

REGIONS

Health Equity and Regional Development in the EU

Applying EU Structural Funds



EQUITY ACTION

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This work is part of EQUITY ACTION which has received funding from the European Union, in the framework of the Health Programme. The sole responsibility for this work lies with the author



This report has been produced as part of Equity Action: the EU co-funded Joint Action on Health Inequalities. Equity Action is a collaboration between 15 European Member States and Norway, non-governmental bodies and the European Commission. Its aim is to deliver practical outcomes that improve policy making and implementation by tackling health inequalities across the social determinants of health. The programme started in February 2011 and runs for three years. The total programme funding is approximately €3.6 million with €1.7 million from the European Commission.

EuroHealthNet coordinates the Equity Action work-strand on regional approaches to reduce health inequalities in the EU. A network of regions was brought together to capture and share examples of sub-national policies and initiatives, and to strengthen understanding on how to influence and use Structural Funds to address health equity at regional level. Outcomes of this work are described in this report.

The regional Case Study reports of are available on www.equityaction.eu, while the Structural Funds Review reports of the countries involved in Equity Action can be found on www.fundsforhealth.eu.



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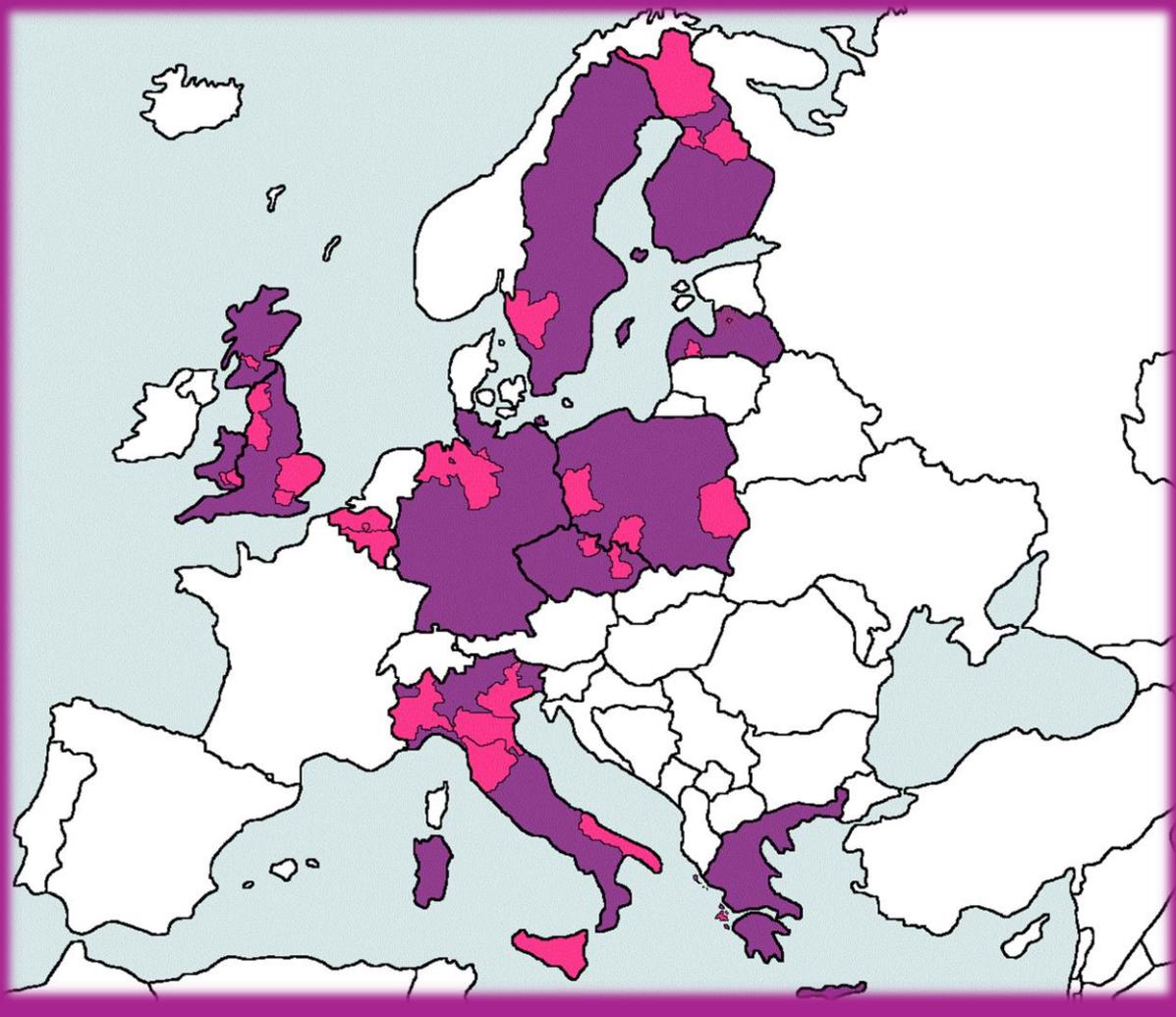


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The Equity Action Regional Network

The Equity Action Regional Network brings together representatives of 30 regions in 10 EU Member States, with the aim of capturing and sharing regional approaches to reducing health inequalities and to strengthen understanding of how to influence and use Structural Funds to address regional health equity issues. Partners have written Case Studies on their experiences with tackling health inequalities. They have also reviewed the use of EU Structural Funds in relation to tackling health inequalities in their regions and countries and identified opportunities and barriers to their use at regional, national and EU level.

All reports produced by Equity Action Regional Network partners are available on the Equity Action website (www.equityaction.eu) and on the online Structural Funds Guidance Tool (www.fundsforhealth.eu). This document presents the conclusions of the Equity Action Regional Network's work and recommendations flowing from it.



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for public health decision-makers and professionals at EU, national and regional level on how to <http://www.qualityaction.eu/login/> use SF for health equity

EXECUTIVE SUMMARY

This publication makes the case for why health and health equity are integral to societies' economic and social development and to achieving the objectives of the EU's overriding 2020 Strategy for 'Smart, Innovative and Inclusive Growth'. The content of the report is based on the outcomes of two studies undertaken by the Equity Action Regional Network. This is a network of thirty European regions in ten Member States that was brought together as part of the Equity Action programme (the EU co-funded Joint Action on Health Inequalities). The network has identified concrete examples of how health inequalities can be addressed at the sub-national level, and has shown how the EU Structural Funds can be used by public health professionals and decision-makers to achieve greater health equity in Europe.

Health inequalities are unfair distributions of health across societies. They are systematic differences in health between social groups, and reflect how large numbers of people are being denied the resources and capabilities for health and are therefore falling short of achieving their full health potential. While some degree of health inequalities exists in all societies, differences in the steepness of the health gradient can be observed across regions and between EU Member States. These differences are the direct result of the kinds of financial, economic, social, health, and other policies and programmes that are being implemented in countries. The variations in health inequalities within and between countries highlight that they are socially constructed, that they can be reduced by reasonable means, and that they are therefore avoidable and unfair.

Regional Case Studies on health inequalities

Breaking cycles of disadvantage ultimately depends on citizens' and governments' ability and commitment to act. Partners of the Equity Action Regional Network undertook Case Studies to describe what is being done in their regions or communities to reduce health inequalities. In total, 24 Case Study reports were produced, which focused on the following aspects: governance, policy, practice, tools, stakeholders and evaluation. The Case Study reports reflected that inequality in health is on the agenda of many regions, though the breadth of action being taken differs widely. Some reported comprehensive strategies and approaches, while others reported ad hoc-initiatives or no explicit action at all.

Outcomes of the Regional Case Studies on Health Inequalities

- Making real progress to reduce health inequalities requires commitment beyond the health sector. Governments and sectors must work together to change their approaches to ensure that policies and practices improve conditions for the more and most-deprived segments of the population, and don't exacerbate inequalities.
- The difficulty for the public health sector lies primarily in engaging those sectors and actors that can make 'hard' impact on the reduction of health inequalities, and in attributing changes in levels of health inequalities to any specific policies.
- There is much evidence that shows that reducing health inequalities is in everybody's interest. The health community must take a strategic approach to communicating this message as widely and effectively as possible in order to embed the issue in national and sub-national governance and policy processes and to engage other actors and sectors.

For more information: see part I of this report or visit www.equityaction.eu

EU Structural Funds to address health equity

The second study focused on EU Structural Funds, one of the EU's largest financing programme that were worth €347 billion during the 2007-2013 programming period, or 35.7% of the total EU budget. The Structural Funds are the EU's financial instrument to implement the EU Cohesion Policy, which aims to reduce the significant economic, social and territorial inequalities that exist between European regions. They are thereby one of the most important mechanisms to take forward the EU 2020 objectives. However, while there are many opportunities to apply Structural Funds to improve health equity in the EU, there has been a lack of engagement by the public health sector in many regions and countries to unlock this potential.

The Structural Funds Review undertaken by the Equity Action Regional Network therefore explored whether and how EU Structural Funds have been used within their countries and regions to reduce health inequalities. Partners identified concrete examples of projects or programmes that received Structural Funds that could (in)directly contribute to health equity, and provided examples of governance structures that could support the use of Structural Funds for health equity. Various partners of the Network also got involved in the negotiation processes for the 2014-2020 programming period, and undertook actions and initiatives to influence processes and to raise awareness of the potential of Structural Funds to address health inequalities. A number of partners also developed ideas for new project proposals that could be funded under the 2014-2020 programming period.

Outcomes of the Structural Funds Review

The opportunities are there, but they are often being lost. To address this, public health decision-makers and professionals must adopt a strategic approach to:

- Raise awareness amongst colleagues at the national, regional and local level of the Structural Funds as a potential co-funding mechanism for initiatives that can directly or indirectly improve health equity.
- Raise its profile vis-à-vis Structural Fund managers and other sectors, and make the necessary contacts and links.
- Advocate for systematic approaches to take health equity into account in initiatives that receive Structural Funds.
- Invest in building capacities within health systems and foster health experts who understand Structural Funds, as well as the social determinants of health and health equity, and who can convey this to others.
- Identify and work through existing partnerships or develop new cross-sectoral partnerships. Learn the language of others and share knowledge and experiences.

As this report has shown, there are many opportunities available to improve health and reduce health inequalities at the sub-national level, especially by using EU Structural Funds, which provide great potential for the public health sector. If you are interested in learning more about EU Structural Funds and in getting in contact with other interested regions in Europe, get involved by leaving your details here: www.fundsforhealth.eu/get-involved.

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We would like to thank the partners of the Equity Action Regional Network from the following countries and regions for developing Case Studies on how health inequalities are being addressed in their regions, as well as their Reviews of how Structural Funds have and can be used for this purpose. The full reports and summaries that partners have produced are available on www.equityaction.eu.

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INTRODUCTION



I. WHY THIS REPORT?

This report has been published as part of Equity Action; the EU co-funded 'Joint Action on Health Inequalities' (2011-2014). Equity Action is a collaboration between 15 European Member States and Norway, non-governmental bodies and the European Commission. The programme aims to deliver practical outcomes that improve policy making and implementation by tackling health inequalities across the social determinants of health.

The report makes the case for why health and health equity are integral to societies' economic and social development and to achieving the EU 2020 objectives of 'Smart, Innovative and Inclusive' growth. It investigates what is needed to improve health equity and provides outcomes of the Equity Action Regional Network's Case Studies to illustrate how the measures required are being implemented in the participating regions.

The report then turns to EU Structural Funds, the EU's largest financing programme and thereby one of the most important mechanisms to take forward the EU 2020 objectives. While there are many opportunities to apply Structural Funds to improve health equity in the EU, there has been a lack of engagement by the public health sector in many regions and countries to unlock this potential. This report therefore explores, on the basis of practical examples, whether and how Structural Funds have to date been used to reduce health inequalities, and draws lessons for the 2014-2020 round of funding. The information is largely based on Structural Funds Reviews that Equity Action regional partners undertook to assess how Structural Funds have or could be applied to reduce health inequalities in their regions. By demonstrating the opportunities that exist to apply Structural Funds to improve health equity and how public health authorities can get involved, the report aims to encourage public health professionals to apply the funds to achieve their objectives.

The report ends with recommendations on how the public health actors at EU, national and regional level can use Structural Funds to improve health and ensure a better distribution of health across society, as an important contribution to national and regional development in the EU.



II. THE LINKS BETWEEN HEALTH EQUITY AND 'SMART, INNOVATIVE AND INCLUSIVE GROWTH'

The Treaty of the EU states that the European Union aims to promote peace, its values, including respect for human dignity, democracy, equality, justice and solidarity, as well as the well-being of its people.¹ The EU's overriding 2020 Strategy for *Smart, Sustainable and Inclusive Growth* (2011-2020) establishes key targets to help the EU achieve these aims. In order to focus efforts and achieve impact, the Strategy includes five headline targets relating to employment, education, poverty and sustainable growth that have to be translated into national targets and plans (see Box 1). All major EU policies must be aligned to these headline policies, while EU Member States must also translate them into national targets and plans.

Box 1

EU2020 Strategy Headline Targets

Smart growth: developing an economy based on knowledge and innovation.

Sustainable growth: promoting a more resource efficient, greener and more competitive economy.

Inclusive growth: fostering a high-employment economy delivering social and territorial cohesion.

- 75 per cent of the population aged 20-64 should be employed;
- The share of early school leavers should be under ten per cent and at least 40 per cent of the younger generation should have a tertiary degree;
- 20 million less people should be at risk of poverty;
- 3% of the EU's GDP to be invested in R&D/innovation;
- Climate change / energy greenhouse gas emissions 20% lower than 1990; 20% of energy from renewables; 20% increase in energy efficiency

EU2020 "flagship initiatives" to support the achievement of the headline targets (relating to health equity).

- "Youth on the move" to enhance the performance of education systems and to facilitate the entry of young people to the labour market;
- "An agenda for new skills and jobs" to modernise labour markets and empower people by developing their skills throughout the life cycle, with a view to increasing labour market participation and better match labour supply and demand, including through labour mobility;
- The "European platform against poverty" to ensure social and territorial cohesion so that the benefits of growth and jobs are widely shared and people experiencing poverty and social exclusion are enabled to live in dignity and to take an active part in society.

EU member states are requested to implement the EU2020 Strategy by applying a series of ten integrated guidelines for the economic and employment policies that were developed by the EU, setting out the reforms that they should undertake to help achieve the 2020 headline targets.

¹ Article 2 and 3, Treaty of the EU: <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=OJ:C:2010:083:0013:0046:en:PDF>

Box 1 (continued)

Member states establish their own targets on the basis of the guidelines, and develop 'National Reform Programmes' (NRPs) explaining in detail the actions they will take to achieve them, with a particular emphasis on measures to remove the bottlenecks that constrain sustainable growth at national level.

As social policies are an integral part of the Europe 2020 Strategy, the Commission adopted in February 2013 its so-called **Social Investment Package** (SIP) for Growth and Cohesion. The SIP aims to encourage Member States to enhance people's capacities and support their participation in society and the labour market. The Package consists of a framework Communication, accompanied by a Recommendation on Child Poverty and various Staff Working Documents, one of them called "**Investing in Health**". This document establishes the role of health as integral to the Europe 2020 strategy and reaffirms that health is a value in itself as well as a precondition for economic prosperity. Health spending is described as 'growth friendly' expenditure. The Investing in Health document is articulated around four main elements: (1) Sustainable health systems; (2) People's health as human capital; (3) Reducing health inequalities; and (4) Adequate support from EU funds for health (such as Structural Funds).

Health has been defined by the WHO as "the complete physical, mental and social well-being, and not merely the absence of disease or infirmity".² Health is an enabler of social and economic participation and daily life. It is therefore a key determinant of a person's well-being, happiness and satisfaction. It is not surprising that in EU surveys, people systematically value their health above other aspects of their life.³

While health is not directly mentioned in the EU 2020 objectives, it is integral to them. People who are physically, mentally and socially well are more likely to perform better in educational systems and in the workforce and to avoid poverty. 'Sustainable' economic growth and environments tend to be those that support health and vice versa. Health is an enabler of economic development as well as a value in itself, as recognized in the EU's upcoming "Health for Growth" Programme⁴, and the Social Investment Package document "Investing in Health".⁵

Yet health is in fact unfairly distributed across our societies. The higher a person's socio-economic status, usually determined by income or educational level, the healthier he/she is likely to be, since many health outcomes are linked to a person's socioeconomic position. This holds true in any of the EU's 271 regions in the EU's 27 Member States: take any person, identify their socio-economic status vis-à-vis others in their region, and this will reflect their likelihood of becoming prematurely ill, of being overweight or obese, or of dying prematurely. This is referred to as health inequalities, or the 'systematic differences in health between social groups'. Health and social status diminish continually along what is called the 'social gradient in health'.

Figure 1 shows a typical social gradient in health: life expectancy in England increases continually as one moves from more to less deprived neighbourhoods. The gradient in disability free life

² World Health Organization. 2006. [Constitution of the World Health Organization](#) – Basic Documents, Forty-fifth edition, Supplement, October 2006.

