon informant's considered it was not a priority even though they thought it should be.

"Tackling inequalities in health should be a priority in the Lisbon Metropolitan Area and is not, directly, a hotly debated topic." Lisbon non-health politician, ID 7

The interviewees of Paris and Brussels explained that their city governments did not have jurisdiction over health matters as these are the responsibility of the regional authorities.

"In France, health is not a responsibility of the cities, although historically it was the cities that were in charge of sanitary aspects." Paris health officer, ID 12.

That's not easy to answer, as not all the areas are governed on the level of the communities or on the city level." Belgium, health officer, ID 4.

Information on health inequalities

To monitor health inequalities, the majority of the informants mentioned relying on health surveys which were published periodically in their cities and mortality statistics from their statistics authority.

"To track differences in health, a health survey is conducted every four years." Amsterdam health officer, ID 1.

London's interviewees described the need to integrate the different sources of information into one to make access to information easier. Informants from Lisbon and Prague declared not having information or assessment of health inequalities. Furthermore, the interviewee from Cluj-Napoca explained that periodic data of health inequalities was not available as this concept was not applicable.

Knowledge on policies and programs implemented

When asked about their knowledge of policies that address health inequalities, policymakers described actions aimed at deprived populations and at modifying attitudes and unhealthy behaviours, such as smoking and poor diets. They emphasised the importance of preventive measures and health promotion and education. Policies to improve access to health care services were also quoted as an important means to reduce health inequalities by most interviewees. However, the informants from London highlighted the need to address health inequalities throughout the general population rather than focusing on the most deprived sectors and developing long-term policies aimed at the social determinants, not only proximal factors, such as physical activity and fruit intake. Moreover, the informant from Turin highlighted local interventions aimed at addressing unemployment and the interviewee from Madrid described tackling health inequalities at the local level.

"We have to work on the processes…I'm talking from the micro level, which is where I have more experience, but I think that's where the solution lies, in the micro level." Madrid health politician, ID 10.

The informants from Prague, however, did not mention any policies implemented by their city government and referred to national health plans as a reference for health-related issues.

Inter-sectoral collaboration and participation of social agents in policymaking

Interviewees from Madrid, London, Rotterdam and Lisbon referred to strategic plans which fostered inter-sectoral collaboration between different administrations, citizens' and non-profit associations and established local partnerships. Barcelona and Turin, in

turn, described inter-sectoral collaboration established only between two sectors, for example between health and welfare or health and education. While Lisbon cited examples of housing policies for groups at risk of exclusion, some informants suggested that inter-sectoral collaboration slowed down the policymaking process and perceived that having different sectors collaborate proved to be difficult.

"Yes. Action on inequalities in health is synonymous with disciplinary cross-cutting. In this sense, this theme is incorporated in several areas such as education, social service, environmental and cultural policies, among others, addressed in the municipal master plan." Lisbon, non-health politician, ID 7.

With respect to community organisations participating in the policymaking process, the majority of the informants thought their city governments collaborated with these, however informants from Rotterdam, Turin and Stockholm considered it was very limited.

"The social networks exist but they need public support. There is no doubt that there should be more shared responsibility among private sector and public services or welfare systems." *Turin non-health politician, ID 18.*

Barriers and opportunities encountered

One of the principal barriers described was the lack of awareness on changing unhealthy lifestyles among the population. Informants from Stockholm and Lisbon considered the obstacles addressing health inequalities to be essentially related to imbedded cultural beliefs which made adopting healthier lifestyles difficult. Bureaucratic restraints and resistance from other levels of the administration along with miscommunication with the private sector as well as budget restrictions were described as important barriers by the majority of interviewees. London's interviewee explained that implementing financial policies from within a city government was complicated in the context of globalisation.

"We come across them all the time and a very important one is the financial issue. Every year we have less money and the crisis only makes it worse." *Barcelona health politician, ID 2.*

Informants also referred to opportunities which enabled policy implementation. For example, the interviewees from Barcelona and Rotterdam made reference to working at the community level or with different sectors which led to learning opportunities. Community groups were seen as especially important in liaising with hard to reach groups. The interviewee from Brussels suggested that the migrant population promoted healthy lifestyle behaviours, as some of their customs had healthy components.

"There are definitely opportunities. Other services have problems as well and see the benefits of cooperation with groups who work with migrant population." *Brussels health officer ID 4.*

Discussion

To the best of our knowledge, this is the first study to explore policymakers' perceptions on health inequalities and policies to reduce these throughout various European cities from diverse geographical areas and with different socio-economic and political contexts. Three discourses were identified depending on the city of the interviewee: 1) London's approach focused on upstream determinants and policies; 2) Cluj-Napoca and Prague's where informants were less acquainted with social health inequalities and 3) the rest of the cities' informants who perceived health inequalities as differences in life expectancy among the population defined by their economic, social and geographical background. Regarding the causes of health inequalities, these were seen as being caused by low-income levels, unhealthy lifestyle behaviours and barriers in accessing health care. Most of the informants agreed that reducing these inequalities was a priority of their local governments and referred to periodic surveys as information sources to monitor them. Nearly all policies and interventions were targeted at modifying health behaviours and some relied upon inter-sectoral collaboration. Furthermore, bureaucracy, funding and the population´s attitudes and beliefs towards healthy lifestyles were considered important barriers.

The majority of informants described upstream determinants such as socio-economic and structural factors as the causes of health inequalities but nevertheless focused on describing downstream policies and programmes. This could be due to the fact that the informants work in city governments and even though they are aware of the main causes of health inequalities, their daily routines involve work with downstream policies and programmes. In this regard, some city councils may have limited authority over upstream determinants[4,32] or over health when it is under the authority of higher levels of government; such was the case of Paris and Brussels. In this sense,

policymakers seemed to refer to what was within their mandate, so even if they understood structural determinants were important in addressing health inequalities, the activities they described were focused within their own jurisdiction. Downstream, interventions targeted at disadvantaged populations such as some of the ones described by the interviewees, which do not aim at reducing inequalities throughout the whole gradient, may end up being diluted into multiple small downstream initiatives and are less effective in reducing health inequalities.[33,34] This also carries the risk of health inequalities becoming the responsibility of each individual, which is already an existing trend,[35] and downplaying the responsibilities and competences of the city government which will constitute a barrier for the local city governments in tackling inequalities. Moreover it has been widely argued that if interventions are not delivered carefully, they are likely to increase inequalities as those who are most in need, might not benefit from the intervention.[36] However, as described elsewhere,[5] the majority of research on health inequalities relates to downstream determinants and focuses on individual lifestyle factors,[37] so little information is provided to policymakers on the wider determinants and the underlying causes of the causes of health inequalities.[38]

Furthermore, with the exception of Brussels' and London's interviewees, the concept of the socioeconomic gradient in health was not present among respondents; their understanding of reducing health inequalities connoted reducing the differences between the most deprived groups and the rest of the city's population. Therefore, their discourses did not seem to acknowledge that inequalities affect the entire population and not only the most disadvantaged populations.[39]

Except for Lisbon and the Central-eastern European cities, most of the informants mentioned having access to information on health inequalities through periodical surveys or health reports. Those with access to regular information on health inequalities would be more likely to see the underpinning structural causes and be willing to act upon them. Furthermore, Prague and Cluj-Napoca expressed not being aware of the existence of inequalities in their cities possibly because they were not as familiar with the concept. There are relevant studies on health inequalities in the Czech Republic[40,41] and in Romania.[42] Nevertheless, the overarching INEQ-Cities project[29] will provide the cities included in the project with further data on health inequalities at the small area level. Data on health indicators and inequalities is important for various reasons: to understand how causal pathways are established and to design effective policies and interventions.[4,11] While elsewhere it was concluded that researchers do not provide policymakers with befitting and timely information

[15,22,43] constantly requiring more evidence runs the risk of delaying having to face the problem and making decisions.[44] Nevertheless, additional evidence on the social determinants of health, and particularly on effective interventions and policies is important.

The majority of the informants understood that reducing health inequalities was a priority for their city government. However, only the city governments of Amsterdam, Barcelona, Helsinki, London, Madrid, Rotterdam, Lisbon and Stockholm had health plans, and within these only London has a specific plan for reducing health inequalities, as has also been described elsewhere.[13] Our findings partly reflect the different stages of awareness and action undertaken in the cities as it describes a spectrum of different approaches towards inequalities adopted by countries throughout Europe. We understand that a strong political will is inherent to tackling health inequalities along with supplying policymakers with information on the social determinants and how the gradient operates.[33]

Many of the participants described participation between sectors at some level, even though not all cities showed the same involvement. A study carried out also within the INEQ-Cities project analysing policy documents of some of the cities included in this study showed similar results.[13] Another study[23] observed that the structure of political responsibilities in the Canadian context offered important constraints for inter-sectoral collaboration. Encouraging the continuation of collaborative strategies may have a substantial impact on reducing health inequalities, previous research has shown that inter-sectoral collaboration between the health and other sectors is essential to achieving health outcomes in a more effective way than form the health sector alone.[45] Fewer cities described participatory processes and collaborating with social actors. Including other stakeholders in policy-making processes is an important step to city governance and empowerment, both decisive in reducing health inequalities more effectively.[34,46] However, there are many different barriers which policymakers encounter when trying to establish collaborative relationships such as an overall lack of awareness of health inequalities among those who work in the city government, difficulties to coordinate with other authorities, a lack of mandate, and limited resources.[16,8]

Along with the barriers mentioned above, lack of awareness on health inequalities and bureaucratic restraints were the main barriers to reduce health inequalities as quoted by the interviewees and have been categorised elsewhere as ideological and

institutional.[23] Institutional limitations are related to values attitudes and opinions; one possible explanation why this approach has been underlined is that informants seemed to focus mostly on lifestyles and healthy behaviours instead of structural determinants as the causes of health inequalities. Furthermore, the second group of barriers referring to rigid bureaucracy and funding might also be reinforced by the ideological barriers and exacerbated by the social and financial crisis and subsequent austerity measures.

Limitations and strengths

It should be also taken into account that in some cases, the politicians interviewed gave political discourses and it was a difficult task to make them follow the topics. Participants were selected through an opportunity sampling, they might not be the most representative informants in their fields; other respondents might have wider knowledge on the subject or they possibly participated due to their willingness, accessibility as well as interest in the area of health inequalities and therefore may be more sensitive to the issue. The interviews were carried out by different interviewers from each city in their native language so that participants could express themselves more freely. The results of politicians and officers have been presented together as we found no differences in their discourses. Nevertheless, the informants included in this study were selected following the pre-established criteria so both elected and non-elected informants were highly positioned in their municipal government´s structure and had decision making competences. The data was collected 3-4 years ago so parties governing in the cities may have changed and the elected officials may not be working in decision making positions at the present moment. However, describing these beliefs provides very valuable information on the governance of cities given the key role of policymakers.

