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HEALTH EQUITY 2020

HEALTH EQUITY-2020 PROJECT
REDUCING HEALTH INEQUALITIES
PREPARATION FOR REGIONAL ACTION PLANS

RESULTS OF NEEDS ASSESSMENT AND ACTION PLAN

TALLINN, ESTONIA

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This document arises from the project HEALTH EQUITY-2020 which has received funding from the European Union, in the framework of the Health Programme.

Content

Overview

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

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

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

Part 2: Regional Action Plan to tackle health inequalities

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

Part 3: Developing the regional Action Pan: The process

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

PART 1 WHAT DOES THE EVIDENCE for your region SAY?

Introduction to Part 1

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

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

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

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

The full HE2020Toolkit is available at this link:

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

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

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

Phase 1 Carrying out the NEEDS ASSESSMENT

Assessing the magnitude and determinants of socioeconomic health inequalities

1.1 Introduction

The needs assessment was undertaken in order to make a fuller overview of the current situation. All the available statistical data was used, either from the Department of the Statistics and Tallinn City Departments or published statistical reports.

1.2 Regional profile

Tallinn occupies an are of 159,2 km2 and is divided in 8 districts. Based on the data of 2015 the population of Tallinn is 413 782 (55% of population are Estonians). Natural increase of the population is positive.
The economic sectors of Tallinn include the light, textile, and food industry, tourism as well as the service and government sector. Tallinn produces almost 49% of the Estonian GDP.

Registered unemployment rate in Tallinn is 4%. In 2011, the share of 0–19-year-olds was the biggest in Pirita and the smallest in the Mustamäe district. The comparison of 2000 and 2011 shows that the share of young people has decreased in all city districts in Tallinn, although the decrease in the Pirita district has been very marginal. The share of young people has decreased the most in Lasnamäe (by 8.2 percentage points). In 2000, the share of young people in the Lasnamäe district was the highest compared to other districts in Tallinn. In 2011, however, only Mustamäe had a smaller share of young people. This is a remarkable change. It may come as a surprise that the share of 0–19-year-olds in Tallinn is smaller than the Estonian average. This was true in 2011 and in 2000 as well. One of the reasons could be the age structure of immigrants.

The share of persons aged 65 and older is the highest in the Mustamäe district. The share of the elderly is the smallest in the Pirita district. In Tallinn as a whole, the share of the elderly increased between 2000 and 2011. But there are two districts where this share has fallen: by 4.1 percentage points in Pirita and by 3.2 percentage points in Kesklinn. There is a general trend of population ageing, so why has the share of older persons decreased in the Pirita and Kesklinn districts? It could, among other things, be related to the different levels of property prices – these prices are lower in Mustamäe (where the dwelling stock is old), and higher in Pirita (which has many new developments) and in the prestigious Kesklinn.

The labour force participation rate in Tallinn and all its districts is higher than the Estonian average. The Urban Audit studies the labour force using two age groups: 20–64-year-olds and 55–64-year-olds, i.e. the working-age population and the persons reaching retirement age within the next ten years. The results for these age groups also show that the labour force participation rate in Tallinn and all its districts is higher than the Estonian average. In

all three age groups considered (the two aforementioned groups and age group 15+), the labour force participation rate is the highest in the Pirita district. In the age group 20–64, the labour force participation rate does not vary much between city districts (by up to 2.9 percentage points). The indicator varies by up to 8.4 percentage points across districts in the age group 15+, and by up to 9.9 percentage points in the age group 55–64. These variations do not indicate very significant differences between the city districts, but they do raise some questions. For example, a more detailed survey could find out why the labour force participation rate in the Mustamäe district is slightly smaller than in other districts, or why the labour force participation rate among 55–64-year-olds in the Põhja-Tallinn and Lasnamäe districts is smaller than in the other districts.

The male and female labour force participation rates in Tallinn and its districts are higher than the Estonian average in all three age groups considered. In all age groups and in all city districts, men have a higher labour force participation rate than women.

The difference between the labour force participation rate of males and females is the biggest in the age group 15+: the gap is the biggest in Haabersti (11 percentage points) and the sm llest in Kesklinn (6.7 percentage points). However, the differences between city districts are not big. There also are no significant differences between the districts when we compare the labour force participation rates of the age groups 20–64 and 55–64. In these age groups, the difference between male and female labour force participation rates is again the biggest in the Haabersti district.