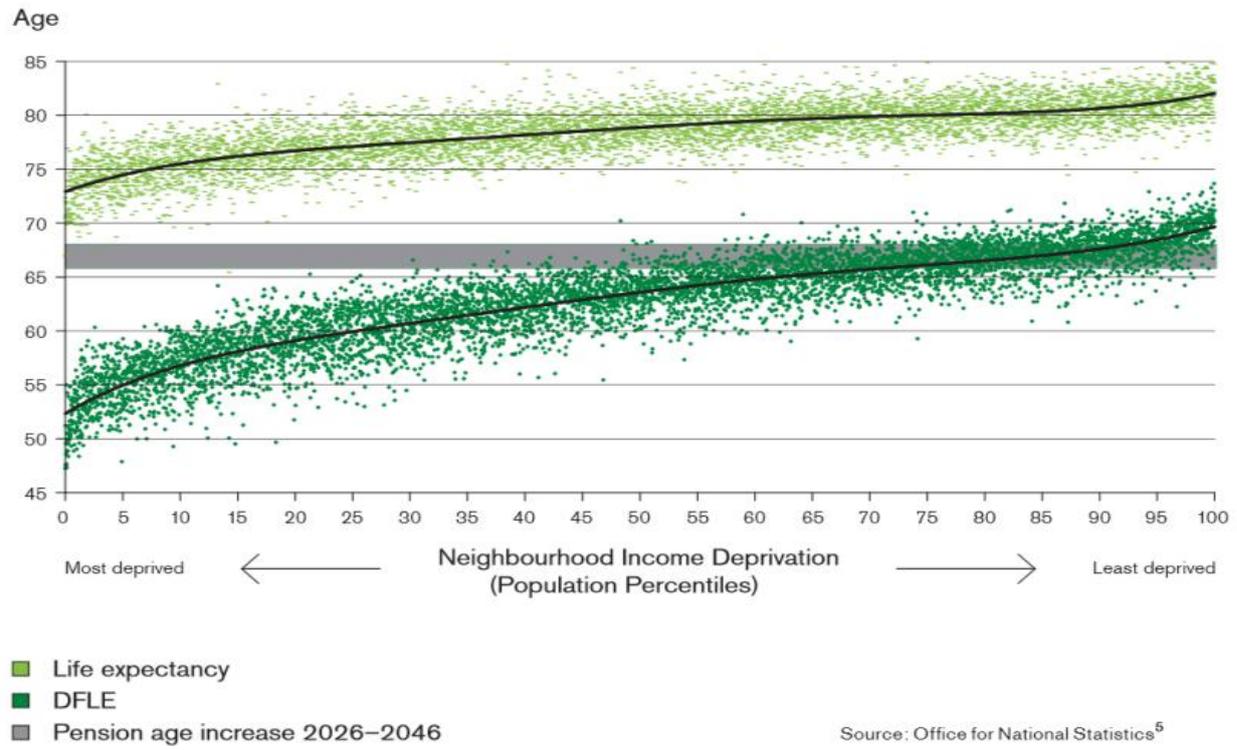
³ EuroFound, 2012. Quality of Life Survey: <http://www.eurofound.europa.eu/surveys/eqls/index.htm>

⁴ http://ec.europa.eu/health/programme/policy/proposal2014_en.htm

⁵ [Towards Social Investment for Growth and Cohesion – including implementing the European Social Fund 2014-2020](#)

expectancy (DFLE), or the amount of time one can expect to live without disability, is even more pronounced.

Figure 1: Life expectancy and disability-free life expectancy (DFLE) at birth, persons by neighbourhood income level, England, 1999-2003 (Marmot Review, 2010)



Health inequalities reflect how large numbers of people are being denied the resources and capabilities for health, and that they are falling short of achieving their full health potential. They also reflect that the principle of equal opportunity is not being achieved in practice.⁶ Estimates suggest that inequality-related losses to health amount to more than 700,000 deaths per year and 33 million prevalent cases of ill health in the EU as a whole.⁷ This is not only a tragic for the individuals' concerned and a challenge to the common EU values of equality, solidarity and justice, it also undermines societal well-being in the following ways:

- High levels of health inequalities put a higher demand on public spending. Estimates suggest that inequality-related losses to health account for 20% of the total costs of healthcare and 15% of the total costs of social security benefits. The monetary value of health inequality related welfare losses is estimated to be €980 billion per year or 9.4% of GDP.⁷
- Those whose health is less than optimal are less productive and less able to contribute to government revenues and economic growth. A study commissioned by the EU found that if health inequalities in the EU were reduced by 10%, the economic benefits would amount to 14 billion Euros through gains in health as a 'capital good' (how health contributes to individual's productive capacities), and 70 billion through gains in health as a 'consumption good' (health as a good that yields direct satisfaction and utility).⁷

⁶ Anand, S. The concern for equity in health. *J Epidemiol Community Health*, 56 (7), 485-487. Doi: 10.11136/jech.56.7.485

⁷ Mackenbach J P, Meerding W J, Kunst A E. Economic Costs of Health Inequalities in the European Union. 2011

- Finally, epidemiological research shows that high levels of social inequalities, which can lead to health inequalities, undermine the well-being of everyone in society, even the best off. This is because, researchers contend, inequality reduces social cohesion, which leads to more stress, fear, and insecurity for everyone. More socially cohesive, educated populations by contrast are likely to have lower rates of crime and civil disorder and more highly skilled workforces.⁸

While some degree of health inequalities exists in all societies, differences in the steepness of the health gradient can be observed across regions and between EU Member States.⁹ These differences are the direct result of the kinds of financial, economic, social, health etc. policies and programmes that are being implemented in countries. The variations in health inequalities within and between countries highlight that they are socially constructed, that they can be reduced by reasonable means, and that they are therefore avoidable and unfair.¹⁰

Ensuring that the benefits of economic growth are fairly distributed within communities, between regions, as well as across Member States, is in line with the EU 2020 objectives. Levels of health inequalities provide a good indicator of whether economic growth is indeed being achieved in ways that are 'Smart, Innovative and Sustainable' and contributing to what all citizens consistently indicate that they value most –their health.

⁸ Wilkinson RG, Pickett, K. *The Spirit Level: Why More Equal Societies Almost Always Do Better*. London, 2009.

⁹ WHO, *European Health Report 2012. Charting the way to well-being*. WHO Regional Office of Europe. 2013.

¹⁰ CSDH (2008). *Closing the gap in a generation: health equity through action on the social determinants of health*. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization



III. HEALTH EQUITY AND THE EUROPEAN UNION

The European Union is aware of this link between health inequalities and the broader EU 2020 objectives. Since the European Union gained specific competencies in public health in 1992,¹¹ the issue of health inequalities has slowly established itself on the European agenda, and gained more prominence over the past decade. Addressing health inequalities was a key action of the EU Health Strategy “Together for Health: A Strategic Approach for the EU (2008-2013)”.¹² In 2008, the European Commission established an Expert Working Group on Social Determinants and Health Inequalities.¹³ Additionally, the Commission adopted in 2009 a joint Communication by DG SANCO and DG EMPL entitled: “Solidarity in Health: Reducing Health Inequalities in the EU”, which aimed to reduce health inequalities by supporting action by Member States and stakeholders, and through EU policies.

Health Inequalities have also been addressed by the Council of the European Union. In 2004, the Council set up a Social Protection Committee¹⁴, with advisory status, to promote cooperation on social protection policies between Member States and the European Commission. The objectives of the Social Protection Committee are, among others, to promote social inclusion and to ensure high-quality and sustainable health care.

In addition to this, various EU Presidencies have explicitly focused on the need to reduce health inequalities in the EU. Examples include the Spanish Presidency (1st semester in 2010), which adopted Council Conclusions on “Equity and Health in All Policies: Solidarity in Health”¹⁵ and organised the high level conference: “Moving Forward Equity in Health”. The Belgian Presidency (2nd semester 2010) also organised various high level events addressing health equity, such as the international conference: “Reducing health inequalities from a regional perspective. What works, what doesn’t?”¹⁶. This conference considered how the regional policy level can best influence the social determinants of health in order to close the health gap between rich and poor at all stages of life.

In June 2011, the Hungarian Presidency adopted the Council Conclusions: “Towards modern, responsive and sustainable health systems”¹⁷, and called for the need to move away from hospital-centred systems towards integrated care systems to enhance equitable access to high quality care

¹¹ Treaty on European Union (Treaty on Maastricht), OJ C 191 of 29.7.1992

http://europa.eu/legislation_summaries/institutional_affairs/treaties/treaties_maastricht_en.htm

¹² White Paper: Together for Health: A Strategic Approach for the EU 2008-2013 - EU Health Strategy: Brussels, 23.10.2007 - COM(2007) 630 final http://ec.europa.eu/health-eu/doc/whitepaper_en.pdf

¹³ Meetings of the EU Expert Group on Social Determinants and Health Inequalities http://ec.europa.eu/health/social_determinants/events/index_en.htm

¹⁴ Council Decision 2004/689/EC of 4 October 2004 establishing a Social Protection Committee Decision 2000/436/EC http://europa.eu/legislation_summaries/employment_and_social_policy/social_protection/c10119_en.htm

¹⁵ Council Conclusions on Equity and Health in All Policies: Solidarity in Health – 3019th Employment, Social Policy, Health and Consumer Affairs Council Meeting (Brussels, 8 June 2010) http://www.consilium.europa.eu/uedocs/cms_Data/docs/pressdata/en/lsa/114994.pdf

¹⁶ Belgian Presidency, international conference: “Reducing health inequalities from a regional perspective. What works and what doesn’t?” (8-9 November 2010). <http://www.eutrio.be/reducing-health-inequalities-regional-perspective-what-works-what-doesnt>

¹⁷ Council conclusions: Towards modern, responsive and sustainable health systems. 3095th Employment, Social policy, Health and Consumer Affairs; Council meeting - Health issues - Luxembourg, 6 June 2011 http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/122395.pdf

and reducing inequalities. The Polish Presidency, which followed the Hungarian Presidency, organised during the second semester of 2011 a Ministerial conference on “Solidarity in Health – Closing the health gap between European Union States”.

The European Parliament adopted on 8 March 2011 the Resolution: “Reducing health inequalities in the EU”¹⁸, which underlined the need to make a more equitable distribution of health part of the overall goals for social and economic development, to build commitment across society for reducing health inequalities and meet the need of vulnerable groups. It also recognises that the reasons for differences in health are, in many cases, avoidable and unjust, because they are a consequence of differences in opportunity, in access to services and material resources, as well as differences in the lifestyle choices of individuals.

More recently, in early 2013, the European Commission issued a Staff Working Document on ‘Investing in Health’, as part of its Social Investment Package¹⁹ (see Box 1). Investing in reducing health inequalities and investing in health through support from EU funds are two of the four themes developed in the document. The Commission also published a Staff Working Document on health inequalities in the European Union (Sept 2013)²⁰, which presents an overview of the size and trends in health inequalities in the EU and which describes progress made in implementing the EC Communication “Solidarity in Health”. The Staff Working Document shows that, while the gap between the longest and shortest life expectancy found in EU-27 as well as the average infant mortality in the EU has decreased between 2006/2007 and 2011, significant and unacceptably large health inequalities still exist between and within EU Member States. The health divide indeed remains persistently large - and is in some cases growing - and further action at regional, national and EU level is thus needed.

The WHO is also strong advocate and driver for action on health inequalities. Most recently, it published a European Review on Health Inequalities²¹. This document reports on developments in the field since the publication of the WHO Global Review on health inequalities in 2008²², which was the final report of the WHO Commission on Social Determinants of Health, led by Sir Michael Marmot. The European Review builds on this global evidence and provides policy recommendations to reduce health inequalities and the health divide across the 53 countries of the WHO European Region.

¹⁸ European Parliament Resolution (8 March 2011): ‘Solidarity in Health’

<http://www.europarl.europa.eu/sides/getDoc.do?type=REPORT&reference=A7-2011-0032&language=EN>

¹⁹ Commission Staff Working Document “Investing in Health”, accompanying the document “Towards Social Investment for Growth and Cohesion - including implementing the European Social Fund 2014-2020” - Brussels, 20.2.2013 - SWD(2013) 43 final http://ec.europa.eu/health/strategy/docs/swd_investing_in_health.pdf

²⁰ Commission Staff Working Document “Report on health inequalities in the European Union” - Brussels, September 2013 - SWD(2013) 328 final http://ec.europa.eu/health/social_determinants/docs/report_healthinequalities_swd_2013_328_en.pdf

²¹ World Health Organisation Regional Office for Europe (Sept 2013), Review of social determinants and the health divide in the WHO European Region: final report <http://www.euro.who.int/en/what-we-publish/abstracts/review-of-social-determinants-and-the-health-divide-in-the-who-european-region.-final-report>

²² World Health Organisation (2008) - Closing the gap in a generation: health equity through action on the social determinants of health: final report of the Commission on Social Determinants of Health http://www.who.int/social_determinants/thecommission/finalreport/en/index.html

PART 1

What can be done (at the subnational level) to improve health equity?

I. INTRODUCTION

Part one of this report focusses on the outcomes of Case Studies that partners of the Equity Action Regional Network undertook to identify and describe what is being done in their regions or communities to reduce health inequalities. Many regional level governments have strong competencies in public health and in areas regulating other key determinants of health and can identify and address entry points to reducing health inequalities that reflect the specific socio-economic conditions within their regions. Part one begins with an overview of what, in theory, can be done to address health inequalities, and then turns to what is being done in practice, on the basis of the information shared by 24 regions from 12 EU Member States, in relation to the following aspects: governance, policy and practice.

II. MULTI-FACETTED SOLUTIONS

Over the last decade there has been a considerable focus on the issue of health inequalities.²³ Reports addressing health inequalities reflect that a lot can be done by the health sector in terms of raising and maintaining awareness and ensuring that health systems are based on the core values of universality, access, goods, equity and solidarity. Yet while the health sector can treat ill health and promote health, it does not shape peoples' health. Health, rather, is influenced by the 'conditions in which people are born, grow, live, work and age' which are also referred to as the 'social determinants of health'.²⁴ Improving health equity can therefore mostly be achieved through the commitment of a broad range of actors that collectively shape the determinants of health.

Models have been developed by e.g. the WHO Commission on the Social Determinants of Health (2008) to reflect the deep-rooted, interrelated and cyclical causes of health inequalities. The models reflect how power structures in societies affect social stratification, which impact the socio-economic and cultural conditions in which people are raised, their educational outcomes and their income levels. This in turn affects people's ability to influence the conditions in which they live, work, and raise their children as well as how likely they are to e.g. smoke, exercise, and eat fresh-fruits and vegetables. The full culmination of these factors will affect whether people are likely to suffer from early onset of disease or early death.

Breaking such cycles of disadvantage entails identifying the core causes, or determinants of health inequalities, which may lie in e.g. conditions of early child development, income, physical environment and the work environment. Breaking such cycles ultimately depends on citizens' and

²³ E.g:

- CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, WHO
- Marmot M, Allen J, Bell R, Bloomers E Goldblatt P. WHO European review of social determinants of health and the health divide. The Lancet, Volume 380, Issue 9846, Pages 1011 - 1029, September 2012
- Stegeman I, Costongs C eds. The Right Start to a Healthy Life, EuroHealthNet (2012)
- EuroHealthNet, The Story of DETERMINE (2010)
- Mackenbach JP. Health Inequalities: Europe in Profile (2005)
- Judge K, Platt S, Costongs C, Jurczak K. Health Inequalities: A challenge for Europe (2005)

²⁴ CSDH (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization

governments' ability and commitment to act on such determinants. Governments must establish systems that take holistic approaches and address not just symptoms but the root causes of societal problems. Citizens must support and take part in measures that contribute to healthier and fairer societies. The health sector, in turn, has an important role in raising awareness and providing the evidence on health inequalities and on what kinds of measures governments and social actors can effectively take to reduce them, in order to instigate collective action. The health sector must also ensure that a focus on health inequalities is mainstreamed into their services and programmes, and identify and act on the key determinants of illness (e.g. health behaviours like smoking and alcohol use) as well as those generating unequal consequences of illness (e.g. access to health services).

A key measure to reduce levels of health inequalities is greater investment in health promotion and disease prevention, particularly amongst those where prevalence of ill health is highest. An increasing number of studies reflect that investing in prevention is a "good buy" in that it is both cost-effective and can help to save money in the long run, through economic and social returns²⁵. It costs less, in terms of resources and human suffering, to prevent ill health, than to cure it. Yet public spending on health promotion represents on average approximately 3% of health care costs²⁶, and these budgets are the first cut under austerity programmes. While this can lead to savings in the short run, it will lead to greater health care expenditures in the long run.

Effective health promotion and disease prevention measures however call for the health sector to move beyond the narrow confines of measures aimed at modifying health related behaviours. Many of the more effective measures that can promote health and prevent disease lie beyond the scope of health systems. These are social protection measures that provide assistance according to need, as well as education systems that provide equal opportunities and that enable people to develop the skills and the control over their lives to make choices that benefit health. They also involve market regulations, and urban planning measures that create environments in which 'the healthy choice is the easy choice'. The health sector must work with those responsible for the implementation of such policies and measures, to improve opportunities for, and ensure a more equal distribution of health.

Finally, an important role for the health sector is to provide a clear picture of the situation relating to health inequalities and of the effectiveness and impact of relevant strategies, policy measures and practices that are being taken to address it. Such information can motivate action and help to identify those measures that are most likely to contribute to greater health equity.

²⁵ The WHO estimates for example that reducing risk factors (such as nutrition, physical activity, alcohol, tobacco and stress) through health promotion and disease prevention can lead to a decrease of 80% of premature heart disease, 80% type 2 diabetes cases and 40% of cancers.

²⁶ OECD Health Data 2012: www.oecd.org/health/healthdata.

III. OUTCOMES EQUITY ACTION SUBNATIONAL CASE STUDIES

The reports reflected that inequality in health is on the agenda of many regions, though the breadth of action being taken to address this issue differs widely, with some reporting explicit comprehensive strategies and approaches, and others only reporting ad hoc-initiatives, or no explicit action at all. The full case studies as well as summaries of these and an overview analysis report are available on www.health-inequalities.eu. The following provides a brief overview of the outcomes and includes exemplary efforts taking place to reduce health inequalities.



A. EVIDENCE

While most EU Member States have national level data on health inequalities via, at the least, health and social data collected for the EU-level²⁷, many regions were not able to provide specific information on levels of health inequalities in their borders. In some countries it is only possible to correlate health and socio-economic data at the more generalised community level. It is not surprising that those countries and regions that regularly collect data reflecting levels of health inequalities at national, regional and local level are also those taking the most comprehensive action on the issue. A number of partners in the Equity Action Regional Network provided information on innovative data collection and dissemination approaches, as illustrated below.

Example 1.1: Health Inequality monitoring systems



England

In England, the [Health Inequalities Intervention Tool](#) provides information on life expectancy by local authority, and enables the comparison between the gap in life expectancy of the general population and of those living within the most deprived quintile of each local authority. The tool is able to estimate the effect of certain interventions on the life expectancy of defined populations.

The Eastern Region Public Health Observatory (ERPHO)'s [Fingertips tool](#) presents key indicators measuring health inequalities. The tool, developed by Public Health England, allows the comparison of information by demographic, time period and by geographical area. It also enables comparison between the most deprived quintile and the rest of the local population.

In the North West region of England innovative methodologies to track health inequalities have been introduced using near real-time mortality data. The [Office for National Statistics \(ONS\)](#) provides real time mortality data at local authority level on provisional deaths counts in most recent months.

²⁷ See for example the Health in Europe: Information and Data Interface (HEIDI): http://ec.europa.eu/health/indicators/indicators/index_en.htm

Example 1.2: Health Inequality monitoring systems



Scotland

Scotland has a tradition of collecting, analysing and making available a range of information to understand health inequalities and has established long-term indicators of health inequalities that are updated annually. The region of Fife has developed the [Know-Fife data set](#) that provides information relating to health and health inequalities at neighbourhood level to the public.

