JOINT ACTION

HEALTH EQUITY EUROPE

JAHEE

Work Package 9

Health Equity in All Policies – Governance

Deliverables 9.2 and 9.3

WP9 – Final Report

Report Information

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Glossary and acronyms

CA	Country Assessment
Governance	Governance is the system of decision-making whereby directions are set, authority is exercised, and events are monitored and managed. Governance may include action that goes well beyond government by delegating policy formulation and policy implementation or parts of it to stakeholders or stakeholder organizations. In essence governance is about power relationships in the decision chain.
Health equity	Greater socioeconomic inequality in society is associated with poorer average health at aggregate level. Many policy decisions have a particularly detrimental effect on the health of lower socioeconomic groups, with many health determinants and vulnerabilities being unevenly distributed among populations.
Health inequalities or inequities – HI	These can be of two types, concerning (a) health status or (b) the provision of health services or health protection in the wider sense.
Health in All Policies – HIAP	Health in All Policies is an approach to policies across sectors that systematically takes into account the health implications of decisions, seeks synergy and avoids harmful health impacts.
Health Equity in All Policies – HEIAP	Utilizing Health in All Policies approach by focusing to health equity. It aims to improve population health and health equity by making different choices, and have an unequal investment.
Health Lens Analysis – HLA	The Health Lens Analysis (HLA) is one method of HEIAP approach; a process description of implementing HIAP.
Health (Equity) Impact Assessment – HIA	Combination of procedures, methods, and tools by which a policy, program, or project may be judged as to its potential effects on the health of a population, and the distribution of those effects within the population by making clear if a policy will differentially impact on different groups. It can be described also as a prospective Health Impact Assessment with equity focus.
Health Equity Audit – HEA	A review procedure, which examines how health determinants, access to relevant health services, and related outcomes are distributed across the population. It can be described also as a retrospective Health Equity Impact Assessment.

IA	Implementation Action
Inequality	A difference (regardless of how it is caused).
Inequity	An unfair and avoidable difference. It is often unclear to what extent differences in health status should be regarded as inequities; inequalities in service provision are much more likely to be regarded as unfair and avoidable.
ISP	Integration and Sustainability Plan
JAHEE	Joint Action Health Equity Europe
MS	Member State
PFA	Policy Framework for Action
SDH	Social Determinants of Health
WP	Work Package

1. INTRODUCTION AND OBJECTIVES

This report describes contribution of work package nine (WP9) within the Joint Action Health Equity Europe project (JAHEE). JAHEE gave an important opportunity for countries to work jointly to address health inequalities and achieve greater equity in health outcomes across all groups in society in all participating countries and in Europe at large. WP9 focused on governance and strengthening a Health in All Policies approach with equity focus. The challenge of reducing health inequalities in participating countries cannot be eliminated within the course of a three-year project. The JAHEE project, however, offers a unique opportunity to move forward by working together in a structured work process that allow partner countries to share, build and transform available knowledge into concrete actions and gain experience on how to progress cross-sectoral collaboration concerning health inequalities.

The main aim of the Joint Action projects is the orientation towards action. The participating countries have to implement concrete activities that can improve current situation in their country regarding governance and HEiAP. This report compiles each country's reporting on their implemented actions. In this report, we will present experiences and learnings from this process. We will reflect WP9 contribution, summaries results gained during WP9 work and give examples on concrete actions and initiatives taken in JAHEE WP9 and in partner countries.

WP9 objectives

The general objective of the WP9 is to focus on governance and systems, that is on Health and Equity in All Policies at local, regional, national and EU levels, taking into account the wider society.

The specific objectives of this WP are:

- to generate more vigorous interest and commitment in tackling HI and their causes in MSs;
- to strengthen MSs capacity, abilities and commitment to develop and implement effective and concrete policy actions to tackle HI;
- to develop and apply a HiAP approach and implement at least one action during the course of the JA.

Background

The earlier enforced Joint Action Equity Action (Equity Action 2012) suggested by a literature review:

- Although technical skills (such as data analysis and interpretation) were recognised as important capacity and capability issues, stronger emphasis needs to be placed on the development of softer skills (such as negotiation and relationship building) to influence OGDs and other sectors and to resolve conflicts and raise awareness of health equity and
- There were few concrete examples given of successful HiAP work that had been undertaken with a strong equity focus. This needs to be addressed as a priority by EU Member States, Countries and Regions.

These notions were taken into account while planning JAHEE WP9 and within WP9 implementation both of these ideas were pursued and accomplished.

To tackle health inequalities (HI) need actions in all sectors across governance at national, regional and local level. Therefore persistent structures are needed for a broad based collaboration to accomplish common trust, commitment and accountability. The objectives should be formulated together and everybody do their own share in their sector. When inequalities are reduced in all sectors (eg. employment, education, environment, etc.) that will lead in the end towards more equal and desired health outcomes. The main point is to take into account all citizens and their different needs and adjust actions/measures accordingly (e.g. proportional universalism).

Participants of WP9

WP9 was led by Tuulia Rotko and coordinated by Katri Kilpeläinen, both from the Finnish Institute for Health and Welfare (THL) from Finland. There were 16 participating countries and 19 Implementation Actions in JAHEE WP9: Finland, Belgium (2 actions), Bulgaria, Croatia, Estonia, Greece (2 actions), Italy, Lithuania, the Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain (2 actions), UK Wales.

Picture 1. WP9 in Rome, Italy in October 2019.

Implementation of Actions in WP9

There were all together 17 countries involved in WP9 at the beginning. Germany dropped out due to lack of personnel resources. 17 out of 19 Implementation Actions (IAs) were implemented during project period. Implementation in Estonia, Slovakia and Spain/Andalucia was cancelled due to Covid 19 situation. Three countries had two IAs namely Belgium, Greece and Spain. Implementation actions were done at national level (11), at regional level (9) and at local level (7). Some IA's focused to several levels.

