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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

VYSOCINA REGION, CZECH REPUBLIC

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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

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

We conducted a needs assessment in order to analyse the situation in the region and identify areas were data are lacking and what are the most problematic areas in the region.
There wasn´t a bigger problem with the collection and availability of data. We used data primarily from: Czech Statistical Office, National Health Registry, Statistical Yearbook of the Vysocina region, Health Yearbook of the Vysocina Region, Institute of Health Information and Statistics of the Czech Republic, data from hospitals and so on. We have gained quite detailed data that we can use without major modifications. We had a problem to obtain data about lifestyle (physical inactivity, healthy eating …).

1.2 Regional profile

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

Population: 509 429
Population density: 75 km2
Districts: 5 (704 municipalities)
Men: 49,7 % of population
Population aged:
0-14: 14,8 %
15-64: 67,5 %
65+: 17,7 %
Average age: 41,6
Index of ageing (65+ / 0-14): 119,6
Average wage: 865 EUR
GDP per capita: 12,211 EUR
Share of GDP of CR: 4,1 %
Regional GDP per capita, EU 28 = 100: 68
Average unemployment rate: 6,7 %

1.3 Socioeconomic inequalities in health

Mortality and life-expectancy

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

The development of the number of deaths varies by gender. The number of men aged 15-29 and 50-59 years is two times higher than in women in these age groups. The most common cause of death for both is the failure of the circulatory system (cardiovascular system). The number of woman who died from the disease is higher than the number of men. The second most frequent cause of death in the region are neoplasms. The number of male deaths from neoplasms is higher than the numebr of women. The next most commos causes of death are: endocrine, nutrirional and metabolic diseases and respiratory diseases. Generally, the population in the Czech Republic is threatened by poor lifestyle (smoking, drinking alcohol, poor eating habits, lack of physical activity). The Czech Republic occupies the first place in Europe in the incidence of colon cancer. Life expectancy for women is 81,2 ad for men it is 75,6 years. There are 15 regions in the Czech Republic and the Vysocina Region has got the 6th lowest life expectancy in comparison with others regions.

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.]

The incidence of chronic disease increases. Only a third of Czechs are healthy, others are chronically ill. Generally, the most common chronic diseases are: musculoskeletal diseases, hypertension, respiratory diseases, asthma, diabetes, thyroid disorders, depression and cancer. In terms of basic socio-demographic characteristics were statistically significant differences in the average number of chronic disease by income, family status, education and economic activity. In terms of income, the highest average number of chronic diseases recorded among people with the lowest average monthly household income. With increasing income, its value declined. A statistically significant difference was also the average number of chronic diseases in terms of family status, especially among woman. Single people showed the highest number of chronic diseases, while the minimum number amounted to a person living in a marriage. In terms of education, the highest number recorded for persons with basic education, the lowest for people with medium education. Unemployed men and women showed a higher average number of chronic diseases than people employed. Average percentage of incapacity is 3,9 % and this is average compared to the other regions (in 2013).

1.4 Socioeconomic inequalities in health determinants

Health behaviours

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

Lifestyles of men are in many aspects worse than the lifestyles of women (higher proportion of smokers, higher alcohol consumption): on the contrary, men have got more physical activity, but lower consumption of fruits and vegetables. Worse lifestyle characteristics show people in middle age (35-64 years). Lifestyle also affects the education: more educated persons less smoke, drink less alcohol and eat more fruits and vegetables. The less educated have higher physical activity. The Czech Republic is among the countries with a higher proportion of people with overweight. The CR is characterized by a higher proportion of women smokers. The increase in alcohol consumption over the past 10 years, the CR belongs to countries with the high consumption of alcohol. Physical activity is relatively high. Consumption of fruit and vegetables is growing, even though it is still relatively low.

Working & living conditions

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

Poverty and social exclusion threaten nearly 1.51 million of Czech population. Of these, 140 200 have not a sufficient level of even one of the three components defining poor living conditions. Thus they have not sufficient income or material resources or job. The number of people at risk of poverty is lower. Household incomes grow nominally, but in recent years actually decreased. Risk of poverty rate also declined at last year. Czech households in distress had the biggest problem with paying for rent, with an extraordinary expense or a vacation. On the contrary, they were not missing washing machines, televisions or telephones. The average salary in the Vysocina Region is 920 EUR. The minimum wage is 331 EUR.

