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HEALTH EQUITY 2020

HE2020 - REGIONAL FINAL REPORT

POMURJE REGION, SLOVENIA

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Content

Overview

This report is summarizing the work of the regions in the framework of the Action Learning and Capacity Building programmes of the HealthEquity-2020 project. This document consists of 3 interrelated parts:

Part 1: Developing the regional action plan. What does the evidence say?

Part 1 summarises the work that has been done in relation to testing the HE2020 Toolkit. The regions went through on different phases to collect the necessary evidence providing step-by-step guidance in designing evidence-based action plans: (i) conducting a needs assessment, (ii) a capacity assessment, (iii) selecting entry points, (iv) carrying out an impact assessment. Based on the Toolkit this template helps the regions summarize the data and information collected during the process of assessing and addressing socioeconomic health inequalities.

Part 2: Regional Action Plan to tackle health inequalities

Part 2 is the main output of the work of the regions. The key activity of the HE2020 project is that participating regions prepare region-specific action plans that are evidence-based and are integrated with regional development plans & that have appraised financial options including ESIF. The provided information and template help develop the regional Action Plan.

Part 3: Developing the regional Action Pan: The process

The HE2020 Action Learning and Capacity building programmes put a strong emphasis on the process of learning, developing, and sharing. Part 3 helps thinking through the action planning process in the project and documenting it. It summarises the context in which the regional team works, the used approach, what has been achieved and how, as well as the opportunities and challenges encountered.

PART 1 WHAT DOES THE EVIDENCE for your region SAY?

Introduction to Part 1

The aim of the HealthEquity-2020 project was to assist regions in Europe in drawing up evidence-based action plans to address socioeconomic health inequalities. Having an evidence-based approach is important as it provides a rational, rigorous, and systematic approach to: setting up interventions, designing policies, programmes, and projects. The rationale is that well-informed decisions will produce better outcomes.

A key product of the project is the HE2020 Toolkit providing step-by-step guidance in designing evidence based action plans: (i) conducting a needs assessment, (ii) a capacity assessment, (iii) selecting entry points, (iv) carrying an impact assessment. Following the Toolkit structure this template helps regions document the data and information collected during the course of the process of assessing and addressing socioeconomic health inequalities.

Regions are advised to fill in this template as much as possible with the information gathered and assessments made along the development of the project by testing the Toolkit. What is important is providing the best available evidence that can: (i) explain the health gaps between people and the corresponding socio-economic determinants leading to the inequalities; (ii) assess the capacities (existing/missing) to implement actions to address inequalities; (iii) show how the entry points for actions/policies or interventions were chosen; and (iv) assess the policy impact of the interventions chosen.

In practice this summary can serve as an annex to a regional Action Plan or any wider strategy. It can also be used by regions to (i) draw policy makers` attention to a policy issue; (ii) monitor policy implementation; and (iii) evaluate the outcomes of the interventions.

The full HE2020Toolkit is available at this link:

https://survey.erasmusmc.nl/he2020/

Additional support for the completion of this template can be found at:

http://wiki.euregio3.eu/display/HE2020EU10/Home

This template has already been used at the Action Learning Workshops and regions have already been asked to provide information using this framework. Please review your earlier work and add into your finalised data collected during the action learning and capacity building processes. You can freely increase the size if the textboxes where necessary. Where you cannot provide data, please explain why. Thank you.

Phase 1 Carrying out the NEEDS ASSESSMENT

Assessing the magnitude and determinants of socioeconomic health inequalities

1.1 Introduction

[Insert here a short introduction on why a needs assessment was undertaken. Please describe the overall process: what methods and sources you used to obtain the data, how the data was edited or analysed, was there any action undertaken to improve data availability through conducting additional surveys or improving monitoring of data.]

Pomurje region is one of twelve statistical regions in Slovenia. It is situated in the northeast of the country and is since the independence of Slovenia in 1991 until today one of the least developed and most deprived regions with lowest GDP and highest unemployment. These problems are still persisting from the first economy breakdown in 1990s, when regions top industries lost their markets in former Yugoslav republics (textile, food processing, farmer's equipment and commerce companies). Region slowly recovered, though much slower than regions in central or western Slovenia, but there was a progress, until the second, this time a financial breakdown in 2008. At the same time, region has the worst health and lifestyle indicators in Slovenia and these two unfavourable conditions can be clearly linked and identified as health inequalities between different regions in Slovenia. This is why Slovenian government, especially Ministry of health, Regional Institute of public health and Regional development agency with strong support of WHO, became very active to reduce health inequalities in Pomurje through different programs, starting with Programme Mura in 2001 with Investment in health approach (http://czr.si/files/murahealthinvest---arhiv.pdf) to additional support of region's economy through Law on development support for Pomurje region in 2009 and supporting different programmes and actions to reduce health inequalities, including our project, Health Equity 2020, to this day. In all this time, health was put forward on the development agenda of the region, with the most notable success in 2004-2006 period, when new Law on balanced regional development in Slovenia was identified as entry point for investment in health approach and with political support and WHO support, health became one of the 3 regional priorities, beside business zones and water system. In time, other priorities emerged and were added, but health is in one form or another always present in the development policies and strategies of Pomurje, mainly because of the institutions and capacities in the region, build in the last decade, that are investing their resources to this result, and support of Ministry of health and WHO Venice office..

Needs assessment was one of the key process steps necessary, to inform regional development planning for 2014 – 2020 with evidence of health inequities between regions in Slovenia and between different groups of population within the region. This was conducted largely by desktop research, when obtaining routinely collected data and also through different interactions with different stakeholders and NGOs, representing mainly vulnerable

groups such as Roma population, elderly and disabled people (through personal contact, project partnership, publications,...).
The routine data sources used were:
- National institute for public health (NIPH)
- Statistical office of Republic of Slovenia (SORS)
- Institute for macroeconomic development (IMAD)
- Health insurance institute of Slovenia
We have reviewed other data available as well, such as surveys, reports and publications, but one of the most valuable data sources for the needs assessment was the publication Health inequalities in Slovenia (Buzeti et all, 2010), that was a joint effort of our organisation (Centre for health and development Murska Sobota), National institute for public health, Ministry of health of Slovenia and World Health Organisation, Regional office for Europe. This publication clearly showed health inequalities between population of different regions in Slovenia - a correlation between wealth and level of development of regions and health status of their population. A clear social gradient is also present, measured by level of education and different health indicators and prevalence of risk factors between groups with different socioeconomic status, clearly less favourable for groups with lower SES.
There is no possibility for now to obtain data necessary to measure or identify health inequalities within the regions municipalities, because the data available is not linked with socioeconomic status or is not desegregated to municipal level. This is something that we would like to improve in the future and there is also an initiative to decision makers to introduce routine systematic monitoring of health inequalities on all levels of political and statistical entities of our country to provide evidence and trends on development of health inequalities in shorter time and thus prepare more adequate and quicker interventions to prevent or reduce avoidable health inequalities also on regional and municipal level.

1.2 Regional profile

[Please provide a short description of the region. You can refer to aspects such as: population size and density, distribution of the population by age and gender, distribution of indicators of socioeconomic position, degree and distribution of urbanity.]

Pomurje region is situated in north-east part of Slovenia, bordering with Austria, Hungary and Croatia, on 1.337 km^2. It has a population of 118.573 residents (2012), which represents 5,8 % of Slovenia's population. Around 48,8 % are men, and 51,1 % are women. Density of population is low (89,1), Slovenian average is 101,4 residents living within km^2. Hungarian minority and Roma ethnic group are situated in the region. Population aged to 14 years presents 13,1 %, population aged 65 and more presents 17,5% of the whole population. Region capital is Murska Sobota, with 11.679 residents (density of population 858).

Pomurje region is one of the most deprived regions in Slovenia, with highest unemployment rate (18%) in 2011 (Slovene average is 11,8%). GDP per capita amounts to 11.445 Euro in year 2010, reaching only 65,9% of national average or 57,3% of EU-27 average.
Education: 28,6% people have primary school or less (Slovenia's average is 20,8%), 55 % have secondary education and only 15% have tertiary education. 10,5% of the population is included in lifelong learning (Slovenia's average is 16%).
During transition period in the nineties unemployment rate in Pomurje rose. The region is traditionally agricultural, having large share of farmers earning a low income and above average share of elderly people. Aging index in Pomurje is 139,0 (Slovenia's average is 117,8). Central region of Slovenia, where the capital Ljubljana is situated, and western regions, experienced fast economic growth during last decade and a half, while eastern parts of the country stagnated.
In Slovenia we do not have regional governments and the regions are statistical regions (there is no authority between municipalities and national government), but we do have regional development councils, that make decisions about future development of the regions and (some) development resources allocation. Primary health care is under municipal authority, secondary and tertiary is under national authority, both of them are funded through universal state insurance fund and additional private insurances. High unemployment, unhealthy lifestyle and low education level (agricultural tradition) are the main drivers of health inequities in our region, researched in publication Health inequalities in Slovenia by Tatjana Buzeti and all. in 2011.
Traditionally agricultural, the region sets up on development of tourism since last decade. Tourists made more than 931.000 overnight stays in 2012 in the region. Mutual influence and interest between agriculture, tourism and health have been recognized. Joint efforts of different sectors in region toward promotion of health as precondition for prosperity experienced affirmation in programme Mura.

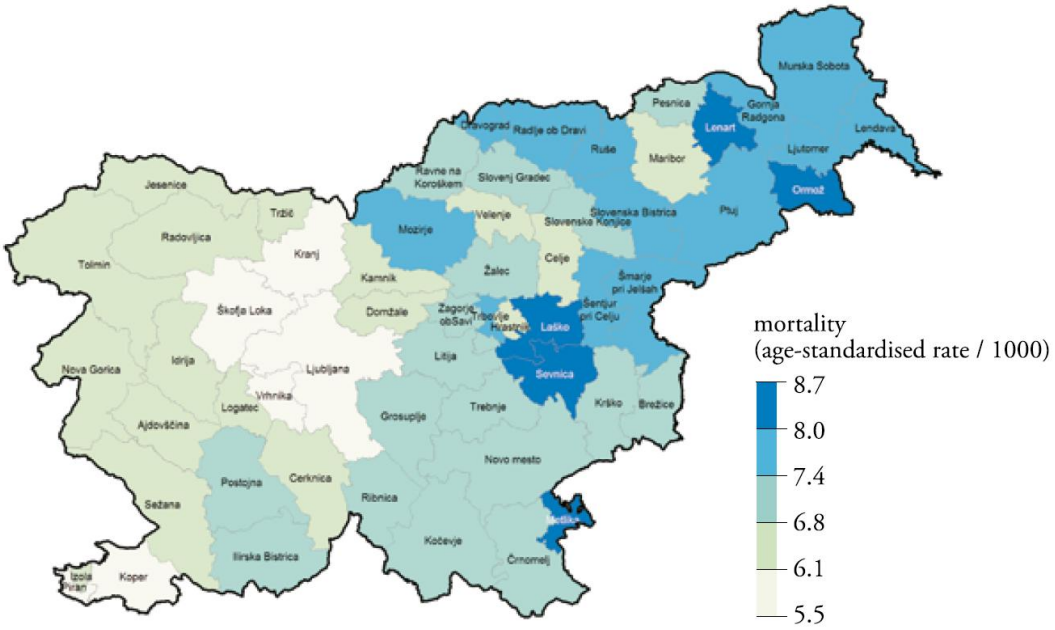
1.3 Socioeconomic inequalities in health

Mortality and life-expectancy

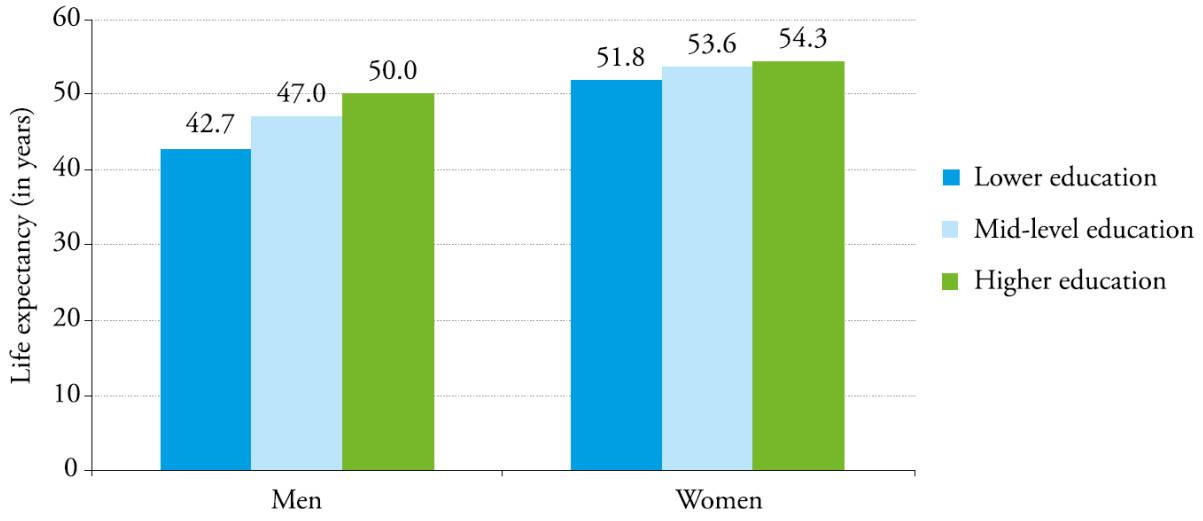
[Describe here the socioeconomic inequalities in mortality or life expectancy.]

