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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

TRENČÍN REGION, SLOVAK REPUBLIC

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Content

Overview

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

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

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

Part 2: Regional Action Plan to tackle health inequalities

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

Part 3: Developing the regional Action Pan: The process

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

PART 1 WHAT DOES THE EVIDENCE for your region SAY?

Introduction to Part 1

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

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

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

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

The full HE2020Toolkit is available at this link:

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

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

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

Phase 1 Carrying out the NEEDS ASSESSMENT

Assessing the magnitude and determinants of socioeconomic health inequalities

1.1 Introduction

The needs assessment was undertaken by personnel of The Office of Self-governing region of Trenčín by collecting data from various sources through of taking them from different institutions for exploring the real region status:

- *The Office of Statistics*
- *The National centre of health information*
- *Register of health care institutions - Department of health and human pharmacy – The Office of the Self-governing region of Trenčín*
- *Social Insurance*
- *EUROSTAT*

Data was from 2012 and earlier and was edited for the project HE2020 by taking into account the objectives of the project. It means that only those data were selected which are considered appropriate for determining health inequalities.

1.2 Regional profile

The Self-Governing Region of Trenčín is 1 of 8 self-governing regions in Slovak Republic.
Region of Trenčín with a surface area of 4502km2 covers the north-western part of the Slovak Republic, bordering on Czech Republic. According to the 2012 census, the region had 593 159 inhabitants, with Slovaks forming a relatively homogeneous majority (97.3%), with a small minority of Czechs (1%) and others (Hungarians, Germans etc.).
Women comprise 51% of population, but in distribution of population by age, women comprise the plurality only in the category of post-productive group. Density is 131 persons per km2 and has declining tendency. There is a big gap between the life-expectancy at birth of men and women. The women´s is more over 80 years whereas the men´s is only 73 years but it has increasing tendency for both. The biggest group of population has reached upper secondary education.
Region of Trenčín like many other regions in Slovakia and also in Europe feels that population is aging. The number of pre-productive population declines since 2001 and vice versa number of post-productive population grows.

1.3 Socioeconomic inequalities in health

Mortality and life-expectancy
There is a big gap between the life-expectancy at birth of men and women. The women´s is more over 80 years whereas the men´s is only 73 years but it has increasing tendency for both (average in 2012: 76,96 years).

Most people in Trenčín region are dying on diseases of circulatory system, on the 2nd place there are neoplasm diseases, 3rd place: diseases of the respiratory system, 4thplace: injury, poisoning and others.
Average age of deaths in 2012 was different for men and for women. For men it was the age of 69 years, for women 77 years. In general, it is less than life expectancy at birth for both. Average age of deaths in 2012 was 73 years.

Health during life

We have no obtain data regarding health during life. It is for not collecting the data by relevant institutions. In despite of, we know that:
1, the main regional health problem is cardiovascular diseases
2, problem of children obesity
3, the elderly – low level of living conditions

Most sick people in our region are sick and dying from diseases of circulatory system, on the 2nd place there are neoplasm diseases and at least on diseases of the digestive system. Within the health care system our region has a main problem with disintegration of services in healthcare so there isn´t a continuity of services , especially a deficiency of subsequent treatment (for instance rehabilitation and aftercare) and absence of health care and social care cross connection. There is also a deficiency some of high-specialized outpatient´s department in our region, for example a neurosurgery, an invasive cardiology etc.

1.4 Socioeconomic inequalities in health determinants

Health behaviours

We do not have health behaviours regional data. We have only data at the national level but their origin is from different reports, not from the relevant database.
Health indicators, like BMI, blood pressure, level of blood glucose and cholesterol in Slovak population, are at the average in comparison with other EU members.

Working & living conditions

Regarding to housing, roughly half the population lives in houses and half in apartments.
In terms of the economy, the economically active population comprises more than 50% of total population; while for men it is a higher percentage of activity. The average gross nominal monthly earnings was 798 EUR in 2012 and it grows from year to year. Registered unemployment reached 10.89 % (2012). It was higher percentage of women than men. Most registered unemployed is from the group of lower secondary educated. The second are those with upper secondary education, then basic or uneducated and least of registered unemployed are academic educated. Persons below the bound of poverty comprise 8,3% of regional population in 2012 (below 60 % of median). The elderly as one of disadvantage group has a poorer living conditions in comparison with other parts of population.