Example 1.3: Health Inequality monitoring systems



Finland

In Finland, a [Health Care Act](#) that entered into force on 1 May 2011 requires local authorities to monitor the health of the population in their municipalities by population group, including socio-economic groups. Local authorities are required to prepare a wellbeing report once in every electoral period.



B. STRATEGIES AND ACTION PLANS

Real progress on health equity at population level is most likely to occur through cross-sectoral commitment and action to achieve this goal. The Case Studies of the Equity Action Regional Network partners reflect that there are some countries where comprehensive action is being taken, such as Scotland and Finland (see Example 3). Here, governments have an expressed commitment to reduce levels of health inequalities, and have made efforts to align policies to contribute to this objective. These efforts extend across government sectors, and engage the regional and local level. National governments set the strategic drivers around health and health equity and monitor actions and outcomes, but leave it up to the regional and local levels to develop and implement actions that address their specific needs, as reflected through local data.

In Scotland, reducing health inequalities is currently one of six policy priorities for Community Planning, the process by which local government, Health Boards and other public bodies across Scotland work together with local communities, businesses and voluntary groups to plan and deliver better services to improve the lives of people in Scotland. In Finland, the Strategy on health inequalities is led by the health sector.

Example 2.1: Countries and regions with health Inequality Strategies



Scotland

Scotland appears to have one of the most comprehensive, cross-sectoral approaches to reduce health inequalities, as the issue is reflected in Scottish Government policies and programmes at national, regional and local levels. The structure for this is established by the government's [National Performance Framework](#), which has five strategic objectives. These objectives are for a Scotland that is: wealthier and fairer, smarter, healthier, safer and stronger, and greener. The National Performance framework sets out 16 national outcomes, one of which is to "have tackled the significant inequalities in Scottish society", - including health inequalities. The '[Equally Well](#)' policy document sets out the agreed approach to tackling health and other inequalities in Scotland and identifies priorities and principles that are key to reducing health inequalities.

The Equally Well Implementation Plan announced details of eight local test sites to implement and assess innovative approaches, reflecting these priorities and principles at local level. Learning from the local test sites could then be more generally and widely applied across Scotland. An evaluation of the tests sites was published in 2011.

The region of Fife in Scotland provides a good example of Community Planning in practice. The Fife Community Plan for 2011-2020 aims for three high-level outcomes: reducing inequalities, increasing employment and tackling climate change. Since it began in 1999, strategic partnerships have been formed to lead on five key areas (Economy, Education and Skills, Environment, Community Safety and Health and Well-being.) The Fife Health and Well-Being Alliance was established to lead work on improving health and well-being and reducing health inequalities in Fife and to ensure that organisations work together and genuinely engage communities in doing this. It has a three year strategy – the Health and Well-Being Plan (2011-2014, 3rd one) - which has the overarching aim of reducing health inequalities.

The Plan calls for work across three themes: supporting healthier lifestyles for individuals and families; creating and sustaining healthier places and communities; and changing the way organisations work. The Health and Well-Being Alliance also links with other partnerships addressing the wider determinants of health such as the Fife Housing Partnership and the Children in Fife Partnership.

By far the largest resources to reduce health inequalities exist within mainstream services and their budgets across community planning partners and organisations. Fife is also a local test site in Scotland to implement and assess innovative approaches to reduce health inequalities that focus mainly on antisocial behaviour in relation to alcohol and underage drinking within a specific neighbourhood.

Example 2.2: Countries and regions with health Inequality Strategies



Finland

One of the goals of the Finnish 2015 Public Health programme (Ministry of Social Affairs and Health 2001) is to reduce health inequalities and to increase the number of healthy life years. The Ministry of Social Affairs and Health requires Regional State Administrative Agencies to draw up plans that outline how they aim to promote health. Since the Primary Health Care Act of 2006 emphasised the importance of promoting the health and well-being of the least well-off and on reducing inequalities, this has become the focus of the regional plans.

A National Action Plan for Reducing Health Inequalities (2008 -2011) has also been developed to achieve the national goal of reducing health inequalities. The project for reducing socio-economic health inequalities in Finland (TEROKA) played an important role in the development and implementation of this National Action Plan. In a first stage (2004-6), the TEROKA project collected information on national health inequalities and applied this to raise public awareness.

The project then focused on co-operation with the Kainuua and North Ostrobothnia regions and the city of Turku, which served as tests sites to identify how health inequalities can be addressed in practice (2006-2008). This included the development of two comprehensive reports on health inequalities in the two regions, as well as guidelines on how these should be addressed.

It also included the establishment of multi-sectoral Health and Well-Being groups at the supra-regional (State Authority) as well as at the regional and municipal level. These groups brought together all actors responsible for promoting health and well-being at these different levels. They were given the statutory task of processing and considering information on socio-economic differences in health and, on the basis of this information, engaging in cross-sectoral co-operation for health.

The role of the Health and Well-Being group at the State Authority level is to advise and supervise the work of the regional and municipal level groups and to facilitate exchange of experience and learning on how to improve well-being amongst the least well-off and reduce health inequalities.

In most cases, the extent to which action is being taken at regional level is directly related to whether health inequalities are prioritised at national level, although there are some exceptions. While the overall objective of the National Public Health Policy (2004) in Sweden is to 'create the social conditions for good health on equal terms for the entire population', the national government has, in recent years, placed emphasis on individual responsibility to improve health-related behaviours rather than on the underlying structural factors that may contribute to poor health. The regions and municipalities in Sweden have a high level of self-determination. The Region Västra Götaland which has identified good health as one of its main priorities, recognises that this involves 'creating the conditions for equal and equitable living conditions'. The regional government therefore commissioned the development of an Action Plan for Health Equity to help achieve this objective.

Example 2.3: Countries and regions with Health Inequality Strategies



Sweden

In the 2011 budget, the Regional Council commissioned the Regional Executive Board to prepare an [Action Plan for Health Equity](#) throughout Region Västra Götaland to contribute to the overall long-term strategy of the region, entitled 'Vision Västra Götaland – A Good Life'. Different parties such as municipalities, employment agencies and trade union confederations and organisations like the County Council and NGOs have been invited to participate in the development of the Action Plan.

The Action Plan focuses on childhood conditions, work participation and **ageing** and has two cross-cutting themes: life-long learning and good living habits. Those involved are currently taking part in a process of identifying what kinds of measures they can take that can contribute to the reduction of health inequalities, and how these can be achieved. The Public Health Committee has responsibility for co-ordinating the development of the Action Plan, and must report to the Regional Executive Board by the turn of the year 2012/2013.

A considerable barrier to effective action on health inequalities, even in those countries and regions that are taking comprehensive action, lies in the difficulty of engaging those sectors and actors that can influence the 'hard' factors and underlying conditions leading to health inequalities. As in Sweden, Italy currently has no comprehensive national strategies to address health inequalities. Regions in Italy however have a high level of autonomy when it comes to health and social policy. In 2007 the region of Piedmont for example passed the Health Profile and Plan, a regional law that charged local health authorities with measuring health inequalities and implementing local policies to improve general health and to reduce these. This law has not however proved to be successful as, according to their Case Study report, 'many local policies with a big impact on health and on health inequalities tend to avoid dialogue and cooperation with social and equity-related issues.' This reinforces the need for awareness and commitment from the highest levels of government to engage all sectors in clear plans about what actions need to be taken that can make a real, population-level impact.



C. PRACTICE

While only some of the countries and regions taking part in the Equity Action Regional Network had comprehensive Strategies and Action Plans to address health inequalities, all identified practices in their regions that specifically aimed to or could contribute to this objective. Most partners identified practices that addressed the more immediate causes of health inequalities, and facilitated access to health care, or that addressed health-related behaviours (e.g. alcohol consumption, smoking, diet), like those on the next pages.

Example 3.1: Activities / Initiatives addressing immediate causes of health inequalities



Latvia

In Latvia health care services are financed by state, personal payments and voluntary health insurance schemes. The 2008 economic crisis forced Latvia to cut back on all public spending, including health care expenditures. Compared to 2008, health care budgets were reduced by 13% in 2009 and by a further 12% in 2010. Patient co-payments also increased significantly after 2009.

The Latvian Case Study describes the Social Security Network Strategy that was implemented in Latvia in September 2009, as part of welfare related emergency security measures to help needy and low income persons. The Strategy involved measures to ensure that needy and low income persons could still have access to primary health services and hospital care as well as any required pharmaceuticals. An assessment of the Strategy revealed that it significantly decreased inequalities in the provision of health care amongst this target group. Its only weakness was that recipients had to be aware of and actively seek out the opportunities available in order to benefit from them.

Example 3.2: Activities / Initiatives addressing immediate causes of health inequalities



Germany

The data from Hamburg illustrates that social and health inequalities are most visible on the city district level; it is thus important to tackle the issue here. The city district level is especially well-suited for implementing new health promotion concepts. By taking a social-environmental approach, local residents can be more strongly integrated into the communal task of planning, implementing and evaluating of measures to reduce health inequality.

The “Lurup Health Promotion Centre” is located in a heterogeneous district in the Western part of the region of Hamburg with poor social conditions. The centre has been set up to provide relevant organisations with advice and support, also relating to the financing and planning of projects, on health promotion for socially disadvantaged groups. The Centre is funded by the Hamburg Office for Health and Consumer Protection and the Techniker health insurance company.

‘Lenzgesund’ (Lenz-health) is another programme being implemented in a socially disadvantaged city district. It is a prevention programme by the Health and Environment Office of the Precinct of Hamburg-Eimsbüttel, targeting the residents of the Lenz housing estate. The programme includes a focus on immigrants and aims to coordinate the activities of all actors and institutions involved in the provision of pre and post natal health care in the area as well as other health promotion and prevention activities linked to e.g. immunisations, dental care, nutrition and exercise."

Example 3.3: Activities / Initiatives addressing immediate causes of health inequalities



England

An initiative in the East of England aims to ensure that the National Health Services smoking services are targeted at the most deprived fifth of the population, where the prevalence of smoking is known to be the highest, so that the proportion of those giving up smoking in the most deprived areas is comparable with those living in less deprived areas. The initiative has led to insights into what is most likely to succeed in targeting this segment of the population, and also resulted in improved data collection and monitoring systems.

In the North West of England, alcohol-related hospital admissions have increased by 73 per cent over the past seven years, and are thereby contributing to widening health inequalities in the region. Drink Wise North West (DWNW) is an initiative being implemented in 24 Primary Care Trusts in the region, which aims to reduce alcohol-related hospital admissions by 5 % in two years. These Primary Care Trusts are applying a 'Large Scale Change' (LSC) approach, that requires all those that are part of the multi-sectoral project team (public sector services including NHS, social care and housing as well as local authorities, the police, and the voluntary sector) to organise themselves very differently.

The LSC model draws on the best international practice from the private, public and voluntary sector, and uses tools and techniques which support creating and maintaining momentum by framing and engaging people and partnership to deliver pragmatic changes in systems, process and behaviours in an emergent way. An evaluation of project implementation was carried out in September 2011 and reported positive results. The initiative is likely to gain momentum, since it is considered an "invest to save model".



D. TOOLS AND EVALUATION

The systematic use of tools such as Health Inequalities Impact Assessment (HIIA) which measure the distributional impact of policies and other measures on health, can make an important contribution to greater health equity. Equity Action Regional Network partners Case Study reports reflect that the use of such tools is however not commonplace. Fife Scotland was the only region to indicate that HIIA tools are being developed at national level. Fife applies integrated impact assessments as part of efforts to improve local policy and practice, although Equality Impact Assessment tools tend to be used more frequently, due to legislative requirements. Other regions too, reported using Health Impact Assessments, but on an ad-hoc basis.

The evaluation of policies and practices (similar to *ex post* HIIA) is important to efforts that aim to reduce health inequalities. There are however many complexities around evaluating policies and measures' impact on health inequalities, relating to the availability of data, the time it takes for outcomes to become evident and the difficulty of isolating causal relations. Nevertheless, the Case Study report from Brussels, Belgium reflects how qualitative methods can also be useful to assess the impact of projects and to identify further measures that can contribute to greater health equity.

Example 4.1: Examples of health equity evaluation methods/tools



Belgium

The [Health and Social Observatory in Brussels](#) undertook a qualitative evaluation of five different projects, financed by the [King Boudewijn Foundation](#), whose aim is to reduce health inequalities amongst youth (15-25 years). The evaluation was based on in-depth semi-structured interviews with all parties involved in the projects to establish their views about e.g. the assumptions underpinning, the objectives and the effectiveness of the projects.

Field actors from the five projects and the funding bodies were then brought together for two days of exchange and discussion. The parties discussed facilitators and barriers to good health as well as good practice and they developed recommendations. In this way, they negotiated a shared framework on health inequalities in Brussels and how they should be reduced.

Amongst the lessons learned was that this 'realist evaluation' approach and process leads to better informed partners and participants who are more able to recognize and create further opportunities for action and collaboration. The results of the evaluation will be used by the participating partners to further discuss and clarify how health inequalities can be reduced in Brussels, and how some of the successful approaches identified, like measures to improve the self-esteem of vulnerable youth, can be implemented and tested.

The next example in the Case Study from Aneurin Bevan (Wales) shows the importance of evaluating in this case a large scale programme that addressed health inequalities, in order to modify and improve measures for greater effectiveness.

Example 4.2: Examples of health equity evaluation methods/tools



Wales

[Community First](#) is a large scale national community regeneration programme in Wales, with expenditures of 40 million Euros, which aimed to involve many different actors and sectors, improve overall conditions and thereby reduce health inequalities in the most deprived parts of the country. Rigorous evaluations of the programme concluded that it has led to some commendable outcomes, such as a better engagement of residents and better community planning processes. Yet the programme also received criticism that it was not achieving value for money, since it wasn't making 'hard' impacts on key drivers of poverty such as worklessness, health and educational attainment.

As of April 2012, Community First has therefore been adapted into a 'Community Focused Tackling Poverty Programme' that is taking place in 52 larger areas, known as clusters. Community-supported actions will work alongside other programmes to narrow education, skills, economic and health equity gaps between the most deprived and the more affluent areas of Wales. The programme is being guided by a National Outcomes Framework and supported by individual Delivery Plans for each Cluster. The aim is that it will thereby achieve the measurable outcomes for individuals that are ultimately needed to reduce health inequalities in the cluster areas.

This example highlights the importance of evaluation to ensure that resources are being optimally used to achieve the desired objectives. The evaluation outcomes again emphasize that reducing health inequalities can only be achieved by engaging and coordinating the activities of key sectors. While this is an ambitious endeavour, success, as measured through reductions in levels of health inequalities, also represents the effectiveness of public policies to shape just, cohesive and efficient societies that improve the well-being of all. As discussed in the next section, public financing, including EU Structural Funds, can and should therefore be applied in ways that contribute to this goal.

PART 2

How can EU Structural Funds be used to improve health equity?

I. INTRODUCTION

EU Cohesion Policy, also referred to as the ‘Regional Policy of the EU’, is an investment policy that supports job creation, competitiveness, economic growth, improved quality of life and sustainable development. It aims to reduce the significant economic, social and territorial disparities that exist between Europe's regions and is an expression of the EU's solidarity with less developed countries and regions, recognizing that such disparities undermine the objectives of the EU. The Structural Funds are the European Union's financial instrument to implement the EU Cohesion Policy.

A sound approach to economic development in regions is to ensure that it is driven in ways that also reduce health inequalities. As elaborated in part one of this report higher levels of health equity imply higher levels of productivity, lower levels of welfare expenditures and greater social stability. The health sector can contribute to this by applying Structural Funds to improve access to health care for all, to enhance capacities within health systems to address health inequalities and to coordinate actions across sectors and levels to promote health equity. The health sector can in addition use Structural Funds spending to help leverage existing initiatives in their regions that can contribute to a reduction of health inequalities.

The importance of Structural Funds to tackling health inequalities was acknowledged by the Hungarian Presidency in June 2011. In the Council Conclusions ‘Towards modern, responsive and sustainable health systems’²⁸ it invites Member States to “make smarter use of EU financial programmes, including Structural Funds, which can contribute to health systems innovation and to reducing health inequalities, and can trigger further economic growth.”

Projects and programmes that receive Structural Funds that are implemented by other sectors can also have a significant indirect effect on health equity, by addressing key determinants of health. The public health sector can therefore help ensure that Structural Funds spending contributes to public health - and health equity in particular - by calling for measures to assess the health equity related impacts of all initiatives that receive funding. They can also work with projects and programmes managed by other sectors to maximize these health related impacts.

This part of the report will first give an overview of EU Cohesion Policy and EU Structural Funds and how public health and health equity fits in. This is followed by a summary of the key findings of the Structural Funds Reviews that were conducted by the partners of the Equity Action Regional Network within their countries and regions. These outcomes will provide more insight into approaches outlined above on how the public health sector can get more involved in securing EU Structural Funds for reducing health inequalities.

²⁸ Council conclusions: Towards modern, responsive and sustainable health systems. 3095th Employment, Social policy, Health and Consumer Affairs; Council meeting - Health issues - Luxembourg, 6 June 2011
http://www.consilium.europa.eu/uedocs/cms_data/docs/pressdata/en/lsa/122395.pdf

II. EU COHESION POLICY AND EU STRUCTURAL FUNDS

The Structural Funds, invested during a period of seven years, were together worth €347 billion during the 2007-2013 programming period, or 35.7% of the total EU budget. In the upcoming 2014-2020 period, Cohesion Policy will receive approximately €325 billion, or 34% of the total EU budget.²⁹ The Structural Funds and the Cohesion Fund represent one of the largest budget items of the European Union, currently only slightly behind expenditures on the Common Agricultural Policy (CAP).

All European regions are eligible for funding, but the poorer regions receive most of the support. Over 80% of the overall funding has been allocated to less developed regions in Europe during the 2007-2013 period. The funding can be used for projects and programmes that, for example, support job creation and competitiveness, improve quality of life, and for sustainable development. Structural Funds have therefore been spent on improving transport and internet links in regions, boosting small and medium-sized enterprises in disadvantaged areas, developing new products and production methods, investing in a cleaner environment and improving education and skills.

In many of the EU's relatively poorer regions, Structural Funds represent a large proportion of their overall development budget. In Hungary, for example, 75% of the funds available for nation-wide development currently derive from Structural Funds.³⁰ In the 'less developed' or 'transition' regions of Europe (see below) Structural Funds can therefore have an enormous impact on the nature of development in these countries and regions.