As a relevant strength of the study, the interviewees included many examples of their everyday experiences and realities providing rich and detailed information. They expressed their own beliefs and describing them provides very valuable information on the governance of cities given the key role of policymakers. Moreover, carrying out the interview, an activity seldom performed previously, probably drew politicians to review the issue, update their knowledge and learn about the INEQ-Cities project (INEQ-Cities 2012). The findings of the present study to some extent mirrors the findings of the analysis of health policy documents in the same cities, and illustrates the different stages at which cities are concerning work on health inequalities.[13] This exploratory

study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, will hopefully be a stepping stone for further studies and also has the important advantage of having information from quite a large number of cities.

Conclusions and recommendations

The majority of the interviewed policymakers gave an account of interventions focusing on the immediate determinants and aimed at modifying lifestyles and behaviours in the more disadvantaged classes. Some described inter-sectoral action explicitly and for most cities reducing health inequalities was a priority and policymakers had access to periodic information.

Future collaboration between the research centres from Cluj-Napoca and Prague and their local governments could possibly foster more awareness about health inequalities and their causes and the importance of addressing them. Providing decision makers from the municipal governments with information on policies aimed at addressing upstream determinants alongside health indicators should be encouraged further to promote knowledge on their role in addressing health inequalities.

More funding should be put towards academic research on effective universal policies, evaluation of their impact and training policymakers and officers on health inequalities in city governments. Further advocacy must be carried out to place health inequalities and their implications in the municipal government's agenda and in city health plans.

Acknowledgements

We would like to thank the informants who participated in the interviews and the interviewers who carried them out and all the partners involved in the INEQ-Cities project. This article has been partially funded by the project: INEQ-Cities, "Socioeconomic inequalities in mortality: evidence and policies of cities of Europe"; project funded by the Executive Agency for Health and Consumers-DG Sanco (Commission of the European Union), project nº2008 12 13 and CIBERESP Epidemiología y Salud Pública.

Conflicts of interests

The authors declare not to have any conflicts of interest.

Data sharing statement

No additional data are available.

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Table 1. City profile indicators[1]

City	Year of the indicator	Population aged 0 – 14 %	Population aged 65 and older %	Population aged 16 - 64 in the labour market %	Unemployment %	Immigrant population %
Amsterdam	2001	16.1	11.3	72.0	13.3	48.3
Barcelona	2005	12.3	20.8	57.2	8.7	21.5
Brussels	2001	18.3	15.4	64.9	18.2	26.3
Helsinki	2004	14.5	13.8	78.9	9.1	7.3
Lisbon	2001	14.9	15.4	73.3	7.6	5.7
London	2001	20.2	12.0	67.6	5.2	24.9
Madrid	2005	12.8	18.7	74.1	8.2	14.1
Paris	2007	14.4	14.1	75.5	11.3	20
Prague	2006	12.3	15.6	74.8	3.5	7.6
Rotterdam	2001	17.2	14.3	69	9	45
Stockholm	2005	18	14.1	76	5.3	24.3
Turin	2005	11.4	23.4	67.8	11.4	5.6

1. The information was provided by each city and proceeds from different information sources

Table 2. Description of the 19 informants*

Identification	City (Country)	Status	Profile	Party
1	Amsterdam (Netherlands)	Officer	Health	NA
2	Barcelona (Spain)	Politician	Health	Eco-socialism
3	Barcelona (Spain)	Politician	Non-Health	Eco-socialism
4	Brussels (Belgium)	Officer	Health	NA
5	Cluj-Napoca (Romania)	Officer	Health	NA
6	Helsinki (Finland)	Officer	Health	NA
7	Lisbon (Portugal)	Politician	Non-Health	Social democracy
8*	London (United Kingdom)	Officer	Health	NA
9*	London (United Kingdom)	Officer	Health	NA
10	Madrid (Spain)	Officer	Health	NA
11	Madrid (Spain)	Officer	Health	NA
12	Paris (France)	Officer	Health	NA
13	Prague (Czech Republic)	Officer	Health	NA
14	Prague (Czech Republic)	Officer	Health	NA
15	Rotterdam (Netherlands)	Officer	Non-Health	NA
16	Stockholm (Sweden)	Politician	Health	Christian democratic
17	Stockholm (Sweden)	Politician	Health	Social democracy
18	Turin (Italy)	Politician	Non-Health	Social democracy
19	Turin (Italy)	Politician	Non-Health	Social democracy

^ NA= Not applicable

* Both informants 8 and 9 from London were interviewed together. The information was generated through 18 in-depth interviews

Table 3. Summary of cities' discourses

City	Knowledge on HI[1] and their causes	Reducing HI as a priority for the city government	Information on health inequalities	Knowledge on policies and programs	Intersectoral collaboration/ participation of social agents	Barriers	Opportunities
Amsterdam	Economic, genetic, environmental, ethnic factors	It is a priority, through changing economic and political factors	Health survey, city memo, collaboration with academics	The city has a Health Plan	There is specific collaboration with other sectors	Funding and the administrative organisation	Health topics are placed in the agenda of organisations
Barcelona	Capitalist economic system, different life expectancy between neighbourhoods structural poverty, traditional and emerging inequalities	HI is a priority but mostly for the health sector and at the local level	Annual city health report and health policy evaluation. Social observatory	Urban regeneration policies. Non-health policies with health outcomes, Health in the neighbourhoods strategy to reduce HI	Not a formal intersectorality, council organisation still compartmentalised. 18 plans with community action, civil society	Financial restraints, factual powers	Proximity to the community and intersectorality
Brussels	Gradient in health, socio-economic position, lack of redistribution mechanisms, segregation, personal traits, access to health care	Reducing HI is an absolute priority	Death certificates, census, national health survey, more data is needed on children	No specific policies aimed at health inequalities	Collaboration is transversal with 3 political structures. Social agents are advisory bodies and also participate in action plans	The liberal course of EU[2]. Geographic proximity of actors	Migrant population contribute to healthy lifestyles
Cluj-Napoca	Health inequalities are not an issue	Reducing HI is not a priority, health is a right for all people	The city has the population health statistics	There are preventive measures for the whole population	There is close cooperation with municipalities	Funding and administrative restraints are a barrier	
Helsinki	Sex, education, unemployment, living conditions, social relations, exclusion of young people and ways of life	Strategy of city council 2009-2012. Resources directed at reducing HI	There is some information because it is a strategy of the city	Healthy Helsinki project to reduce HI. Non-smoking and responsible alcohol consumption programmes	There is not enough intersectorality. Steering committees include various social agents. Intersectorality might be slow	Difficulty to obtain funding. Administrative structures	Funding and good cooperation create opportunities
Lisbon	Socioeconomic, demographic, income and age inequalities. Housing conditions	Reducing HI is not explicitly a priority, but it should be. We have the Municipal master plan	There is no information or assessment	Policies and plan targeted at aging	Intersectorality is inherent in tackling health inequalities	Cultural, economic and legislative obstacles	Initiatives with multiple dimensions

London	Social determinants in a global context. Lack of evidence base of strategies. Policies directed at most deprived instead of all population	The informants did not answer explicitly that reducing HI was a priority	There is not a must on information. Data is pieced together	Primary care interventions, employment programmes, partnership approach, no knowledge on EU funds	There is intersectoral work with local partnerships not only health services	Little capacity to influence the upstream determinants of inequalities	Promoting local integration and pool resources
Madrid	Socio-economic inequalities, housing, lifestyles, education, Income, cultural behaviours. Inequalities at the district level, access to healthcare services	A priority to be dealt with by health care systems	Yes, through research and the annual report	Plan Vallecas to change behaviours. Law for health, programme for the homeless with tuberculosis, for sexual trade workers, for women of Roma ethnicity, children at risk	Plan Vallecas which is multidisciplinary, communitary and participatory. The aim is to work transversally but it is difficult. Neighbours' associations and participation at the micro level	Relations with other institutions, budget delimitation, lack of awareness of the population, little information on the impact of programmes	To integrate the actions on the groups affected by health inequalities
Paris	Access to health care	Health is not responsibility of the city government or a priority	Epidemiological information and on local health issues for specific municipalities	City policy: measures at the city level, preventive measures, public Health programmes in the neighbourhoods	City health workshops	The consideration of health in the context of urban policy	
Prague	Social status, poverty, chosen lifestyle, voluntarily socially excluded	Health inequalities are not a priority	National plan of social politics but no periodic support	Health 21, strategic plan of Prague	Complex a to work with different sectors, social agents make themselves heard	Legislative and coordination issues, financial barriers	NGO´s[3] are very close to the socially excluded
Rotterdam	Socioeconomic differences	Yes, with a broad view on health. Health is a precondition for the life of the city	Health is included in a general biannual survey	Directed at unhealthy behaviour of low SES, air quality and traffic, health plan	Work, participation, education. "Healthy in the city": city health plan. "From complaint to strength", depression and diabetes. Many joint projects but no collaboration with social actors	Long timeframe in cooperating with other networks. Different levels in institutions have trouble communicating	Benefits of cooperation
Stockholm	Structural differences: housing segregation, education level, age group, income, migration criminal acts/safety and living conditions. Health inequalities in Stockholm are very large	Based on health care services. Legislation is there but the educated are the ones who benefit. Accessibility to health care is the highest priority	Public health survey produced every four years, review of health care services, Karolinska Institute Public Health Academy reports	Wide range of choice of health providers, addressed at behavioural and cultural determinants, resources for prevention are too small	Action plan for health, Hard for actors to cooperate voluntary organisations which strengthen the community but nonexistent in participatory process	Lack of competence, knowledge and methods to change behaviours	Resources, Evidenced based health prevention, Engaged people working in health centres

Turin	Housing conditions, overcrowding, economic and employment crisis, deterioration of social conditions	The city has a direct and privileged approach to dealing with inequality but there are conflicts of interest	No use of effectiveness indicators for evaluation and modification of policies	Policies not addressed at specific groups, traffic calming and public transport development, security, social housing, local welfare strategies	Sentinel events arise interest but there is a conflict of interests in the political administration	Structural policies tend to be slow	Social cooperatives for housing by improving existing assets

1. HI: Health Inequalities

2. EU: European Union

3. NGOs Non-Governmental Organisations

Box 1. Interview topic guide

Topics
• *Can you explain your point of view on health inequalities in [name of city]?* • *Which do you consider are the causes of these health inequalities?* • *Is tackling health inequalities a priority in [name of city] or your local area?* • *Do you have periodic information on health inequalities and policies designed to reduce them?* • *Are there policies aimed at reducing health inequalities in [name of city]? Could you name and describe them?* • *Do these policies cover different areas?* • *Were these policies designed with the participation of different social agents?* • *Sometimes some opportunities arise which may enable the implementation of interventions or policies. Please, can you provide any experience or thoughts about this?* • *Which barriers do you face when reducing health inequalities?* • *Do you know of policies funded with European structural funds?*