1.3 Socioeconomic inequalities in health

Mortality and life-expectancy

Highest mortality among women and men is due to disease of circulatory system.

Health during life

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

22,4% has to some extent limitations of everyday activities due to health problems.
58,9% of population state that their health status is good.

1.4 Socioeconomic inequalities in health determinants

Health behaviours

19,6 % of women and 33,2% of men are daily smokers, alcohol consumption at least a few times a week 14,5 % of females and 36,5% of males. Overweight 25,1% females, 37,3% males; obese 15,2% females and 14,7 of males.

Working & living conditions

In Estonia, the average size of a private household is 2.13 persons. In Tallinn, the average private household is slightly smaller – 2.04 persons. The size of private households varies significantly from district to district: it is the biggest in Pirita (2.45 persons) and the smallest in the Kesklinn district (1.84 persons). The fact that the average size of private households in Tallinn is small indicates that the share of one-person households is probably relatively high among private households. This is confirmed by the statistics. In Estonia, the average share of one-person private households among all private households is 39.9%. In Tallinn their share is 42%. This share varies greatly between Tallinn's city districts: the share of one-person private households is 49.7% in Kesklinn and only 28.4% in Pirita. In the Kesklinn district, one-person non-pensioner households hold a large share among all private households. Such households (one person, who is not a pensioner, living alone) constitute 37.1% in Kesklinn, which is 6.7 percentage points more than in the Kristiine district, which ranks second, and 17.7 percentage points more than in the Pirita district, where the share of such households is the smallest (19.4%). The households of lone parents raising children aged under 18 constitute 6.08% of private households in Estonia and 6.48% of private households in Tallinn. In seven of the eight sub-city districts of Tallinn, the share of lone-parent households is above the Estonian average (the exception is the Kristiine district, where this share is equal to the Estonian average). But the differences between the districts are marginal: the value of this indicator ranges from 6.08% (Kristiine) to 6.77% (Põhja-Tallinn).

Conventional dwellings: Here, the main indicator is the share of conventional dwellings lacking basic amenities. It is not a surprise that the share of dwellings lacking basic amenities is much smaller in Tallinn than in Estonia on average. In Tallinn, the share of such dwellings varies a great deal from district to district. The share of conventional dwellings lacking basic amenities is the biggest in Põhja-Tallinn and Nõmme, and the smallest in Mustamäe and Lasnamäe.

Access and use of health services

Overall the access to the health care is rather good, however 11% of the population has experienced some difficulties with access to the specialised medical care.

1.5 Economic consequences of health inequalities

Labour related indicators

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

No data collected/is available

Direct costs related indicators

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

93,1% of Tallinn population is covered by health insurance

42% of population have some kind of long-term illness.

Phase 2 Conducting a CAPACITY ASSESSMENT

Introduction

The capacity audit was performed in January –June 2014. Interviews were done in the same period. Statistical data as well as national and local strategic documents were used. Most of the interviews were done with the representatives of different organisations. A round table was done with local health promotion specialists as well as representatives of different departments of Tallinn City government.

Findings

Statistical data shows that Tallinn in most of the determinants is in better position than the whole country that is a problematic issue in the negotiations between different state actors, especially in financial questions. Introduction of the inequalities to the wider public is seen as problematic, mainly because experts and specialist are familiar with the term, but it is essential to translate it to "other" languages.

However there are some fields that need more attention: health inequalities are not the priority area for the policy makers; child poverty is still a worrying issue and is rather important factor for future inequalities. Increasing segregation in inhabiting areas poor vs wealthy; health literacy is high among the population, but the action behind it is lacking; complicated social benefit system at the local level makes it easy to disappear. High need for the empowerment not only among whole population but among specialists working in the field of health promotion.