Box 2

The history of EU Cohesion Policy

The principle of solidarity between European regions can be traced back to the Treaty of Rome (1957) which established the European Economic Community (EEC), but the use of initiatives and financial instruments was only applied on an ad-hoc basis during the 1960s and 1970s. The legal basis for a Cohesion Policy was first introduced in the Single European Act in 1986, closely followed by the adoption of the first regulation in 1988 for Cohesion Policy for the period 1989-1993. Cohesion Policy has continued to be implemented through a series of programming periods which has seen an increase in both its size and importance. Cohesion Policy and the Structural Funds are reviewed by the EU institutions once every seven years. The next round of programming will be launched in 2014.

²⁹ At the time of writing (October 2013), the EU's Multiannual Financial Framework still had to be agreed by the EU Parliament and Council and these figures could not be confirmed.

³⁰ Comment made by Hungarian Equity Action Partner at 3rd Stakeholder Work Package Meeting, Cologne, 2 May 2013.



A. BRIEF OVERVIEW OF EU COHESION POLICY: 2014-2020

The following provides an introductory overview of the EU Cohesion Policy and Structural Funds for 2014-2020. The main aims of the 2014-2020 Cohesion Policy are to invest in growth and jobs and to stimulate European territorial cooperation. These investments support the delivery of the EU 2020 strategy to promote smart, sustainable and inclusive growth.

Various Structural and Investments Funds have been established for the implementation of EU Cohesion Policy 2014-2020. These include the European Regional Development Fund (ERDF), the European Social Fund (ESF), the Cohesion Fund (CF), the European Agricultural Fund for Rural Development (EAFRD) and the European Maritime and Fisheries Fund (EMFF). Since ERDF and ESF offer most opportunities for the public health sector to address health equity, this report will focus on these two funding programmes.

1. The European Regional Development Fund (ERDF)

The ERDF supports programmes addressing regional development, economic change, enhanced competitiveness and territorial co-operation throughout the EU. Funding priorities include modernising economic structures, creating sustainable jobs and economic growth, research and innovation, environmental protection and risk prevention. Investment in infrastructure also retains an important role, especially in the least-developed regions.

➤ *European Territorial Cooperation*

Some funds within ERDF (around 4.5% of the total ERDF funding during the 2007-2013 period) have been earmarked to promote cooperation between European regions, as well as the development of common solutions for issues such as urban, rural, and coastal development, and improved transport links. The objective applies to all regions of the EU territory. These funds are divided into strands: cross – border cooperation; transnational cooperation; and interregional cooperation.

2. The European Social Fund (ESF)

The ESF focuses on four key areas: increasing the adaptability of workers and enterprises, enhancing access to employment and participation in the labour market, reinforcing social inclusion by combating discrimination and facilitating access to the labour market for disadvantaged people, and promoting partnerships for reform in the fields of employment and inclusion.

While the general architecture is similar to that of the 2007-2014 Cohesion Policy, Figure 2 reflects how these have been revised and how the objectives of the Funds have been simplified (these were formally Convergence, Competitiveness and Employment and European Cooperation), to reinforce the strategic dimension of the policies.

Figure 2: Cohesion Policy Architecture

COHESION POLICY ARCHITECTURE				
2007-2013		2014-2020		
Objectives		Goals	Category of regions	Funds
Convergence	ERDF ESF	Investment in Growth and Jobs	Less developed regions	ERDF ESF
Convergence phasing out			Transition regions	
Regional Competitiveness and Employment Phasing in				
	Cohesion Fund			Cohesion Fund
Regional Competitiveness and Employment	ERDF ESF		More developed regions	ERDF ESF
European Territorial Cooperation	ERDF	European Territorial Cooperation		ERDF

A region's Gross Domestic Product (GDP) vis-à-vis the EU average, determines the category a region belongs to and therefore the amount of Structural Funds that they can receive (figure 3). For the 2014-2020 programming period, regions can fall into one of **three main categories of recipients**:

1. 'Less developed' regions

These are regions where GDP per capita is below 75% of the EU average. Regions in this category, which covers 119.2m people, will continue to be a high priority for Cohesion Policy and will benefit from significant support from the Structural Funds.

2. 'Transition' regions

These are regions, covering 72.4m people, where GDP per capita is between 75% and 90% of the EU average. This is a new category designed to provide an extra boost to regions that have become more competitive in recent years but that could still benefit from targeted investment. It has been introduced with a view to replacing the 'phasing – in' and 'phasing – out' system that existed under the 2007 – 2013 programming period.

3. 'More developed' regions

These are regions where GDP per capita is above 90% of the average. This category covers 307m people.

Figure 4 provides an overview of the budget (broken down) for 2014-2020 Cohesion Policy.

Figure 3: Three categories of European regions (Source: DG Regional Policy – InfoREGIO)

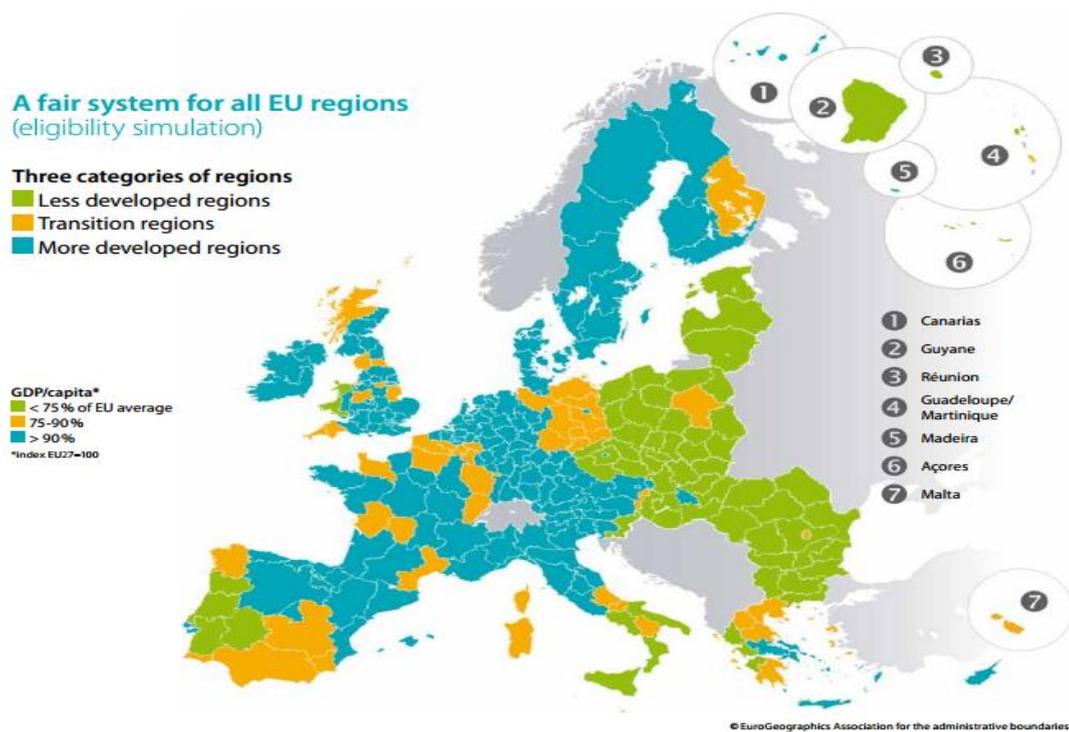
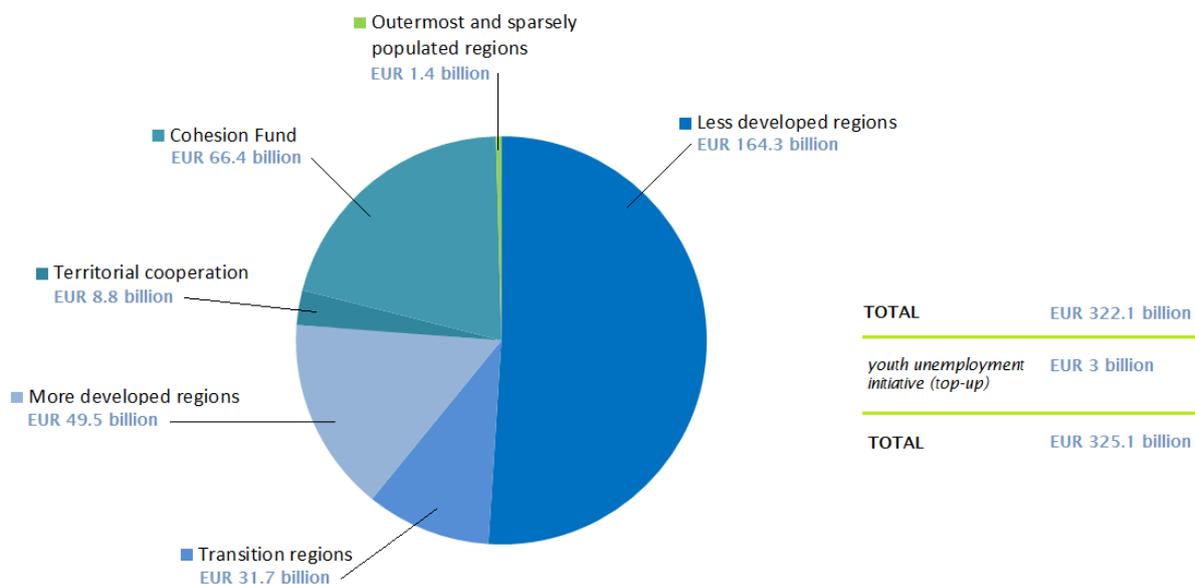


Figure 4: Budget for Cohesion Policy 2014-2020³¹



Structural Fund support always involves co-financing. Structural Fund programmes in regions with a capita GDP below 75% of the EU average can receive up to 85% of the total funding, while the more developed regions in Europe (with a GDP per capita above 90%) will receive a co-financing of 50%. All cofounded initiatives must comply with EU legislation, particularly with regard to competition, the environment and public procurement.

³¹ This figure was developed based on a letter from the Commission relating to the list of programmes under the MFF 2014-2020 and indicative breakdown after EC conclusions, and which reflects the political agreement reached between the European Parliament and the Council at the end of June 2013. Ref. Ares(2013)2708589 – 19/07/2013. <http://register.consilium.europa.eu/pdf/en/13/st12/st12602.en13.pdf>

B. HOW IS COHESION POLICY DEVELOPED AND IMPLEMENTED?



The development and implementation of Structural Funds is a shared responsibility between the European Commission (DG Regional Policy and DG Employment, Social Affairs and Inclusion), EU Member States and Regions. Figure 5 provides an overview of the process. This section provides information on the main EU Regulations, establishing the new Cohesion Policy (EU Legislative Package) and highlights the provisions that are most relevant to applying Structural Funds to tackle health inequalities. It will also outline processes and actors involved in the implementation of Structural Funds. Key tips and opportunities for action are provided at relevant points throughout the text for public health professionals that opt to use Structural Funds to address health inequalities.

Please note that at the time of writing this report, the proposals by the European Commission had not yet been adopted by the European Parliament and Council. The information provided is thus subject to change.

Figure 5: Shared management of Structural and Investment Funds 2014-2020



EU Legislative Package

A key milestone in the implementation of the upcoming Cohesion Policy was the European Commission's adoption, on 6 October 2011, of an elaborate draft legislative package that framed EU Cohesion Policy for 2014-2020. The '**Common Provisions Regulation**' (COM (2011) 615 Final)³² sets out the overall direction and the main changes envisaged for the new Cohesion Policy. The Regulation applies to the European Regional Development Fund (ERDF), the European Social Fund (ESF), the Cohesion Fund, the European Agricultural Fund for Rural Development (EAFRD) and the European Maritime and Fisheries Fund (EMFF). Under previous Structural Funds programmes, there were separate guidelines for different Funds, but the Common Provisions Regulation now applies to all of these, in order to simplify Cohesion Policy delivery and to ensure stronger alignment with Europe 2020 and with EU economic governance.

The Common Provisions Regulation establishes a common set of basic rules relating to all Structural Fund instruments. The Commission proposes that the new policy should concentrate funding on a smaller number of priorities that are strongly linked to the Europe 2020 Strategy. The Regulation to this end sets out the eleven thematic objectives of Cohesion Policy and Structural Funds (see Part II, subchapter III), which are strongly linked to the Europe 2020 Strategy.

KEY TIP & OPPORTUNITY FOR ACTION

The new Cohesion Policy is designed to support the implementation of the EU 2020 Strategy for Smart, Sustainable and Inclusive Growth. If the public health sector would like to apply Structural Funds to support its objectives, it is crucial that it is able to demonstrate how health and greater health equity can contribute to the achievement of the EU 2020 objectives. The information included at the start of the report can help to make this case, while subchapter III below elaborates on opportunities for action within the established thematic objectives.

The Regulation also proposes that the new Cohesion Policy focuses on results, increases the use of conditionalities, optimises synergies and efficiency in the use of different EU funding instruments, improves monitoring of progress towards agreed objectives and simplifies delivery and procedures. The Common Provisions Regulation sets out that this latter point will be achieved through a more coherent approach to planning and by simplifying and digitalizing procedures where possible. In addition, the European Commission has specified that the administrative burden for beneficiaries and managing authorities should be significantly reduced.

³² Proposal for a Regulation of the European Parliament and of the Council laying down common provisions on the European Regional Development Fund, the European Social Fund, the Cohesion Fund, the European Agricultural Fund for Rural Development and the European Maritime and Fisheries Fund covered by the Common Strategic Framework and laying down general provisions on the European Regional Development Fund, the European Social Fund and the Cohesion Fund and repealing Regulation (EC) No 1083/2006 - Brussels, 6.10.2011- COM(2011) 615 final <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2011:0615:FIN:EN:PDF> An amended proposal was adopted on 22/04/2013; Brussels, 22.4.2013 - COM(2013) 246 final <http://eur-lex.europa.eu/LexUriServ/LexUriServ.do?uri=COM:2013:0246:FIN:EN:pdf>

OPPORTUNITY FOR ACTION

One of the difficulties in accessing Structural Funds has been that processes of applying for funding and in administering Structural Funds projects and programmes are complex, cumbersome and require specialized knowledge. This has enabled certain sectors that have developed this expertise, to benefit over others, and it has discouraged others, including new actors, from (re) applying. An aim of the new Cohesion Policy is to make it easier for new and relevant actors (like public health) to access the Funds.

The Regulation introduces macroeconomic conditionalities and includes **ex-ante conditionalities**. These are conditions that must be in place before funds are disbursed, to ensure that the effectiveness of EU funding is not undermined by unsound macro-fiscal policies. This includes ensuring that measures that receive Structural Funds contribute to existing government policy frameworks or strategies. Conditionality will also take the form of ex-post conditions that will make the release of additional funds contingent on performance.

Various ex-ante conditionalities have been proposed that are of relevance to public health actors and that could have an impact on reducing health inequalities. The ex-ante conditionalities include thematic conditionalities, such as research and innovation, health, early school leaving, active and healthy ageing, access to employment and Roma inclusion, and horizontal conditionalities, such as anti-discrimination and gender equality. Examples of thematic ex-ante conditionalities can be found below. A (draft) guidance document³³ has been developed by DG REGIO on ex-ante conditionalities to provide a framework for the Commission when assessing the information provided by Member States on the applicability and fulfilment of the conditionalities.

Ex-ante conditionality: HEALTH

Some investments in the health sector supported by the 2007-2013 programming period of the EU Structural Funds failed to achieve the intended objectives and impacts on effective, sustainable and quality healthcare systems. Experience has shown that interventions lacked overall strategic thinking and budgetary planning.

To avoid this in the 2014-2020 programming period, health ex-ante conditionality requests the adoption of a coherent strategic policy and budgetary framework for health. A strategic policy framework is defined as: “a comprehensive document (or set of complementary documents) providing strategic direction and priorities for health care delivery and public health, which is defined and approved by the competent national or regional authorities”. The strategic policy framework may be an annual or multi-annual policy document or a legal act containing programmatic aspects.

³³ European Commission, DG Regional and Urban Policy, Draft Guidance on ex-ante conditionalities – Part II, 12 April 2013 - http://ec.europa.eu/regional_policy/what/future/pdf/preparation/part2_guidance_ex-ante_conditionalities_guidance.pdf

This conditionality needs to be in place in case a Member States selects the following investment priorities:

- ESF: Enhancing access to affordable, sustainable and high-quality services, including health care and social services of general interest
- ERDF: Investing in health and social infrastructure which contribute to national, regional and local development, reducing inequalities in terms of health status, and transition from institutional to community-based services

Ex-ante conditionality: ACTIVE INCLUSION

Due to changing demographics as well as budget constraints as a result of the economic and financial crisis, there is a growing risk of poverty and social and labour market exclusion in many countries. This ex-ante conditionality therefore requires Member States to have a national strategic policy framework in place for poverty reduction, aimed at active inclusion. It should provide a sufficient evidence base to develop policies for poverty reduction and monitor developments and should be in accordance with national poverty and social exclusion targets (as defined in the National Reform Programmes).

The strategic policy framework should also include measures for the shift from institutional to community based care and involve all relevant stakeholders in combating poverty, such as government, education providers, labour market stakeholders, social partners, etc. Community based care refers to a wide range of services, including disease prevention and health promotion, that will enable an individual to live in a community or family environment as opposed to institutions. It includes services such as housing, healthcare, education, employment, culture and leisure, which should be accessible to everyone regardless of the nature of their impairment or the required level of support. It also refers to specialised services, such as personal assistance for persons with disabilities.

This conditionality needs to be in place in case a Member State selects the following investment priorities:

- ESF: Active inclusion
- ERDF: Investing in health and social infrastructure which contribute to national, regional and local development, reducing inequalities in terms of health status, and transition from institutional to community-based services
- ERDF: Support for physical and economic regeneration of deprived urban and rural communities

Ex-ante conditionality: ROMA INCLUSION

For the 2014-2020 period, investment priorities have been set to benefit the Roma communities. An ex ante conditionality has been proposed that requires Member State to show that strategies or policy measures on Roma inclusion are in place, appropriate and under implementation. This will ensure that ESF and ERDF funds are efficiently invested, better targeted and contribute more effectively to the implementation of the National Roma Integration Strategies.