BMJ Open

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Journal:	*BMJ Open*
Manuscript ID:	bmjopen-2013-004454.R2
Article Type:	Research
Date Submitted by the Author:	15-Apr-2014
Complete List of Authors:	Morrison, Joana; University College London, Department of Epidemiology and Public Health; CIBERESP, Pons-Vigués, Mariona; Institut Universitari d'Investigació en Atenció Primària Jordi Gol (IDIAP Jordi Gol), ; Universitat de Girona, Becares, Laia; University of Manchester, Burström, Bo; Karolinska Institutet, Department of Public Health Sciences, Division of Social Medicine Gandarillas, Ana; Subdirección General de Promoción de la Salud y Prevención. Consejería de Sanidad. Comunidad de Madrid (Subdirectorate-General for Health Promotion and Prevention. Madrid Regional Health Authority), Domínguez-Berjón, Felicitas; Subdirección General de Promoción de la Salud y Prevención. Consejería de Sanidad. Comunidad de Madrid (Subdirectorate-General for Health Promotion and Prevention. Madrid Regional Health Authority), Díez, Elia; Agència de Salut Pública de Barcelona, ; Ag&#65533;ncia de Salut P&#65533;blica de Barcelona Costa, Giuseppe; University of Turin, Department of Clinical and Biological Science Ruíz, Milagros; University College London, Department of Epidemiology and Public Health Pikhart, Hynek; University College London, Department of Epidemiology and Public Health Marinacci, Chiara; Epidemiology Department, Local Health Unit TO3, ; Ministry of Health, Italy, Hoffmann, Rasmus; Erasmus Medical Centre, Santana, Paula; Centro de Estudos de Geógrafa e Ordenamento do Território (CEGOT), Departamento de Geografia, Universidade de Coimbra, Borrell, Carme; Ag&#65533;ncia de Salut P&#65533;blica de Barcelona; CIBERESP,
Primary Subject Heading:	Health policy
Secondary Subject Heading:	Qualitative research, Public health, Epidemiology
Keywords:	Health inequalities, Public policies, Municipal government, Policymaker, Knowledge, QUALITATIVE RESEARCH

Health inequalities in European cities: Perceptions and beliefs among local policymakers

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Keywords Health inequalities, public policies, municipal government, policymaker, knowledge, qualitative research, urban health

Word count: 4238

Abstract

Objective To describe the knowledge and beliefs of public policymakers on social inequalities in health and policies to reduce them in cities from different parts of Europe during 2010 and 2011.

Design Phenomenological qualitative study.

Setting Thirteen European cities.

Participants Nineteen elected politicians and officers with a directive status from thirteen European cities.

Main outcome Policymaker's knowledge and beliefs.

ResultsThree emerging discourses were identified among the interviewees, depending on the city of the interviewee. Health inequalities were perceived by most policy makers as differences in life expectancy between population with economic, social and geographical differences. Reducing health inequalities was a priority for the majority of cities which use surveys as sources of information to analyse these. Bureaucracy, funding and population beliefs were the main barriers.

Conclusions The majority of the interviewed policymakers gave an account of interventions focusing on the immediate determinants and aimed at modifying lifestyles and behaviours in the more disadvantaged classes. More funding should be put towards academic research on effective universal policies, evaluation of their impact and training policymakers and officers on health inequalities in city governments.

Limitations

- Respondents possibly participated due to their willingness, accessibility as well as interest in the area of health inequalities and therefore may be more sensitive to the issue.
- The data was collected 3-4 years ago so parties governing in the cities may have changed.
- In some cities, either officers or politicians were interviewed; it might have been more desirable to have one of each for every city.
- As the interviewees were selected by INEQ-Cities partners from each city, these were chosen by opportunity sampling.

Strengths

- The interviewees included many examples of their everyday experiences and realities providing rich and detailed information.
- Carrying out the interview, an activity seldom performed previously among policymakers, possibly drew them to review the issue, update their knowledge and learn about the INEQ-Cities project and its results on heath inequalities in their cities.
- Since this is an exploratory study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, it will hopefully be a stepping stone for further qualitative research on the topic.
- This study has the important advantage of having collected information from quite a large number of cities throughout Europe.

Introduction

Health inequalities in urban environments are complex[1,2] affect the entire population throughout the health gradient[3] and require a multi-sectoral approach to address multiple social and economic determinants.[4] To that effect, although city governments' competences and authorities vary, they are endowed with jurisdiction to develop strategic plans and policies, provide services and deliver interventions which may address health inequalities.[5-7]

Within governments, policymakers are responsible for decision and policy-making in the form of laws, guidelines, and regulations[8] and their knowledge, beliefs and perceptions are relevant in the implementation of these. It is important to know whether the concept of the social determinants of health inequalities is imbedded in their discourse[9,10] in addition to the information on health issues provided to them as reports or surveys. These topics, explored in this study, may determine the course of the policy-making process.[11,12] Furthermore, their perceptions regarding the responsibilities and priorities of city governments and the city government's strategic plans possibly influence the policies in place.[13,14] These issues along with how policymakers make use of their knowledge will influence decision making and affect how health inequalities are addressed by city governments.[8,15,16]

The majority of studies exploring the knowledge and beliefs of health inequalities have explored lay perceptions[17-20] and the few studies describing expert beliefs focused on researchers and policymakers working in regional and national governments.[9,21,22] To our knowledge, there are only a small number of studies focusing on policymakers in the city government[5,6,14,23] and this is among the first qualitative studies to compare the perceptions of policymakers in different European cities. The use of rigorous qualitative research methods has been on the rise in health services and health policy research[24] to explore the experiences of participants and the meanings they attribute to them, to contribute new knowledge and to provide new perspectives.[25] It is consistent with developments in the social and policy sciences at large and has been described to reflect the need for more in-depth understanding of naturalistic settings the importance of understanding context and the complexity of implementing social change.[26] Selecting policymakers from different European cities provided a description of the different socio-political realities and contexts according to the participant's daily experiences to provider a richer and wider view on reducing health inequalities at the municipal level throughout the continent. Notwithstanding their

diversity, the participant cities share important commonalities as European democracies and urban settings, allowing to explore the study object from a new view. Previous studies[13] in the project have analysed written policy documents in these cities. The objective of this study is to further increase the understanding of how policies are realised, through the perception and beliefs of public policy makers in thirteen European cities during 2010 and 2011.

Methods

Methodological development

We carried out a descriptive and exploratory qualitative research study from a phenomenological perspective[27] as it sought to capture policymakers' unique accounts of reality in order to capture a breadth of discourses on health inequalities[28]. Data was collected from thirteen cities (Amsterdam, Barcelona, Brussels, Cluj-Napoca, Helsinki, Lisbon, London, Madrid, Paris, Prague, Rotterdam, Stockholm and Turin; see Table 1 for information on the cities' profiles) from eleven different European countries participating in the project; Socio-economic inequalities in mortality: evidence and policies in cities of Europe 2009-2012 (INEQ-Cities)[29] during the years 2010 and 2011.

Participants and sampling technique

The study population consisted of nineteen public policymakers, selected through opportunity sampling[28], see Table 2, working in the aforementioned cities' governments during the research period. A sample of elected politicians which included councillors and or aldermen and high ranked, non-elected, officers was selected. Policymakers were chosen from the health sector as well as other non-health sectors to provide a wider range of discourses. Interviews were performed by INEQ-Cities' partners, who interviewed a maximum of two participants, in their respective cities. Furthermore, subjects were chosen only if they held a decision making position.

Data collection and generation techniques

Seventeen semi-structured individual interviews and one semi-structured interview where two informants participated were carried out from November 2010 to June 2011 using an open-ended question topic guide (Box 1). The interviews provided information on the participant's knowledge and beliefs of health inequalities and policies to address these, as well as the role of the municipal government. The interview topic guide was

developed following the requirements listed in INEQ-cities' description of work and was further discussed with other project partners. Three pilot interviews were performed in Barcelona to test the topic guides and final versions of the guide were distributed to the project partners in the abovementioned cities who then conducted the interviews. The sessions were carried out in each city's native language and lasted between 45 minutes and an hour, where clarification of the topics was needed, some interviewers made city-specific questions. The interviewers belonged to partner groups from the INEQ-Cities project. A data collection manual designed by the authors of this study was sent to each partner and interviewer, providing guidelines on how to perform the interview to ensure that these were carried out in a standardised way. To our knowledge the only participant who did not wish to participate was from the city of Kosice and was therefore not included in the study. Interviews were translated to English by each partner and several sent the transcripts and summaries to the informants for approval. The summaries and the transcripts were sent to the authors carrying out the analysis in English.

Processing and analysis of information

All transcripts and summaries were analysed centrally on the basis of a thematic interpretive content analysis[27] by 2 researchers (JM and MP). Interviews were read numerous times until researchers reached pre-analytical intuitions on each of the interviewee's discourses and texts were then coded using predefined and emergent categories. The text was divided following these categories before performing an analysis of the written content and finally the content was articulated into results. Two research members carried out the analysis process independently with the support of Atlas.Ti software,[30] and compared the main findings with the original data. The working manuscript was sent to informants through each project partner for approval.[31]

Ethical considerations

Informed consent was obtained through verbal means and the information was anonymised and confidential. No participants received a salary or reward as participation was completely voluntary and the study received formal ethical approval by a research ethics committee (Hospital del Mar de Barcelona Research Ethics Committee).

Results

Three emerging discourses were identified among the interviewees, as follows, depending on the city of the interviewee: London's informants focused on structural determinants as the main causes of health inequalities and described universal policies aimed at these, Prague and Cluj-Napoca's interviewees were not as familiar with the concept of the social health inequalities. Informants from other cities had a mixed approach, although they referred to the wider determinants as the causes of health inequalities, they also suggested downstream interventions to address these. It was not possible, however, to distinguish differences in discourses between officers and politicians or health and non-health informants. Table 3 shows a summary of the responses giving by each city´s participants. Presented below, the results have been arranged in six sections following the major topics explored in the interviews. The informant's identification (ID) can be seen in Table 2.

Knowledge on health inequalities and their causes

Two broad discourses were found within the informant's perceptions and knowledge of health inequalities. The first discourse corresponds to the majority of informants who were aware of such inequalities and described them as differences in health. These were expressed, for example, as differences in life expectancy.

We have large differences in health: people live five years longer in areas such as Kungsholmen (inner city area of Stockholm municipality) compared to areas such as Järva fältet" Stockholm health politician, ID 16

They also explained that health inequalities existed among the population according to their levels of education or income, gender, age and the neighbourhood in which they lived.

"There are factors which relate to education, employment or unemployment, living conditions, income, social relations and ways of life. Also the social exclusion of young people generates inequalities in health." Helsinki health officer, ID 6.

In addition, the interviewee from Lisbon pointed out that inequalities were increasing as did the informant from Brussels who understood them as a gradient.

