HEALTH EQUITY 2020

Reducing health inequalities - preparation for regional action plans and structural funds projects

Policy Brief

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Using integrated planning for leveraging stakeholder commitments to tackle health inequalities

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Introduction

Equity is about fairness and justice. Promoting equity is essential if human and social development is to be combined with economically productive societies. Health equity is the absence of systematic differences in health and its determinants between groups of people at different levels of social advantage. The opposite is health inequity, which results from unequal economic, social and environmental conditions. Such differences are inherently unfair, unjust and avoidable. Therefore reducing health inequities are essential, and the upward trends for such differences call for further innovative, collaborative actions at all levels.

Socioeconomic disadvantage translates into a disadvantage in health of economically marginalised regions and social groups. Worse health among those with a lower socioeconomic status leads to labour productivity losses, unemployment, increased demands for health care and higher uptake of social security benefits. Therefore, action is not only about safeguarding human rights, but also has a strong economic rationale.

In order to address human rights and the economic and social consequences of health inequities, current strategies need to be strengthened and combined with new ways of delivering them. In this context, the purpose of the HealthEquity-2020 project was to assist EU regions and sub-regions to develop evidence-based action plans that prioritised how to reduce health inequalities locally. This then informed identifying opportunities for using European Structural and Investment Funds (ESIF) in the current and future programming periods to address action plan priorities.

A starting point for funding and implementing action plans is to ensure that they do not exist in isolation. Beyond this there are several interdependent issues that need attention: genuine engagement with key stakeholders in prioritising needs; use the Health in All Policies agenda as a means to an end and not as an end in itself; nesting action plan priorities within more powerful national and/or regional development processes.

Stakeholder engagement

A problem for transition and less developed regions or localities across the EU seems to be the rather limited nature of stakeholder engagement (e.g. not only between decision makers, public sector professionals, business and communities but also within organisations) and between different levels of governance. Conversations with regional public authorities and services in Central, Southern and Eastern Europe suggest that engagement between national and regional stakeholders is usually formal and symbolic. At all levels stakeholder engagement needs improvement. In particular, there is a need for:

- Better synergies between ministries (including in their intermediate ESIF roles) & regions
- Clarity about sincere consultation methods for establishing priorities for National Reform Programme, Country Specific Recommendations, ESIF and regional/local development programmes
- Engaging all stakeholders (including local communities) with the whole process of regional planning from priority setting to planning and onto implementation and review.
- Securing and using budget lines and capacity building to strengthen active involvement of stakeholders in this process, especially for local communities.

The HE2020 experience - Regions were asked to establish a Regional Action Group with representatives from different sectors (e.g. regional planning, public health and management authorities for the European Structural Funds, different industries). This was easier for regions from decentralized systems, where there is greater autonomy and culture for developing action at the community level. Nonetheless, there are also examples where there is no formal regional level (Latvia; Pomurje, Slovenia) but where mobilization of stakeholders for local action was successfully undertaken. In addition, active leadership structures in the community carry great influence in coordinating efforts and facilitating partnerships (e.g. between the Slovene Ministry of Health and the Centre for Health and Development Murska Sobota; between Klaipėda District in Lithuania with local stakeholders and national structures).

Overall, policies and planning do not often benefit those who don't have a voice in their design or implementation. So, transparent and timely engagement is a necessary first step if local needs are to inform consensus on and commitment to addressing priorities for tackling health inequalities.

***Key message**: To address the lack of effective stakeholder engagement, a starting point for regions would be to conduct a stakeholder analysis exercise that covers the following axis: within region; region-national; and interregional.*

Health and Equity in All Policies as a means to an end

Health in All Policies (HiAP) is a "collaborative approach to improving the health of all people by incorporating health

considerations into decision-making across sectors and policy areas." The addition of "equity" to this framework emphasizes the importance of assessing the impact of policy decisions on health disparities and opportunities for all people to achieve optimal health. This includes improving the accountability of policy-makers for health impacts at all levels of policy-making (Leppo et al, eds. 2013).

These include but are not limited to: social and regional policy; taxation; environment; education and research. HIAP can be applied in different ways. For example (from Blas and Sivasankara Kirup 2010):

- the use of intersectoral government targets (France, Lithuania, Sweden, the United Kingdom)
- the use of health impact assessment units at local authority, parliamentary and inter-ministerial levels (Sweden, Wales, the Netherlands and Lithuania, respectively)
- passing 'shared' public health legislation, such as bans on smoking in public places (Ireland, Italy, Norway, Scotland, Spain);
- facilitating intersectoral action, including horizontal public health committees (England, Sweden), formal consultations and communication between sectors (Wales) and public health reporting with other sectors (Finland, the Netherlands, Wales).

As these examples show, HIAP shapes intersectoral action for health to address the structural drivers and the conditions of daily life.