The strategy or policy measures on Roma inclusion should set achievable national goals for Roma integration (addressing goals relating to access to education, employment, healthcare and housing)

to bridge the gap with the general population. The strategy or policy measures should also identify those disadvantaged micro-regions or segregated neighbourhoods where communities are most deprived, by using already available socio-economic and territorial indicators such as very low educational level and long-term unemployment. Finally, they should include strong monitoring methods to evaluate the impact of Roma integration actions and they should be designed, implemented and monitored in close cooperation with Roma civil society, regional and local authorities.

This conditionality needs to be in place in case a Member States selects the following investment priorities:

- ESF: Integration of marginalised communities such as the Roma
- ERDF: Investing in health and social infrastructure which contribute to national, regional and local development, reducing inequalities in terms of health status, and transition from institutional to community-based services
- ERDF: Support for physical and economic regeneration of deprived urban and rural communities

KEY TIP

The focus on ex-ante conditionality means that countries and regions should have policy strategies or frameworks in place on health inequalities and/or that include the reduction of health inequalities as an objective. Reducing health inequalities should therefore be a specific objective in existing (health) policy frameworks or strategies. In addition, health inequalities should be incorporated into the policy frameworks or strategies of other sectors, like those relating to Active Inclusion, Sustainable Development or Transport. This will make it easier to apply Structural Funds to initiatives that aim to reduce health inequalities and to collaborate with other sectors to achieve this objective.

OPPORTUNITY FOR ACTION

The European Commission is particularly committed to supporting Member States on Roma integration strategies. Structural Funds have also been earmarked for this purpose. Public health professionals should explore existing opportunities to develop initiatives that promote health amongst the Roma population and to incorporate public health and health promotion dimensions into wider initiatives that address this target group.

The CPR establishes that for the upcoming funding period, Structural Fund programmes in EU Member States will be allowed to combine objectives and spending from different funding streams (e.g ESF and ERDF) to allow more flexibility in achieving results and to maximize the effects of spending. The Regulation proposes a number of mechanisms to encourage integrated approaches to programming, to achieve coordination and synergies during implementation.

The Common Provisions Regulation also strengthens the European Social Fund:

- Each category of regions must spend a minimum of the overall funds that they receive on ESF priorities (at least 25% for less-developed regions, 40% for transition regions and 52% for more-developed ones). This share of funding corresponds to at least €84 billion for the ESF budget, compared €75 billion that was available for ESF funds during the 2007-2014 period;

- There is a greater emphasis on combating youth unemployment, promoting active and healthy ageing, and supporting most disadvantaged groups and marginalised communities such as Roma;
- More support will be provided for social innovation, i.e. testing and scaling up innovative solutions to address social needs – for example, improving social inclusion;
- Greater participation by social partners and civil society in implementing ESF activities;
- Equipment linked to investments in social and human capital will become eligible for support from the ESF – for example, computers for schools;
- A minimum share of 20% of the ESF should be dedicated to social inclusion actions.

OPPORTUNITY FOR ACTION

The fact that a minimum of 25% of Structural Funds must be spent on ESF programmes and at least 20% of this ESF spending must be spent on social inclusion is a big opportunity for the public health sector to get more engaged. ESF funding should be spent on generating employment opportunities, promoting education and lifelong learning, enhancing social inclusion, combating poverty, and improving the capacity of public administrations to serve citizens and job-seekers better. These are all objectives that are strongly linked to tackling health inequalities.

The public health sector should in particular identify how they can strengthen health promotion components in ESF projects and programmes, such as those employment activation programmes. See Part 2, subchapter IV for specific examples.

Common Strategic Framework (EU level)

Following the Cohesion Policy legislative proposals, the Commission presented in March 2012 the "**Common Strategic Framework**" (CSF)³⁴, which provides Member States with more strategic direction on how to develop national and regional programmes that address their specific needs, while meeting the objectives of Cohesion Policy. In addition to providing guidance on how Member States should establish their strategic priorities, it provides guidance on e.g. how Structural Funds and other EU policies and instruments can be coordinated, horizontal principles and cross-cutting policy objectives and on arrangements to address territorial challenges.

To help EU Member States and regions identify what strategic priorities they should focus on, and how these can be funded, the Common Strategic Framework details how each of the eleven **thematic priorities** identified in the Common Provisions Regulation (see Part II, subchapter III) relate to the Europe 2020 targets and policy objectives. It also sets out the main actions for each Fund. **ESF** will for example support the following four thematic priorities (TP): employment and labour mobility (TP8); education, skills and lifelong learning (TP 10); promoting social inclusion and combating poverty (TP 9) and administrative capacity building (TP 11). **ERDF** will in turn contribute to all thematic priorities and focus on areas of investment linked to the context in which firms operate (e.g. infrastructure, support for business, innovation, ICT and research) and to the provision of services to citizens in certain areas (energy, on-line services, education, health, social and research infrastructures, accessibility, quality of the environment).

KEY TIP & OPPORTUNITY FOR ACTION

Thematic priority eleven relates to Capacity Building. This offers opportunities to build expertise within the public health sector to address the social determinants of health and health inequalities, as reflected in Example 10 (Part II, subchapter IV) of this publication. These funds can for example be applied to build capacities of administrators and public health professionals to monitor health inequalities, incorporate health equity in the design and implementation of programmes and maximize the health equity impacts of initiatives taken within and beyond their sectors.

The Strategic Reference Framework also indicates that a number of challenges faced by regions and Member States cut across national and regional boundaries. Responding to such challenges requires joint, cooperative action and the exchange of knowledge at the appropriate territorial level. This issue is addressed through European territorial cooperation programmes³⁵, which focus in particular on cross-border challenges confronting outermost regions and sparsely populated areas. Annex II of the CSF sets out in detail the areas which should be the focus of territorial cooperation activities.

³⁴ Commission Staff Working Document: Elements for a Common Strategic Framework 2014 to 2020, Part I - Brussels, 14.3.2012 - SWD(2012) 61 final
http://ec.europa.eu/regional_policy/sources/docoffic/working/strategic_framework/csf_part1_en.pdf and Commission Staff Working Document: Elements for a Common Strategic Framework 2014 to 2020, Part II - Brussels, 14.3.2012 - SWD(2012) 61 final
http://ec.europa.eu/regional_policy/sources/docoffic/working/strategic_framework/csf_part2_en.pdf

³⁵ http://ec.europa.eu/regional_policy/cooperate/cooperation/index_en.cfm

KEY TIP

Actors that would like to apply for Structural Funds in their countries should look carefully at Annex I of the Common Strategic Framework to get a better understanding of what type of actions will be eligible for funding. If they have an idea for a project or programme in mind for funding, they should identify what funding priorities have been established in their country's Partnership Agreements (see below), and how these have been elaborated into Operational Programmes (see below).

The CSF also calls on Member States to identify priority areas for funding on the basis of economic priorities and recommendations developed annually at the EU level. Each Spring, Member States present their **National Reform Programmes** (NRPs), outlining what policy measures they will take to address EU policy priorities to boost growth and jobs and reach national targets set in relation to broad economic targets established at EU level.

On the basis of these NRPs, the Commission proposes **country-specific recommendations**³⁶ (CSRs). These cover a broad range of topics such as: measures to create jobs and to fight unemployment, pension system reforms, education and reforms of healthcare systems. The latter includes recommendations to improve cost-effectiveness of healthcare systems, shift from institutional to home care, improve access to primary care, provide coverage to disadvantaged groups, and place greater emphasis on prevention and independent living.

The CSRs are relevant to the Structural Funds as they reflect deep underlying structural challenges that need to be addressed in each EU Member State. The Structural Funds should be used to support measures outlined by the country-specific recommendations to bring about necessary structural change and address gaps in relation to the Europe 2020 headline targets.

KEY TIP

Public health actors that are interested in applying for Structural Funds should familiarize themselves with the Country Specific Recommendations issued for their Member State. They should formulate how projects or programmes that they would like to develop could address specific recommendations and help bring about the recommended change.

The CSF also focuses on mechanisms to achieve cross-sector coordination and encourage potential synergies between funding programmes, in order to maximise efficiencies while reducing administrative burdens for applicants and beneficiaries. It calls for Member States to:

- Identify areas of intervention where the Funds can work together in a complementary manner to achieve the thematic objectives set out in the proposed Common Provisions Regulation. This can be achieved by close coordination of mono-fund programmes to ensure they are complementary and aim to achieve common objectives, or Member States can prepare and implement multi-fund programmes combining the ERDF, ESF and the Cohesion Fund in a single programme;

³⁶ Country-specific recommendations 2013: <http://ec.europa.eu/europe2020/making-it-happen/country-specific-recommendations/>

- Involve relevant ministries and managing authorities in the development of support schemes to ensure synergies and avoid overlaps;
- Establish joint monitoring committees and management and control arrangements;
- Make greater use of joint eGovernance solutions and "one-stop shops" to reduce the administrative burden for beneficiaries.

It also elaborates on how Member States can promote integrated approaches to territorial development. Beyond economic and social cohesion, the Lisbon Treaty stresses the importance of territorial cohesion and the necessity to address the role of cities and sub-regional regions facing specific geographical and demographic problems. The CSF therefore proposes two new mechanisms to help facilitate this. The first is **Community Led Local Development**, which delegates decision-making and implementation to a local partnership of public, private and civil society actors and thus allows different structures for to share responsibility for specific programmes. The second is the **Integrated Territorial Investment** mechanism, that enable funding from several priority areas and programmes to be brought together into an integrated investment strategy for a certain territory or investment areas.

OPPORTUNITY FOR ACTION

Community-Led Local Development and the Integrated Territorial Investment mechanisms can offer opportunities for public health actors at the local level to take part in partnerships that aim to regenerate local areas. Public health actors should therefore explore if these instruments can and are being applied in their areas and how to get involved.

Partnership Agreements (Member State level)

Member States will use the Common Strategic Framework as a guide to draft their '**Partnership Agreements**' for the 2014-2020 programming period, which set out priorities and approaches at national and regional level. The contracts must be linked to the objectives of the Europe 2020 Strategy and the National Reform Programmes and provide a framework for close coordination.

The Common Provision Regulation places a strong emphasis on the 'partnership' component in the development of Partnership Agreements. The Regulation states that:

“For the Partnership Agreement and each programme respectively, a Member State should organise a partnership with representatives of competent regional, local and other public authorities, economic and social partners, and bodies representing civil society, including environmental partners, non-governmental organisations, and bodies responsible for promoting equality and non-discrimination. The purpose of such a partnership is to respect the principle of multi-level governance, ensure the ownership of planned interventions by stakeholders and build on the experience and know-how of relevant actors”

The Regulation also states that partners should be involved in the preparation, implementation, monitoring and evaluation of Partnership Agreements and programmes in a consistent manner.

KEY TIP & OPPORTUNITY FOR ACTION

The CPR provides a clear mandate for public health professionals at all levels to get involved in the development, implementation, monitoring and evaluation of the Partnership Agreements. It is therefore important that public health professionals become involved in these processes to ensure that public health interests and objectives are adequately represented in the Contracts and in Structural Fund programmes.

At the time of writing, in many Member States, Partnership Agreements and Operational Programmes are in the process of being finalized. Numerous Equity Action partners engaged in these preparation processes, although in many Member States, there is much room for improvement in relation to participation from the public health sector. Once Partnership Agreements and Operational Programmes have been established, it is still possible for public health actors to get involved by identifying opportunities available within established programmes, and by monitoring implementation and outcomes of spending with a view to impacts of these programmes on public health and health inequalities.

Each Partnership Agreement will be agreed between the Commission and the individual EU country, bringing together all the country's commitments to delivering European objectives and targets. The Partnership Agreement will include a Performance Framework that includes clear and measurable targets. According to Common Provisions Regulation, Member States must, in their Partnership Agreements, set out the following:

- Arrangements to ensure alignment with the EU 2020 Strategy, including an analysis of disparities and development needs with reference to the thematic objectives, the CSF, the targets set in the EU's country specific recommendations, and for each of the thematic objectives, a summary of the main results expected from each of the Funds;

- An integrated approach to territorial development supported by the Funds;
- An integrated approach to address the specific needs of geographical areas most affected by poverty or target groups at highest risk of discrimination or exclusion, with special regard to marginalized communities, including indicative financial allocation for the relevant Funds;
- Arrangements to ensure effective implementation, including e.g. a consolidated table of milestones and targets established in programmes for the Performance Framework, together with the methodology and mechanisms to ensure consistency across programmes and Funds.
- Arrangements to ensure efficient implementation of the Funds, including e.g. an assessment of whether there is a need to reinforce the administrative capacity of authorities and, where appropriate, beneficiaries and actions to be taken for this purpose. Arrangements must also include a summary of the actions planned to achieve a reduction in the administrative burden for beneficiaries.

Many Structural Fund investments have in the past been made in wealthier parts of deprived regions. The EU is therefore pushing for a voluntary process of **poverty mapping** to identify localities that are most deprived. As set out in the requirements for Partnership Agreements, and elaborated upon in the latest Commission Communication on “Strengthening the Social Dimension of the Economic and Monetary Union”³⁷, Member States will be expected to provide a comprehensive view of how the poorest groups in society will be targeted by the Structural Funds. It is up to Member States to determine what groups in their societies are regarded as ‘marginalized’.

KEY TIP & OPPORTUNITY FOR ACTION

The process of poverty mapping will contribute to the reduction of health inequalities by ensuring that Structural Funds are invested in ways that benefit the poorest and most vulnerable groups in society, as has often not been the case in practice. Public health authorities should help to ensure this by:

- *Raising awareness of health inequalities amongst particular groups, such as the Roma, undocumented migrants, lesbian or gay communities etc and ensuring that Structural Funds target these groups;*
- *Monitoring to ensure that Structural Funds are indeed reaching the most deprived areas and the most deprived groups within regions.*

³⁷ Communication from the Commission to the European Parliament and the Council: “Strengthening the social dimension of the Economic and monetary Union” – Brussels, 2.10.2013 – COM(2013) 690 provisoire: http://ec.europa.eu/commission_2010-2014/president/news/archives/2013/10/pdf/20131002_1-emu_en.pdf

Operational Programmes (Member State level)

While the overall Cohesion Policy objectives are decided at EU level, management of the Policy takes place at Member State level. On the basis of the priorities identified in Partnership Agreements, National, regional and local governments develop Operational Programmes (OPs) that establish what amount of funding will be spent on which areas for the 2014-2020 programming period, and how this will be managed. EU Member States are free to determine how funds are managed within their constituencies, which means that approaches and structures that have been developed for this purpose differ per country and region in the EU. Member States must however ensure that the ministries and managing authorities responsible for the implementation of funds work closely together in the preparation, implementation, monitoring and evaluation of the Partnership Agreements and Operational Programmes.

Operational Programmes can be based on thematic priorities (e.g. social inclusion, transport) and implemented at the national level, covering different regions, or they can be established at the regional level. Each region in the EU is covered by at least one Operational Programme. Each project that is co-financed through the Structural Funds must fall under the priorities stipulated in an Operational Programme covering the region where the project will be implemented. The Operational Programmes have to be approved by the European Commission before implementation, to ensure that the programmes will contribute to achieving the overall objectives of Cohesion Policy and that they are aligned to the Europe 2020 Strategy.

The website of DG Regional Policy³⁸ provides summaries of the Operational Programmes, available in English, French, German and in the language of the country in question, that have officially been adopted by the European Commission at the beginning of a programming period. These Operational Programmes are financed by the European Regional Development Fund or the Cohesion Fund. The website of DG Employment, Social Affairs and Inclusion³⁹ provides examples of Operational Programmes adopted and financed by the European Social Fund.

³⁸ http://ec.europa.eu/regional_policy/country/prordn/index_en.cfm

³⁹ <http://ec.europa.eu/esf/main.jsp?catId=45&langId=en>

Managing Authority (Member State level)

Member States have several **Managing Authorities** in place that are in charge of administering the Funds and deciding on which individual projects and beneficiaries should receive support. A Managing Authority may be a national ministry, a regional authority, a local council, or another public or private body that has been nominated and approved by a Member State. The Managing Authorities determine how the funds will be spent, in accordance to the Partnership Agreements. Its main attributions are to inform potential beneficiaries, select the projects, and generally monitor implementation.

After the Operational Programmes have been approved by the European Commission, it will pay a 'pre-financing' amount. Once this has happened, the Managing Authority will start with the selection and financing process. Apart from the Managing Authorities, two other bodies are involved. The certification body, which ensures that claims to the European Commission are free of errors, and the audit authority, which ensures that the control and management systems work, and they also check whether the projects comply with EU regulations. Before additional Funds are paid out, authorities will have to demonstrate that satisfactory strategic, regulatory and institutional frameworks are in place to ensure the Funds are used effectively. The release of additional funds will be dependent upon performance.

KEY TIP

Those who want to find out more about the Operational Programmes in place in their country or region, and resulting projects and programmes, should contact their Managing Authorities. The DG REGIO and DG EMPL websites provide contact details of all Managing Authorities per Member State.

III. THEMATIC OBJECTIVES (2014-2020) AND HEALTH EQUITY

EU Member States and Regions must identify how they will invest Structural Funds in ways that are in line with the thematic objectives that have been established for 2014-2020 (see Box 4 below), to help achieve the EU 2020 objectives for Smart, Sustainable and Inclusive Growth. While health is not explicitly mentioned in the headlines of these thematic priorities, there are nevertheless opportunities in all of the thematic areas to promote health and reduce health inequalities. This section will explore and highlight these opportunities.

During the 2007 -2013 Structural Funds programming period, health was identified as a priority intervention area within the ERDF and ESF framework. Health activities were classified as a sub-section within the theme on Social inclusion, Jobs, Education and Training. EUR 5 billion was committed to health, representing 1.5 % of the total Structural Funds. Some of these funds were spent on initiatives relating to e-health, access to services and health promotion, although most went to health care infrastructure projects like building or modernizing hospitals. While there is a need for such investments in many of the less developed regions in EU Member States, it is not always clear if the funds spent on e.g. health infrastructure benefitted vulnerable sectors of the population most and thereby contributed to health equity.

Example 5: Structural Funds spending on health care infrastructure in Latvia



Latvia

During the 2007-2013 programming period, Latvia placed a very high priority on Structural Funds investments in health infrastructure. The proportion of investment in health infrastructure (219.6 million Euro, or 4.6% of the total EU funds received, coming from two Operational Programs: Human resources and Employment (ESF) and Infrastructure and Services (CF/ERDF)) was second highest amongst EU countries. The decision to invest heavily in health infrastructure was made due to the urgent needs in this area. Latvia intended to use the maximum available amount on funds for the renovation and creation of health infrastructure during the 2007 -2014 programming period and to focus on services during the next programming period.

