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Deliverable 5.2.1- Recommendations on policies, programmes and action plans in GR CB areas

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City & Region Planning

Study entitled "Proposals for policies, programs and action plans related to the treatment of health inequalities, in the implementation area of the Program" in the framework of the Equal2Health project which is part of the Operational Programme INTERREGV-A GREECE BULGARIA 2014-2020

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Deliverable 5.2.1 "Recommendation on policies, programmes and action plans in GR CB areas"

Introduction – Conceptual Placement

The World Health Organization (WHO) Health Equality Report shows that 90% of health inequalities can be interpreted as a result of economic insecurity, living in poor quality housing and neighborhoods, social exclusion, lack of proper work conditions, as well as poor working conditions. Also, health inequalities reduce economic and social productivity and lead to higher costs of health care and welfare benefits (EU, 2013).

In particular, according to McNamara et al. (2017) the educational level has a dominant role in the access to health services as well as in the manifestation of diseases. The risk from certain diseases such as cardiovascular disease, depression, obesity and diabetes is increased in certain populations of low educational level.

Moreover, people living in socio-economically vulnerable areas are more likely to be exposed to higher levels of air pollution (WHO 2019b).

The purpose of this deliverable is to analyze, record and propose strategic policies as well as measures, programs and actions to address social inequalities in health in Greece. Socially important diseases affect a large part of the population and create a gap in the demand and supply of the health and social welfare system. The isolated and degraded population groups were studied in the Observatory (Deliverable 4.2.1 On-going evaluation of short-term results on health of Thess pilot action community

population “SOS DCP” Center in Diavata Thessaloniki) and the main conclusions of that pilot structure are included in this study. Furthermore, this study mentions valuable elements of the deliverable 3.2.1. (Deliverable 3.2.1 analysis of current situation in health inequalities for socially significant diseases in GRC area).

This deliverable takes into account the data obtained from:

A) the awareness campaigns of the main population, the Medical Staff and the Authorities, mainly from the 3 workshops that have been carried out by the KEBE with professionals of health and social services, as well as,

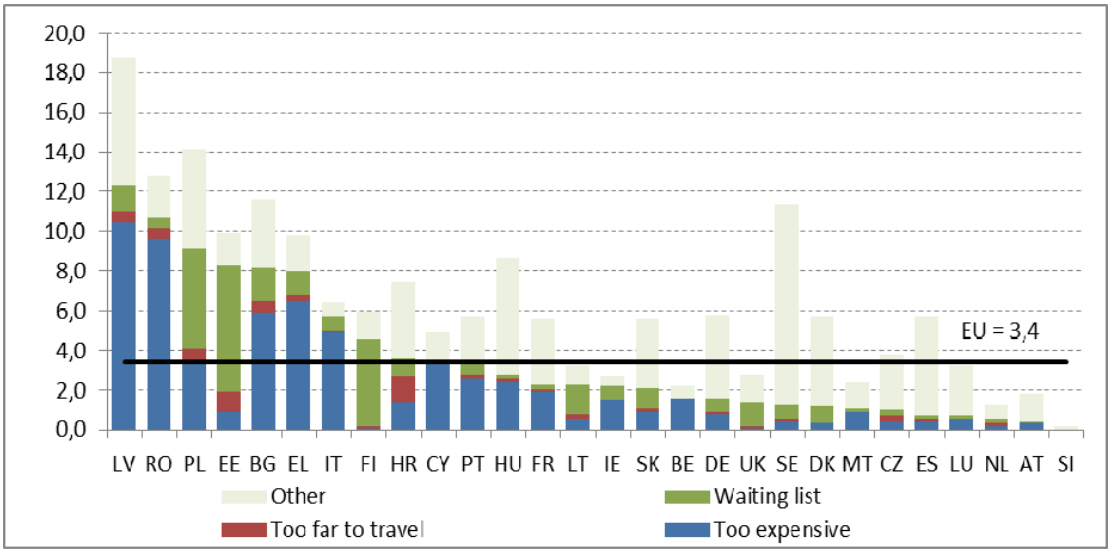
B) the creation of an "open network" between interested parties such as: Medical staff, local and regional authorities, Hospitals and Primary Health Care Units, Regional and National Health Authorities, civil society, etc. for the exchange of know-how on specific diseases and proposals between parties to reduce the barriers to equal access to the primary health care system for specific disadvantaged and isolated communities (implemented by Partner 3).