Access and use of health services

The big problem is the lack of primary care disciplines – mainly GPs, paediatricians and dentists. Another big problem is very high average age of doctors. Health care in the region is fairly well distributed geographically. The problem is only in the smallest areas where there is a shortage of doctors. Inpatient care is provided in 5 regional hospitals (and other private institutions). Hospitals are evenly distributed in the region. Hospitals also suffer from a lack of doctors. Due to the size of the region, the absence of universities there is not a comprehensive super specialized centre. Generally, a big problem is the lack of money in

health care. Doctors have very low wages (compared to other countries) and go to work outside the CR.

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.]

If a person is recognized incompetent to do work, that person has not income. In the case of short-term social events person receive secure monetary benefits arising from the area of health insurance. Sickness insurance is compulsory for all employees and it is based on solidarity system. The most common reasons for sickness leave are respiratory diseases and musculoskeletal system (57% of all sickness leave).

The economic activity rate is 58,3 % (average in the CR is 59,3 %). The unemployment rate is 6,7 % (average is 7 % in the CR)

Direct costs related indicators

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

Total expenditure on health in 2014 represented 7,04 % of the GDP. Public expenditure on financing accounted 84,9 %: 79,7 % from health insurance companies and the rest from the public authorities. In comparison with other years spending increases mainly due to higher costs of health insurance.

Phase 2 Conducting a CAPACITY ASSESSMENT

Introduction

[Please describe the overall process of conducting the capacity audit in your region (what data was used, did you conduct interviews, during what period of time?]

We conducted capacity assessment based on available data. Generally, we had no problem in obtaining the necessary data. Sometimes data were available only at national level and not at regional level.

Findings

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

Among our weaknesses include flexibility, given that we are the public institutions and we have to follow the political will.

Among our strengths include negotiating force, clearly defined budget (sometimes could be weaknesses), and good information and knowledge about situation in the region.

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.]

Our organization is highly structured – it is a public body, with clear rules of decision-making at various levels. Strategic visions are decided at the highest levels (political leaders of the region). Sometimes the problem is to reconcile the various political interests and follow the "direction" of previous years. Generally, it is very difficult to decide, because of the need for the approval of many different levels, and therefore it is not very flexible. Information systems are well set up and constantly working on their improvement and expansion.

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.]

We work primarily with the regional office employees – Department of Health, Social Welfare, Informatics and Regional development. We also use the services of external bodies (analyses, data processing etc.). Finances are limited. We have a regional budget – section of Health and also we use money from the Structural Funds of EU. The problem is flexibility in decision-making. We depend on politicians and our work depends on their willingness and interest.

Workforce development

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

We have many educated and highly specialized experts. Occasionally, however, we lack practice. If necessary, we use the services of external experts. We have a sophisticated system of continuous education.

Leadership

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

The problem is the lack of long-term concept (in healthcare) at national level and frequent personnel changes at the Ministry of Health of the Czech Republic. At regional level we have enough strategic documents relating to specific areas (e.g. eHealth). Regional strategies are

based on the needs of the region and the political direction of the ruling party in the region.

Partnerships

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

Our region is relatively small and there aren´t any important institutions (e.g. university, research centrum), which could be our partners. We cooperate with all important subjects in the area of health and also outside the health sector (Health Insurance Companies, associations of doctors, hospitals, State Health Institute, Ministry of Health of the CR, Medical Associations, with subjects of social care, regional development, the area of education).

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?]

As our priority, we have chosen the access to health care and adapting of health care to current needs in the region. We want to focus on the theme of the aging population. Palliative care is among the most important social processes in the early 21st century.

That is why we have to find a new way to identify, describe, secure and mitigate the difficulties and needs of serious long terminally ill and dying patients. Czech Republic lags far behind some of the economically less developed, not only European countries in the development of palliative care. Public opinion surveys show that most people wanted to spend the end of their life at home (in their "own social environment"). Social and clinical reality, however, is different. At home in the Czech Republic takes only around 20% of all deaths. Most people die in inpatient acute and follow-up care.