CASE EXAMPLE: Programme MURA (Slovenia)

The Pomurje region is one of the most deprived in Slovenia. The majority of indicators of economic performance are significantly below the national average. It has the lowest GDP per capita, and the highest percentage of long-term unemployed of any region. Long-term unemployment is linked to the low level of education. As income, employment and education are determinants of health, with more disadvantaged populations often having higher rates of morbidity and mortality, it is no surprise that the population has relatively poor health. Life expectancy is the lowest of any region, and the number of years of life lost per 1 000 people under 65 is the highest.

Programme MURA became a development priority in the Regional Development Programme for Pomurje for 2000–2006. Financing in this period came from the Ministry of Health fund for tackling health inequalities and the direct regional investments transferred through the Regional Development Agency and endorsed by mayors in all 26 municipalities of Pomurje, and different EU funds, such as Phare and Interreg. Programme MURA's working priorities were: (1) improving healthy lifestyles; (2) increasing healthy food production and distribution; (3) developing healthy tourism products and programmes; and (4) preserving the natural and cultural heritage and reducing the ecological burden.

The lessons learnt provide practical knowledge of the challenges and benefits of the stewardship role of health systems. Of particular value to the Health and Equity in All Policies approach are the following:

- *Policy development* - (i) Achieving policy coherence between different sectors requires that policies be aligned with broad, shared objectives that provide space for intersectoral working. Administration of finances should also permit joint working. (ii) Focusing intersectoral effort requires that common priorities are identified. There is a need to focus resources on areas of greatest opportunity for health (and social) gains, which means where resources are most likely to have the greatest impact and where conditions for success exist. (iii) During the policy formation stage, considering issues of delivery, capacity (human and financial), and mechanisms for monitoring and evaluation is crucial.
- *Systems for delivery* - (i) The establishment of clear roles and responsibilities is essential. Parties should be made accountable for their differing roles and levels of engagement. (ii) Performance management systems are required. These should account for milestones, targets (at all levels of implementation), outputs and outcomes, and the monitoring and review process.

That said, while HIAP promotes health as one of several common drivers for sustainable growth, in times of continuing financial and economic insecurity it exists in an operating environment in which the funding of social policies has taken a distant second place to fiscal and economic policies. In the public sector, this means competition for funding between public authorities, different public services and social security.

Merging HiAP with sustainable regional development

HIAP needs to bind itself to a more neutral but insistent platform that provides the space necessary for collaborating across sectors, between levels of governance and policy priorities: sustainable development at regional level.

Sustainable development integrates three core goals: economic growth, social stability, and environmental protection within one framework (Whitford & Potter 2007; López-Casasnovas, Rivera & Currais 2005; SERI 2008)[1]. Such integrated frameworks are certainly easier to achieve at regional level, as argued by the Sustainable Europe Research Institute (SERI 2008). As pilots, they may become the triggers for larger-scale developments (Watson and Agger 2009) and the conditions of daily living fit well into such integrated policy frameworks (Watson 2010).

[1] There are a growing number of examples where such integrated frameworks are being implemented. For example, the northeast of England integrated health priorities under the umbrella of sustainable economic growth models, Berlin-Brandenburg successfully modernized its health systems by ensuring that all developments contributed to an overarching regional master plan, while in Western Australia integrated assessment frameworks have informed regional sustainability strategies (Jenkins 2003; Buselich 2002).

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Co-funded by the Health Programme of the European Union

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In parallel, there is growing interest in *the inclusion of health-related indicators in models of sustainable development.* This

> ***Key message**: Achieving coherence in policy design, planning and implementation between different sectors requires that policies be aligned with broad, shared objectives that provide space for intersectoral working.*

can facilitate quantification of the socio-economic and environmental consequences of direct health sector investment and the health impacts of indirect and non-health sector investments. A next step could be to effectively integrate health equity considerations into a risk assessment of all ESIF and regional development programme funding applications and post evaluation assessments. Essentially, there is a need to develop and use more inclusive near real-time indicators that provide a more reliable knowledge base for policy-making, associated investment choices, monitoring and project management[2].

Health equity agendas and integrated planning

Appropriate vehicles for collaboration could be regional health master plans and the filtering of competing funding priorities for regional development programmes. A critical element in many of the regional examples is the role of national health strategies or regional master planning for health and the broader umbrella of regional development plans based on sustainable development frameworks (this is picked up in Section 5). It is an element of regional development that promotes an integrated approach to urban and rural regeneration, stimulation of local economies and the positioning of health services across sectors.

The essence of longer-term strategic planning is not about a static list of investment priorities that are tossed out and replaced during election cycles. It is about having a clear and transparent set of strategic principles to guide planning decisions. And then blending this with participation through genuine consultation to identify the needs and priorities of the people you provide services for This is critical for action plans to tackle health inequities when in competition and collaboration with other economic and social policy agendas. Perhaps most important, longer-term planning and associated needs assessment supported by informed consultation can help communities work the economy to achieve their priorities rather than hollow-out communities to serve the economy.

[2] New disaggregated data and programmatic evidence are required to better document the distribution of disease, the impact of policies on health equity and the efficacy of programmes addressing the upstream determinants of inequities. The need for such data was affirmed in the European Commission communication *Solidarity in health: reducing health inequalities in the EU* (European Commission, 2009), the *Council conclusions on equity and health in all policies: Solidarity in Health* (Council of the European Union, 2010), and the Sixty-second World Health Assembly (World Health Assembly, 2009).

