Tackling health inequalities in Europe – What can the EU do to support the work done at local and regional level?

On 6 November 2014, Swedish Association of Local Authorities and Regions (SALAR), EuroHealthNet and European Regional and Local Health Authorities (EUREGHA) organised a seminar, 'Tackling health inequalities in Europe – what can the EU do to support the work done at local and regional level?' The aim of the conference was, building on local and regional examples from Europe, to identify and discuss how existing EU tools can support, as well as recognise and bridge the gaps between what is needed by the EU and what can be provided by local and regional authorities in tackling health inequity. Introductory remarks were presented by Ms. Catarina Segersten Larsson, 1st Vice President Region Värmland and representative for Swedish Association of Local Authorities and Regions, and Jonas Frykman, Senior Advisor, Swedish Association of Local Authorities and Regions.

Health inequalities in the EU: from a local and regional perspective

Ms. Constance Hannify, Rapporteur on the draft opinion "Report on health inequalities in the European Union", former member of the Committee of the Regions:

Ms. Constance Hannify presented her draft opinion and its conclusions on health inequalities in the European Union from a local perspective. The main findings of her report stated inequity cannot be reduced by the health sector alone but required introduction and implementation of integrated strategies along all sectors – the health in all policy approach.

In her opinion she underlined for constant focus for reducing health inequities at all levels – at the EU level, national, regional and local level. However, she explained it was often the regional and local levels where crucial cross-sectorial approaches in targeted and efficient manner and results could be achieved. Increasing cross-sectorial efforts engaging all levels of governance required shared targets and tools for joint review. One important precondition for this approach was strong organisational and political leadership to help drive commitment across sectors that would ensure results were sustained during a longer period.

Ms. Hannify's view was that EU policies had the mechanisms for greatly improving in the health domain and EU's complementary role in matter of coordination was crucial in the effort to tackle health inequity. Specifically, the third programme in the field of health complemented by Horizon 2020 and EU structural funds had the potential to impact on health. However, Ms. Hannify considered due to the top-down nature of the process there was a lack of engagement from potential stakeholders. She recommended expanding contact points as information sources and referred to Equity Action's report on the use of structural funds on health equity 'New Equity Action report on the use of Structural Funds for health equity'.

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Ms. Hannify mentioned the EU2020 strategy had potential to create target setting, establishing policy coordination and assessment mechanisms which could be implemented in national programmes. This involved including health inequity and equity in the country specific reports and a greater focus on social challenges.

Furthermore did Ms. Hannify urge all relevant parties to add to the consultation of the mid-term review of EU2020 and recommended more structured engagement with local and regional parties and public health actors.

Ms. Hannify also mentioned that EU had committed itself to connecting health issues to other policy fields. Specifically, she explained the third health programme had linked health and economic prosperity. This meant increased economic output required an increased expenditure on health to create a proper platform for progress. Ms Hannify also highlighted the EU's role in promoting equity in a wider international context. She specifically mentioned the Transatlantic Trade and Investment Partnership (TTIP), and that the EU should not let international agreements have an effect on the fundamental principles of our healthcare systems; universality, solidarity and equity.

Panel Discussion: What is needed by the EU to effectively address equity in health at the local and regional level? Introductory presentations by regional representatives on best praxis

The panel discussion involved key speakers Ms. Maria Berhe, Senior officer Public Health, Region Västra Götaland, Sweden, Dr Carol Tannahill, Director of the Glasgow Centre for Population Health, Scotland, Ms. Magda Michalek, EU Policy Officer at Regional Officer of the Lodzkie Region, Poland and was moderated by Ms. Elisabeth Bengtsson, Director of Public Health, Region Skåne, Sweden.

Ms. Maria Behre, Senior officer, Public Health, Region Västra Götaland, Sweden

Ms. Maria Behre presented the praxis of working with health inequity in Region Västra Götaland, Sweden. She explained that a regional public health secretariat had been installed to bridge the health, public care and development sectors. This effort used the whole of government approach focusing on building a network and platform for relevant stakeholders from a variety of societal sectors.