The deliverable is structured in four (4) chapters. The first lists the proposed policies and strategies (funding programs, pilot programs, main topics) to reduce and ultimately eliminate social inequalities in health. The second chapter includes proposals for policies, programs and action plans by bodies involved in social policies on facing health inequalities in Greece. The third chapter lists proposals in the implementation of the 3 workshops while the last one, analyzes specific and general proposals in relation to the findings of the actions (Observatory, Pilot implementation, Information campaign, workshops).

List of relevant proposed policies by the European Union / European Commission

It is a notable fact that according to the European Core Health Indicator the level of inequalities in the field of health is mostly related to the long waiting lists for medical operations / examinations, due to increased costs and due to geographical distances. In Greece, the costs constitute an increased factor of injustice and inequity in the field of health.

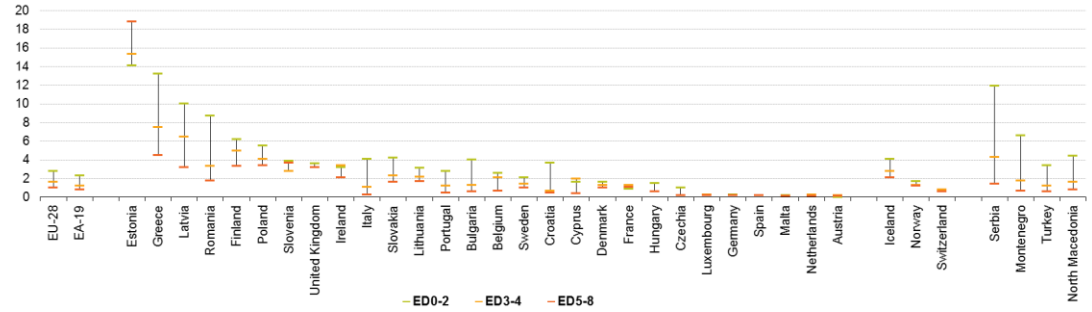
Figure 5: Self-declared unmet needs for medical examination by reason, proportion of population (%)



Source: Eurostat, Statistics on Income and Living Conditions 2012 (2011 data for AT and IE)

In the EU-28, 1.0% of people who have completed higher education reported unmet needs for medical examination or treatment due to cost, long geographical distance or long waiting list (2018). This percentage reached 1.6% for those who have completed non-tertiary education in upper secondary or post-secondary education and 2.8% for those who have completed upper secondary education. **This general trend of increased unmet needs in relation to the decrease of the education level has been observed in most EU Member States, with distinct examples being Greece, Latvia and Romania.**

Persons reporting unmet needs for medical examination or treatment due to being too expensive, too far to travel or waiting lists, by educational attainment level, 2018
(% share of the persons aged 16 and over)



Note: ED0-2 (Less than primary, primary and lower secondary education (levels 0-2), ED3-4 (Upper secondary and post-secondary non-tertiary education (levels 3 and 4), ED5-8 (Tertiary education (levels 5-8)
(1) Estimated data.
(2) 2017 data.
(3) 2016 data.
Source: Eurostat (online data code: hlth_silc_14)

eurostat

The above diagram highlights the existing inequalities and inequities in the field of public health between EU countries but also between the different population groups in these countries. The determining social factors are the main reasons for these inequalities as they have an impact on life expectancy and general health. These factors include employment, income, education and ethnicity.

To address the inequalities in the field of health EU promotes policies and supports national authorities and interested parties to take measures to reduce these inequalities.

Persons reporting unmet needs for dental examination or treatment, by main reason, 2018
(% share of the persons aged 16 and over)