Life expectancy is lower than Slovenia average for men for 3 and women for 2 years. There is highest percentage of death from cardiovascular diseases (46,1%), highest premature mortality for men 32,4% in Slovenia (Slovenia average 29,4%). Birth rate in Slovenia is very low (2010 1,57), under EU-27 average, in Pomurje even one of the lowest in Slovenia (1,32). There is very limited data about health inequalities within the region and different life expectancy and mortality rates between different socioeconomic groups, but there is a clear social gradient in Slovenia between those with high education and those with low education. Mortality rates in municipalities with lower income from taxes (means less economic activity and higher unemployment) are higher than in those with higher income from taxes.

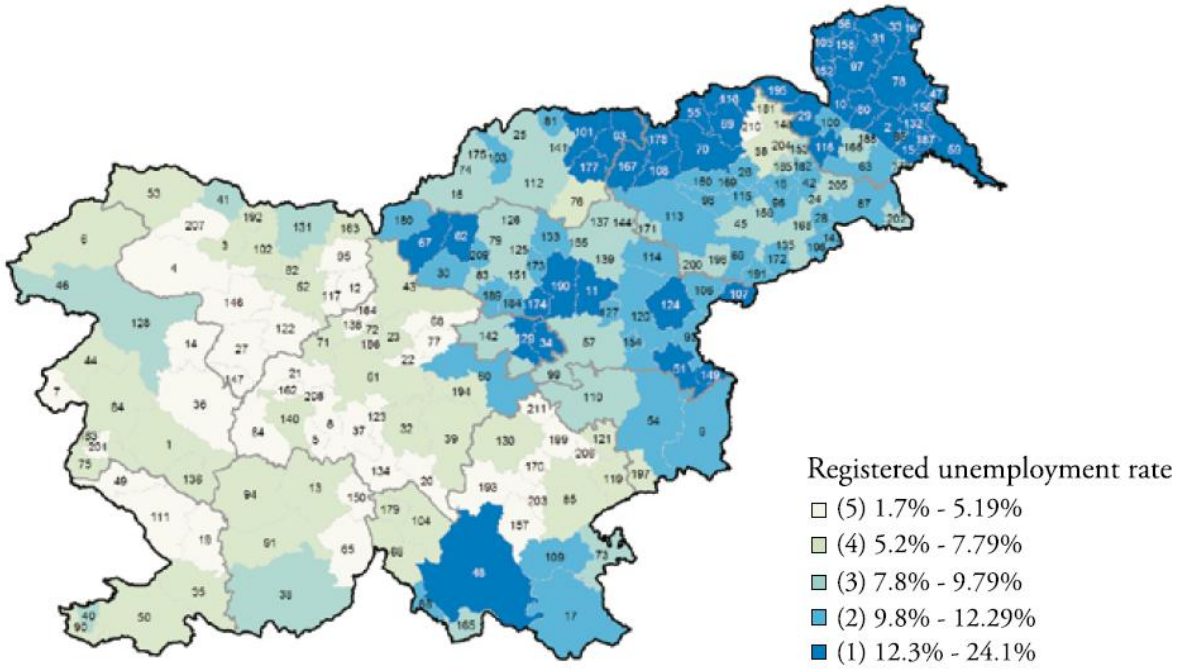
Mortality by Slovenian administrative units, 2005–2009
(NIPH Database of deaths 2005-2009; SMARS)



Life expectancy at 30 relative to education and gender, Slovenia, 2008 (Corsini, 2010)



Distribution of Slovenian municipalities into quintiles relative to income tax base per capita and registered unemployment rate, 2004–2008 (TARS, 2004-2008 (recalculations IMAD); SMARS 2010)



Distribution of Slovenian municipalities into quintiles relative to income tax base per capita and registered unemployment rate, 2004–2008 (TARS, 2004-2008 (recalculations IMAD); SMARS 2010)

Health during life

[Also during life, health inequalities can exist. Describe them for a few of the main indicators such as disabilities, prevalence of certain chronic diseases and self-reported health.]

Eastern part of Slovenia has the most registered disabled people of third degree in Slovenia (9,5%), first and second degree are almost the same (first 4,7 and second 2,2) (CINDI Health Monitor Survey, 2008). The reason and connection to health inequalities here is difficult to measure. We can connect them to access to different services, such as use of health care and preventive services such as general practitioners, medical specialists, hospitals on one hand and in general mobility issues for disabled on the other hand. Pomurje region tackles health inequalities of disabled through NGO's which deal with problems of one special population (for instance physically disabled recreationists), whereas there are no public institutions that would tackle inequalities of disabled people on regional or even policy level.
Chronic diseases: for most of the chronic diseases in eastern part of Slovenia the results show higher level of concern than for other parts of Slovenia. More than 46% of deaths are caused by CVDs. The most common reason for visiting primary health care institutions are respiratory diseases, muscular-skeleton system diseases and cardiovascular diseases.
Self-reported health: CINDI Health Monitor survey shows that eastern part of Slovenia stated: very good (8,8%), good (36,6), middle (42,8), bad (10,0), very bad (1,9) which presents the worst self-reported health among the three parts of Slovenia (east, central, west). Although, when answering the question "How do you take care of your health?" it is interesting that there are almost no differences between all three parts of Slovenia. The percentage of taking good care of health rises with age. Survey also shows that residents in rural communities also do not take as much care of their health, compared to residents in urban and suburban communities.
Most of the people in CINDI survey answered that stress mostly contributes to bad health and high mortality rate (27%), physical work and bad nutrition are second in eastern part of Slovenia, whereas bad nutrition and bad living conditions are next in the Slovenia average. Access to health services is stated also as what mostly contributes to bad health more in eastern part of Slovenia than in other two parts.

1.4 Socioeconomic inequalities in health determinants

Health behaviours

[Describe the socioeconomic inequalities in health behaviours like: smoking, physical inactivity, alcohol consumption or diet.]

The data in years 2001, 2004 and 2008 (CINDI Survey) shows systematic increase of healthy life style also in Pomurje region in general. The fact is, that all national prevention programs also took place in Pomurje region. Residents in general all live healthier with better nutrition, more recreation and exercise and smoke less in this period of time. Health inequalities in Pomurje were identified as product of all socio economic determinants of health, not only of

the performance or access to the health care system. Still, although the lifestyle indicators are in some cases even better or the same, than in other more developed regions (in many cases they are worse and need to be improved) in general, they are not improving fast enough. There is also an identified lifestyle difference between people with different socioeconomic status, making our region (being the poorest and least developed) among the worst in the country. Lifestyle and health behaviour indicators are especially problematic between the Roma population and so are other health indicators, meaning that universal approach alone is not working good enough and that we also have to create various targeted measures for those, that are worse off and most vulnerable in our region. Roma, with highest unemployment rates, mortality rates as well as morbidity rates are one of those groups.

In the needs assessment and in capacity audit the stakeholders and experts also pointed out the elderly, or those, that just recently became retired, as a potential (even existing) vulnerable group. We don't have any evidence on that topic, but talking to persons with personal and institutional experiences from working in the region, we identified inequities between elderly and the rest of population in the region. They are at risk to slowly slide into poverty and social exclusion, due to lack of social contacts, relatively small pensions, small or no family in the neighbourhood to help them, too high costs of maintaining their houses without extra income (being at risk to sell their property and end in institutions), reduced mobility (especially with women) because of poor and/or relatively expensive public transport in rural areas (practically the whole region is rural area with some smaller towns, poorly connected to each other with public transport) and entering in retirement in bad health due to working conditions or risky health behaviour.

Regarding alcohol consumption the share of heavy drinkers from 2001 gradually decreased in age groups 40-54 and 55-64 and according to education level in the group with the lowest education level. According to self-reported social status, the share of heavy drinkers statistically decreased in low working class and middle class and in rural environment. The share of heavy drinkers statistically decreased in health regions of Murska Sobota (region Pomurje) and Maribor (both eastern part of Slovenia). Over all in eastern part of Slovenia we still do have higher share of heavy drinkers and high-risk intoxication. Alcohol contributes to inequalities in health: the differences are between genders, regions and socio-economic population groups; more vulnerable are men and residents in eastern regions of Slovenia (Publication: Alcohol in Slovenia).

Working & living conditions

[Present inequalities in social conditions, such as social support and demand-control imbalance, as well as physical conditions, such as housing quality, traffic safety, and exposure to noise.]

In the field of housing quality we are facing the trend that more and more houses are empty or only one elderly person is living in it. Connected to this problem we have poverty issues and high use of energy issues due to old, energy inefficient houses. With low income, people in general are not able to improve the energy efficiency of their homes. Average useful floor space (m^2) is 86,1 (which is slightly higher than Slovenia average-80,0), whereas by central heating (74,3% - SLO 78,8%) and bathroom (89% – SLO 92,9%) in Pomurje region we are below Slovenia average.

Unemployment in Pomurje is high since the transition period in nineties. The global financial crisis has hit the region harder than the average in Slovenia and we have a negative GDP growth. Although Pomurje was fairly industrialized during the 20th century, above all in textile, machinery (agricultural machines mainly), food and beverages production and tourism services, the region remains traditionally agricultural, having a large share of farmers earning a low income and above national average share of elderly people. One of the main reasons for high unemployment in Pomurje was the collapse of textile industry in Europe in the nineties and the aftermath is still persistent, since the region was not prepared on such structural unemployment, although it took several years from the beginning to the final closure of most textile factories. Because of the loss of markets in the former Yugoslavian republics and not being able to replace it adequately in the EU countries also the other traditional industries suffered a great deal, luckily not as hard as the textile, but did significantly contributed to the higher unemployment, contributing to rise of health inequities in connection with socioeconomic status. Education level in Pomurje is lower than in other regions in Slovenia and the entrepreneurship is not well developed. Young professionals, trained in Ljubljana or Maribor, are staying there in pursue of their professional carriers, since there are more opportunities for high educated persons in western regions of Slovenia. Young (and also older, experienced) skilled workers are leaving Pomurje in the direction of Austria and Germany, where they can find better wages and work in the first place. These trends - brain drain and skilled workforce drain from Pomurje, enhanced with demographic change towards aging population and higher mortality than birth rates, are suggesting, that in a not so distant future the region will be full of elderly with no community or families to support them, causing great social and health problems and even greater inequities between regions and the population within the region.

One of the development directions is therefore definitely investment in people and building their capacities for entrepreneurship and skills to create new employment possibilities with taking into account the regions assets and comparative advantages. Entrepreneurship culture on basis of Global Entrepreneurship Monitor (GEM) show, that Slovenia in general is among "sleepy" countries concerning entrepreneurship compared to other developed economies. Pomurje lacks contents and services that would connect entrepreneurs and help them improve their knowledge and services. Region Pomurje did help innovators in last ten years, but more progress is still needed. We have Pomurje technological park that connects and helps in the development of entrepreneurs at the beginning of their business. These concepts are working, but have to be increased in order to achieve constant growth during longer period of time. With capacity building and infrastructure it is necessary to encourage

prosperous environment for new entrepreneurship that is based on private-public partnership, with connection to health. Pomurje region has a potential of good quality of life, good business zones for new investors. We need to connect this endeavour with constant striving to use health as regional development opportunity and regional development as opportunity to improve health of regions population.
Traffic safety and exposure to noise are not such a big problem, while the biggest city has (only) 11.500 residents – more likely we are facing lack of good public transport in rural areas, because of the low demands, low density of population and lack of qualitative traffic strategy on regional level, and with 4 primary health care centres in bigger towns and one hospital in Murska Sobota, this is producing some inequities in physical access to health care. Especially the elderly and disabled people, living in rural areas have therefore mobility issues, if they do not have any members of family or other relatives or friend to help them face that needs.

Access and use of health services
[Describe inequalities in access to and use of health care and preventive services such as general practitioners, medical specialists, hospitals, dental care, screening, vaccination programs, and maternal and prenatal care. Consider both the geographical access as well as the financial barriers.]