Most health infrastructure investments were spent in the regions around Riga, since this is where all university clinics and hospitals are located. This means that per capital allocation of funds for health infrastructure were highest in these areas, which could undermine health equity by creating greater differences in the availability and quality of health care services between regions.

Under the new 2014-2020 Structural Funds thematic priorities, health is explicitly included in priorities relating to 'Employment' and 'Social Inclusion and Combating Poverty', but no specific budget line has been allocated to this. There is nevertheless much scope for the public health sector to develop projects and programmes within almost all of the thematic priorities that can directly or indirectly impact health equity.

Box 4

Thematic objectives 2014-2020 programming period

1.  Strengthening research, technological development and innovation
2.  Enhancing access to and, use and quality of information and communication technologies
3.  Enhancing the competitiveness of SMEs, the agricultural sector and the fisheries and aquaculture sectors
4.  Supporting the shift towards a low-carbon economy in all sectors
5.  Promoting climate change adaptation and risk prevention and management
6.  Protecting the environment and promoting resource efficiency
7.  Promoting sustainable transport and removing bottlenecks in key network infrastructures
8.  Promoting employment and supporting labour mobility
9.  Promoting Social Inclusion and Combatting Poverty
10.  Education, Skills and Lifelong Learning
11.  Enhancing Institutional Capacity

There are clear links between all of the thematic objectives, public health and health equity, that provide entry points for applying Structural Funds to reduce health inequalities. For developed regions, 80% of ERDF funds must be invested on **Innovation (Thematic Priority [TP] 1)**, **SME support (TP 3)**, **low carbon economy (TP 4)** and **energy efficiency (TP 6)**, since these are closely related to the achievement of the EU 2020 objectives. Less developed regions must spend 50% of ERDF funds on these priorities. This means that it is important to identify and build on the links between these thematic priorities and health equity.



The thematic priority on **research, technological development and innovation (TP 1)** can be closely linked to all other thematic priorities, and the public health and health promotion sectors must identify where more knowledge is needed to achieve the objectives of other thematic priorities in ways that also improve health and health equity. The European Commission encourages linkages between initiatives funded under this priority and other EU funding programmes, such as the Horizon 2020, which includes 'Inclusive, innovative and secure societies' as a funding area. ESF and ERDF funds can be used to improve research capacities and promote transnational networking between education institutes as well as between education, business and research.



SME's are a key driver of growth, job creation and cohesion in EU regions, providing two out of three private sector jobs and contributing to 58% of the total value created by businesses in the EU. They can contribute to greater health equity by generating employment in deprived areas. They can also contribute to health equity by developing innovative products and services that improve access for all to social and health services, a low-carbon economy and resource efficiency. The health sector can get involved by ensuring that strategies, programmes and initiatives to **enhance the competitiveness of SMEs (TP 3)** generate good employment opportunities in deprived areas, while contributing to sustainable development and the social economy.



Initiatives that **support the shift towards a low-carbon society (TP 4) and protect the environment and promote resource efficiency (TP 6)** also promote health. Initiatives that address environmental problems such as indoor and outdoor air pollution, poor water quality, poor sanitation and the release of hazardous chemicals can contribute to the reduction of respiratory and cardiovascular diseases, cancer, asthma, allergies and reproductive and neurodevelopmental disorders. People in low income groups are most likely to suffer from the consequences of inefficient use of energy or of environmental degradation, and have the least access to green spaces. The public health and health promotion sector can get involved in this thematic priority by ensuring that measures taken in these areas place a special emphasis on the needs of people with lower socio-economic status. They can e.g. undertake initiatives to consider the relationship between socio-economic status and pollution or chemical exposure and make the case for action in deprived areas. Similarly, it is generally vulnerable groups like the poor and older people are likely to be worst affected by the health risks associated with **climate change**, like heat waves and flooding **(TP 5)**.



Enhancing access to and use and quality of information and communication technologies (TP 2) can benefit individuals and health systems by facilitating the provision of e-inclusion, including e-health and/or m-health. Technological innovations in e-health or m-health are receiving increasing attention due to their potential to fill the gaps between the growing demand for health and long-term care, the shortage of health professionals and financial restrictions. Such innovations can radically reshape the way health services are structured and delivered. E-health and m-health developments include e.g. electronic health records, provision of remote healthcare services, health monitoring technologies, behavior supporting technologies, online information resources, and online health communities. While people with low income, older or disabled people as well as those in under-served, remote areas can benefit from such technologies, they tend more often to be sidelined by them. If ICT technologies such as e-health or e-government applications and solutions are not practically influenced by equity considerations, it can increase health inequalities within and between EU Member States. The public health sector can help to ensure that relevant strategies,

programmes and initiatives relating to this priority area also focus on how they can reach and improve the lives of marginalized groups.



Similarly, it is crucial that the public health sector is involved in initiatives that **promote sustainable transport and remove bottlenecks (TP 7)** in key network infrastructure. The public health and health promotion sector should ensure that these promote walking and cycling, and are implemented in ways that maintain air quality and minimize noise pollution and road accidents. They should also ensure that transport related strategies enhance access of more deprived people and communities to services, nutritious food options and employment. People in lower socio-economic groups tend to be most exposed to the negative consequences of transport infrastructure development.



Employment (TP 8) is not only a source of income, it also enables individuals to e.g. achieve fulfillment, structure time and have social contacts. The material constraints and psychosocial stress resulting from a loss of employment affect both the individuals concerned and their families. High levels of employment are important for society as a whole since they lead to productivity, competitiveness and sustainable welfare systems. Employment conditions must however be good, so that they don't undermine physical and mental health. Good health, in turn, is necessary for individuals to attain and maintain employment. The public health sector can therefore contribute to TP8 through initiatives that create new employment opportunities and that promote the physical and mental health of unemployed people, and improve their chances of attaining and remaining in employment. It can in this respect include health promotion elements in employment generating projects led by others, to maximize health-related outcomes. The public health sector can also take part in initiatives to promote healthy workplace conditions, in for example, SMEs.



Initiatives to improve **Education and Training (TP 10)** are linked to thematic priorities on employment and social inclusion, since educational achievements influence access to employment, income, housing and other underlying determinants of health. Education and lifelong learning are important to developing good life-skills and to attaining and maintaining employment as well as to social inclusion and well-being. The health sector can become involved in achieving this thematic priority by, particularly in deprived areas, providing health education in schools and ensuring that school facilities and educational programmes promote health. The public health sector can also help ensure that education and training courses are accessible to low-income and other vulnerable groups like older people and migrants, since this can provide them with life skills, prepare them for employment, and contribute to social inclusion, thereby also reducing health inequalities.



During the Structural Fund programming period for 2014-2020 a strong emphasis is being placed on **Promoting Social Inclusion and Combatting Poverty (TP9)**, as this is also in line with the EU 2020 Objectives. A total of 20% of all European Social Fund (ESF) spending should be spent on promoting social inclusion and combatting poverty which means that developed regions must spend 52% of all their ESF funds on this priority, and transition and less developed regions 40% 25%, respectively. Health, poverty and social inclusion are closely inter-related. Initiatives that promote health can contribute to a reduction in poverty and social inclusion and vice-versa.⁴⁰ The health sector can therefore take part in advancing this thematic priority by instigating or taking part

⁴⁰ See: Stegeman I, Costongs, C. Health, poverty and social inclusion in Europe. Literature review on concepts, relations and solutions. EuroHealthNet. September 2003, and Stegeman I, Costongs, C. Promoting Social Inclusion and Tackling Health Inequalities in Europe, an overview of good practices from the health field. EuroHealthNet, December 2004.

in initiatives that promote social inclusion of marginalized groups like those on low income, migrants or older people. It can also take part in regeneration projects, to maximize the health benefits of e.g. housing and planning initiatives, and stimulate initiatives that enhance social capital, which has been linked to stronger health equity outcomes.⁴¹ The public health sector can also take forward this priority area by establishing low threshold one-stop community centers for health and social services.



The thematic priority on **Enhancing institutional capacity and efficient public administration** (TP 11) offers opportunities to co- fund initiatives that aim at better regulation and good governance, as well as capacity building for stakeholders delivering health, education and social policies at national, regional and local government. The public health sector can use this opportunity to encourage whole-of-government approaches to ensuring health equity in all policies. It can also organize training for public health staff on health inequalities strategies, and build institutional capacities to address health inequalities within and beyond the health sector by for example improving skills to measure health inequalities and assess the health equity impacts of policy measures.

⁴¹ See e.g.: Putland C. et al. Enabling pathways to health equity: developing a framework for implementing social capital in practice. *BMC Public Health* 2013, 13:517.

IV. OUTCOMES EQUITY ACTION SF REVIEWS

Despite these opportunities, the public health sector has to date played a marginal role in Cohesion Policy and in the application of EU Structural Funds. National, regional and local partners involved in the Equity Action Regional Network therefore conducted a Review within their country to assess if and how the Structural Funds are currently being used to address health inequalities. They identified concrete examples of projects or programmes that received Structural Funds that could (in)directly contribute to health equity, and provided examples of governance structures that could support the use of Structural Funds for health equity.

As the next Structural Funds programming period will kick off in 2014, negotiations are on-going between Member States and the European Commission to define priorities and programmes. Various partners of the Equity Action Regional Network got involved in these preparations, and undertook actions and initiatives to influence processes and to raise awareness of the potential of Structural Funds to address health inequalities. A number of partners also developed ideas for new project proposals that could be funded under the 2014-2020 programming period. Outcomes of the Structural Funds Reviews are described below.



A. SYSTEMATIC APPROACHES

a) Health (equity) as a selection and evaluation criteria / a cross-cutting SF theme

The most effective way to ensure Structural Funds contribute to greater health equity would be to make health equity a selection as well as an evaluation criterion for all projects and programmes that receive Structural Funds. A first step is for national and regional governments to recognise health as a means as well as an end to development, as is the case in Italy's Structural Fund programming plans:

Example 6: Health as a cross-cutting theme in Italy's Regional development and SF Programming



Italy

Italy's National Strategic Reference Framework for 2007-2013 recognizes that promoting health is key to the development of the country. It has identified health, quality of life and physical, mental and social well-being as a principle that runs transversally through the conceptual model of regional policy. The National Strategic Framework states that "increasing the well-being and health of citizens ... must take on uttermost importance and become the ultimate measure of the political and social comparisons of regional policy".

All of the operating plans of the southern regions include references to the importance of promoting the health of the population. Improving mental and physical well-being is not an independent item in the various documents that define the areas to be financed by Cohesion Policy – but are scattered throughout priority areas identified by the OPs of each region.

Although Italy has identified health as a key principle that runs transversally through regional policy, it has not gone so far as to translate this theory into practice by making ‘impact on health and health equity’ a criterion for the selection and evaluation of measures that receive Structural Funds. Public health advocates at EU level called for this in EU level Consultation processes relating the development of the 2014-2020 Cohesion Policy Guidelines, but this was not taken up. There are however still opportunities to make the impact on health inequalities a selection and evaluation criteria for Structural Fund spending at national or regional level. The Scottish Equity Action Regional Network partners for example encouraged key partners in health, government (local and national) and the third sector to advocate for this.

Another systematic approach, which is closely related to this, would be to include health and health equity as a cross-cutting theme across Structural Funds Programmes. This implies considering health equity impacts not just at the outset and at the end of projects, but also during project and programme implementation, so that they would be screened for unintended consequences that might actually increase health inequalities. Efforts to include health as a cross-cutting theme were made by ESF managing authorities in London:

Example 7: Health as a cross-cutting theme in London ESF programme: an opportunity found and lost



England

Health was introduced as a cross-cutting theme in the London ESF Programme (2007-2013), alongside equal opportunities and sustainability. This happened because the management of Structural Funds in London prior to 2007 sat with the Mayor, who also had a statutory duty to reduce health inequalities in the region. In addition, the London Development Agency (LDA) was the lead for health for all the Regional Development Authorities (RDAs) that managed ESF Programmes across the country.

These structures were however decentralised, which meant that five co-financing bodies in London became responsible for ESF funding. These bodies all had different approaches and lacked awareness of health as a cross-cutting theme. With no pressure from above to implement the cross-cutting theme, and with a lack of understanding of how tackling the underlying SDH could influence job and training outcomes (even amongst those with a health background), this opportunity was lost.

This situation could have been avoided if people within co-financing agencies had been identified as “champions” for the cross-cutting theme, and basic “understanding health improvement” training had been provided for both co-financers and prospective delivery agencies to increase awareness of how the wider determinants of health operate.

A manual entitled “The Health as a Cross Cutting Theme Guidance and Performance Management Framework for ESF Providers” was developed as a part of this process and can be a useful resource to implement this approach. The manual is available on the Structural Funds Tool Kit (www.fundsforhealth.eu), under the ‘resources’ section.

Introducing health equity as a selection and evaluation criteria as well as a cross-cutting theme calls for stronger capacities to implement this by the public health sector and amongst Structural Funds Managing authorities. Managing authorities and perspective project delivery agencies must have access to public health expertise to increase awareness of how the wider determinants of health

operate and about health inequalities. The examples from Italy and England reflect that any efforts to introduce health equity as a transversal theme in Structural Fund programming at national and regional level must be coupled with strong capacities and support programmes to implement this practice, or it will become everybody's, and thereby nobodies, responsibility.

Cross-cutting themes like Sustainable Development, Equal Opportunities and Environmental Sustainability can also be used to advance the well-being agenda, since health is integral to these themes. The Structural Funds Review report from Wales indicates that the Welsh Government for example uses the Sustainable Development Integration Tool (Creating Sustainable Places) to assess initiatives that could receive Structural Funds. The Tool incorporates social economic and environmental factors including health benefits. Although it is not as thorough as using a health impact assessment or health equity impact tool, it can help to demonstrate the potential benefits of a project to health and health equity.

b. Social clauses in procurement procedures

Another cross-cutting approach that could contribute to health equity would be to include social clauses in procurement procedures, so that they stipulate that, for example, local labour, training opportunities and specified goods and services (e.g. social enterprises) be used in the implementation of the project. This would help ensure that any initiatives that received funding are implemented in ways that benefit socially vulnerable groups or individuals, thereby indirectly contributing to health equity. In practice, however, this can be difficult. The Structural Funds Country Report from Wales states that although including social clauses in UK public sector procurement rules is possible, it is difficult to ensure compliance and to penalize for non-compliance. Environmental sustainability requirements seem to be easier to regulate than social clauses.

c. Leveraging existing approaches

The public health sector can also ensure that Structural Funds are applied in ways that reduce health inequalities by ensuring that funds are used to leverage existing regional and local initiatives and strategies relating to this objective. An important exercise for public health authorities is to compare their regional and local development priorities against their Structural Funds Programming priorities and identify how matches can be made. Structural Funds could then be applied to support existing regional objectives relating to health equity, as was done in the “Developing Well-Being in Northern Ostrobothnia” project (see Example 11). The Structural Funds Review reports also included further examples of this.

Example 8: Scottish Community Planning Partnership



Scotland

Community Planning has a statutory basis in Scotland. Community Planning is a process which helps public agencies to work together with the community to plan and deliver better services and to align national, regional, local and neighbourhood level priorities.

The Scottish government decided to use Community Planning Partnerships (CPP) to allocate Structural Funds under the 2007-13 funding period in a strategic manner, so that they would be spent in line with community priorities, which in many cases included the reduction of health inequalities. During this period, Structural Funds were targeted at the 13 most deprived CPP areas, identified via the Scottish Index of Multiple Deprivation. An evaluation of this approach concluded that it was successful since it allowed for local variation to meet local need and led to numerous examples of good practice. Some of the benefits identified were that it enabled spending to be matched with that for mainstream services, ensuring sustainability. It also ensured local political sign up, since local elected representatives were a part of these processes too.

Example 9: Welsh mapping of regional and local health related priorities against SF priorities



Wales

As part of their Welsh Structural Funds Review, participating local authorities in Wales mapped their local Health Board priorities as well as their Regional partners' desired health outcomes and identified how these could be matched against Structural Fund thematic priorities relating to Educational Skills and Employment: (1) Children and young people are safe, healthy and equipped for adulthood; (2) Working age adults enjoy healthy and happy lives for longer; (3) Older people age well into their retirement; (4) Reduce smoking prevalence; (5) Increase participation rates in physical activity and reduce unhealthy eating; (6) Improve mental wellbeing; (7) Stop the growth in harm from alcohol and drugs; (8) Improve health at work; (9) Reduce health inequities.

They found that these could be financed through the following Structural Funds priorities:

Educational Skills and Lifelong Learning

Use Structural Funds to e.g:

- Reduce smoking prevalence, through educational interventions to ensure people are aware of the harms of smoking and know how to get support to stop smoking;
- Provide people with the knowledge, skills and support to increase their physical activity levels and improve their eating habits;
- Improve mental well-being, which is important to educational attainment;
- Reduce alcohol and drug misuse, to reduce absenteeism, poor attainment and anti-social behaviour and improve educational outcomes.

Wales (continued)

Use Structural Funds to e.g.:

- Reduce smoking, alcohol and substance misuse since these can act as deterrents to employment;
- Increase levels of physical activity and reduce unhealthy eating to avoid the onset of chronic disease and help individuals attain and maintain employment;
- Improve mental well-being, to help individuals attain and maintain employment.

The examples above reflect systematic approaches that can be applied by the public health sector and national and regional Managing Authorities to ensure that more Structural Funds contribute to a reduction of health inequalities. Although there is much promise in these strategic approaches, Structural Funds Regional reports suggest that these are only being employed, to some degree, in the UK and Finland.



B. PROJECTS AND PROGRAMMES

Structural Funds can be used to co-finance specific projects and programmes that are directly designed to reduce health inequalities, or that do so indirectly, by addressing underlying determinants of health. Structural Funds Review reports included many examples of initiatives that could lead to a reduction of health inequalities that were either led by the health sector, that were led by other sectors but with health sector involvement, or that had no health sector involvement at all. In the latter categories of projects and programmes, there appears to be potential for even greater collaboration between the health and other sectors to enhance the health impacts of these initiatives.

a) Specifically focused on reducing health inequalities

The Structural Funds Review reports included two examples of initiatives that received Structural Funds that specifically focused on the reduction of health inequalities.