	All other reasons	Reasons related to the health system				Reasons other than those related to the health system					
		Total	Too expensive	Too far to travel	Waiting list	Total	No time	Didn't know any good doctor or specialist	Fear of doctor, hospital, examination or treatment	Wanted to wait and see if problem got better on its own	Other
EU-28 (1)	4.1	3.0	2.7	0.0	0.3	1.1	0.3	0.0	0.4	0.2	0.3
EA-19 (1)	4.1	3.0	2.8	0.0	0.2	1.1	0.2	0.0	0.4	0.1	0.2
Belgium	4.3	3.0	3.0	0.0	0.0	1.3	0.3	0.1	0.4	0.2	0.3
Bulgaria	3.2	2.5	2.4	0.1	0.0	0.7	0.1	0.1	0.1	0.2	0.1
Czechia	2.6	1.0	0.6	0.1	0.3	1.6	0.3	0.1	0.4	0.5	0.4
Denmark	6.2	4.0	3.9	0.0	0.1	2.2	0.2	0.0	0.6	0.5	0.7
Germany	1.2	0.4	0.4	0.0	0.0	0.8	0.1	0.0	0.2	0.1	0.4
Estonia	6.9	6.5	5.5	0.1	0.9	0.4	0.2	0.1	0.0	0.1	0.1
Ireland (2)	4.6	3.2	3.0	0.0	0.2	1.4	0.1	0.0	0.6	0.3	0.3
Greece	10.3	9.7	9.5	0.1	0.1	0.6	0.1	0.0	0.2	0.3	0.0
Spain	5.3	4.6	4.6	0.0	0.0	0.7	0.2	0.0	0.3	0.1	0.2
France	5.6	3.2	2.9	0.0	0.3	2.4	0.6	0.1	1.0	0.3	0.4
Croatia	2.8	1.2	0.8	0.3	0.1	1.6	0.4	0.0	0.5	0.2	0.4
Italy	3.0	2.8	2.7	0.0	0.1	0.2	0.0	0.0	0.0	0.1	0.0
Cyprus	5.3	4.3	4.3	0.0	0.0	1.0	0.2	0.0	0.4	0.4	0.0
Latvia	17.3	14.2	13.4	0.2	0.6	3.1	0.9	0.1	1.1	0.8	0.2
Lithuania	4.3	3.8	3.0	0.1	0.7	0.5	0.1	0.0	0.2	0.2	0.1
Luxembourg	0.8	0.5	0.5	0.0	0.0	0.3	0.1	0.0	0.1	0.0	0.0
Hungary	3.5	1.7	1.6	0.0	0.1	1.8	0.6	0.0	0.6	0.3	0.2
Malta	1.5	0.5	0.4	0.0	0.1	1.0	0.1	0.0	0.5	0.1	0.3
Netherlands	0.5	0.2	0.2	0.0	0.0	0.3	0.0	0.0	0.0	0.1	0.1
Austria	0.8	0.5	0.4	0.0	0.1	0.3	0.1	0.0	0.1	0.1	0.1
Poland	4.0	2.1	1.4	0.0	0.7	1.9	0.6	0.0	0.7	0.4	0.2
Portugal	14.3	10.9	10.7	0.1	0.1	3.4	0.9	0.0	1.3	0.5	0.6
Romania	6.8	4.9	4.6	0.1	0.2	1.9	0.4	0.1	0.8	0.5	0.1
Slovenia	4.6	3.6	0.6	0.1	2.9	1.0	0.3	0.2	0.2	0.1	0.3
Slovakia (2)	3.6	1.9	1.4	0.1	0.4	1.7	0.4	0.1	0.5	0.5	0.1
Finland	6.6	5.7	0.5	0.0	5.2	0.9	0.0	0.0	0.2	0.1	0.6
Sweden	2.9	1.9	1.4	0.0	0.5	1.0	0.2	0.0	0.1	0.1	0.7
United Kingdom (2)	4.2	2.9	2.0	0.0	0.9	1.3	0.2	0.1	0.3	0.0	0.7
Iceland (3)	11.3	8.0	7.9	0.1	0.0	3.3	0.2	0.0	0.5	0.4	2.2
Norway	7.2	4.5	4.4	0.0	0.1	2.7	0.8	0.1	0.9	0.2	0.7
Switzerland	4.8	2.8	2.8	0.0	0.0	2.0	0.5	0.0	0.4	0.2	0.8
North Macedonia (2)	3.8	2.3	2.0	0.1	0.2	1.5	0.2	0.0	0.7	0.4	0.2
Serbia	13.8	8.0	7.0	0.4	0.6	5.8	1.5	0.1	1.7	0.7	1.8

Note: The value "0.0" from the table is considered as "non significant" data.
(1) Estimated data.
(2) 2017 data.
(3) 2016 data.
Source: Eurostat (online data code: hlth_silc_22)

eurostat

1. Solidarity in Health

The Communication of the European Commission in 2009, entitled Solidarity in Health - Reducing Health Inequalities in the EU, provides a first approach which includes:

- Assessment of the impact of EU policies on health inequalities and inequities
- Improving of the data on health inequalities and the successful strategies to reduce these inequalities
- Information on EU funding for the support of national authorities and other bodies in tackling the inequalities.
- Report on health inequalities in the EU.