Table 1. Chosen actions to be implemented in WP9.

n/19	IMPLEMENTED ACTION TITLE	Country	n.IA per country
1	Health and ecological inequalities	Belgium	2
2	The rewriting of the prevention and health promotion decree		
3	Facilitation of Health in All Policies Planning at Municipal Level	Bulgaria	1
4	Current situation analysis and definition of the interventions addressing the reduction of health inequities	Croatia	1
5	Guidelines for County Health Profiles tackling health inequalities	Estonia	1
6	Coaching two regions	Finland	1
7	Joint implementation of medical information and support of vulnerable groups registered in the Greek Fund for European Aid to the Most Deprived (FEAD / TEBA)	Greece	2
8	Strategic recommendations on HIAP for both municipal and regional authorities		
9	Building an intersectoral mechanism of collaboration and coordination for Health Equity in All Policies at national level	Italy	1
10	Recommendations for a new Occupational Health Services delivery model development. Establishment of a pilot service	Lithuania	1
11	Establishing of the cross-cutting Working team for the analysis and assessment of the impact of policies on social inequities in health	Poland	1
12	Implementation of the National Health Plan	Portugal	1
13	Assessing the impact on the vulnerable population, of the community centers set up in 10 regions in the center and west of Romania	Romania	1
14	Health in All policies - Healthy cities and Committee for Roma Health	Slovakia	1
15	Development of health equity reporting, from population data to relevant policies	Slovenia	1
16	Action to include the perspective of Health Equity Impact Assessment (HaIA) in the Network of Andalusian Local Actions for Heal in the Andalusia Community Region	Spain	2
17	Building a methodology to support Health Impact Assessment (HIA) at local level in the Valencian Community Region		
18	Intersectoral action on health equity in Dutch Municipalities	the Netherlands	1
19	How the Well-being of Future Generations (Wales) Act 2015 is being implemented to deliver conditions for improved governance for Health in All Policies and sustainable development at national, regional and organisational levels	Wales / UK	1

The Implementation Actions were clustered as follows.

Group 1: Assessments & reporting: Estonia, Romania, Croatia, Belgium, Spain/Valencia, Spain/Andalucia, Slovenia

Group 2: Structure & mechanisms

a) Local level: Bulgaria, Netherlands, Germany
b) Regional level: Finland, Greece Belgium / Wallonia, Spain/Andalucia
c) National level: Italy, Poland, Portugal, Slovakia, Lithuania, Germany

Wales/UK supported and helped other participating countries while testing their tools.

Policy framework for Action and Country Assessments

The purpose of the WP9 Policy framework for Action (PFA) is to describe the horizon of our expected standard to be achieved in the future of HEIAP and inter-sectoral governance. In addition to operating horizontally (cross-sectoral), HEIAP can also operate vertically, to bridge local, regional and national actors engaged in policy making and implementation. In the implementation phase the participating countries could utilize HEIAP tools as described in the PFA like SIFT tool, advocacy, health equity audit (HEA), health lens analysis, health impact assessment with an equity focus (HEIA), or Be the Change – campaign. At least advocacy, HEA and HEIA were used during WP9 implementation.

Each participating country has chosen the target of their Implementation Action (IA) to facilitate cross-sectoral collaboration with different stakeholders for strengthening health equity and reducing health inequalities. The chosen target of the implementation action is dependent on what is useful and feasible in each country. All interventions require cooperation of those responsible for the activity in which it is proposed to intervene.

Country Assessment (CA) of WP9 concentrates on the specific situation/challenge chosen to be the target of implementation in each country, the context around this challenge, and how it could be solved. Each participating country describes the context (current situation) in their country concerned to the topic of the chosen Implementation Action (a context analysis/country assessment (CA)). The Country Assessment of WP9 helped the participating countries to focus and clarify what they should do within their Implementation Action. At the minimum the Implementation Actions were "exemplary" in order to learn and demonstrate that "it can be done". At its best the IAs started building new structures for HEIAP or governance exploring barriers and success factors for further implementation.

The Country Assessment of WP4 from the participating countries collected the general/national situation, “a big picture” where the country is now according to HEIAP. The CA of WP4 and CA of WP9 complement each other.

At the reporting phase of WP9 each participating country describe the learnings, enablers, barriers and solutions recognized during the implementation. The main question is, what has changed compared to the situation in the beginning, and what are the possibilities to do better in the future.

Tasks performed during WP9

WP Leader:

Drafting and finalizing Policy Framework of Actions (PFA), clustering the countries, providing and collecting Country Assessment (CA) template, organizing 13 online meetings in every 6 weeks + one workshop, organizing two face-to-face meetings Jan. 2019/Brussels and Oct. 2019/Rome, providing and collecting IA reporting template, evaluation, facilitating WP9 recommendation formulation and finalizing them, suggesting and rating promising practices from WP9 IAs, drafting and finalizing JAHEE WP9 final report, finalizing JAHEE WP9 Integration and Sustainability Plan (ISP), participation to JAHEE Steering Committee meetings, GAB/PAB/SAB meetings, planning and participating conferences and general assemblies.

Participating countries:

Commenting WP9 Policy Framework for Action (PFA), commenting and filling in WP9 Country Assessment (CA) template, filling in WP4 Country Assessment template, choosing and implementing their own Implementation Action, participating online and face-to-face meetings, reporting Implementation Action, filling in interim report, filling in the evaluation (internal & external) templates and participating to the evaluation interviews, participating to the WP9 recommendation formulation, commenting WP9 final report.

Needs and situations of participating countries differ a lot. However, all countries need experiences, practice and strengthening in cross-sectoral collaboration concerning health inequalities. That's what we did in WP9.

2. GAPS IDENTIFIED IN GOVERNANCE AND CROSS-SECTORAL COLLABORATION CONCERNING HEALTH EQUITY

The information reported below describes the gaps identified on capacity of policy response to health inequalities (HI) that have led to design the Actions Implemented within WP9. These gaps were identified at local, regional and national levels, taking into account the wider society, in participating countries. These replies have drawn from the WP9 Country Assessments, that were filled in in the beginning of the JAHEE.