The second discourse corresponded to informants from Cluj-Napoca and Prague did not have a clear concept on social health inequalities, as described in the quote below.

"In this city we cannot talk about this concept. It is estimated that there are no legal criteria to make any differences between individuals in terms of access and use of medical care." Cluj-Napoca health officer, ID 5.

Concerning the causes of inequalities, the majority of the interviewees, identified a strong relationship between economic position, educational level and health. Furthermore, low income was perceived as the main cause of unhealthy lifestyle behaviours and reduced access to health care which lead to health inequalities. Other social determinants were also highlighted, such as gender, age group, type of household and residential segregation. The current economic crisis and reduced public expenditure were considered to exacerbate the problem and reduce the capacity of action of the local system.

In contrast, interviewees from Prague and Cluj-Napoca considered that health inequalities were chiefly a result of individual responsibility.

Reducing health inequalities as a priority for the city government

Most interviewees reported that reducing health inequalities was an objective of the city government included in either strategic plans or in specific laws. However interviewees from Prague and Cluj-Napoca did not consider it to be a priority of their municipal governments, whereas Lisbon informant's considered it was not a priority even though they thought it should be.

"Tackling inequalities in health should be a priority in the Lisbon Metropolitan Area and is not, directly, a hotly debated topic." Lisbon non-health politician, ID 7

The interviewees of Paris and Brussels explained that their city governments did not have jurisdiction over health matters as these are the responsibility of the regional authorities.

"In France, health is not a responsibility of the cities, although historically it was the cities that were in charge of sanitary aspects." Paris health officer, ID 12.

That's not easy to answer, as not all the areas are governed on the level of the communities or on the city level." Belgium, health officer, ID 4.

Information on health inequalities

To monitor health inequalities, the majority of the informants mentioned relying on health surveys which were published periodically in their cities and mortality statistics from their statistics authority.

"To track differences in health, a health survey is conducted every four years." Amsterdam health officer, ID 1.

London's interviewees described the need to integrate the different sources of information into one to make access to information easier. Informants from Lisbon and Prague declared not having information or assessment of health inequalities. Furthermore, the interviewee from Cluj-Napoca explained that periodic data of health inequalities was not available as this concept was not applicable.

Knowledge on policies and programs implemented

When asked about their knowledge of policies that address health inequalities, policymakers described actions aimed at deprived populations and at modifying attitudes and unhealthy behaviours, such as smoking and poor diets. They emphasised the importance of preventive measures and health promotion and education. Policies to improve access to health care services were also quoted as an important means to reduce health inequalities by most interviewees. However, the informants from London highlighted the need to address health inequalities throughout the general population rather than focusing on the most deprived sectors and developing long-term policies aimed at the social determinants, not only proximal factors, such as physical activity and fruit intake. Moreover, the informant from Turin highlighted local interventions aimed at addressing unemployment and the interviewee from Madrid described tackling health inequalities at the local level.

"We have to work on the processes…I'm talking from the micro level, which is where I have more experience, but I think that's where the solution lies, in the micro level." Madrid health politician, ID 10.

The informants from Prague, however, did not mention any policies implemented by their city government and referred to national health plans as a reference for health-related issues.

Inter-sectoral collaboration and participation of social agents in policymaking

Interviewees from Madrid, London, Rotterdam and Lisbon referred to strategic plans which fostered inter-sectoral collaboration between different administrations, citizens' and non-profit associations and established local partnerships. Barcelona and Turin, in turn, described inter-sectoral collaboration established only between two sectors, for example between health and welfare or health and education. While Lisbon cited examples of housing policies for groups at risk of exclusion, some informants suggested that inter-sectoral collaboration slowed down the policymaking process and perceived that having different sectors collaborate proved to be difficult.

"Yes. Action on inequalities in health is synonymous with disciplinary cross-cutting. In this sense, this theme is incorporated in several areas such as education, social service, environmental and cultural policies, among others, addressed in the municipal master plan." Lisbon, non-health politician, ID 7.

With respect to community organisations participating in the policymaking process, the majority of the informants thought their city governments collaborated with these, however informants from Rotterdam, Turin and Stockholm considered it was very limited.

"The social networks exist but they need public support. There is no doubt that there should be more shared responsibility among private sector and public services or welfare systems." *Turin non-health politician, ID 18.*

Barriers and opportunities encountered

One of the principal barriers described was the lack of awareness on changing unhealthy lifestyles among the population. Informants from Stockholm and Lisbon considered the obstacles addressing health inequalities to be essentially related to imbedded cultural beliefs which made adopting healthier lifestyles difficult. Bureaucratic restraints and resistance from other levels of the administration along with miscommunication with the private sector as well as budget restrictions were described as important barriers by the majority of interviewees. London's interviewee explained

that implementing financial policies from within a city government was complicated in the context of globalisation.

"We come across them all the time and a very important one is the financial issue. Every year we have less money and the crisis only makes it worse." *Barcelona health politician, ID 2.*

Informants also referred to opportunities which enabled policy implementation. For example, the interviewees from Barcelona and Rotterdam made reference to working at the community level or with different sectors which led to learning opportunities. Community groups were seen as especially important in liaising with hard to reach groups. The interviewee from Brussels suggested that the migrant population promoted healthy lifestyle behaviours, as some of their customs had healthy components.

"There are definitely opportunities. Other services have problems as well and see the benefits of cooperation with groups who work with migrant population." *Brussels health officer ID 4.*

Discussion

To the best of our knowledge, this is the first study to explore policymakers' perceptions on health inequalities and policies to reduce these throughout various European cities from diverse geographical areas and with different socio-economic and political contexts. Three discourses were identified depending on the city of the interviewee: 1) London's approach focused on upstream determinants and policies; 2) Cluj-Napoca and Prague's where informants were less acquainted with social health inequalities and 3) the rest of the cities' informants who perceived health inequalities as differences in life expectancy among the population defined by their economic, social and geographical background. Regarding the causes of health inequalities, these were seen as being caused by low-income levels, unhealthy lifestyle behaviours and barriers in accessing health care. Most of the informants agreed that reducing these inequalities was a priority of their local governments and referred to periodic surveys as information sources to monitor them. Nearly all policies and interventions were targeted at modifying health behaviours and some relied upon inter-sectoral collaboration. Furthermore, bureaucracy, funding and the population´s attitudes and beliefs towards healthy lifestyles were considered important barriers.

The majority of informants described upstream determinants such as socio-economic and structural factors as the causes of health inequalities but nevertheless focused on describing downstream policies and programmes. This could be due to the fact that the informants work in city governments and even though they are aware of the main causes of health inequalities, their daily routines involve work with downstream policies and programmes. In this regard, some city councils may have limited authority over upstream determinants[4,32] or over health when it is under the authority of higher levels of government; such was the case of Paris and Brussels. In this sense, policymakers seemed to refer to what was within their mandate, so even if they understood structural determinants were important in addressing health inequalities, the activities they described were focused within their own jurisdiction. Downstream, interventions targeted at disadvantaged populations such as some of the ones described by the interviewees, which do not aim at reducing inequalities throughout the whole gradient, may end up being diluted into multiple small downstream initiatives and are less effective in reducing health inequalities.[33,34] This also carries the risk of health inequalities becoming the responsibility of each individual, which is already an existing trend,[35] and downplaying the responsibilities and competences of the city government which will constitute a barrier for the local city governments in tackling inequalities. Moreover it has been widely argued that if interventions are not delivered carefully, they are likely to increase inequalities as those who are most in need, might not benefit from the intervention.[36] However, as described elsewhere,[5] the majority of research on health inequalities relates to downstream determinants and focuses on individual lifestyle factors,[37] so little information is provided to policymakers on the wider determinants and the underlying causes of the causes of health inequalities.[38]

Furthermore, with the exception of Brussels' and London's interviewees, the concept of the socioeconomic gradient in health was not present among respondents; their understanding of reducing health inequalities connoted reducing the differences between the most deprived groups and the rest of the city's population. Therefore, their discourses did not seem to acknowledge that inequalities affect the entire population and not only the most disadvantaged populations.[39]

Except for Lisbon and the Central-eastern European cities, most of the informants mentioned having access to information on health inequalities through periodical surveys or health reports. Those with access to regular information on health inequalities would be more likely to see the underpinning structural causes and be willing to act upon them. Furthermore, Prague and Cluj-Napoca expressed not being

aware of the existence of inequalities in their cities possibly because they were not as familiar with the concept. There are relevant studies on health inequalities in the Czech Republic[40,41] and in Romania.[42] Nevertheless, the overarching INEQ-Cities project[29] will provide the cities included in the project with further data on health inequalities at the small area level. Data on health indicators and inequalities is important for various reasons: to understand how causal pathways are established and to design effective policies and interventions.[4,11] While elsewhere it was concluded that researchers do not provide policymakers with befitting and timely information [15,22,43] constantly requiring more evidence runs the risk of delaying having to face the problem and making decisions.[44] Nevertheless, additional evidence on the social determinants of health, and particularly on effective interventions and policies is important.

The majority of the informants understood that reducing health inequalities was a priority for their city government. However, only the city governments of Amsterdam, Barcelona, Helsinki, London, Madrid, Rotterdam, Lisbon and Stockholm had health plans, and within these only London has a specific plan for reducing health inequalities, as has also been described elsewhere.[13] Our findings partly reflect the different stages of awareness and action undertaken in the cities as it describes a spectrum of different approaches towards inequalities adopted by countries throughout Europe. We understand that a strong political will is inherent to tackling health inequalities along with supplying policymakers with information on the social determinants and how the gradient operates.[33]

Many of the participants described participation between sectors at some level, even though not all cities showed the same involvement. A study carried out also within the INEQ-Cities project analysing policy documents of some of the cities included in this study showed similar results.[13] Another study[23] observed that the structure of political responsibilities in the Canadian context offered important constraints for inter-sectoral collaboration. Encouraging the continuation of collaborative strategies may have a substantial impact on reducing health inequalities, previous research has shown that inter-sectoral collaboration between the health and other sectors is essential to achieving health outcomes in a more effective way than form the health sector alone.[45] Fewer cities described participatory processes and collaborating with social actors. Including other stakeholders in policy-making processes is an important step to city governance and empowerment, both decisive in reducing health inequalities more effectively.[34,46] However, there are many different barriers which policymakers

encounter when trying to establish collaborative relationships such as an overall lack of awareness of health inequalities among those who work in the city government, difficulties to coordinate with other authorities, a lack of mandate, and limited resources.[16,8]

Along with the barriers mentioned above, lack of awareness on health inequalities and bureaucratic restraints were the main barriers to reduce health inequalities as quoted by the interviewees and have been categorised elsewhere as ideological and institutional.[23] Institutional limitations are related to values attitudes and opinions; one possible explanation why this approach has been underlined is that informants seemed to focus mostly on lifestyles and healthy behaviours instead of structural determinants as the causes of health inequalities. Furthermore, the second group of barriers referring to rigid bureaucracy and funding might also be reinforced by the ideological barriers and exacerbated by the social and financial crisis and subsequent austerity measures.