In 2013, the Commission presented a working document entitled Report on Health Inequalities in the European Union. The report includes updated facts and figures on health inequalities in the EU and an assessment of progress in the implementation of the 2009 strategy.

The document concludes that, although some progress has been made, more action is needed at local, national and EU level. The EU policies offer opportunities which the EU countries and interest groups should utilize to improve the state and the uniformity in the health sector.

2. Strategy of the European Commission

The Commission is implementing projects on specific aspects of reducing health inequalities with funding from the European Parliament. The joint action on health inequalities and inequities (JAHEE) under the respective EU program started in 2018 as the basis for cooperation between EU countries for greater equality in health.

Image - Future EU budget for health in MFF 2021-2027 Source: EU

European Social Fund Plus 2021-2027

The Multiannual Financial Framework for 2021-2027 is governed by the same spirit as the current European Social Fund 2014-2020. ESF + will provide the EU's main financial instrument for improving labour mobility and employment opportunities and for strengthening social cohesion, improving social justice and increasing competitiveness across Europe for the period 2021-2027.With a provisional budget of € 101.2 billion (current prices), ESF + should integrate

the existing European Social Fund (ESF), the Youth Employment Initiative (YEI), the Fund of European Aid to the Most Deprived (FEAD), the Employment and Social Innovation Programme (EaSI) and the EU Health Programme. The new fund will focus its investments on three main areas: education, employment and social inclusion. In the European Parliament, the dossier was entrusted to the Committee on Employment and Social Affairs (EMPL), which approved its report on 3 December 2018. On 16 January 2019, the European Parliament voted on the committee's amendments for increased funding and made youth and their children the main beneficiaries.

Indicative EU policy measure for the deprived is the education in disease prevention and health promotion through webinars or recreational activities such as activities for the children of the deprived in relevance to healthy eating and for the deprived elderly in relevance to home hygiene and accident prevention.

Child Obesity

Obesity entails significant physical and mental problems, such as heart disease, diabetes, cancer, and psychological disorders. It accounts for over 8% of the healthcare cost in the EU. Given that obesity is a complex problem and is often linked to socio-economic criteria, the cooperation of a wide range of experts at local, national and international level is of vital importance.

The EU Action Plan on Childhood Obesity (2014-2020) aims to halt the increase in the number of overweight and obese children and young people by 2020.The June 2017 Council conclusions on the issue called for an effective approach that will introduce health into account in all policies by promoting health, disease prevention and nutrition issues across all sectors and initiatives.

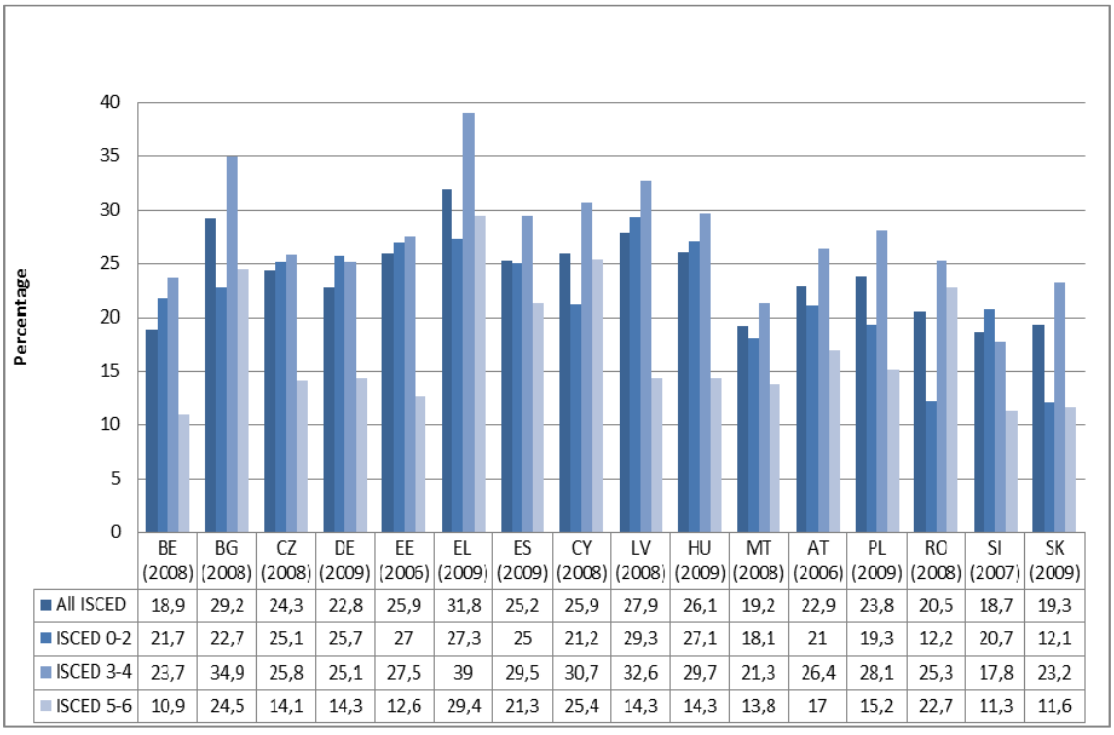
The European Platform for Action on Diet, Physical Activity and Health, established in 2005, brings together a wide range of European organizations that act in the treatment of malnutrition and lack of exercise. To date, it has supported 300 actions by key EU industry and civil society actors, such as banning the advertising of sugary drinks to children, providing better nutrition information in restaurants, revising recipes to use less salt, less sugar and less