Access and use of health services

The data regards to access to health services are from register of health care institutions (official register which create and use The Office of the Self-governing region of Trenčín, Department of Health). It contains only geographical access, not the financial barriers. With regards to the geographical access, the access in towns is different to the access in villages. It is why data is only the average with respect the surface area of our region (4500 km2). We have no concrete data about the vaccination programs, maternal and prenatal care.

There is a high number of visit´s patients at GPs 11,3 per year;(OECD average – 6,4 per year) in Slovak republic.

80% of patients are recommended to the medical specialists. But there is a long-waiting duration to be treated by medical specialists.

Geographical access to health services	*Number*	*Geographical access*	*Per 100 000 inhabitants*
General practitioners for adults	*255*	*1 to 17,72 per km^2*	*42,33*
General practitioners for children	*130*	*1 to 34,62 per km^2*	*21,66*
Dentists	*269*	*1 to 16,73 per km^2*	*44,83*
Gynecologists	*75*	*1 to 60 per km^2*	*12,5*
Other medical specialists	*675*	*1 to 6,6 per km^2*	*112,5*
Hospitals	*10*	*1 to 405 per km^2*	*1,66*

1.5 Economic consequences of health inequalities

Labour related indicators

The highest labour productivity with the highest earnings have people between 30 and 39 years of age. For men it is a higher percentage of economic activity. The most economically active group comes from upper secondary educated.

Registered unemployment rate: 10,89 % ***Men: 10,03 %*** ***Women: 11,98 %***	***2012***
Basic and uneducated	*13%*
Lower secondary	*46%*
Upper secondary	*30%*
Tertiary (academic)	*11%*

Registered unemployment reached in 2012 10.89%. It was higher for women than for men. Most registered unemployed is from the group of lower secondary educated, especially men and least are academic educated.

Number of overtime per month sick leave	***2010***	***2011***	***2012***
Men	*5*	*5,1*	*5*
Women	*6,2*	*6,4*	*6,8*
Average	*5,6*	*5,7*	*5,8*

The table Number of overtime per month sick leave shows that the women have more not worked hours as men.

Direct costs related indicators			
Payment of health insurances to healthcare (in thous. Eur)	***2010***	***2011***	***2012***
All categories	*263 004*	*261 805*	*272 699*

Payment of health insurances to healthcare is increasing in almost all categories (primary healthcare, specialized HC) but only in one category is falling, namely medicines on prescriptions.

Costs of social security benefits - all pensions (in thous. Eur)	***2010***	***2011***	***2012***
All	*632 559*	*647 519*	*676 468*

Costs of social security benefits are increasing almost in all types of benefits, only the one category: unemployment benefits remain at roughly same level for several years.

Number of pensioners	***2010***	***2011***	***2012***
All	*154 325*	*154 252*	*156 596*

The average monthly pension payments (in Eur)	***2010***	***2011***	***2012***
All	*339,32*	*345,71*	*358,32*

The tables: Number of all pensioners and The average monthly pension payments show that both values are increasing from year to year in Trenčín region. For these two matters, the payment of pensions can be serious problem in the future.

Phase 2 Conducting a CAPACITY ASSESSMENT

Introduction

Capacity Audit was undertaken by personnel of Department of health (Self-governing region of Trenčín) from November 2013 to January 2014. Used data are based on internal policy of The Office of Self-governing region of Trenčín.

Findings

The main findings of capacity assessment are: the lack of support, political stability of decisions, human capacity and financial resources. On the other hand, regarding the role and responsibilities the Office of Self-governing region has tools needed to achieve development in our region.