Primary health care is under municipal authority, secondary and tertiary is under national authority, both of them are funded through universal state insurance fund and additional private insurances. There is 18,9 physicians per 10.000 inhabitatnts in Pomurje region (Slovenia average is 25,7), 89,1 nurses with upper secondary and tertiary education (Slovenia average 84,5), 4,7 dentists (Slovenia average 6,4), 5,6 pharmacists (SA 6,1), 39,5 hospital beds (SA 47,6), more sick leave 4,6 (SA 4,0).
Visits at general practitioners, or medical specialists: CINDI survey shows that in eastern part of Slovenia visits of 3-4 times a year or more are highest than in central and western region. Related to education, people with lower education visit the general practitioners or specialists more often as well as people with lower income. In terms of rural or urban the result are basically the same. Percentage of people who have never been to dentist in a year's time is highest in eastern Slovenia (10%), where there are mostly people with lower education, living in rural areas and elderly (age above 70). Maternal and prenatal care: Infant mortality for 2011 shows 3,8 per 1.000 live births (SA – 2,9).

1.5 Economic consequences of health inequalities

Labour related indicators

[Describe here labour related consequences of health inequalities (ill health), such as labour participation, sickness leave, and labour productivity.]

Health promotion is a concept accepted broadly in Slovenia and numerous projects are already making good evidence, progress and results are positive. Employers are becoming more and more aware of importance of good health and health behaviour among employees and therefore The Health Insurance Institute of Slovenia already for a third year in a row published public tender for employers to tackle absentism and health in the area of work. Nevertheless costs because of health absentism on a year's level in Slovenia (2 mio inhabitants) are approximately 450 mio EUR directly (Health insurance and employer's costs) and 900-950 mio EUR indirectly. In Slovenia we evident around 9 – 10 mio lost working days per year because of sick leave, which means that on a daily basis there are 36.000 people out of work. A decade ago this number was higher for around 10%. We consider presentism could be the basis of absentism due to the fact that there are significant differences in absentism between public and private sector. Absentism in public sector is bigger and bigger problem, absence is caused by health diagnosis: muscular-skeletal system injuries (diseases), injuries outside work, respiratory diseases, mental and behavioural disorder. Presentism on the other hand is becoming an issue in private sector, while there the most common reasons for absentism are severe forms of cardio-vascular diseases (that can be the result of presentism). Research since 2004 show that 1 EUR of investment in workplace health promotion saves up to 6 EUR (WHO,2004).

Direct costs related indicators

[Describe here costs of health inequalities (ill health), such as healthcare costs and costs of social security benefits.]

We do not have indicators for our region but, as shown in previous chapters, in Pomurje we have more sick leaves (4,6) as Slovenian average (4,0), and if we compare other health indicators, we can conclude, that the costs of healthcare and social transfers are higher than Slovenian average. Unemployment is one the biggest social security issues and costs, since the health insurance of those unemployed is covered by municipalities and state and they also can not contribute to health budget in the forms of contributions, deducted from wages from each employee's salary. At the same time, people that are long time unemployed are more likely to develop health condition, preventing them to re-enter labour market and are ending in vicious cycle towards poverty and social exclusion resulting in bad health and dependent on long term care or dead. In Slovenia there is a high level of institutionalization of people in need of long term care, provided by state and municipalities. Unemployment in Pomurje is structural, coming from one type of industry (textile mainly) and is highly unlike to be reduced during this generation, since the workers have no other alternative industry to restructure to, they are left with state and municipality costly long term unemployment or

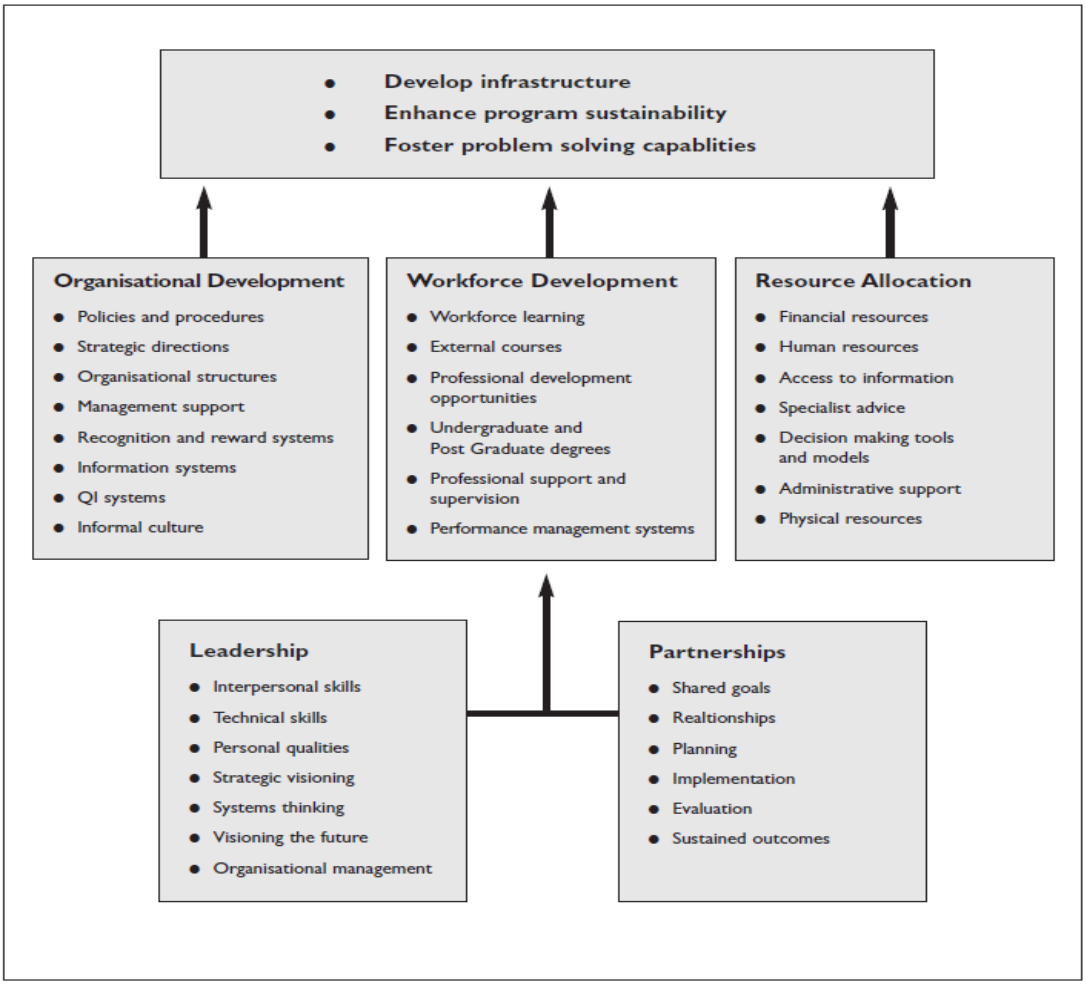
self-employment, that is much more difficult to manage than to be employed and is therefore also much more unlikely.
The costs of health inequalities and inequalities in general is at the end not burdening only health system itself. It contributes also to the uncompetitive labour market in the region. Sick, disabled, elderly, people with special needs are lost capital of the region, that needs to be activated, included into the labour market and we should strengthen their health and working capability with it. To achieve that, we need to invest in healthy society and environment, where living healthy is an easy and simple choice. We need to invest in disease prevention, promotion of healthy lifestyle and development of integrated services, that will enable the deprived active inclusion in society and care for health. It is important, that all inhabitants take care of their health and live healthy and with that contribute to the image of a " healthy and active region", that will attract tourist, visitors and investors.

Phase 2 Conducting a CAPACITY ASSESSMENT

Introduction

[Please describe the overall process of conducting the capacity audit in your region (what data was used, did you conduct interviews, during what period of time?]
The process of conducting capacity assessment began with establishment of a team within the project Health Equity 2020 to test the Capacity assessment tool. This means, that Pomurje region was selected to test the capacity assessment tool between the stakeholders and Regional Action Group members to provide a tool, tested and approved on the field. The process was divided in two phases – one phase was development and provision of the tool framework, where in our case we used 5 domains of capacity building for addressing health inequities – organizational development, workforce development, resource allocation, partnership and leadership, all in connection with cross-sectoral communication and cooperation. The aim was to develop capacities of people, organizations and communities to tackle health inequities with cross-sectoral collaboration.

Capacity building framework key action areas



After identifying the basic legislation, programmes, actions and institutions, that are or could be stakeholders in the regional development and thus influencing the social determinants of health. We have identified regional stakeholders and invited them to take part in our audit. We also decided, that we will make two rounds with some time in between, to assess the first round, the questionnaire, the methods for interviewing stakeholders, the stakeholders mapping, the approach and also to identify additional stakeholders, that might come up during interviews with different people from regional institutions in Pomurje.

Our team has decided to make capacity audit in the form of personal interviews. We have developed a questionnaire, suitable for personal interviews and a introduction for the interviewee, to explain some theoretical and technical details and to make a general introduction of health, social determinants of health and health inequalities, how are they linked and what could be the sectors, that the interviewee is working in, contribution to tackle health inequalities. We took special care to make a research about the sectors, institutions and organizational structure they are working in, the role of the institution in the region and the work of the person we are interviewing.

Our team has split in two teams and we made the interviews simultaneously on 6th and 8th of May and from 17th to 19th of June in 2013. In both periods together we interviewed 14 stakeholders from 7 different sectors.

Findings

[What are the findings with regards to the main domains of the capacity audit? Please refer to weaknesses as well as strengths and opportunities for development.]

Since the tool has been tested for the first time, we have learned from it and adjusted the process between the two different periods of interviewing. The stakeholders were prompted, that there is no good or bad answer and because they were from different sectors, the concepts of health and health equity were explained in the beginning of the interview. For explanatory part of the interview, the Introduction to the interview, that was developed by the team, was very useful and the explaining of the concept how social determinants of health are linked to health and health inequities with Whitehead/Dahlgren model proved to be very efficient. Capacities and cross-sector cooperation are more or less familiar to interviewees.

Findings:

The most important health inequalities are among:

- elderly,
- Roma population,
- people with mental problems

The most important social determinants of health:

- income (the crisis; unemployment)
- education
- governance/management issues
- culture/mentality

Most of the interviewees agreed, that there are capacities in the region, but are not well coordinated or used in a proper manner. Different sectors work isolated, lacking even informal communication, that sometimes results in overlapping activities, when addressing social determinants of health and sometimes no activities for addressing identified problems. Clear need for coordination between different stakeholders in the region was identified and stated amongst the stakeholders, not only on strategic/planning level, but also on implementation level, given that the resources are limited and the region must compete for them with other regions. There is no common vision, that could support such coordinated and synchronised approach to reduce health inequities, but this is going to be a process, that we have already started in the region and the vision of public health and health and wellbeing sector is being integrated into the regional development plans.

Organizational development

[You can talk about: organizational structures, policies and procedures/strategic directions, management support, recognition and reward systems, information systems, quality improvement systems, informal culture.]

Findings

- *Cross sectoral collaboration exists, however it is not or mainly not formal, when formal, it is only for a limited time*
- *Identified lack of involvement in processes of policy creation in organisations, especially in public sector, since the main policy development is done on national level, regional institutions are not enough involved*
- *Is the policy development based on evidences or based on "buzzwords" and success stories – problem with information system and information delivery*
- *Development agencies – lack of involvement of stakeholders in creation of regional development policies, especially the implementation part*
- *Non-government organisations – the problem is the way of management, structure and financing of NGOs – it is mainly project managed and financed, should me more systematic, volunteerism not developed enough*

Recommendations for the organizational development:

- *building flexible system structures that facilitate clear avenues of communication;*
- *encouraging a community capacity-building: empowering communities to address their own concerns;*
- *creating a long-term commitment to a shared goal*
- *regional self-government*

Resource allocation

[You can talk about: financial and human resources, time, access to information, specialist advice, decision making tools and models, administrative support, physical resources.]

Findings:

- *Money is not always a decisive issue*
- *Health system has enough resources, the problem is right allocation*
- *Human resources – brain drain – not enough professionals and specialists in the region*
- *"know how"*
- *Infrastructure is a problem (technology, space)*
- *Sustainability of the resources, especially after successfully implemented projects*
- *duplication of actions, projects and with it – resources*
- *way of thinking, that the infrastructure has priority over content and human resources is a problem*

Recommendations for resource allocation

- *investments from government agencies are theoretically important to provide resources, advice and information, but money allocation should listen to regions needs*

and capacities

- *regional coordination of goals and actions/projects – common allocation of resources*
- *most of the interviewees recognized money is not necessarily the critical issue but rather how it is spent. It is important to allow the community to participate in decision making or to be able to provide some feedback on how the resources are allocated.*
- *sustainability of successful project results through regional budget or other systemic source*
- *Infrastructure for covering the needs and content of the population*

Workforce development

[You can talk about: workforce learning, external courses, professional development opportunities, undergraduate/graduate degrees, professional support and supervision, performance management systems.]