Lack of interest and commitment in tackling HI in the non-health related sectors

- Poor level of awareness and engagement with respect to health inequalities and health impact of social determinants in the non health policy domains.

Lack of experience in crossectoral collaboration related to health equity

- Insufficient political experience in systematic, crossectoral and broad-based strategies for achieving sustainable social change and equality.

Lack of capacity and abilities to implement effective and concrete policy actions to tackle HI at different levels of governance

- To build and develop the capacity between & within these institutions.
- Counties capacity and abilities to assess and implement effective and concrete governance measures to tackle health inequalities.
- Capacity building at local level needed.

Limited use of information to promote cross-sectoral work on HI

- There is still a comprehensive approach in terms of getting the information on the "bigger picture" missing.
- Limited use of information to monitor and drive performance improvement at the local level.

Insufficient use of tools tackling HI

- To assess the three years of experience of the institutioanlization of HeIA implemented by a Regulation.

Insufficient consideration of vulnerable/minority groups and their needs

- To provide integrated services for vulnerable group at community level.
- Low percentage of access to Occupational Health services (OHS) in micro and small enterprises in the country.
- To identify the gabs between legislation and reality concerning vulneragble groups.

3. IMPLEMENTATION

Cross-sectoral collaboration (horizontal and vertical, broad based)

In all the Implementation actions within WP9 the focus was to tackle health inequalities somehow or other. Many IA's focused to build multisectoral collaboration, HIAP structures and governance to reduce health inequalities. Some IA's target groups were vulnerable groups or the focus was on deprived areas. Collaboration was done in many ways, both horizontally and vertically.

> **Example the Netherlands**:
>
> The IA improved intersectoral collaboration on health equity between the public health/social sector and urban planning in the municipalities at local level. They also involved 5 ministries by sharing these experiences with them. In addition to strengthening horizontal collaboration between sectors, they could also strengthen the vertical line between levels of government (local-national).

All implementation actions needed at least consultation from other sectors/organizations.

1) Horizontal collaboration between ministries
   According to WP4 infographics done to the country Integration and Sustainability Plans ministries involved in WP9 Implementation Actions (18) were as follows: Health (14), Social policies/Welfare (6), Labour (4), Economy (2), Education (2), Urban planning (2), Housing (1), Transport (1), Interior (1), Environment (1), Development, Agriculture (1).

   Poland, Portugal, Slovenia and the Netherlands succeeded well involving different ministries during their HIAP implementation at WP9. In addition, many IA's could build connection between two or three ministries, e.g. Italy and Lithuania.

   Example Poland:
   They established a cross-cutting Working team for the analysis and assessment of the impact of policies on social inequities in health under the Public Health Council, an inter-sectoral scientific-advisory body. Ministries involved were: Education, Health, Social Policies/Welfare, Labour, Development, Agriculture, Sport, Economy, Culture, Environment, Defense and Science.

2) Broad based multisectoral collaboration at regional and local level
   At regional and local level implementation there were broad based collaboration between many relevant organizations, regional and municipal authorities from different sectors as well as NGO's. For example, Finland strengthened regional level and the Netherlands, Bulgaria and Spain/Valencia local level multisectoral collaboration concerning health inequalities.

   Example Bulgaria:
   Developing municipal Action plan on health equalities in all policies. The IA was carried out in partnership with the Municipality of Stara Zagora. Other local institutions and organizations were involved in the IA such as the Regional Health Inspectorate, Social Assistance Directorate, Municipal center for prevention and information on drug problems, International Youth Center, local civil society's organizaions working with vulnerable groups. Different areas' municipal experts participated in the process of planning – from the Healthcare and Social Affairs Department, Education Department, Ecology Department, Sports Activities Department, Youth Activities Department.

3) Collaboration with research institutes
   Many IA's at WP9 build also collaboration between research institutes, e.g. Belgium, Croatia, the Netherlands, Poland and Slovenia. Also Italy and Greece had strong research part included in their implementation.

Example Slovenia:
Development of health equity reporting, from population data to relevant policies. Currently, a obligatory reporting system with elements of health equity is in place, implemented in siloes by three national institutions, NIJZ (public health), IER (economic research) and IRSSV (social protection). At testing phase of the reporting Platform also OI (Institute of Oncology) and UMAR (Institute of Macroeconomic Research and Development) participated. The steering group for the Platform consisted of four ministries.

4) Collaboration mostly within health and social sector between many different organizations were done e.g. in Greece (complex) and Romania.

Example Romania:
Assessing the impact of community centers on the vulnerable population. Twenty-four community centers (health and social) have been established in rural areas in order to improve the access and quality of medical and social services of the vulnerable population. This IA was implemented with the help of local authorities, the mayors, and County Public Health Directorates from the 10 counties.

Participation of civil society

WP9 was mostly about building multisectoral collaboration, HIAP structures and governance to reduce health inequalities at organizational and national levels and these actions did not involve citizens during JAHEE period.

In regional and local settings civil society was more important and easier to involve. In structural collaboration civil society was represented by e.g. youth councils, senior councils, independent citizen's movements/organizations and NGO's. In Lithuanian IA employees that do not have access to occupational health services were considered as vulnerable groups and they participated. Also, individual citizens were involved in some IA's e.g. in Finland, Greece and Romania. The most difficult was to involve vulnerable population.

Example Greece (complex):
Giving medical information and support of vulnerable groups. Civil society was involved in the municipality of Patras through training from health professional. The vulnerable target group of women realized their efficiencies and were motivated to be more active and participate more actions that concern them. The participation of the vulnerable target group of women was achieved with the help of Region of Western Greece since they are beneficiaries of the Greek Fund for European Aid to the Most Deprived (FEAD / TEBA).

In some IA's civil society was not involved during WP9, but mechanisms to do so in the future were planned e.g. in the Netherlands and Slovenia.