Example 10: Strengthening capacities to assess impact of health & social interventions across gradient



Italy

The POAT Salute refers to the “Plan for Re-organisation and Capacity Building” of Southern Italy’s health-care systems. The Plan, which has received Structural Funds co-financing since 2010, does not focus on health infrastructure, but on addressing deficits in knowledge and skills that limit the health-systems range of action and effectiveness. This includes strengthening the capacities of the public administration to cope with social inequalities in health, and promoting a series of technical assistance interventions aimed at increasing technical and specialist skills on this topic.

Italy (continued)

The A.T.S.E.SI project in Sicily for example focused on the implementation of pilot projects that aim to strengthen health-authorities' capacities to implement action to tackle social inequalities in health, to evaluate interventions and their impact on different socio-economic groups, and to apply the equity lens systematically in health programming.

These interventions are a part of the overall "Re-organisation and Capacity Building" Plan (11 million Euro) that the Ministry of Health presented to the Department of Public Administration under the National Governance and Technical Assistance Programme, which enables administrations to apply for technical assistance to take forward the objectives of Cohesion Policy. Regions can tailor these funds to their specific needs in this area.

Example 11: Regional Welfare Programme in Finland



Finland

The 'Developing Well-Being in Northern Ostrobothnia' project, which ran from 2008 to 2011, aimed to take forward health equity related objectives in the Region's Welfare Programme. Welfare is one of the leading themes of Northern Ostrobothnia's Regional Programme. The primary focus of the Welfare Programme is on promoting health and reducing health inequalities and preventing social exclusion. The Programme runs for ten years (2008–2017), and is divided into three implementation terms.

The objective of the 'Developing Well-Being' project was 'to implement and incorporate the Northern Ostrobothnia Welfare Programme into the daily functioning of the region'. The Welfare Programme and the project stemmed from an observation that Northern Ostrobothnia was highly polarised both externally (disease rate 1.4 times that of the national average) and internally and that the populations' needs for services were changing. New solutions and operating models were required to meet the needs of citizens and areas.

In addition, there was agreement in the region that priority must be given to preventive work and early support. A lack of resources however meant that corrective treatment continued to prevail over out-patient care and prevention. Extensive cooperation between different areas, operators and decision-makers was required to change this situation. One of the key objectives of the 'Developing Well-Being in Northern Ostrobothnia' project was therefore to coordinate extensive, regional and area-level welfare development, actions and projects as well as to encourage network-based cooperation especially between businesses and the public sector with regard to innovative service provision.

The project also helped to integrate numerous national programmes and projects in Northern Ostrobothnia. It focused on both getting health inequalities written into strategies and engaging municipalities and stakeholders in efforts to reduce health inequalities. This provided actors with a mandate to reduce health inequalities.

These provide strong examples of how Structural Funds can be applied to support programmes that reduce health inequalities at the regional level. Neither of these programmes was financed under thematic objectives that mentioned health. Nor were they funded through ESF programmes. They

were co-funded under the 2007 -2013 ERDF Programmes, under thematic priorities relating to ‘Promotion of innovation and networking and strengthening of knowledge structures’ and ‘Re-organisation and Capacity Building’, reflecting again how most of the thematic priorities can provide opportunities to co-fund initiatives in this field.

b) Addressing underlying determinants of health with health sector involvement

Equity Action regional network partners also identified numerous other initiatives receiving Structural Funds that were not specifically designed to reduce health inequalities, but that, by addressing key underlying determinants of health, could contribute to this objective. Under the Structural Funds Programming period 2014-2010 these initiatives related primarily to the thematic priorities (Box 4) on e.g. promoting Employment, Social Inclusion and Combatting Poverty, Education, Sustainable Transport, and Institutional Capacity.

Many of the projects and programmes that were identified targeted young people, particularly those at risk of or that are early school leavers. Various projects also aimed at supporting people in their efforts to enter and/or remain in the labour market, to reduce discrimination and to promote social inclusion. Examples submitted included regeneration projects and programmes that aimed at improving community mental health by increasing the quality of living environments and protecting and providing access to the natural environment. Projects in this latter category also enhanced the opportunity for physical activity.

The following are examples of such projects and programmes with health sector involvement:

Funding Theme: Promoting social inclusion and combating poverty

Example 12: “Hands on experts”



Belgium

This innovative approach involves the employment of “expert with experience in poverty and social exclusion” within federal public services. The initiative employs people experiencing poverty in e.g. hospitals and the justice system to support others in the same situation that must use these systems. The initiative thereby intends to provide a “missing link between the administration and the poorest citizens.”

Between 2008 and 2011, 27 hands on experts worked in different services of the Federal administrations, and helped to sensitize officials to the realities and problems of those facing poverty and social exclusion.

While professionals involved in the services were initially very sceptical, they came to realise the benefits and the initiative has been well evaluated. It was identified as a ‘good practice’ by the European Platform against Poverty and Social Exclusion. The project has received funding through the Federal ESF Programme focusing on Axes 2 ‘career planning, promoting diversity and tackling discrimination’. This pilot lies within the responsibility of the Minister of Social Integration, and has a budget allocation of 2,800,000 Euro.

Example 13: “Multi-Generational Houses II”



Germany

Multi-Generational Houses (MGH) are community centres located in districts with a particular need for development that provide support to disadvantaged groups. The Federal ESF Programme “Multi-Generational Houses II” was launched by the Federal Ministry for Family Affairs, Senior Citizens, Women and Youth at the start of 2012. 450 MGH form part of the Programme II throughout Germany and receive co-financing by the European Social Fund for a period of 3 years.

The MGH in Braunschweig offers health-promotion services (leaflets, brochures and web-pages) and child care and education services, first aid for children, yoga or dancing for adults, counselling and services around nutrition and diet. This MGH receives ESF funds amounting to 120.000 Euro for three years, to match the approximately 175.000 Euro per year that it receives from other funding sources.

Example 14: “Help-at-Home”



Greece

This programme provides support services to older people living at home in Greece, enabling them to care for themselves with the help of their family and social environment and to prevent social exclusion. Older people can therefore avoid having to go into institutionalized care services, which can have a negative impact on their psychological and physical well-being. Priority is given to older people who are dependent, live alone and have a low income. The project was designed by the Ministry of Health and Welfare and is supported through the ESF Funds.

Funding Theme: Promoting employment and supporting labour mobility

Example 15: North London Cluster Programme



England

The North London Cluster programme which received funding through ESF, assists young people aged 14-21 who are at risk of becoming NEET –(Not in Employment, Education or Training). While the main focus of the project is to get people into employment, there is also a strong emphasis on health promotion, since project leaders recognised that good physical and mental health are strongly correlated with individual success in the labour market. Modules were incorporated into the programme to discuss issues like stress, diet and exercise with young people and how they could modify behaviours that undermined their health to improve their overall well-being.

Example 16: “Well-being through Work”



Wales

The “Well-being though Work” project is delivered in partnership between Remploy, Abertawe Bro Morgannwg University Health Board and Public Health Wales and provides early intervention health and employment services aimed at retaining people in work.

The “Peer Mentoring programme” is sponsored by the Welsh Government and has been running across Wales since 2009. Its aim is for participants to achieve economic independence through paid work with support from Peer Mentors, many of whom have suffered from issues like substance misuse themselves.

Example 17: Centre of Teaching and Research for Environment and Health (CERES)



Belgium

This Centre, at the University of Liege, conducts research and provides training courses on Health and Communication and the Environment and Communication. This Centre and the courses are oriented towards helping unemployed people re- enter the labour market. Health inequalities are a central concept in the course focussing on Health (promotion). The programme is managed by the University, but the employment sector and health sector contribute through financial support and advice. The project has been co-financed through ESF since 1987.

Funding Theme: Investing in education, skills and lifelong learning by developing education and training infrastructure

Example 18: “Komm auf Tour”



Germany

The “Komm auf Tour” cooperation between the Federal Centre for Health Education (BZgA), the Federal Employment Agency and respective Ministries of different Lander in Germany helps support youth in secondary education discover their strengths and interests at an early age by giving them guidance and decision-making aids for forthcoming practical training periods in companies, and to learn about vocational options that could await them. It also provides age-appropriate information regarding friendship, sexuality and contraception.

Funding Theme: Urban regeneration and air pollution

Example 19: Valleys Regional Park



Wales

Valleys Regional Park is an extensive regeneration programme of a former coal-mining region incorporating some of the most deprived areas in Wales in South Wales, receiving support through the ERDF, (21.7 million Euros). The Programme aims to transform this area into a visitor destination, and a prime location to live and work due to the high quality environment and opportunities for outdoor recreation, heritage and environmental interpretation. The sponsors included nine local authorities together with environmental bodies and charities.

As part of the implementation of the wider Valleys Regional Park plan, an ongoing subgroup on 'health and well-being' was set up, with the aim of maximising health gain from the various constituent projects and encouraging local residents to access the facilities and activities available. This group included someone from the Public Health Improvement Division within the national government Department of Health and Social Services, and a public health professional attached to a local Health Board. The input from the health sector was in terms of advice, with time provided free of charge as part of a general professional duty to improve population health. However, because of the directions around the various funding sources, health benefits have never been considered in as much detail as some of the other perceived benefits. This means that while the project has benefitted health in the area, its potential in this respect has not been maximised.

One of the initial health aspirations of the programme for example was to promote exercise in the natural environment as an alternative to drug therapy. This has been difficult to take forwards because of difficulties in engagement with the health sector on a broad and systematic enough scale. An unforeseen spin off from the programme however is that there is now a postgraduate student from a local University working with a variety of groups newly engaged in walking clubs, conservation and horticultural activities to study the physiological effects of such activities as a PhD thesis.

The Structural Fund Regional reviews contained fewer examples of projects or programmes with public health involvement in initiatives relating to thematic priorities on research, access to information and communication technologies and climate change (Box 4). There are nevertheless many ways the public health sector can contribute to the achievement of these thematic objectives, while also contributing to greater health equity. The following example from England reflects how Structural Funds were used by the health sector to stimulate the development of innovative products to help the sector while also benefitting disadvantaged people:

Example 20: Health Enterprise East



England

“Health Enterprise East” in the East of England, is an organization that was set up to provide feasibility and start-up costs for small to medium sized companies to develop products that would help the National Health Services (NHS) be more efficient. It was established to help accelerate the uptake of innovative MedTech products and services that improve the quality of healthcare delivery, and support the development of innovative new products and services to meet the needs of the NHS. The project was run from 2009-2013 and received 1 million Euro through ERDF funding, which was matched by a number of other organisations. Funded projects were selected through two national-level ‘industry challenge competitions’ that were run in 2009 and 2011.

Amongst the companies that received funding by Health Enterprise East was one that developed a product called Outminder, which assisted independent living of people who had suffered e.g. brain injury, stroke, dementia that affected their memory and their ability to remember directions. The initiative generated employment whilst also contributing to well-being and social inclusion of people with disabilities. It thereby also contributed to greater health equity. Another project that received funding for six months aimed to promote physical activity amongst children by enabling them to monitor it through a wrist band and download information at school.

c) Addressing determinants of health without direct health sector involvement

The following are examples of projects and programmes that can indirectly contribute to the reduction of health inequalities. While the health sector was not involved in these projects, there is scope for this in future initiatives that are of a similar nature.

These examples serve to highlight how the public health sector can apply Structural Funds to initiatives that can directly or indirectly reduce health inequalities, and therefore also contribute to the overall Structural Funds objective of reducing economic, social and territorial disparities between the EU’s regions.

Funding Theme: Promoting social inclusion and combating poverty

Example 21: Transnational “Net-Roma” project



Transnational

“Net-Roma” is an inter-regional partnership (co-funded through ERDF) involving nine European countries including Scotland that aims to integrate Roma populations, overcome negative attitudes and improve consultation and engagement with the Roma community.

Funding Theme: Promoting employment and supporting labour mobility

Example 22: Coompanion Gothenburg and the NoLimit Business Centre



Sweden

The “Coompanion Gothenburg” organisation in Sweden operates two separate projects designed to assist people excluded from working life. The company provides information to government authorities, agencies, companies, the entrepreneurial sector and associations about what ‘cooperative companies’, or social enterprises, involve. It thereby aims to encourage them to employ individuals that have been excluded from the labour market, and to support such social enterprises. It also coordinates the ‘NoLimit Business Center’ which employs individuals that have been excluded from the labour market and serves as a model of a sustainable social enterprise.

While the NoLimit Business Centre did not include a specific health-promotion component, efforts were made at the end of the project to assess how it had contributed to people’s health. This reflects the strong link between employment and health and suggests that there is scope in such initiatives for collaboration with health promotion professionals to further enhance the project’s health-related outcomes.

Example 23: Café Bistro with Two Friends



Czech Republic

Café Bistro situated in the region of Hradec Králové, provides young adults with mild mental disabilities with employment opportunities. The Bistro seats approximately 30 people and has a children’s play area and a summer garden, and offers food like baguettes, pancakes and waffles. It also offers snack delivery to schools and businesses. The initiative, managed by the charitable trust called Jump into Life, gives young adults with mental disabilities in the region an opportunity to learn new skills and become more self-sufficient. It runs from 1 December 2011 to 30 November 2013 and received approximately 194,000 Euro from ESF.

Example 23: Three examples of programmes in England



England

- The “Growing Well” organic vegetable farm project in the North West Region of England helps mental health service users to move towards education and employment.
- The Department of Work and Pensions and Job-Center Plus are ESF co-financing agencies that concentrate on projects that deal with multi-generational worklessness in families, trying to get them into employment while also addressing debt, health and housing issues.
- Enabled4Growth (ERDF) in London aims to strengthen the capacity and opportunities for business growth for disabled business owners and to help them secure the funding needed to expand and create more jobs.

V. EXAMPLES OF HOW THE PUBLIC HEALTH SECTOR CAN GET ENGAGED

While Structural Funds offer opportunities to advance and finance public health objectives, the public health sector across Europe faces the challenge of getting involved in an area in which they have little experience. A number of Equity Action Regional partners expressed apprehension at the outset of the Structural Funds Reviews, and feared that they would not advance much. Some indicated that Structural Funds in their countries have traditionally been reserved for specific sectors that have developed expertise and control, making it very difficult for 'new' sectors to access funds. In addition, public health authorities in some of the relatively more developed regions indicated that they saw few opportunities to apply Structural Funds, since their regions get relatively few funds and these seem earmarked for specific sectors. Despite this apprehension, all partners made contact with Structural Funds managing authorities and identified examples of how Structural Funds directly or indirectly contributed to improved health and health equity in their regions and countries. This has provided them with a basis for further action. If no such action is taken, the public health sector will continue to miss the potential opportunities offered by the Structural Funds to advance and finance public health and health equity objectives.

Political structures and policy making processes, which determine how Structural Funds are managed, how funding priorities are established, whether and how these can be influenced, and how they can be secured, differ per Member State. This means that approaches to involvement will also differ per region and Member State. There are nevertheless many ways that public health authorities can get involved, as reflected through the examples below. The following indicate how Equity Action Partners have aimed to influence Structural Funds priority setting processes in their countries and how they raised awareness amongst the public health sector.

Example 24.1: Actions taken to raise awareness and lay the groundwork



England

Representatives from the national Department of Health for England have met with officials from the Department for Business, Innovation and Skills (BIS) who are developing the English proposals for Structural Funds to raise awareness of the opportunities to improve health and tackle health inequalities through the use of Structural Funds. Public Health authorities participated in a National Consultation process on Structural Funds and raised the issue of health and its wider determinants.

There have been discussions with Directors of Public Health (acting locally and regionally) to make them aware of Structural Funds, and the action they can take locally. A briefing paper (made available on www.fundsforhealth) was produced by the Equity Action members for these Directors, making Public Health teams aware of forthcoming consultations on SFs for 2014-2020, and encouraging them to link up with local authority Regeneration and Business departments who will be developing proposals, now that local Public Health teams have been transferred from the NHS to local government.

England (continued)

The English Equity Action members have encouraged and supported Public Health and NHS partners to raise the issue of health as a cross cutting theme at the local and regional level, and to actively influence the content of programmes being developed to maximize health impacts and address the wider determinants of health and health inequalities.

Equity Action Regional partners have in addition, as a result of their work in the context of the programme, been invited to discuss how Structural Funds should be spent in the former six Olympic and Paralympic Host Boroughs (or sub-regions, now called the 'Growth Boroughs') in London. The UK Government announced the national allocation of ESF/ERDF of £748.6 million for London. The Greater London Authority will be responsible for managing the funds, and will in July 2014 present its plans relating to funding priorities and criteria. Stakeholders are being brought together to discuss ideas around this, which currently include using the funding to tackle mental health barriers to employment and promoting mental wellbeing as a theme throughout all programme proposals, as well as using the funds to provide 'in-work' and 'employee assistance' support to SME's. The Equity Action Regional partner from London has been invited to take part in these discussions.

Example 24.2: Actions taken to raise awareness and lay the groundwork



Scotland

Equity Action Regional Network partners in Scotland prepared a briefing note for Directors of Public Health (DsPH) in Scotland outlining how Structural Funds can be used to tackle health inequalities. They followed this up with a presentation on the Equity Action at a meeting between Scotland's Chief Medical Officer and DsPH. At that meeting they encouraged DsPH to respond to the Scottish consultation on the future use of Structural Funds, in order to advocate for the inclusion of health inequalities in, for example, the new selection criteria. In addition, they prepared a briefing note for the Health & Wellbeing Group of the Convention of Scottish Local Authorities (COSLA) outlining how Structural Funds can be used to tackle health inequalities and encouraged the Group to respond to the consultation.

Scottish Equity Action Regional Network partners also met with colleagues from the Scottish Government's Structural Funds Division on several occasions to discuss how reducing health inequalities can contribute to Europe 2020 targets. Finally, they secured agreement from the Scottish Government's Structural Funds Division that a health representative should be included on one of Scotland's Local Development and Social Inclusion Delivery Partnerships.

Example 24.3: Actions taken to raise awareness and lay the groundwork



Poland

Polish Equity Action Regional Network partners participated in ad-hoc working groups organised by the European Funds Departments from the Ministry of Development and the Ministry of Health, on the preparation of the 2014-2020 Structural Funds financing period. The issue of health equity was raised at these meetings and is broadly accepted, laying the groundwork for local authorities to develop and implement actions in this area.

While other Equity Action partners felt less able to try to influence Structural Funds priority setting processes in their countries, they are taking and planning actions to share and build on the learning gained through their Equity Action work. The following examples from the Czech Republic, Latvia, Germany and Italy reflect initiatives to share information, develop relevant contacts and apply learning from the Equity Action to ensure that more Structural Funds are applied to support public health objectives and improve health equity.