fat as well as promoting sports activities in schools. In 2007, the EU set up a High-Level Group on nutrition and physical activity issues to find solutions to health issues associated with obesity. This group includes representatives of governments from all EU countries, Norway and Switzerland.

Other initiatives include the establishment of EU rules on food labeling. The goal is for consumers in all EU countries to be able to rely on food labels for accurate health and nutritional information. The EU cooperates with organizations in the Member States and other countries to tackle the problems associated with malnutrition and obesity.

Smoking

In most Member States, differences in smoking rates by social group represent an important part of health inequalities by social group. The chart below shows the reported smoking by level of education of the selected Member States that are participating in the first round of the European Health Interview Survey. With a few exceptions (Bulgaria, Cyprus, Greece, Romania) smoking rates for those with university education (ISCED 5-6) are lower than those with secondary or primary education.



	BE (2008)	BG (2008)	CZ (2008)	DE (2009)	EE (2005)	EL (2009)	ES (2009)	CY (2008)	LV (2008)	HU (2009)	MT (2008)	AT (2006)	PL (2009)	RO (2008)	SI (2007)	SK (2009)
All ISCED	18,9	29,2	24,3	22,8	25,9	31,8	25,2	25,9	27,9	26,1	19,2	22,9	23,8	20,5	18,7	19,3
ISCED 0-2	21,7	22,7	25,1	25,7	27	27,3	25	21,2	29,3	27,1	18,1	21	19,3	12,2	20,7	12,1
ISCED 3-4	23,7	34,9	25,8	25,1	27,5	39	29,5	30,7	32,6	29,7	21,3	26,4	28,1	25,3	17,8	23,2
ISCED 5-6	10,9	24,5	14,1	14,3	12,6	29,4	21,3	25,4	14,3	14,3	13,8	17	15,2	22,7	11,3	11,6

Daily smokers in relation to their educational level in EU Member States

Source: Eurostat.

Alcohol

Excessive alcohol consumption is the third leading cause of premature death and disease in the EU, after smoking and hypertension, especially in socio-economically vulnerable groups. Since 2006, the EU promotes responsible drinking through the European strategy in reducing alcohol related harm. This strategy encourages cooperation and coordination between EU countries to promote the education and information of consumers. The strategy includes actions that are part of all EU policies. For example, the EU Road Safety Action Plan supports initiatives to prevent driving under the influence of alcohol. An "Alcohol and Health Forum" has been created which aims to mobilize social actors who would commit to take initiatives in support of the EU strategy. In this forum are participating key Interested parties, such as spirits producers, advertisers and retailers, as well as health professionals, youth organizations, and NGO's that act in the health sector. To date, the forum members have made 246 commitments. At the same time, a committee on National Alcohol Policy and Action enables EU countries to exchange information and promote good practices.

European Reference Networks

In the field of complex or rare diseases, the EU has contributed to the concentration of scarce resources currently scattered across the Member States by setting up European Reference Networks, i.e., virtual networks that link healthcare providers across Europe. Their purpose is to bring together experts and to maximize the synergies between the Member States to improve the diagnosis and treatment of these diseases. As of March 2017, approximately 24 European Reference Networks have been set up, including 300 hospitals from 26 EU countries.