The theme of ageing population is topical at European level too. There are networks at European level, which are directly concerned with this topic. One of the most important is European Innovation Partnership on Active and Healthy Ageing. There is possibility to use money from European funds, especially from the Operational Programme Employment. Announcement of the 1st call is in September 2015. Specific Objective 2.2 "Improve the availability and efficiency of health services and allow the refocusing of mental health care into the community. We also present our priority in network EUREGHA (European Regional and Local Health Authorities). Here we look for experiences and examples of good practices from more experienced partner region.

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?]

The Vysocina Region wants to create a system accessible palliative care throughout the region, primarily as a home-based care, supplemented as inpatient care, which will be carried out in particular medical service providers which are established by region. It is necessary to establish close clinical and organizational contacts with other key providers and subjects in the region. Scope of the proposed system must be modelled with respect to the demand for this service within existing budgetary resources of the region. Palliative treatment has a positive effect not only on the patient but also on the quality of life and their families and relatives. The main objective of the concept is a quality system setting functioning of palliative care in the region, which will cover all the needs in the region. This is our own project created in collaboration with stakeholders. A similar concept should be implemented also in the South Moravian Region in future.

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?]

Actions should have a positive effect not only on patients but also on their families and relatives. The strategy aims to ensure: The available mobile specialist palliative care, Available outpatient specialist palliative care, Available bed palliative care providers established by the region, A single database linking health and social services (needs and offer). The actions will be implemented in collaboration with hospitals established by region, non-profit organizations (regional charity), home hospices and private providers. In the period 2015-2020 is expected to expand the network of palliative care. The aim is to have a palliative patient care in every hospital in the territory of the Vysocina Region and to have the territory covered by mobile form of palliative care.

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?]
The results of our intervention will reflect on the determinants of health and the health of the regional population. Disadvantaged population are older people suffering from chronic diseases. Intervention should effect also on patients´ families and relatives (indirectly).
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?]
Intervention will focus on the number of elderly treated at home, at hospitals or others centres, on the number of beds in hospitals, on the number of employees in that area. Seniors are in the long term disadvantaged group not only in the region, but in whole country. We used examples of good practices of others European regions and adapted them to regional conditions.
Impact assessment
[Quantify or describe potential, important health and health equity impacts.] *We can describe a direct impact – e.g. the number of bed and we are able to quantify the costs of the intervention.* *The main benefit of the intervention will be a better quality of life for patients and their families.*
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).] - *it is based on current, accurate analysis* - *the process involved stakeholders* - *real ideas and real timetable* - *consensus across political parties and various bodies*
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?)]
After the implementation of the intervention will be performed evaluation (2020). Some data

(determinants) can be easily evaluated (e.g. number of created beds, the number of clinics..). It will be difficult to evaluate the quality of life of the concerned population (if it is higher). We plan to carry out qualitative research and find out how patients and families perceive "new" services.

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.)]

The Regional Action Plan is part of the Health Plan of the Vysočina Region which is valid for period 2015-2020 and it is one of the most important strategies of the Region. The plan is based on the needs of the Region and aims to provide a comprehensive view on health and related areas. The document is very important because there is not a long-term strategy at national level. The plan will be approved by the regional government and should be valid also in the case of political changes.

2.7 List of partner organisations

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

- Other departments of The Regional Authority of the Vysočina Region (Department of Social Affairs, Department of Informatics and other)
- Regional hospitals
- Emergency Medical Services
- Health insurance companies
- Private providers of health and social services (physicians, hospices)
- Private entities

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).]

The most important annexes of the action plan are:
- Analysis of demographic trends In the Region,
- Analysis of Health Care in the Region (hospitals, private providers)
- Investment and financial plans of hospitals

2.9 Action Plan table

Actions	Output/ Deliverables	Responsible party	Others to involve to complete action	Timeline	Indicators	Financial resources
Creating a system accessible palliative care throughout the region, primarily as a home-based care, supplemented as inpatient care, which will be carried out in particular medical service providers established by the Vysocina Region.						
Creating a mobile specialist palliative care teams in the Vysocina region	Provision of specialist palliative care in the home or substitute social environment of patients through visits to the multi-disciplinary team.	Providers of health care		2015-2020	The number of teams	Public health insurance Additional payment from the patient or Additional payment from the regional budget
Operation of mobile (field) specialized palliative care in the region	Operation of field units	Existing group of providers (GPs, church and civic associations)		2015-2020	The number of functional teams	Public health insurance
Consultant palliative care teams within healthcare providers	Creating a functioning interdisciplinary	Hospitals, facilities for the chronically ill		2015-2020	The number of teams	Public health insurance