Limitations and strengths

It should be also taken into account that in some cases, the politicians interviewed gave political discourses and it was a difficult task to make them follow the topics. Participants were selected through an opportunity sampling, they might not be the most representative informants in their fields; other respondents might have wider knowledge on the subject or they possibly participated due to their willingness, accessibility as well as interest in the area of health inequalities and therefore may be more sensitive to the issue. The interviews were carried out by different interviewers from each city in their native language so that participants could express themselves more freely. The results of politicians and officers have been presented together as we found no differences in their discourses. Nevertheless, the informants included in this study were selected following the pre-established criteria so both elected and non-elected informants were highly positioned in their municipal government´s structure and had decision making competences. The data was collected 3-4 years ago so parties governing in the cities may have changed and the elected officials may not be working in decision making positions at the present moment. However, describing these beliefs provides very valuable information on the governance of cities given the key role of policymakers.

As a relevant strength of the study, the interviewees included many examples of their everyday experiences and realities providing rich and detailed information. They

expressed their own beliefs and describing them provides very valuable information on the governance of cities given the key role of policymakers. Moreover, carrying out the interview, an activity seldom performed previously, probably drew politicians to review the issue, update their knowledge and learn about the INEQ-Cities project (INEQ-Cities 2012). The findings of the present study to some extent mirrors the findings of the analysis of health policy documents in the same cities, and illustrates the different stages at which cities are concerning work on health inequalities.[13] This exploratory study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, will hopefully be a stepping stone for further studies and also has the important advantage of having information from quite a large number of cities.

Conclusions and recommendations

The majority of the interviewed policymakers gave an account of interventions focusing on the immediate determinants and aimed at modifying lifestyles and behaviours in the more disadvantaged classes. Some described inter-sectoral action explicitly and for most cities reducing health inequalities was a priority and policymakers had access to periodic information.

Future collaboration between the research centres from Cluj-Napoca and Prague and their local governments could possibly foster more awareness about health inequalities and their causes and the importance of addressing them. Providing decision makers from the municipal governments with information on policies aimed at addressing upstream determinants alongside health indicators should be encouraged further to promote knowledge on their role in addressing health inequalities.

More funding should be put towards academic research on effective universal policies, evaluation of their impact and training policymakers and officers on health inequalities in city governments. Further advocacy must be carried out to place health inequalities and their implications in the municipal government's agenda and in city health plans.

Acknowledgements

We would like to thank the informants who participated in the interviews and the interviewers who carried them out and all the partners involved in the INEQ-Cities project. This article has been partially funded by the project: INEQ-Cities, "Socioeconomic inequalities in mortality: evidence and policies of cities of Europe"; project funded by the Executive Agency for Health and Consumers-DG Sanco (Commission of the European Union), project nº2008 12 13 and CIBERESP Epidemiología y Salud Pública.

Contributorship Statement

All authors made substantial contributions to conception and design of the study and interviews. They carried out the interviews in their own cities and translated these and provided a summary or transcription. Once the data was analysed by the coordinating centre, the authors interpreted the results and provided critical feedback as well as sending the results to informants and providing the coordinating centre with comments or suggestions made by them. Authors also participated in drafting the article and reviewed it critically several times, making substantial comments and suggestions regarding form, analysis and concepts. Authors also reviewed and approved the final version of the manuscript and provided their approval for publication.

Conflicts of interests

The authors declare not to have any conflicts of interest.

Data sharing statement

No additional data are available.

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Table 1. City profile indicators[1]

City	Year of the indicator	Population aged 0 – 14 %	Population aged 65 and older %	Population aged 16 - 64 in the labour market %	Unemployment %	Immigrant population %
Amsterdam	2001	16.1	11.3	72.0	13.3	48.3
Barcelona	2005	12.3	20.8	57.2	8.7	21.5
Brussels	2001	18.3	15.4	64.9	18.2	26.3
Helsinki	2004	14.5	13.8	78.9	9.1	7.3
Lisbon	2001	14.9	15.4	73.3	7.6	5.7
London	2001	20.2	12.0	67.6	5.2	24.9
Madrid	2005	12.8	18.7	74.1	8.2	14.1
Paris	2007	14.4	14.1	75.5	11.3	20
Prague	2006	12.3	15.6	74.8	3.5	7.6
Rotterdam	2001	17.2	14.3	69	9	45
Stockholm	2005	18	14.1	76	5.3	24.3
Turin	2005	11.4	23.4	67.8	11.4	5.6

1. The information was provided by each city and proceeds from different information sources

Table 2. Description of the 19 informants*

Identification	City (Country)	Status	Profile	Party
1	Amsterdam (Netherlands)	Officer	Health	NA
2	Barcelona (Spain)	Politician	Health	Eco-socialism
3	Barcelona (Spain)	Politician	Non-Health	Eco-socialism
4	Brussels (Belgium)	Officer	Health	NA
5	Cluj-Napoca (Romania)	Officer	Health	NA
6	Helsinki (Finland)	Officer	Health	NA
7	Lisbon (Portugal)	Politician	Non-Health	Social democracy
8*	London (United Kingdom)	Officer	Health	NA
9*	London (United Kingdom)	Officer	Health	NA
10	Madrid (Spain)	Officer	Health	NA
11	Madrid (Spain)	Officer	Health	NA
12	Paris (France)	Officer	Health	NA
13	Prague (Czech Republic)	Officer	Health	NA
14	Prague (Czech Republic)	Officer	Health	NA
15	Rotterdam (Netherlands)	Officer	Non-Health	NA
16	Stockholm (Sweden)	Politician	Health	Christian democratic
17	Stockholm (Sweden)	Politician	Health	Social democracy
18	Turin (Italy)	Politician	Non-Health	Social democracy
19	Turin (Italy)	Politician	Non-Health	Social democracy

^ NA= Not applicable

* Both informants 8 and 9 from London were interviewed together. The information was generated through 18 in-depth interviews

Table 3. Summary of cities' discourses

City	Knowledge on HI[1] and their causes	Reducing HI as a priority for the city government	Information on health inequalities	Knowledge on policies and programs	Intersectoral collaboration/ participation of social agents	Barriers	Opportunities
Amsterdam	Economic, genetic, environmental, ethnic factors	It is a priority, through changing economic and political factors	Health survey, city memo, collaboration with academics	The city has a Health Plan	There is specific collaboration with other sectors	Funding and the administrative organisation	Health topics are placed in the agenda of organisations
Barcelona	Capitalist economic system, different life expectancy between neighbourhoods structural poverty, traditional and emerging inequalities	HI is a priority but mostly for the health sector and at the local level	Annual city health report and health policy evaluation. Social observatory	Urban regeneration policies. Non-health policies with health outcomes, Health in the neighbourhoods strategy to reduce HI	Not a formal intersectorality, council organisation still compartmentalised. 18 plans with community action, civil society	Financial restraints, factual powers	Proximity to the community and intersectorality
Brussels	Gradient in health, socio-economic position, lack of redistribution mechanisms, segregation, personal traits, access to health care	Reducing HI is an absolute priority	Death certificates, census, national health survey, more data is needed on children	No specific policies aimed at health inequalities	Collaboration is transversal with 3 political structures. Social agents are advisory bodies and also participate in action plans	The liberal course of EU[2]. Geographic proximity of actors	Migrant population contribute to healthy lifestyles
Cluj-Napoca	Health inequalities are not an issue	Reducing HI is not a priority, health is a right for all people	The city has the population health statistics	There are preventive measures for the whole population	There is close cooperation with municipalities	Funding and administrative restraints are a barrier	
Helsinki	Sex, education, unemployment, living conditions, social relations, exclusion of young people and ways of life	Strategy of city council 2009-2012. Resources directed at reducing HI	There is some information because it is a strategy of the city	Healthy Helsinki project to reduce HI. Non-smoking and responsible alcohol consumption programmes	There is not enough intersectorality. Steering committees include various social agents. Intersectorality might be slow	Difficulty to obtain funding. Administrative structures	Funding and good cooperation create opportunities
Lisbon	Socioeconomic, demographic, income and age inequalities. Housing conditions	Reducing HI is not explicitly a priority, but it should be. We have the Municipal master plan	There is no information or assessment	Policies and plan targeted at aging	Intersectorality is inherent in tackling health inequalities	Cultural, economic and legislative obstacles	Initiatives with multiple dimensions

London	Social determinants in a global context. Lack of evidence base of strategies. Policies directed at most deprived instead of all population	The informants did not answer explicitly that reducing HI was a priority	There is not a must on information. Data is pieced together	Primary care interventions, employment programmes, partnership approach, no knowledge on EU funds	There is intersectoral work with local partnerships not only health services	Little capacity to influence the upstream determinants of inequalities	Promoting local integration and pool resources
Madrid	Socio-economic inequalities, housing, lifestyles, education, Income, cultural behaviours. Inequalities at the district level, access to healthcare services	A priority to be dealt with by health care systems	Yes, through research and the annual report	Plan Vallecas to change behaviours. Law for health, programme for the homeless with tuberculosis, for sexual trade workers, for women of Roma ethnicity, children at risk	Plan Vallecas which is multidisciplinary, communitary and participatory. The aim is to work transversally but it is difficult. Neighbours' associations and participation at the micro level	Relations with other institutions, budget delimitation, lack of awareness of the population, little information on the impact of programmes	To integrate the actions on the groups affected by health inequalities
Paris	Access to health care	Health is not responsibility of the city government or a priority	Epidemiological information and on local health issues for specific municipalities	City policy: measures at the city level, preventive measures, public Health programmes in the neighbourhoods	City health workshops	The consideration of health in the context of urban policy	
Prague	Social status, poverty, chosen lifestyle, voluntarily socially excluded	Health inequalities are not a priority	National plan of social politics but no periodic support	Health 21, strategic plan of Prague	Complex a to work with different sectors, social agents make themselves heard	Legislative and coordination issues, financial barriers	NGO´s[3] are very close to the socially excluded
Rotterdam	Socioeconomic differences	Yes, with a broad view on health. Health is a precondition for the life of the city	Health is included in a general biannual survey	Directed at unhealthy behaviour of low SES, air quality and traffic, health plan	Work, participation, education. "Healthy in the city": city health plan. "From complaint to strength", depression and diabetes. Many joint projects but no collaboration with social actors	Long timeframe in cooperating with other networks. Different levels in institutions have trouble communicating	Benefits of cooperation
Stockholm	Structural differences: housing segregation, education level, age group, income, migration criminal acts/safety and living conditions. Health inequalities in Stockholm are very large	Based on health care services. Legislation is there but the educated are the ones who benefit. Accessibility to health care is the highest priority	Public health survey produced every four years, review of health care services, Karolinska Institute Public Health Academy reports	Wide range of choice of health providers, addressed at behavioural and cultural determinants, resources for prevention are too small	Action plan for health, Hard for actors to cooperate voluntary organisations which strengthen the community but nonexistent in participatory process	Lack of competence, knowledge and methods to change behaviours	Resources, Evidenced based health prevention, Engaged people working in health centres