Common Financial Tool–European Social Fund

The European Commission published its proposal for a new multiannual financial framework (MFF) for the period 2021-2027, as well as for a new own resources system on 2 May 2018. Under this new proposal, the European

Social Fund + (ESF +) will operate as the main EU financial instrument for the implementation of the social pillar and it will raise investments in education, employment and social inclusion, including healthcare. The ESF + should be merged with the current ECB, the Youth Employment Initiative (YEI), the FEAD, the EaSI and the health program. The Commission proposes to allocate € 101.2 billion to the ESF+ at current prices (€ 89.7 billion at constant prices in 2018) from the EU budget.

EU pilot project GenCAD (Gender-specific mechanisms in coronary artery disease in Europe)

This European pilot project aims to improve the understanding of gender in relation to the treatment of chronic diseases by using the coronary heart disease (CAD) as an example to highlight differences in treatment and prevention. The existing evidence is sometimes incomplete and the findings are rarely presented to the medical community and the public.

The GenCAD project (2015-2019) aims to:

• Analyze knowledge about gender differences in coronary heart disease (CAD) risk factors, disease mechanisms, clinical manifestations, treatment options and access to healthcare.

• Assess the awareness of health professionals and the general population to identify the most effective practices to raise awareness of CAD in relation to gender.

• Develop and spread information based on the results of the studies, research and the overall needs assessment. The brochure of the specific EU pilot campaign can be found at the following link:

https://ec.europa.eu/health/sites/health/files/social_determinants/docs/2017_gencad_gendercoronaryarterydisease_flyer_en.pdf.

Proposals for policies, programs and action plans from various actors involved in social policy

Ministry Action Plans

Provided that the appearance and development of many chronic diseases are affected by common risk factors such as smoking, excessive alcohol consumption, poor diet and lack of exercise, in Greece social policy actors promote lifestyle changes. The EU confronts this problem with a variety of actions, for example, through public awareness campaigns, promotion for action by relevant sectors and NGOs, support of individual country initiatives as well as specific, targeted measures such as helping e.g., smokers to quit smoking.

In Greece, the Ministry of Health together with various civil society organizations aim to provide assistance in reducing smoking. Over the years, the EU has introduced various rules to reduce smokers and therefore the costs associated with smoking. These rules include the mandatory labeling of all tobacco products with warnings about the effects of smoking on human health: for example, "Smoking kills", "Smoking causes deadly lung cancer", "Smoking causes heart attack and stroke" and "Smoking during pregnancy harms your baby's health." Greece, though slowly, has also promoted the use of images and photographs on cigarette packs to send a stronger message that smoking can seriously harm health and, following European law, bans the advertising of tobacco products in the press, on the radio and on the internet. For socio-economically vulnerable groups (e.g., FEAD beneficiaries) some regions have highlighted the need for prevention through personalized smoking cessation seminars and sessions. Smokers - beneficiaries of FEAD have access to an extensive support network through some regions - for focused campaigns.

Campaigns for vulnerable groups by Local Health Units

Furthermore, the Primary Health Care program, that takes place in recent years in Greece, is important for the better awareness of the vulnerable groups of the population and in order to reduce the social injustices and which includes:

a. Clinical pediatric examination
b. Vaccinations
c. Dental examination (for children)
d. Clinical examination of adults (pathological - cardiological examination)
e. Gynecological Examination: breast examination, Test pap
f. Recording of cases that need immediate secondary care and directing them to Health units.

In addition to the cooperation of the bodies involved in the design and implementation of the project, Ministry of Health, National Centre for Social Solidarity, Hospitals, PEDY Units, National Vaccination Committee, Scientific bodies, Local Authorities, properly equipped mobile units have been provided (Gynecological mobile unit with digital mammogram, dentistry). Mobile units have access and target geographically isolated populations as well as groups with low socio-economic background.

The action of Local Health Units according to article 106 of Law 4461/2017 (Government Gazette 38 / A / 28-3-2017) also aims, at affordable universal access "to quality services for the entire population without discrimination, and to reduce inequalities in health (Reducing Health Inequalities)". The new model of services aims at the rational direction of individuals within the National Health System (NHS) by redirecting the demand from secondary and tertiary care, such as Hospitals, by providing quality, holistic and community-oriented Primary Health Care services.

Article 1 of Law 4486/2017 explicitly states the universal and free health coverage of the population, the equal access to health services with special care for the vulnerable social groups, the insurance of quality and safety of the provided services, the continuation of healthcare and the responsibility of healthcare providers.