Ms Berhe explained Region Västra Götaland's key lessons from operating the whole of government approach was that it operated well on policy level; it involved stakeholders from public and social society and all levels of society in an established expert group. Regarding support from the EU level in addressing equity, Ms Berhe mentioned that Region Västra Götaland had been involved in the Joint Action "Equity Action" and in the WHO Regions for Health Network (RHN). She emphasised the importance of such involvement in benchmarking with other stakeholders and establishing collaboration with other regions across Europe.

Regarding the implementation level, Ms Berhe mentioned that challenges remain and she pointed to challenges in involving a variety of stakeholders regarding shared budgets and ensuring policy-coherence. She also highlighted difficulties in advocating for a whole of government and health in all policies approach at the regional level when this is not yet fully implemented at the EU level. Ms Berhe requested from the EU a joint system of monitoring and an assessment mechanism since making common priorities required common system of tackling health inequity.

Dr Carol Tannahill, Director of the Glasgow Centre for Population Health, Scotland

Dr Tannahill presented Glasgow's efforts on tackling health inequalities and added that a different method of working was needed and different types of response beyond the material and behavioural responses to health inequity were essential. She mentioned that inequities are increasing although Glasgow is implementing approaches to tackle inequities. Hence, she concluded that the main problem is not relating to policy or lack of policy, rather it is a problem of implementation.

She continued by presenting Glasgow's use of the 'Scottish approach'. In common with Region Västra Götaland Glasgow experienced similar challenges on the implementation level on health equity. In order to meet these challenges Glasgow had set up new priorities, one of these was working in community planning partnerships which took place on all government authority levels and included all sectors who would have a role in tackling health inequalities. The community planning partnerships focus on 4 Ps – prevention, partnership, place and people, and performance. Dr Tannahill explained how the use of improvement methodology as small tests of changes had been important to measure progress made. She also mentioned that Glasgow was increasingly trying to move the focus down to community partnerships at a more local level allowing a more locally strategic use of the EUs structural funds.

Dr Tannahill concluded that the local level required the development of know-how and non-financial support on working with tackling health inequalities which EU could promote. She also mentioned the need for a pan European approach on poverty. Regarding non-financial support, she opened for further discussion on whether evidence in tackling inequities can be translated from the regional and local level across countries, and what sort of evidence that is useful given the different context of regional and local authorities across Europe.

Ms. Magda Michalek, EU Policy Officer at Regional Office of the Lodzkie Region, Poland

Ms. Magda Michalek started by presenting the Lodzkie region's efforts saying that there is a lot of work to be done as it is the poorest ranking region in Poland regarding health. She also mentioned that data was fragmented and difficult to extract from the national level to the local level. However, there are also great potential in the region. Lodzkie has the fastest growing university hospital in Poland so great academic progress is happening, and it will hopefully translate into policy. The Medical University of Lodz is also a member of the project Health Equity 2020 which will help tackle inequities in the region.

Ms. Michalek furthermore explained there had been a lack of leadership and partnership in building a common platform for continuous dialogue with all relevant stakeholders during the process of drafting the regions' recently adopted Health Strategy 2014 - 2020. Ms. Michalek described that strategy on health inequity in Lodzkie had lacked collaboration with stakeholders after initial comments had been provided on the policy level.

Ms. Michalek concluded that it was important within future strategy to ensure that sufficient time was allocated for monitoring and reporting on the results in order to adequately measure the progress of the programme. She also mentioned the clear need for developing leadership and partnership for the region to coordinate divided responsibilities among relevant stake holders for tackling health inequality.

Panel Discussion: what is needed to effectively address equity in health at the local and regional level?

In her introductory remarks, the moderator, Ms Elisabeth Bengtsson, summarised the views shared between the speakers. The speakers considered regional and local actors were suited for the role of gathering data; the regional level had the access to population data and was in the position to analyse it and identify what the health gaps were. This was important for the continued effort of the regional and local level as data extracted from national level cannot be easily translated into workings of the regional and local level. Ms Bengtsson suggested that one role for the regional and local level could be providing common grounds for a variety of relevant stake holders. Ms Bengtsson concluded the next step was to discuss implementation and what kind of support was needed after funding had been allocated. The panel's focus was on what other supportive tools and mechanisms were needed to become available.