Findings

- *There are existing resources for workforce development but are not systematic. Workforce development is based on projects, that are implemented in the region and are involving these issues and/or are paid by the workers themselves*
- *Workers has to be "right for very systemised working place, instead to find a right person for the right job – high degree of inflexibility*
- *In case of health inequalities and capacities of workers – there are some trainings, but only informal and mainly for health professionals*
- *Identified lack of social skills amongst employees in health and social sector and in general*

Recommendations for the workforce development:

- *Investments should not only be done in infrastructure but also in the level of service delivery (e.g. education). Alternatively, this could also be sorted out through a "learning by doing approach" as one of the interviewees suggested (integrating within programs and projects a workforce component).*
- *more open and flexible systemisation of working places – public sector*
- *systemic resources for training and education in organisations*
- *system of rewarding for workforce development initiatives and development itself (trainings, educations, workshops,…)*

Leadership

[You can talk about: interpersonal skills, technical skills, personal qualities, strategic visioning, systems thinking, visioning of the future, organizational management.]

Findings

- *Very important – support of managament*
- *There are no leaders or we don't recognize them*
- *Lack of common vision of the region*
- *no clear responsibility to address health inequities*
- *lack of coordination between different projects*

Recommendations:

- *stakeholders should feel a sense of ownership over the decisions they make;*
- *capacity building coordinators, motivators, people that connect*
- *stakeholders need to own the decisions they make*

Partnerships

[You can talk about: shared goals, relationships, planning, implementation, evaluation, sustained outcomes.]

Findings

- *There is less informal cooperation than formal*
- *There is a big NGOs network, but is lacking voice at decision making and is not enough developed*
- *Health workers cannot fight health inequities alone*

Recommendations

- *merging stakeholders or programs that have already demonstrated positive outcomes.*
- *problems and issues should be tackled cross-sectoral*

Phase 3 Setting the potential ENTRY POINTS for action

1.6 Setting priorities

[What are the health inequalities that raised concerns in your region? Why?
How did you choose a/ between priorities? Explain it by taking into account factors like: impact, changeability, acceptability, resource feasibility.
Talk about European regional priority setting! European Structural and Investment Funds are a potential source for funding actions but they also set up the political agenda in terms of developing priorities. Have you managed to relate your priorities set up for your region/country to the European level?]

European Commission adopted 'Partnership Agreement' with Slovenia on using EU Structural and Investment Funds for growth and jobs in 2014-2020 on 30. October 2014
The EU investments will help tackle unemployment, boost competitiveness and economic growth, promote entrepreneurship, fight social exclusion and help to develop an environmentally friendly and a resource-efficient economy.
The Partnership Agreement between Slovenia and EU focuses on the following priorities:
- Promoting investments in R&D to strengthen SMEs and to enhance the innovation capacities of Slovenia;
- Promoting incentives to increase employment and employability, while taking into account the existing social challenges;
- Encouraging the shift to a low-carbon economy
- Improving the quality of the transport
- Improving the institutional capacities and efficiency of the public administration and the judicial system.

First results of needs assessment showed, that the region has lowest economic and lowest health indicators and on is on top of Slovenia's regions with risky health behaviours. Clearly, the regions underdevelopment in economic sense is contributing to most of the health inequalities, when comparing the region with other regions in Slovenia, but we also saw a clear social gradient between regions populations with different socioeconomic status.

For our region, the most important autonomous process is the Regional development programming. This process involves most of the stakeholder institutions and people, who are concerned about the future of the region and its inhabitants. It is a mixture of bottom – up approach (when assessing regions assets and needs) and bottom-down approach in terms of the framework and priorities set from government, in which the process should be conducted and the final documents presented. This makes Regional development programme Pomurje 2014 – 2020 in line with Development strategy of Slovenia, Partnership agreement and Operational programme and therefore also eligible for EU structural funding.

After conducting needs assessment and capacity audit in the project, using the toolkit, prepared for us in the project, the result led our team to the conclusion regarding the key action areas. The potential to change social determinants of health by creating new jobs, creating healthier environment for the population by moving more with non-motorised transport, promote healthier lifestyle, grow healthier food and consume healthier food coming from local production is the biggest in this 4 identified key action areas (here with their subareas):

HEALTH, HEALTHY LIFESTYLE
Physical activity programs, infrastructure, accessibility for vulnerable groups
Healthy diet in kindergartens, schools,
Healthy ageing
Social inclusion, social management
Mental health
AGRICULTURE
Healthy food (organic food production)
Local food supply, short food supply chains
Social enterprises and cooperation's for quality food production and processing
Fruit and vegetables production, diverse quality food
HEALTHY TOURISM
Hiking, biking, Nordic walking, active tourism (programs, infrastructure)
Local healthy food in local tourist offer
Sustainable tourism
ENVIRONMENT
Active mobility
Water resources
RES, EEU

In our Regional action group Mura, we have divided our members or stakeholders into 4 working groups by those 4 key action areas. Each working group had a leader, a specialist or expert in the field of the working group, each working group had also a coordinator from the

coordinating body, Centre for health and development and had meetings, to create, develop, produce or write the project ideas or project proposals. These were then synthesized by the coordinator, put in a form that were required by the Regional development programme planners and presented to the Regional Development Agency and regional development Council. All our projects were integrated in the Regional Development Programmes under different priorities, but mainly in Priority 2 in measures:
Measure 8: Strengthening of healthy and active lifestyle and
Measure 10: Access to integrated health and social services and inter-generational cooperation, but also in other priorities of the RDP

1.7 Choosing actions

[What are the actions you can take to address this health inequality?
Talk about the mechanism chosen! (e.g. (a) reducing the inequalities in socioeconomic position itself (education, income, or wealth); (b) improving health determinants prevalent among lower socioeconomic groups (living and working conditions, health behaviours, accessibility to and quality of health care and preventive services) ; (c) reducing the negative social and economic effects of ill health (school drop-out, lost job opportunities and reduced income)
Talk about the strategy chosen: e.g. (a) a targeted approach; (b) a whole population approach; (c) a life-course perspective; (d) tackling wider social determinants of health.
Have these interventions already been proved successful in reducing inequalities in other regions or studies?]

All of the actions are tackling wider social determinants of health, although there are some exemptions, such as Palliative care or Mental Health and quality of life of vulnerable population groups, that are using targeted approach for special groups of population. Some of the interventions are pilot projects, that we are not aware of that they have been tried somewhere before or have been implemented in such circumstances. Most of the actions are proven to work in changing the determinants of health (e.g. creation of jobs, creation of recreational infrastructure, health care infrastructure) or to change health outcomes of the population by changing their behaviour and/or environment (e.g. promotion of physical activities, promoting healthy ageing and workplace health promotion, improving access to rehabilitation for elderly,…).
Health and health promotion activities are obviously directed toward improvement of health of the population, but this is why we think, that also other chosen key action areas can influence health outcomes and reduce health inequalities in our region:

Healthy tourism
Development of sustainable and environment friendly forms of tourism that also offers physical activities and local healthy food, will enhance the awareness of local inhabitants and tourists about the sustainable land use and environment protection, as well as the importance of physical activity as a protective factor against NCDs. Healthy tourist offer is connecting different sectors of local economy into a complex service for today's demanding tourism industry. With its need for infrastructure for different activities, it is encouraging public and private investments in healthy tourism infrastructure and thus creating jobs in

local construction and maintenance industry. This infrastructure is then used not only by tourists, but also by local inhabitants, creating opportunities for healthier lifestyle for all. Another vital connection is with local food production - healthy tourist offer generates high demand of locally produced (healthy) food with all its local culinary diversity, prepared and served as local specialties. Such demand usually generates new, "green" jobs, with higher value added. With short food supply chain we avoid high costs of transports, decrease pollution generated by transport, consume the food fresh and seasonal and if the food is produced in a sustainable way, mitigate negative impact of extensive farming and food production on environment and population's health.

Agriculture and health
Facts:
"NCDs are the leading cause of morbidity and mortality, accounting for two out of three deaths and half of all disability worldwide. 80% of NCD deaths are occurring in low and middle income countries (LMICs), exacting a heavy and growing toll on both physical and mental health and economic security. NCDs are related to both under and over nutrition. " (source: www.ncdalliance.org)
"Overweight and obesity is associated with increased total mortality and increased risk of disease or death from cardiovascular diseases, diabetes, and several types of cancer. It does so by increasing high blood pressure, blood cholesterol, insulin resistance and inflammation as well as hormone levels." (source: www.wcrf.org)
When we consider risk factors for NCDs and major causes for different illnesses, we cannot avoid the question of what and how we eat. Food production and supply is every country's major strategic question, yet in the modern world, most of the (even those, that we call developed) countries became dependant of few major food producing countries. Food that we buy in supermarkets and eat in Europe is cheap and available through whole year, but it comes with high externalized costs, paid by the whole community in form of environment pollution (unsustainable extensive food production, long distance transport of food), negative impact on populations health by chemical treatment of food for transport and processing of food for retail sale as well as aggressive marketing of inappropriate food, especially to children, causing health problems associated to malnutrition. Most of these costs can be avoided by establishment of local food supply chains, where this is possible. There are many benefits of producing in a sustainable way and consuming food locally. Creation of local markets for local agricultural products are an opportunity for job creation in rural areas, where extensive farming is not an option because of too small yields for global markets. Food is consumed fresh and seasonally by local population, having a positive and protective impact on their health. With the development of local food production, opportunities for supplying public sector through "green procurements" with local food emerge, especially in education (schools, kindergartens) and health sector (hospitals, primary health care centres, rehabilitation centres), where healthy diet is most needed. The connection with healthy tourist offer is obvious and can generate extra jobs in the food processing sector and gastronomy by selling locally produced food and specialties to tourist and local population. We also must consider the effect of consumption multiplier, when putting extra money in local economy, usually spent by public sector and tourism sector (and local population) on produce from overseas or intensive food producers in Europe. This effect is causing extra growth of local GDP, because of extra spending and investing in local economy and thus creating jobs and wealth, that are major social determinants health.

Environment
Our region is small and has no larger cities to have major air pollution or traffic problems. Nevertheless, Murska Sobota is one of the seven cities with the highest level of small particles (PM10) in the air in Slovenia (source: ARSO), mainly because of the individual wood heating in winter, but also because of traffic. Measures against such air pollution range from hard measures, such as building long distance heating systems on biomass, that is in abundant supply in Slovenia, efficient energy use (insulation of buildings to reduce energy consumption), use of renewable sources of energy (biomass, sun, water, wind and in Pomurje also geothermal energy) and soft measures. Promotion of active mobility has great potential to reduce air pollution by reducing traffic (most of the traffic is caused by commuting to work or delivering children to schools and kindergartens and its done individually) and at the same time it promotes physical activity of the population. Both of the results have a large impact on health outcomes of the population.
Water is an important issue not only in Pomurje, but globally. Although we have sufficient local sources of water and two major rivers running through Pomurje (Mura and Drava river) we face some problems with water supply in drought and oh higher grounds. This is due to the meliorations of the rivers, that is running faster through our region, not filling the underwater reservoirs sufficiently. Eco-remediations are measures to remedy this, to slow down the river and streams, so it can fill the reservoirs and flooded meadows and small pawns are at the same time valuable biotope for animals and plants. Water quality is not on a satisfactory level, mainly because of the intensive farming. The chemical treatments of plants, used to spray crops is poisonous to humans and is slowly reaching groundwater reservoirs and it will not be possible to clean such water, thus having a great impact on a daily living and health of population. Organic farming doesn't use such spraying and is much more sustainable by preserving our water resources.

1.8 Translating actions into regional action plans

[For the actions chosen did you think about? (a) the reach of the action (the intended target population)?, (b) effectiveness/ efficacy of the action (the desired effect of the action) ?; (c) who will adopt the action?; (d) who should implement the action? (e) what type of maintenance of the action was required?]

As stated above, almost all of our planned actions were planned in accordance with Regional Development Plan Pomurje 2014 – 2020 and are in line with the Operational programme for Slovenia 2014 – 2020. Some of our actions planned are more suitable for rural development strategies and are now integrated in the Community Led Development programmes of our region or CLLDs, that are having a separate budget, funded from European agricultural fund for rural development.
Two of our regional project proposals –"Healthy to the end" and "Palliative care in Pomurje" were selected (merged with other two projects in the social field) as one of the three priority projects of the region, what we consider as a great success, since this projects are, if selected in negotiations with line ministries, financed directly and are not subject to tenders.

Phase 4 The IMPACT ASSESSMENT

Assessing the potential impact of actions on health and health inequalities

Screening

[Is the policy/ intervention likely to impact health/ determinants of health considerably? Which populations are currently relatively disadvantaged in the context of this policy or intervention? Does the policy enhance equity or increase inequity? What might be the unintended consequences?]

Health impact assessment was conducted with focus on health inequities in Regional development programmes priorities and measures, that will provide prospective recommendations for mitigation of negative impacts and exacerbation of positive effects on social determinants of health and health inequalities for priorities and measures of RDP Pomurje and consequently on population of the region. CHD MS is placing health and reduction of health inequities into development goals and measures of regional development plan through "Regional Action Group for investment in health and development Pomurje" (RAG Pomurje).

We decided to give special consideration to assess the impact on health of proposed priorities, measures and projects on vulnerable groups in the region and assessed the impact of them not being taken into consideration by the universal approach and what would be the consequences of implementing such measures and projects on vulnerable groups, but also on general population.