For the evaluation / measurement of indicators have effect the *“125694”* Common Ministerial Decision (CMD) "Procedure - Framework for the Implementation of the Actions for the Operation of Local Health Units" and the provisions of article 5 (as the CMD applies each time), which states, among other things, that for managing reasons (indicator monitoring, eligibility of beneficiaries, etc.) as beneficiaries are considered the persons affected by poverty or are residing in the defined areas, that are specified in the Decision of Establishment of each Local Health Unit, and who receive services / benefits from the LHU".

The provided services include:

- The promotion of health to the covered population, with an emphasis on disease prevention and health education.
- The development of interventions and actions for the promotion of health in the family, in the workplace, in schools and in general throughout the community in collaboration with social care and solidarity bodies.
- The prevention, assessment and risk management for communicable or non-communicable diseases in groups or individuals of the population in cooperation with public health services.
- The collection and utilization of epidemiological surveillance data, in accordance with the International Health Regulations in cooperation with the relevant public health services.
- The systematic monitoring of the health of the covered population, both in LHU and at home, especially for the vulnerable groups of the population who are not able to move.
- Scheduled adult and child health care.
- The monitoring and co-management with the doctor, who is separate of the LHU and is treating chronic diseases, in the LHU and at home, especially for geographically remote areas.
- The education and guidance of individuals and families in managing chronic illnesses and high-risk situations for their health.
- The counseling and support to individuals and families, especially in isolated population groups.

- The recognition of mental illness in collaboration with the Mental Health Units of the Mental Health Sector.
- Elderly healthcare and multi-disease monitoring.
- Home healthcare - home treatment and home blood sampling to those who are unable to go to the relevant PHC units and especially to socio-economically vulnerable groups of the population.

ThedecisionofestablishmentofeachLHUdeterminesitsareaofresponsibilityinwhich the population of responsibility ranges from 10,000 to 12,000 inhabitants. It is important to note that in special cases, especially in areas with population, age, geographical peculiarities (e.g., islands, mountainous and isolated areas), the population of responsibility of LHUs may, by decision of the relevant Health Authority, be higher or lower.

“Street-work” by the Hellenic National Public Health Organization (NPHO)

In the basis of primary disease prevention, the Community Intervention Department is the part of the Hellenic NPHO that runs the design, planning and implementation of information and awareness campaigns on Disease Prevention and Health Education for both the general population and specific social groups (men who have sex with men, immigrants - drug addicts - extradited people), about HIV / AIDS, STDs and other infectious and chronic diseases with the aim of communicating and disseminating medical and social messages, but mainly focus on prevention and the protection of public health.

New virus infections mainly concern young people (25-35 years old) and while a significant percentage concerns men who have sex with men (55.5%), there is an increase of new cases in heterosexual people (24.6%).[1]

Of particular concern is the huge increase (almost 580% compared to the same period last year) in the rates of HIV infection in intravenous drug users, as well as the fact that 12.9% of people with HIV in our country are immigrants, with

[1]Epidemiological Surveillance of HIV / AIDS infection in Greece. Data until 31.10.2010.

this number having increasing tendencies as the influx of immigrants in Greece is constantly growing.

So far, the data from the mobile health units of the NPHO gathered in the squares of Omonia, Victoria, Attica, Larisis, Karaiskaki and Amerikis as well as the data from AIDS helpline and the telephone line of the Operations Center of the NPHO, show an increase in the prevalence of other communicable diseases (HPV) such as warts (HPV), syphilis and gonorrhea and outbreaks of infectious diseases such as hepatitis and tuberculosis, but also recurrence of diseases that had disappeared for years such as polio and multiple sclerosis parasites.

The most appropriate way of intervention in these population groups, which are scattered in different areas of the historic center of Athens (in squares, parks, bars, streets, brothels, etc.), is street intervention (outreach social work or street-work) which started on August 25, 2020 and continues to this day.

There are different types of social intervention on the street and the ones that were deemed most suitable for the specific population groups are the following:

- Detached street work which involves contact at fixed reference points (e.g., mobile units).

- Street work which involves contact within structures, i.e., streets / parks / bars where the groups operate and live, as well as the combination of them where necessary.

Recording of proposals in the context of the implementation of the 3 workshops

In the context of implementation of the 3 workshops emerged the need for a clear assessment of both the unchanging and changing needs of the population through multilevel, intersectoral and coordinated work.