Ms. Behre mentioned networks for sharing experience were helpful but emphasised that EU-funded projects needed to be complemented with structures for regional collaboration on a long-term basis. Translating good practices into other regional structures and contexts required a longer sustainable collaboration framework.

Ms. Magda Michalek added that in inter-regional projects one of the conditions was that results from the course of the process should be translated into policy and the results of putting them into practice needed to be reported to the commission. She furthermore considered sharing the same policy in different regions as a result from inter-regional projects created a network and ensured sustainable partnership between regions.

Ms. Tannahill made a point about helping people using data and the work in terms of making data into a range of different forms that people can use. She believed these could be operated at local level to encourage people from different organisations and communities to think about what the issues were for them and what sort of responses might work.

Furthermore Ms. Tannahill's view was that learning across different areas was done well on regional level when it came to high level policies on the health in all policies approach. However, in terms of process she experienced it was less documented and was interested in

establishing a leadership programme for health inequality activity on local level which people across Europe could work in.

Ms. Bengtsson summarised in her conclusive remarks that work on the implementation level was the real challenge and a new set of cross-cutting priorities and methods in all sectors involved was necessary. Additionally, the panel had agreed that assessment tools were essential as a smart test of change and process-development. Furthermore, the use of structural funds had been helpful and as Dr Tannahill reported member states such as Scotland had increasingly tried to develop a more regional strategic use of funds on a community partnership level, something Dr Tannahill recommended for future workings towards health equity. For the following panel debate Ms. Bengtsson established that the regional and local level sought the knowledge and adequate supportive measures provided from the EU to ensure success in the processes of implementation of policy towards health equity.

Q&A

The panel was asked after mentioning the important role of leadership on what it entailed at the implementation level. Dr Tannahill replied what needed to be developed was distributed leadership, a sort of leadership which increase involvement across a range of sectors. She considered community planning partnerships was the place where it needed to sit because it is led politically but involve senior people from different organisations in the area and viewed it as an important mechanism. Ms Behre added that based on her experience implementation tasks did not require to be implemented by public health leaders but could be done in collaboration with other sectors.

Another question was on whether external technical expertise was helpful for regions. Dr Tannahill answered that she agreed external enforcement from WHO European regional office added a different valuable dynamic.

Panel Discussion: which EU tools and mechanisms can more effectively contribute to health and health equity?

This panel discussion involved the speakers Mr. Wolfgang Bücherl, Team leader "Health Strategy", Strategy and International, EC/DG SANCO, Ms. Marie-Anne Paraskevas, Senior Expert, Policy and Legislation, EC/DG EMPL, Mr. Andor Urmos, Political analyst, Regional and Urban Policy EC/DG REGIO and Mr. Francesco Zambon, Policy Development Officer, WHO Regional Officer for Europe. The Panel was moderated by Ms. Caroline Costongs, Managing Director at EuroHealthNet.

Ms. Caroline Costongs introduced the panel discussion by describing how the social investment package could be better implemented and how regions could use it to encourage inter-sectorial work. Furthermore she mentioned that EuroHealthNet currently monitoring the EU semester and country specific recommendations for reform of health systems to ensure they promote health equity. She pointed out "business as usual created health-inequity".

Mr. Wolfgang Bücherl, Team leader "Health Strategy", Strategy and international, EC/DG SANCO

Mr. Bücherl was tasked with presenting his view on how Commissioner Andiukaitis is revising the current health strategy with regards to health equity.

Mr Bücherl responded that Commissioner Andriukaitis had in his parliamentary hearings provided three guiding themes; the prevention, protection and promotion slogan. Additionally, Mr Bücherl referred to Andriukaitis' "health for all – all for health" slogan which entailed access to health care and working in many if not all policy fields in order to support health goals.

Mr Bücherl furthermore raised the Commission's progress report (2013) on EU action on health inequalities and mentioned that in the third EU health programme 2014-2020 reducing health inequity was recognised as a cross-cutting objective. This supported the regional actors' shared view of promoting the health in all policy approach on tackling health inequities.

Mr. Bücherl explained that regions can fully participate in the investments in health from the Commission when it came to projects; however in joint actions it was different. He explained that regions can participate in the joint actions only if they were the competent health authority (regional and local governments can be appointed to take part in joint actions depending on the set up of their national health system).