Organizational development *[You can talk about: organizational structures, policies and procedures/strategic directions, management support, recognition and reward systems, information systems, quality improvement systems, informal culture.]*
No data collected/is available
Resource allocation *[You can talk about: financial and human resources, time, access to information, specialist advice, decision making tools and models, administrative support, physical resources.]*
At the district level there is one health promotion specialist that is responsible for the managing and keeping the intersectoral working team among other responsibilities. Work of the health promotion specialist is financed from the Tallinn City budget or extra activities must be financed from external funds.
Workforce development *[You can talk about: workforce learning, external courses, professional development opportunities, undergraduate/graduate degrees, professional support and supervision, performance management systems.]*
There is need for mentor training as well as leadership trainings.
Leadership *[You can talk about: interpersonal skills, technical skills, personal qualities, strategic visioning, systems thinking, visioning of the future, organizational management.]*
One of the results of capacity audit is that leadership is lacking on the local level.
Partnerships *[You can talk about: shared goals, relationships, planning, implementation, evaluation, sustained outcomes.]*
Health promotion specialists should lead the intersectoral cooperation on the district level with all the important actors in order to solve problems.

Phase 3 Setting the potential ENTRY POINTS for action

1.6 Setting priorities

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

The priorities were chosen based on the current situation as well as based on the views of our partners from Health and Social care department.

1.7 Choosing actions

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

1.8 Translating actions into regional action plans

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

Target population district inhabitants, continuously working intersectoral health team as a result projects and programmes to tackle health inequalities in the district. The maintenance of the health teams as well as future actions to support the work of the teams or leadership training etc. could be added to the future strategic documents of Tallinn City.

Phase 4 The IMPACT ASSESSMENT

Assessing the potential impact of actions on health and health inequalities

Screening
[Is the policy/ intervention likely to impact health/ determinants of health considerably? Which populations are currently relatively disadvantaged in the context of this policy or intervention? Does the policy enhance equity or increase inequity? What might be the unintended consequences?]
We consider that the intersectoral cooperation on the district level would help to enhance equity among population of the district because actions would be overwhelming.
Scoping
[Which health outcomes or determinants of health outcomes does this impact assessment focus on? How was it carried out (literature reviews, quantitative modelling, qualitative analysis- expert consultations, interviews, focus groups)? What evidence was used to show how the health equity impact was identified?]
Impact assessment
[Quantify or describe potential, important health and health equity impacts.]
Decision making
[Provide recommendations to improve policy (evidence-based, practical, realistic and achievable measures that would reduce the negative and enhance the positive health equity impacts of the policy).]
Monitoring & evaluation
[Talk about: the process evaluation (Was the impact assessment carried out successfully? Were there challenges or barriers?); the impact evaluation (will the recommendations of the impact assessment be adopted/implemented?); the outcome evaluation (How will you know if health inequities have been reduced in real life?)]

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

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

PART 2 Action plan to TACKLE HEALTH INEQUALITIES

Introduction to Part 2

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

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

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

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

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

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

Translating HE2020 actions into regional action plans

2.1 Main questions to answer by an action plan

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

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

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

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

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

2.2 Recommended key steps

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

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

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

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

2.2.3 Develop the action plan by

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

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

3.2 *Filling in the action plan table* by identifying

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

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

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

2.3 Integrated planning

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

2.4 Monitoring and evaluation of the implementation of the Action Plan

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

2.5 Financial appraisal

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

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

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

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

Action Plan

2.6 General context

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

Around 6-7% of the potential workforce is not active in labour market due to health issues, disabilities or injuries, such situation is seen not only in the whole country, but in Tallinn as well. Based on the previous research (Tallinn Health Profile), inhabitants of Tallinn rate own motivation and capacity to deal with health issues in the community as rather low: only 28% of the population are motivated to deal with different social issues in local community. Taking into account the size and differences between the districts (population, ethnicity, area, environmental determinants etc.) the best result gives the interventions done on the level of the district. The same Tallinn Health Profile states that it is important to involve local inhabitants in decision making concerning their own health, by that local authorities expect to increase health sustainability, improve social cohesion. Tallinn Population Health development plan stresses the importance of establishment of the intersectoral health councils in every district, the main goal of which would be evaluation of citizens' needs, choosing the priorities and search for the solutions as well as its implementation. The main document behind this plan is that under the supervision of district's government health board should develop for each district a health action plan. In order to make such a document a deep knowledge of the current situation is needed as well as participation of most of the interested parties.