The problem is that many citizens don´t know our Office, it means its competences and opportunities for regional development. They don´t understand it, they see only another bureaucratic colossus. Especially, older people take note of the changes coming mainly from central level and don´t know that the regional level is closer to them and young people are not interested in. Perhaps, there is a possibility of change in approach in the future, for example, our office covers Office of Europe Direct, it is a representation of European Commission in our region. There are many activities for youth, it means for pupils and for regional high schools students and in this way it brings them an issue of European affairs and regional government, through various activities and games. We see the opportunities in promotions competences to the citizens of the region and therefore their involvement into regional development.

Organizational development

The Office of Self-governing Region of Trenčín has scopes in various areas covered by laws: competence in transport and transport pathways, civil defence, tourism and regional development, social assistance, culture, educational system, health services, territory planning. These areas are covered up to the individual departments: Department of culture, education, health, finance, transport, international cooperation. The individual departments cooperate in the case of joint interest. Budget consists of taxes.

The proposal of the Head of Office is accepted by the regional government, but the Head can refuse to sign the regional government approval.

Reward system for staff: reward is for the extra work, it suggests the head of department and then it goes to suggest to head of office.

Information system - mainly we know 2 types of region status report, the first type is the external report which is made by external experts. The second type is report made by each office department once a year where is assessed the development in the area of its interest.

There isn´t an informal association for colleagues connections between departments to share some action or values within the organization.

There exist cooperation with various medias - radio, regional TV´s where is a possibility to inform about events held under the auspices of our office.

And finally, we publish the information on official office website, too.

Resource allocation

Regarding resource allocation in the area on health care, there is a need to note that the regional health care is inefficiently financed from regional budget. There is only capital investment for hospitals working under the authority of Office (3), they get minimum percentage of office budget. Current expenditure is financed by the health insurance companies on the basis of concluded contracts among hospitals and insurance companies. The problem is that the regional hospitals are also disadvantaged compared with state or private hospitals by unprofitable contracts with insurance companies for providing health care.

Another problem is that at this time, no money goes to education, for example nurses have an opportunity to get higher salary if they obtain a university degree, but the fees associated

with achieving higher education have to pay yourself. By Department of Health was successfully implemented Operational Programme Education „Supplementation of the health system by qualified experts in the Trenčín Region". But it was only focused on education of physicians, more specifically, to help young doctors in our region to attain postgraduate degree which is necessary for the practice of their professional career.

Moreover, financial resources are mostly used to technical equipment and crisis situation in hospitals; for example to repair of buildings, roofs, systems of heating etc. but there is the lack of finance, too.

In terms of administrative support, actually we have no support from management and we don´t have sufficient capacity.

Workforce development

In relation to the undergraduate and post graduate degrees, our employer offers no advantages or support to us. If someone studies on university he must to take a holiday for preparing to exams. Also offer no foreign language courses. More or less supports only external courses for employees, for example about administrative proceedings, about the news in specialized areas. Within Department of Health we inform each other, for instance when enter into force a new law.

Some opportunities for professional support doesn´t exist, because the position of department head is often a political question. But there is a possibility to reach a personality development when you will learn a lot.

Leadership

The Office of Self-governing region; it has necessary tools and opportunities how to reach some development in our region. We have some visions for regional development in the health and health care within the Department of Health. On the other hand, in general, we see a lack of vision at the office because there is a real possibility to have at the head office new boss every four years, and it means that each new boss comes with new ideas different compared to previous boss for regional development. Then it is difficult for us to implement something new boss does not want to support.

Others possible leaders are NGOs which are probably the most important partners, but they are small organisations without big impact on wider population.

An organization at a higher level with a wider implementation of decisions on population can be for example Ministry of Health. But it is too far regional level and individual needs of the region.

We think that from this perspective should be the most appropriate leader The Office of Self-governing region.

Partnerships

We have a list of potential partnership, stakeholders.