Impact of Covid-19 pandemic to implementation

Covid-19 had mostly **negative** impacts to implementation during JAHEE. Covid-19 situation delayed almost all the IAs in WP9. However, the extra 6 months for project period helped many. While the main action in WP9 was to collaborate with different/new partners, the Covid-caused face-to-face meeting limitations made that more difficult. In addition, overloading of collaborating parties e.g. municipal administration slowed down the implementation.

Participation of civil society was also difficult due to Covid-19.

> *"We wanted to include civil society, but Covid-19 kept everyone inside and the digital tools available were not fit for this group." "Due to the pandemic we were unable to involve all the key players in the neighborhoods, such as: people living in the area."* (the Netherlands)

Some countries had to stop their implementation totally. E.g. Estonia, Slovakia and Spain/Andalucia could not start their Implementation Actions due to Covid-19 situation. In Estonia and Andalucia other interests (Covid-19) took attention and working time. Covid also partially shifted the focus of welfare goals so that non-emergency services and health promotion were reduced.

Also some **positive** impacts were noticed. The Covid-19 situation made health inequalities visible/obvious. Some countries could use this window of opportunity as justification to build Health Equity in All Policies approach and got different sectors interested and more committed to reducing health inequalities e.g. Italy and Poland.

> **Example Italy**:
> Building an intersectoral mechanism for Health Equity in All Policies at national level. The pandemic put the health outcomes in the centre of the policy agenda. The interinstitutional coordination working group of the MoH caugth on the fly this opportunity and worked hardly to elaborate an Health Inequalities Impact Assessment (HIIA) of the pandemic, in order to introduce the equity lens in this new social climate that is apparently ready to scrutinize the health impact of the non health decisions. For the first time, by default, Health in All Policies (HiAP) has been put in practice by all the actors. The pandemic prepared the ground for the HEiAP development, given that for the first time the benefit-risk ratio was systematically introduced to take decision in every economic and social activity of the society.

In some cases practical arrangements helped implementation. Due to Covid-19 situation cross-sectoral collaboration in Slovenia was organized in digital environment. *"A beneficial consequence was the fact that the whole group was meeting once in every 14 days with higher rates of participation."* Due to the

pandemic, many of the planned in-person events had to be done online, which turned out to be more cost-effective and time-saving.

Target/focus of implementation

While choosing how the target will be reached and action will be implemented, the countries chose some of the most reasonable from the tick lists of a) HEIAP key components and b) governance actions. (see in more detail WP9 PFA)

a) HEIAP key components

The most relevant HEIAP key components chosen were 'Identify supportive structures and processes', 'Build institutional capacity' and 'Establish the need and priorities for action across sectors'.

Which of the following HEIAP key components did you use in your Implementation Action? (17 IA responses)

HEIAP key components	no of countries/IAs who selected
Establish the need and priorities for action across sectors	9
Identify supportive structures and processes	12
Frame planned actions	7
Facilitate assessment and engagement	7
Build institutional capacity	12
Establish a monitoring and evaluation mechanism	5
Putting the action across sectors into practice	8

b) Governance actions

The most relevant targets within Governance actions that were concentrated and needed were 'Evidence support', 'Policy Guidance' and also 'Coordination', 'Advocacy' and 'Monitoring & Evaluation'. Only two IA's were able to mark 'Providing legal mandate'.

> **Example Belgium/Walloon**:
> The operationalization of the Health Prevention Plan (WAPPS2030). One of the objectives of WAPPS2030 is to tackle health inequalities. Implementation Action carried out a new decree, which obliges operators to achieve the objectives relating to health inequalities.

Which of the following Governance actions did you use in your Implementation Action? (17 IA responses)

Governance actions	no of countries/IAs who selected
Evidence support	10
Setting goals & targets	3
Coordination	7
Advocacy	7
Monitoring & Evaluation	7
Policy Guidance	8
Financial support	3
Providing legal mandate	2
Implementation & Management	2

The framework of "Five I's"

The framework of "Five I's" has been used to a) include and integrate equity tightly into HIAP, and b) build up a Health and Equity in all Policies –approach (Palosuo et al 2013; Weiss 1995; Collins & Hayes 2007). This is done to highlight and deliberate on the different tensions and trends in the field of policies, programmes and action plans addressing health inequities and the social determinants of health. (see in more detail WP9 PFA)

The idea using of 5 I´s framework was to split the analysis for smaller parts, so that the Member States would recognize issues that can have impact on the result and which of them they themselves have the most power to influence. So, they could choose what elements they should concentrate in implementation and not necessarily choose them all. The most often was chosen Information (14) and Institutions (11) (among 17 responses) as targets.

> *"We were struggling to work with the 5 i's. Eventually we put this structure aside, to be more creative and focus on the demands of the municipalities, and not (only) the structure. We would have liked to add a 6th I, Individuals, as they are key."* (the Netherlands)

Which of the 5 I's did you concentrated in your Implementation Action?

Five I's	**no of countries/IAs who selected**
Information	14
Ideologies	5
Interests	7
Institutions	11
Implementation	8

4. RESULTS AND LEARNINGS

4.1. Succes factors and changes reached

All Implementation Actions (IA) that were implemented during WP9 were self-assessed to be succesfull and objectives set to each IA were mostly achieved. All IA's aimed to focus on health equity, reducing health inequalities and improving situation of vulnerable groups by broad-based collaboration.

The main determining factors for **success in generating interest/commitment** in tackling health inequalities

- The network of ambassadors was key to increase advocacy and HiAP and political commitment
- The situation analysis (data)
- Integration (to existing work) in the local processes, which gave more importance and credibility.
- The growing interest in the topic of reducing inequalities in the ministries and other public entities due to Covid-19.
- 1) Working on the common terms for health equity, and 2) contact persons were active and keen to participate.
- Flexibility at local level. Municipal administrations are willing and motivated to embrace innovative models and approaches. The active position and involvement of the experts.