Furthermore, he mentioned the current growth survey published by the Commission in November 2014. The survey posed economic objectives for the next year and the priorities for the EU-government level to concentrate their efforts for improvements. In spring 2015 these will be followed up by country specific recommendations and country specific recommendations on health. Mr Bücherl explained that the annual growth surveys were linked to health policy in regards to reform of health systems and promoting affordable health care services.

Mr. Bücherl spoke about a joint chaired expert group on health systems' performance assessments which had been set up by the Commission and Sweden. Membership was voluntary but all member states but two had registered their interest in participating. This group is to work on methodology for how to enhance accessibility of health systems. Its work would not just focus on the availability of health care systems but also acknowledge that the affordability of health care can play a role in health equity.

One last mentioning was that the Commission has issued a guide for 2014-2020 health investments. This is to educate those who are not experts on health and to present to them that under thematically defined objectives there are possible activities that could be funded based on documents that the Commission or the Council have issued earlier on (i.e. recommendations, existing legislation etc.). It does not express to member states what must be done but is a menu of possible actions and a source for inspiration. Mr Bücherl added that the

Commission's view was this will set the agenda and delivers guidance for action and enhance the link between different sectorial areas to tackle health inequity.

Mr. Andor Urmos, Political analyst, Regional and Urban policy EC/DG REGIO

Mr Urmos was tasked to present his views on what public health authorities could do to access funding for tackling health inequity now when the operational plans and priorities have been set in the context of new structural fund programmes for 2014-2020.

In his short introductory remarks Mr Urmos underlined it was important to understand in which context health inequity was operating in. The discussion on health inequity had a strong link to structural funds. In the new programme period the Commission had tried to make the view more comprehensive and to tackle all relevant issues which could contribute to this particular issue; tackling different areas which should be understood as a contribution to health inequalities and for structural funds this was particularly important. The Commission is trying to promote this more than before.

Mr. Urmos set the context by clarifying that in the EU cohesion policy budget at the beginning of negotiations of unilateral provisions one new category of regions (transitional regions) had been introduced. He furthermore explained the structural funds allocation would be investing more in less developed and transitional regions than in the more developed.

When it came to the Regional Development Fund (RDF) it sought to build infrastructure. In the previous programming of the RDF the highest allocation had been on education infrastructure, a decision made by the member states, with more investments than was put on health. The budget allocated to member states for the next period is not finalised since negotiations are currently taking place. However Mr. Urmos' expectations were that the picture would be the same - education would still be in the lead in investments.

Mr Urmos mentioned health infrastructure investments from structural funds had previously been allocated to health system reform which had not been efficiently structural and effective and also lacked sustainability. Mr Urmos' view was that this was one of the biggest challenges for EU on tackling health inequality.

Mr Urmos furthermore explained that the Commission works within the thematic objectives framework which is important in order to understand health investments. This is a menu for possible EU-funded actions. The important new feature from previous programme period was the ex-ante conditionality for effectiveness in different areas. As a member state if you are to invest in health you need to provide evidence that your health system reform is sustainable and effective. He concluded that absorption was the leading factor in the case of the structural funds which is also new compared to previous period.

One important message Mr Urmos wanted to provide was that in response to demography changes the EU had set up different legal instruments in the new regulations for 2014-2020. This meant when member states do the problem analyses and discuss expected results and

horizontal principles they could focus more on demographic challenges than before. In the context of tackling health inequalities it was important to understand how the Commission is pushing member states to make more pressure on communicative services and not on institutional services when it came to social structure in general.

Mr. Urmos highlighted that in the strategic frameworks the Commission is taking into account the broader context of poverty reduction how tackling social exclusion factors contribute to tackling health inequalities.

Mr Urmos concluded by presenting the new instrument for the new programming period; the poverty maps. These maps have been produced by the World Bank in close cooperation with the Commission and would be sent to the member states to be used when the EU is allocating its funds and are to be used in order to provide information on how member states will contribute to reducing health inequalities.