2.7 List of partner organisations

[Please list the partner organisations contributing to the development of the Action Plan.]
Tallinn University, Tallinn Local government , Local Districts

2.8 List of supporting documents

[Please list the supporting documents as annexes of the action plan (e.g. a more detailed review of the determinants of socioeconomic health inequalities in your region).]

2.9 Action Plan table

Actions	Output/ Deliverables	Responsible party	Others to involve to complete action	Timeline	Indicators	Financial resources
Priority area/Objective						
Building intersectoral cooperation on the district level	Improving work of health teams in every district	Social Care and Health Department, Tallinn City government,	Tallinn University	Spring 2016	Continuous work of intersectoral health teams, measurable outcomes (eg. projects)	ESF
Families with small children	Increase the ability of families to look after small children	Social Care and Health Department, Tallinn City government,		Autumn 2016	Decrease in "learned" helplessness amoung young parents with children	ESF, Local funds

2.10 Additional support

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

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

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

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

For further information you can also consult:

The HE2020 Policy Matrix link at HE2020 wiki

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

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

Other potentially relevant websites:

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

PART 3 DEVELOPING THE ACTION PLAN: the process

Introduction to Part 3

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

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

3.1 General overview of the process

Based on the circumstances the overall process of development actions was done based on the negotiations with local authorities, taking into account strategic documents of Tallinn City.

3.2 Using an evidence-based approach

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

As most of the strategic documents are long-term documents we hope to introduce the topic of health inequalities in the future documents. Each year Tallinn City Government publish statistical data and based on that Health Report is done. Actions were chosen based on the current need of Tallinn.

3.3 A community & intersectoral approach

[Health inequalities is a cross-cutting issue. In dealing with health inequalities, it is important to implement a community/intersectoral approach to develop action. For this reason regions were encouraged to set up a Regional Action Group with stakeholders from various sectors/organizations who either directly or indirectly are dealing with the inequity problem. Please describe how you managed to set up the Regional Action Group. Please list the member organisations of your RAG in the Annex of this part of the document. Have you had already used an intersectoral approach before? Is this something that is part of your institutional/working culture or quite the opposite? If it was not possible to set up a Regional Action Group, please explain why not (e.g. no interest or support, reluctance in sharing information or competencies).]

As our region was in bit different position compared to other participating regions, the establishment and continuing work of intersectoral team in each district is on the of the goals of given project. In order to support that we have organised on workshop in Tallinn with the health care promotion specialists, education council representatives etc. in order to share the experience and discuss main problems and obstacles that specialist in the districts face. We hope to continue with such workshops in order to develop the intersectoral cooperation in the districts.

3.4 Building Support

We have gained political support and support from local administration at some level.

3.5 Typology of the region

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

Tallinn is usually in better position compared to the whole country so it can be hard to negotiate further developments. Another issue is that health inequalities must be translated into political level as well as everyday one.

3.6 Challenges

[Describe the major challenges you encountered in the process of attaining your goals during the course of the action learning process (e.g. changes within the institutional context, lack of support from higher level authorities, weak collaboration or partnership with others sectors/stakeholders, lack of data to make the case of health inequalities, lack of financing or capacities to take forward actions)?]

The main problem was to include the actions into the planned agenda. All current actions are already planned. Second issue is finance question, who is going to pay for the actions.

3.7 Validating the regional Action Plan – Integrated planning

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

Not applicable on given stage of the process, however we have gained the support for planned actions from the Social Care and Health Department of Tallinn Government.

3.8 Financing the Action Plan

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

So far there were no announcement made on the topic of ESF implementation in Estonia.

3.9 Benefits for the region, lessons learnt, good practices

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

It was a good opportunity to share the experience and see where others are standing, also it was good to know that many countries are dealing with the same issues and similar obstacles, the ways how they overcome those were really important.

3.10 Cascade learning into other regions

The process has shown that it is of great importance to share the experience internationally, especially with the countries having the same historical backgrounds and similar political situation. Furthermore the "fresh view" is also important, meaning that expertise from different countries can help to find solutions to old problems. It is important to share the positive experience internally as well, however in different parts of the country there can be different issues that need solutions.

3.11 Annex – Information on the Regional Action Group

A stakeholder workshop was organised in Tallin 8 December 2015 within the framework of the project.