> **Example Belgium (fed.)**:
> They succeeded to put the topic of equity and health inequalities on the political agenda. It was explicitly mentioned in the policy brief of their minister and they have mentioned the implementation of HIAE in all Federal administrations in the new plan of sustainable development.

> **Example Croatia**:
> Situation analysis to see how health inequalities are addressed at national level, who is in charge of health inequalities and is there an intersectoral cooperation in dealing with health inequalities.

The main determining factors for the **success in strengthening MS capacity** in tackling health inequalities

- Active coaching/working together/encouraging from JAHEE-people to country participants
- Using data (HI metric) to facilitate communication between different policy sectors and providing up-to-date evidence based information
- Concrete tools used (HIA, HEA, check lists, etc.)

> **Example Finland**:
> Extra support to identify and keeping the focus on health inequalities was needed at regional level. We supported counties by helping identify, measure and value health inequalities as well as produced the same material to all other counties too.

The main determining factors for **success in terms of HiAP implementation**

- Backbone in national legislation/programmes, etc., political will
- JAHEE-representatives' straight relationship/connection to ministries (an appropriate position in the organization)
- Active way of working and advocating, using data & tools to promote the purposes

> **Example Lithuania**:
> Activities were part of the strategic tasks at the governmental level – this helped to take relevant decisions, execute the IA, and reach the positive change.

Country examples:

- Belgium (fed.) IA succeeded by integrating into existing work: Implementation of Health Equity Impact Assessment was included in the new proposition of plan of sustinable development and strenghening Health Equity in All Policies approach was incorporated to One World One Health project.
- Intensive support was needed to help local level actors. This IA achieved to bridge local actors and facilitate the establishment of cross-sectoral cooperation. A HEiAP Municipal Action Plan was developed by rational and careful planning. (Bulgaria)
- A situation analysis needs to be made to see how health inequalities are addressed at national level, who is in charge of health inequalities and is there an intersectoral cooperation in dealing with health inequalities. (Croatia)
- Support to identify and keeping the focus on health inequalities was needed at regional level as well. (Finland)
- A secure and trusty climate during the training helped to build partnership with different participants. (Greece)
- A concrete tool, Health Equity Audit (HEA), helped encourage other policy sector to be accountable for their health equity impact. (Italy)
- IA activities were part of the strategic tasks at the governmental level – this helped to take relevant decisions, execute the IA, and reach the positive change. (Lithuania)
- Also, brief guidance available is needed to support developing and evaluating of public policies, including also non-health policies. (Poland)
- They succeeded to raise the interest of decision makers and policy makers to extend the health community centers all over the country, especially in rural areas. Convincing the policy makers and especially the local authorities about the need to help vulnerable population. (Romania)
- They convinced the different sectors (health, education, social affairs, family, environment and spatial planning) and national sectoral scientific institutions on the importance and benefits, added values of collaboration within HI. IA succeeded to reaffirm joint actions by building understanding of the common concepts. (Slovenia)
- The Literature Review was an important enabler in helping public services embed the welsh sustainable development legislation. (Wales)

4.2. The main challenges during implementation

In addition to Covid-19 situation caused delays and difficulties, other challenges during implementation was as follows:

- How to convince different parties
    - The 3 parts have different interests.
    - To develop human capacity and to create a common language.
    - It was difficult to involve the non-health departments.
    - A more diverse representativeness was planned but didn't respond to the invitation. Probably they have not recognized their role in HEiAP planning.
    - Insufficient engagement of stake-holders other than health sector.
    - We identified differences in the policy makers knowledge and awareness.
- How HI can be reduced
    - It is difficult for them to make the link between health inequalities and their daily work.
- Gathering resources to be able to give enough support
    - Implementing Health Equity is an ongoing process. This requires never ending input and support.
    - We would have needed at least two persons on a permanent base so that we can create a helpdesk "HiAP, HIAE" on a structured base.
- HI is a multidimensional problem, how to catch relevant participants
    - The main challenge was to cover all legal acts dealing with health inequalities and all stakeholders that are competent authorities.
    - The major challenge was the participation of the right participants (employees).
- Changing personnel
    - The resignation of the government, which suspended the preparation of welfare reports and led to the dismissal of preparatory staff. After new government, new forms of funding, new recruits.
- Changing political athmosphere
    - The coordination with non-health ministries was non-structural and episodic, and also disturbed by changes in government.
    - Along new governance period health inequalities were not the case and no priority was given to that.
- Research is needed
    - Recognition of how complex and demanding it is to research the health equity dimensions in the policy context.

4.3. Monitoring and evaluation

It is too early to show impacts of the IA's, however it seems that awareness of health inequalities has increased in participating countries. The data will be collected by a) indicators of the different evaluations are already identified and b) discussions with key informants, interviews of population, interviews and questionnaires of pilot service participants. Many action plans and reports have been developed. The impact and usefulness of these documents will be seen when their implementation starts. A broad-based collaboration has collected several authorities from different sectors from national, regional and local level, as well as other actors like NGOs. These participants that have been involved in the work are committed to promote/implement the measures and policies. The impacts will be seen later. A lot of research is delivered and there is still research ongoing. It is too early to evaluate the impact of progress in HEiAP and governance. Dissemination of results and learnings, continued collaboration and implementation of action plans is the key to have a greater impact in each country. Outcomes and possible changes in health inequalities will been seen in coming years.

4.4. Concrete achievements and learnings within WP9

Examples of the achievements of the WP9 Implementation Actions

- A new decree between the 3 parts (Belgium/Walloon)
- Collaboration with our research institutes and the network of named ambassadors. To put the topic of equity and health inequalities on the political agenda and implemention of HIAE. (Belgium, fed.)
- Develop a HEiAP Municipal Action Plan and establishment of a multisectoral work group on local level (Bulgaria)
- Established a subdivision (Division for Health Inequality Reduction) in the Public Health Department in the CIPH (Croatia)
- Raise the issue of inequality in the discussions (regional level) and document it in both objectives and measures (Finland)
- Achieved to build partnership with different participants and to provide a policy guide (Greece)

> **Example Greece (feasible)**:
> Utilizing the knowledge on health inequalities: Strategic recommendations were given for both Municipal Authorities and Regional Health Authorities to reduce inequalities, based on the research and questionnaire for the regions.