Ms. Marie-Anne Paraskevas, Senior Expert, Policy and Legislation, EC/DG EMPL

Regarding the European Structural Fund (ESF), Ms Paraskevas explained that as on the first of November there would be the restructuring of the DG Employment. This entailed incorporating the disability unit which meant DG Employment would have a stronger focus on issues related to health.

Ms Paraskevas presented the two major developments with regard to the new European Social Fund (ESF). For the first time there is an earmarked amount dedicated to the ESF of the Cohesion Policy budget. The second important element was that out of the ESF allocation which each member state received, 20 percent should be going to social inclusion.

Ms Paraskevas explained that social inclusion was the thematic objective under which the funding on health care was coming from. This related to two of the investment priorities under the social inclusion thematic objective. First, access to health, access to polity and affordable health care for all and second, under the strategy on active inclusion which is a strategy launched in 2008. Ms Paraskevas added that the ex-ante conditionality applied to ESF as well.

Ms. Paraskevas explained that the main framework in which the DG Employment operates is the European semester, the country specific recommendations and the social investment package in which DG EMPL had developed series of actions to be performed and taken on. A further element of importance to all European Structural investment funds was the increased focus on partnership. EU has a new regulation which establishes the European code of conduct of partnerships. This requires from all member states to involve in each monitoring committee that will be put in place or in the management of operational programmes representatives of all the stake holders that may have an interest in the ESF and include social partners and relevant NGOs beyond regional actors. With this new framework Ms. Paraskevas stated the EU wished to push for the involvement of partners.

Ms. Paraskevas mentioned the EU had produced policy guidance to funding and focused mostly on (especially in regards to funding from the ESF) choosing the investment priority

and set for actions relevant for the specific country recommendation. This involved the EU trying to persuade the member states to choose the relevant priority meeting the particular need of the member state. In that way the EU would be able to better monitor with health indicators how this had been implemented. Since the programming had been changed the EU would not measure the outcome on the basis of how much money was spent but on what results had been achieved.

Mr. Francesco Zambon, Policy Development officer, WHO Regional Office for Europe

Mr Zambon was tasked with giving his views on the regional approach to health inequalities, the EU tools available and how WHO could complement strategies by EU.

Mr Zambon started by presenting the 2020 policy framework was the key document developed by the WHO for the European region and had been endorsed through a consultation with the EU member states. The regional and local level was formally involved in this consultation process which meant local actors would be able to find points that could be used on the regional and local level.

Zambon mentioned some of the platforms useful for sharing information and practices around health inequalities. He mentioned the RHN network targeting the regional level of governance and the Healthy Cities network available for the regional level. He furthermore stated the Athens declaration for healthy cities endorsed political commitment from the local level to promote actions to tackle health inequalities. Mr. Zambon explained that the RHN network was a platform were WHO mainly tried to align regional health plans with the principles of health 2020 articulated at the national and regional level. Additionally this network sought to organise capacity building events on key implementation issues, provide a platform and contact point for regions to share best practices and to produce publications aimed at addressing specific issues and bring the know-how of regions which had tackled specific issues made available for other regions to replicate.

Mr Zambon also brought up the WHO's published specific publications aimed at two main things: one was on a specific topic which provided a step by step guide for how a specific issue was solved and for other regions to replicate; the other type was documented process. The latter was particularly useful for regions since this focused on the processes of incorporating the health inequality dimension in regional planning and as such is applicable to other regions who want to do the same.

Mr Zambon presented a tools developed by the WHO in association with the Commission, first the 'health inequality atlas' which is a website and a dynamic tool illustrating for key indicators what the situation is on the national and subnational level. Another tool was five policy briefs which all used the same framework on key problems in public care. The relevant layers used in these policy briefs were the differential exposure and differential vulnerabilities which could differentiate groups of society and was something that could be used by local and regional actors.

When it came to implementation Mr. Zambon stated that a little amount of literature could be found on the differentiate impact of interventions. The main aim of policy briefs published by the WHO was to close this gap and take into consideration the differentiated impact of interventions.

Q&A

Ms. Paraskevas explained the difference from the ESF to other EU funds. The ESF had a set of indicators that were different from the indicators used for the other funds and they were focusing mostly on the number of participants that have been included in a programme supported by the ESF. However, in order to be able to assess the sustainability of the results, effects were measured three or six months after the participation of the person in a specific activity in order to assess if, for example three or six months after its participation in training course the person had found a job.