Also necessary are information campaigns in marginalized geographical areas and in particularly vulnerable populations because, often, these populations have a low socio-economic profile and are at greater risk of contracting certain diseases such as cardiovascular disease. Street work, group seminars or individual sessions, as part of the European Social Fund (ESF) programs for the beneficiaries of FEAD and in the context of disease prevention of the NPHO in vulnerable groups, are proposals that are suitable as campaigns to reduce inequities in health.

During these workshops were analyzed the main characteristics of the population groups. The subjects were mostly smokers with severe obesity problems and unhealthy behaviors. The waiting time in the public system was long and the information regarding the existence of appropriate structures and services was deficient. A large part of the marginalized population in question was a rural population with a low level of education and economic status. Furthermore, several patients were suffering from diabetes. These data highlighted the need for disease prevention in geographically inaccessible areas of Greece. Targeted information and awareness campaigns in unions and associations by field of activity (e.g., farmers) could also have an impact.

The analysis of the social gradation of health inequalities made during the workshops highlights the differences in health-related outcomes between different socio-economic groups.

The cardiovascular disease risk factors prevalence in the examined population was increased. At the same time, the level of information regarding key issues of disease prevention and health promotion was low. Informing the general public about the risk of cardiovascular disease is necessary through e.g., radio and television spots, through printed material (posters, leaflets).

The main proposals focus on two topics:

a. on the one hand in the focused and general promotion of actions in the media for the general public and

b. on the other hand, in the special importance of the patient-doctor relationship and the need to strengthen the citizen's trust in the health system through interpersonal relationships.

The role of health professionals is crucial in regaining trust. Training of professionals for better communication with these population groups is necessary for better integration of the latter in the system by providing equal access and appropriate type of treatment to each patient. Investment in education and skills is a key policy tool for integrating vulnerable groups into the health system and for reducing injustices in the health sector in order to promote equal opportunities.

Specific and general proposals in relation to the findings of the actions (Observatory, Pilot implementation, Information campaign, workshops)

The skill development of health professionals is crucial in order to better understand the concept of health inequalities due to social, economic and educational inequalities, to provide appropriate, personalized services and to do intersectoral work to improve health determinants, such as unemployment and social exclusion.

Adopt specialized prevention measures such as e.g., anti-smoking campaigns in conjunction with the development of environmental measures and address commercial health determinants such as the implementation of a tax on unhealthy products and subsidies for fruit growing.

Under the joint action for Health JAHEE (health inequalities) program, in which the 6th Health Region is a partner and which is in the third year of implementation, are very important proposals to address the social injustices in health in Greece.

We list some of them below. Greece needs to:

- Develop the health professional skills in data analysis and in the design and evaluation of measures in order to reduce health inequalities. For example, improve the understanding of how the principle of "proportionate universalism" is applied to policies.

- Increase the use of public resources (e.g., European Structural and Investment Funds, European Investment Bank loans) to develop the skills of health professionals and health service administrators in tackling health inequalities. Promote cross-sectoral investments and collaborations in human and social capital (including in the private sector) and in health determinants.

Health policies should aim to increase the bottom-up approach where participatory processes can bridge the health gap so as to raise the level of health of the population groups that are in a worse situation compared to the groups that are in a better situation. Social capital must be based on values, social cohesion, transparency in decision-making and fair social policy. (Wilkinson, 2005; Braum, 2007).

It is also important to invest in health promotion and disease prevention services and to improve health literacy and digital health literacy, focusing on those most in need. Improving the health literacy of vulnerable groups will require extensive media campaigns and public transport campaigns (e.g., on buses, bus stops, traffic lights).

There is also a proposal to collect comparable data at local, regional and national levels that can be used to record and address health inequalities. A reasonable policy would be to establish a National Inequality and Injustice Observatory at the national level where indicators and strategies per region would be created to eradicate socially important diseases.

In addition, we propose that campaigns and policies focus on the poorest population groups (targeted approach) so as to reduce the health gap between economically disadvantaged populations and the rest of the population.

Finally, it is necessary to highlight and use the potential of local authorities in the field of social policy. To this end, the networking of local authorities that have common features / indicators related to health and well-being could play an important role (e.g., in terms of geographical distribution of the population, in terms of GDP, the population at poverty risk and social exclusion).

The Networking and the exchange of know-how, action models and policies between local authorities is an important tool for reducing health injustices. The experience of civil society should not be ignored either.

The creation of communication channels of the Local Authorities with bodies and voluntary organizations / movements that act towards he protection of

socially vulnerable groups with the aim to inform the more focused needs analysis and to explore action possibilities would strongly help the betterment of the organization and management of campaigns, actions and measures.

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