Aim:

- *Assessment of potential impact on health (positive and negative) of projects, programs and priorities programmed in Regional development plan*
- *Improvement of decision making processes in public policy (regional development programs and policies and projects in public domain) through recommendations as a result of HIA*

Scoping

[Which health outcomes or determinants of health outcomes does this impact assessment focus on? How was it carried out (literature reviews, quantitative modelling, qualitative analysis- expert consultations, interviews, focus groups)? What evidence was used to show how the health equity impact was identified?]

Scope:

- *Assessment of potential impact on health (positive and negative) of Regional development programme, to the level of measures in the RDP*
- *It will be done prospective*
- *Desktop research with a workshop with stakeholders, to assess health impacts*
- *Geographical limitation of impact assessment is Pomurje region*

Planned activities:

- *Planning of HIA and pre-HIA activities, screening*
- *Establishment of coordination group, assignment of tasks and responsibilities*
- *Definition of scope of HIA*
- *HIA - workshop, desktop research*
- *Agreement on the best alternatives and production of recommendations*
- *Monitoring and evaluation of processes and results of HIA – 2014 - 2020*

Impact assessment

[Quantify or describe potential, important health and health equity impacts.]

Methodology of HIA of RDP of the region:

- *Policy analysis – priorities and programs of RDP*
- *Involvement of experts and key information sources on potential impacts*
- *Profiling of affected vulnerable groups, communities and areas*
- *Assessment of importance, scale and probability of occurrence of predicted impacts on health*
- *Negotiating favourite option(s)*
- *Evaluation and monitoring*

Stakeholders involved:

- *Regional development agency Mura as managers of preparation of Regional development programme*
- *Stakeholders from different sectors, representatives of minorities*
- *Members of Regional Action Group Mura*
- *Coordinator Centre for Health and Development*

Experts involved:

- *National Institute for public health*

Decision making

[Provide recommendations to improve policy (evidence-based, practical, realistic and achievable measures that would reduce the negative and enhance the positive health equity impacts of the policy).]

The findings of HIA are described in a support document Report on HIA RDP Pomurje 2014 – 2020 in Slovenian language. The main findings of the HIA was, that in universal approach of implementing projects on regional level, we tend to forget, how will this impact vulnerable groups. The recommendations are generally in the direction, that this impact should be assessed and mitigated. There were also concerns about the quality of the jobs created with support of public money – are this jobs with higher value added, are they paid well, are the investors considering the working conditions and health of their workers, so all this recommendations were included in the report. In the investment part, especially the tourism development had some big investment proposal, usually not considering the impact on health of local population and environment, so the recommendations were to consider this two impacts, even if not legally necessary, before supporting such investment with public money.

Monitoring & evaluation

[Talk about: the process evaluation (Was the impact assessment carried out successfully? Were there challenges or barriers?); the impact evaluation (will the recommendations of the impact assessment be adopted/implemented?); the outcome evaluation (How will you know if health inequities have been reduced in real life?)]

Decision by the project group was, to monitor the impacts of the Regional development

programme through yearly meetings of Regional Action Group Mura in the period of the programme 2014 – 2020.

1.9 Any other information related information to building your evidence-base

[If you had any difficulties with regards to the data collection and interpretation, please describe it here.]

PART 2 Action plan to TACKLE HEALTH INEQUALITIES

Introduction to Part 2

The key outputs of the Action Learning and Capacity Building programmes are the evidence-based regional Action Plans to address socioeconomic health inequalities.

There are many different types of action plans in practice: from simple to more complex. Ideally action plans are linked to a wider strategical plan and can be developed annually, biannually.

The HealthEquity-2020 project did not plan to introduce a particular action plan format as there are many factors in practice that can influence their particular design and content. The regions themselves are also differing in their priorities and objectives they want to focus on and achieve, their stakeholders and their institutional background, their political context, the mandate or role to be played as a strategic document for the region.

Nonetheless, this document aims to present the key characteristics of an action plan and provides some guidance on the most important elements that should be considered together with providing a simple template.

The regions are kindly asked to fill in this template based on their work, or use any other format that is also in line with the basic characteristics of an action plan and with the characteristics of their own local/national policy planning/action planning processes.

Whichever way the region chooses, the main point is to build the Action Plan on the data and knowledge gathered via the action learning process documented in Part 1.

Translating HE2020 actions into regional action plans

2.1 Main questions to answer by an action plan

An action plan is detailed plan related to a strategic document outlining:

1. **What** will be done (the steps or actions to be taken) and by **whom** (which organisation).
2. Time horizon: **when** will it be done (when the actions/steps will be done)
3. **Resource** allocation: what specific funds are available for specific activities.

In practice we can find various different kinds of documents that are called Action Plans with elements like vision, mission, aims, objectives, goals built on each other, and actions etc., but these documents are more likely should be considered as Strategies.

Within the HealthEquity-2020 project the idea was to look for (to develop) action plans to be integrated into regional development plans, national reform programmes etc. These

Action Plans should be aligned to these existing strategical documents' vision, mission, objectives etc.

2.2 Recommended key steps

Considering the special context of the HE2020 project and the steps already taken as part of the HE2020 Actin Learning programme, the following key steps are recommended to be taken to finalize your regional Action Plan.

2.2.1 *Bring together the different people/organizations/sectors to be involved in developing the Action Plan* to get various views in the planning work.
This group is ideally the Regional Action Group. While action planning can take place within single departments, organizations and sectors, the HealthEquity-2020 project encouraged cross-sectoral action planning.

2.2.2 *Review your data and information that you have collected with the help of the Toolkit*.
Regions assessed the magnitude and determinants of health inequalities in their region by conducting a needs assessment, assessed the capacities, formulated entry points, and some of them have taken to the impact assessment phase.
Please review what you have learned about health inequalities, and what capacities you have to tackle that. Examine again the selected priorities based on the data, and the possible actions by which you can address the assessed inequalities. Critically evaluate the chosen strategy to tackle the problem. If data exist evaluate the potential impact of possible actions on health and health inequalities.

This information and careful analysis should provide the background and basis of your action plan; it is going to be the so called evidence-base of the Action Plan.

2.2.3 Develop the action plan by

3.1 *Presenting the general context* under which the action plan was developed.

a) Explain why actions are needed, make a reference to the evidence collected by briefly summarizing the results of the health inequality assessment (key considerations, why these priorities/objectives have been selected)
b) Briefly explain how this plan was developed
c) Explain how the action plan fits within or linked to a wider development strategy or other document(s) (Operational Program/National Reform/Health or Social Strategy etc.)

3.2 *Filling in the action plan table* by identifying

a) the key actions of the priority area/identified objective (you can also chose to prioritize actions if you want to bring focus on certain issues (essential; high; medium; low)
b) the output/deliverable of the action
c) the responsible parties
d) other parties to involve
e) the timeline
f) key outcome indicators to measure success
g) financial resources.

3.3 *Listing the partner organisations* contributing to the development of the Action Plan

3.4 *Listing the supporting documents* as annexes of the action plan (e.g. a more detailed review of the determinants of socioeconomic health inequalities in your region).

2.3 Integrated planning

A key element in the HealthEquity-2020 project is that the developed Action Plans should be integrated into regional development plans. Please describe in the General context to which regional or national strategical document your Action Plan can be linked to and how.

2.4 Monitoring and evaluation of the implementation of the Action Plan

Monitoring and evaluation is a key to demonstrate the results achieved to policy makers/ policy entrepreneurs/ decision makers/supporters/stakeholders and to generate financial or political/institutional support further on during/after the implementation stages of the action plan. However, building a monitoring and evaluation system requires special expertise, thus here you can focus only on listing a few key indicators measuring outcomes.

2.5 Financial appraisal

Getting financed the action plan is crucial for implementation. HE2020 puts an emphasis on the use of the European Structural and Investment Funds (ESIF) as an important source of funding for actions related to the inequalities area.

Please make a financial appraisal. A few points for consideration:

- What are the funds available for your region?
- Consult the Operational Program(s) that cover your region. Can you make a match with its priorities that can support the Action Plan? Are you eligible to apply for funding?

- Can you build synergies/partnerships with your stakeholders, officials, industry representatives and NGOs from your Regional Action Group to increase your profile?
- When the Calls for Proposals are organized and how does that fit with the implementation stages of the Action Plan?
- Funds are allocated to those projects that can demonstrate their ability to achieve the results in a measurable way relevant to the priorities mentioned in the Operational Programs. Can the evidence you collected in your assessments support this approach?
- Other sources of funding might also be available at national/regional level or within other frameworks (regional, national, or other international funds e.g. the Norwegian Grant). Have you considered them?

Action Plan

2.6 General context

[Please (i) Explain why actions are needed, (ii) Make a reference to the evidence collected by briefly summarizing the results of the health inequality assessment (key considerations, why these priorities/objectives have been selected), (iii) Briefly explain how this plan was developed, (iv) Explain how the Action Plan fits within or linked to a wider development strategy or other document(s) (Operational Program/National Reform/Health or Social Strategy etc.)]

(i) In previous steps of action planning, we have established that there are significant health and socioeconomic inequalities between inhabitants of Pomurje and other regions in Slovenia. These can be linked to the fact, that the region is the most underdeveloped and has highest unemployment in whole country. Health and lifestyle indicators follow this general situation, so action to change this situation is definitely needed. Most of the inequalities derive from wider social determinants of health, so the action must be directed towards changing them with combination of target approach to reduce or mitigate health inequalities that the vulnerable groups in the region are and will additionally be exposed to.

(ii) We have selected four priorities for changing social determinants of health in the region. These priorities are Tourism, Agriculture, Environment and Health. These priorities were decided in the Regional Action Group, after considering the new needs assessment and capacity audit. RAG has also considered which priorities are most likely to be funded by different development programmes in our region and are having the greatest potential to improve social determinants of health and consequently health of the population. Health and health promotion activities are obviously directed toward improvement of health of the population. Development of sustainable and environment friendly forms of tourism that also offers physical activities and local healthy food, will enhance the awareness of local inhabitants and tourists about the sustainable land use and environment protection, as well as the importance of physical activity as a protective factor against NCDs.

When we consider risk factors for NCDs and major causes for different illnesses, we cannot avoid the question of what and how we eat. Food that we buy in supermarkets and eat in Europe is cheap and available through whole year, but it comes with high externalized costs, payed by the whole community in form of environment pollution (unsustainable extensive food production, long distance transport of food), negative impact on populations health by chemical treatment of food for transport and processing of food for retail sale as well as aggressive marketing of inappropriate food, especially to children, causing health problems associated to malnutrition. Most of these costs can be avoided by establishment of local food supply chains, where this is possible. The connection with healthy tourist offer is obvious and can generate extra jobs in the food processing sector and gastronomy by selling locally produced food and specialties to tourist and local population.

Murska Sobota is one of the seven cities with the highest level of small particles (PM10) in the air in Slovenia (source: ARSO), mainly because of the individual wood heating in winter, but also because of traffic. Measures against such air pollution range from hard measures, such as building long distance heating systems on biomass, that is in abundant supply in Slovenia, efficient energy use (insulation of buildings to reduce energy consumption), use of renewable sources of energy (biomass, sun, water, wind and in Pomurje also geothermal energy) and soft measures. Promotion of active mobility has great potential to reduce air pollution by reducing traffic (most of the traffic is caused by commuting to work or delivering children to schools and kindergartens and its done individually) and at the same time it promotes physical activity of the population. Both of the results have a large impact on health outcomes of the population.

(iii) Action plan was developed in the working groups of Regional action group Mura. We have divided members into four working groups for each priority and assigned a leader of the group and a coordinator of a group from CHD MS. Based on the needs assessment we than established the current situation and the situation we want to be in for each of the priorities set in the beginning. Each group presented their project ideas, interventions and project proposals. that are not part of their institutions plans, or they are, but have not sufficient funds to implement them. Members of RAG presented some completely new ideas on solving old problems and some good practices from other European countries and regions. We have also made a desk research on some of the practices in EU (especially the local food supply chain and energy waste reduction in public sector) and synthesized the ideas, action, interventions and project proposals into standardised format projects. All the projects, that we have considered presenting and integrating into regional development programmes have to contribute to health inequalities reduction in a direct or indirect way.