- Creation of the interinstitutional coordination working groups under the responsibility of the MoH. Encouraging other policy sector to be accountable for their health equity impact and a concrete tool Health Equity Audit (HEA) was used. (Italy)
- New OHS delivery concept was developed. Program to increase mental health competences of employees was created. We succeeded to open and moderate inter-ministerial roundtable discussion. (Lithuania)

- They stimulated HIAP in three Dutch municipalities by strengthening intersectoral collaboration between the health/social sector and urban planning sector on the topic of health equity. We are working on the common terms for health equity and each community has made progress in some way. (the Netherlands)
- The Working team for the analysis and assessment of the impact of policies on social inequities in health has been established. The brief guidance supporting the developing and evaluating of public policies. (Poland)
- Development of the National Health Plan 2021-2030. (Portugal)
- Community centers help the vulnerable population (Romania)
- Developed a health equity reporting platform (Slovenia)
- We have developed an adapted tool for HIA of local policies, a checklist tool was drafted and a pilot study involving 6 different municipalities was carried out. (Spain/Valencia)
- Tested and tailored tools (e.g. SIFT Tool, Sustainable Improvement for Teams, Be the Change – campaign) for wider dissemination, which are now freely available on the Hub website. The Literature Review was an important enabler in helping public services embed the welsh sustainable development legislation. (Wales)

Some main learnings

> **Example Wales/UK**:
> Key area of learning is the practical benefits that tools and resources can have to assist policy makers to embed sustainable development principles into their work. We will continue to use the experience of our implementation action to work within the health sector and other partners to embed the delivery and maximise our work to attain the well-being goals of the Well-being of Future Generations (Wales) Act 2015 across all relevant public bodies.

Use the HI metric (and situation analysis) as the more powerful metric to facilitate communication between different policy sectors, provide up-to-date evidence-based information and good examples.

Make it practical. Help with a clear understanding of what it is (reducing HI), but also HOW to do this. Evidence support and on-going guidance for institutions responsible for planning and implementation. Propose policies that reduce health inequalities and can be implemented in practice.

Don’t work isolated but interconnected with other existing policies; integrate equity focusing to existing work.

Collaboration between different sectors is possible and valuable. It has great potential to initiate and implement long-term programs and short-term activities that can make positive changes to Health Equity in all Policies-Governance.

Support: the coaching from Institute of Hygiene side is valuable and needed.

5. National integration and sustainability

It seems that many parts of implemented actions continue after JAHEE. Many broad-based working groups were established, and health action plans and guidance were developed, and situation analyses made. The learnings as well as now existing plans and guidance will be implemented. All countries have plans how to disseminate the results achieved. Also, many tools were tested and taken into use. In addition, many new ideas of further actions and policies were born. Although not all countries could implement their actions during JAHEE, they gained still learnings and ideas what should be done next in their countries.

Continuing issues

- Maintain, improve and enlarge the established working groups
    - The animation of the network of ambassadors (Belgium)
    - A new subdivision was established under the CIPH - Division for Health Inequality Reduction (Croatia)
    - In the future the interinstitutional coordination working group exists and continues (Italy)
    - Next meetings with the Working Group are considered (Poland)

- Use of the developed health action plans, guidance and strategies/degree
    - Putting the action across sectors into practice: the rewritten degree of the prevention and health promotion. (Belgium/Walloon)
    - Putting the action across sectors into practice as we see this happening in Utrecht after the session with the scientists. (the Netherlands)
    - The regional welfare report was completed in both coached regions. Joint preparatory work and an extensive approval procedure provide a good opportunity for implementation. (Finland)
    - The Municipal Action Plan on HEiAP of Stara Zagora is a medium-term plan (2021-2025) and in this period its implementation will continue. (Bulgaria)
    - To provide a policy guide that is addressed to different vulnerable groups of women. (Greece)
    - Improve and establish new OHS delivery model making it part of Lithuanian Occupational Health Policy. (Lithuania)
    - We have already planned further joint piloting of the Platform. (Slovenia)

> **Example Portugal**:
> Development and implementation of the National Health Plan (NHP) 2021-2030, which is a value-based and action-oriented strategic population health planning instrument, designed to be implemented not only at the national but also at the regional and local levels. It takes a broad view of health, with a particular focus on sustainable health, and is very extensive in its scope and coverage. All Ministries are represented in the NHP Stakeholders' Commission.

- Adopting tested tools in practice, the results/work done will be compiled
    - We will develop further our work by promoting the use of HIAE and by collecting the ongoing HIAEs (Belgium)
    - In the future the interinstitutional coordination working group aims to follow on the workplan of dissemination of the report on HEA of the pandemic in order to inform better those developing the RRP projects with health equity lens. (Italy)

> **Example Spain/Valencia**:
> Health Equity Impact Assessment (HEIA) at local level through the adaptation of "HIA tool Fem Salut?" (Are we doing health?) program, that is addressed to assess the heath impact of regional policies, to be used at local level.