Turin	Housing conditions, overcrowding, economic and employment crisis, deterioration of social conditions	The city has a direct and privileged approach to dealing with inequality but there are conflicts of interest	No use of effectiveness indicators for evaluation and modification of policies	Policies not addressed at specific groups, traffic calming and public transport development, security, social housing, local welfare strategies	Sentinel events arise interest but there is a conflict of interests in the political administration	Structural policies tend to be slow	Social cooperatives for housing by improving existing assets

1. HI: Health Inequalities

2. EU: European Union

3. NGOs Non-Governmental Organisations

Box 1. Interview topic guide

Box 1. Interview topic guide

Topics
• *Can you explain your point of view on health inequalities in [name of city]?* • *Which do you consider are the causes of these health inequalities?* • *Is tackling health inequalities a priority in [name of city] or your local area?* • *Do you have periodic information on health inequalities and policies designed to reduce them?* • *Are there policies aimed at reducing health inequalities in [name of city]? Could you name and describe them?* • *Do these policies cover different areas?* • *Were these policies designed with the participation of different social agents?* • *Sometimes some opportunities arise which may enable the implementation of interventions or policies. Please, can you provide any experience or thoughts about this?* • *Which barriers do you face when reducing health inequalities?* • *Do you know of policies funded with European structural funds?*

Health inequalities in European cities: Perceptions and beliefs among local policymakers

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Keywords Health inequalities, public policies, municipal government, policymaker, knowledge, qualitative research, urban health

Word count: 4212

Abstract

Objective To describe the knowledge and beliefs of public policymakers on social inequalities in health and policies to reduce them in cities from different parts of Europe during 2010 and 2011.

Design Phenomenological qualitative study.

Setting Thirteen European cities.

Participants Nineteen elected politicians and officers with a directive status from thirteen European cities.

Main outcome Policymaker's knowledge and beliefs.

Results Three emerging discourses were identified among the interviewees, depending on the city of the interviewee. Health inequalities were perceived by most policy makers as differences in life expectancy between population with economic, social and geographical differences. Reducing health inequalities was a priority for the majority of cities which use surveys as sources of information to analyse these. Bureaucracy, funding and population beliefs were the main barriers.

Conclusions The majority of the interviewed policymakers gave an account of interventions focusing on the immediate determinants and aimed at modifying lifestyles and behaviours in the more disadvantaged classes. More funding should be put towards academic research on effective universal policies, evaluation of their impact and training policymakers and officers on health inequalities in city governments.

Limitations

- Respondents possibly participated due to their willingness, accessibility as well as interest in the area of health inequalities and therefore may be more sensitive to the issue.
- The data was collected 3-4 years ago so parties governing in the cities may have changed.
- In some cities, either officers or politicians were interviewed; it might have been more desirable to have one of each for every city.
- As the interviewees were selected by INEQ-Cities partners from each city, these were chosen by opportunity sampling.

Strengths

- The interviewees included many examples of their everyday experiences and realities providing rich and detailed information.
- Carrying out the interview, an activity seldom performed previously among policymakers, possibly drew them to review the issue, update their knowledge and learn about the INEQ-Cities project and its results on heath inequalities in their cities.
- Since this is an exploratory study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, it will hopefully be a stepping stone for further qualitative research on the topic.
- This study has the important advantage of having collected information from quite a large number of cities throughout Europe.

Introduction

Health inequalities in urban environments are complex[1,2] affect the entire population throughout the health gradient[3] and require a multi-sectoral approach to address multiple social and economic determinants.[4] To that effect, although city governments' competences and authorities vary, they are endowed with jurisdiction to develop strategic plans and policies, provide services and deliver interventions which may address health inequalities.[5-7]

Within governments, policymakers are responsible for decision and policy-making in the form of laws, guidelines, and regulations[8] and their knowledge, beliefs and perceptions are relevant in the implementation of these. It is important to know whether the concept of the social determinants of health inequalities is imbedded in their discourse[9,10] in addition to the information on health issues provided to them as reports or surveys. These topics, explored in this study, may determine the course of the policy-making process.[11,12] Furthermore, their perceptions regarding the responsibilities and priorities of city governments and the city government's strategic plans possibly influence the policies in place.[13,14] These issues along with how policymakers make use of their knowledge will influence decision making and affect how health inequalities are addressed by city governments.[8,15,16]

The majority of studies exploring the knowledge and beliefs of health inequalities have explored lay perceptions[17-20] and the few studies describing expert beliefs focused on researchers and policymakers working in regional and national governments.[9,21,22] To our knowledge, there are only a small number of studies focusing on policymakers in the city government[5,6,14,23] and this is among the first qualitative studies to compare the perceptions of policymakers in different European cities. The use of rigorous qualitative research methods has been on the rise in health services and health policy research[24] to explore the experiences of participants and the meanings they attribute to them, to contribute new knowledge and to provide new perspectives.[25] It is consistent with developments in the social and policy sciences at large and has been described to reflect the need for more in-depth understanding of naturalistic settings the importance of understanding context and the complexity of implementing social change.[26] Selecting policymakers from different European cities provided a description of the different socio-political realities and contexts according to the participant's daily experiences to provider a richer and wider view on reducing health inequalities at the municipal level throughout the continent. Notwithstanding their

diversity, the participant cities share important commonalities as European democracies and urban settings, allowing to explore the study object from a new view. Previous studies[13] in the project have analysed written policy documents in these cities. The objective of this study is to further increase the understanding of how policies are realised, through the perception and beliefs of public policy makers in thirteen European cities during 2010 and 2011.

Methods

Methodological development

We carried out a descriptive and exploratory qualitative research study from a phenomenological perspective[27] as it sought to capture policymakers' unique accounts of reality in order to capture a breadth of discourses on health inequalities[28]. Data was collected from thirteen cities (Amsterdam, Barcelona, Brussels, Cluj-Napoca, Helsinki, Lisbon, London, Madrid, Paris, Prague, Rotterdam, Stockholm and Turin; see Table 1 for information on the cities' profiles) from eleven different European countries participating in the project; Socio-economic inequalities in mortality: evidence and policies in cities of Europe 2009-2012 (INEQ-Cities)[29] during the years 2010 and 2011.

Participants and sampling technique

The study population consisted of nineteen public policymakers, selected through opportunity sampling[28], see Table 2, working in the aforementioned cities' governments during the research period. A sample of elected politicians which included councillors and or aldermen and high ranked, non-elected, officers was selected. Policymakers were chosen from the health sector as well as other non-health sectors to provide a wider range of discourses. Interviews were performed by INEQ-Cities' partners, who interviewed a maximum of two participants, in their respective cities. Furthermore, subjects were chosen only if they held a decision making position.

Data collection and generation techniques

Seventeen semi-structured individual interviews and one semi-structured interview where two informants participated were carried out from November 2010 to June 2011 using an open-ended question topic guide (Box 1). The interviews provided information on the participant's knowledge and beliefs of health inequalities and policies to address these, as well as the role of the municipal government. The interview topic guide was

developed following the requirements listed in INEQ-cities' description of work and was further discussed with other project partners. Three pilot interviews were performed in Barcelona to test the topic guides and final versions of the guide were distributed to the project partners in the abovementioned cities who then conducted the interviews. The sessions were carried out in each city's native language and lasted between 45 minutes and an hour, where clarification of the topics was needed, some interviewers made city-specific questions. The interviewers belonged to partner groups from the INEQ-Cities project. A data collection manual designed by the authors of this study was sent to each partner and interviewer, providing guidelines on how to perform the interview to ensure that these were carried out in a standardised way. Interviews were translated to English by each partner and several sent the transcripts and summaries to the informants for approval. The summaries and the transcripts were sent to the authors carrying out the analysis in English.

Processing and analysis of information

All transcripts and summaries were analysed centrally on the basis of a thematic interpretive content analysis[27] by 2 researchers (JM and MP). Interviews were read numerous times until researchers reached pre-analytical intuitions on each of the interviewee's discourses and texts were then coded using predefined and emergent categories. The text was divided following these categories before performing an analysis of the written content and finally the content was articulated into results. Two research members carried out the analysis process independently with the support of Atlas.Ti software,[30] and compared the main findings with the original data. The working manuscript was sent to informants through each project partner for approval.[31]

Ethical considerations

Informed consent was obtained through verbal means and the information was anonymised and confidential. No participants received a salary or reward as participation was completely voluntary and the study received formal ethical approval by a research ethics committee (Hospital del Mar de Barcelona Research Ethics Committee).

Results

Three emerging discourses were identified among the interviewees, as follows, depending on the city of the interviewee: London's informants focused on structural

determinants as the main causes of health inequalities and described universal policies aimed at these, Prague and Cluj-Napoca's interviewees were not as familiar with the concept of the social health inequalities. Informants from other cities had a mixed approach, although they referred to the wider determinants as the causes of health inequalities, they also suggested downstream interventions to address these. It was not possible, however, to distinguish differences in discourses between officers and politicians or health and non-health informants. Table 3 shows a summary of the responses giving by each city´s participants. Presented below, the results have been arranged in six sections following the major topics explored in the interviews. The informant's identification (ID) can be seen in Table 2.

Knowledge on health inequalities and their causes

Two broad discourses were found within the informant's perceptions and knowledge of health inequalities. The first discourse corresponds to the majority of informants who were aware of such inequalities and described them as differences in health. These were expressed, for example, as differences in life expectancy.

We have large differences in health: people live five years longer in areas such as Kungsholmen (inner city area of Stockholm municipality) compared to areas such as Järva fältet" Stockholm health politician, ID 16

They also explained that health inequalities existed among the population according to their levels of education or income, gender, age and the neighbourhood in which they lived.

"There are factors which relate to education, employment or unemployment, living conditions, income, social relations and ways of life. Also the social exclusion of young people generates inequalities in health." Helsinki health officer, ID 6.

In addition, the interviewee from Lisbon pointed out that inequalities were increasing as did the informant from Brussels who understood them as a gradient.

The second discourse corresponded to informants from Cluj-Napoca and Prague did not have a clear concept on social health inequalities, as described in the quote below.

"In this city we cannot talk about this concept. It is estimated that there are no legal criteria to make any differences between individuals in terms of access and use of medical care." Cluj-Napoca health officer, ID 5.

Concerning the causes of inequalities, the majority of the interviewees, identified a strong relationship between economic position, educational level and health. Furthermore, low income was perceived as the main cause of unhealthy lifestyle behaviours and reduced access to health care which lead to health inequalities. Other social determinants were also highlighted, such as gender, age group, type of household and residential segregation. The current economic crisis and reduced public expenditure were considered to exacerbate the problem and reduce the capacity of action of the local system.