(iv) Regional action plan has been produced in the framework of Regional development programme so its aims and objectives are in line with Development strategy of Slovenia, Partnership agreement and Operational programme and therefore also eligible for EU structural funding. The link to the Regional development programme Pomurje 2014 – 2020: http://www.rcms.si/RRP%202014-2020_1.0_maj%2015%20FINAL.pdf

2.7 List of partner organisations

[Please list the partner organisations contributing to the development of the Action Plan.]
National institute of Public Health - Unit Murska Sobota, Regional Public General Hospital Murska Sobota, Primary Health Centre Murska Sobota, Regional development agency MURA, Development Agency SINERGIJA, PORA Development Agency GORNJA RADGONA, Development Agency Slovenska Krajina, DOSOR RADENCI - Elderly Home Radenci, Podjetje za informiranje Murska Sobota – regional media information office, Development Centre Murska Sobota, Local Energy Agency LEA POMURJE, Public institute Goričko nature park, Local Development Foundation for Pomurje, Public university – lifelong learning university Murska Sobota, SAVA Tourism, Chamber of Commerce Murska Sobota, Institute of Republic of Slovenia for Education, Špan ik – trade and services, Orange Thread – institute for education in traffic, Pomurje Fair, Institute for sustainable development of local communities Ljutomer, NGO for promotion of Prlekija ecological farmers – Vila NaturaCentre for Social Work Murska Sobota, MIKK – Youth information and culture club Murska Sobota, PIRA - Pomurje educational regional agency, NGO – for healthy life New path Radenci, Pomurje regional association of seniors, Hospic Murska Sobota, Institute PEC (Pomurje ecological centre), EKO countryside – institute for development of ecological farming and countryside, Romano Kher – Roma house, NGO – friends of agrarian economics

2.8 List of supporting documents

[Please list the supporting documents as annexes of the action plan (e.g. a more detailed review of the determinants of socioeconomic health inequalities in your region).]
Regional Development Programme Pomurje 2014 – 2020
http://www.rcms.si/RRP%202014-2020_1.0_maj%2015%20FINAL.pdf
Health inequalities in Slovenia (Buzeti et al, 2010)
http://czr.si/files/neenakostivzdravjuknjbl-ang-web.pdf
Programme Mura (Buzeti, Maučec Zakotnik, 2008)
http://czr.si/files/murahealthinvest---arhiv.pdf
HIA report (Beznec, 2013)

2.9 Action Plan table

Actions	Output/ Deliverables	Responsible party	Others to involve to complete action	Timeline	Indicators	Financial resources
Priority area/Objective **HEALTH**						
Reducing Health Inequalities in Pomurje	Increase of cross-sectoral development projects to tackle health and health inequalities Increase of awareness among policy makers Increase of understanding of social determinants of health	CHD MS, RAG MURA	National institute of Public Health, RDA Mura,	2014 - 2020	Members of RAG MURA (+7) HIA – recommendations (1) Manual (1) Recreational programs for children (+15) Promotion material (4) Programs for target groups (15)	National resources, EU Funds –ERDF, ESF, own contribution (870.000,00 EUR)
Mental Health and quality of life of vulnerable population groups	Increase of individual and group counselling Increase of number of programs for workshops, trips, companionships	CHD MS	DOSOR (Home for elderly Radenci), municipalities, local communities	2 years	Analysis in the region (1) Individual and group counselling (200) Workshops, trips, activities (30)	National resources, ESF, own contribution (230.000,00)
Counselling centre for children, youth and parents in Pomurje	Continuous expert help for children with special needs, their parents and	National Education Institute of	Municipalities in Pomurje, RDA Mura,	2014-2020	Counselling centre for children, parents and institutions in	Local community budget, ESF, ERDF (1.500.000,00 EUR)

	institutions in the region Increase of equality for children, parents and institutions Ensuring availability for implementation of programs, workshops education, supervisions Measures to prevent difficult psychological and other development problems	the Republic of Slovenia	Housing Funds, NGO's		Pomurje region (1)	
We are walkers, we are bikers, we are winners	Increase of active young bikers Increase of active adult bikers Reduction of newly registered vehicles	CHD MS	Orange thread, Police station MS	24 months	Educated pupils (800) Educated parents (800) Number of implemented education workshops (32) Teachers and mentors involved (40) Promotion brochure (1 – 15.400) Promotion movie on proper use of bicycle (1)	Intelligent Energy, own contribution (245.528,02 EUR)
My years	Less hospitalisations due to uncontrolled chronic	DOSOR – elderly home	Specialists, therapists',	3 years	GGC Centre (1)	National resources, ESF, ERDF, own

	diseases Less used drugs Less diagnostic interventions Less urgent ambulance transfers Increase of expertise of implementators	Radenci	rehabilitation experts and institutes			contribution (953.000,00 EUR)
Lüftanje	Increase of adults who regularly exercise (+10%) Increase of youth and children who regularly exercise (+10%) Increase of recreative and sports programs for elderly, women, children (20%)	CHD MS	Municipalities, NGO's	2014-2020	Recreation programs for adults in Pomurje (20) Promotion activities (60) Recreation programs for children and youth (30) Sport trainers educated in the project (30) Football and wrestling schools for children (2)	National resources, CBC (INTERREG), own contribution, local communities budget (485.000,00 EUR)
Healthy and active ageing	Tackling health inequalities among elderly people in Pomurje region Preparation for qualitative and active ageing Increase of community approach in tackling institutional gaps regarding	CHD MS	ZDUS, HR ZDUS	2017-2020	Mobile rehabilitation at home, capacity building in national health care programs – transfer of good practices	Cross border cooperation SLO - HR, own contribution

	elderly					
Capacity building Slovenia to Croatia	Not known yet	National institute of public health	CHD MS	2017-2020	Cross-sectoral capacity building for investment in health	Cross border cooperation SLO - HR, own contribution
Social innovations	Not known yet	Institute for Social works Voitsberg	CHD MS, University Maribor, TU Graz	2016-2020	Development of regional social management through software programs	CBC SI-AT EU funds, own contribution
On the move	Increase of healthy dieting and healthy nutrition for children prone to obesity Promotion of movement	Međimurje County (Croatia)	CHD MS, Međimurje alliance of sport, gymnastic centrum, municipality of Lusada, CVS, FOPSIM	Jan 2016 – june 2017	Promotion of voluntary activities in sport, social inclusion, equal opportunities and awareness	Erasmus + (583.390,20 EUR)
Pomurje – Healthy and active region	Increase of helthy eating people (+25%) Increase of recreations and sport programs (+20%) Increase of active elderly people (+10%)	CHD MS	NIJZ, centres, institutes and elderly homes, local communities	2016-2020	Increase of people that eat healthier, increase of sport programs, increase of active elderly	ERDF, regional funding, own contribution (1.340.000,00 EUR)
Model for Paliative Care	**Development of communities approach and network** **Development of the centre Education and trainings**	**General Hospital Murska Sobota**	**CHD MS, Primary health centre Murska Sobota,**	**2016-2018**	**Centre for palliative care (1), increase of number of implementators (150) and number of**	**Regional priority project - EU funds, own contribution (1.650.000,00 EUR)**

			Hospic MS, municipalities		**included sick people (300/year)**	
Healthy till the end	**Healthy and active in the work place** **Healthy and active lifestyle of people 65+** **Increase of awareness of health promotion in the work place**	**CHD MS, PORA GORNJA RADGONA**	**Municipalities, homes for elderly, National institute of public health**	**2016-2020**	**Employees involved in programs of active ageing (2000)** **Program (1)** **Companies (30)** **Employees involved in health promotion in the workplace (500)**	**Regional priority project – EU funds, National financing (2.190.000,00 EUR)**

Actions	**Output/ Deliverables**	**Responsible party**	**Others to involve to complete action**	**Timeline**	**Indicators**	**Financial resources**
Priority area/Objective **TOURISM**						
Pomurje in four seasons	Data on existing tourist offer Increase of aware residents and tourists Increase of overnight stays Awared tourist workers Identity of tourist products with the increase of visited web site	CHD MS	RDO, Tourist offices, Municipalities, Development agencies	2015-2020	Analysis of existing offer (1) Tourist products (+15) Investments (3) Innovative tourist products (3) Quality Criteria (1)	National resources, ERDF, own contribution (470.000,00)

	Joint promotion and marketing Increase of numbers of tourists and reserved packages					
Green exercise in the countryside	Cross-border tourist packages in nature protected area Joint map of tourist offer Sustainable tourist product Raised awareness of sustainable nature protected areas connected to tourism	Orszeg national park (Hungary)	CHD MS, Goričko Nature park, DA Slovenska krajina, Municipalities	2016-2019	Cross-border tourist products for bikers in the nature protected areas (no. not known yet) Cross-border tourist packages Tourist guides	CBC SI –HU EU Funds, own contribution (appr. 950.000,00 EUR)
Stop&taste	Hiking offer in the project area, not known yet	ZRS Bistra Ptuj	CHD MS	2016-2018	Hiking tourist products in the countryside	CBC SI – HR EU Funds, own contribution
Mura.Drava.Bike	Sustainable tourist offer for bikers along Mura and Drava river Packages for overnight stays	ZRS Bistra Ptuj	CHD MS	2016-2018	Biking tourist products along river Mura and Drava	CBC SI – HR EU Funds, own contribution

Actions	**Output/ Deliverables**	**Responsible party**	**Others to involve to complete action**	**Timeline**	**Indicators**	**Financial resources**

Priority area/Objective **AGRICULTURE**						
Sustainable local supply in Pomurje region	Increase of gardens Increase of households with own gardens Increase of households with locally produced food Increase of local sustainable supply	CHD MS	Agricultural and Forestry Institute, EC Svit, local communities, Municipalities	2014-2020	Analysis (1) Number of workshops for preparing local food and dishes (70) Logistic systems (2) Community garden (1)	Agriculture funds, national resources, own contribution (482.000,00)
Youth for development of countryside	Increased number of young experts in agriculture Increased number of cross-sectoral programs and projects on development of the countryside Increased number of institutions that work in networks Increased number of activities for better lifestyle in the countryside	CHD MS	Agricultural and Forestry Institute, EC Svit, local communities, Municipalities	2014-2020	Number of school gardens (+10) Number of cross-sectoral programs (8) Networks (4)	National resources, Agriculture funds, own contribution, local communities budget (295.000,00 EUR)

Actions	**Output/ Deliverables**	**Responsible party**	**Others to involve to complete action**	**Timeline**	**Indicators**	**Financial resources**
Priority area/Objective **ENVIRONMENT**						

Mobility Centre	Establishemnt of Mobility centres in the regions to help institutions to promote non motorised transport and spatial planning	City of Varaždin	City of Čakovec CHD MS	2017-2020	Mobility centre	National resources, EU Funds, own contribution
Mobility capacity building	Mobility awareness actions	DA Sinergija	CHD MS, West Pannon DA	2016-2020	Awareness actions for public employees in cross-border area	CBC SI-HU EU funds, own contribution

Please add further rows as necessary.

2.10Additional support

Additional support for different types and models of action plans can be found on the HE2020 Wiki Page under the section "Action Plans Examples". These documents can be used as a source of inspiration and adapted according to the needs of the regions.

http://wiki.euregio3.eu/display/HE2020EU10/Action+Plans+Examples

Regions can also consult other sources or documentation on action planning like:

http://ctb.ku.edu/en/table-of-contents/structure/strategic-planning
https://www.hitpages.com/doc/6289108800372736/1
http://www.open.edu/openlearnworks/mod/oucontent/view.php?id=53774&section=1.4]

For further information you can also consult:

The HE2020 Policy Matrix link at HE2020 wiki

The Regional Development Agency in your region:
http://ec.europa.eu/regional_policy/index.cfm/en/atlas/managing-authorities

A large database with successful projects available for review for the past period that can serve as inspiration:
http://ec.europa.eu/regional_policy/projects/stories/index_en.cfm

Other potentially relevant websites:

http://ec.europa.eu/regional_policy/en/checklist/
http://ec.europa.eu/regional_policy/en/atlas/
http://ec.europa.eu/health/health_structural_funds/used_for_health/index_en.htm
http://www.esifforhealth.eu/
http://fundsforhealth.eu/

PART 3 DEVELOPING THE ACTION PLAN: the process

Introduction to Part 3

Regions have different starting points in the action planning process and they also have region-specific development scenarios depending on their organizational background, institutional, political, and cultural context. The regions differ in their policy making processes, problem perceptions, and problem solving practices, as well as they work with various stakeholders.

This template helps thinking through the action planning process in the project and helps documenting it. It summarises the context in which the regional team works, the used approach, what has been achieved and how, as well as the opportunities and challenges encountered.

Regions are advised to describe their learning experience as detailed as possible, as the process is as much important as the final output. These summaries serve also as an important feedback for the project and will be used in making the final conclusions in the final report for the funder.

3.1 General overview of the process

[Please describe the overall process of developing the action plan throughout the HE2020 project. Please define the context.
How the process has started? Have you had dealt with the topic of health equity before within your region/country (in a direct or indirect way)? Have you built your work in the project on any earlier regional work/developments related to the inequities field? Have health/health equity/social determinants of health issues had been on the discussion table of policy makers before? How did this have an effect on the general process of developing the Action Plan as part of the project?]