The representatives from the Commission made the recommendation to member states to use the EU health indicators in order to increase comparability between the Commission's data and the member states' data.

One question was asked on how the Commission considered using indicators that were not GDP. Mr. Urmos replied the EU was already going beyond GDP and an effort from the EU was currently on-going to encourage member states to use the same indicators in order to increase transnational comparability and reduce the different sets of data indicators.

Ms. Costongs concluded in her summary of the second panel that opportunities and mechanism tools were available for regional level either indirectly through high level policy or directly by programme mechanisms. She remarked one of the challenges was the information gaps between policy makers on regional level and the EU. The workings for enhancing access of information were a process which could be discussed with relevant NGOs on how to proceed with this effort. Furthermore, she concluded that answers needed to be settled on how the regional and local level can best respond to EU tools and operate them such as integrating the investment package – this effort could be a task for organisations such as Phase conducted by EuroHealthNet. EuroHealthNet was one of several potential actors mentioned who are in the position to organise events bringing together government on implementing social investment package for health.

The seminar was closed with conclusive remarks by Ms. Catarina Segersten Larsson. Based on the presentations and panel debates she recognised the shared view on the importance of providing tools and mechanisms for networking on a long-term basis, the Commission's responsibility to provide support for implementation of policies and the Commission's pivotal role in agenda-setting in order to support the work by the regional and local level on tackling health inequalities. Based on the discussions from the seminar five draft recommendations on EU support for local and regional authorities on health equity were presented (in this documentation the final recommendations are presented)

FIVE RECOMMENDATIONS ON EU SUPPORT FOR LOCAL AND REGIONAL ACTION ON HEALTH EQUITY

The Swedish Association of Local Authorities and Regions, EuroHealthNet and Euregha have the following recommendations for the European Institutions when it comes to tackling inequalities in health in Europe and meaningfully involving local and regional authorities:

1. RECOGNIZE THE KEY ROLE OF LOCAL AND REGIONAL AUTHORITIES

To recognize the key roles that local and regional authorities play to promote health and reduce inequalities in health by conducting services such as public health, health promotion and disease prevention, social services, employment, education, childcare, housing, transport, planning, environment and public safety.

2. RECOGNIZE THE NEED OF A WHOLE-OF-GOVERNMENT APPROACH TO HEALTH EQUITY

To recognize that almost all policies impact on health, and that there is therefore a need for a health in all policies approach at all levels of government, from local and regional to EU level.
To support the use of structural and investment funds, health impact assessments and health equity indicators to achieve a whole-of-government approach at the local and regional level, and co-fund capacity building initiatives to facilitate the use of these tools for health equity.
To support research on efforts to introduce health in all policies at the local and regional level.

3. HIGHLIGHT THE REDUCTION OF HEALTH INEQUALITIES IN EU POLICIES AND PROGRAMMES

To highlight the issue of health inequalities and the need to reduce them in EU policies, programmes and processes: e.g. in the European semester process, the future European investment plan, the review of the Europe 2020 strategy, the revision of the health strategy, the structural and investment funds, third public health programme, Horizon 2020 (within the various societal challenges strands) and the Employment and Social Innovation programme.
To call on the member states to cooperate closely with local and regional authorities to make the Social Investment Package reach out to the subnational level.

4. FACILITATE INCREASED ENGAGEMENT OF LOCAL AND REGIONAL AUTHORITIES

To facilitate the meaningful engagement of and exchange between local and regional authorities in order to identify where and how actions aimed to tackle health inequalities have best effect. It is on the local and regional level where most of the concrete action takes place. The European Commission should therefore support a space for continuous dialogue with regional and local authorities both directly or through European networks that bring these bodies together to ensure that the issue of health inequalities is high on their political agendas and encourage further action to reduce them.

5. FURTHER ENGAGE WITH WHO EUROPE AND ITS NETWORKS

To further engage with the WHO Europe in order to align its polices and share resources with the WHO networks for local and regional authorities such as Healthy Cities, Regions for Health Network, Health Promoting Hospital Network.