Firstly, within the Office, Department of Social care will assist in the realization of shared goals, it means in absence of health care and social care connection and in the area of elderly people. There is a possibility to cooperate with regional social care centres which are covered by Department of social care. Another possible partner is Department of regional development. These are two main possibilities within the Office. We also have a list of NGOs

working in different areas of interest as potential partners. There are about forty within Trenčín region. The next step will informal communication with them for seeking cooperation, share our values, visions. The NGOs are really different in their field of action, we tried to choose a wide range of activities, for instance NGOs providing counselling for youth, social services to disabled people, educational activities, help for mental disabled children, for abstainers, and also NGOs aimed on development of micro-regions, to improving of citizen awareness and so on. We have enough opportunities to gain partners.

Phase 3 Setting the potential ENTRY POINTS for action

1.6 Setting priorities

We chose 2 entry points based on the process of needs assessment: The Elderly and Cardiovascular diseases. These chosen entry points are two main problems in the area of health at the regional level but also at the national level. The entry points were also chosen because the fact that by positive influence the causes that cause these problems it can be possible to minimize them or give rise to their fall. This is the main impulse why we chose exactly them. They aren´t issues strictly given and not be possible to prejudice or change them.
In terms of ESIF and European regional priority setting, we have not managed our priorities set up to the European level yet.

1.7 Choosing actions

On the basis of the all passed parts of learning how to develop evidence-based action plans on reducing health inequalities, we decided the aim of our action plan will be an EDUCATION, it means reduce health inequalities by prevention and by raising awareness about various topics: healthy lifestyle, physical activity, possibilities in social care services for the elderly, rights of the elderly, law in health and social care, active ageing etc. Chosen mechanism can be helpful to improving health determinants prevalent within vulnerable groups (in our case: the elderly) and also can be useful in prevention of cardiovascular diseases at any stage of people´s life, it means from primary prevention in children to secondary prevention in people with cardiovascular problems. It means, the chosen action will be use a whole population approach and a whole life-course perspective.
We don´t know about concrete study or example of proven successful in reducing inequalities by education, but it is the only one way how to effectively influence the awareness about health problems within the wide population.

1.8 Translating actions into regional action plans

The chosen action will be a reach on the whole population, it means on all ages. The enhancement of awareness about healthy lifestyle topics is the main desired effect of the action thereby achieving reduction of our regional health inequalities. The implementation of the action will be coordinate by The Office of the Self-Governing Region of Trenčín in cooperation with our partners (schools, regional media, social care centres etc.)
Thus, the basis of it will be the cooperation with partners and stakeholders.

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 are not sure about real impact of our action, but we hope that although only a small consequence caused by our action (for example a reduction in mortality from CVD) it would be our great success with which we could also share with other Slovak regions, and maybe it will help to change the thinking about health in our country. *Whereas the intervention will cover the whole society we do not know about possible disadvantaged group in the context of our action. Certainly, the aim of intervention is a reducing the health inequity in our region.* *At this moment, we don't know about unintended consequences.*
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?]
In the case of cardiovascular diseases, we consulted our intention with several experts including cardiologists. All of them think through the education is possible influence the health. They showed us many tables which confirmed positive effect of their treatment (in this case: secondary prevention of cardiovascular diseases) on health. It is real evidence that secondary prevention helps reduce the number of mortality on cardiovascular diseases. And now, how secondary prevention is related to education? Education is a type of information, and a lot of people who live in our region do not know about above-mentioned type of treatment. We think that through our Action plan, it means by educating we can change it. It is statistically proven that with the increase of education decrease socio - economic and therefore health inequalities. *So far we have not made any consultation or research in the area of elderly but likely the conclusion will be the same as in the case of cardiovascular diseases: the awareness-raising can helps more people who do not have access to information and this reason makes them vulnerable.*
Impact assessment
[Quantify or describe potential, important health and health equity impacts.] *CVD: Most people in Trenčín region are dying on diseases of circulatory system: 54%. Any percentage reduction in this number would be success for us. It is too big number compared to other European countries.* *The elderly: Deliverables in the area of the elderly are difficult to measure (how we can measure a quality of life), and also the change process can take a long time to see some results. Perhaps, we can see it in increasing of life expectancy (actually it is: 76,2 years).*
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).] *If our Action plan will be successful and our main action – education would have a proven positive effect, we could provide our recommendation to improve regional health policy to other Slovak regions with the help of Ministry of health SR.*
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?)]
I think the impact assessment was carried out successfully. As I mentioned, there is a possibility to adopt our recommendations by other Slovak regions if we will have a good results within implementation process. Reducing of health inequalities we will see mainly within statistics data.