In contrast, interviewees from Prague and Cluj-Napoca considered that health inequalities were chiefly a result of individual responsibility.

Reducing health inequalities as a priority for the city government

Most interviewees reported that reducing health inequalities was an objective of the city government included in either strategic plans or in specific laws. However interviewees from Prague and Cluj-Napoca did not consider it to be a priority of their municipal governments, whereas Lisbon informant's considered it was not a priority even though they thought it should be.

"Tackling inequalities in health should be a priority in the Lisbon Metropolitan Area and is not, directly, a hotly debated topic." Lisbon non-health politician, ID 7

The interviewees of Paris and Brussels explained that their city governments did not have jurisdiction over health matters as these are the responsibility of the regional authorities.

"In France, health is not a responsibility of the cities, although historically it was the cities that were in charge of sanitary aspects." Paris health officer, ID 12.

That's not easy to answer, as not all the areas are governed on the level of the communities or on the city level." Belgium, health officer, ID 4.

Information on health inequalities

To monitor health inequalities, the majority of the informants mentioned relying on health surveys which were published periodically in their cities and mortality statistics from their statistics authority.

"To track differences in health, a health survey is conducted every four years." Amsterdam health officer, ID 1.

London's interviewees described the need to integrate the different sources of information into one to make access to information easier. Informants from Lisbon and Prague declared not having information or assessment of health inequalities. Furthermore, the interviewee from Cluj-Napoca explained that periodic data of health inequalities was not available as this concept was not applicable.

Knowledge on policies and programs implemented

When asked about their knowledge of policies that address health inequalities, policymakers described actions aimed at deprived populations and at modifying attitudes and unhealthy behaviours, such as smoking and poor diets. They emphasised the importance of preventive measures and health promotion and education. Policies to improve access to health care services were also quoted as an important means to reduce health inequalities by most interviewees. However, the informants from London highlighted the need to address health inequalities throughout the general population rather than focusing on the most deprived sectors and developing long-term policies aimed at the social determinants, not only proximal factors, such as physical activity and fruit intake. Moreover, the informant from Turin highlighted local interventions aimed at addressing unemployment and the interviewee from Madrid described tackling health inequalities at the local level.

"We have to work on the processes…I'm talking from the micro level, which is where I have more experience, but I think that's where the solution lies, in the micro level." Madrid health politician, ID 10.

The informants from Prague, however, did not mention any policies implemented by their city government and referred to national health plans as a reference for health-related issues.

Inter-sectoral collaboration and participation of social agents in policymaking

Interviewees from Madrid, London, Rotterdam and Lisbon referred to strategic plans which fostered inter-sectoral collaboration between different administrations, citizens' and non-profit associations and established local partnerships. Barcelona and Turin, in

turn, described inter-sectoral collaboration established only between two sectors, for example between health and welfare or health and education. While Lisbon cited examples of housing policies for groups at risk of exclusion, some informants suggested that inter-sectoral collaboration slowed down the policymaking process and perceived that having different sectors collaborate proved to be difficult.

"Yes. Action on inequalities in health is synonymous with disciplinary cross-cutting. In this sense, this theme is incorporated in several areas such as education, social service, environmental and cultural policies, among others, addressed in the municipal master plan." Lisbon, non-health politician, ID 7.

With respect to community organisations participating in the policymaking process, the majority of the informants thought their city governments collaborated with these, however informants from Rotterdam, Turin and Stockholm considered it was very limited.

"The social networks exist but they need public support. There is no doubt that there should be more shared responsibility among private sector and public services or welfare systems." *Turin non-health politician, ID 18.*

Barriers and opportunities encountered

One of the principal barriers described was the lack of awareness on changing unhealthy lifestyles among the population. Informants from Stockholm and Lisbon considered the obstacles addressing health inequalities to be essentially related to imbedded cultural beliefs which made adopting healthier lifestyles difficult. Bureaucratic restraints and resistance from other levels of the administration along with miscommunication with the private sector as well as budget restrictions were described as important barriers by the majority of interviewees. London's interviewee explained that implementing financial policies from within a city government was complicated in the context of globalisation.

"We come across them all the time and a very important one is the financial issue. Every year we have less money and the crisis only makes it worse." *Barcelona health politician, ID 2.*

Informants also referred to opportunities which enabled policy implementation. For example, the interviewees from Barcelona and Rotterdam made reference to working at the community level or with different sectors which led to learning opportunities. Community groups were seen as especially important in liaising with hard to reach groups. The interviewee from Brussels suggested that the migrant population promoted healthy lifestyle behaviours, as some of their customs had healthy components.

"There are definitely opportunities. Other services have problems as well and see the benefits of cooperation with groups who work with migrant population." *Brussels health officer ID 4.*

Discussion

To the best of our knowledge, this is the first study to explore policymakers' perceptions on health inequalities and policies to reduce these throughout various European cities from diverse geographical areas and with different socio-economic and political contexts. Three discourses were identified depending on the city of the interviewee: 1) London's approach focused on upstream determinants and policies; 2) Cluj-Napoca and Prague's where informants were less acquainted with social health inequalities and 3) the rest of the cities' informants who perceived health inequalities as differences in life expectancy among the population defined by their economic, social and geographical background. Regarding the causes of health inequalities, these were seen as being caused by low-income levels, unhealthy lifestyle behaviours and barriers in accessing health care. Most of the informants agreed that reducing these inequalities was a priority of their local governments and referred to periodic surveys as information sources to monitor them. Nearly all policies and interventions were targeted at modifying health behaviours and some relied upon inter-sectoral collaboration. Furthermore, bureaucracy, funding and the population´s attitudes and beliefs towards healthy lifestyles were considered important barriers.

The majority of informants described upstream determinants such as socio-economic and structural factors as the causes of health inequalities but nevertheless focused on describing downstream policies and programmes. This could be due to the fact that the informants work in city governments and even though they are aware of the main causes of health inequalities, their daily routines involve work with downstream policies and programmes. In this regard, some city councils may have limited authority over upstream determinants[4,32] or over health when it is under the authority of higher levels of government; such was the case of Paris and Brussels. In this sense,

policymakers seemed to refer to what was within their mandate, so even if they understood structural determinants were important in addressing health inequalities, the activities they described were focused within their own jurisdiction. Downstream, interventions targeted at disadvantaged populations such as some of the ones described by the interviewees, which do not aim at reducing inequalities throughout the whole gradient, may end up being diluted into multiple small downstream initiatives and are less effective in reducing health inequalities.[33,34] This also carries the risk of health inequalities becoming the responsibility of each individual, which is already an existing trend,[35] and downplaying the responsibilities and competences of the city government which will constitute a barrier for the local city governments in tackling inequalities. Moreover it has been widely argued that if interventions are not delivered carefully, they are likely to increase inequalities as those who are most in need, might not benefit from the intervention.[36] However, as described elsewhere,[5] the majority of research on health inequalities relates to downstream determinants and focuses on individual lifestyle factors,[37] so little information is provided to policymakers on the wider determinants and the underlying causes of the causes of health inequalities.[38]

Furthermore, with the exception of Brussels' and London's interviewees, the concept of the socioeconomic gradient in health was not present among respondents; their understanding of reducing health inequalities connoted reducing the differences between the most deprived groups and the rest of the city's population. Therefore, their discourses did not seem to acknowledge that inequalities affect the entire population and not only the most disadvantaged populations.[39]

Except for Lisbon and the Central-eastern European cities, most of the informants mentioned having access to information on health inequalities through periodical surveys or health reports. Those with access to regular information on health inequalities would be more likely to see the underpinning structural causes and be willing to act upon them. Furthermore, Prague and Cluj-Napoca expressed not being aware of the existence of inequalities in their cities possibly because they were not as familiar with the concept. There are relevant studies on health inequalities in the Czech Republic[40,41] and in Romania.[42] Nevertheless, the overarching INEQ-Cities project[29] will provide the cities included in the project with further data on health inequalities at the small area level. Data on health indicators and inequalities is important for various reasons: to understand how causal pathways are established and to design effective policies and interventions.[4,11] While elsewhere it was concluded that researchers do not provide policymakers with befitting and timely information

[15,22,43] constantly requiring more evidence runs the risk of delaying having to face the problem and making decisions.[44] Nevertheless, additional evidence on the social determinants of health, and particularly on effective interventions and policies is important.

The majority of the informants understood that reducing health inequalities was a priority for their city government. However, only the city governments of Amsterdam, Barcelona, Helsinki, London, Madrid, Rotterdam, Lisbon and Stockholm had health plans, and within these only London has a specific plan for reducing health inequalities, as has also been described elsewhere.[13] Our findings partly reflect the different stages of awareness and action undertaken in the cities as it describes a spectrum of different approaches towards inequalities adopted by countries throughout Europe. We understand that a strong political will is inherent to tackling health inequalities along with supplying policymakers with information on the social determinants and how the gradient operates.[33]

Many of the participants described participation between sectors at some level, even though not all cities showed the same involvement. A study carried out also within the INEQ-Cities project analysing policy documents of some of the cities included in this study showed similar results.[13] Another study[23] observed that the structure of political responsibilities in the Canadian context offered important constraints for inter-sectoral collaboration. Encouraging the continuation of collaborative strategies may have a substantial impact on reducing health inequalities, previous research has shown that inter-sectoral collaboration between the health and other sectors is essential to achieving health outcomes in a more effective way than form the health sector alone.[45] Fewer cities described participatory processes and collaborating with social actors. Including other stakeholders in policy-making processes is an important step to city governance and empowerment, both decisive in reducing health inequalities more effectively.[34,46] However, there are many different barriers which policymakers encounter when trying to establish collaborative relationships such as an overall lack of awareness of health inequalities among those who work in the city government, difficulties to coordinate with other authorities, a lack of mandate, and limited resources.[16,8]

Along with the barriers mentioned above, lack of awareness on health inequalities and bureaucratic restraints were the main barriers to reduce health inequalities as quoted by the interviewees and have been categorised elsewhere as ideological and

institutional.[23] Institutional limitations are related to values attitudes and opinions; one possible explanation why this approach has been underlined is that informants seemed to focus mostly on lifestyles and healthy behaviours instead of structural determinants as the causes of health inequalities. Furthermore, the second group of barriers referring to rigid bureaucracy and funding might also be reinforced by the ideological barriers and exacerbated by the social and financial crisis and subsequent austerity measures.