	consultant palliative care teams in hospitals and palliative care settings within hospitals for patients who for various reasons can not stay at home.	persons				
Ambulance of specialist palliative care	Creation of ambulances in hospitals, where it is linked to possible further treatment	Hospitals		2015-2020	Number of ambulances	Public health insurance
Palliative care beds	The separation of the total number of beds of aftercare beds, internal and surgical care – according to the situation at the hospital. Each of the established hospitals in the region will have	Hospitals		2015-2020	Number of beds, number of or separate palliative department	Public health insurance Payment from patients

	about 2-4 beds that are fully equipped and designed for accompanying family members					
Linking databases of health and social affairs	Transmission of information on the health status of the patient electronically between providers of health and socials services	Hospitals, Health and Social Care Providers		2015-2020		The Vysocina Region
Training of personnel in social and health services and education of families	Training in palliative care for low staff, for workers of home hospices care, training within the certification of The Czech Society for Palliative Medicine	Hospitals, Health Care Providers, families of patients, educational centres		2015-2020	Number of training course, Number of graduates	The Vysocina Region
Information Support	Creating of brochures for	The Vysocina Region		2015-2020	The number of brochures	The Vysocina Region

	palliative care in the region designed for patients and their family members, providers of health and social services. Information will be also published through electronic communication systems.					

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?]

We are aware of the importance of the regional action plan, given the lack of a long-term approach (conception) at the national level. In recent years, we try to have a current regional concept of health care and related areas, based on the needs of the region while respecting national legislation. HE2020 project helped us realize the need to think more broadly and focus more on health inequalities - define them, determine the outcome and ways to reduce them. The issue of an aging population and ensure quality, affordable care is solved for a long time and finally was made strategy for palliative care based on evidence. It was not easy to coordinate the political will and cooperation between different areas.

3.2 Using an evidence-based approach

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

Regional strategies are usually evidence-based. We have enough data from the health and social field. We try to cooperate with health insurance companies that have large amounts of data and also we cooperate with external entities that are asked necessary data to identify and analyse. We try to work with primary data.

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 try to deal with problems comprehensively. This means that we try to deal with a broad spectrum of stakeholders (areas). The draft concept of palliative care has been discussed with: the department of social affair, health insurance companies, health care providers (public, private), social services providers and with representatives of political parties in the region.

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?]

As a public authority – Regional Authority, we are burdened with a certain set of rules. Decision-making processes are therefore sometimes complicated and lengthy. Our participation in the project was politically and institutionally supported. The concept must be approved by the political will in the region – like all other strategies in the region.

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?]

Our region is an autonomous region with higher competences in designing policies at regional level. Within the framework of regional powers – the legal possibilities, we try to create health policy, which corresponds to the conditions in the region. However, we are limiting by regulations at the national level and by health insurance companies (primarily).

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 biggest challenge was working with partners and the lengthy process of negotiation – approval. Problematic is also consensus of politicians in the region.

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?]

Since we didn´t have the capacity to create a separate action plant to tackle health inequalities, regional action plan is a part of one of the most important regional strategic plans – the Health Plan of the Vysocina Region. The fact that the regional action plan will be include in the Health Plan was clear from the beginning, because we just dealt with updated health plan.

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.]

We think we have enough information on EU funds and we are also involved in the process of creating calls IROP in the CR. Supported types of projects are:
- activities for follow-up care
- activities for highly specialized care
- activities to transform the provision of psychiatric care.

Our regional hospitals plan to draw money from the structural funds – eg. Project of Comprehensive Cancer Center in Jihlava Hospital and other projects. We regulary participate in meetings of supported areas and looking for opportunities to take money from EU funds. We don´t plan to finance the concept of palliative care from the EU funds. The main source of funding should be health insurance.

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?]

We consider the process of creating the strategy plan for the greatest success. The most troublesome was to agree with the other partners – to find a suitable date, organize meetings and especially to coordinate the interest of all and to create a uniform concept, which is the result of consensus. We have learned that it is important not give up at the first failures.

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?]

Our project is a pilot and is adapted to conditions in the region. We have no problem to provide our project to other entities in case of interest. So far the South Moravian Region expressed interest.