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.] *The availability of certain data at the regional level was the main problem in data collection phase.*

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.)]

The need for actions set in the Action Plan is because the fact that the chosen entry points (the cardiovascular diseases, the elderly) are two main problems in the area of health (but not only at the regional level but across whole country). And above all, we think that these problems are variable according to the impact that we can act on them. So why should we not do something when we can? We used our experience with toolkit phase 1 – Needs Assessment – we renewed data and statistics repeatedly showed us the same main regional problems as when we carried out it for the first time in the years 2012 – 2013 within the project HE2020.

Our Action Plan was developed under supervision of experts, step by step guided by specialists from Maastricht University and the cooperating organizations and institutions. The process was difficult, we had to face many obstacles, mainly the lack of: support of our top management, partners/stakeholders, human resources and needed exact data. But slowly, step by step we arranged the Action Plan for our region.

We know about 2 documents our Action Plan can be fits within (for this action we will need a wider support of our Ministry of Health): National Action Plan for Obesity Prevention; National Programme for Active Ageing.

2.7 List of partner organisations

[Please list the partner organisations contributing to the development of the Action Plan.]

Partner organisations consists:

-Department of Social Care (The Office of the Self-Governing Region of Trenčín)

-The Ministry of Health SR

-The Office for Public Health

-Association for hospitals

-The Statistics Office

-The National Centre for Health Information

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						
1, to obtain more partners and stakeholders *2, closer cooperation with existing partners and stakeholders* *3, coordinate partners each other in Action plan activities.*	*1, reduce percentage of mortality from cardiovascular disease (actually 54%)* *2, increase life expectancy (actually 76,2 years)*	*The Office of the Self-Governing Region of Trenčín:* *-Department of health and social care* *-Department of education*	-hospitals -social care centres -schools - municipalities - physicians/nurses	*Because of main principle in which is based on our Action plan: the volunteerism, we do not have a specified time horizon. It is possible to start the actions at any time.*		*Our Action plan can be implemented by external form. It means, the actions will be based on volunteerism, so some specific fund will not be necessary.* *On the other hand, a fund would certainly be needed if we want our Action plan activities institutionalize.*

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

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

The HE2020 project has been a new experience for us. Before the project start we never talked about health equity. So, our work on this is not built on any regional projects or developments related to inequities. Initial information about HE2020 came from the Ministry of Health SR which offered us this opportunity to learn something new. Participation on the projects has brought us new insight and new ways to solve problems on health. We know about the problems on health in the region but we didn´t see them as "health inequities" and thus we had a different approach to their solution. This all changed with the developing the Action Plan.

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?]

Firstly, there is not enough available data related to health at the regional level. Some of them are at the national level (for example blood pressure, level of blood glucose and cholesterol), some are not available at all (for example combined stats: education vs. health). And therefore I think the evidence is not usually background for policy making decision for this reason.
Our Action plan is built on collected data; we chose two entry points based on data: the elderly and the cardiovascular diseases. And, of course, the evidence (collected data) had the greatest influence on the choice of the Action Plan aim (EDUCATION) and type of the interventions (counselling, lectures).

3.3 A community & intersectoral approach

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

We do not usually use the intersectoral approach. It is mainly because of lack of interest to solve health problem from different points. Various sectors/organizations have their own problem which they must solve.

3.4 Building Support

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

All process related to developing Action plan has been influenced by political issue. We have started our participation on the project HE2020 with the support of preceding Head of the office where we are employees (2012). Also we have had a support of Ministry of Health SR. But meantime, the Head of the Office was changed in election 2013, and actually, the new Head of the Office has not been interested in support our participation in the project HE2020. I think this is a big problem almost all long-term strategies/projects which then lose support because of political changes in the priorities of current policy decisions makers.