Pomurje region is one of the least developed and most deprived regions with lowest GDP and highest unemployment. At the same time, region has the worst health and lifestyle indicators in Slovenia and these two unfavourable conditions can be clearly linked and identified as health inequalities between different regions in Slovenia. This is why Slovenian government, especially Ministry of health, regional Institute of public health and Regional development agency with strong support of WHO, became very active to reduce health inequalities through different programs, starting with Programme Mura in 2001 with Investment in health approach (http://czr.si/files/murahealthinvest---arhiv.pdf) to additional support of region's economy through Law on development support for Pomurje region in 2009 and supporting different programmes and actions to reduce health inequalities, including our project, Health Equity 2020, to this day. Putting health on the development agenda has, as shown in previous chapters, longer tradition in our region - since the

accession of Slovenia to EU and balanced regional development paradigm that was introduced in Slovenia in 2005. From the beginning, the question was how to promote health as development potential and vice versa, how to use development processes to promote health and wellbeing within the framework of regional development planning agenda. The first results came in the financing period 2004 – 2006 (not a full cycle, since Slovenia joined EU in 2004), when health was with Programme Mura one of the three priorities of the regional development plan. In this period the Programme council Mura was established and Centre for health and development was founded. Key action areas were set by the Programme council and took into account regions assets and resources, regions capacities and willingness to change, potential impact on health and health equity and assessed, where the biggest potential to use health as driver for development is. In the next programming period, we have added a 4th action area, environment. In all this time, health was put forward on the development agenda of the region, with the most notable success in 2004-2006 period, when new Law on balanced regional development in Slovenia was identified as entry point for investment in health approach and with political support and WHO support, health became one of the 3 regional priorities, beside business zones and water system. In time, other priorities emerged and were added, but health is in one form or another always present in the development policies and strategies of Pomurje, mainly because of the institutions and capacities in the region, build in the last decade, that are investing their resources to this result, and support of Ministry of health and WHO Venice office.
All this processes prior to Health Equity 2020 project have largely influenced the implementation of the project and the way, how Pomurje could adapt to the new methodology and approach to regional development planning. The experiences we brought into the project were useful for other regions, as well we could learn from other regions and partners in the project. Project results and implementation itself gave structure and inclusion of evidence to the process of action planning and most of all, it gave us the tool as help and a guideline, so it can be easier repeated in the same region or transferred to another. With this tool we were able to rethink our priorities, based on needs assessment and capacity audit and assess impact on health of the proposed priorities and measures of Regional development programme. Actions, planned in HE 2020 project with newly established Regional Action Group are now on solid ground, backed with evidence or largely adopted knowledge, based on good practices throughout Europe.

3.2 Using an evidence-based approach

[How much does evidence usually matter in decision making? Are strategies usually evidence-based in your region? Were there enough available (regional) data on health status, social determinants of health to conduct the necessary needs assessments for designing this action plan?
Have you managed to build your Action Plan on the collected evidence? To what extent did the evidence gathered influenced: setting the priorities; choosing actions and interventions?]

Regional development planning is an open process, coordinated by Regional development agency and sub regional development agencies of Pomurje. For the analysis of the current situation they use statistical data and all the information they can obtain from other relevant sources, but also the data from different institutions in the region. This far, the process is mainly evidence based and has a solid background in research and official data. For the next stage of the process, stakeholders are invited to present their views on the situation in the region, problems and issues and ideas, how to solve them. Some of this views and proposals are evidence based, mainly from the institutions that are working in the field of development programmes priority (such as health care experts, social workers, experts in the field of education, economists, lawyers,...), some of them are lay knowledge or experience and some of them are based on good practices in other countries and regions. So far, so good. The main problem of the development programme is, how to divide the limited resources available for implementation of the programme between different project proposals or even different priorities. What is the best way to spend the resources, which priority and what project will give us the best value for money, while in this case, value is not measured only in financial terms, but also in improvement of its people's wellbeing?
At this point region should prioritise and find the optimum combination of the interventions that will be eligible for the next programming period. This never happens, because we don't have sufficient data or evidence, supporting the cost-benefit analysis of the proposed projects and there are too many project proposal that we could analyse, even if could in this short period of time of regional development planning. So we use the indicators, set in the Operational programme for the national level, to give those projects priority, that are the most likely to contribute to achievement of targeted value of the indicators, set in the Operational programme and are at the same regional development projects. For health and health equity related projects this is good, because this topics and indicators are in the target objective 9 and 11 of the Operational programme for Slovenia and are therefore more likely to be implemented in the region. If we look back at the process, it is very useful to find out the needs of the region and its capacities to fulfil them in the field of reducing health inequalities. With the knowledge of the process of regional development planning we were also able to prioritise in the way, that the interventions and actions of our Regional Action plan are contributing to the fulfilment of the Operational programme and are thus more likely to be financed from the ESIF.

3.3 A community & intersectoral approach

[Health inequalities is a cross-cutting issue. In dealing with health inequalities, it is important to implement a community/intersectoral approach to develop action. For this reason regions were encouraged to set up a Regional Action Group with stakeholders from various sectors/organizations who either directly or indirectly are dealing with the inequity problem. Please describe how you managed to set up the Regional Action Group. Please list the member organisations of your RAG in the Annex of this part of the document. Have you had already used an intersectoral approach before? Is this something that is part of your

institutional/working culture or quite the opposite? If it was not possible to set up a Regional Action Group, please explain why not (e.g. no interest or support, reluctance in sharing information or competencies).]

We are one of the first regions in Slovenia that put health on the regional development process agenda as a development opportunity. We have relatively good health system that is based on decentralised, relatively easy to access health care centres and regional hospitals through universal health care insurance. Through cross sectoral collaboration we have established cross sectoral Regional Action Group for tackling health inequities and putting health on development agenda from the already existing cross sectoral Program council Mura. This program council was more a council body for conceiving strategies for investment in health in the region, than an implementation group, such as the following, in the HE 2020 project established, Regional Action Group.
The process for establishment of RAG:
- Assessment of needs and capacities of the Region to tackle Health inequities
- Defining of a concept for HI reduction – through SDH and cross sectoral cooperation
- Stakeholder mapping
- Engage identified stakeholders, who had interest on common action to tackle the problem, involved regional and national authorities (RDA, RIPH and MoH)
- Established Regional Action Group for investment in health and development Mura
39 members - regional institutions from different sectors
-Regional Development Programme as entry point

RAG programmed a lot of projects that will help to introduce some positive changes in the way of thinking of institutions, decision makers and population about health. We managed to join different sectors to work together for better health of population (e.g. traditionally agricultural, the region sets up on development of tourism - mutual influence and interest between agriculture, tourism and health have been recognized)
As a small region, we are very flexible and can pilot or introduce new ways of tackling health inequities, especially the most recent increase in inequities, produced by demographic changes and economic crisis and also natural disasters.
Successful and sustainable establishment of RAG MURA was therefore possible because of several reasons. Here we name some of the most important:
- We invested in capacity building of regional stakeholders in social determinants of health and developed new ways of communication with other sectors on how SDH are connected to health outcomes and wellbeing of the population
- Cross sectoral cooperation is supported and encouraged on the national level
- Involvement of private sector as well as NGOs
- Social cohesion important issue at local level and an area of significant investments in the past
- There is a sustained commitment of an institution in the region (CHD MS) to put health in the development agenda and reduction of health inequalities with cross sectoral cooperation

- Support on national level (Ministry of Health) and international level (WHO)

3.4 Building Support

[How would you describe the political/institutional support that you have received during your pursuit of developing an action plan to tackle health equity (either in the framework of a RAG discussed above or in any other forms)? Have key decision-making bodies (municipalities, local/regional governments, Ministry of Health, other professional bodies at the health and social field, European Structural and Investment Funds Managing Authorities, etc.) been involved in drafting/adopting/implementing the action plan? Have they been supportive?]

The first and most important support that makes our Regional Action Group for investment in health unique and the only working one in Slovenia, is that we have built the capacities for the cross sectoral cooperation and reducing health inequalities with substantial support from National Institute of Public Health, Ministry of Health and WHO Country Office and WHO Venice Office. This was possible through years of previous work on Programme Mura and investment in people and institutions in the region. After the establishment of Regional action group, it decided in one of its meetings, to produce the action plan in accordance with the processes and methods developed by the HE 2020 project. We had a full support of all members in RAG. Pomurje has a full support of Slovenian Ministry of health from the beginning of the project, they have also a representative in the Advisory board of the project. On the local level, we have received support from Regional development agency and from the Regional development council. Just recently two of our projects – Active and healthy ageing (Healthy to the end) and Palliative care in Pomurje were selected (merged with other two projects in the social field) as one of the three priority projects of the region. The Regional Development council is consisting from representatives of local authorities (municipalities), local economy and local NGOs. This priority projects (and RDP as a whole) were confirmed by Regional development council, meaning, that the contents of our Regional Action plan have been confirmed by these institutions.

Experiences with involvement of decision makers:

With broad regional network of institutions that pursue common goal, we gain on political influence

- Initial support from WHO, MoH on national level became the main supporter of the cross sectoral HIaP approach

- Using balanced regional development agenda of the Ministry of economy as entry point to address regional HI proved to be successful

- Usually, the decision makers set the goals, but are not involved in planning, so the involvement is at the policy setting – this is where we presented our case

- Middle and high level civil servants are usually the ones, that we present our problems and solutions to at national level

- Mayors are the decision makers in our region, so we present our plans to them and try to get their support in the regional council.

3.5 Typology of the region

[The characteristics of a region can have a strong influence on the process of developing an action plan at the local level. Is your region only an administrative/statistical reporting unit or an autonomous region with higher competences in designing policies at local level? What are the opportunities usually to develop actions for health/health equity at a regional level?]

Pomurje (micro)region is situated in north-east part of Slovenia with total area of 1.337 km2, bordering to Austria, Hungary and Croatia with cca 120.000 inhabitants (roughly 5% of the Slovenia population). We do not have regional government and the region is a statistical region (there is no authority between municipalities and national government), but we do have regional development council, that makes decisions about future development of the region and (some) development resources allocation.
Primary health care is under municipal authority, secondary and tertiary is under national authority, both of them are funded through universal state insurance fund and additional private insurances. High unemployment, unhealthy lifestyle and low education level (agricultural tradition) are the main drivers of health inequities in our region, researched in publication Health inequalities in Slovenia by Tatjana Buzeti and all. in 2011.
In general, there is lack of capacities in governance, especially on the regional level, since the most important policies and decisions regarding the direction of health improvement and reduction of health inequalities and the process of regional development are decided in Ljubljana or Brussels. This is then keeping regional institutions in the role of executive implementers of national programmes, even if we have some saying in regional development planning. The issue here is, that Operational programmes are addressing topics that are many times not necessarily directed towards specific regions development vision and strategy, but the regional development plans, if they want to be co-funded by EU structural or other funds, need to be in line with national Operational programme. There is also very little or none influence of single region on Operational programmes objectives and indicators. This all leads to governance issues, the capacities to self govern the region based on the identified needs and entry points for actions and it also has a strong impact on cross-sectoral cooperation in a negative way. This is a consequence of Slovenia's political structure – the regions as self-governing authorities do not exist yet. We have statistical and cohesion regions for data gathering purposes and cohesion regions for EU structural funds financing level.

3.6 Challenges

[Describe the major challenges you encountered in the process of attaining your goals during the course of the action learning process (e.g. changes within the institutional context, lack of support from higher level authorities, weak collaboration or partnership with others

sectors/stakeholders, lack of data to make the case of health inequalities, lack of financing or capacities to take forward actions)?]

Major challenges are:
- Data on health inequities on the regional level – they are not analysed systemically
- Sustaining the commitment of institutions in Regional Action Group
- Involvement of decision makers in the process- when to involve them, how deep
- Financing of Regional Action Group in the long run – systemic sources, membership fees, different sponsors
- What is more sustainable on the long run – formal or informal structure of RAG, should it become a part of the official regional development planning structure or stay independent
- Monitoring and evaluation of the action plan implementation

3.7 Validating the regional Action Plan – Integrated planning

[One guarantee of successful implementation of actions is taking an integrated approach by incorporating specific, health inequality focused action plans into wider regional and/or national development plans in order to promote and ensure synergies in decision making and funding. This means that higher-level decision-making processes can validate regional plans. However, getting those priorities integrated into a regional or even a national planning cycle is one of the biggest challenges in this work. What preparations have you made through your RAG or any other way to have the Action Plan join a more powerful process (regional planning, regional masterplan, national reform programme, etc.) or what opportunities exist for this?]

Regional action plan is integrated in Regional development programme Pomurje 2014 – 2020 and in the Community Led Local Development strategy 2014 – 2020. In the first we have cooperated with the programmers from the beginning of the process, we were asked to provide content for two measures of the programme:
Priority 2: KNOWLEDGE, TOLERANCE AND HEALTH
Measure 8: Strengthening of healthy and active lifestyle
Measure 10: Access to integrated health and social services and inter-generational cooperation

3.8 Financing the Action Plan

[Do you think you (your region) have enough knowledge about using European Structural and Investment Funds (ESIF) in your own country? How do you get the information? If no, why?
What investment opportunities have been identified for your region under ESIF? Are health/health equity issues compatible with them? Or are any of them health related?
Have your region had any opportunities to influence the drafting of the Operational Programs or the overall programming process?
What about your stakeholders? Do you have the possibility/competences/know-how/resources to access this type of funding?
If you think about the financial aspect of the developed action pan, what future actions are you planning to take to finance it? What resources do you have available for implementing the Action Plan? What resources do you think will be available in the future? Is there an opportunity to fund the Action Plan from ESIF? Please add into details that are not explained in the Action Plan.]