Sector-specific regional master plans have value where they address and build on local capacity and so tackle territorial differences within and between Member States. At the ScanBalt Forum "Healthy Future" in Tallinn 22 – 24 September 2010, the issue of master planning was acknowledged as essential to the successful implementation of the ScanBalt Health Region flagship project between 8 Member States:

> *ScanBalt BioRegion is a model macro-region for promoting interactions between universities, industries and public authorities. In addition it is a tool for developing and implementing EU policies. However, we still need to enhance our efforts towards removing barriers for the free mobility of people, knowledge and ideas and reduce regional disparities. A balanced regional development is a necessity and a master plan on health would be a major benefit*. (Wolfgang Blank, Now Former Chairman of ScanBalt)

In essence, it provides a clear vision of what people are collectively aiming for.

In this respect, the Brandenburg example below demonstrates how health service developments were dependent on ERDF-funded improvements in road and rail transport systems in the region. This was considered critical in ensuring good access to services among the elderly and improving connections between small towns and cities in Berlin−Brandenburg so that the region could enhance its appeal to potential investors and ensure better accessibility for younger people to higher education. Underpinning this, Brandenburg is an example of improving access to care in rural regions (for the elderly and excluded groups). But it also shows that tackling deficits in rural health services need to be part of a wider drive to address rural poverty.

CASE EXAMPLE: Modernizing health care services as part of rural development in Brandenburg−Nordost

Brandenburg−Nordost was an Objective 1 region in 2000–2006 and is currently a Convergence Region with a Gross National Product of €18 000 to €22 000. The Fontanestadt Neuruppin is a case in point: rural, sparsely populated and with a diminishing number of doctors. Of those Neuruppiners in employment, 18% are employed in the public health sector. This region also has poor accessibility to higher education for younger people. At the time of the unification of Germany, it had a run-down rural infrastructure, including the state of hospitals, polyclinics and road networks. Politics led to the closure of previous state-run polyclinics in favour of single-physician offices while investing in medical technology for larger hospitals was favoured. This tended to neglect accessibility for widely dispersed rural communities.

A regional health master plan for Berlin−Brandenburg was developed in 2007 with 12 objectives.

The RHS saw its challenge as being to modernize its services in ways that would provide quality access in a largely rural region while controlling budgets and prospectively enabling distance learning. In the master plan, the priorities for Brandenburg were medical technology and telemedicine, care of the elderly and prevention and rehabilitation: these were integrated into the wider master plan. These priorities have been translated into intersectoral action, ideas, and concepts by:

- building regional networks composed of all players

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- developing common (transsectoral) clinical pathways
- trying to link these pathways with telemedicine
- extending telemedicine with telecoaching

In essence, what they seek to achieve is close-to-home medicine directly financed with minimal bureaucracy. What is critical for other RHS to understand is that modernizing RHS in ways that address health inequities, especially in rural regions, cannot take place in isolation. In the 2000–2006 SF period, these developments were linked to other SF OP priorities such as transportation, data highway communication, telemonitoring to support disadvantaged groups, rural teleworking and developing a lifelong learning network.

New innovative health care projects, such as "The sheltered way: technical and organizational network structures for cardiological processes", are being explored to help take forward an ongoing modernization process. So far, the main lessons learnt are:

- avoid ideologically inspired investments
- avoid simply focusing on prestigious projects, such as big hospitals
- encourage networking of all regional stakeholders
- identify focal points in support of dialogue
- facilitate competition of ideas but chose projects based on quality
- seek to achieve synergy between ERDF and ESF investments.

Effective longer-term strategic planning as part of a regional development process is about aligning local needs with clear growth goals through a continuous process that is: intelligent, innovative, integrated and implementable. To achieve and maintain this, strategic principles are important because they define the purpose and goals of sustainable regional development. They should also be a product of informed consultation giving them credibility and making them adaptable and resilient to policy changes in the shorter-term e.g. a compact and carbon efficient city, housing diversity and choice, social inclusion and fairness, affordable living, natural resources management, community engagement. Strategic planning aligned to regional development offers a dynamic economic and social operating environment for social and health policy.

When the process that defined and adopted strategic principles as a driver for regional development is transparent, this agenda specific funding cases have a harbour they can clearly align with. However, as the Mura case example above and subsequent work by the Pomurje HE2020 Partner (CHD) shows, regional development programmes are not static. Existing plans should be reviewed and updated within a sustainable development framework so that it continuously evolves.

In summary, long-term planning may be sectoral specific (e.g. transport, utilities, health) or integrated and place-based (region, city, municipality). There are four clear questions here: What do we want to achieve? What needs to change? What are the risks? How do we make it happen?

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Further information can be found on the Health Equity 2020 website: www.healthequity2020.eu

The full document can be accessed at: http://www.healthequity2020.eu/media/attachment/HealthEquity-2020_Policy_Matrix_Final.pdf

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