Limitations and strengths

It should be also taken into account that in some cases, the politicians interviewed gave political discourses and it was a difficult task to make them follow the topics. Participants were selected through an opportunity sampling, they might not be the most representative informants in their fields; other respondents might have wider knowledge on the subject or they possibly participated due to their willingness, accessibility as well as interest in the area of health inequalities and therefore may be more sensitive to the issue. The interviews were carried out by different interviewers from each city in their native language so that participants could express themselves more freely. The results of politicians and officers have been presented together as we found no differences in their discourses. Nevertheless, the informants included in this study were selected following the pre-established criteria so both elected and non-elected informants were highly positioned in their municipal government´s structure and had decision making competences. The data was collected 3-4 years ago so parties governing in the cities may have changed and the elected officials may not be working in decision making positions at the present moment. However, describing these beliefs provides very valuable information on the governance of cities given the key role of policymakers.

As a relevant strength of the study, the interviewees included many examples of their everyday experiences and realities providing rich and detailed information. They expressed their own beliefs and describing them provides very valuable information on the governance of cities given the key role of policymakers. Moreover, carrying out the interview, an activity seldom performed previously, probably drew politicians to review the issue, update their knowledge and learn about the INEQ-Cities project (INEQ-Cities 2012). The findings of the present study to some extent mirrors the findings of the analysis of health policy documents in the same cities, and illustrates the different stages at which cities are concerning work on health inequalities.[13] This exploratory

study, possibly one of the first of its kind in comparing policymaker's knowledge and beliefs across several cities of Europe, will hopefully be a stepping stone for further studies and also has the important advantage of having information from quite a large number of cities.

Conclusions and recommendations

The majority of the interviewed policymakers gave an account of interventions focusing on the immediate determinants and aimed at modifying lifestyles and behaviours in the more disadvantaged classes. Some described inter-sectoral action explicitly and for most cities reducing health inequalities was a priority and policymakers had access to periodic information.

Future collaboration between the research centres from Cluj-Napoca and Prague and their local governments could possibly foster more awareness about health inequalities and their causes and the importance of addressing them. Providing decision makers from the municipal governments with information on policies aimed at addressing upstream determinants alongside health indicators should be encouraged further to promote knowledge on their role in addressing health inequalities.

More funding should be put towards academic research on effective universal policies, evaluation of their impact and training policymakers and officers on health inequalities in city governments. Further advocacy must be carried out to place health inequalities and their implications in the municipal government's agenda and in city health plans.

Acknowledgements

We would like to thank the informants who participated in the interviews and the interviewers who carried them out and all the partners involved in the INEQ-Cities project. This article has been partially funded by the project: INEQ-Cities, "Socioeconomic inequalities in mortality: evidence and policies of cities of Europe"; project funded by the Executive Agency for Health and Consumers-DG Sanco (Commission of the European Union), project nº2008 12 13 and CIBERESP Epidemiología y Salud Pública.

Conflicts of interests

The authors declare not to have any conflicts of interest.

Data sharing statement

No additional data are available.

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Table 1. City profile indicators[1]

City	Year of the indicator	Population aged 0 – 14 %	Population aged 65 and older %	Population aged 16 - 64 in the labour market %	Unemployment %	Immigrant population %
Amsterdam	2001	16.1	11.3	72.0	13.3	48.3
Barcelona	2005	12.3	20.8	57.2	8.7	21.5
Brussels	2001	18.3	15.4	64.9	18.2	26.3
Helsinki	2004	14.5	13.8	78.9	9.1	7.3
Lisbon	2001	14.9	15.4	73.3	7.6	5.7
London	2001	20.2	12.0	67.6	5.2	24.9
Madrid	2005	12.8	18.7	74.1	8.2	14.1
Paris	2007	14.4	14.1	75.5	11.3	20
Prague	2006	12.3	15.6	74.8	3.5	7.6
Rotterdam	2001	17.2	14.3	69	9	45
Stockholm	2005	18	14.1	76	5.3	24.3
Turin	2005	11.4	23.4	67.8	11.4	5.6

1. The information was provided by each city and proceeds from different information sources

Table 2. Description of the 19 informants*

Identification	City (Country)	Status	Profile	Party
1	Amsterdam (Netherlands)	Officer	Health	NA
2	Barcelona (Spain)	Politician	Health	Eco-socialism
3	Barcelona (Spain)	Politician	Non-Health	Eco-socialism
4	Brussels (Belgium)	Officer	Health	NA
5	Cluj-Napoca (Romania)	Officer	Health	NA
6	Helsinki (Finland)	Officer	Health	NA
7	Lisbon (Portugal)	Politician	Non-Health	Social democracy
8*	London (United Kingdom)	Officer	Health	NA
9*	London (United Kingdom)	Officer	Health	NA
10	Madrid (Spain)	Officer	Health	NA
11	Madrid (Spain)	Officer	Health	NA
12	Paris (France)	Officer	Health	NA
13	Prague (Czech Republic)	Officer	Health	NA
14	Prague (Czech Republic)	Officer	Health	NA
15	Rotterdam (Netherlands)	Officer	Non-Health	NA
16	Stockholm (Sweden)	Politician	Health	Christian democratic
17	Stockholm (Sweden)	Politician	Health	Social democracy
18	Turin (Italy)	Politician	Non-Health	Social democracy
19	Turin (Italy)	Politician	Non-Health	Social democracy

^ NA= Not applicable

* Both informants 8 and 9 from London were interviewed together. The information was generated through 18 in-depth interviews

Table 3. Summary of cities' discourses

City	Knowledge on HI[1] and their causes	Reducing HI as a priority for the city government	Information on health inequalities	Knowledge on policies and programs	Intersectoral collaboration/ participation of social agents	Barriers	Opportunities
Amsterdam	Economic, genetic, environmental, ethnic factors	It is a priority, through changing economic and political factors	Health survey, city memo, collaboration with academics	The city has a Health Plan	There is specific collaboration with other sectors	Funding and the administrative organisation	Health topics are placed in the agenda of organisations
Barcelona	Capitalist economic system, different life expectancy between neighbourhoods structural poverty, traditional and emerging inequalities	HI is a priority but mostly for the health sector and at the local level	Annual city health report and health policy evaluation. Social observatory	Urban regeneration policies. Non-health policies with health outcomes, Health in the neighbourhoods strategy to reduce HI	Not a formal intersectorality, council organisation still compartmentalised. 18 plans with community action, civil society	Financial restraints, factual powers	Proximity to the community and intersectorality
Brussels	Gradient in health, socio-economic position, lack of redistribution mechanisms, segregation, personal traits, access to health care	Reducing HI is an absolute priority	Death certificates, census, national health survey, more data is needed on children	No specific policies aimed at health inequalities	Collaboration is transversal with 3 political structures. Social agents are advisory bodies and also participate in action plans	The liberal course of EU[2]. Geographic proximity of actors	Migrant population contribute to healthy lifestyles
Cluj-Napoca	Health inequalities are not an issue	Reducing HI is not a priority, health is a right for all people	The city has the population health statistics	There are preventive measures for the whole population	There is close cooperation with municipalities	Funding and administrative restraints are a barrier	
Helsinki	Sex, education, unemployment, living conditions, social relations, exclusion of young people and ways of life	Strategy of city council 2009-2012. Resources directed at reducing HI	There is some information because it is a strategy of the city	Healthy Helsinki project to reduce HI. Non-smoking and responsible alcohol consumption programmes	There is not enough intersectorality. Steering committees include various social agents. Intersectorality might be slow	Difficulty to obtain funding. Administrative structures	Funding and good cooperation create opportunities
Lisbon	Socioeconomic, demographic, income and age inequalities. Housing conditions	Reducing HI is not explicitly a priority, but it should be. We have the Municipal master plan	There is no information or assessment	Policies and plan targeted at aging	Intersectorality is inherent in tackling health inequalities	Cultural, economic and legislative obstacles	Initiatives with multiple dimensions

London	Social determinants in a global context. Lack of evidence base of strategies. Policies directed at most deprived instead of all population	The informants did not answer explicitly that reducing HI was a priority	There is not a must on information. Data is pieced together	Primary care interventions, employment programmes, partnership approach, no knowledge on EU funds	There is intersectoral work with local partnerships not only health services	Little capacity to influence the upstream determinants of inequalities	Promoting local integration and pool resources
Madrid	Socio-economic inequalities, housing, lifestyles, education, Income, cultural behaviours. Inequalities at the district level, access to healthcare services	A priority to be dealt with by health care systems	Yes, through research and the annual report	Plan Vallecas to change behaviours. Law for health, programme for the homeless with tuberculosis, for sexual trade workers, for women of Roma ethnicity, children at risk	Plan Vallecas which is multidisciplinary, communitary and participatory. The aim is to work transversally but it is difficult. Neighbours' associations and participation at the micro level	Relations with other institutions, budget delimitation, lack of awareness of the population, little information on the impact of programmes	To integrate the actions on the groups affected by health inequalities
Paris	Access to health care	Health is not responsibility of the city government or a priority	Epidemiological information and on local health issues for specific municipalities	City policy: measures at the city level, preventive measures, public Health programmes in the neighbourhoods	City health workshops	The consideration of health in the context of urban policy	
Prague	Social status, poverty, chosen lifestyle, voluntarily socially excluded	Health inequalities are not a priority	National plan of social politics but no periodic support	Health 21, strategic plan of Prague	Complex a to work with different sectors, social agents make themselves heard	Legislative and coordination issues, financial barriers	NGO´s[3] are very close to the socially excluded
Rotterdam	Socioeconomic differences	Yes, with a broad view on health. Health is a precondition for the life of the city	Health is included in a general biannual survey	Directed at unhealthy behaviour of low SES, air quality and traffic, health plan	Work, participation, education. "Healthy in the city": city health plan. "From complaint to strength", depression and diabetes. Many joint projects but no collaboration with social actors	Long timeframe in cooperating with other networks. Different levels in institutions have trouble communicating	Benefits of cooperation
Stockholm	Structural differences: housing segregation, education level, age group, income, migration criminal acts/safety and living conditions. Health inequalities in Stockholm are very large	Based on health care services. Legislation is there but the educated are the ones who benefit. Accessibility to health care is the highest priority	Public health survey produced every four years, review of health care services, Karolinska Institute Public Health Academy reports	Wide range of choice of health providers, addressed at behavioural and cultural determinants, resources for prevention are too small	Action plan for health, Hard for actors to cooperate voluntary organisations which strengthen the community but nonexistent in participatory process	Lack of competence, knowledge and methods to change behaviours	Resources, Evidenced based health prevention, Engaged people working in health centres

Turin	Housing conditions, overcrowding, economic and employment crisis, deterioration of social conditions	The city has a direct and privileged approach to dealing with inequality but there are conflicts of interest	No use of effectiveness indicators for evaluation and modification of policies	Policies not addressed at specific groups, traffic calming and public transport development, security, social housing, local welfare strategies	Sentinel events arise interest but there is a conflict of interests in the political administration	Structural policies tend to be slow	Social cooperatives for housing by improving existing assets

1. HI: Health Inequalities

2. EU: European Union

3. NGOs Non-Governmental Organisations