In the 2014-2020 period, Slovenia will be eligible for EUR 3.07 billion under the EU Cohesion Policy Funds (ERDF, ESF and Cohesion Fund), of which million EUR:
159.8 for Instrument Connecting Europe Facility – CEF (for transport),
9.2 to the Youth Employment Initiative (YEI)
21 for the Fund for European Aid to the Most Deprived
64 for programmes under the European Territorial Cooperation (ETC)
837.8 for development of the agricultural sector and rural areas from the EAFRD. The allocation will amount to EUR 24.8 for the EMFF

Slovenia will be divided into two cohesion regions at the NUTS 2 level: the more developed cohesion region of Western Slovenia and the less developed Eastern Slovenia. The cohesion region of Western Slovenia will be eligible for EUR 847 million, while the cohesion region of *Eastern Slovenia will be eligible for EUR 1.26 billion. The Cohesion Fund (CF) will be available for the whole country (EUR 1.055 billion)*

Concentration of funds on a limited number of priorities:
85% of ERDF expenditure will be aimed at research and innovation, information and communication technology, competitiveness of small and medium sized enterprises and low carbon economy
70% of the ESF will cover employment and lifelong learning
The share of ESF in the allocation of ESI Funds amounts to 34 % or 716.9 million EUR, 20.2% of the ESF will be allocated to measures supporting social inclusion.

Cohesion policy will be delivered through 1 operational programme (OP), co-financed by the ERDF, ESF and CF, compared to 3 programmes in the 2007-2013 period.

One Rural Development Programme will be supported by the EAFRD and 1 OP for the implementation of the EMFF.
Slovenia will also participate in thirteen European Territorial Cooperation programmes.

Thematic objective 9 „Promoting social inclusion, combating poverty and any discrimination“
ERDF 75.053.657 €
Eastern Slovenia 40.035.380 €, Western Slovenia 35.018.277 €
ESF145.249.585 €
ES 80.265.224 €, WS 64.984.361 €
EAFRD 41.892.491 €
TOTAL 262.195.733 €

3.9 Benefits for the region, lessons learnt, good practices

[What do you think are the major achievements of your planning process? What main lessons your team learned during the course of developing/adopting the action plan? What are the main influencing factors and drivers for your success? What good practices or recommendations would you like to share with other regions? What helped you overcome some of your challenges, problems?]

NEEDS ASSESSMENT
Learnings:
Data is available, but collected by different institutions and for different purposes
Needs can be assessed on the basis of analyzing data available on national level, by research of reports, publications and surveys available (CINDI…), and interviews with local institutions within their sectoral data and reports
Obstacles:
No or little connection between health and socioeconomic status data on regional level
No systematic reporting on HI on regional level
Challenges
Systematic monitoring and reporting of HI on regional level
Systematic response on reports, if problems or needs are identified

CAPACITY AUDIT
Findings
Most important health inequalities among: the elderly, the Roma population, people with mental health problems
Most important social determinants of health: income (the crisis; unemployment), education, governance/ management issues, culture/mentality
Learnings
Qualitative information, subject to interviewee's knowledge, perception and experiences
Important for identification of stakeholder's interest
Good incentive to raise the issue of HI and their causes
Valuable for problem/interests and capacity identification
Challenges
Capacity building based on the findings of capacity audit
Communication with stakeholders outside health sector – language, common objectives

3.10Cascade learning into other regions

[On of the objectives of HE2020 project is to cascade learning from HE2020 project into other regions. Have you managed to share your learning and experiences from the project with other regions (in your own country or with any other regions in the EU)? How important do you think for your region is to build working relationships nationally or internationally with other regions in order to exchange experiences and learn from each other?]

As a pilot region for micro regions in the project, we have committed ourselves to share the learning experience and knowledge, deriving from this project, to other regions in Slovenia as well as in regions in Europe. Partly, this has already happened by offering peer support to regions in the project (Covasna, Stara Zagora, Tallin and to some extent, Debrecen).
We will translate the toolbox in Slovenian language and disseminate it through our website and different events that we take part of, especially in the summer school, that we are organising in our region. We have decided, that in the next years we will present the concept in other regions in Slovenia, especially the ones, that are least developed and have the biggest health inequalities. we already have presented the concept in Lithuania, Croatia and through the WHO Regions for Health Network, that we are members of,, we can disseminate it more broadly in the European union. As a collaborative centre of WHO we are preparing the feasibility study for implementation of the Growth strategy for South East European Health Network and will present the toolkit and the concept of cross sectoral tackling of health inequalities to this countries as well.

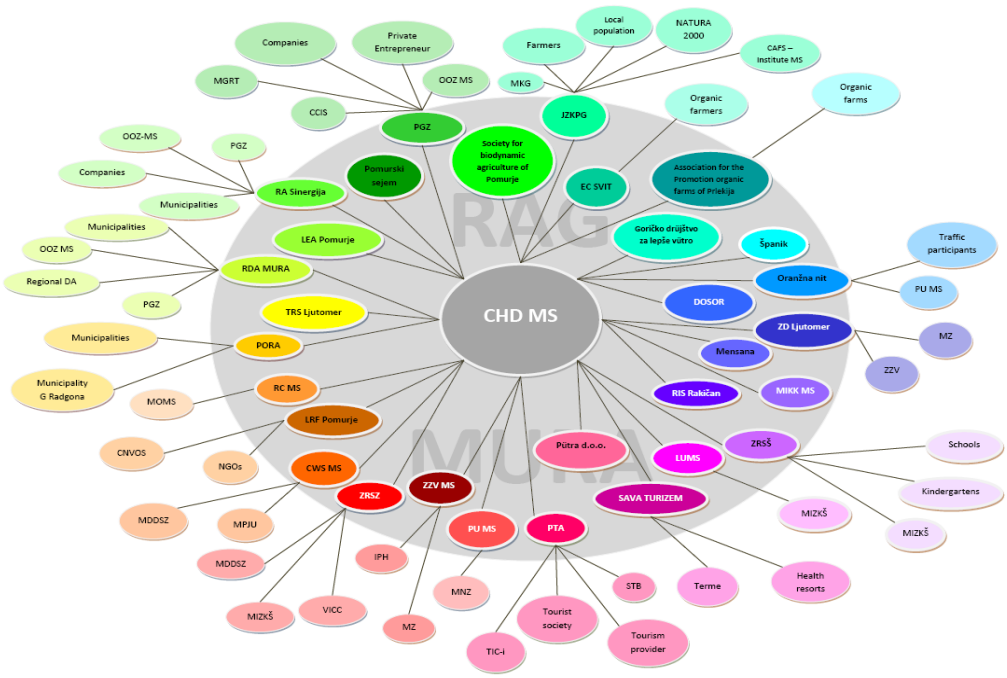
3.11Annex – Information on the Regional Action Group

Official name of the group:

List of member organisations of the Regional Action Group

1. National institute of Public Health - Unit Murska Sobota,
2. World Health Organization – regional office for Europe – Office Ljubljana,
3. Regional Public General Hospital Murska Sobota,
4. Primary Health Centre Murska Sobota,
5. Primary Health Centre Ljutomer,
6. Regional development agency MURA,
7. Development Agency SINERGIJA,
8. PORA Development Agency GORNJA RADGONA,
9. Prlekija Development Agency,
10. Development Agency Slovenska Krajina,
11. DOSOR RADENCI - Elderly Home Radenci,
12. Podjetje za informiranje Murska Sobota – regional media information office,
13. Development Centre Murska Sobota,
14. Local Energy Agency LEA POMURJE,
15. Public institute Goričko nature park,
16. National institute for employment - regional office Murska Sobota,
17. Local Development Foundation for Pomurje,
18. Radenci Health Resort,
19. PÜTRA – Tourist agency,
20. Public university – lifelong learning university Murska Sobota,
21. Local Tourist Organisation PRLEKIJA LJUTOMER,
22. Pomurje tourist association,
23. Biodinamic society – NGO of POMURJE,
24. Ecologic centre SVIT POMURJE GORNJA BISTRICA,
25. Regional newspaper VESTNIK,
26. NGO for promotion of Prlekija ecological farms,
27. GORIČKO NGO DRÜJŠTVO ZA LEPŠI VÜTRO,
28. SAVA Tourism,
29. MENSANA Company,
30. Public Library Ljutomer,
31. Police station Murska Sobota,
32. Chamber of Commerce Pomurje,
33. Slovene Filanthrophy – Hiša sadeži družbe – NGO,
34. Health Insurance Institute of Slovenia – office in Murska Sobota,
35. Research and educational institute RIS Rakičan,
36. Institute of Republic of Slovenia for Education,
37. Špan ik – trade and services,

38. Orange Thread – institute for education in traffic,
39. Pomurje Fair,
40. Institute for sustainable development of local communities Ljutomer,
41. NGO for promotion of Prlekija ecological farmers – Vila Natura,
42. Agricultural and forestry institute Murska Sobota,
43. Centre for Social Work Murska Sobota,
44. MIKK – Youth information and culture club Murska Sobota,
45. PIRA - Pomurje educational regional agency,
46. NGO – for healthy life New path Radenci,
47. Pomurje regional association of seniors,
48. Hospic Murska Sobota,
49. Institute PEC (Pomurje ecological centre),
50. EKO countryside – institute for development of ecological farming and countryside,
51. Bioterme Mala Nedelja,
52. Romano Kher – Roma house,
53. NGO – Namesto pike vejica – for help for people with intellectual development issues
54. NGO – friends of agrarian economics,
55. Regional and academic library Murska Sobota,
56. ŽIVA – General medicine clinic of Dean Köveš.



[Any other information concerning the work of the RAG (e.g. working method, who is coordinating the group, responsibilities etc.)]

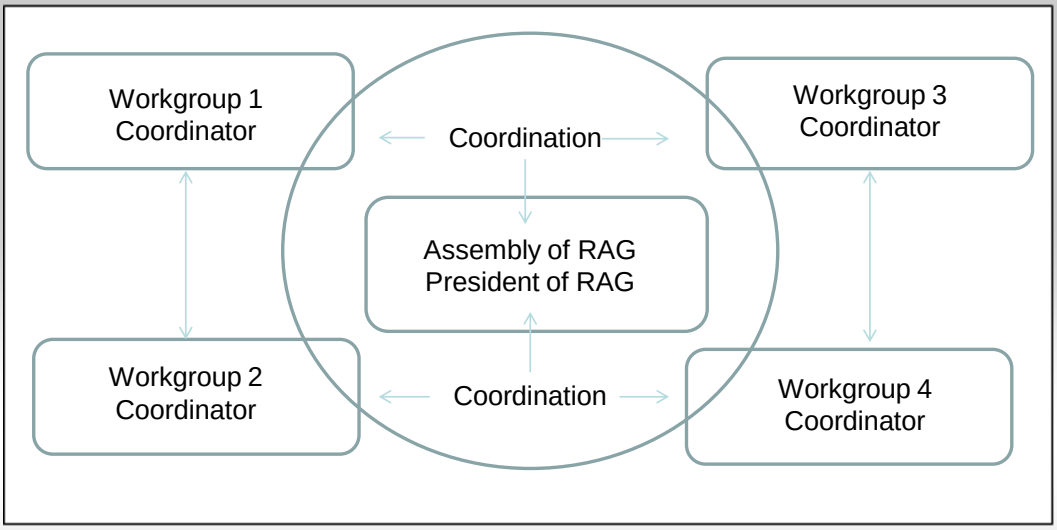
Regional Action Group is a community, deriving from Programme Mura (56 member institutions from different sectors) and from project Health Equity 2020. It has:
- open horizontal structure to organizations, societies and civic initiative
- Cross- sectoral (not only health care system)
- The wider the range, the better
- Flexible structure (if any!)
- Involves regional "champions" in development planning and project implementation
- RAG has a coordinator that collects, evaluates and presents the results of working groups in Regional action plan. The coordinator is CHD Murska Sobota

Benefits of this approach:
- Sustaining the commitment
- Cross-sectoral communication (informal)
- Easy adaptation on changes of priorities
- Intra-sectoral advocacy for health as development driver
- Clear and measurable goals

CZR CHD MURSKA SOBOTA

HEALTH EQUITY 2020

RAG Structure



The workgroups were on the key action areas Health and health promotion, Tourism, Agriculture and Environment. Each working group had a expert leader and a member of coordination team, to coordinate and document the process.

Main objectives of RAG for investment in health and development MURA:
- Creating conditions for higher quality of life of all inhabitants of Pomurje region and broader
- Health should become development capital of the region and vice versa, development should be the basis for good health
- Implementation of general and specific objectives of Regional Action Plan 2014 - 2020 in Pomurje Development Programme 2014 – 2020 and other regional development strategies