- Dissemination of learnings and measures/policies to other regions, municipalities and nation wide
    - The promotion of the HiAE to the other Federal administrations (Belgium)
    - The policy document on HEiAP in Stara Zagora could be a model for other Bulgarian municipalities to develop their own HEiAP policies on local level. (Bulgaria)
    - The project's experiences will be shared in national network meetings of regional welfare coordinators, allowing all regional welfare coordinators to apply the results of the project in their own work and to exchange experiences on the challenges of reducing inequality in their work. (Finland)
    - In the near future, involving participants in more actions in the future and fill the gaps that exist in the field of health inequalities. (Greece)
    - We are going to disseminate the Italian results through an ad hoc policy brief that will summarize for the public and the stakeholders the main results and progress achieved in the Joint Action. (Italy)
    - Expand number of OH services delivered via Public Health Bureaus. (Lithuania)
    - Lessons we learn from this implementation action will be disseminated across other municipalities in the Netherlands. We will also share our experiences with the ministries. (the Netherlands)
    - The dissemination of the assessment results on the implemention of community centres in the Center and West of the country will lead to the extension of the policy nationwide by succesively implementing community centers in other regions. (Romania)
    - The dissemination plans are comprehensively prepared. We are starting the dissemination in Slovene Parliament in October this year. (Slovenia)
    - We are going to participated in a national conference in order to disseminate the guide and how to use it. (Spain/Valencia)
    - We will continue to use the experience of our implementation action to work within the health sector and other partners to embed the delivery and maximise our work to attain the well-being goals of the Well-being of Future Generations Act 2015 across all relevant public bodies. (Wales)

- Utilizing situation analysis and research
    - The evaluation and in function of this evaluation the revision of the HIAE. (Belgium)
    - The knowledge sessions with the scientists will probably be repeated, focussing on more rural areas, with other national institutes. (the Netherlands)
    - We are planning joint seminars and exchange of knowledge among the participating institutions. (Slovenia)

New ideas of further actions and policies

The implementation phase encouraged those participating and new ideas what should be done next in the country were born. Also, those countries that couldn't finish their implementation know now what to do next. Worth mentioning here is that the below notions are each countries'/participants' own ideas and not given from someone outside.

- Improvement the implementation of Health in All Policies in other sectors than health and social care. As a process this would require a creation of a specific framework and many stakeholders involved. The data that are available in Croatia are relevant at the national/regional level and have a great potential to be improved in context of the HI. A certain changes and improvements not only in the collection of the data but rather in the analysis and creation of the HI report-making system are needed in Croatia. (Croatia)
- We hope that we can create a helpdesk on HIAE on a permanent base and that we will get the commitment of the other Federal departments to do HIAE's. (Belgium)
- The production of regional inequality data at national level should be continued uninterrupted in order to maintain the possibility for regions to develop inequalities. An element describing inequality should be added to existing data collections, so that the phenomenon of inequality becomes more visible in different services, lifestyles or values. (Finland)
- Spreading the results in our country we hope that our national coordinator will contribute our action to become part of our national strategic plan for public health in order to bridge the provision of primary health care with public health actions and eliminate social inequalities and provide access to health care services. We think that there should be established a department with the only objective to help different vulnerable groups in order to eliminate health inequalities and to guide organizations in achieving this. (Greece)
- In the future the interinstitutional coordination working group aims to follow on the workplan of dissemination of the report on HEA of the pandemic in order to inform better those developing the RRP projects with health equity lens. In this context we expect that a few non health sector may be engaged by the working group such as been done with the committee on reform of pension age. (Italy)
- Make our Health ministry the lead in a national health equity approach, combining a variety of funds to make it easier for municipalities to work intersectorally. (the Netherlands)
- The engagement of the stake-holders beyond health sector shall be reinforced through systematic capacity builidng and advocacy at all levels – from high level decision makers to specialists/desk officers. Further interviews as well as next meetings with the Working Group are considered – main goal is to better map and understand their needs. (Poland)

- With the development of the NHP 2021 - 2030, we expect to have a roadmap and the stakeholders' explicit commitment to attain sustainable health, which also implies addressing health inequalities, especially at the subnational/local level. (Portugal)
- Based on the past and current collaboration with local authorities new other actions related to Health Equity in All Policies – Governance, could be implemented in the future. (Romania)
- We are organizing workshops with municipalities in order to train municipal technicians and public health practitioners to use the developed tool. (Spain/Valencia)
- We will look to further enhance the policy and legislative context supporting work to tackle health inequalities by delivering regulations on Health Impact Assessments (HIA) to place legal requirements on specified public bodies in Wales to carry out HIAs in prescribed circumstances, and to provide support for the bodies in carrying out HIAs. As we emerge from the pandemic, we will also work to ensure that action on health equity is embedded across our recovery from the pandemic. (Wales)

Countries that could not implement their actions; Estonia, Slovakia and Spain/Andalucia

- Estonia: There is new public health development plan for 2020-2030 and inequity is more detailed brought out. At present we are updating county health overviews which are input for renewing county health and wellbeing profiles.
- Slovakia: We just had again experience how difficult is to implement action which is connected to the political will. Next, we must improve our advocacy approaches. There is a window of opportunity still to break the institutional silos.
- Spain/Andalucia:
    - Continuing the development of the equity and social determinants of health surveillance, articulated in the Public Health Surveillance.
    - Advancing in the efficient incorporation of the existing regulations on Health Equity Impact Assessment in policies, plans and programs
    - Moving towards Health and Equity in All Policies, advancing in consolidated structures and procedures for intersectoral action.
    - The equity approach and intersectoral action at local level will continue to be strengthened in the joint work with local entities, as well as advancing in the evaluation of health promotion with an equity approach at local level.
    - Integration of an equity focus will be strengthened by the availability of a comprehensive guide and tools to analyse equity and SDH approach of health interventions.

6. Reflections and recommendations

In the WP9 among participating countries and representatives there was common and shared objective. All participants recognized the need for HEiAP & governance and reducing HI. However, the political atmosphere of the countries varies, as well as participating people were from very different positions in different organisations and their changes to impact in their own country varied. In general, success of the IA in WP9 depends on

a. general possibilities (political atmosphere) for improving health inequality issues in the country (at what level) and
b. the status and position of the country representative, her/his understanding on health inequalities, and his/her contacts/activity for the relevant stakeholders.

However, this Joint Action helped keep focus on health inequalities. In addition WP9 actions created, strengthened and established broad based collaboration in the European countries. Also, HI could be raised to political agenda along with JAHEE.