Example 25.1: Actions taken to apply and share learning gained through Equity Action work



Czech Republic

Equity Action regional partners from the Hradec Kralove region have found that potential Structural Funds applicants in peripheral border areas of the region do not have sufficient information to submit and implement initiatives that can contribute to the reduction of health inequalities. They will therefore disseminate information suitable for different target groups to inform them about funding opportunities around this issue, as well as specific interesting and inspiring projects that potential applicants could implement and expand.

Equity Action regional partners from the Hradec Kralove region will also organize a regional Conference in early 2014 to introduce and discuss Equity Action outcomes and that will involve site visits to projects financed through Structural Funds. They will, in addition, develop a Web Portal section in the regional website (<http://zdravotnictvi.kr-kralovehradecky.cz>) on “European subsidies for health in the Hradec Kralove Region”.

Example 25.2: Actions taken to apply and share learning gained through Equity Action work



Latvia

Latvian Equity Action partners organized a workshop in April 2013 for Latvian municipalities about the results and recommendations of the Equity Action Project. Representatives of the Ministry of Health provided information about the next programming period and possibilities of the municipalities to get involved in planning.

Example 25.3: Actions taken to apply and share learning gained through Equity Action work



Germany

German Equity Action partners have focused on how BZgA as a federal health education institution could be involved in applying Structural Funds to co-finance its work. In April 2013 BZgA organised a workshop and invited a representative of the European Social Fund (ESF) managing authority at the Federal Ministry of Family Affairs, Senior Citizens, Women and Youth (BMFSFJ) to discuss future perspectives of using the ESF for initiating ESF-funded health promotion projects with an equity lens. A further meeting is envisaged in the second half of 2013.

Example 25.4: Actions taken to apply and share learning gained through Equity Action work



Italy

An interregional technical group, “Equity in Health in the Healthcare Sector” (EES) has been developed in Italy to analyze data and studies on this topic and identifying priorities for action. The final report will contain recommendations and will be submitted to the Italian State-Region Conference, and could represent the basis for a future national strategy. The outcomes of the Equity Action including those relating to Structural Funds can be applied to inform this strategy.

Other partners are developing initiatives that they will propose for funding under the upcoming Structural Funds programming period (2014-2020). The Equity Action partner from the Municipality of Kefallonia in Greece is for example planning to apply for Structural Funds to support the development of a Child Prosperity Alliance:

Example 26: Potential Structural Funds recipient: Child Prosperity Alliance



Greece

What happens in early childhood can have consequences across the life-course, making this a key entry point to reduce health inequalities. Given the lack of holistic approaches integrating health, social and educational services for children in Greece, the Equity Action partner from the Municipality of Kefallonia would like to develop a ‘Child Prosperity Alliance’ to promote and protect the physical and social development of children on the basis of such an approach. The programme will aim to raise awareness of what this requires amongst all key stakeholders and develop the infrastructure to meet these requirements. Key stakeholders involve parents and guardians, teachers and educators, social workers, local political actors and state officials, social researchers and the medical community. The initiative will include open seminars and an intensive media campaign. The initiative would address various thematic priorities relating to Social Inclusion, Education, Capacity Building and ICT and could therefore be covered by the ESF and ERDF.

Two further ideas developed by Equity Action Regional partners for initiatives that involve the public health sector and that could contribute to the reduction of health inequalities are also described on the next page:

Example 27: Community well-being coaches**Wales**

Welsh local authorities envision a potential project involving Community Wellbeing Coaches, based on a pilot that has been running in the region for 12 months. Community Wellbeing Coaches are employed by a community interest company from local communities and are trained to reach those who want to adopt healthier lifestyles, but who have little contact with existing services. The intention is not to create a new service, but to work specifically with those who traditionally do not access services. The proposal is to offer individualised handholding services to support those who do not have the confidence, self-esteem or ability to access existing services alone, and to work with them to ensure successful outcomes. The initiative could fall under the SF priority area of Social Inclusion and Combatting Poverty.

Behaviours are a major cause of ill-health and premature death. By setting personal goals for change and using learning strategies to achieve these, people can develop a greater sense of control and improve both their health and well-being. By targeting those people who would like to change their health related behaviours, but who are 'hard to reach' by existing services, the Community Well-Being Coach has the potential to reduce health inequalities.

Example 28: Preventing unwanted pregnancies among young girls**Latvia**

Teenage pregnancy is a considerable issue in Latvia, where 9% of teenagers get pregnant, and half of these go on to have babies. Many who become young parents are from lower-socio-economic groups and therefore put themselves and their children at further disadvantage. Latvian Regional Network partners would therefore like to develop a proposal to address this issue, which could fall under the SF priority area of Social Inclusion and Combatting Poverty

The project would focus in particular on youth from low-income families, and aim to decrease the number of unwanted births amongst them, and improve their health, by increasing awareness and knowledge about sexual health and providing the necessary support and care services. It would be delivered by and cooperated amongst schools, health care providers, general practitioners and social services and would include, amongst other things, the development of an information package that can be used by lecturers and made available on internet, magazines and social media. The aim is to cooperate with other regions and design an initiative that will become sustainable. .

These examples reflect that all public health actors at national and regional level can take actions that are suited to their contexts to apply (for) Structural Funds to achieve public health goals and improve health equity.

PART 3

Recommendations for public health decision-makers and professionals at EU, national and regional level on how to use SF for health equity

There are many opportunities available in Cohesion Policy and Structural Funds to improve health and reduce health inequalities. The objectives of Cohesion Policy are in fact strongly related to those of improving health and well-being and ensuring that opportunities for health are more equally distributed across the EU.

Where Structural Funds have been spent on health, they have mainly been invested in health care rather than on initiatives to promote health and prevent ill health or on ensuring that opportunities for health are more fairly distributed across populations. This report, which reflects the outcomes of the work of the Equity Action Regional Network, suggests how the public health sector can make greater use of Structural Funds to advance their objectives, by raising awareness, building its own capacities and working with other sectors. The Structural Funds online Guidance Tool for Health Equity www.fundsforhealth.eu has also been developed in this context to help build and exchange knowledge.

The following Recommendations set out more specifically what the public health sector can do to ensure more Structural Funds contribute to health and health equity.

I. TAKE A STRATEGIC APPROACH

Public health decision makers should recognise the potential of Structural Funds to help re-orientate health and social systems to deliver sustainable services that contribute to health equity, and adopt a strategic approach to exploit this potential.

Between 2014-2020 EU Cohesion Policy is likely to receive 325 billion Euros. This means that over a third of the EU-budget will be spent through Structural Funds, making it the second largest EU financing mechanism, closely behind the EU's Common Agricultural Policy (CAP). Structural Funds are a source of public funding that can be used to help finance regional development priorities at a time when funding is scarce.

The EU Common Provisions Regulation includes clear mandates for partners from all sectors and levels to become more involved in identifying national and regional strategic Structural Fund spending priorities and in developing, implementing and monitoring Structural Fund programmes. This provides a clear mandate for greater public health involvement. Section II subchapter II of this report outlines some of the many opportunities that are available, such as those offered by the Social European Fund, the Community Led Local Development Mechanism, and thematic priority eleven on Capacity Building, to apply Structural Funds to improve health equity.

These opportunities can only be maximized if public health professionals do not apply Structural Funds on an ad-hoc and short-term basis. Public health authorities should, rather, adopt a strategic approach to involvement in and the implementation of Cohesion Policy. This includes a strategic approach to building capacities within health systems to exploit the opportunities available to ensure that public health interests, including improvements in levels of health equity, are supported by Structural Funds.

The public health sector must continue to make the moral and economic case for health equity and ensure that it becomes and remains an important element in EU, National and Regional Health Strategies.

To ensure Structural Funds are spent in ways that directly or indirectly promote health equity, it is important to ensure that health equity becomes and remains a political priority. The importance of reducing health inequalities can draw on arguments presented in the first part of this report. Communities with a high level of health that is fairly distributed across the population are more able to generate economic and social development and keep health and social welfare costs sustainable. Progress to achieve higher levels of health equity requires the systematic collection and review of relevant data, coordinated cross-sectoral action at all levels of government and the regular use of tools like Health Impact Assessments (HIA) with an equity focus.

The importance of the new conditionality provisions in the upcoming Structural Fund programme means that the chances that the Funds can be a driver for greater health equity will be much higher if health equity is a strategic objective of health systems, and incorporated into the strategic objectives of other sectors (e.g. social policy, sustainable development, research, ICT, transport, etc).

II. ADVOCATE and RAISE AWARENESS

Public health authorities must raise awareness among themselves of the Structural Funds as a potential co-funding mechanism for initiatives that can promote public health objectives and improve health equity.

Public health professionals at all levels of government must raise awareness among themselves, as well as the wider health sector, of the untapped potential to use the Funds to contribute to public health goals and improve health equity. This can be done through briefing papers, workshops, Conference and events, and presentations to high-level public health officials at national, regional and local level. Part II, Section IV of this report includes examples of how public health officials have raised awareness amongst the public health community in their countries. Briefings and information available from www.health-inequalities.eu, www.fundsforhealth.eu, and www.equityaction.eu can be used to inform and raise awareness.

The public health sector should raise its profile vis-à-vis Structural Fund managers and other sectors, and make the necessary contacts and links

To maximize opportunities to use Structural Funds to improve health and reduce health inequalities, public health professionals at national and regional level must lay the groundwork. Since public health has not traditionally had a strong voice in the development and implementation of Cohesion Policy, it has not been heard in these processes. Many national governments have, since 2012, organised public consultations to identify their national Structural Fund spending priorities.

National, regional and local health authorities should identify how Structural Fund priorities are being developed in their countries and aim to become more involved in these processes. They should advocate for action on health and health equity as a means of fulfilling their country and

regions' Structural Fund programming objectives, and ideally remain informed about developments relating to Structural Funds programmes. They should also strengthen the links between public health and other sectors, by demonstrating to other sectors how they affect public health and health equity and why and how they could cooperate to address this.

Important developments under the 2007-2014 Structural Funds are the emphasis on conditionality provisions and on partnerships across sectors and synergies between initiatives that receive Structural Funds, to maximize their strategic effectiveness. It is therefore important that the public health sector is, where possible, involved in the strategic planning processes of other sectors, to identify linkages between intended initiatives, public health, health inequalities and sustainable development. This can facilitate the public health sector's ability to secure funds for projects and programmes financed through different Operational Programmes that can contribute to health equity.

The public health sector should advocate for systematic approaches to take health inequalities into account.

An ambitious but effective way to ensure that Structural Funds contribute to reducing health inequalities is to make health equity impact a selection criterion for initiatives applying for Structural Funds, and to make it an indicator of successful implementation. Another approach is to include health inequalities as a cross-cutting theme within Structural Funds programmes (See Part II, Section IV of this report). Health inequalities can also be incorporated into concepts like 'social sustainability', which could in turn be a selection or evaluation criteria, or a cross-cutting theme.

III. PREPARE ACTIONS

The public health sector should identify what regions, areas within regions and target groups in their countries have the worst health status and monitor Structural Fund spending to ensure that it is reaching those in need. It should also develop initiatives that can improve the health of those in need, like the Roma.

The public health sector should push for and support efforts of poverty mapping in their countries and regions to ensure that the most deprived localities and target groups are those that benefit from Structural Funds. They can do this by identifying what localities in regions have particularly poor levels of health and should be considered for prioritising, and by exploring how micro-mapping of deprivation (including health-related outcomes as an indicator) is or isn't being used to allocate Structural Funds. Public health actors can also identify which groups in their Member State are considered to be marginalized, and which department is responsible for defining this, to see to what extent this accords with vulnerable and excluded groups from a health perspective. They should then identify and pursue funding opportunities and develop initiatives to improve health status in those regions, micro regions or amongst target groups in their countries in most need.

The European Commission is particularly committed to supporting Member States on national Roma integration strategies. These should include improving access to health services and reducing the

gap in health between the Roma and the general population. Public health officials should therefore identify whether their countries have Roma integration strategies and whether health-related measures are adequately incorporated. Since a significant proportion of ESF funds must be allocated for Roma integration, the public health sector should identify how they can contribute to efforts in this area.

The public health sector should identify opportunities to use Structural Funds to leverage existing regional level priorities and activities that relate to health equity

Structural Funds can be used to co-finance existing or planned regional actions or initiatives that can contribute to greater health equity. Public health authorities should investigate Structural Fund priorities in their countries and regions and compare them to their regional policy priorities in the areas public of e.g. public health, health promotion, equity and social welfare, to identify how they could be used to advance these existing priorities.

Before taking action and developing initiatives for funding, the public health sector must investigate and establish links ...

...Between potential initiatives and the objectives of a relevant Operational Programme:

Public health officials that have identified initiatives that they would like to propose for co-funding must ensure that these can be linked to the specific objectives of a specific Operational Programme. The better an initiative applying for funding can be formulated according to the logic of an Operational Programme, the better.

...Between potential initiatives and their Country Specific Recommendations:

Country Specific Recommendations are documents prepared by the European Commission for EU Member States, analysing its economic situation and providing recommendations on measures, it should adopt over the coming 12 months. They are tailored to the particular issues the Member State is facing and cover a broad range of topics: the state of public finances, reforms of pension systems, measures to create jobs and to fight unemployment, education and innovation challenges, etc. They also include recommendations relating to the sustainability of health systems and on access to quality health services for all. Member States have for example received recommendations to improve the cost-effectiveness of healthcare systems, shift from institutional to home care, improve access to primary care, provide coverage to disadvantaged groups, and place greater emphasis on prevention and independent living.

Country-Specific Recommendations are adopted by national leaders in the European Council. In future, there will be a stronger link between Structural Funds allocation and the Country-Specific Recommendations. It is therefore important to demonstrate what the public health sector can do to help advance the recommendations.

...With their Managing Authorities:

Public health authorities and organizations that are interested in applying Structural Funds to support or implement initiatives to reduce health inequalities should contact their Managing

Authorities to discuss their ideas, identify how they could fit into existing priorities, and identify potential partners. Some national and regional Managing Authorities have established 'help-desk' services to provide guidance on Structural Funds and the application writing process. It is important to identify whether this is the case in your region or to inquire whether such services are available elsewhere in your country. Information on Managing Authorities in each EU Member States is available on www.fundsforhealth.eu.

IV. IDENTIFY AND DEVELOP CAPACITY

The public health sector should build capacities of sub-national public health authorities to apply for Structural Funds, on the basis of Health in All Policies principles and health equity.

Beyond raising awareness, public health should also build capacities with the sector to apply for Structural Funds. This could be done by organising workshops and training sessions to inform public health professionals working at the regional and local level about the opportunities available to use Structural Funds to promote public health objectives and reduce health inequalities. They could invite representatives of projects and programmes that have or are receiving Structural Funds to discuss their experiences. They could also invite Managing Authorities to present on relevant Operational Programmes that offer opportunities and to speak about procedural issues.

The public health sector should invest in fostering health experts who understand Cohesion Policy and the Structural Funds, as well as the social determinants of health and health equity, and who can convey this to others

Promoting health and preventing ill health by working with other sectors to address the underlying determinants of health is a complex field that requires specialised knowledge and skills. Similarly, the process of applying for and implementing Structural Funds requires expertise. If public health authorities are serious about applying for Structural Funds and ensuring that they contribute to health equity, they should invest in fostering experts that are able to bring these two areas of expertise together. These experts can act as champions for health within Cohesion policy, as well as professionals who can help assess and enhance the health equity impacts of different projects and programmes that receive Structural Funds.

Although efforts are being made to simplify procedures, Structural Funds application and administration processes are, and are likely to remain, very complicated. For those who have little experience with these procedures, it is best to get engaged through or to engage individuals or organisations that are already familiar with these processes, either within or outside of the health sector.

The public health sector should pursue opportunities available within the Structural Funds to build capacities

The public health sector should design initiatives under the Structural Fund Thematic Priority 11 of Enhancing Institutional Capacity to build capacities within health systems to improve health equity. They should aim to get funding to train public health professionals to systematically monitor health inequalities and to incorporate a focus on health equity in the design, implementation and evaluation of all relevant policies and programmes. They should also aim to get funding to build the capacities of public health professionals to work with other sectors to promote health and ensure a fairer distribution of opportunities for health. See Example 10 in Part II of this report on how Structural Funds have been applied to build capacities within the health system to address health inequalities in the South of Italy.

V. BUILD PARTNERSHIPS

The public health sector should identify and work through existing partnerships or develop new cross-sectoral partnerships

While the public health sector can develop their own initiatives for co-financing under the Structural Funds, it should also seek out opportunities to take part in projects and programmes being led by other sectors and widen the scope for health equity action, such as regeneration programmes or those that aim to enhance access to employment. Public health could get involved in order to maximise the health and health equity related impacts of such initiatives. See e.g. Examples 17 and 22 in Part II of this report. This implies being proactive in networking, identifying and contacting relevant organisations within other sectors that are developing or implementing such projects and programmes. The public health sector could get involved as a partner from the outset of such projects, and help with their design, or they could become involved in projects that are already receiving financing, to bring in or strengthen their health element.

Learn and use the language of others

Public health professionals should never assume or expect that professionals in other sectors understand and prioritize concepts like health promotion, the social determinants of health and health inequalities. It is up to public health professionals to learn the language of other sectors and to demonstrate how efforts to improve health and reduce health inequalities are also in others' interest. When engaging with other sectors it is in this respect prudent to talk about health in terms of wellbeing, sustainability, resilience, and other social determinants. It is also up to public health professionals to provide concrete suggestions of how other sectors can contribute to greater health equity.

Share knowledge and experiences

The outcomes of the Equity Action Structural Funds Reviews reflect that there is knowledge and experience available across EU Member States and their regions on how to apply Structural Funds to address the social determinants of health and promote health equity. Nevertheless, in many

countries and regions it remains difficult for the public health sector to get involved and to increase investments in these areas. Information on successful approaches, arguments, proposals and compelling evidence used can provide ideas and inspiration to other regions across the EU and serve as a basis for action.

The Structural Fund online Guidance Tool for Health Equity www.fundsforhealth.eu has been developed for this purpose and provides an entry point to gain and share knowledge and experiences. Interested parties can get involved by leaving their details here: <http://fundsforhealth.eu/get-involved/>. They can also join networks like EuroHealthNet and the Equity Action Regional Network to exchange experiences and expertise.



www.healthpromotion.eu

www.eurohealthnet.eu

www.health-inequalities.eu

www.fundsforhealth.eu