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?]

The Self-governing region of Trenčín is one from eight administrative unit to which our country is divided. Some competences are central, it means managed by the ministries and government, and some of them are at the regional level. From this reason, the Office of the SGR of Trenčín works as regional authority in some areas under the jurisdiction of the law. So we have some competences in designing policies at the regional level.
The opportunities to develop actions for health:

- to ensure quality health care across the region (by coordinating of healthcare institutions (for example hospitals) which work under our authority

- to participate in health prevention programmes and projects financed by EU (we have successfully implemented):

- Operational Programme Education: „Supplementation of the health system by qualified experts in the Trenčín Region“

- Operational Programme Environment: Hospital in Myjava – reconstruction of boiler and incinerator

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)?]

There were many challenges during the course of the action learning process: non-available data, lack of human resources – personal capacity, lack of support from our Head of Office, reluctance to collaborate on Action plan goals…
Our main actual challenges are: lack of support of our top management, closer cooperation with stake-holders and partners. If we overcome the challenges, the Action Plan will be possible to implement.

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?]

It does not directly relate to our Action Plan but we cooperate with Ministry of Health in its intention to actuate integrated model of health care: Primary Health Care Centres. These centres will offer a comprehensive health care for patients. This concept is planned at the national level, across whole country. At the moment, our main role is help to MoH SR with elaborating regional masterplan. We utilize our experience with conducting toolkit Needs Assessment that we used in the project HE2020. To the future, there is a possibility to connect our Action plan goals/interventions/actions with policy/activities/aims of Primary Health Care Centres.

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.]

Our region has had experience with using ESIF. In the area of health we have successfully implemented:

- Operational Programme Education: „Supplementation of the health system by qualified experts in the Trenčín Region“

- Operational Programme Environment: Hospital in Myjava – reconstruction of boiler and incinerator

Besides that our office has had more experience with other projects in other areas of interest: schools, rural development, roads etc.

Our Action plan is designed that the implementation could be possible by external from without a need for space, complicated organization, the actions will be based on volunteerism, so some specific fund will not be necessary. We do not want people had somewhere to go for information, the aim is to get information to the people so that our efforts are effective. On the other hand, a fund would be certainly needed if we will want our Action plan activities institutionalize.

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?]

Our major achievement of planning process is that even without the support we have drawn up an Action Plan. During the workshops we have learnt a lot of new things: new approach how to tackle the health inequalities, how to design an action plan step-by-step, what is important in planning, and more other things. The main influencing factor for success in implementing of our Action Plan is to obtain support – top management support and to obtain more stakeholders from various areas of interests for cross-sectoral approach. These are our two main challenges which we had not been overcome until now.
Finally, I think that all materials, information which we have got during the whole learning process are so valuable so all would be appropriate to share with other Slovak regions.

3.10 Cascade learning into other regions

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

I think the participation on project HE2020 was a big experience for regions. And it was good chance how to share problems, challenges, visions, plans with other European regions because each of them are in a different situation, has a different background and therefore it was very interesting to exchange advices and experiences with them. So, I can confirm it is very important to build working relationships.
Until now, we did not share our learning and experience from the project with other Slovak regions. Nevertheless, if we are successful in Action plan activities, we will contact at least the nearest regions with presentation of our participation on learning process in project HE2020 and our Action Plan.

3.11 Annex – Information on the Regional Action Group

Official name of the group:

List of member organisations of the Regional Action Group

1. Department of Social Care (The Office of the Self-governing Region of Trenčín) 2. *Department of Education (The Office of the Self-governing Region of Trenčín)* 3. 4.

[Any other information concerning the work of the RAG (e.g. working method, who is coordinating the group, responsibilities etc.)] *The activities within Action Plan will coordinated by Department of Health. With the help of Dep. of Social Care and Dep. of Education will organized various actions with partners on which we have impact; which are in our founding competence: hospitals, social care centres, physicians, schools…Then we will able to ensure mutual cooperation between them easily to reach our common goals/aims.*