In some countries link between HI and sustainable development were found e.g. Belgium, Italy, Poland and Wales and could be useful and possible in other countries too.

Reasons not to have success in a) generating interest/commitment, b) in strengthening MS capacity in tackling health inequalities as well as c) in terms of HiAP implementation, appeared in some participating countries.

a) generating interest/commitment in tackling health inequalities:
   - Other interests (Covid-19) took attention.
   - Political atmosphere changed along new governance period and health inequalities was not the case and no priority was given to that.

b) strengthening MS capacity
   - lack of commitment/understanding/political will

c) success in terms of HiAP implementation
   - lack of understanding (possibilities?) what HiAP requires
   - lack of understanding about benefits of HiAP to other sectors

Some IA's succeeded to build cross-sectoral collaboration to other ministries or at regional and local levels to other sectors. However, some IA's started the collaboration from the health sector, and they should broaden that to other sectors in the future. All countries would benefit of strengthening further the cross-sectoral collaboration to other sectors.

The WP9 objectives were achieved quite well. The IA's in WP9 focused on governance and Health and Equity in All Policies at local, regional and national levels by building and strengthening broad-based collaboration. Some IA's could also involve citizens into the implementation.

As described before in this report actions that were implemented during JAHEE WP9 succeeded to

- generate interest and commitment in tackling HI and their causes,
- strengthen MSs capacity, abilities and commitment to develop and implement concrete policy actions to tackle HI and
- develop and apply a HiAP approach.

Based on the experiences during the implementation within WP9 many started actions seem to continue, the developed plans and guidance exist and will be implemented and can be disseminated. Also many new ideas of further actions and policies were born.

In addition, the gained experience about cross-sectoral collaboration remains for those who participated; now they have better understanding what works in their country, what needs to be taken into account, how to convince different parties, who should be involved, etc.

We also believe that the participants got peer support from other participants and confirmation that HI can and must be reduced. Many of them can use these learnings in the future as well.

RECOMMENDATIONS

The WP9 recommendations are based on learnings from the Implementation Actions carried out during the JAHEE period.

An extended online meeting of JAHEE work package 9 (WP9) was held on Monday 20nd September 2021. The aim of this meeting/workshop was to formulate the WP9 recommendations together. 14 of 17 partner countries of WP9 were present in the meeting. All together there were 21 participants. In addition, all the WP9 participants had possibility to give comments to the draft recommendations via email after this meeting. The idea behind the WP9 recommendations is "How to promote taking health equity into account in Health in All Policies and governance".

Recommendation 1
Use data and evidence to increase understanding about Health Inequalities (HI), Health Equity (HE) and social determinants of health
Provide up-to-date data and evidence-based information and good examples in the early stages of establishing cross-sectoral collaboration. It helps the potential partners to recognize their role in HEiAP.

- Confirm that relevant data from HI is produced and available from national, regional and local level. Both quantative and qualitative data (also from vulnerable groups and communities) is needed. Data from different sectors and linkages between them are needed.
- Make and utilize situation analysis on HI and HE. Analysing regional/local comparable data is the first step to recognize HI in a country.
- A minimun dataset of HI indicators is needed for HiAP purposes.
- Establish a national multidisciplinary platform (integrating data from different sectors) for assessing the impact of policy measures on health inequalities.
- Focus on equity when assessing the impact of policy measures.

Recommendation 2
Start, establish and maintain broad based collaboration for tackling Health Inequalities
Intersectoral working is necessary to tackle health inequalities to be able to strengthen commitment, build trust to each other and set common objectives.

- Build partnerships with different sectors and organizations in order to gain know/how and future collaboration. Both horizontal (cross-sectoral) and vertical (national-regional-local incl. citizens/communities) collaboration is needed. NGOs are also a powerful tool and need to be involved.
- Involve policy actors. Political commitment is key to support this process (Notice: the political actors are more receptive during electoral campaign). Also a link between authorities and policy makers is needed.
- Put all kind of authorities work together. A responsible party can be set together to facilitate the work. Health sector should take at least an advocacy role.

Recommendation 3

Build capacity on Health Inequalities and make it practical

Help the partners with a clear understanding of what reducing HI means, but also how to do it by providing concrete tools.

- Do regular mapping of the capacity and needs of entities/authorities responsible for planning and implementation of national/regional/local public policies having impact on health.
- Propose policies and measures that reduce health inequalities. Provide concrete tools (e.g. HIA, checklists) that different sectors can take to reduce inequality.
- Integrate to existing work by working interconnected with other existing policies. Integrate equity focus into the required procedures.
- Review and establish new governance mechanisms (if needed) in public health at national, regional and local level.

Recommendation 4

Be prepared to use windows of opportunities and recognize strategic opportunities for reducing Health Inequalities

- Scan and recognize windows of opportunities. E.g. COVID-19 pandemic forced us all to put public health in the center of all policies. It was an exceptional opportunity, but now there is a need to enlarge the view for other health and social policies.
- Be ready to react/use windows of opportunities when available.
- Recognize also strategic opportunities. Link HE and HI with other developments, such as climate issues or poverty, and show the link, create bonds when the link is there and work jointly.

References and links

Policy framework for action (PFA) of JAHEE WP9 is available at (WP9 PFA_final):
https://www.wrike.com/workspace.htm?acc=133505#path=folder&id=253301295&c=files&p=243716632&a=133505&so=10&bso=10&sd=1&f=status%3Dactive%26assigned%3DfF4Nkjv9UWi5%26between%3Dtoday%26keyword%3Doverdue&st=nt-1

The Country Assessments are available at:
https://www.wrike.com/workspace.htm?acc=133505#path=folder&id=253301296&p=243716632&a=133505&c=files&so=10&bso=10&sd=1&f=assigned%3DfF4Nkjv9UWi5%26status%3Dactive%26between%3Dtoday%252Coverdue&st=nt-1

Final reports from IA's in each country (attached in this report)

ANNEX: Reports on actions from partner countries